Gender Violence 2009 Report

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Gender Violence
2009 Report

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Presentation

> 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).

In the Commission's Communication to the European Council and Parliament, which establishes a framework program of fundamental rights and justice for the period 2007-2013 (COM[2005]0122, combating violence against women, children and young people, plays an important role as part of the endeavour to create a true space of freedom, security and justice.

Not only is male violence against women a criminal offense but also a social issue. Violence against women is in itself a general violation of human rights –the right to life, to freedom, to physical and mental integrity– and represents an obstacle to the development of a democratic society.

Violence against women may affect women of all ages, regardless of their education, their income or social position. In 2005, studies conducted on a large scale in Sweden, Germany and Finland on this phenomenon extension show that at least 30-35 % of women with ages ranging between 16 and 67 have, on occasion, been victims of physical or sexual violence and if psychological violence is to be taken into account figures reach 45-50 %.

The types of violence affecting women may vary in accordance with cultural traditions or ethnic or social origin. Genital mutilation and so called "honour crimes", as well as forced marriages are also part of the reality of women who live in our country and in Europe.

Men's violence against women is a factor significantly influencing women and young girls' becoming victims of trafficking in human beings for sexual purposes or otherwise and of prostitution. Investigation reveals that 65 to 90 % of prostituted women were the object of sexual assault during childhood or afterwards.

In November 2004, the Commission against Gender Violence was created within the National Health System's Inter-Territorial Council. Its fundamental aim was giving technical support and orienting the planning of the Health Care measures established in Chapter III, Title I of Organic Act 1/2004 on Comprehensive Protection Measures against Gender Violence, where actions are envisaged in terms of awareness, prevention and detection of this problem in the Health Care field.

Developed by consensus and cooperation between Autonomous Communities (ACs) and the Ministry of Health, Social Policy and Equality, the Commission has been publishing its annual report since 2005, to present the basic lines of action and interventions that from the health services of the Autonomous Communities are being made to improve healthcare attendance for abused women and their children.

In 2007, the Common Protocol for the National Health System (NHS) was already providing common guidelines that enabled any healthcare professional to confront cases of violence specifically targeting women both in terms of healthcare attendance and follow-up as well as in prevention and early diagnosis.

The National Health System professionals' implementing, accepting and putting into practice the Protocol guidelines is the pivotal aim of all Plans and Training Programmes of Autonomous Communities' Health Services.

Systematic and normalised processing of all detected cases within the Health System, will allow us to better know the extent and profile of the abuse we are dealing with in our health centres and thus improve the quality of the care we provide.

Epidemiologic surveillance of detected cases as well as training of professionals are primary action lines aimed at improving the quality of care in the NHS. That is why in 2009, ACs were awarded grants totalling 4 million Euros (RD 924/2009)[1]. Additional funding was secured to

1 These are the Grant lines of the 2009 Gender Violence Strategy, according to RD 924/2009.

1st Training of Health Services' professionals following the Common Quality Standards and Educational Objectives approved by the Inter-Territorial Board of the National Health System in December 2007.

2nd Inclusion of Health Care Indicators of Gender Violence in the Portfolio of services, in management contracts or the like, as well as incorporation of the relevant variables for their being obtained and implemented in the digital history.

3rd Awareness of the fundamental lines of the Common Protocol for a Healthcare Response to Gender Violence among managers and officials of the administration and management of health services and health planning in their territories.

4th Intra-health-services coordination plans in each Autonomous Community for comprehensive healthcare attendance to gender violence (Mental Health, Primary and Specialty Care, Paediatrics-Family Medicine) and devising of coordination and monitoring of such care between the different healthcare attendance levels of Health Services in the National Health System.

5th Methodology and tools for evaluating healthcare interventions in gender violence matters: assessment of the implementation of the Common Protocol and professional training programmes.

provide healthcare attendance for the children of abused women or for the development and implementing of tools that may ensure action assessment as well as for the devising of inter-institutional cooperation and intra healthcare coordination formats.

In spite of the above-mentioned financial support we still do face important limitations as far as improving 17 ACs + Ingesa's healthcare information systems is concerned. It must be considered that adapting the said systems for their incorporating the necessary elements to enable implementing of the Common Protocol for a Healthcare intervention in all healthcare areas and regions of each AC has not been a reality until recently (the end of 2010) in most territories.

The present National Health System's 2009 Annual Report on Health Attendance to Gender Violence is the 5th Organic Act 1/2004 follow-up Annual Report on Gender Violence.

This report starts its first chapter by contributing a *2009 Analysis of the Situation*. To this purpose, it releases the 11 Epidemiologic Surveillance Indicators' most relevant results in what concerns magnitude of male violence cases detected in Primary Care (PC) and Specialty Care (SC). In addition, it studies in greater depth the distinctive character of abuse detected (type and cohabitation relationship with the perpetrator) and the most significant profile traits of women experiencing an abusive relationship (age, nationality and cases detected in pregnant women). The Analysis is additionally complemented with a description of the projects conducted in the ACs and Ingesa relating to the improvement of their healthcare-information-gathering systems.

In the second section of this first chapter, we have included an analysis of the training of professionals in gender violence related matters throughout 2009. We have addressed both the type of educational actions performed (Basic Courses, Awareness Activities and Other Educational Actions) as well as their coverage and the different territories' related specificity. In the same way, we have analysed the composition and character of both the learners and the educational corps following the Quality Standards the

6th Care Programmes for male abuse inflicted on most vulnerable women (immigrant women, disabled women and rural areas' women).

7th Health Action Programmes against gender violence targeting the daughters and sons of women who suffer gender violence.

8th Plans and programmes and experiences of best practices for coordinated action between health services and local government and civil society organisation (women's councils and associations) for dealing with women suffering male abuse, their children and persons in their care, from a health and psychosocial care perspective.

Inter-Territorial Council adopted in 2007 and taking into account the prior training background of the professionals integrating them both.

The second chapter of the Report describes the most significant actions ACs and Ingesa performed among all those undertaken for detecting and delivering care to gender violence victims in 2009. They chiefly consist of initiatives that concern the redesigning of healthcare information systems, development of specific services for dealing with male abuse in Primary Care, training of professionals, specific actions addressing especially vulnerable groups, actions' assessment, research and other initiatives relating for instance to the use of information new technologies.

The third and last chapter covers, as every year, a summary of activities conducted from the Inter-Territorial Council's Commission against Gender Violence, among which the work of the Technical Groups of Information Systems, Epidemiologic Surveillance and Training of Professionals deserve pointing out. A highlight is also the role of subsidies established by Royal Decree 924/2009, of May 29, which regulates the direct granting of subsidies to Autonomous Governments and Cities with Autonomy Status (CAS) like Ceuta and Melilla[2], for implementing the strategies of the National Health System.

2 Subsidies for Ceuta and Melilla are directly awarded to the Institute of Health Management *(Instituto de Gestión Sanitaria, Ingesa)* responsible for administering Health Care in these cities.

Analysis of the Situation

Cases Detected and Cared for in the Health Care Sector (2009)

From proposals drawn up and agreed within the Inter-Territorial Council's Commission against Gender Violence, of the National Health System (CISNS), *the Common Indicators for Information on Gender Violence (GV)* were agreed for a better knowledge of GV's extent, its consequences on women's health and its impact on the Health Care System.

These indicators were devised in compliance with the measures and actions established by *Organic Act 1/2004, December 28, on Measures for Comprehensive Protection against Gender Violence* applicable to Healthcare Services within the conceptual framework and intervention lines proposed for all Public Administrations in the National Plan for Awareness and Prevention of Gender Violence.

The aims these Indicators were devised with, follow:

- Facilitate the planning of health care to gender violence victims by knowing its extent and the particular circumstances of women suffering it.
- Promote improved quality and equity in the comprehensive healthcare attendance to gender-based violence by assessing the impact of actions heath authorities carry out, especially those relating to the Common Protocol.
- Promote collaboration and exchange of experiences and best practices among authorities involved in the healthcare attendance to women experiencing abuse.

For the drafting of this report the Technical Working Group, *Information Systems and Epidemiologic Surveillance of GV* in which all ACs and Ingesa (Ceuta and Melilla) are currently represented, has worked in the collection and analysis of the first 9 Common Indicators out of a total of 11 approved (Table 1).

Despite the efforts being made from the health services of all territories, to adapt existing healthcare information systems to include the variables needed for the devising of common indicators and computerise the Grievous Bodily Harm Report, (GBH R) there remains a duality of sources of information: Medical History (MH) and Grievous Bodily Harm Report (GBH R), for data collection.

Table 1. Common Indicators. Health Care for Victims of Male Abuse in the National Health System

Overall Objective	
To know the magnitude of male violence and its consequences in health and the Health System	
Specific Objectives	
• Facilitate the planning of healthcare attendance to gender-violence-affected women upon knowing its real extent and the particular circumstances of women suffering it • Promote improved quality and equity in comprehensive care to gender violence through assessing the impact of actions Health Authorities perform especially those listed in the Common Protocol • Promote collaboration and exchange of experiences and best practices among authorities involved in healthcare to abused women	
Common Indicators	
Magnitude	1. Cases detected in women aged 14 years or over per 100,000 2. Number of Grievous Bodily Harm Reports issued by Level of Care
By Level of Care and Source	3. Cases detected at Primary Care 4. Cases detected at Specialty Care
By Profile of Abuse	5. Cases detected per type of abuse 6. Cases detected as per duration of abuse 7. Cases detected as per cohabitation relation with the perpetrator
By Personal Profile of Abused Women	8. Cases detected per age 9. Cases detected per nationality 10. Cases detected as per occupational profile 11. Cases detected among pregnant women

* http://www.mspsi.gob.es:80/organizacion/sns/planCalidadSNS/pdf/equidad/A4ViolIndicadoresIng.pdf

Therefore, the Technical Working Group has had to develop during 2009 and early 2010, two forms of data collection taking into account the two main sources of information for data collection (see Annexes).

The Table 2 describes this duality of sources and the starting point for the collection of the first 9 common indicators in each AC and Ingesa (Ceuta and Melilla).

Besides duality of sources, ACs and Ingesa' Systems of computerised information are going through different stages of adaptation to incorporate variables, encode them and computerise the GBH Report; in fact, in some ACs the process of adaptation has not yet reached 100 % of their healthcare operative units.

It is also important to point out that this adaptation of the information systems to obtain the common indicators of GV is in general terms more advanced in Primary Care than in Specialty Care.

Table 2. Indicators of GV Obtained from Medical History and/or GBH Report in each AC and CAS

Autonomous Communities	GV Common Indicators Obtained from GBH Reports and/or Medical History										
	1	2	3	4	5	7	8a	8b	9a	9b	11
Andalusia	R		R	R							
Aragon	MH	MH	MH	MH	MH	MH	MH	MH	MH	MH	MH
Asturias	MH/R		MH/R	R	MH/R	R	MH/R	MH/R	MH[a]	MH[a]	R
Balearic Islands	MH/R		MH/R	MH/R	MH		MH/R	MH/R	MH/R	MH/R	
Canary Islands	MH/R	MH	MH/R	MH/R	MH/R		MH/R	MH/R	MH/R	MH/R	MH/R
Cantabria	MH	MH	MH								
Castile and Leon	MH	MH	MH				MH	MH	MH	MH	MH
Castile-La Mancha	MH/R	MH	MH/R	MH/R	MH	MH/R	MH/R	MH/R	MH	MH	MH
Catalonia[b]											
Community of Valencia	R		R	R	R	R	R	R	R	R	R
Extremadura	R		R	R							
Galicia[c]											
Madrid	MH		MH		MH	MH	MH	MH	MH	MH	
Murcia	R		R	R	R	R	R	R[b]	R		R
Navarre	MH		MH		MH	MH	MH	MH			
Basque Country	MH		MH	MH	MH	MH	MH	MH[c]			
La Rioja	MH	MH	MH	MH	MH	MH	MH	MH	MH	MH	MH
Ceuta	R		R	R	R	R	R	R	R		R
Melilla	R		R	R	R		R	R	R		

[a] These data have not been included in the analysis because the information on foreign population was not broken down by nationality.
[b] The information submitted could not be included in the analysis because it only comes from a minority of ACs.
[c] The information submitted has not been included in the analysis since it is not broken down according to the requirements for each one of the common indicators.

MH/R, Data from Medical History and GBH Report; MH, Data from Medical History; R, Data deriving from GBH Report.

Caption of Indicator Number
1. Cases detected in women aged 14 years or more per 100,000
2. Num. of GBHRs issued by each level of healthcare attendance
3. Cases detected in Primary Care
4. Cases detected in Specialty Care
5. Cases detected per type of abuse
7. Cases detected as per type of cohabitation relation with perpetrator
8.a Cases detected per Age (Percentage)
8.b Cases detected per Age (Rate)
9.a Cases detected as per Nationality (Percentage)
9.b Cases detected as per Nationality (Rate)
11. Cases detected in Pregnant Women

All the above circumstances are still hampering the obtaining of common indicators and thus the values they present for 2009 span a wide range of variability. The working group has hence decided to present the results obtained in the form of median and range (minimum-maximum) of values for cases detected at healthcare services, which as a whole integrate the National Health Service.

Despite all this, two indicators could not be analysed because of the low number of ACs that were in a position to meet their requirements:

- Indicator 6: Cases detected as per duration of abuse.
- Indicator 10: Cases detected as per occupational status.

Finally, it is important to remember that the data we here provide reflect only cases detected and attended to in healthcare services and by no means the number of women being brutalised in each AC. Each registered case corresponds exclusively to a woman over 14 years of age who in a healthcare service expresses for the first time that she is being abused and so the professional taking care of her registers it.

Extent of GV Cases Detected in the National Health System

All ACs and Ingesa[3] provided the necessary information for calculating rates of cases detected in the NHS, both in Primary Care (PC) as well as in Specialty Care (SC). For the calculus of rates from data obtained in Specialty Care, 13 ACs and Ingesa supplied information. As you can see in Table 3, the rate of GV cases detected in the National Health System varies in accordance with the source of information ranging between a median value of 93.7 cases per 100,000 women aged 14 or over (Medical History) and 115.5 cases (Grievous Bodily Harm Report).

Per healthcare level, the number of cases detected in PC is higher both when the source of information is the Medical History and when it is the GBH R. A possible explanation for this greater registering of cases in PC, apart from abused women's most direct access, may be the influence of a greater implementation of training programmes in Primary Care when compared to Specialty Care.

3 As seen in Table 2, Catalonia and Galicia's information did not qualify for inclusion in the analysis, hence, from now on, when referring to all ACs and Cities with Autonomy Status (CAS) in this Chapter, both will be excluded.

Table 3. Rates of Cases Detected Among Women Aged 14 or Over per 100,000, in General and per Level of Care (2009)

	Source: Medical History			Source: Grievous Bodily Harm Rep.		
	n	Median	Range (Min-Max)	*n*	Median	Range (Min-Max)
Rate of Cases Detected among women aged 14 or over per 100,000	11	93.7	2.3-330.2	10	115.5	37.2-352
Rate of GBH R issued per Level of Care	6	28.4	10.5-117.5	-	-	-
Rate of Cases Detected at Primary Care	11	68.7	0.2-330.2	10	76.7	20.1-272.9
Rate of Cases Detected at Specialty Care	6	8.7	0.2-100.9	10	40.4	1.9-212.3

n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

Again, when evaluating indicators, it is necessary to remember the existing variability among ACs, Ceuta and Melilla, in the degree of both professional training and of adaptation of health information systems to the specificity of epidemiologic recording of GV cases.

Indicator 2 relating to the rate of GBH Rs issued per healthcare attendance level, yielded, from the source on information *Medical History*, a median of 28.4 in the range between 10.5 and 117.5.

Main Patterns of GV Situations Detected and Registered in the National Health System

Type of Abuse

Most gender violence cases reported in the NHS during 2009 fit into a physical violence pattern. This might be due to healthcare professionals' greater easiness to detect this kind of abuse. Sexual violence was the least detected and registered type of abuse (Table 4). The percentage of cases of physical violence detected and registered in Primary Care (through Medical History or Grievous Bodily Harm Report) and in SC (through GBHR) exceeds 60 % of total cases.

Detecting and recording cases of physical violence turned out to be easier than identifying cases of sexual and psychological violence, both when the information came from medical records and when it did from GBHR as described in Table 4. The number of ACs that provided this particular sort of abuse differs depending on the source the information comes from: Medical History (9) or Grievous Bodily Harm Report (6).

Per healthcare level and concerning the detection and recording of psychological abuse, it emerges that in Specialty Care the percentage of registered cases is significantly higher, as per the information gathered in the Medical History.

Table 4. Proportion of Cases of Psychological, Sexual and Physical Abuse, Detected and Recorded in the NHS in 2009

Types of Detected Abuse (percentages)	Source: Medical History (*n* = 9)		Source: GBH Report (*n* = 6)	
	Median	Range (Min-Max)	Median	Range (Min-Max)
In the National Health System				
Physical Violence	60.6	16.7-89.2	83.2	47.7-90.9
Psychological Violence	16.6	1.2-99.7	25.0	1.2-69.7
Sexual Violence	4.2	0.1-34.2	4.8	3.1-5.8
In Primary Care				
Physical Violence	66.2	16.7-89.2	84.8	76.8-94.4
Psychological Violence	20.1	1.2-99.9	37.6	5.6-69.8
Sexual Violence	3.2	0.1-34.5	2.6	2.1-3.3
In Specialty Care				
Physical Violence	50.0	3.7-85.0	88.2	47.5-97.6
Psychological Violence	51.6	8.3-96.9	11.8	2.4-69.6
Sexual Violence	20.0	3.3-50.0	11.0	5.6-13.3

n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

Cohabitation Relation with Perpetrator

Another feature of gender abuse is the cohabitation relation with the abuser (Indicator 7). In this sense, it is recalled that the Indicators System is not limited to violence of intimate partner or former partner but that it covers all possible manifestations of gender violence.

As per results shown in Table 5 and in terms of cohabitation relation, current intimate partner or ex-partner (husband, boyfriend, fiancé…) account for the highest proportion of cases detected and recorded. This trend applies equally in both sources of information: medical history and GBHR.

Manifestations of gender abuse known or unknown men perpetrated, were detected or recorded in the various health services both through Medical History and to a lesser extent through Bodily Harm Report (Table 5).

Table 5. Proportion of Cases of Gender Abuse Detected and Recorded in the NHS as per Cohabitation Relation with the Perpetrator in 2009

Type of Abuser (percentages)	Source: Medical History (*n* = 6)		Source: GBH Report (*n* = 5)	
	Median	Range (Min-Max)	Median	Range (Min-Max)
In the National Health System				
Present Intimate Partner	57.1	30.0-92.3	72.7	70.0-84.5
Ex-partner	7.7	3.0-11.4	14.8	9.5-15.5
Father	1.1	0.9-1.3	1.2	0.6-2.7
Brother	2.5	2.0-2.6	2.4	2.0-3.3
Outsider / Unacquainted / Man Outside the family	2.0	0.9-3.0	3.8	1.2-6.4
In Primary Care				
Present Intimate Partner	61.7	30.0-95.2	73.0	64.3-91.0
Ex Partner	7.2	1.6-11.1	9.0	5.6-14.8
Father	1.6	1.3-1.9	1.8	0.8-2.8
Brother	1.2	0.0-2.5	4.1	1.7-11.1
Outsider / Unacquainted / Man Outside the family	-	-	3.4	3.4-3.4*
In Specialty Care				
Present Intimate Partner	76.4	36.7-81.3	71.8	63.2-78.0
Ex Partner	11.7	3.7-18.8	15.1	10.6-22.0
Father	-	-	2.0	1.5-2.5
Brother	3.7	2.5-5.0	2.1	1.5-2.8
Outsider / Unacquainted / Man Outside the family	2.7	1.7-3.7	7.4	1.5-13.2

*For this case, *n* equals 1.
n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

Profile of Women who for the First Time, in the National Health System, admit being Experiencing a Situation of Abuse

Age

From Medical History records, a total of 9 ACs registered rates of gender violence rising above 100 cases per 100,000 women of ages ranging between 20 and 44 years. From Grievous Bodily Harm Report records, 7 ACs registered rates of above 100 cases per 100,000 women aged 20 to 39 years (Table 6).

Per healthcare level, registered rates showed Primary Care services' greater ability in gathering data, both through medical history as well

as through bodily harm report. Something to highlight in Table 6, is the proportion of women aged 50 to 54 in Specialty Care as per data deriving from Medical History, since they account for the highest percentage of cases detected for this age and through this source of information. There is another related fact to highlight too: it reflects a reality that was not detected or recorded at Primary Care, either through the Medical History or the GBH Report.

Table 6. GV Cases Detected and Recorded in the NHS as per Women's Age, in 2009 (Rate per 100,000)

Detected Cases' Age (rate)	Source: Medical History (*n* = 9)		Source: GBH Report (*n* = 7)	
	Median	Range (Min-Max)	Median	Range (Min-Max)
In the National Health System				
14-19	99.9	16.4-582.8	91.1	4.5-230.6
20-24	171.5	3.0-724.2	167.1	65.7-580.3
25-29	140.1	2.2-778.2	167.5	60.3-1,059.2
30-34	169.9	5.9-534.9	160.6	53.8-656.9
35-39	171.1	4.2-415.8	133.7	51.7-405.6
40-44	140.7	2.3-362.5	89.4	40.2-447.2
45-49	91.4	5.1-248.3	73.1	26.9-169.1
50-54	88.1	9.3-145.1	38.8	20.4-213.6
55-59	63.6	13.1-133.6	38.4	10.3-228.8
60-64	53.1	10.9-152.5	19.8	6.3-212.8
65-69	35.5	4.6-161.3	10.0	7.1-72.0
70 and over	30.3	0.6-80.9	5.7	4.6-28.5
In Primary Care				
14-19	28.8	5.7-582.8	44.4	3.0-150.8
20-24	128.9	8.1-724.2	177.6	30.6-435.2
25-29	102.2	4.4-778.2	167.1	26.2-745.4
30-34	144.3	11.2-534.9	168.7	29.9-474.5
35-39	170.2	19.4-415.8	125.7	29.6-331.9
40-44	119.1	11.8-362.5	108.5	26.4-301.2
45-49	100.5	8.3-248.3	77.6	20.6-169.1
50-54	83.9	4.6-145.1	42.7	11.9-75.4
55-59	64.6	5.2-133.6	36.2	8.2-228.8
60-64	5.3	10.9-152.5	18.0	4.9-32.7
65-69	68.9	9.9-161.3	9.2	2.4-26.8
70 and over	49.9	8.4-80.9	10.2	3.4-38.2

In Specialty Care				
14-19	11.4	1.5-186.4	3.5	0.0-197.7
20-24	13.1	3.0-335.2	31.6	5.9-355.1
25-29	25.1	2.2-309.1	33.2	6.5-564.2
30-34	11.9	1.1-171.8	29.3	2.0-326.8
35-39	13.4	4.2-168.4	26.7	2.1-173.1
40-44	11.3	2.3-145.8	16.2	2.3-309.6
45-49	5.7	4.1-42.7	12.9	4.4-72.1
50-54	31.7	4.6-58.8	11.2	3.1-170.9
55-59	7.9	4.1-11.6	8.1	2.1-57.4
60-64	6.1	0.0-12.1	4.2	1.4-65.1
65-69	3.3	2.4-14.7	4.8	4.2-72.0
70 and over	2.5	0.6-5.2	3.9	2.3-5.5

n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

Nationality

When considering the nationality of brutalised women cases registered either in Medical History or in GBH Report, it emerges in the first place that foreign women registered the highest rates.

Among nationalities, Andean[4] women featured prominently in GBH Reports where their rates were higher than other nationalities'.

Cases of abused women from impoverished countries' figures exceeded those of women from western countries.

These trends did not exhibit important differences at Primary Care registers, regardless of the source of information (Medical History or GBH Report). However, in Specialty Care and according to data issued from Medical Histories, Moroccan women account for the highest rates, while when the source is GBH Reports, Rumanian women cases run highest (Table 7).

Pregnant women

Concerning women suffering abuse and who were detected and registered in the NHS during their pregnancy, results obtained in some ACs, very limited, suggest that registering took place principally in Primary Care services through the Medical History. No conclusions may be drawn from resulting data considering the limited number of ACs ($n=5$) that were able to register this aspect in 2009 (Table 8).

4 Women nationals of some of these countries: Peru, Ecuador, Colombia and Bolivia.

Table 7. GV Cases Detected and Recorded in the NHS, as per Nationality, in 2009 (Rate per 100,000)

Nationality; Detected Cases (rate)	Source: Medical History (*n* = 8)		Source: GBH Report (*n* = 3)	
	Median	Range (Min-Max)	Median	Range (Min-Max)
In the National Health System				
Spaniards	54.5	1.6-132.8	47.4	27.0-72.4
Rumanians	138.7	28.5-351.7	144.9	144.4-145.5
Andeans	449.1	6.5-1,271.7	825.8	517.2-1,134.4
Moroccans	381.9	66.7-766.5	103.9	54.5-153.3
Other Nationalities (Developing Countries)	213.8	4.3-571.8	211.6	179.1-244.1
Other Nationalities (Developed Countries)	128.4	4.0-451.1	70.9	54.6-87.2
In Primary Care				
Spaniards	54.5	7.4-132.8	45.5	20.0-72.4
Rumanians	128.3	8.2-212.7	164.5	124.7-144.4
Andeans	254.3	19.6-1,265.3	825.8	517.2-1,134.4
Moroccans	137.7	22.6-694.6	95.4	54.5-136.3
Other Nationalities (Developing Countries)	149.0	24.6-571.8	211.6	179.1-244.1
Other Nationalities (Developed Countries)	49.2	0.0-454.1	70.9	54.6-87.2
In Specialty Care				
Spaniards	5.3	1.6-38.6	4.9	1.9-8.0
Rumanians	20.4	14.8-351.7	20.8	20.8-20.8*
Andeans	23.3	6.5-1,017.3	-	-
Moroccans	71.9	67.8-550.7	17.0	17.0-17.0*
Other Nationalities (Developing Countries)	31.5	4.3-425.8	-	-
Other Nationalities (Developed Countries)	24.2	2.0-200.9	-	-

*For this case, *n* equals 1.
n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

Table 8. Cases of Abuse Detected and Registered in the NHS, in 2009, as per Pregnancy Stage (Rate per 100,000 Births)

	Source: Medical History (*n* = 5)		Source: GBH Report (*n* = 5)	
Pregnant Women; Cases Detected (rate)	Median	Range (Min-Max)	Median	Range (Min-Max)
In the Health Sector	128.9	7.3-343.5	3.4	1.4-4.7
In Primary Care	154.6	28.4-338.6	1.8	1.5-8.3
In Specialty Care	6.1	4.3-255.8	3.3	0.8-7.7

n refers to the number of ACs that were able to provide these data from each primary source (Medical History of Grievous Bodily Harm Report [GBHR]).

By way of conclusion: Strengths and Aspects to be Improved in the Gathering of Indicators for Epidemiologic Surveillance of GV

- The analysis of the situation of GV in 2009 was possible thanks to the cooperation of all ACs, that unanimously contributed information relating to the first 9 Common Indicators of the NHS.
- We must highlight the effort some ACs made which furnished information on GV common indicators by inquiring into the two proposed sources of information for analysing the situation of GV in 2009.
- The low representativeness of the information Autonomous Communities supplied concerning indicators 5 and 7 from the GBH Report and indicators 2 and 4 from the Medical History, limits the assessment of the situation of these aspects of gender violence in the Spanish setting.
- We must point out the representativeness of the gathered outcome for indicators 1 and 3, both from GBH Report and from Medical History. As it is also the case for Indicator 5 from the GBH Report and Indicator 8.a from the Medical History.
- In the short and medium run, it is a first priority in all ACs to progress in the collection of information that may enable an assessment of the situation of GV detected in the Health Sector in all aspects reflected in GV Common Indicators.

Projects for the Collection of Epidemiological Indicators in Autonomous Communities, Developed in 2009

To follow, and by way of complementary information to the analysis of the situation conducted, we present the list of projects (Table 9) that ACs submitted in 2009 for their financing through Subsidies. These would be regulated by Royal Decree 924/2009, of 29 May, for Direct Granting of Subsidies to Autonomous Communities and the cities of Ceuta and Melilla through the *Instituto de Gestión Sanitaria* (Institute for Healthcare Management), aiming to implement the National Health System's Strategies. Among them, the Strategy for Gender Violence Prevention, among whose lines, one referred to the *Inclusion of Healthcare indicators of Gender Violence in the Services Portfolio or in Management Contracts or the like, as well as inclusion of the necessary variables for their being obtained and implemented in the computerised Medical History.*

Most of the projects presented, head towards the designing of a unified system for data collection that may allow reacting to the information common indicators of gender violence in the Healthcare sphere, approved by the ICNHS *(CISNS)* provided.

Programmed activities in the said projects have been aimed at incorporating the indicators relating to detection and attention to GV, into the computerised Medical History[5] (Andalusia, Aragon, Asturias, Castile and Leon, Extremadura, Galicia, Madrid and La Rioja) and at computerising and exploiting data drawn for the GBH Report (Andalusia, Aragon, Asturias and La Rioja).

Other projects have been devoted to incorporating the Grievous Bodily Harm Report and the notification to the court, into the computerised Medical History (Andalusia, Aragon, Asturias, Castile-La Mancha, Castile and Leon, Murcia and La Rioja).

Table 9. Projects under Funding Line 2: Collection of Epidemiological Indicators (2009)

AC	Project Name
Andalusia	Project for action, from within the health field, to combat violence against women
	Improve professionals' screening performance
	Improve knowledge of the extent and profiles of GV against women in Andalusia relying on Common Indicators (evaluative research from Grievous Bodily Harm Reports)
Aragon	Design of a personalised plan for collecting clinical and healthcare attendance information within the framework of Primary Care's Medical History of Aragon Health System
	Incorporation in hospital Emergency departments of identification of women likely to be victims of gender violence
	Exploitation of Primary Care Indicators
	District coordination procedures in the prevention of gender violence
Asturias	Promotion and improvement of healthcare attendance to women suffering abuse in Asturias
Balearic Islands	Evaluation of specialty healthcare attendance for addressing gender violence
	Evaluation of Primary Care's dealing with gender violence in Ibiza and Formentera's Health Area
Canary Islands	Implementation of the strategy for addressing GV
Cantabria	Implementation of the strategy for addressing GV

5 The Medical History is called different names in the different ACs: OMI-AP (Aragon, Asturias and Murcia), Selene (La Rioja) or Turriano-AP (Castile-La Mancha).

Castile and Leon	Project implementation and development of the service for healthcare attendance to GV victims in the Health Services of Castile and Leon and training and support strategies for professionals and of interprofessional and intersectoral coordination
	Care Programme in Psychiatric Care Operational Devices for women who are of have been in a situation of abuse and for their sons and daughters
Castile-la Mancha	Awareness and training strategy for health professionals, for dealing with women victims of GV, applying common quality standards and attaining educational objectives, the NHS's Inter-Territorial Council approved in December 2007
Catalonia	Implementation of recommendations of the Strategy for Prevention of GV
Extremadura	Epidemiologic Surveillance of GV in Extremadura
	Awareness of Management Commissions of Health Areas
Galicia	Prevention of GV
Madrid	Evolution of the extent of intimate partner abuse inflicted to women, its impact on health and response from the health sphere targeting general population of women
	Indicators of GV in Primary Care
	Detection of victims of GV upon hospital admittance for healthcare attendance to delivery in Puerta de Hierro Hospital, VI Health Care Area, Madrid Community
Murcia	Comprehensive Training in GV Plan in the Murcia Region
	Project for an integrated intervention against gender violence in healthcare services of the Murcia Region
	Action Guidelines for dealing with Gender Violence in Healthcare services of the Region of Murcia, issued by the Ministry of Health and Social Policy
	Promotion of actions oriented to early detection, healthcare attendance and rehabilitation of brutalised women in the Murcia Region
Basque Country	Prevention of GV
	Research: Domestic Violence burden in the districts of High and Low Deba and Goierri
La Rioja	Designing and computerising the GBH R and Medical report of GV cases detected on the platform of electronic medical records (Selene)
Ceuta	Prevention of GV
	Implementation of the Strategy for Addressing GV

In some ACs' Portfolios or Programme Contracts, specific objectives relating to the detection and attention to GV, have been included.

Likewise, the putting into practise of actions to facilitate implementation of the Common Protocol for a Healthcare Response to Gender Violence, continues (Andalusia, Asturias, Castile-La Mancha, Castile and Leon and Murcia) or the early detection of situations of abuse through validated tools like the WAST (Woman Abuse Screening Tool) Questionnaire, in the

Canary Islands. Existing medical records have been revised and evaluated to adjust to the new needs for data collection.

Some of these projects funded in 2009 are being implemented and others have already been successfully implemented. Some ACs reported that from 2010 onwards a full analysis of the magnitude of cases detected in health services would be possible both in the PC sphere as in SC (Andalusia, Aragon, Asturias, Balearic Islands, Castile and Leon and Madrid).

Professionals' Training in the National Health System (2009)

The National Plan for Awareness and Prevention of Gender Violence (2006) proposes among its priority objectives in the health sphere the training of health professionals in GV matters applying common quality standards and indicators for evaluating the training.

In 2007, the Inter-Territorial Council of the National Health System adopted the Common Quality Standards for Basic Training of its Healthcare Professionals. These Standards state that:

- All health workers in the fields of Management, Administration and Care, directly involved in providing health services to women, will be adequately trained.
- The contents of the training will be suited to the working skills required for their particular job, in order to provide women with quality care.
- The academic team will be multidisciplinary, made up of experts in the area of gender violence and coordinated among them to deliver homogeneous messages and promote group work.
- Any training action will be considered a training *basic course* when its duration equals or exceeds 20 teaching hours. It will be considered an *awareness activity* when its duration is below 10 hours.
- Training will be conducted at a nearby and accessible place with adequate conditions of infrastructure and equipment to provide a participative kind of training.
- There will be a reference figure in health services, which will know, coordinate, facilitate and ensure the planning, implementation and evaluation of the training plan.
- Teaching hours received, will be accredited to the personnel of health services attending these courses for their using them in their careers in accordance with current legislation.
- There will be mechanisms to facilitate attendance to educational actions to all above-mentioned personnel.

This is the second Annual Report that includes an assessment of this training of professionals.

It should be highlighted that through *Royal Decree 924/2009, of 29 of May*, direct granting of subsidies to Autonomous Communities and the Cities with Autonomy Status of Ceuta and Melilla would be regulated through the Institute of Healthcare Management (Ingesa) for implementation of the National Health System strategies, among them the Strategy for Prevention of Gender Violence. This strategy envisaged 8 main subsidy lines, one of which concerned training programmes for professional at health services. This has been the funding line attracting the greatest number of projects for the whole Strategy (see Subsidies for 2009 on page 97 of this Report).

The information contained in this chapter about training is structured into two sections: The first of them is a *descriptive* one where the different *initiatives about training in gender violence* are detailed; they are conducted by ACs and Ingesa and grouped under the following subsections:

- New educational formats used for training.
- Specific aspects not included in training.
- Drafting of educational materials and guides or protocols.
- Adjustment of training to the different trainees' profiles.
- Evaluation of training.
- Integrated Plans and Training Programmes.
- Inter-institutional and interdisciplinary coordination and collaboration in training for dealing with gender violence.
- Inclusion of new recruits (Intern Medicine [MIR], Intern Nursing [EIR], etc.), in gender violence training programmes.
- Mechanisms or tools used for facilitating health professionals' training.
- Strengths and weaknesses of training provided.
- Recommendations and/or proposals for the future.

In the second subsection, analysis is based on the *common indicators* the Inter-Territorial Council approved for training of professionals in this matter, displaying aggregated data on a nationwide scale and disaggregated by Autonomous Community, concerning:

- Number of educational activities.
- Number of teaching hours provided.
- Number and type of educational activities as per healthcare levels.
- Trainees' participation data broken down by sex.
- Data relating to teaching staff, considering their professional profile, their work affiliation and sex.

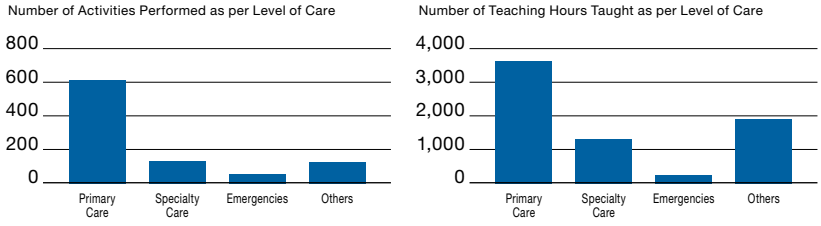
As regards criteria for improvement of the information and last year's envisaged recommendations in this same section of the Report, new analyses listed below have been included for 2009:

- Data on Training in "Others" healthcare spheres.
- Teachers Accreditation.
- Trainees' professional profile.
- Mechanisms or tools provided to facilitate assistance to training in the different ACs and Ingesa.

Initiatives on Training in Gender Violence in the National Health System

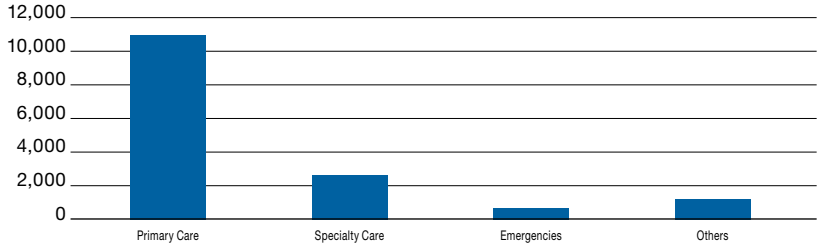
The figures 1-3, taken from the analysis of indicators described in the second part of this chapter, are shown for gauging the state of the training

Figure 1. Number of Activities Taught and Number of Teaching Hours as per Care Level (2009)



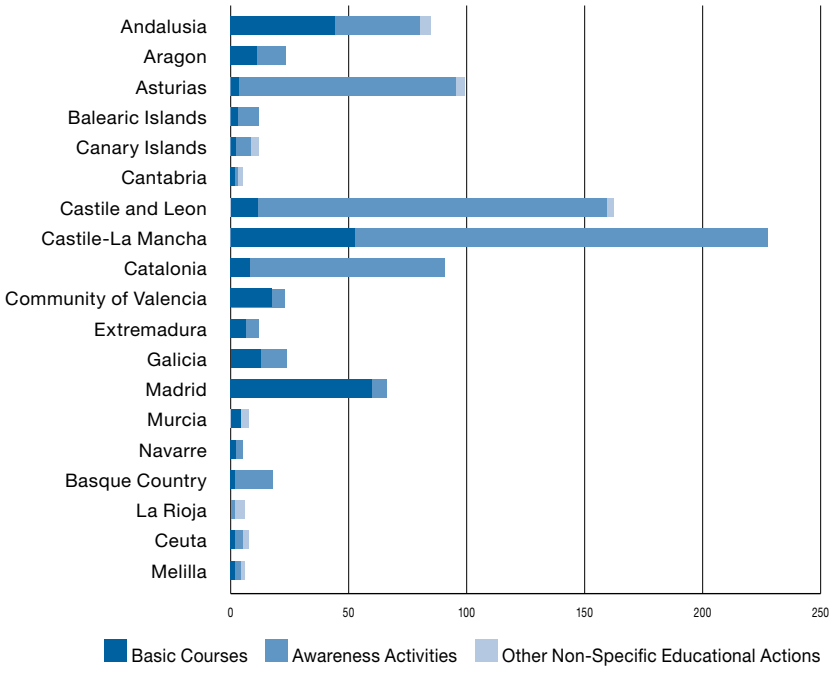
	Number of Activities	Number of Teaching Hours
Primary Care	604	3,658
Specialty Care	125	1,228
Emergencies	17	99
Others	129	1,878

Figure 2. Trained Healthcare Personnel as per Level of Care (2009)



	Healthcare Personnel
Primary Care	10,940
Specialty Care	2,574
Emergencies	502
Others	1,531

Figure 3. Training Provided by ACs (2009)



	Basic Courses	Awareness Activities	Other Non-Specific Educational Actions
Andalusia	44	37	2
Aragon	11	10	-
Asturias	3	94	2
Balearic Islands	3	8	-
Canary Islands	1	8	1
Cantabria	2	3	1
Castile and Leon	12	150	2
Castile-La Mancha	54	175	-
Catalonia	9	81	-
Community of Valencia	20	3	-
Extremadura	7	5	-
Galicia	14	10	-
Madrid	61	6	-
Murcia	5	-	1
Navarre	1	3	-
Basque Country	1	15	-
La Rioja	-	1	2
Ceuta	1	4	1
Melilla	1	2	1

of professionals in gender violence matters, in 2009. In this sense and as can be seen, it is Primary Care the healthcare attendance level where a higher number of activities have been performed and teaching hours been given.

In 2009, awareness activities were the educational format most commonly taught in all territories.

However, the geographic and organisational features of the different ACs, the growing trend in training of professionals and the need for more specialised and advanced training in the different actions established in the Common Protocol (example: Medical interview, early detection of psychological abuse, etc.) have led to designing new formats and educational tools that may co-exist with classic ones (basic course, awareness activity).

New Educational Formats Used for Training

Training for Trainers

The educational format Training for Trainers has developed in most Autonomous Communities: Andalusia, Balearic Islands, Community of Valencia, Catalonia, Castile and Leon, Madrid and Murcia. In Galicia, they had envisaged to implement it in 2010 (Table 10). It aims to enable professionals to design, implement and evaluate training programmes in prevention and attention to gender violence. In one Autonomous Community, it was put into action for the first time; in others, either it is included in Comprehensive Training Plans or, the development of educational actions only takes place after this educational format has been first implemented.

Online Training

Training through virtual methodology, e-learning and/or distance learning, focusing on issues of gender violence, has been taught in several Autonomous Communities. This format allows participating in all discussions and reflections, and obtaining documents, abstracts and contributions that can be used in other activities. Online seminars to raise awareness on gender violence have also taken place, addressing professionals who directly provide healthcare attendance to women affected, those who do not, as well as those responsible for the administration and management (Table 10).

Advanced Training

Objectives of this type of training have revolved around working on the gender in health perspective and on gender abuse in Primary Care and Specialty Care; also on improving the general understanding of the psychological processes of women suffering abuse, improving the techniques of emotional self-control of professionals and delving into teaching best

practices in gender violence matters (Table 10). Advanced training has targeted both specific groups of trainers in gender violence as well as health care professionals.

Table 10. New Educational Formats used for Training (2009)

Training of Trainers	
Andalusia	The project Andalusian Training Network against Abuse of Women *(Red Formma)* –Formma Network– which aims to train all health personnel, includes the format Trainer of Trainers
Balearic Islands	Its goal is to train professionals to design, implement and evaluate prevention and care programmes to deal with gender violence
Castile and Leon	There is a stable multi-year Programme for Trainers' Training in GV, within the Institutional Training Programme of the Health Care Regional Department
Catalonia	A 75 teaching-hour Training of Trainers in GV course –55 classroom hours and 20 of personal work– was given
Community of Valencia	Running of a Training Course for Trainers with a duration of 32 hours
Madrid	Three Editions of the format Training of Trainers have been staged for Primary Care (the last one in 2009) and two for Specialty Care
Murcia	Format included in the Comprehensive Plan for Training in Gender Violence
Online Formats	
Asturias	Design of a Training Project in Gender Violence through basic, intermediate and advanced tele-training with the Asturian Institute for Women, which has not so far been implemented
Balearic Islands	They imparted the course for socio-healthcare attendance of abused women following e-learning methodology targeting PC and Reinforcement Services
Castile and Leon	Online collaborative group for trainers from the institutional website of Castile and Leon Junta
	Completion of two editions of the Course Socio-Healthcare attendance for Abused Women, through the e-learning method and in cooperation with The Women's Institute *(Instituto de la Mujer)*
Catalonia	A 22-hour GV-issues-tailored training course in Virtual Methodology to train teachers running the 45-hour Part-Classroom Presence Basic Course (30 hours of online training and 15 hours of presence-staged teaching)
Community of Valencia	Completion of 3 online workshops on awareness of gender violence: one directed at professionals who work directly with patients, one for professionals with no direct involvement in patient care and a third addressed to Heads of Administration and Management
Advanced Training	
Castile and Leon	Training addressed to the specific group of trainers in gender violence
Madrid	Single edition of a Best Practice Workshop (5 hours) involving trainers' participation, held to analyse in greater depth the teaching provided
	Completion of an Advanced Workshop on clinical cases addressed to trainers (30 hours)

Murcia	The Comprehensive Plan for Training in GV includes three levels: Advanced, Transverse and Expert
Navarre	Advanced Workshop on GV aiming to improve both the overall comprehension of abused women's psychological processes and to improve the techniques for professionals' emotional self-control
Basque Country	Completion of a Master's Degree in intervention in GV through a cooperation agreement with Deusto University
Ceuta	Training targeting Primary and Specialty Care health professionals for their working on an approach to health from a gender perspective and gender violence itself
Others	
Galicia	Conference for information and awareness of professionals, and women's associations
	Organising of the I Congress on Gender Violence and Health
Melilla	Conducting of workshops on Gender Violence dealing with healthcare attendance, prevention and detection of GV at different areas: social services, penitentiary institutions, Law Enforcement State Bodies, etc.

Advanced Training in Specific Aspects

Besides Common Training Syllabuses approved by the NHSIC *(CISNS),* training has been given in specific aspects of healthcare attendance to cases of male abuse that need a deeper knowledge for capacities and abilities to be developed that may improve professional performance or specific characteristics of such care to more vulnerable groups due to social or cultural reasons (Table 11):

- Cultural and conditioning aspects of health care of immigrant women.
- Female genital mutilation and HIV.
- Training in clinical interviews with women victims of abuse.
- Training in dealing with sexual abuse victims.
- Male Abuse and use of substances.
- Detection of gender abuse during hospitalisation for delivery care.
- Ethical and Legal Aspects relating to the care of victims of male abuse.

Production of Teaching Materials, Guides and Protocols

Regarding the publishing of teaching materials, even though there already exist materials (approved in 2009) common to the whole of the National Health System, different AC have issued their own as a complement to the existing ones and have compiled them in databases (Table 12). Formats for disseminating such materials feature various differences:

- Informative Bulletins.
- Visual Teaching Materials.
- Teaching Guides.
- Interactive materials for online training.
- Tools for giving support to teaching activities and computerised tools for evaluating teaching and awareness of health professionals, etc.

Table 11. Specific Aspects Included in Training (2009)

Aragon	Awareness activities in Primary Care about Prevention of Female Genital Mutilation (FGM)
Balearic Islands	Aspects of the medical interview during care of women victims of abuse and ethical and legal aspects of the healthcare attendance of women suffering violence
Castile and Leon	Conference on HIV/AIDS and gender violence in cooperation with the National Secretariat for Drugs
Catalonia	Subjects discussed include intervention against sexual abuse, detection of violence against women immigrants and violence within the couple, and substances abuse
Community of Valencia	Issues are addressed which relate to cultural and conditioning aspects of health care of immigrant population, gender approach or differential morbidity
Madrid	Implementing of the Project "Detection of Victims of Male Abuse upon their Admission for Delivery Care" aiming to provide healthcare personnel in care of abused women, with training in partner abuse"
Murcia	Ethical and legal issues arisen when providing care to abused women, are addressed
	Feminist approach. Professionals providing training should be sufficiently trained in gender perspective
Navarre	They address legal and ethical aspects arisen while providing care to abused women
La Rioja	They address issues relating to cultural aspects and factors conditioning the care provided to the immigrant population, gender approach or differential morbidity in women
Basque Country	Aspects of the medical interview as part of the care provided to abused women

Training Adapted to Fit Trainees' Different Profiles

Training Targeting Health Care Sector Professionals

Awareness and educational activities for health sector professionals in many ACs group mental health, gynaecology and obstetrics, orthopaedics, Primary Care nursing assistants, hospital casualty services, emergency units, midwifery, social work, physiotherapy, linesman/lineswomen, etc.

Different teaching formats were used to provide training: continuing education courses, clinical sessions at centres and specific workshops (Table 13). The methodology used was expository, participatory and based on case studies.

Table 12. Production of Teaching Materials and Guides or Protocols (2009)

Andalusia	Production of teaching materials for all three educational formats. Creation of a database with reference materials in matters of violence inflicted on women and gender perspective
	Production and fortnightly release of an informative bulletin breaking news on gender violence and gender perspective. It is all available in your website
Asturias	Design and publishing of visual and teaching materials and teaching guides for training PC professionals thus completing existing materials in SC. Visual materials proved useful for giving support to awareness actions performed in health centres
Castile-la Mancha	Documentation and leaflets production for their being disseminated among all workers at the Health and Welfare Department of the Autonomous Community
Castile and Leon	Issuing of a brief guide to clinical practice in dealing with women abused by their intimate partners that, besides recommended interventions in cases of abused women and their children, includes situations that require referral to other healthcare resources (Gynaecology and Mental Care) and other social resources
Community of Valencia	Devising of computerised tools for evaluating implementation of the Common Protocol for Health Care and the training and awareness of healthcare professionals
	Reissuing of advertising elements for the awareness of gender violence, translated into Arabic, English, Rumanian and Braille. Purchase and translation of *No alla violenza* authored by Trieste University, for the prevention of GV among youths and adolescents. Devising of computerised materials targeting women from especially vulnerable groups
Galicia	Production of audiovisual materials and specific writings for the Training Programme. Publishing of the Guide to Care for Disabled Women and a different guide to resources for promoting healthy affective relationships aimed at young people
Madrid	Gynaecology and Obstetrics Service of Puerta de Hierro Hospital publishing of a Protocol for Detection of Victims of Abuse by Intimate Partner, targeting women admitted to the Obstetrics Area. Production of standard instructional material to support teaching activities. Action Guide to Addressing Violence in Specialty Care (launched in 2010)
Basque Country	Devising of tools for supporting teaching activities. Search for information on a nationwide/international scale regarding all processes of healthcare attendance of victims of gender abuse. The most relevant information was distributed in electronic form among administration and healthcare staff. Drafting of a guide to support the Health Care Protocol for Women Victims of Domestic Abuse

Training Targeting Staff Outside the Health Sector

Awareness of gender violence and training in addressing it also targeted non-healthcare personnel from Local Police, Civil Guard, Women's Centres

and social workers, mediators, prison workers, social educators, associations and Non-Profit Organisations' members, Customer Service Staff and administration professionals. Instructional actions were also performed at Schools and High Schools; training and awareness addressing women and more specifically immigrant women. Training was completed and/or awareness raised through courses, symposiums, sessions and workshops (Table 13).

Training Addressed to Administration and Management Personnel

Seven Communities provided training to executive personnel, aiming to raise awareness of the importance of women's health and of the repercussion of gender differences on work and on health, among Administration and Management teams. Some Communities organised Symposiums, some others did it through specific courses or projects (Table 13).

Table 13. Training at Different Healthcare and Non-Healthcare Areas (2009)

	Training Addressed to Professionals of the Healthcare Sector
Balearic Islands	Training aimed at raising the awareness of GV among Mental Health and Gynaecology professionals, through a continuing training course specifically designed for Mental Health workers, specific clinical sessions and symposiums
Cantabria	Training aimed at raising the awareness of GV among Primary Care nursing assistants, hospital casualty units' and emergency services' professionals, midwives and mental health teams. Methodology used was expository, participative and based on case studies
Castile and Leon	Training addressed to Mental Health Teams, Children and Adolescents Mental Health Teams, and to Midwives
Madrid	Project Detection of gender abuse victims in the course of their admission to hospital for Delivery Care, during which training was provided to Nursing professionals (Registered Nurses *[DUE]* and Midwives)
	Project Strategy for Prevention of Gender Violence; training activities were aimed at nursing assistants, caretakers and administrative staff
	Professionals from Obstetrics and Gynaecology, Casualty and Mental Health, are being given specific training
Navarre	Project Prevention of Gender Violence, addressed to health care professionals and featuring three types of activity: 1. Workshop for improving prevention, early detection and addressing domestic violence in Primary Care; 2. Advanced Workshop on GV, and 3. Ethical and Legal aspects of the healthcare attendance of victims of abuse
Basque Country	Awareness activities and technical sessions for presenting the Healthcare Protocol, addressed to professionals from Casualty Services, Mental Health, Gynaecology, Obstetrics, Orthopaedics and to the Administration and Managing personnel of the Healthcare Network
Ceuta	Clinical sessions on early detection of gender violence for Registered Nurses *(DUE),* Nursing Assistants, Social Workers, Physiotherapists and Midwives, as well as for Specialty Care, Casualty and Emergency Services' professionals

Training Addressed to Workers Outside the Healthcare Sector	
Cantabria	Watch on Gender Violence and Intervention Course for Police Forces where the methodology followed was expository, participative and based on study cases
	Training addressed to Customer Services staff, caretakers, clinical assistants and administration personnel
Castile-la Mancha	Sessions addressed to Local Police, Civil Guard, Women's Centre and Social and Healthcare Experts, and run by multidisciplinary teams. They identified instructional needs planned them and produced educational supportive materials
Catalonia	Organising of symposiums for *Mossos d'Esquadra* mediators, prison staff and social educators
	Releasing of the CD *Dones del nord, dones del sud* (Northern Women, Southern Women). It is a multimedia application starred by immigrant women and addressed to professionals in general, not just healthcare workers
Community of Valencia	Conducting of awareness activities intended for associations' and Non Profit Organisations' workers, to prevent and watch for gender violence against especially vulnerable women
	Training and awareness specifically addressed to immigrant women
Extremadura	Conducting of a conference addressed to executive staff and professionals from the healthcare, legal, social, educational and police fields
Madrid	Bringing out of two editions of the Course Professionals of Administrative Units on the Watch for Gender Violence (5 hours per edition). Intended for professionals integrating Primary Care and Specialty Care Administrative Units
Murcia	Training addressed to women themselves within the Comprehensive Training Plan in Gender Violence
Training Addressed to Executive and Managerial Personnel	
Andalusia	Organising of conferences for executives of the Andalusian Health Service
Castile and Leon	Training and awareness activities for Administration Officials in charge of Managerial Direction
Community of Valencia	Conducting of two Conferences within the healthcare context of gender violence, addressed to socio-healthcare heads and professionals
Extremadura	Project Awareness of the Executive Commissions for the 8 Health Areas aiming to raise Managerial teams' awareness of the importance of women's health and of gender differences repercussion on work and on health
Madrid	Conference for the Update of the Regional Strategy for Health Action against Intimate Partner Violence against Women in Primary Care addressed to Primary Care Management Teams
Murcia	Training integrated in the Comprehensive Plan for Training in Gender Violence (Basic Level)
Basque Country	Awareness of the broad lines of the Protocol for Care of Women Victims of Gender Violence among Management Personnel and Positions of Responsibility within the Healthcare Administration

Assessment of Training Provided

Evaluation of the training provided in ACs highlighted the need for extending it after considering some of its aspects (Table 14):

- Assessing of the adequacy of the training, knowledge acquired and usefulness of what was learned.
- Assessing of the teaching activity through anonymous surveys filled in by trainees.
- Evaluation of specialised health care provided in cases of gender violence
- Evaluating of graduate, postgraduate and continuing training in gender issues and gender violence, professionals received.
- Activities conducted in accordance with contents approached from a gender perspective.
- Training and awareness activities Health Care professionals performed in Secondary Schools *(IES)*.

Table 14. Evaluation of Training (2009)

Andalusia	Evaluation of compliance of instructional activities with ICNHS's *(CISNS)* quality criteria for basic training of professionals
	Number of participants, profiles and reference centres taking part in Symposiums
	Evaluating of activities performed, in terms of contents including the gender perspective
Balearic Islands	The study Evaluation of Specialty Health Care Addressing Gender Violence evidenced professionals' poor training
	Evaluation of graduate, postgraduate and continuing training, professionals receive in gender and gender abuse related issues
	Evaluation of training provided through survey techniques
Castile and Leon	An assessment of satisfaction is made of all training activities in terms of objectives achieved, usefulness for practice, contents, teaching methodology, appraisal of trainers, etc.
Castile-la Mancha	Assessment of workshops and theoretical-practical training courses
Catalonia	Evaluation of the training for the vast majority of activities, assessing their adequacy, knowledge imparted, usefulness of learning, the need for its expanding having been frequently expressed
Community of Valencia	Designing and issuing of questionnaires for assessment of training courses (basic courses and trainers' training). Developing of the second phase of a computerised tool *(Sivio)* that allows evaluation of the Protocol for Health Care Watch on Gender Violence's implementation. This tool allows easy access to the Protocol from an Internet Website, enabling its testing, its being prepared for final implementation and also its being used for teaching purposes
Madrid	Credentials for 100 % of organised courses and evaluation of the different teaching activities in accordance with the Quality Criteria the Continuing Training Commission of the Madrid Community's NHS established
	Assessment of student's satisfaction in terms of objectives met, usefulness for their professional practice, contents, teaching methodology, assessment of teachers, duration, etc.
Navarre	Students through anonymous survey assessed the teaching activity

Comprehensive Plans and Training Programmes

The technical workgroup considered mentioning in this section Murcia's experience, for its being, so far, the only Autonomous Community having designed and developed a Comprehensive Plan for Training in Gender Violence Issues, addressing health care and non-health care professional groups who deal with abused women. For the said Plan, they created a Technical Commission. Learning was organised in four levels according to subject: Basic Level, Advanced Level, Expert Level and Training for Trainers; and one additional level transverse to all four.

Even though other Autonomous Communities do not have specific training Plans against GV, they do rely on annual or multiannual training programmes for confronting GV aiming to train and raise professionals of the health care sector's awareness of the health problematic gender violence triggers, and the necessary coordination among healthcare attendance levels through producing audiovisual materials and drafting specific documents.

Catalonia Training Plan for Confronting Gender Violence complies with the common quality criteria and indicators for the evolution of training the National Health System's Inter-Territorial Council approved, and they have envisaged identification, planning and performing of new training activities to confront gender abuse (Table 15).

Table 15. Comprehensive Training Plans and Programmes (2009)

Andalusia	The devising of the Andalusian Network Training Plan for Confronting Abuse of Women *(Red Formma),* complies with the common quality criteria for basic training of professionals as the Andalusia Health Care Quality Agency *(ACSA)* duly accredited. The Training Plan incorporates the following training activities: Awareness Sessions; Basic Training Course and a Course for Training in the Healthcare Response to Abuse of Women
Aragon	They have an annual Plan for the Training in Addressing Gender Violence
Castile and Leon	Specific multiannual Programme for Training in the Response to Gender Violence addressed to Health Services' professionals, currently under development and initiated 4 years ago
Catalonia	Developing of an assessment of training needs regarding GV
	A 2009 Plan for Training in Confronting Gender Violence addressed to the whole of health professionals in accordance with the Common Criteria for Quality and the Indicators of the evolution of training, approved by the National Health System's Inter-Territorial Council. Identifying, planning and carrying out of new training activities relating to gender violence
Galicia	Training Programme to raise awareness of the health care sector's professionals on the health problematic gender violence entails and the necessary coordination among levels of assistance; it includes production of audiovisual and written materials
Madrid	The Plan for Training in the Prevention and Watch on Gender Violence integrates into the Annual Plans for Continuing Training of the *Agencia Laín Entralgo*. Designed from a gender perspective, it complies with the common quality criteria for the training of professionals. The Commission for Continuing Training of the Madrid Community's NHS accredits this training plan
Murcia	Devising and developing of a Comprehensive Plan for the Training in Gender Violence Issues, addressing health care and non-health care professional groups. For the said Plan, they created a Technical Commission and organised learning in four levels according to subject: Basic Level, Advanced Level, Expert Level and Training for Trainers; and an additional level, transverse to all four

Some of the training activities multiannual Training Plans and Programmes contain are:

- Sessions on Awareness of abuse of women.
- A Basic Training Course in the healthcare approach to abuse of women.
- Course for the training in healthcare's addressing violence inflicted on women.

Interinstitutional and Interdisciplinary Coordination and Collaboration for Training in Addressing Gender Violence

Some Autonomous Communities developed different instructional actions with the cooperation of various public and private bodies and institutions. Activities were addressed to different health care and non-health care professional profiles that participated in providing healthcare attendance to abused women: Law Enforcement State Forces, mediators, correctional institutions and penitentiaries' professionals, social educators, social services of the different Autonomous Communities, Courts and Prosecutors, Executive Management, etc. (Table 16).

Table 16. Coordination and Interinstitutional and Interdisciplinary Collaboration for Training in Addressing Gender Violence (2009)

Aragon	Project Training for Interinstitutional Cooperation against Gender Violence aiming to complete health professionals', Social and Law Enforcement workers' training and awareness
Asturias	Educational Programme for Primary and Specialty Care professionals in cooperation with the Asturian Women's Institute and the Asturian Institute for Public Administration *(IAAP)*
Castile and Leon	Educational Activities for coordination, principally in rural areas, in collaboration with the Civil Guard and Police
Catalonia	Three Conferences about GV related matters for prison professionals, social educators, *Mossos d'Esquadra* and mediators
Extremadura	Activities carried out in collaboration with the Health Sciences School of the Health and Dependence Department, the Feminism School of the Equality Department and the Health Service of Extremadura
Madrid	Training coordinated by the Technical Commission against Abuse of Women by the Intimate Partner of the Healthcare Department in cooperation with the *Agencia Laín Entralgo* and the participation of the General Directorate of Primary Care, Hospitals' General Directorate, *SUMMA 112* and the Community of Madrid's Women's Directorate General

Postgraduate Training in Dealing with Gender Violence

Currently, few Communities include modules for training in gender violence (GV) in postgraduate training. When they do, they often integrate them into Medicine and Nursing training programmes for residents (housewomen/men) (Table 17).

Some Communities included gender violence modules in Specialty Training Programmes within Family and Community Medicine and Internal Medicine Resident *(MIR)* in a number of hospitals. They also provided training for Preventive Medicine and Public Health *MIRs* and for the Internal Nursing Resident *EIR,* and Obstetrics and Gynaecologic Nursing Resident. They also held Symposiums addressed to Preventive Medicine and Public Health *MIRs* and to Emergency Services within the Resident Midwives Programme (Table 17).

Table 17. Postgraduate Training in Dealing with Gender Violence (2009)

Cantabria	Training Course Addressing Violence against Women in Health Services for Residents of Family and Community Medicine, Preventive Medicine and Public Health and Obstetrics and Gynaecology Nursing *EIR*
	Conference Violence against Women a Public Health Issue for Residents
	Basic Course Addressing violence against women in Primary Health Care for newly recruited professionals
Castile and Leon	Inclusion of GV Modules in the Specialty Programme of Family and Community Medicine
	Inclusion of GV Modules in the Resident Midwives Programme (Intern Nursing Resident) of Valladolid and Salamanca Teaching Units
La Rioja	Inclusion of GV training in First Year *MIR* Training

Mechanisms or Tools Used for Facilitating Learning to Health Professionals

Most Communities rely on replacement mechanisms to enable their professionals to attend Training (Table 18) like the ones listed below:

- Reediting same Course to allow various people of the same service to attend.
- Replacement of all people attending training in rural areas' health centres.
- Running of clinical sessions during work hours.
- Replacement of the longest activities (like those involving area trainers) for them to be able to give training in centres themselves,

or awareness and training activities during symposiums, congresses, etc. on gender violence.

- A seemingly successful replacement is the use of shorter teaching formats like clinic or case solving sessions, which allow a larger number of professionals to attend because of their being held in centres themselves and during work hours.
- Using scheduled annual time for training.
- Coordination of the teams among themselves to be able to attend training.
- Organising activities at mid-day for professionals of both morning and evening shifts to be able to participate with no major problems
- Institutional annual agreement for devoting a number of hours to training of professionals.
- Including training in GV issues in Programme-Contracts.

Table 18. Mechanisms or Tools Used to Facilitate Attendance to Training or Healthcare Professionals' Training in Addressing GV (2009)

Andalusia	Whenever financing is available, they use replacements. Another mechanism to make attendance to training easier is through the Formma Network
Aragon	Replacement in rural areas' health centres of all people attending training, and organising two editions of the same course to allow many people from the same emergency service to attend
Asturias	Running clinical sessions during working hours. Workers authorised to attend training courses are replaced by *Sespa* (Health Service of Asturias) whenever the service needs to be covered
Balearic Islands	They run some of the training activities within working hours
Cantabria	They use replacements. Training is included in programme-contracts
Castile and Leon	Replacement of a significant proportion of professionals to enable them to attend training in GV (mostly to the longest activities: training for trainers, Symposiums, Congresses and some Courses) and replacement of area trainers to enable them to provide training in centres
	There was no need to replace part of the trainers; shorter teaching formats were found instead (1-4 hours): clinical session or case resolution at Primary Care Teams centres. These formats allowed to reach a larger number of professionals who were thus able to attend the courses since they were taught in the centres themselves and during working hours
Castile-La Mancha	They resort to replacements whenever needed in order to ensure healthcare attendance
Catalonia	Replacements were organised for a part of the participants in two of the activities. All training is subsidised and professionals contribute their personal effort to train staff using their own annual training time available (approx. 40 hours) or teams coordinate among themselves to attend. Many activities are organised in mid-day sessions to allow professionals from both shifts (morning and evening) to participate without too much trouble

Community of Valencia	Courses are given in most departments of the *Conselleria de Sanitat.* Each worker is allowed 3 continuing training courses a year, to be received during the evening shift
Extremadura	Replacement and Programme-Contracts
Galicia	There is an institutional annual agreement for a series of hours to be devoted to training of professionals. If, once those hours used up, a professional expresses strong interest in attending any other course and the centre management thinks it advisable, colleagues renegotiate work among themselves for the number of days the course will take and in order for the patients not to be affected. At any rate, those days are never remunerated and possibilities are few outside an agreement at the beginning of each year
Madrid	Training in GV has been included in the Primary Care programme-contract since 2008
	To favour accessibility, basic courses addressed to Primary Care professionals are given in Health Centres in hinge timetable: 13.30-15.30 h
	Replacements of trainers or trainees when needed
Murcia	The introduction of an Indicator in Management Contracts between Murcia Health System and the different area managements for training in gender violence has made attendance to training courses easier for professionals
Navarre	These courses are not estimated within the Management Agreement with Primary Care Teams
La Rioja	Courses are included in the Training Programme for Health Care professionals
Basque Country	Replacement of professionals who attended the workshop. Training of professionals for 2009 was included in the Programme-Contract, both for Primary and Specialty Care. Running of sessions and awareness workshops at the end of the morning and beginning of the afternoon make attendance easier for professionals working either shift

Weaknesses and Strengths in Training Provided

Listed below are both the main factors for success and the weaknesses detected in the projects for training in confronting gender violence in different Communities.

Weaknesses

Some of them result from aspects as follows:

- Management staff's low degree of involvement in management centres.
- Organisational difficulties that require changes if planning and information gathering from a gender perspective are to be implemented.
- Geographical extension of a community, the large number of professionals and structures involved.
- Replacement of professionals to enable attendance.
- Health Care overload hampers participation in training.

- Poor training received by management personnel.
- Socialising processes of people involved in other management areas developing different activities: their beliefs, values and prejudices.
- Resistance from the health sector to switch from the bio-healthcare model to the bio-social model –that incorporates the gender perspective– accepting that violence against women is a health issue not just a social one.
- Absence of common and comparable indicators in health centres nationwide.
- Health professionals' low awareness of their role in the endeavour to detect gender abuse, which often hinders their involvement in this type of educational activities.

Strengths

Some strong points or factors for success in the training provided were:

- Proposal for global action in terms of gender violence, which encompasses all initiatives.
- Strong motivation of personnel involved and acceptance to act from a gender perspective by people with no previous knowledge of its magnitude.
- Relying on a multidisciplinary team of female and male trainers.
- Support from the management team.
- Involvement in training of services and professionals who develop their activity in the territorial sphere and depend either on this or on other administrations but that, because of their specificity provide healthcare attendance to abused women.
- Previous experience of training in gender violence issues and being able to rely on both GV experienced and multidisciplinary teaching staff.
- The interdisciplinary approach and heterogeneity of participants.
- The close cooperation and communication between Healthcare and Social Services.
- Subsidies by the Ministry of Health and Social Policy and the willingness to put into action a cohesive project that includes training and awareness.
- The enforcement of the Law on Equality and the existence of the *CISNS*'s Common Protocol for a Healthcare Response to Gender Violence.

Recommendations and/or Proposals for the Future

Autonomous Communities have put forward a number of recommendations necessary for the future and aiming to improve the quality of the training of professionals in gender violence issues:

- Value the criterion basic course or awareness activity conceptually and not just according to the number of hours they last; in other words: some training activities for specific subjects within Advanced Training take less than 10 hours and should not be called Awareness Activity when they were performed after having gone through basic training.
- Expand training to other groups that play a significant role in confronting gender violence and its consequences on children: Paediatricians, Paediatric Nurses, Gynaecologists, Physiotherapists, etc.
- Intensify research in this field so that it may improve interventions.
- Continue maintaining gender violence as a priority issue in postgraduate education, especially for the staff in training (residents of clinical specialties like Family and Community Medicine, Internal Medicine, Orthopaedics, Gynaecology, Internal Nursing Resident, Internal Psychology Resident) and newly hired professionals.
- Take training and awareness strategies into consideration both initial and periodically to give actions continuity.
- Continue the training of professionals, training and informing women and women's associations and elaborating definitive indicators to rely on more complete information.
- Establish when a professional should be considered as fully trained.
- Issue at the beginning of each year a rough copy listing Ministry financing possibilities to enable a better planning of projects.
- Persevere in the study of detection of violence issues to allow effective intervention through instructional actions of a practical character that may improve response to the problem of gender abuse.

Quantitative Analysis of Gender Violence-Related Educational Actions in the National Health System

Data on a Nationwide Scale

Listed below please see data obtained through analysis of the whole of training actions put into practice on a national scale.

On the one hand, data show number and type of the many activities developed: Basic Courses, Awareness Activities and Other Non-Specific Educational Actions.

According to the quality criteria for basic training of professionals approved by ICNHS *(CISNS)* a training action will be considered Basic Training Course when lasting around 20 teaching hours. It will be estimated

Awareness Activity when lasting less than 10 hours. In the section Other Educational Actions reference is made to Non-Specific (non-specifically related to gender violence) Educational Actions in which some related module has been included.

Categorised differently, appears the number of teaching hours as per level of healthcare attendance: Primary Care, Specialty Care, Casualty/ Emergencies and Others.

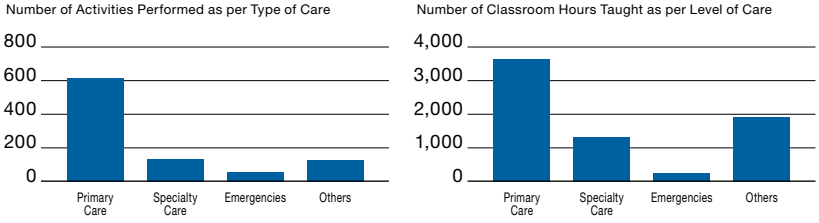
The subsection Others, where the type of training activities is described, refers to those activities that although provided at healthcare services, include participating professionals from the three levels of attendance and/ or from other non-healthcare sectors.

Data are also offered on courses credentials, professional profile and sex of participants and trainers as well as institutional affiliation.

Training Provided in Primary Care (PC), Specialty Care (SC), Casualty and Others. Teaching Hours and Total Activities Conducted as per Level of Care

Primary Care is the area where the most activities for the training of professionals were performed, totalling 486. On the contrary, Casualty/ Emergencies is the service where the least activities were conducted and least hours taught: 17 and 35 respectively. Others is the section where the most teaching hours were given as it groups, apart from all three healthcare attendance levels, other non-healthcare sectors (fig. 4).

Figure 4. Number of Activities a Classroom Hours Taught as per Level of Care (2009)



	Number of Activities	Number of Classroom Hours
Primary Care	604	3,658
Specialty Care	125	1,228
Emergencies	17	99
Others	129	1,878

Note. This same Figure appears on page 26 as Figure 1.

Type of Training Activities Conducted in Primary Care, Specialty Care, Casualty/Emergencies and Others

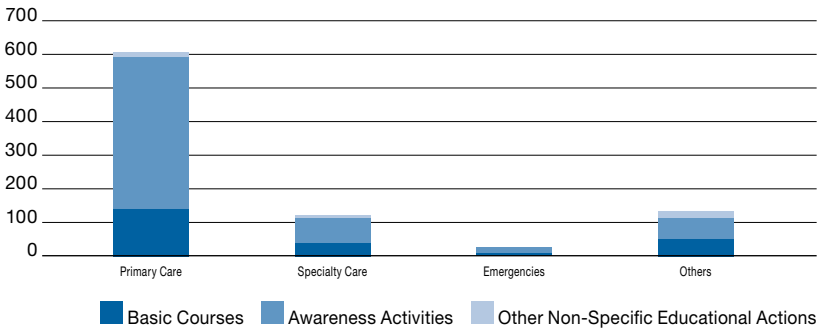
Regardless of the attendance level concerned, the training activity Awareness Activities is the most frequent, accounting for 459 activities in PC, 78 in SC, 14 in Casualty/Emergencies and 63 in Others. Awareness Activities are followed by Basic Courses totalling 142 in PC, 59 in Others, 46 in SC and 3 in Casualty/Emergencies.

Other Non-Specific Educational Actions are those performed to a lesser degree in any one of all healthcare attendance levels, with a total number of 7 actions (fig. 5).

Number of Courses Accredited in Primary Care, Specialty Care, Emergencies and Others

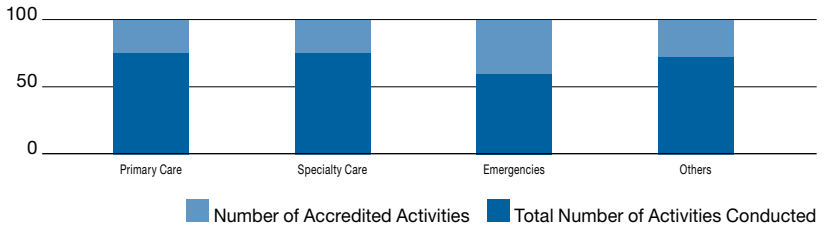
Primary Care accounted for the greatest number of accredited courses that totalled 198, equivalent to 32.8 %. Others followed with 47 accredited activities of a total of 129 performed (36.4 %). Credentials were established for 41 activities in Specialty Care (32.8 %). Casualty or Emergencies was however, the area with a higher percentage of Credentials earned as, out of the 17 activities performed, 11 were accredited which means 64.7 % (fig. 6).

Figure 5. Training activities as per Level of Care (2009)



	Basic Courses	Awareness Activities	Other Non-Specific Educational Actions
Primary Care	142	459	3
Specialty Care	46	78	1
Emergencies	3	14	-
Others	59	63	7

Figure 6. **Accredited Activities as per Level of Care (2009)**



	Number of Accredited Activities	Total Number of Activities Conducted
Primary Care	199	604
Specialty Care	41	125
Emergencies	11	17
Others	47	129

Participation in the Different Training Activities (Data broken down by Sex)

Regarding figures 7-11, you must remember that not all Communities offer training for each one training activity. We must also highlight that accumulated data shown do not include those from Communities that were unable to furnish them itemised or disaggregated by sex (Canary Islands, Cantabria, Ceuta and Melilla).

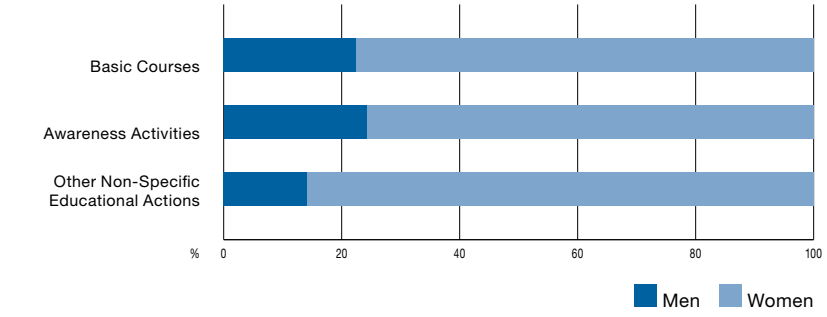
Broadly speaking, women appear to be the most assiduous participants in all types of training actions. Only 22.3 % of men participated in Basic Courses versus 78.7 % of women. In Awareness Activities, women (76.1 %) again outnumbered men (23.9 %) and similarly, 86.6 % of women in Other Non-Specific Educational Actions against 13.4 % of men seem to confirm the trend (see figs. 7-11).

In Specialty Care, women participated in training –in any of the training categories– in percentages beyond 50 %.

It should be highlighted that it is in Specialty Care and Emergencies where men's participation reached the highest percentage when compared with Primary Care. In Specialty Care, participation of men in Other Non-Specific Educational Actions reached 41.2 % and in Awareness Activities of the Emergencies area, 38 % (see figs. 9 and 10).

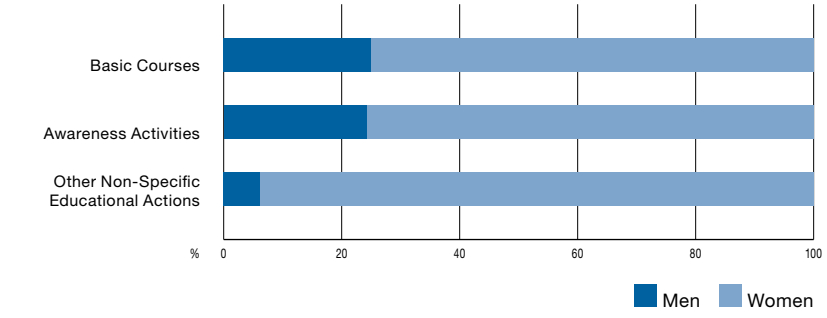
In Others, Awareness Activities showed the broadest participation of Men, reaching 20.2 %. In Basic Courses the percentage of male participants was 17.5 % and in Other Non-Specific Educational Actions, 12.6 %. (see fig. 11).

Figure 7. Participation in the Different Educationl Actions as per Sex (2009)



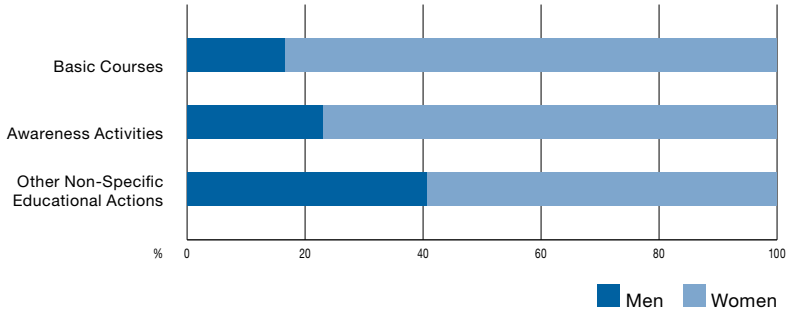
	Men	Women
Basic Courses	1,405	4,888
Awareness Activities	2,263	7,188
Other Non-Specific Educational Actions	59	380

Figure 8. Participation in Primary Care as per Sex (2009)



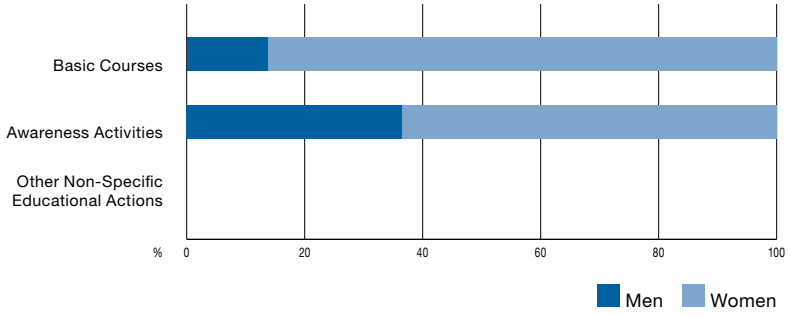
	Men	Women
Basic Courses	1,036	3,086
Awareness Activities	1,642	5,111
Other Non-Specific Educational Actions	1	15

Figure 9. Participation in Specialty Care as per Sex (2009)



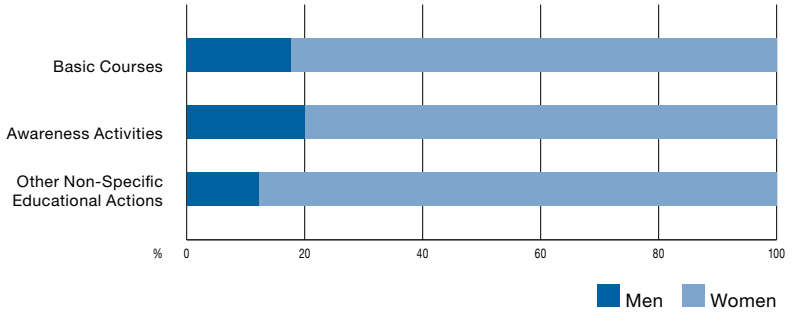
	Men	Women
Basic Courses	225	1,107
Awareness Activities	219	721
Other Non-Specific Educational Actions	7	10

Figure 10. Participation in Emergency Care as per Sex (2009)



	Men	Women
Basic Courses	33	203
Awareness Activities	105	177
Other Non-Specific Educational Actions	-	-

Figure 11. Participation in Others Area as per Sex (2009)



	Men	Women
Basic Courses	108	491
Awareness Activities	301	1,178
Other Non-Specific Educational Actions	51	355

Total Healthcare Professionals Having Received Training as per Level of Care

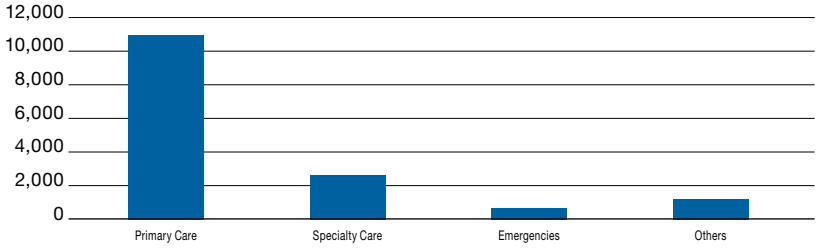
The care level with the largest number of professionals trained was Primary Care where they totalled 10,940; Specialty Care followed with 2,574 professionals. In Others, 2,787 workers were trained and finally Emergencies scored a total of 502 (fig. 12). Table 19 lists the conclusions drawn from these last five sections.

Professional Profile of Participants (sex-itemised data)

Something to be mentioned for the next figure is that some Communities (Cantabria, Catalonia, Extremadura, Melilla and Navarre) were unable to furnish data on sex-itemised professional profile of participants; that is why their information has not been included in the total data on professional profiles of students disaggregated by sex.

Broadly speaking, women's participation as students scored higher than men's for all professional profiles; a highlight is Medicine where 2,402 women participated against 1,168 men. Also, this profile with 33 % of men, together with Psychology with 28 % of male participants put men's participation figures into the lead over other profiles such as Social Work or Nursing (fig. 13).

Figure 12. Trained Healthcare Personnel as per Level of Care (2009)



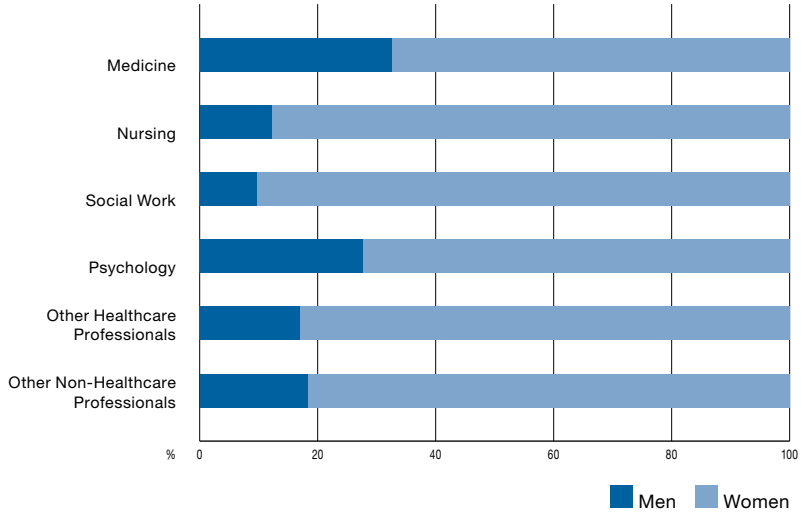
	Healthcare Personnel
Primary Care	10,940
Specialty Care	2,574
Emergencies	502
Others	1,531

Note. This same Figure appears on page 26 as Figure 2.

Table 19. Conclusions at Nationwide Level on Care Level, Educational Format, Participation as per Sex, Total Number of Professionals Trained and Number of Accredited Courses

Care Level	Primary Care (PC) scored the greatest number of activities and teaching hours completed. Emergency Services the lowest
Educational Format	The most frequently used educational format was Awareness Activities (459) in PC. Basic Courses followed scoring 142 in Primary Care and 59 in Others. Other Non-Specific Educational Actions were the least taught in all three levels of care
Participation as per Sex	Women starred the greatest participation in the different training actions and in all levels of care
Total Number of Professionals Trained	In order of number of professionals trained as per level of care, it emerges that Primary Care was the most trained, Specialty Care came second, followed by Others and finally Emergency Units
Number of Accredited Courses	It is Primary Care where the largest number of Courses were Accredited (199) followed by Others (47). However, Emergencies featured a greatest percentage of Credentials as 11 out of 17 activities were accredited

Figure 13. Trainees Professional Profile as per Sex (2009)



	Men	Women
Medicine	1,168	2,402
Nursing	449	3,181
Social Work	41	367
Psychology	32	82
Other Healthcare Professionals	107	505
Other Non-Healthcare Professionals	33	145

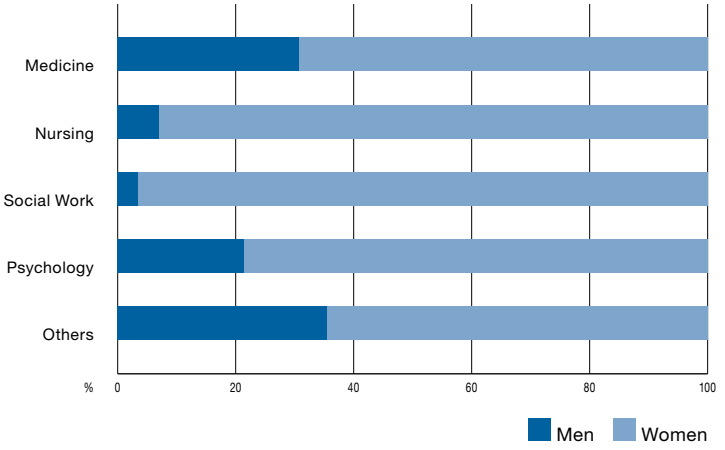
Note. The sum total of disaggregated data does not match the sum total of absolute data for the professional profiles of Medicine, Social Work, Nursing and Other Non-Healthcare Professionals because not all Autonomous Communities provided sex-disaggregated data.

Professional Profiles of Teaching Staff (sex-itemised data)

Something to be mentioned for the figure that follows is that the Community of Melilla with Autonomy Status did not rely on data on sex-itemised professional profile of trainers; that is why their information could not be included in the total data on professional profiles of teachers disaggregated by sex.

Teachers' professional profiles were basically divided between Medicine (the most frequent) Nursing, Social Work, Psychology and Other Professional Profiles. As it happened with Students, the proportion of women trainers was higher than that of men. The highest percentage of men occurred in Other Professional Profiles with 36 % and in Medicine with 31 % (fig. 14).

Figure 14. Teacher's Professional Profile as per Sex (2009)



	Men	Women
Medicine	73	163
Nursing	10	126
Social Work	3	78
Psychology	22	80
Others	36	65

Trainers Affiliation

As far as affiliation of Trainers is concerned, they by far belong to the Autonomous Administration (526 Professionals). Then come the teachers considered Experts (27): after, the ones working for the Local Administration (26 Professionals) followed by General Administration's Professionals (23) and Other Public Institutions (16). To a lesser extent trainers coming from the University (11), from Other Private Institutions (9) and Non-Profit Organisations (NPOs) (8). Table 20 lists the conclusions drawn from these last three sections.

Data Disaggregated by Autonomous Community (AC)

This section summarises the information handed by the different ACs and CAS regarding the training offered. The type of format adopted to convey training is dealt with in this section. Equally, information is provided, concerning both trainers and students regarding their professional profiles, affiliation to different institutions and sex.

Table 20. Conclusions at Nationwide Level on Trainer's Professional Profile as per Sex, Teaching Staff as per Sex, Trainers' Affiliation and Professional Profile of Students as per Sex	
Trainers' Professional Profile as per Sex	Trainers' Professional Profile was for the most part Medicine followed by Nursing
Teaching Staff as per Sex	Men coming from Medicine were the most numerous among teachers although female trainers outnumbered men in all professional profiles
Trainers' Affiliation	As regards Trainers' Affiliation, the majority of them come from the Autonomous Administration or are independent Experts
Professional Profile of Students as per Sex	Students come principally from Medicine, Nursing and Other Healthcare Profiles coming next. Among Students, participation is higher among women

Training Provided in each AC as per Type of Educational Actions

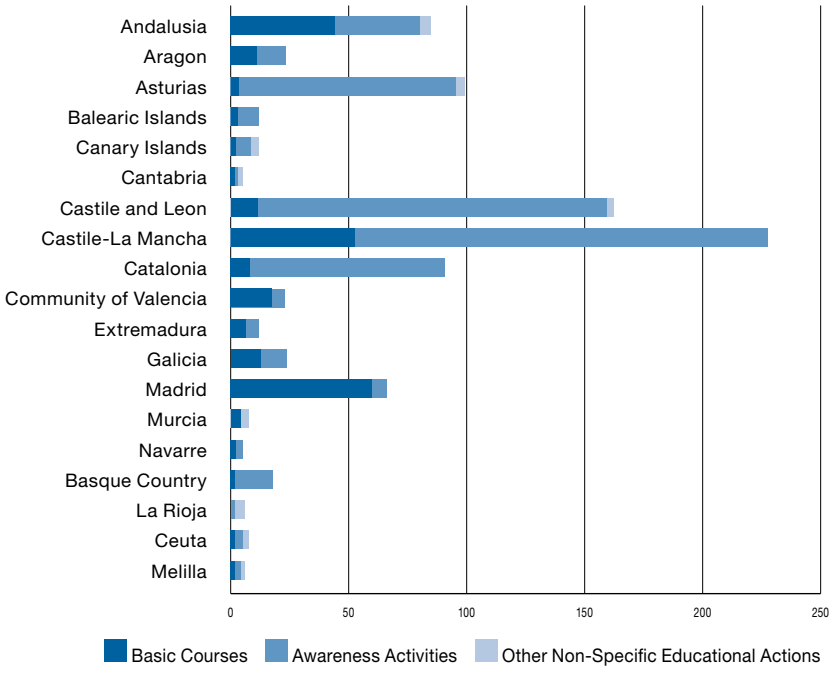
Concerning training provided in the different ACs, 18 of them taught both Basic Courses and Awareness Activities. Nine of them taught Other Non-Specific Educational Actions.

During 2009, the Madrid Community (61) offered the highest number of Basic Courses. Castile-La Mancha was the one to conduct the most Awareness Activities (175). Andalusia, Asturias, Canary Islands, Cantabria, Castile and Leon, Murcia, La Rioja, Ceuta and Melilla were those who developed the Other Non-Specific Educational Actions format, although they did not perform more than 2 activities. Murcia on its failed to organise Awareness Activities and La Rioja did not offer Basic Courses either (fig. 15).

Total Number of Teaching Hours Taught in Training in each Autonomous Community as per Level of Care

Andalusia (635 in PC and 243 in SC) and Madrid (475 PC and 279 SC) offered the largest number of teaching hours in Primary Care and Specialty Care. In the Emergencies Area, only Andalusia, Community of Valencia, Castile and Leon, Madrid and Galicia offered training, but not exceeding 30 teaching hours. Castile-La Mancha offered the highest number in Others Area (1,450) where training was also aimed at professionals of various fields other than health (fig. 16).

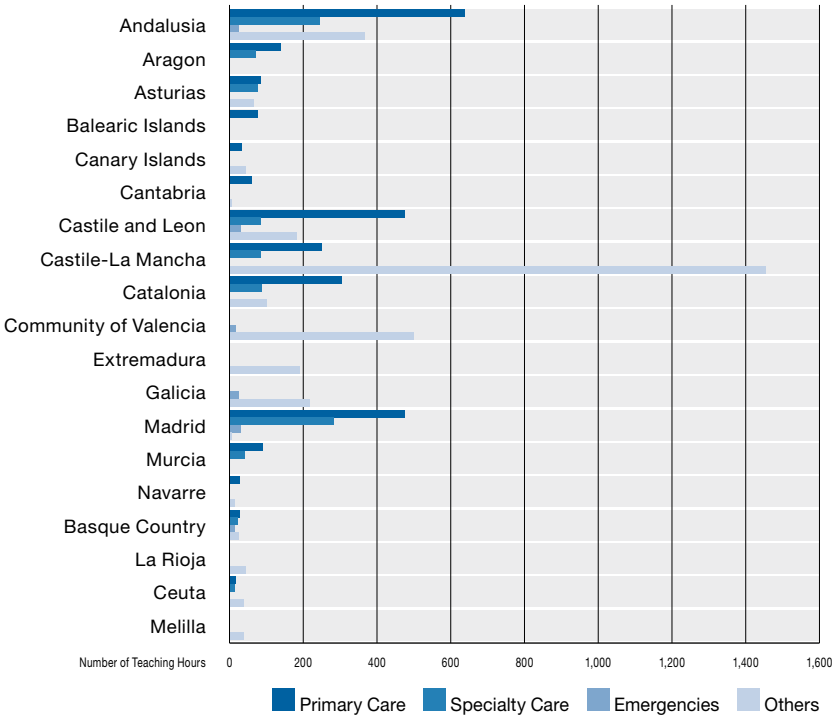
Figure 15. Training Provided by ACs (2009)



	Basic Courses	Awareness Activities	Other Non-Specific Educational Actions
Andalusia	44	37	2
Aragon	11	10	-
Asturias	3	94	2
Balearic Islands	3	8	-
Canary Islands	1	8	1
Cantabria	2	3	1
Castile and Leon	12	150	2
Castile-La Mancha	54	175	-
Catalonia	9	81	-
Community of Valencia	20	3	-
Extremadura	7	5	-
Galicia	14	10	-
Madrid	61	6	-
Murcia	5	-	1
Navarre	1	3	-
Basque Country	1	15	-
La Rioja	-	1	2
Ceuta	1	4	1
Melilla	1	2	1

Note. This same Figure appears on page 27 as Figure 3.

Figure 16. Total Training Hours Given by ACs as per Level of Care



	Primary Care	Specialty Care	Emergencies	Others
Andalusia	635	243	20	365
Aragon	137	70	-	-
Asturias	80	72	-	60
Balearic Islands	74	-	-	-
Canary Islands	28	-	-	39
Cantabria	54	-	-	1
Castile and Leon	472	80	25	179
Castile-La Mancha	250	80	-	1,450
Catalonia	302	84	-	95
Community of Valencia	-	-	8	497
Extremadura	-	-	-	185
Galicia	-	-	16	216
Madrid	475	279	30	-
Murcia	82	35	-	-
Navarre	24	-	-	4
Basque Country	25	15	-	20
La Rioja	-	-	-	37
Ceuta	6	4	-	30
Melilla	-	-	-	30

Types of Instructional Activities Conducted in each AC as per Level of Care

In the main, it was Primary Care where all training formats were the most largely afforded. Contrarily, Emergencies conducted the least activities; in fact, only five Communities provided teaching in this area. Of the different educational formats, Other Non-Specific Educational Actions was the least taught, not exceeding 2 activities.

In Primary Care, eleven Communities provided Basic Courses, Madrid being the one offering the largest volume of this type of training. In Specialty Care however only seven Communities were able to provide this training format. Regarding Others, twelve ACs provided Basic Courses, being Castile-La Mancha (47), Community of Valencia (20) and Madrid (14), the ones to run the largest number. In this area of training, some Communities did not restrict training to only healthcare professionals.

In the Emergencies area, the only Community having provided training, actually Basic Courses, was Madrid with a total of 3 courses (fig. 17).

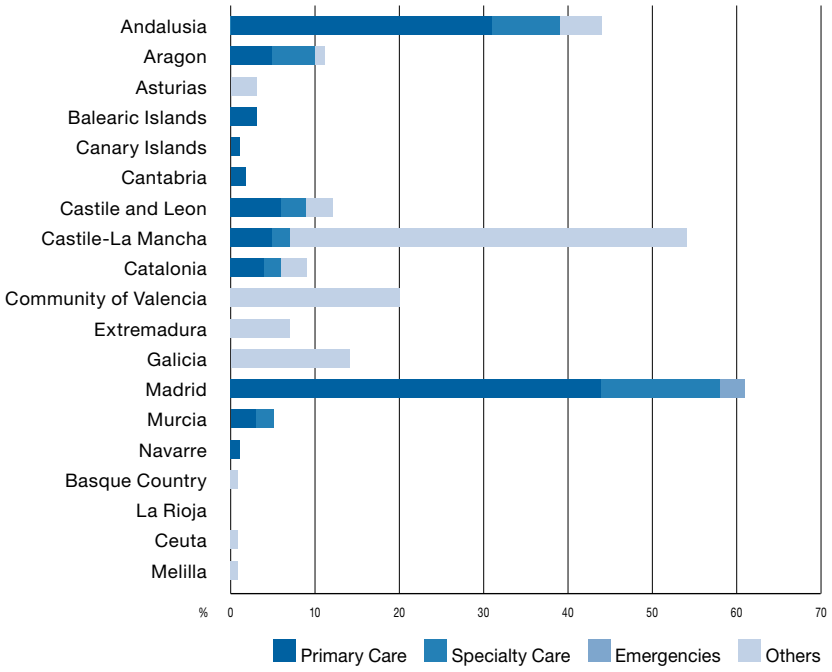
Castile and Leon, Asturias and Catalonia are the Communities that provided the highest number of Awareness Activities in Primary Care while in Specialty Care Asturias took the lead with 15 of them. In the Emergencies Area, only Andalusia, Castile and Leon, C. of Valencia and Galicia offered this training format, while in Others Area, 11 Communities offered it, Castile-La Mancha being the Community having offered the largest number of Awareness Activities, reaching a total of 145 of them. Murcia, for its part, did not provide this kind of teaching format (fig. 18).

Other Non-Specific Educational Actions as per level of care where they are carried out, was the educational format least used not having exceeded 2 activities in Asturias and La Rioja in the Area Others. Only 8 Communities included it in their programmes. Murcia, Ceuta and Melilla used it in Primary Care while Asturias, Canarias, Cantabria and La Rioja in the Others area. Only Andalusia offered Other Non-Specific Educational Actions in the Specialty Care level. On the contrary, Emergencies failed to provide this educational format (Table 21).

ACs' Participation in Training (sex-itemised data)

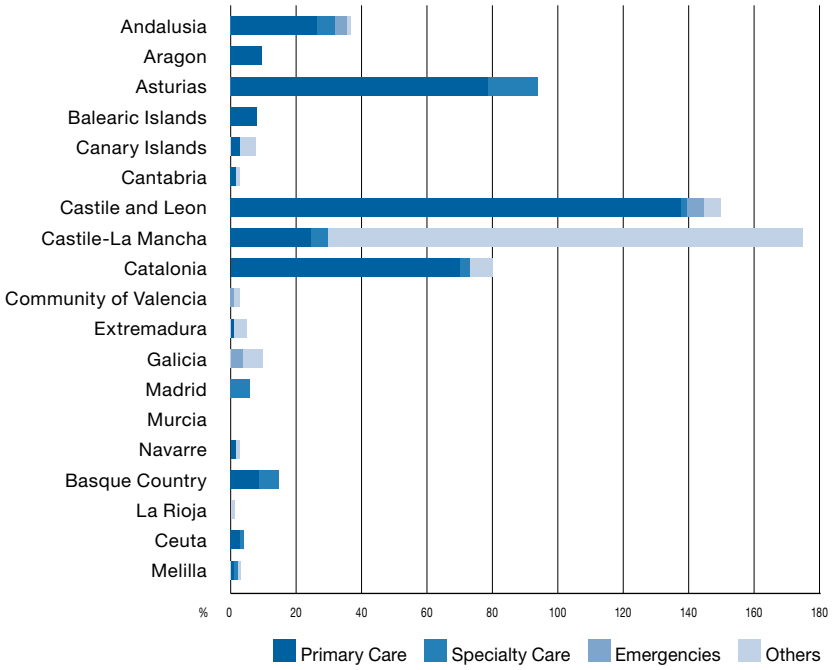
For this set of figures, something to be mentioned is that some Communities do not rely on sex-itemised data (Canary Islands, Cantabria, Extremadura, Melilla and Navarre). Also, that not all Communities provided the whole set of training actions.

Figure 17. Total number of Basic Courses per Levels of Care (2009)



	Primary Care	Specialty Care	Emergencies	Others
Andalusia	31	8	-	5
Aragon	5	5	-	1
Asturias	-	-	-	3
Balearic Islands	3	-	-	-
Canary Islands	1	-	-	-
Cantabria	2	-	-	-
Castile and Leon	6	3	-	3
Castile-La Mancha	5	2	-	47
Catalonia	4	2	-	3
Community of Valencia	-	-	-	20
Extremadura	-	-	-	7
Galicia	-	-	-	14
Madrid	44	14	3	-
Murcia	3	2	-	-
Navarre	1	-	-	-
Basque Country	-	-	-	1
La Rioja	-	-	-	-
Ceuta	-	-	-	1
Melilla	-	-	-	1

Figure 18. Number of Awareness Activities per Level of Care (2009)



	Primary Care	Specialty Care	Emergencies	Others
Andalusia	27	5	4	1
Aragon	10	-	-	-
Asturias	79	15	-	-
Balearic Islands	8	-	-	-
Canary Islands	3	-	-	5
Cantabria	2	-	-	1
Castile and Leon	138	2	5	5
Castile-La Mancha	25	5	-	145
Catalonia	70	3	-	7
Community of Valencia	-	-	1	2
Extremadura	1	-	-	4
Galicia	-	-	4	6
Madrid	-	6	-	-
Murcia	-	-	-	-
Navarre	2	-	-	1
Basque Country	9	6	-	-
La Rioja	-	-	-	1
Ceuta	3	1	-	-
Melilla	1	1	-	1

Table 21. Other Non-Specific Educational Actions as per Level of Care (2009)

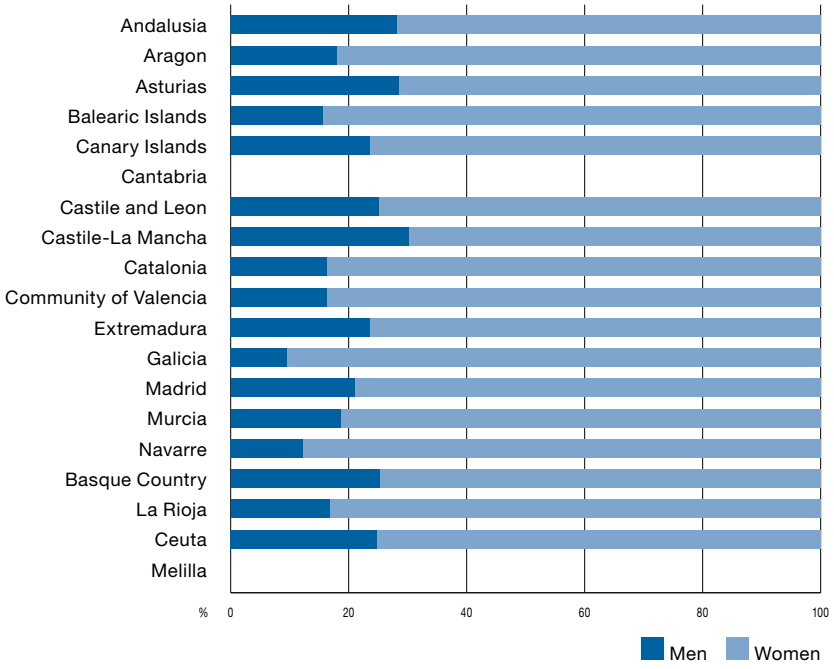
AC	Primary Care	Specialty Care	Emergencies	Others
Andalusia	-	1	-	1
Aragon	-	-	-	-
Asturias	-	-	-	2
Balearic Islands	-	-	-	-
Canary Islands	-	-	-	1
Cantabria	-	-	-	1
Castile and Leon	-	-	-	-
Castile-La Mancha	-	-	-	-
Catalonia	-	-	-	-
Community of Valencia	-	-	-	-
Extremadura	-	-	-	-
Galicia	-	-	-	-
Madrid	-	-	-	-
Murcia	1	-	-	-
Navarre	-	-	-	-
Basque Country	-	-	-	-
La Rioja	-	-	-	2
Ceuta	1	-	-	-
Melilla	1	-	-	-

As happens when analysing all Communities globally, greatest participation of women in training was the most frequent occurrence. The Communities featuring the greatest men's participation were Andalusia, Asturias, Castile-La Mancha, Basque Country and Ceuta although never exceeding 30 %. In Cantabria, participants totalled 214 but as they were unable to provide this information disaggregated by sex, it has not been included in the figure 19.

In no Autonomous Community did male participation exceed 30 %, Castile-La Mancha, Asturias, Andalusia, Extremadura and Basque Country having registered the highest male participation.

Participation Percentage in Basic Courses (sex-itemised data). Considering sex when analysing participation in Basic Courses, it should be mentioned that, in general, women participated more. Andalusia, Castile-La Mancha and Castile and Leon registered the highest male participation; on the contrary, Ceuta is where men's participation was lowest. La Rioja and

Figure 19. Participation per Sex in Training Provided (2009)



	Men	Women
Andalusia	925	2,397
Aragon	72	341
Asturias	278	697
Balearic Islands	32	177
Canary Islands	15	49
Cantabria	-	-
Castile and Leon	1,015	3,084
Castile-La Mancha	198	461
Catalonia	304	1,586
Community of Valencia	65	344
Extremadura	210	689
Galicia	52	518
Madrid	419	1,600
Murcia	16	71
Navarre	6	44
Basque Country	99	298
La Rioja	11	56
Ceuta	14	43
Melilla	-	-

Melilla did not implement this type of educational format. In the Basque Country and the Canary Islands, 100 % of participants were women. In Cantabria, 68 people participated in Basic Courses although they cannot supply that information disaggregated by sex (fig. 20).

Participation Percentage in Awareness Activities (sex-itemised data). Ceuta, La Rioja, Castile-La Mancha and Asturias registered the highest percentage of male participation in Awareness Activities.

Murcia did not offer this educational format. Although in Cantabria and Navarre professionals participated in the Awareness Activities organised they cannot make that information available as it is not sex-itemised (fig. 21).

Participation Percentage in Other Non-Specific Educational Actions (sex-itemised data). Also in Other Non-Specific Educational Actions, women's participation was higher. In four Communities (La Rioja, Murcia, Galicia and Andalusia) out of the six that contributed information, men did participate although to a lesser extent than women did. In Ceuta and Asturias, men did not participate at all. The Canary Islands, Cantabria and Castile and Leon offered this type of training but as their outcomes lacked sex-itemisation, they could not be used. The rest of Communities did not afford this Training categorisation (fig. 22).

Participation as per Levels of Care (sex-itemised data)

In terms of participation, women outnumbered men in all four Levels of Care.

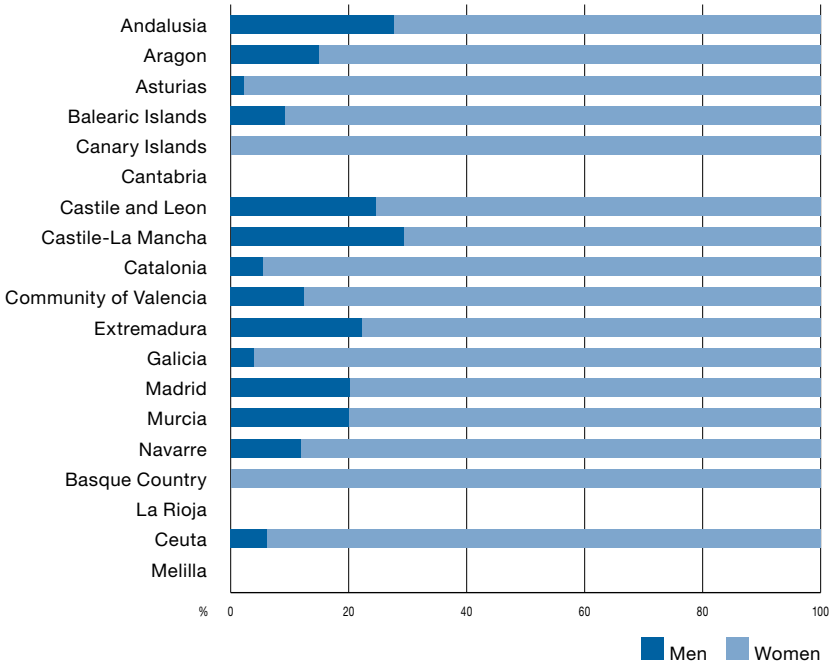
Primary Care. Women's participation in Basic Courses was greater than men's in: Andalusia (622 men and 1,444 women); Madrid (227 men and 619 women); and Castile and Leon (81 men and 176 women). Women participants in Awareness Activities also outnumbered men in Castile and Leon (782 men and 2,409 women), Asturias (277 men and 619 women) and Catalonia (268 men and 1,085 women).

Specialty Care. Again, women's participation in Basic Courses was greater than men's in: Andalusia (89 men and 329 women) and Madrid (79 men and 349 women). Likewise, participation of women in Awareness Activities was greater than that of men, in Madrid (89 men and 334 women) and Basque Country (45 men and 122 women).

Emergency Units. To be noted in Basic Courses is the significant difference between men and women's attendance figures: in Galicia (7 men and 133 women) followed by Madrid (24 men and 65 women).

A conspicuous detail in Awareness Activities is how evenly participation of men and women match at this Level of Care in Andalusia (53 men and 56 women). Castile and Leon is again a highlight for its broader participation of women (37 men and 83 women).

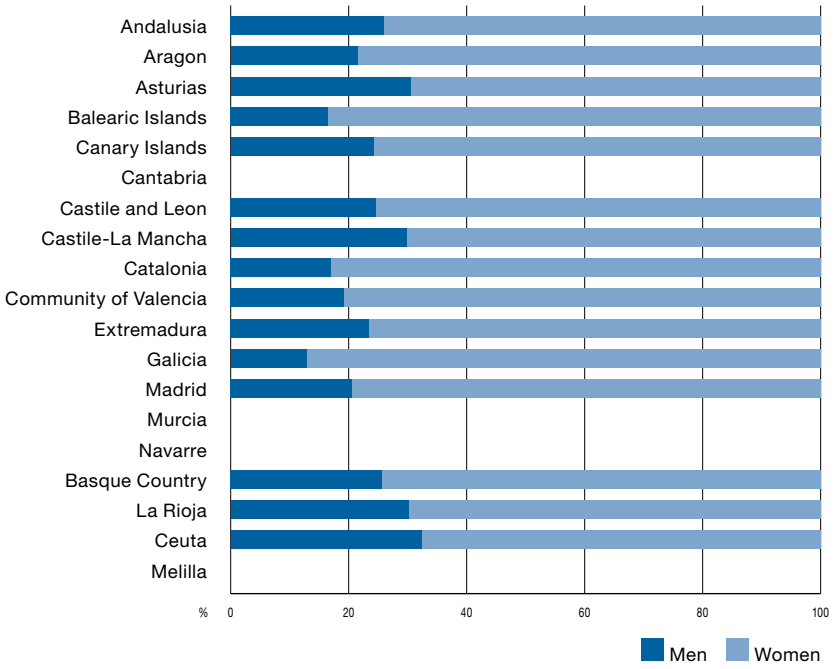
Figure 20. Participation in Basic Courses as per Sex (2009)



	Men	Women
Andalusia	725	1,856
Aragon	41	232
Asturias	1	38
Balearic Islands	4	38
Canary Islands	-	3
Cantabria	-	-
Castile and Leon	125	373
Castile-La Mancha	46	110
Catalonia	13	215
Community of Valencia	29	198
Extremadura	60	207
Galicia	9	216
Madrid	330	1,266
Murcia	15	57
Navarre	6	44
Basque Country	-	20
La Rioja	-	-
Ceuta	1	15
Melilla	-	-

Note. Either unavailable or non-sex-itemised data from the ACs of Cantabria and Melilla. No Basic Courses run in La Rioja.

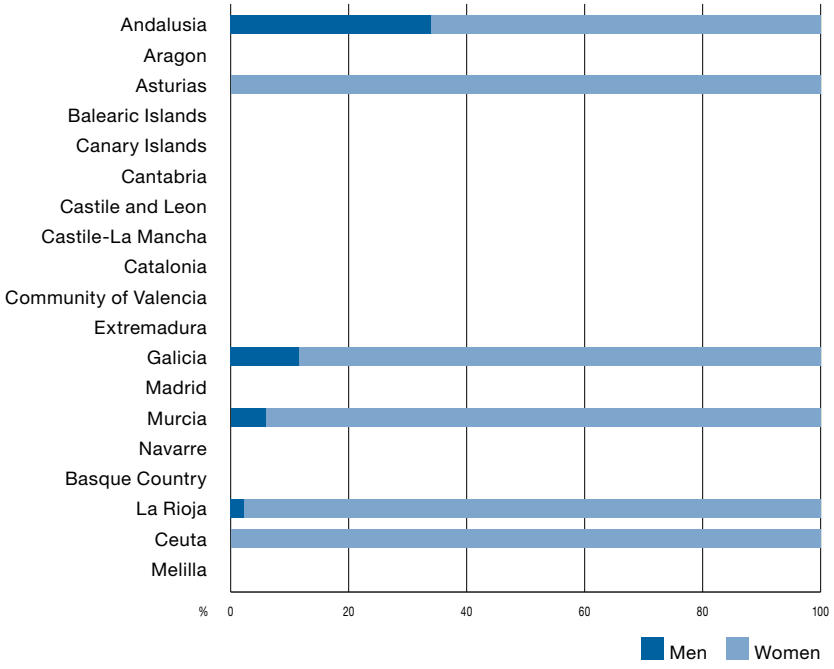
Figure 21. **Participation in Awareness Activities as per Sex (2009)**



	Men	Women
Andalusia	178	499
Aragon	31	109
Asturias	277	619
Balearic Islands	28	139
Canary Islands	15	46
Cantabria	-	-
Castile and Leon	890	2,711
Castile-La Mancha	152	351
Catalonia	291	1,371
Community of Valencia	36	146
Extremadura	150	482
Galicia	8	52
Madrid	89	334
Murcia	-	-
Navarre	-	-
Basque Country	99	278
La Rioja	10	23
Ceuta	13	27
Melilla	-	-

Note. Either unavailable of non-sex-itemised data from the ACs of Cantabria, Melilla and Navarre. No Awareness Activities undertaken in the AC of Murcia.

Figure 22. Participation in Other Non-Specific Educational Actions as per Sex (2009)



	Men	Women
Andalusia	22	42
Aragon	-	-
Asturias	-	40
Balearic Islands	-	-
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	-	-
Catalonia	-	-
Community of Valencia	-	-
Extremadura	-	-
Galicia	35	250
Madrid	-	-
Murcia	1	14
Navarre	-	-
Basque Country	-	-
La Rioja	1	33
Ceuta	-	1
Melilla	-	-

Note. Unavailable or non-sex-itemised data from the Canary Islands, Cantabria, Castile and Leon, Extremadura and Melilla. No Other Educational Actions provided in Aragon, Balearic Islands, Community of Valencia, Castile-La Mancha, Catalonia, Madrid, Navarre and the Basque Country.

Others. In Others Area, a broader participation of women versus men in Basic Courses occurs in Extremadura (56 men and 170 women) and Castile and Leon (24 men and 96 women). In Awareness Activities, Extremadura, Catalonia and Castile and Leon, take the lead in terms of female broader participation, Extremadura being the Community with the greatest participation of men (150). In Galicia, a highlight is the broader participation of women in Other Educational Actions (35 men and 250 women).

Total of Healthcare Professionals Having Received Training in 2009 as per Level of Care

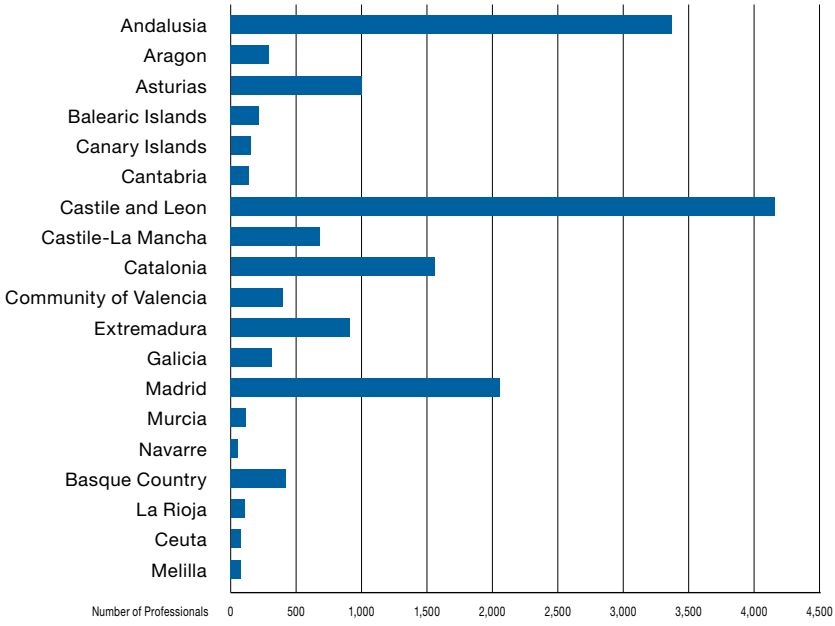
ACs that registered the highest figures of trained Healthcare professionals during 2009 were: Castile and Leon, Andalusia, Madrid, Catalonia, Asturias and Extremadura. On an Autonomous Community scale, participation ranged between 4,100 participants in Castile and Leon and 57 in Ceuta or Melilla (fig. 23).

As regards Training Received by Level of Care and Autonomous Community, it emerges that Primary Care trained the highest number of professionals. The Autonomous Communities that trained the highest number of professionals in that area were Castile and Leon (3,448), Andalusia (2,469), Catalonia (1,441) and Madrid (1,079). Specialty Care trained a total of 2,574 professionals, Madrid and Andalusia being the Communities that trained the highest number of professionals (940 and 575, respectively). It should be remembered that activities at Others are always developed from health services and group participants from all Levels of Care and other non-healthcare sectors. Therefore, in this area, professionals who received training totalled 2,676, being Catalonia (382), Castile and Leon (350), Galicia (345) and Valencia (207) the Communities that trained more professionals. Finally, in Emergency Services a total of 502 professionals were trained nationwide, being Castile and Leon (120), Galicia (110) and Andalusia (109) the Communities presenting the largest figures of professionals trained at this Level of Care (fig. 24). Table 22 lists the conclusions drawn from these last sections.

Teaching Staff and Participants' Profiles

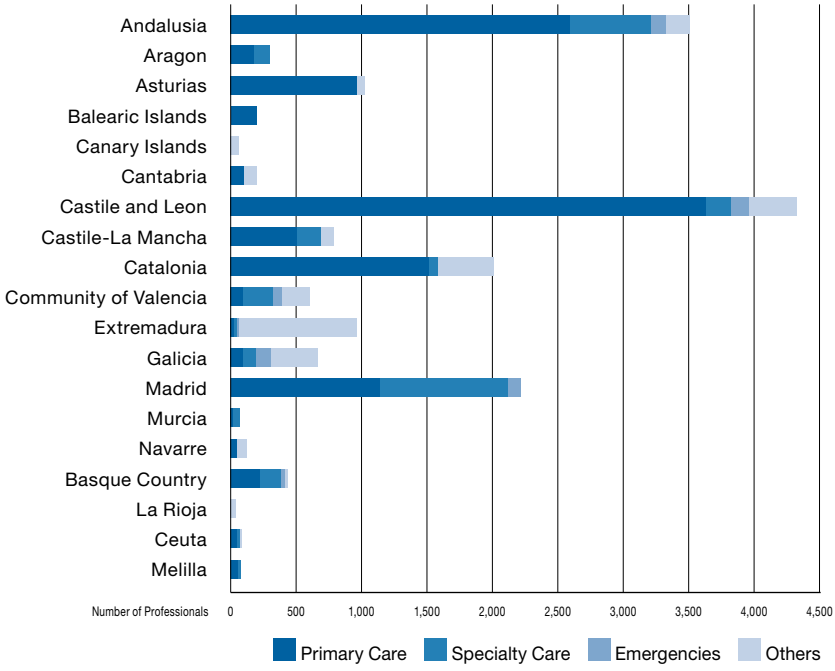
Teaching Staff's Profile. When studying the figures 25-29 you must bear in mind that not all Communities rely on all Teaching Professional Profiles (Balearic Islands, Canary Islands, Cantabria, Ceuta, Madrid, Melilla and Navarre).

Figure 23. Total Number of Trained Healthcare Professionals (2009)



	Total Number
Andalusia	3,322
Aragon	277
Asturias	975
Balearic Islands	192
Canary Islands	119
Cantabria	112
Castile and Leon	4,100
Castile-La Mancha	659
Catalonia	1,508
Community of Valencia	368
Extremadura	899
Galicia	292
Madrid	2,019
Murcia	85
Navarre	50
Basque Country	397
La Rioja	67
Ceuta	57
Melilla	57

Figure 24. Total Number of Trained Healthcare Professionals as per Level of Care (2009)



	Primary Care	Specialty Care	Emergencies	Others
Andalusia	2,469	575	109	169
Aragon	170	107	-	-
Asturias	935	-	-	40
Balearic Islands	192	-	-	-
Canary Islands	-	-	-	55
Cantabria	112	-	-	74
Castile and Leon	3,448	182	120	350
Castile-La Mancha	490	169	-	86
Catalonia	1,441	67	-	382
Community of Valencia	92	224	52	207
Extremadura	29	7	4	859
Galicia	90	92	110	345
Madrid	1,079	940	89	-
Murcia	25	44	-	-
Navarre	50	-	-	62
Basque Country	216	163	18	8
La Rioja	-	-	-	34
Ceuta	51	6	-	5
Melilla	51	6	-	-

Table 22. Conclusions on Educational Ations as per Level of Care, Educational Format, Teaching Hours, Participation as per Sex and Total Healthcare Professionals Trained

Level of Care	Primary Care hosted most of the training given in all possible educational formats while Emergency Units scored the lowest number of teaching units taught; only 5 Communities provided training in this Level of Care, 11 Communities offered training in Specialty Care and 15 in the Others Area
Educational Format	Of all Communities, 17 of them ran Basic Courses and Awareness Activities and 8 organised Other Non-Specific Educational Actions. The latter is the least used educational format with a total of 2 activities registered in Asturias and La Rioja
Teaching Hours	Primary Care provided the largest number of teaching hours, in the Communities of Castile-La Mancha (1,264) and Andalusia (635). In the Area Others, it was the Community of Valencia (497) and Andalusia (365) which offered the most teaching hours. Madrid provided 30 in Emergency Units
Participation as per Sex	Women participated to the greatest extent in all Autonomous Communities. The Communities where participation of men was a little higher were Andalusia, Asturias, Castile-La Mancha, Castile and Leon and Madrid. Galicia and Navarre registered the lowest participation of men
Total Healthcare Professionals Trained	Among Levels of Care, Primary Care registered the broadest participation with a total of 10,940 professionals trained. In Specialty Care, total participation in training totalled 2.574 professionals; the Area Others accounted for 2,676 trained professionals and Emergency Units, for 502

The most frequent professional profile among trainers comes from the Medicine sector (236 professionals), followed by Nursing (136), Psychology (102), Other Professional Profiles (99) and Social Work (81). In addition, the percentage of women trainers is higher than the percentage of men (see figs. 25-29).

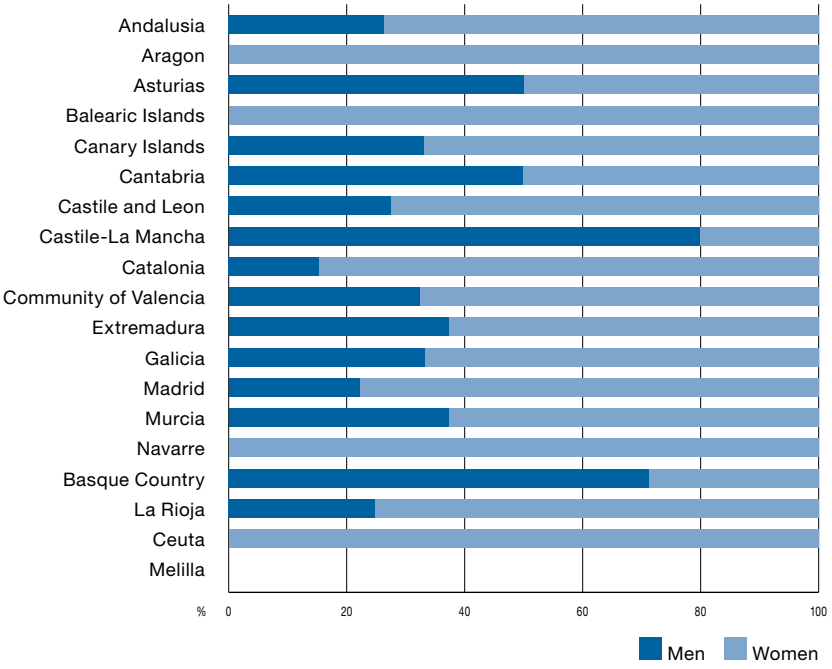
In the Community of Castile-La Mancha, 80 % of trainers included in the Medicine Profile are men while in Asturias, Cantabria and Basque Country 50 % are men and 50 % women.

Nursing is a professional profile principally made up of women, exception made of Murcia where 50 % of Nurses are men. In Aragon, all Psychologists are men and in Galicia, more than 50 % of Psychologists are men too. Nevertheless, in Asturias, Cantabria, Community of Valencia, Extremadura, Madrid, La Rioja and Basque Country, all trainers in the professional category Psychologist are women.

As for Social Work, only men provide training in Aragon and Andalusia. As regards Other Professional Profiles, there are more men than women in Aragon, Castile-La Mancha and Community of Valencia. Something to highlight in Extremadura is that the whole of trainers within this profile are men.

Training Staff's Affiliation. Broadly speaking a considerable proportion of Health Care Professionals' Trainers belongs to the Autonomous

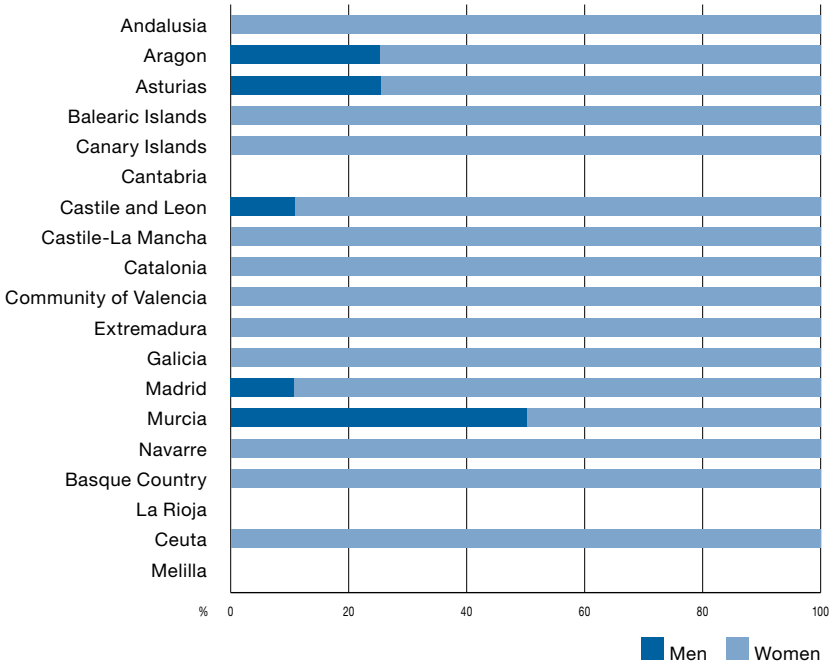
Figure 25. **Medicine Professionals Providing Training in Gender Violence, Per Autonomous Community (2009). Sex-Itemised Data**



	Men	Women
Andalusia	5	14
Aragon	-	5
Asturias	10	10
Balearic Islands	-	2
Canary Islands	1	2
Cantabria	3	3
Castile and Leon	8	21
Castile-La Mancha	4	1
Catalonia	5	28
Community of Valencia	12	25
Extremadura	3	5
Galicia	7	14
Madrid	6	21
Murcia	3	5
Navarre	-	1
Basque Country	5	2
La Rioja	1	3
Ceuta	-	1
Melilla	-	-

Note. No data available from Melilla's CAS.

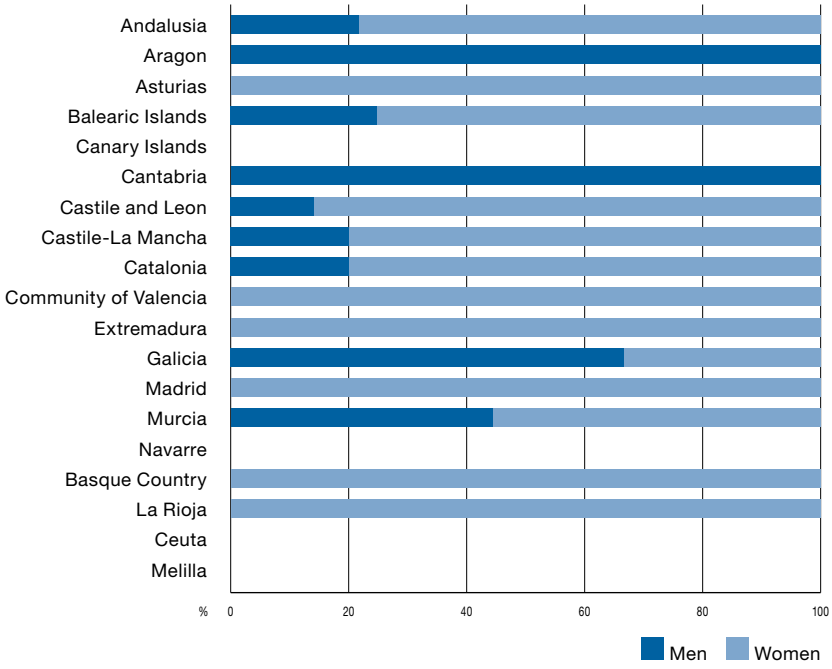
Figure 26. Nursery Professionals Providing Training in Gender Violence, Per Autonomous Community (2009). Sex-Itemised Data



	Men	Women
Andalusia	-	5
Aragon	1	3
Asturias	2	6
Balearic Islands	-	1
Canary Islands	-	1
Cantabria	-	-
Castile and Leon	2	18
Castile-La Mancha	-	2
Catalonia	-	18
Community of Valencia	-	24
Extremadura	-	2
Galicia	-	4
Madrid	4	36
Murcia	1	1
Navarre	-	1
Basque Country	-	2
La Rioja	-	-
Ceuta	-	2
Melilla	-	-

Note. Cantabria and La Rioja did not rely on this professional profile. No data available from Melilla's CAS.

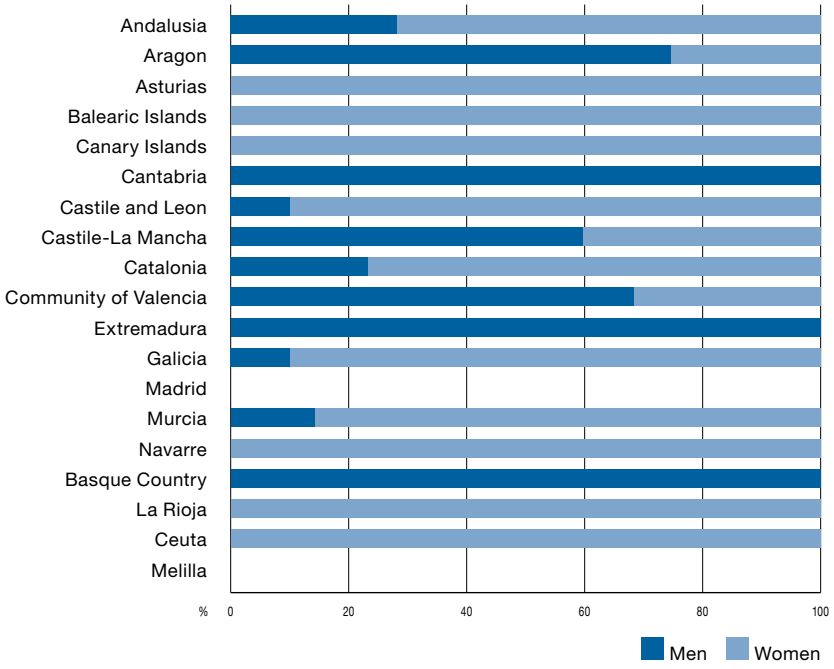
Figure 27. **Psychology Professionals Providing Training in Gender Violence, Per Autonomous Community (2009). Sex-Itemised Data**



	Men	Women
Andalusia	2	7
Aragon	1	-
Asturias	-	2
Balearic Islands	1	3
Canary Islands	-	-
Cantabria	-	3
Castile and Leon	1	6
Castile-La Mancha	2	8
Catalonia	7	28
Community of Valencia	-	9
Extremadura	-	1
Galicia	4	2
Madrid	-	4
Murcia	4	5
Navarre	-	-
Basque Country	-	1
La Rioja	-	1
Ceuta	-	-
Melilla	-	-

Note. Canary Islands, Ceuta and Navarre did not rely on this professional profile. No data available from Melilla's CAS.

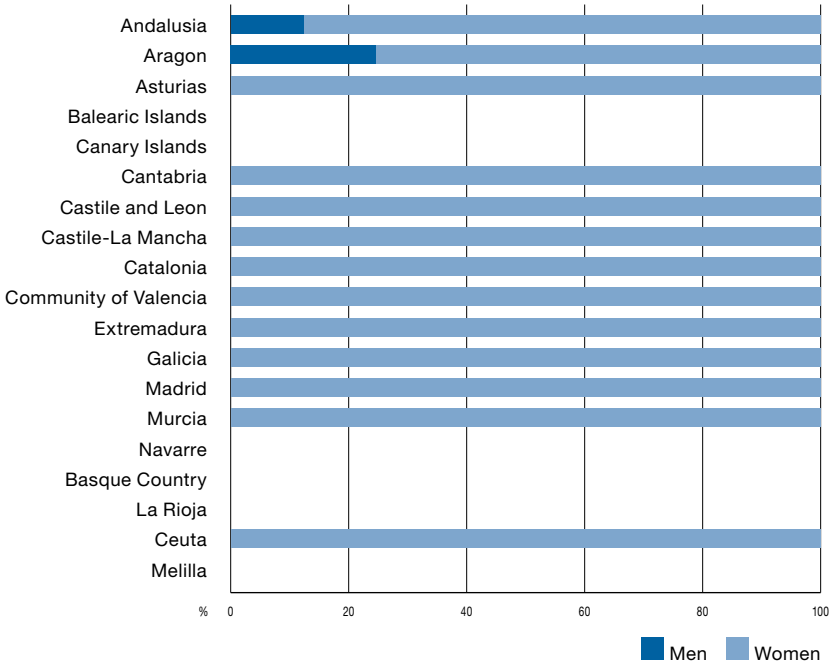
Figure 28. **Professionals of Other Professional Profiles Providing Training in Gender Violence, Per Autonomous Community (2009). Sex-Itemised Data**



	Men	Women
Andalusia	2	5
Aragon	6	2
Asturias	-	3
Balearic Islands	-	1
Canary Islands	-	1
Cantabria	-	1
Castile and Leon	1	9
Castile-La Mancha	6	4
Catalonia	4	13
Community of Valencia	11	5
Extremadura	2	-
Galicia	1	9
Madrid	-	-
Murcia	1	6
Navarre	-	2
Basque Country	1	-
La Rioja	-	1
Ceuta	-	2
Melilla	-	-

Note. Madrid did not rely on this professional profile. No data available from Melilla's CAS.

Figure 29. Social Work Professionals Providing Training in Gender Violence, Per Autonomous Community (2009). Sex-Itemised Data



	Men	Women
Andalusia	1	7
Aragon	2	6
Asturias	-	15
Balearic Islands	-	-
Canary Islands	-	-
Cantabria	-	2
Castile and Leon	-	8
Castile-La Mancha	-	1
Catalonia	-	14
Community of Valencia	-	9
Extremadura	-	1
Galicia	-	5
Madrid	-	7
Murcia	-	2
Navarre	-	-
Basque Country	-	-
La Rioja	-	-
Ceuta	-	1
Melilla	-	-

Note. Balearic Islands, Canary Islands, Navarre, Basque Country and La Rioja did not rely on this professional profile. No data available from Melilla's CAS.

Administration (526 trainers), 26 work for the Local Administration, 27 are independent experts and 23 come from the General Administration. To a lesser extent there are professionals ascribed to "Other Public Institutions (16), University (11), Other Private Institutions (9) and NPOs (Non-Profit Organisations, 8).

In the Canary Islands Training Staff as a whole is ascribed to the Autonomic Administration.

In Catalonia, most of the training staff is linked to the Autonomic Administration, but for 7 trainers who come from other ACs. A 10 % of training staff is ascribed to the University sphere (Psychology) and the odd Social Work professional linked to the Local Administration.

In the rest of Communities Teaching Staff belong to a wide array of Institutions: Women's Institute, General Administration, Private Experts, University, Local Administration, NPOs, etc.

Professional Profiles of Trainees. As happens in the case of Trainers, the most common professional profile among Trainees is Medicine (3,570), followed by Nursing (3,630), Other Healthcare Staff (2,735) and Social Work (485). When it comes to participation in training, women participate to a larger extent than men, accounting for 6,678 of the total versus 1,835 men (figs. 30-35).

This set of figures does not include information on Catalonia, Cantabria, Navarre, Extremadura and Melilla, since they were unable to make sex-itemised/professional-profile-itemised data on trainees, available.

Ceuta, Aragon, Balearic Islands and Basque Country produced a higher percentage of male Physicians, who outnumbered women in the Basque Country (79 vs. 70).

As for Nursing, there is a 30 % of male professional trainees as is the case of Murcia and Castile-La Mancha.

As for Psychology, the Community of Valencia and Galicia present an equal participation of women and men (50 %). In Murcia 40 % are men: In Ceuta, La Rioja and Basque Country all Psychologists trainees are women.

When it comes to Social Work, men are more numerous in Castile-La Mancha and Ceuta.

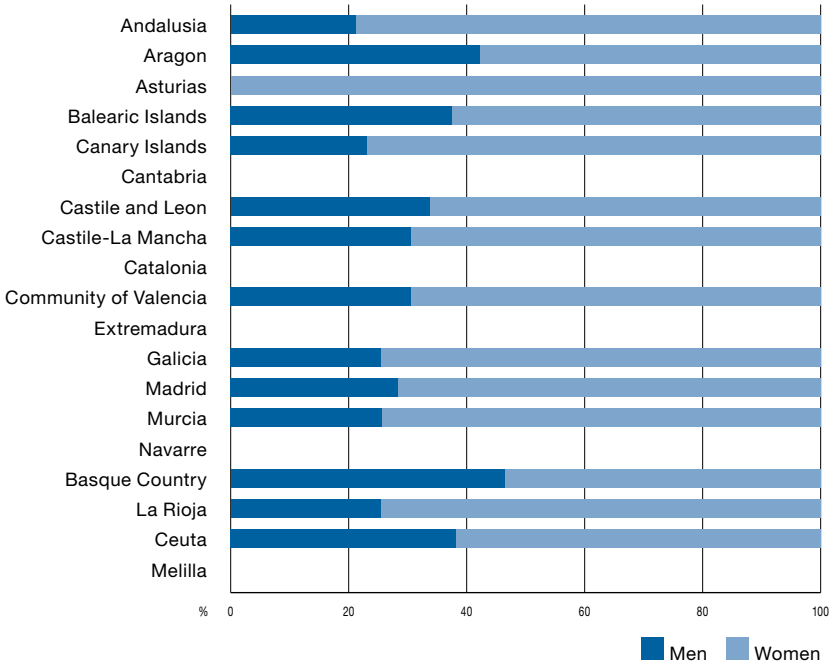
In the category Other Healthcare Profiles, more men than women participated in Madrid as trainees. In Andalusia and Murcia, more men than women participated in training too, but in Other Non-Healthcare Profiles.

Table 23 lists the conclusions drawn from these last sections.

Existing Training Plans in Autonomous Communities and Ingesa

The Table 24 offers a complete account of training plans existing in the different Communities and Ingesa (Ceuta and Melilla).

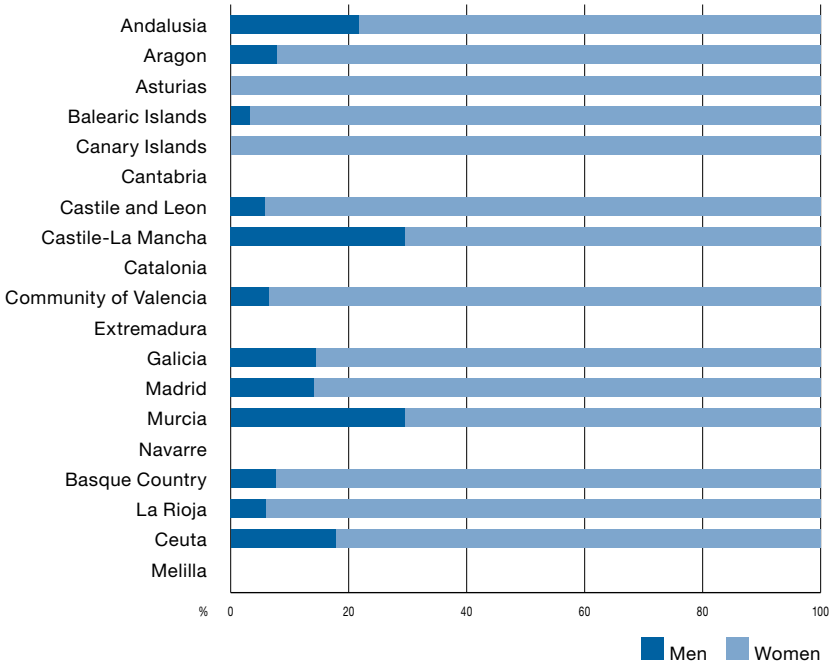
Figure 30. **Medicine Professionals Participating in Training in Gender Violence (2009). Sex-Itemised Data**



	Men	Women
Andalusia	19	69
Aragon	26	35
Asturias	-	1
Balearic Islands	26	43
Canary Islands	15	49
Cantabria	-	-
Castile and Leon	706	1,360
Castile-La Mancha	30	68
Catalonia	-	-
Community of Valencia	13	29
Extremadura	-	-
Galicia	13	37
Madrid	237	586
Murcia	6	17
Navarre	-	-
Basque Country	62	71
La Rioja	10	29
Ceuta	5	8
Melilla	-	-

Note. Either unavailable data or no sex-disaggregated data in the ACs of Cantabria, Catalonia, Navarre and Melilla.

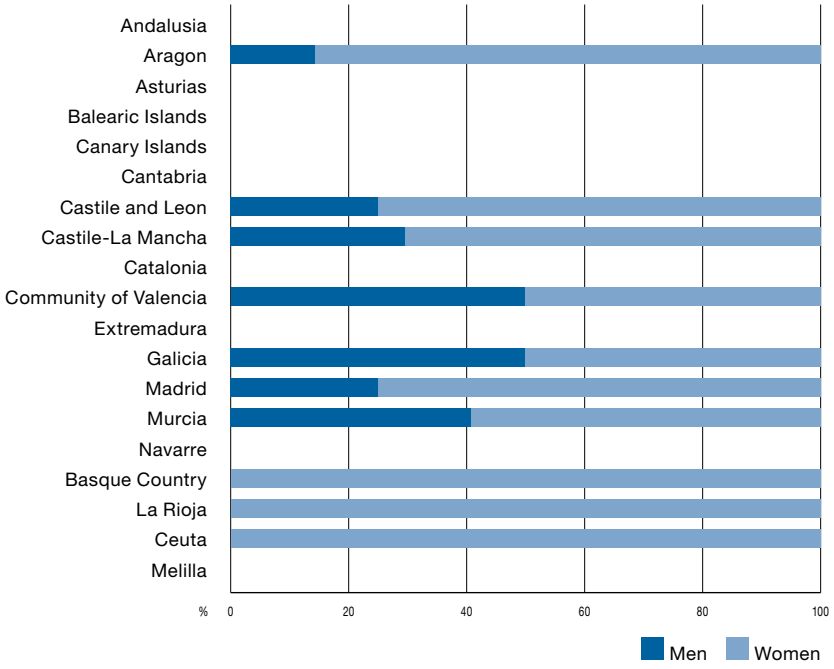
Figure 31. Nursery Professionals Participating in Training in Gender Violence (2009). Sex-Itemised Data



	Men	Women
Andalusia	26	89
Aragon	10	108
Asturias	-	56
Balearic Islands	3	81
Canary Islands	-	9
Cantabria	-	-
Castile and Leon	82	1,187
Castile-La Mancha	107	246
Catalonia	-	-
Community of Valencia	10	130
Extremadura	-	-
Galicia	22	123
Madrid	165	950
Murcia	3	7
Navarre	-	-
Basque Country	14	154
La Rioja	1	14
Ceuta	6	27
Melilla	-	-

Note. Either unavailable data or no sex-disaggregated data in the CAs of Cantabria, Catalonia, Extremadura, Navarre and Melilla.

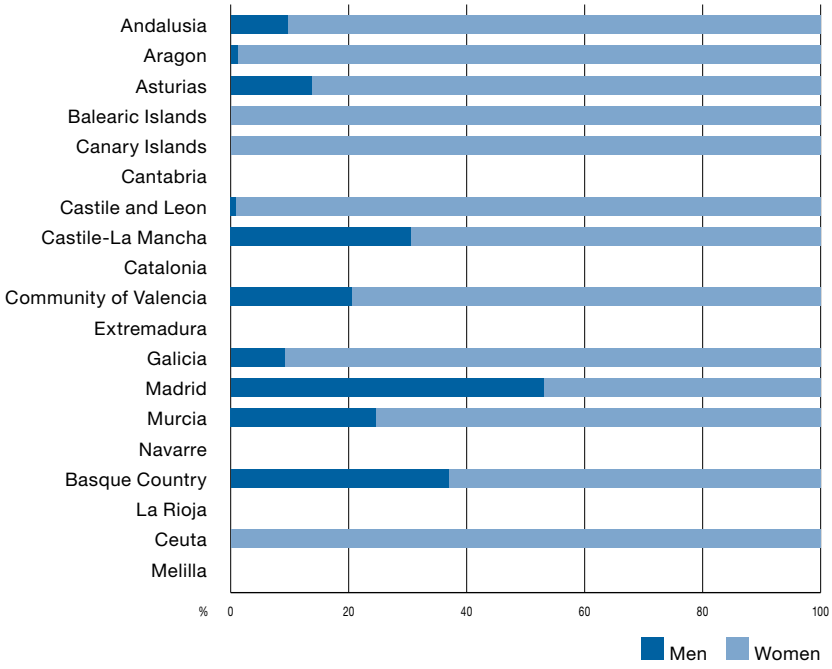
Figure 32. **Psychology Professionals Participating in Training in Gender Violence (2009). Sex-Itemised Data**



	Men	Women
Andalusia	-	-
Aragon	1	6
Asturias	-	-
Balearic Islands	-	-
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	7	21
Castile-La Mancha	8	19
Catalonia	-	-
Community of Valencia	1	1
Extremadura	-	-
Galicia	1	1
Madrid	5	15
Murcia	9	13
Navarre	-	-
Basque Country	-	3
La Rioja	-	2
Ceuta	-	1
Melilla	-	-

Note. ACs lacking this Professional Profile: Balearic Islands and Canary Islands. Either no available data or no disaggregated data by gender in the ACs of Andalusia, Asturias, Cantabria, Catalonia, Extremadura, Navarre and Melilla.

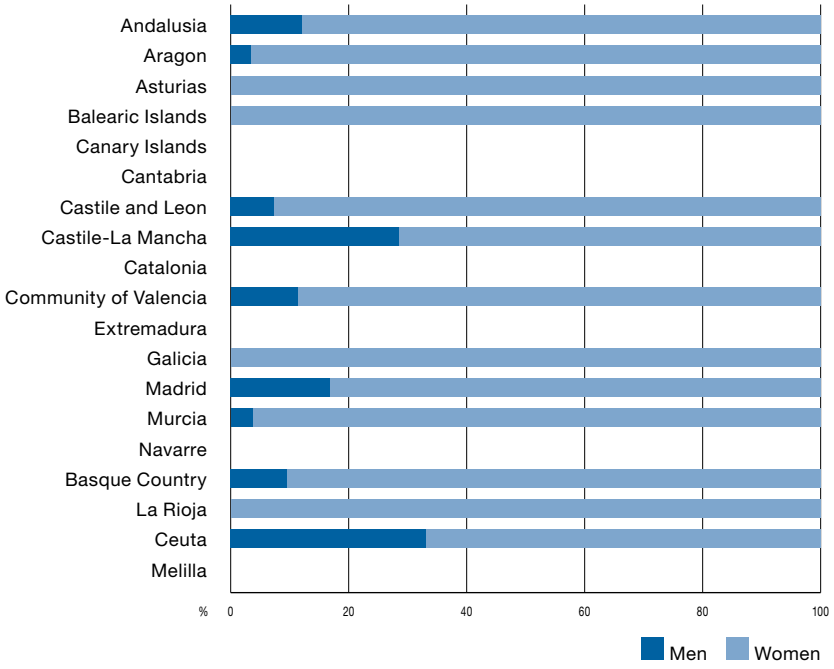
Figure 33. **Professionals of Other Healthcare Profiles Participating in Training in Gender Violence (2009). Sex-Itemised Data**



	Men	Women
Andalusia	2	18
Aragon	1	54
Asturias	1	6
Balearic Islands	-	19
Canary Islands	-	1
Cantabria	-	-
Castile and Leon	2	135
Castile-La Mancha	30	67
Catalonia	-	-
Community of Valencia	28	105
Extremadura	-	-
Galicia	5	47
Madrid	17	15
Murcia	1	3
Navarre	-	-
Basque Country	20	34
La Rioja	-	-
Ceuta	-	1
Melilla	-	-

Note. AC lacking this Professional Profile: La Rioja. Either unavailable data or no sex-disaggregated data in the ACs of Cantabria, Catalonia, Extremadura, Navarre and Melilla.

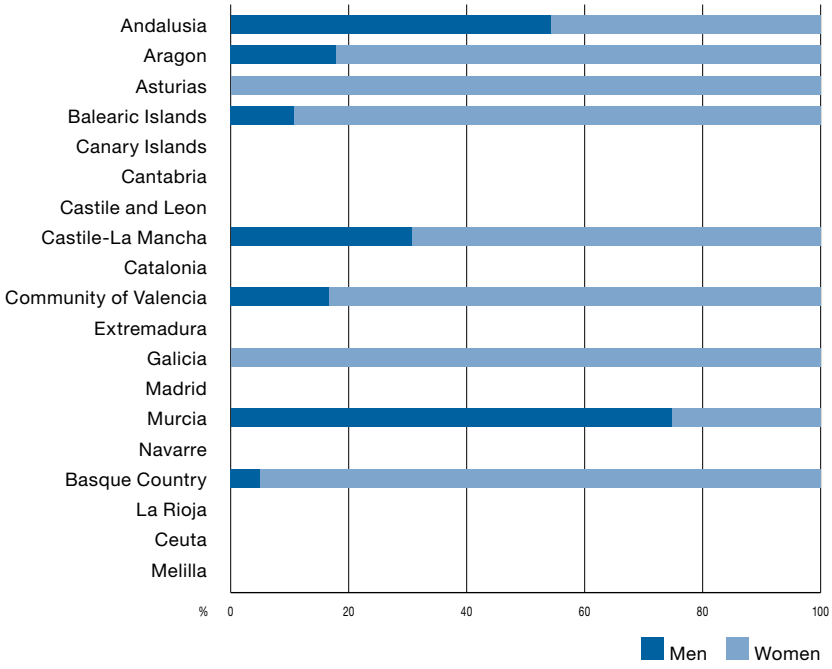
Figure 34. Social Work Professionals Participating in Training in Gender Violence (2009). Sex-Itemised Data



	Men	Women
Andalusia	3	21
Aragon	1	24
Asturias	-	12
Balearic Islands	-	5
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	9	107
Castile-La Mancha	13	32
Catalonia	-	-
Community of Valencia	6	45
Extremadura	-	-
Galicia	-	43
Madrid	5	24
Murcia	1	23
Navarre	-	-
Basque Country	2	18
La Rioja	-	11
Ceuta	1	2
Melilla	-	-

Note. CAs lacking this Professional Profile: Canary Islands. Either no available data or no disaggregated data by gender in the ACs of Cantabria, Catalonia, Extremadura, Navarre and Melilla.

Figure 35. **Professionals of Other Non-Healthcare Profiles Participating in Training in Gender Violence (2009). Sex-Itemised Data**



	Men	Women
Andalusia	36	30
Aragon	2	9
Asturias	-	1
Balearic Islands	2	16
Canary Islands	-	-
Cantabria	-	-
Castile and Leon	-	-
Castile-La Mancha	12	27
Catalonia	-	-
Community of Valencia	7	34
Extremadura	-	-
Galicia	-	7
Madrid	-	-
Murcia	3	1
Navarre	-	-
Basque Country	1	18
La Rioja	-	-
Ceuta	-	-
Melilla	-	-

Note. CAs lacking this Professional Profile: Canary Islands, Madrid, La Rioja and Ceuta. Either no available data or no disaggregated data by gender in the ACs of Cantabria, Castile and Leon, Catalonia, Extremadura, Madrid, Navarre and Melilla.

Table 23. Conclusions on Trainers' Professional Profile, Teaching Staff as per Sex, Affiliation of Teaching Staff, Professional Profile of Trainers and Trainers as per Sex	
Trainers' Professional Profile	Medicine is the most common profile among trainers (236 professionals), followed by Nursing (136), Psychology (102) and Other Professional Profiles (101)
Teaching Staff as per Sex	In general, participation of women Trainers is broader than men's for any of the professional profiles. However, in Medicine, there are more men than women in Castile-La Mancha. In Galicia, male Psychologists who provide training exceed their female counterparts and in Aragon, all Psychologists are men. In Aragon, Castile-La Mancha, Community of Valencia and Extremadura, men outnumber women in the Profile Others and in Extremadura, all Trainers are men
Affiliation of Teaching Staff	Generally speaking, a large proportion of the teaching staff is affiliated to the Autonomic Administration. In the Canary Islands the whole teaching staff are related to this institution
Professional Profile of Trainees	The most widespread profile among trainees is Medicine (4,567 professionals), followed by Nursing (4,157), Other Healthcare Staff (2,735) and Social Work (499). In the Basque Country, there were more male trainees relating to Medicine than female ones. As regards Other Healthcare Profiles, more men than women received training in Madrid in that category. Equally, in Andalusia and Murcia more men than women took part as trainees in Other-Non Healthcare Profiles
Trainees as per Sex	Percentages of women's participating in Training as students were higher; women totalled 6,678 and men 1,835

Table 24. Training Plans in ACs	
AC	**Name**
Andalusia	Andalusian Network Training Plan for Confronting Abuse of Women *(Red Formma)*
Aragon	They do not have any specific training plan for confronting gender violence in Aragon but they do have an Annual Training Plan
Asturias	Programme for Awareness and Training Against Gender Violence in the Asturias Principality. Six-monthly Training Plans of Adolfo Posada Institute
Cantabria	Training of Healthcare Services' Professionals in Awareness, Detection and Watch on Violence Against Women
Castile and Leon	Multiannual Training Programme in Gender Violence (2007-2010). This training programme is currently inserted in the Strategic Training Plan of the Health Care Department
Castile-la Mancha	Programme for the Prevention and Intervention in Gender Violence within the Family Sphere. Prevention, Detection and Healthcare Professionals' Intervention in Gender Violence
Catalonia	Catalonia Health Plan in the Horizon 2010. It places addressing gender violence among its priorities and envisages the training of professionals as a relevant action, which does not materialise in a systematic planning
Community of Valencia	Continuing Training Plan of the *Conselleria de Sanitat* for 2009. Training Plan for Public Employees Serving in the Administration of the Generalitat Valenciana for the Year 2009

Extremadura	School of Health Sciences' Annual Training Plan
	Teaching Commissions' Training Plan of each Health Area
Galicia	Annual Training Plans
Madrid	Continuing Training Plan 2007-2009 of the Department of Health. Strategic Training Plan for Healthcare Professionals in the Madrid Community
Murcia	Comprehensive Plan for Training in Confronting Gender Violence of the Murcia Region (2009)
Navarre	Teaching Plan of the Department of Health 2009
Basque Country	IV Equality Plan for Men and Women of the *CAPV* (it puts together objectives and training actions for the prevention and watch on gender violence in the Healthcare Sector). II Inter-Institutional Agreement for Improving the Healthcare Attendance of Women Victims of Abuse and Sexual Abuse in the Domestic Sphere
Ceuta	Awareness and Training in Detection of Gender Violence in the Healthcare Sphere (Annual)

Compiling of Major Highlights in Prevention and Healthcare Watch on Gender Violence in Autonomous Communities and Cities with Autonomy Status (Ingesa)

This section compiles exclusively programmes and actions ACs and Ingesa (Cities of Ceuta and Melilla with Autonomy Status) decided to highlight among all activities performed in 2009.

The Inter-Territorial Council's Commission against Gender Violence, based on this year's experience, has deemed appropriate to work on the collection of the most significant experiences undertaken in Health Services of ACs and Ingesa since the enactment of Organic Law 1/2004, to be released in the next Annual Report.

In the list of 2009 most significant actions, the majority of ACs submitted experiences of programmes and activities addressed to practitioners with direct involvement in patient care and especially to women who resort to the Health System, to both Primary Care (PC) and Specialty Care (SD).

The attempt to include a gender approach emerges in most phases of these actions (parity or balanced presence in the Human Resources Team concerned, selecting a non-sexist language, initiatives to modify women and men's traditional roles or transforming gender relations, promoting women's empowerment and equal opportunities, etc.).

Some of these actions have not yet been evaluated, thus their impact on women's state of health has not yet been determined either. Each AC has detailed their possibilities of transfer to other territories, explaining why other ACs or organisations might benefit from each initiative.

Intervention Areas to which such gathered experiences are ascribed may substantiate in:

- Adapting existing Healthcare information systems in an attempt to build common indicators on gender violence.
- Developing of specific services for watch on gender violence in Primary Care Services Portfolio.
- Training of Healthcare Services' professionals.

- Specific Actions targeting special vulnerability groups.
- Assessment of Actions.
- Research.

Some experiences may be adscribed to more than one line of intervention. Nevertheless, they have been grouped by area of priority intervention, within the different activities developed.

Adapting of Healthcare Information Systems

The Community of Valencia has developed a unique software application, applicable both in PC as in SC, which allows greater uniformity in data collection and intervention. The tool contains validated instruments for the confirmation of cases of gender violence. One of them has already been used for early detection of cases of gender violence; it is known as AAS Screening Instrument (Abuse Assessment Screen). The other will be used to assess the risk of homicide/suicide in women who are confirmed positive cases of abuse; it is the DA Questionnaire (Danger Assessment). It also enables to record and monitor interventions put in place and Grievous Bodily Harm Reports issued. This application allows to monitor the degree of implementation of the Protocol for a Healthcare Response to Gender Violence in the Community of Valencia *(PDA)* and to compare results over time.

The general objective has been to provide a tool to guide medical personnel in the active search of cases, early detection and type of intervention to perform in each case.

When incorporating a gender perspective, attention has been paid to the use on non-sexist language and the balanced presence of women and men in the workgroup.

The tool is already developed, it is being implemented in PC and they have envisaged devising strategies for healthcare staff training, thus promoting its use.

Table 25 contains information about the adapting of healthcare information systems in the Areas relating to Prevention of Gender Violence and Attendance Care for resulting victims, in Autonomous Communities and Cities with Autonomy Status, throughout 2009.

Table 25. Adapting of Healthcare Information Systems in the Areas Relating to Prevention of Gender Violence and to Attendance Care for Resulting Victims in Autonomous Communities and Cities with Autonomy Status, throughout 2009

AC	Highlight	Initiation and Development Period	Population Targeted
Community of Valencia	*Sivio* (Information System for detection and Assessment of Gender/Domestic Violence)	Since late 2008. Currently in force. Implementation in PC.	PC Professionals; Healthcare Administration Professionals authorised to use the tool.
La Rioja	Designing and computerisation on the platform of electronic medical records *(Selene),* Grievous Bodily Harm Report of abuse for cases of gender violence seen in the Public Health System of La Rioja	2009	PC and SC professionals

Developing of the Specific Services for Response to Gender Violence in the Primary Care Services Portfolio

Based on some Community of Murcia's previous experience, Asturias is applying a training and intervention project based upon a bio-psychosocial approach, for addressing the detection of cases of abused women in healthcare services. To this end, the training of healthcare professionals and the effective coordination between PC and Mental Health, intend to modify the traditional pattern of biomedical approach replacing it with a thorough analysis of the causes originating the request.

The objectives have been: Incorporating the bio-psychosocial care methodology in the Primary Care routine doctor's office visit; address, re-orientate and supervise the rehabilitation of women with psychosocial disorders, among others those originating in intimate partner violence; reducing medicalisation of distress; reinforcing the detection of symptoms relating to abuse; promoting self-care and personal autonomy; and contribute to re-socialising and rehabilitation.

The gender approach is cross-applied from the very conception of the action, as symptoms of "distress" primarily affect women and therefore, this action aims to reduce health inequalities generated and maintained by the prevailing patriarchal pattern.

Outstanding results of the evaluation are:

- Motivation of professionals. Broad participation in the project.
- Sizeable magnitude of demand relating to distress symptoms.

- Overconsumption of healthcare resources.
- Over-prescription of psychopharmaceuticals.
- Dissatisfaction of professionals with treatments available and perception of these patients as difficult, awkward and frustrating.
- The risk of professional burn out is remarkably high as these patients may trigger feelings of frustration and dissatisfaction (for some of the services under study this type of patients amounted to 50 % of the total).
- They perceive the complexity of syndromes and the constraints for their treatment imposed by available biomedical treatments.
- Need for reorienting the care method and for including the bio-psychosocial approach. Exclusively pharmacological approaches are not effective in these cases and results very limited.

Castile and Leon included in the Management Plan 2009, a specific Indicator of gender violence anamnesis targeting women over 14 years of age who would come for medical or nursing consultation on health problems of any kind, with the aim of increasing soliciting and early detection of women victims of gender abuse.

All Primary Care teams conducted training sessions for confronting gender violence with a gender approach; they stayed focused on how and why it arises and the importance of educating on equality to eradicate the problem. These activities ran parallel with the dissemination and implementation of the service for watch on violence.

Interrogating 32,018 women about gender violence meant a 2.9 % coverage of the population of women likely to be seen in healthcare services of Autonomous Communities. Results obtained by the end of June 2010 made 124,430 the number of women over 14 years of age whose medical history on gender violence had been made, which represents a percentage of 5.4 %. Total women diagnosed as victims of abuse currently seen in Primary Care, amount to 1,648 women.

Table 26 provides information about the development of specific services for responding to gender violence, included in Primary Care Services Portfolios of Autonomous Communities, during 2009.

Table 26. Developing of Specific Services for Responding to Gender Violence in Primary Care Services Portfolios of Autonomous Communities and Cities with Autonomy Status (2009)

AC	Highlight	Initiation and Development Period	Population Targeted
Asturias	Drafting of a Bio-Psychosocial Project targeting persons suffering distress in Health Area VII	September 2009-currently in force	Professionals of the PC and SC network of Mieres Area they receive as patients Adult women featuring high frequentation rate and exhibiting psychosomatic disorders encompassed within the category of distress disorders
		Assessment will be made in June 2011	
Castile and Leon	Development of the specific services for response to gender violence in the Services Portfolio and their inclusion in Annual Management Plans *(PAG)*	January 2009 -December 2010	Women over 14 years of age attending consultation
	Assessment of impact of inclusion of indicators for early detection of gender violence in PC Management plans in relation to the medical history and early detection of victims of GV		PC Professionals' activities assessment regarding reception and early diagnosis of cases of gender violence

Professionals' Training

It is the area of Professional Training that concentrates the highest number of Highlights communicated by ACs (Table 27).

Cantabria carried out a training activity aiming at the prevention of GV in a group of special vulnerability, young people, in an attempt to consider the possibility of including prevention and watch on GV in the social benefits of *Consulta Joven* (Young People Consult), a service accessible and well known by young people in this community. The general perception appears to be recognition of this space as a suitable area for consulting or getting information on gender violence.

The general objective has been to raise awareness of the repercussions of gender violence in health; activities in educational centres targeting teachers and students aimed to prevent its occurrence. In all actions performed, the focus has been on the importance of equality relations based on respect.

Table 27. Training of Healthcare Services' Professionals in the Prevention of Gender Violence and Attendance Care for Resulting Victims in Autonomous Communities and Cities with Autonomy Status (2009)

AC	Highlight	Initiation and Development Period	Population Targeted
Andalusia	Andalusian Network for the Training of Trainers in Confronting Abuse of Women *(Red Formma)*	Since 2008 and to date	Health Personnel (healthcare and non-healthcare) of the Public Health System of Andalusia *(SSPA)*
Cantabria	Prevention and Awareness of Violence from the Intimate Partner as a Health Issue in Educational Centres	Date of initiation of the action: November 2009 End Date: April 2010	Professionals, women suffering GV, young population, etc.
			Teachers and 2nd year students of High School Grade at Secondary School Ricardo Bernardo of Solares and Valle del Saja of Cabezón de la Sal
Catalonia	Training Sessions conducted in territorial circuits	2009; currently in force	Professionals who are part of the territorial circuits (medical, nursing, social work, psychology, and education staff, law enforcement, –*Mossos d'Esquadra* and policemen/policewomen– from the educational sector, basic social services and specialised services…) and are open to all people from their teams or centres that might be interested
	Seminar: violence against intimate partner and substances consumption (6 h)	2009	Professionals integrating the *Circuit Barcelona contra la violència vers les dones* who exercise their professional work in the social, healthcare, education and public safety sectors
	Training Course in Referents Detection and Intervention in Patients in Care with a History of Living under any Type of Violence (6 h)	December 2009	Professionals who exercise their work in the hospital sphere in the Specialties of Medicine, Nursing and Social Work
	Seminar for Intervention against Sexual Abuse (4 h)	2009	Professionals integrating the *Circuit Barcelona contra la violència vers les dones* who exercise their professional work in the social, healthcare, education and public security spheres
	Training Course in Referents Addressing sexual Abuse in Healthcare Sphere (24 h)	2009	Professionals integrating the violence circuits and abuse, who fit the Medicine, Nursing, Social Work and Psychology Profiles and who exercise their work in the Healthcare sphere –in Primary and Specialty Care–
Murcia	The Critical Incident applied to Gender Violence	Currently in force	Socio-healthcare Professionals from the Murcia Health Service
Ingesa Ceuta	Training of Primary Care professionals from the Ceuta Healthcare area for early detection of Gender Violence	Currently in force	PC Professionals
Ingesa Melilla	III Healthcare Symposiums on Gender Violence	Currently in force	Healthcare services' professionals from the healthcare attendance area Professionals who deal with GV issues People interested, aware of or committed to GV

As results obtained, they presented a follow-up of the positive evolution of the knowledge and attitudes about gender violence (a study-choice pre and post intervention was made on that).

Ingesa-Ceuta undertook a training action attempting behavioural changes of health care professionals in the sphere of healthcare attendance in Primary Care.

Ingesa-Melilla conducted the third edition of a training activity in Primary Care, drawing together the different social sectors involved, as a way in itself of raising awareness and in an attempt to expand this awareness of existing knowledge and healthcare actions for dealing with gender violence, from PC to the whole of the Melilla society.

The principal aim was to improve area healthcare professionals' actions when faced with suspicion of gender violence cases; also, to learn to distinguish between the different types of violence and provide the knowledge of available means and resources for the care of women victims in this town. In addition, to become acquainted with the degree of involvement and ways of acting of the different public and private entities connected to gender violence.

Murcia's highlight has been the introduction, in the framework of the health regional system, of an innovative tool from a comprehensive point of view of the training, the assessment, and the impact of actions in the socio-healthcare professional context of GV.

The general target has been to improve care of women for preventing errors and reflect on values and attitudes of professionals of the Murcia Health Service regarding this Public Health Issue.

As per factors that allowed to envisage the gender approach, learned guidelines and socio-culturally built factors have been identified, which determine specific complex realities around gender in the specific context of GV. The relation between GV and the institutional and/or professional mechanisms for acting against it has been one of the issues addressed. Reflecting on the influence of determinants (gender relations as determining factors of situations of violence, possibility of empowerment of women to prevent, avoid or address situations of violence, etc.) in the professional sphere has also been a main purpose.

In the makeup of the Technical Team of the Plan, the Counselling Teams and the professional groups that actions, in each one of their editions, targeted, the parity condition was fully respected.

In the context of assessment, an analysis is envisaged of the confronting the various situations of violence, regarding the prevention and acting according to sex roles of persons integrating the healthcare teams.

Andalusia highlighted this Coordinated Training Plan –*Red Formma*– together with the rest of actions carried out from the Health Department,

developed by a team of professionals belonging to the Andalusian Public Healthcare System *(SSPA)* in all provinces that integrate it. The Training Plan envisages Sessions on Awareness of Women's abuse, Basic Training courses in Healthcare's confronting such abuse and a Training Course to train more professionals.

The reference framework of this project has been, at all times, the gender approach. Especially women integrate the team of professionals of the Network and also men (special interest has been taken in incorporating men). A non-sexist language is used in all materials and the whole of the teaching staff has been asked to place special emphasis on the need for changing language for the significance it has in thinking construction and in social change. The importance of language is also addressed with the trainees through specific activities; also gender roles, their importance as inequalities generators and all gender inequalities in health, in all training activities performed.

Results may be structured in three areas:

- *Sessions to raise Awareness* of the abuse of women: We should highlight that 67.9 % of participants gave Interest of the Session the highest score, 46.6 % Usefulness of the Session, 66.4 % Interest of Expanding Training, and 56.7 % gave Training Staff their highest. As per length of sessions, 47.3 % considered it appropriate while 50.2 % found it to be short or very short.
- *Basic Training Course* in the healthcare approach to abuse of women: Trainees' appraisal of the course structure is very favourable: 81.3 % gave scores of 4 or 5. Regarding objectives and contents percentage is even higher (87.5 %).
- *Course in Training to Train* in the healthcare approach to the abuse of women. The global score given by trainees is very high.

Catalonia highlighted five educational experiences conducted in 2009, in the framework of the initiative *Circuit Barcelona contra la violència vers les dones*. The purpose was to extend programmed training for professionals taking part in this initiative, to the rest of professionals of centres and services that form the network for care of women and general population.

Seminars and training workshops included in this initiative, apart from providing professionals with tools to detect cases of gender violence and act accordingly, intend to offer specific expertise in substance abuse and gender violence. This will help them improve assessment, referral, and addressing these specific cases. They also intend to provide tools and strategies for care and approach to cases of sexual abuse and for expanding knowledge in the various fields (acting in sexual abuse experienced in childhood, incorporation of resilience as a strategy of intervention, prevention,

work with the young…). Additionally they aim to promote the actions of the Commission for Intra-Family and Gender Violence at the Hospital, ensuring the presence of professionals with knowledge of violence in the different entities that make-up the Hospital, in order for them to promote actions and training within the latter.

Factors that enabled to envisage a gender approach to actions were the use of inclusive language –non sexist– in the programming and dissemination of the course and addressing the myths and stereotypes surrounding sexual abuse and gender mainstreaming in the professional work of educators.

Assessment of Activities

The Madrid Community has undertaken an evaluative activity on training of professionals in confronting GV. In 2007, within the *Programme for Women's Health Promotion,* the need arose of knowing the value of actions undertaken two years before in the framework of the Regional Strategy for Health Actions to Confront Intimate Partner Violence against Women.

The process started with the drafting and approval of the Document Reference Framework for Evaluation of the Regional Strategy for Health Actions to Confront Intimate Partner Violence against Women (IPVW) *(Marco de Referencia para la Evaluación de la Estrategia Regional de Acciones de Salud frente a la Violencia de Pareja hacia las Women [VPM]).* In it, after a systematic process of analysis and prioritisation of each line of the Regional Strategy, it was agreed to focalise on evaluating the Line of Continuing Training of Primary Care Professionals in IPVW.

Overall Objectives were to assess the adequacy of the design, implementation and results of the training strategy to the context in which it develops and provide relevant feedback for its developing and to help decision-making.

The sex variable as key structural variable, the identification of gender biases and the respect of parity in the Work Team makeup were issues or factors that allowed a gender violence approach to be adopted in both actions and interpretation of the assessment results.

Assessment favoured use of results by the groups of agents involved The creation of an evaluation team that has been working steadily all along, participating in each stage of the evaluative process, from its very setting up until the development and implementation of their evaluative recommendations, has itself been assessed as an added positive element.

The results of the action have been in themselves a considerable wealth of knowledge that has been incorporated to the rest of actions of the Regional Strategy, providing a valuable feedback and generating

new actions. The experience has enabled the consolidating of the line of evaluation of the Regional Strategy, in such a way that, annually, evaluation needs for the different action lines are revised and given response, according to the criteria established initially.

The Balearic Islands evaluative action supplies for the first time in this Community, information on women who suffer abuse, detected in first psychiatric or psychological visit. It also offers information on knowledge, barriers and attitudes perceived by mental health professionals of the Balearic Islands towards gender abuse.

The primary objectives of this study have been: to assess the health care provided in mental health units to women who suffer abuse, to detect difficulties for their diagnosis and care and to raise awareness of mental health professionales in relation to the detection and health care to these women.

The gender approach has been taken into account in all phases of the action, both in the constitution of the working group as well as in the analysis of the data obtained and in the use of non-sexist language in the drafting of the document.

Table 28 offers information on the Assessment of Actions in Prevention of Gender Violence and relating to Attendance Care for resulting Victims in Autonomous Communities and Cities with Autonomy Status, during 2009.

Table 28. Assessment of Actions Performed in Prevention of Gender Violence and Attendance Care for resulting Victims in Autonomous Communities and Cities with Autonomy Status (2009)

AC	Highlight	Duration	Population Targeted
Balearic Islands	Assessment of specialised health care when addressing Gender Violence	Until December 31st, 2009	Mental Health Professionals
Madrid	Intermediate assessment of the strategic line of continuing education for Primary Care professionals about intimate partner violence against women	Currently in force. Beginning of assessment: July 2007. Final Report on the Assessment: December 2008. Dissemination of Results and Implementing of Recommendations: January to December 2009	Healthcare and Non-Healthcare professionals of Primary Care

Research and Specific Actions Targeting Special Vulnerability Groups

Castile and Leon is the Autonomous Community with the largest number of small rural communities in Spain, home to a large number of women. That

is why they have carried out a study on the assumption that rural women experience greater difficulties in detection and care of gender abuse. The overall objective was to know rural/urban women's attitudes and behaviours when facing male violence and to determine to which extent they may act as barriers in the detection and care.

Analysis of these women's discourses provides the visibility and understanding of their experiences. Battered women are not a homogeneous bloc; the uniqueness of their biographies emerges and so do their paths in relation with violence and their living conditions.

Throughout the process, they go through complex and changing experiences, which have an impact on their moods, their perceptions, in their own bodies and their feelings. One of the main conclusions of this study reveals that these women do not remain passive and submissive to violence. Their role in the conquest of autonomy and wellbeing for their lives and their struggle for independence deserves highlighting.

The research signalled by the Canary Islands *(BBPP)* responds to the need for evaluation of the actions that the Canary Islands Health Service has implemented in Primary Care.

Aragon describes a qualitative study aiming to know what women victims of GV need and expect from the Health System of Aragon. Main results show that women often seek professional support in Primary Care and greatly appreciate their listening and guidance.

Women often seek help from health professionals in an implicit way, so it is very important to enable them to know how to identify signs, symptoms and attitudes that may respond to a male abuse situation. Training reveals itself as a key factor to detect women victims of violence. The role of social workers in the support and advice to these women is highly valued; Primary Care is valued as a vital resource because of its proximity to the user.

With respect to basic social services, they are not perceived as a close and supportive resource by these women who still see them as somehow stigmatised and destined to the socially most excluded people.

Work being done in shelters is considered essential to enable women to rebuild their lives. A certain lack of resources emerges as well as of legal counselling devices.

As for women themselves and their own environment and circumstances, the rural area reveals difficulties to maintain confidentiality, which is a barrier for women to take a proactive stance; violence young women tend to suffer is more of a sexual character; migrant women are the primary users of shelters. This implies the need for multicultural adaptation. It is difficult for women having been suffering violence for a long time to identify themselves as victims. Stories of abuse often repeat themselves; migrant women require more intensive initial actions but limited in time.

On the contrary, indigenous women of a certain age do not require so many immediate actions but do need them to be maintained over a more prolonged time.

Table 29 gathers information on research and specific actions aiming for prevention of gender violence and attendance care targeting groups of special vulnerability in Autonomous Communities and Cities with Autonomy Status, during 2009.

Table 29. Research and Specific Actions Aiming For Prevention of Gender Violence and Attendance Care Targeting Groups of Special Vulnerability in Autonomous Communities and Cities with Autonomy Status (2009)

AC	Highlight	Duration	Population Targeted
Aragon	Qualitative Study on Gender Violence against Women in the AC of Aragon	2009-February 2010	Women victims of gender abuse who accept themselves as such, whether or not they reported the situation
Canary Islands	Quantitative research: Evaluation of the Action Programme in Primary Care for training of socio-healthcare personnel in identifying and providing care to women victims of gender violence	December 2009- second half 2010	Primary Care Professionals
Castile and Leon	Study of attitudes and behaviour before gender violence in women victims of abuse in Castile and Leon. Analysis of their views and experiences and appreciation of differences depending on either their rural or urban place of residence	Until 31st of December 2009 (Paper Submittal: June 2010)	Women who suffer abuse and live in rural and urban areas of Castile and Leon

New Technologies

In Catalonia, in 2003, the Website: www.csbcn.net/cvdbcn, was created to facilitate communication and coordination between professionals from different areas of the city of Barcelona assisting victims of gender abuse. Currently, at the request of the professionals who are part of the circuit, a revision or modification is believed to be necessary, and so is the incorporation of new modules and applications on-line.

Objectives have been to improve the current website of reference professionals and resources of the *Circuit Barcelona contra la violència vers*

les dones and supply new tools, online applications and a self-management of contents system that may facilitate networking and coordination of all professionals from the different institutions and services attending them.

Table 30 offers information on new technologies concerning prevention and Healthcare watch on gender violence in Autonomous Communities and Cities with Autonomy Status (2009).

Table 30. New Technologies Concerning Prevention and Healthcare Watch on Gender Violence in Autonomous Communities and Cities with Autonomy Status (2009)

AC	Highlight	Initiation and Development	Population Targeted
Catalonia	Web 2.0 of the *Circuit Barcelona contra la violència vers les dones* (Web that enables communication and coordination between professionals who assist victims of VG)	October 2009, in production	Professionals from all fields who are part of the *Circuit Barcelona contra la violència vers les dones* (committees, working groups...), at a local/social, healthcare, police, educational and legal level

Summary of Activities Performed by the National Health System's Commission against Gender Violence in 2009

Under Organic Law 1/2004, of 28 December, on Comprehensive Protection Measures against Gender Violence[6], on 22 September 2004, the ICNHS *(CISNS)* in Plenary Session, approved the creation of a Commission against Gender Violence. It is key to remember that, headed by the Secretary General of the Ministry of Health, Social Policy and Equality, it incorporates a person representing the Health Service of each Autonomous Community, City with Autonomy Status and Ingesa. This has a positive effect on consensus decision-making and collective involvement in the development of approved actions.

On the part of the State General Administration, members of the Commission are the Government Delegation for Gender Violence, the Women's Institute, the Public Health General Directorate, the Health General Secretariat that assumes the Chairmanship of the Commission, and the Quality Agency General Directorate that, through the Observatory on Women's Health, takes on the coordination and Technical Secretaryship.

Since its inception, the Commission has taken on specific commitments established by Law on Gender Violence prevention, detection and watch, and care of its victims, all from Health Services.

Specifically, during 2009, the period this report spans, were the below listed work actions performed and consensus endeavours made:

1. The Technical Group for Information Systems and Epidemiological Surveillance of Gender Violence *(Grupo Técnico de Sistemas de Información y Vigilancia Epidemiológica de la Violencia de Género)* has continued working on the clarification of and consensus on the collection of information files for each of the 18 Common Indicators[7]. This complex task is essential to obtain a quality information system.

6 *Boletín Oficial del Estado. Ley Orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género. Art. 15. BOE núm. 313, 29-12-2004.*

7 http://www.mspsi.gob.es:80/organizacion/sns/planCalidadSNS/pdf/equidad/A4ViolIndicadoresIng.pdf

The Commission presented and approved these files in its Meeting of April 30, 2009. They were intended to facilitate the normalised and systematised collection of information, key to enable planning and evaluating the magnitude of the Gender Violence issue in the National Health System.

Throughout, and through the said files, ACs collected epidemiological information around the magnitude and characteristics of gender violence in the NHS, for drafting the Annual Report.

2. Secondly, the Technical Group for the Training of Professionals has continued working in the development of common educational contents that may sustain the training objectives approved by the ICNHS, in December 2007. These contents are presented organised in wide areas of knowledge relating to gender violence and its characterisation in the Health Care sphere:

- Basic concepts on gender and inequality.
- Basic concepts on gender violence.
- Impact of violence on women's health. Attitude of Healthcare personnel.
- Performance in Primary and Specialty Care.
- Assessment.
- Resources and Referrals.
- Ethical and Legal aspects.

At the Meeting of April 30, a list of *common and basic teaching materials* was established in line with educational contents. These materials were categorised as follows: scientific papers, regulatory framework, training materials, books and monographs, websites of institutions specializing in gender /gender violence[8].

They were considered quality materials and tools, useful to support the teaching activity of the training teams. Moreover, students will profit from these materials as support for consultation during and after their period of basic training.

The list of materials may be accessed at the Commission's website, within the Quality Plan of the Ministry of Health, Social Policy and Equality[9].

8 Pending approval by the ICNHS *(CISNS)*.

9 http://www.msps.es/organizacion/sns/planCalidadSNS/pdf/equidad/materialesEducativosFormacionVG.pdf

Besides, the Technical Group has continued working on the evaluation indicators for training of professionals, adjusting certain improvements to the data collection form thus enabling their being incorporated to the drafting of this Report.

3. Thirdly, as every year, from the Healthcare National School of the Carlos III Health Institute, in turn depending on the Ministry of Science and Innovation, with the financial support of the Observatory on Women's Health of the Ministry of Health and Social Policy, and the educational support of the Women's Institute, Training Actions for Health professionals, for the detection and care of gender violence cases have been developing through:

- Training Course for Trainers for Prevention and Care of Gender Violence Victims (5th ed.).
- Course on Prevention and Attention to Gender Violence for Mental Health Teams (5th ed.).
- Conference on Programmes for Prevention and Watchful Care of Gender Violence (4th ed.).

In turn, the ACs contributed the indicators relating to training performed by health professionals in gender violence issues. In the corresponding chapter of the present Report, the fresh supply of information may be thoroughly analysed thanks to modifications in the collection.

Subsidies for 2009

Royal Decree 924/2009, of 29 May, published in the State Official Gazette *(BOE)* Num. 145 of 16 June 2009, regulates direct concession of subsidies to ACs and CAS (through Ingesa) for implementing the strategies of the National Health System[10].

One of the subsidised areas is Attention to Gender Violence from the NHS. For its development, 8 Funding Lines were submitted such as: Training of Professionals, Incorporation of Variables necessary for obtaining Common Indicators of Gender Violence in the Digital Medical History, Evaluation of Healthcare Actions, or Programmes addressed to women in situations of special vulnerability, among others (see Annex 1).

Overall, ACs presented 49 projects distributed among the said 8 Funding Lines and presented, broken down, in figure 36, and the budget subsidied per AC (Table 31).

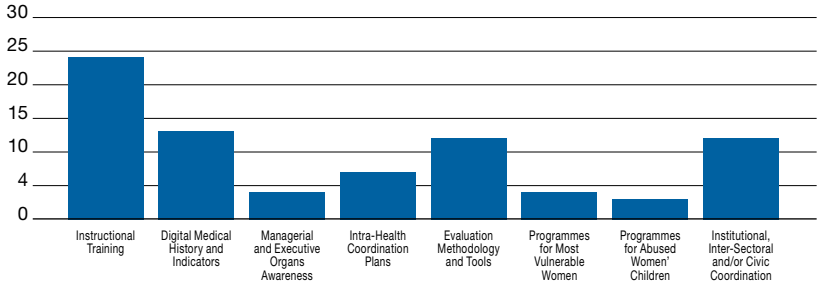
10 May be consulted at http://www.boe.es/boe/dias/2009/06/16/pdfs/BOE-A-2009-9982.pdf

All ACs submitted a justifying written Report on their projects complying with legal requirements regarding due deadlines and presentation form and according to the provisions of the Official Gazette *(BOE)*. Only two Communities failed to invest the total amount they had requested in the projects they had initially presented, which materialised in their refunding part of the Subsidy received.

Table 31. Budget subsidied per AC (2009)

ACs	Budget subsidied in 2009	ACs	Budget subsidied in 2009
Andalusia	710,700.00	Extremadura	94,800.00
Aragon	112,645.75	Galicia	241,273.86
Asturias	70,000.00	Madrid	543,495.14
Balearic Islands	92,971.80	Murcia	123,585.00
Canary Islands	174,300.00	Navarre	13,802.38
Cantabria	50,447.61	Basque Country	186,933.60
Castile and Leon	221,616.00	La Rioja	27,514.38
Castile-La Mancha	177,053.41	Ceuta	6,000.00
Catalonia	638,165.12	Melilla	4,160.00
Community of Valencia	435,861.21		

Figure 36. Prevention of and Healthcare Watch to Gender Violence



Funding Lines 2009	Number of Projects Funded
Instructional Training	24
Digital Medical History and Indicators	13
Managerial and Executive Organs Awareness	4
Intra-Health Coordination Plans	7
Evaluation Methodology and Tools	12
Programmes for Most Vulnerable Women	4
Programmes for Abused Women' Children	3
Institutional Inter-Sectoral and/or Civic Coordination	12

Annex 1.
Indicators for Medical History. Data Collection Sheet

Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Issued at PC: ☐ (mark with an ×)
Issued at SC: ☐ (mark with an ×)

Special registration database*:
**In the event of an AC relying on a special registration database, please specify.*

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It is recalled that **Gender Violence** is the definition agreed by Consensus in *the Common Protocol for a Healthcare Response to Gender Violence:* "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" *(Resolution of the United Nations General Assembly 1993).*

The majority of ACs cannot currently obtain specialty care data from a medical history but even in the event this were possible it would not be correct to add PC and SC cases, without first checking for possible duplications.

Population denominators for calculating rates (annex P)
Quinquennial groups, part of the January 1, 2009 Census update *(INE),* are used, estimating the 14-year old female population as the fifth part of the age quinquennium 10-14 year old.

Same population denominator is used for *nearly* all Indicators expressed as rate (Indicators 1, 3, 4,8b and 9b). *Age groups* break down Indicator 8b. (Please remember that the first group spans six years (14 to 19). Indicator 9b is *nationality*-itemised, Indicator 10 denominator is Live Births (see Annex).

The *denominator* is the *same* whether the Indicator is calculated from PC data, from SC data or from the sum total of both.

Denominators for calculating percentages
Denominators are all cases of Gender Violence obtained from the Primary Care Medical History, from the Specialty Care one, or from both as sum total. The same denominator applies to all Indicators expressed as a percentage with respect to PC or SC with the exception of Indicator 2 where all the reports issued at PC and at SC, whatever the motive, are used as denominator.

Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Magnitude indicators

Indicator 1. Cases Detected in Women Aged 14 Years or Over, per 100,000 (rate)

Definition		
Cases of women aged 14 years or over, per 100,000, attended to at the healthcare system (Primary Care and/or Specialty Care and Total) who for the first time admit being subjected to abuse (analysed period)		
Numerator		
Number of Cases Detected in Medical History at:	Raw Data	Rate × 10^5
Primary Care	PC	
Specialty Care	SC	
Total Cases	Total	
Referring to women aged 14 years or over who for the first time admit being subjected to abuse		
Denominator		
Female population aged 14 years or over in the AC	P	

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state below any other relevant information to clarify data concerning Indicator 1:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 2. Number of Grievous Bodily Harm Reports issued by Level of Care (percentage)

Definition		
Cases of women aged 14 years or over, per 100,000 (who for the first time admit being victims of abuse), detected in Grievous Bodily Harm Reports as a result of any type of gender violence, regardless of who the perpetrator / abuser, issued at different levels: Primary Care and/or Specialty Care and Total in the period under analysis.		
Numerator		
Number of Cases Detected in Grievous Bodily Harm Reports issued at:	Raw Data	Rate × 10^5
Primary Care	PC	
Specialty Care	SC	
Total Reports	Total	
Referring to women aged 14 years or over, brought about by gender violence		
Denominator		
Female population 14 years or over in the AC	P	

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 2:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicators by Level of Care and Source

Indicator 3. Cases Detected at Primary Care (rate)

Definition		
Cases of women aged 14 years or over, per 100,000, attended to by the Healthcare System in Primary Care who for the first time admit being victims of abuse (analysed period)		
Numerator		
Number of cases detected in Medical History at:	Raw Data	Rate × 10^5
Primary Care		
Referring to women aged 14 years or over who for the first time admit being victims of abuse		
Denominator		
Female population aged 14 years or over in the CA		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 3:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 4. Cases Detected at Specialty Care (rate)

Definition		
Rate pertaining to 14 years or over, attended at Specialty Care who for the first time admit being victims of abuse (analysed period)		
Numerator		
Number of cases detected in Medical History at:	Raw Data	Rate × 10^5
Specialty Care		
Referring to women aged 14 years or over who for the first time admit being victims of abuse		
Denominator		
Female population aged 14 years or over in the CA		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 4:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicators by Profile of Abuse

Indicator 5. Cases Detected as per Type of Abuse (percentage)

Please note that denominators here are the numerators of indicators 3 and 4 and that percentages do not have to equal 100 (several different types of abuse can appear in the same case)

Definition						
Percentage of women aged 14 years or over attended at Primary Care and/or Specialty Care who for the first time admit being victims of abuse (analysed period) per type of maltreatment						
Numerator						
Number of cases detected in Medical History at:	Raw Data			%		
	Psychological	Sexual	Physical	Psychological	Sexual	Physical
Primary Care						
Specialty Care						
All Cases						
Referring to women aged 14 years or over who for the first time admit being victims of abuse broken down by type of abuse						
Denominator						
Number of cases detected in Medical History at:						
Primary Care				100		
Specialty Care				100		
All Cases				100		
Referring to women aged 14 years or over who for the first time admit being victims of abuse						

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 5:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 6. Cases Detected as per Duration of Abuse (percentage)

Definition										
Percentage of cases of women aged 14 years or over who for the first time admit being victims of abuse (analysed period) per duration of abuse										
Numerator										
Number of cases detected in Medical History at:	Raw Data					%				
	<1 year	1-4 years	5-9 years	10 + years	nr	<1 year	1-4 years	5-9 years	10 + years	nr
Primary Care										
Specialty Care										
All Cases										
Referring to women aged 14 years or over who for the first time admit being victims of abuse, broken down by duration of abuse										
Denominator										
Number of cases detected in Medical History at:										
Primary Care						100				
Specialty Care						100				
All Cases						100				
Referring to women aged 14 years or over who for the first time admit being victims of abuse										

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 6:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 7. Cases Detected as per Cohabitation Relation with the Perpetrator (percentage)

Definition												
Percentage of women aged 14 years or over attended to at Primary Care and/or Specialty Care who for the first time admit being victims of abuse (analysed period), as per cohabitation relation and type of relationship with the perpetrator												
Numerator												
	Raw Data						%					
Number of cases detected in Medical History at:	Current intimate partner (husband, boyfriend, partner)	Ex intimate partner (ex husband, ex boyfriend, ex partner)	Father, step father or mother's partner	Brother, uncle or other male family member	Male that does not belong to the family sphere	No record	Current intimate partner (husband, boyfriend, partner)	Ex intimate partner (ex husband, ex boyfriend, ex partner)	Father, step father or mother's partner	Brother, uncle or other male family member	Male that does not belong to the family sphere	No record
Primary Care												
Specialty Care												
Total Cases												
Referring to women aged 14 years or over who for the first time admit being victims of abuse as per cohabitation relation with the perpetrator												
Denominator												
Number of cases detected in Medical History at:												
Primary Care							100					
Specialty Care							100					
Total Cases							100					
Referring to women aged 14 years or over who for the first time admit being victims of abuse												

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 7:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicators by Personal Profile of Abused Women

Indicator 8a. Cases Detected as per Age (percentage)

Numerator
Percentage of women aged 14 years or over attended to at the Healthcare System (Primary Care and/or Specialty Care and Total) who for the first time admit being victims of abuse (analysed period) broken down by age groups

Denominator
Number of cases detected in Medical History at:
Primary Care and/or Specialty Care and Total
Referring to women aged 14 years or over, who for the first time admit being victims of male abuse

Indicator 8b. Cases Detected per Age (rate)

Numerator
Cases of women aged 14 years or over per 100,000 attended to at Primary Care and/or Specialty Care and Total Care who for the first time admit being victims of abuse (analysed period) broken down by age groups

Denominator
Female population aged 14 years or over in the AC as per age groups

Data Table for Indicators 8a and 8b

Age Groups	Raw Data				8a %			8b Rate × 10^5		
	PC Cases	SC Cases	Total Cases	Population (14 and over)	PC (%)	SC (%)	Total (%)	PC rate	SC rate	Total rate
From 14 to 19 years										
From 20 to 24 years										
From 25 to 29 years										
From 30 to 34 years										
From 35 to 39 years										
From 40 to 44 years										
From 45 to 49 years										
From 50 to 54 years										
From 55 to 59 years										
From 60 to 64 years										
From 65 to 69 years										
From 70 and over										
No Records										
All Ages					100	100	100			

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicators 8a and 8b:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 9a. Cases detected per Nationality (percentage)

Numerator
Percentage of women aged 14 years or over attended to at Primary Care and/or Specialty Care and Total who for the first time admit being victims of abuse (analysed period) broken down by Nationality

Denominator
Number of cases detected in Medical History at:
Primary Care and/or Specialty Care and Total for women aged 14 years or over who for the first time admit being victims of abuse

Indicator 9b. Cases Detected per Nationality (rate)

Numerator
Cases of women aged 14 years or over per 100,000, attended to at Primary Care and/or Specialty Care and Total Cases who for the first time admit being victims of abuse (analysed period) broken down by Nationality

Denominator
Female population 14 years or over in AC as per Age Groups

Data Table for Indicators 9a and 9b

Nationality	Raw Data				9a %			9b Rate × 10^5		
	PC Cases	SC Cases	Total Cases	Population (14 and over)	PC (%)	SC (%)	Total (%)	PC rate	SC rate	Total rate
Spaniards										
Rumanians										
Andean (Peru + Ecuador + Colombia + Bolivia)										
Moroccans										
Other Female Economic Immigrants										
Other Women from Developed Nations										
No Records										
All Nationalities					100	100	100			

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicators 9a and 9b:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 10. Cases Detected as per Occupational Profile (percentage)

Definition						
Percentage of women aged 14 years or over attended to at Primary Care and/or Specialty Care who for the first time admit being victims of abuse (analysed period), broken down by occupational status						
Numerator						
Number of cases detected in Medical History at:	Raw Data			%		
	Remunerated work			Remunerated work		
	Yes	No	No Records	Yes	No	No Records
Primary Care						
Specialty Care						
All Cases						
Referring to women aged 14 years or over who for the first time admit being victims of abuse, broken down by occupational situation						
Denominator						
Number of cases detected in Medical History at:						
Primary Care				100		
Specialty Care				100		
All Cases				100		
Referring to women aged 14 years or over who for the first time admit being victims of abuse						

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 10:

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Name of Autonomous Community:: .....
Source: **MEDICAL HISTORY**

Indicator 11. Cases Detected in Pregnant Women (rate)

Definition		
Cases of women aged 14 years or over attended to at the healthcare system (Primary Care and/or Specialty Care and Total Cases) who for the first time admit being victims of abuse (analysed period) during pregnancy		
Numerator		
Number of cases detected in Medical History at:	Raw Data	Rate × 10^5 Born alive
Primary Care		
Specialty Care		
All Cases		
Referring to women aged 14 years or over who for the first time admit being victims of abuse and pregnant at the time		
Denominator		
Number of alive newborns in that AC, during the year considered*		
*Denominator deemed to be best for comparing rates, being the possibility of using this indicator as a percentage of the population of pregnant women, seemingly much more complex for calculating the total denominator for pregnant women		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 11:

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Annex 2. Indicators for Grievous Bodily Harm Report. Data Collection Sheet

Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Issued at PC: ☐ (mark with an ×)
Issued at SC: ☐ (mark with an ×)

Please attach relevant formats to furnished Indicators deriving from above source.

This source enables calculating gender violence indicators referring to Primary Care-PC (reports issued from Primary Care) and/or Specialty Care-SC (Specialty Care) and both.

Autonomous Communities using this source are advised to provide data from PC and SC duly itemised. Adding them up only when certain there are no duplicate cases among reports at both levels.

This source does not allow determining whether calculated indicators refer to "impact" cases as required by definitions. Thus this characteristic is given in brackets.

This source may give rise to repetition (more than one report for same woman in same period under analysis), thus inflating the number of cases.

Currently, in most ACs GBH reports from sc are the only possible source to obtain information on GV cases detected at Specialty Care.

GV indicators based on GBH reports issued from SC should be considered complementary to those calculated from the medical history. Whenever possible indicators obtained from both sources-medical history and GBH reports – should be made available.

Attached data collecting sheets allow data disaggregating into PC-and/or SC- sourced and serve as reminders of the composition and calculation of indicators.

It is recalled that **Gender Violence** is the definition agreed by Consensus in *the Common Protocol for a Healthcare Response to Gender Violence:* "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" *(Resolution of the United Nations General Assembly 1993).*

Population denominators for calculating rates (Annex P)
Quinquennial groups, part of the January 1, 2009 Census update *(INE),* are used, estimating the 14-year old female population as the fifth part of the age quinquennium 10-14 year old.

Same population denominator is used for all Indicators expressed as RATE (Indicators 1, 3, 4,8b and 9b). *Age groups* break down Indicator 8b. (Please remember that the first group spans six years: 14 to 19). Indicator 9b is *Nationality*-itemised. Denominator is the same even though only cases deriving from Primary Care or only from Specialty Care may be relied upon.

Denominators for calculating percentages
Denominators are all GV cases obtained from Reports issued either at Primary Care or at Specialty Care or from the Total of Reports as the sum total of both. The same denominator applies to all Indicators expressed as a percentage of PC or of SC except for Indicator 2 where all reports issued at PC and SC are used regardless of the Report motive.

Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Magnitude indicators

Indicator 1. Cases Detected among Women Aged 14 or over per 100,000 (rate)

Definition		
Cases of women aged 14 or over per 100,000 (who for the first time admit being suffering abuse), *detected in GBH Reports issued as a consequence of gender violence of any kind,* regardless of perpetrator/abuser, at the different Primary Care and/or Specialty Care devices or their Total in the course of the period under analysis		
Numerator		
Number of cases detected in GBH Reports at:	Raw Data	Rate $\times 10^5$
Primary Care	PC	
Specialty Care	SC	
Total Reports	Total	
Referring to women aged 14 or over, issued as a result of their having been abused		
Denominator		
Female population aged 14 years or over in the AC	P	

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 1:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 2. Number of GBH REPORTS issued per Level of Care (percentage)

Notice this source features same numerator as Indicator 1, though a percentage is calculated in this case.

Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicators by Level of Care and Source

Indicator 3. Cases Detected at Primary Care (rate)

Definition		
Cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected in GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, at the different Primary Care devices		
Numerator		
Number of cases detected in GBH Reports issued at:	Raw Data	Rate × 10^5
Primary Care		
Referring to women aged 14 or over, drawn up as a result of their having been abused		
Denominator		
Female population aged 14 or over in the CA		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 3:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 4. Cases detected by Specialty Care (rate)

Definition		
Cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected in GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, at the different Specialty Care Mechanisms		
Numerator		
Number of cases detected in GBH Reports at:	Raw Data	Rate × 10^5
Specialty Care		
Referring to women aged 14 or over, issued as a result of their having been abused		
Denominator		
Female population aged 14 or over in the CA		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 4:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicators by Profile of Abuse

Indicator 5. Cases Detected per Type of Abuse (percentage)

Please note that Denominators are the Numerators of Indicators 3 and 4 and that percentages do not need to amount to 100 (several types of abuse may occur in the same case)

Definition						
Cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected in GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, for each type of abuse						
Numerator						
Number of cases detected in Medical History at:	Raw Data			%		
	Psychological	Sexual	Physical	Psychological	Sexual	Physical
Primary Care						
Specialty Care						
Total Reports						
Referring to women aged 14 or over who for the fist time admit being abused, broken down by type of abuse						
Denominator						
Number of cases detected through GBH REPORTS issued at:						
Primary Care				100		
Specialty Care				100		
Total Reports				100		
Referring to women aged 14 or over and issued as a result of their having been subjected to male abuse						

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 5:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 6. Cases Detected per Duration of Abuse

Definition										
Cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected in GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator / abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, as per duration of abuse										
Numerator										
Number of cases detected via GBH Reports at:	Raw Data					%				
	<1 year	1-4 years	5-9 years	10 + years	nr	<1 year	1-4 years	5-9 years	10 + years	nr
Primary Care										
Specialty Care										
Total Reports										
Referring to women aged 14 or over and issued as a result of their having been subjected to male abuse, broken down by duration of abuse										
Denominator										
Number of cases detected via GBH Reports at:										
Primary Care						100				
Specialty Care						100				
Total Reports						100				
Referring to women aged 14 or over and issued as a result of their having been subjected to male abuse										

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 6:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 7. Cases Detected as per Cohabitation Relation with Abuser (percentage)

Definition												
Percentage of cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected in GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator / abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total Cases throughout the analysed period, as per cohabitation relation and type of relationship with the perpetrator												
Numerator												
Number of cases detected in Medical History at:	Raw Data						%					
	Current intimate partner (husband, boyfriend, partner)	Ex intimate partner (ex husband, ex boyfriend, ex partner)	Father, step father or mother's partner	Brother, uncle or other male family member	Male that does not belong to the family sphere	nr	Current intimate partner (husband, boyfriend, partner)	Ex intimate partner (ex husband, ex boyfriend, ex partner)	Father, step father or mother's partner	Brother, uncle or other male family member	Male that does not belong to the family sphere	nr
Primary Care												
Specialty Care												
All Reports												
Referring to women aged 14 or over issued as a result of their being subjected to male abuse as per cohabitation relation with the abuser												
Denominator												
Number of cases detected in Medical History at:												
Primary Care							100					
Specialty Care							100					
Total Reports							100					
Referring to women aged 14 or over, issued as a result of their having been subjected to male abuse												

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 7:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicators by Personal Profile of Abused Women

Indicator 8a. Cases Detected as per Age (percentage)

Numerator
Percentage of cases of women aged 14 or over, per 100,000 (who for the first time admit being abused), detected through GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, broken down by age groups

Denominator
Total number of cases detected via GBH Reports issued at Primary Care and/or Speciality Care for the Total Number of women aged 14 or over, issued as a result of their having been subjected to male abuse

Indicator 8b. Cases detected by age (rate)

Numerator
Cases of women aged 14 or over, per 100,000, detected via GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, broken down by age groups

Denominator
Female population aged 14 or over in the CA, by age groups

Data Table for Indicators 8a and 8b										
Age Groups	Raw Data				8a %			8b Rate × 10^5		
	PC Cases	SC Cases	Total Cases	Population (14 and over)	PC (%)	SC (%)	Total (%)	PC rate	SC rate	Total rate
From 14 to 19 years										
From 20 to 24 years										
From 25 to 29 years										
From 30 to 34 years										
From 35 to 39 years										
From 40 to 44 years										
From 45 to 49 years										
From 50 to 54 years										
From 55 to 59 years										
From 60 to 64 years										
From 65 to 69 years										
From 70 and over										
No Records										
All Ages					100	100	100			

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicators 8a and 8b:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 9a. Cases Detected per Nationality (percentage)

Numerator
Percentage of cases of women aged 14 or over (who for the first time admit being suffering abuse, detected via GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, broken down by Nationality

Denominator
Total number of cases detected through GBH Reports issued at
Primary Care and/or Speciality Care and Total, for cases of women aged 14 or over, as a consequence of their having been victims of male abuse

Indicator 9b. Cases Detected per Nationality (rate)

Numerator
Cases of women aged 14 or over, per 100,000 (who for the first time admit being suffering abuse, detected through GBH Reports issued as a consequence of gender violence of any kind, regardless of perpetrator/abuser, drawn up at the different Primary Care and/or Specialty Care devices and for Total cases throughout the analysed period, broken down by Nationality

Denominator
Female population aged 14 or over, in the AC broken down by Nationality

Data Table for Indicators 9a and 9b

Nationality	Raw Data				9a %			9b Rate × 10^5		
	PC Cases	SC Cases	Total Cases	Population (14 and over)	PC (%)	SC (%)	Total (%)	PC rate	SC rate	Total rate
Spaniards										
Rumanians										
Andean (Peru + Ecuador + Colombia + Bolivia)										
Moroccans										
Other Female Economic Immigrants										
Other Women from Developed Nations										
No Records										
All Nationalities					100	100	100			

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicators 9a and 9b:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 10. Cases Detected as per Occupational Status (percentage)

Definition						
Percentage of cases of women aged 14 or over (who admit for the first time being suffering abuse), detected through GBH Reports issued as a result of their having been victims of abuse of any kind, regardless of perpetrator/abuser at the different Primary Care and/or Specialty Care devices and for Total Cases, throughout analysed period and broken down by Occupational Status						
Numerator						
Number of cases detected via GBH Reports issued at:	Raw Data			%		
	Remunerated work			Remunerated work		
	Yes	No	No Records	Yes	No	No Records
Primary Care						
Specialty Care						
Total Cases						
Referring to women aged 14 or over, issued after an occurrence of male abuse, broken down by occupational status						
Denominator						
Number of cases detected through GBH Reports issued at:						
Primary Care				100		
Specialty Care				100		
Total Cases				100		
Referring to women aged 14 or over and issued after an occurrence of male abuse						

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 10:

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Name of Autonomous Community:: .....
Source: **GBH REPORTS**

Indicator 11. Cases Detected among Pregnant Women (percentage)

Definition		
Percentage of cases of Pregnant women aged 14 or over (who admit for the first time being suffering abuse), detected through GBH Reports issued as a result of their having been victims of abuse of any kind, regardless of perpetrator/abuser at the different Primary Care and/or Specialty Care devices and for Total Cases, throughout analysed period		
Numerator		
Number of cases detected via GBH Reports issued at:	Raw Data	%
Primary Care		
Specialty Care		
All reports		
Referring to women aged 14 or over, consequence of their having been abused and who were pregnant at the time the report was issued		
Denominator		
Number of cases detected via GBH Reports issued at:		
Primary Care		100
Specialty Care		100
All reports		100
Referring to women aged 14 or over, issued after an occurrence of male abuse		

Includes PC Emergencies ☐ (mark with an ×)
Includes in PC all data pertaining to Mental Health Services ☐ (mark with an ×)
Includes SC Emergencies ☐ (mark with an ×)
Includes in SC all data pertaining to Mental Health Services ☐ (mark with an ×)

Comment. Please state any other information deemed relevant to clarify data concerning Indicator 11:

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Annex 3.
Subsidied Activities Relating to the Strategy for the Prevention of Gender Violence in the National Health System in 2009
(Royal Decree 924/2009)

Recipients will be free to channel funds into all or just some of the actions specified for each of the following lines of activity, not being necessary to undertake actions in all activities under this Annex:

1. Training of Health Care professionals according to the Common Criteria for Quality and Educational Objectives approved by the Inter-Territorial Council of the National Health System in December, 2007.
2. Inclusion of Health Care Indicators of Gender Violence in Services Portfolios, Management Contracts or similar figure, and incorporation of the necessary variables for their being obtained, and implemented, in the Digital Medical History.
3. Raising Awareness of the Common Protocol for a Health Care Response to Gender Violence fundamental lines, among management staff and Administration Officials responsible for the administration, management and health care planning in their territories.
4. Plans for intra Health Care coordination within each Autonomous Community to provide comprehensive healthcare attention to gender violence cases (Mental Health, Primary and Specialty Care, Paediatrics and Family Medicine) and devise coordination and follow up of the care provided at different healthcare attendance levels of health services within the National Health System.
5. Methodology and tools for evaluating healthcare actions in gender violence issues: evaluation of implementation of the Common Protocol and Training Programmes for Professionals'.
6. Care Programmes for most vulnerable women (migrants, disabled women and from the rural sphere).

7. Action Programmes for Confronting Gender Violence, addressed to daughters and sons of women victims of male abuse.
8. Plans, Programmes and Best Practice Experiences for coordinated action among Health Services, Local Administration and Civil Organisation (Women and Women's Associations Department) for a healthcare and psychosocial approach to women victims of male abuse, their children and persons in their care.

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DE ESPAÑA

MINISTERIO
DE SANIDAD, POLÍTICA SOCIAL
E IGUALDAD

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