

Protocol for Dealing with  
Sexist Violence in the  
Healthcare Field in  
Catalonia

Framework Document

*Violence within Couples and Families*

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Sexist Violence in the  
Healthcare Field in  
Catalonia

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*Violence within Couples and Families*



**Generalitat de Catalunya**  
Government of Catalonia

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## Tool for online work and consultation

This document is intended to be used as a reference text and handbook, and also as a tool for working in networks. In the document there are sections of text highlighted in a different colour to indicate that the text contains a hyperlink to a website or enables the user to automatically download another document, etc.

This publication has been prepared with the assistance of the Institut Català de les Dones (Catalan Institute for Women) of the Government of Catalonia's Ministry of Social Action and Citizenship, responsible for impulse a model developed for dealing with all forms of sexist violence in the healthcare field in Catalonia.

The Spanish Ministry of Health and Social Policy has participated in raising awareness of the main points of the *Common Protocol on Health Measures to Combat Sexist Violence* and providing practical guidelines for healthcare staff on the provision of integrated care for maltreated women through the concession of a grant for the publication of this document.

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# Foreword

## Foreword

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Violence against women is not a new phenomenon; it is a historical problem affecting around 9% of women in Catalan society. As shown in the latest reports from the World Health Organisation, it has an unquestionable impact on their health.

The 2010 Catalan Health Plan, which is the frame of reference for all the Government of Catalonia's measures in the field of healthcare, recognises violence against women as a health problem that must be tackled and lists priorities for doing this.

The Government of Catalonia's commitment to the struggle against sexist violence was clearly expressed in the passing of Law 5/2008 of 24 April on the right of women to eradicate sexist violence. This law, a pioneering initiative in Spain, guarantees an integrated approach by all the parties involved in preventing and detecting sexist violence and attending to and helping in the recovery of women who are victims of it. However, work on eliminating this social disease has been in progress for many years, promoted and coordinated by the Institut Català de les Dones (Catalan Institute for Women). This document falls within the framework of these measures.

The *Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia*. The framework document is intended to become a practical tool to facilitate action by our professionals against sexist violence, taking such action in a broad sense which goes beyond attending to and following up severe cases. In order to respond to specific needs, the most vulnerable groups and to other situations related to sexist violence the framework document will be complemented with more specific tools.

Finally, I would like to thank all the people involved in drawing up the various documents for their hard work and dedication. I am convinced that this Protocol will contribute to improving our overall sexist violence services and making them more effective and streamlined, and will be a key document for everyone working in the healthcare profession in Catalonia.

Marina Geli i Fàbrega  
Minister for Health

# Introduction

The [Ministry of Health](#) is committed to preparing a Protocol for dealing with sexist violence in the healthcare field in Catalonia, together with a set of regional circuits that will enable the Protocol to be effectively implemented throughout Catalonia.

This measure implements [Law 5/2008 of 24 April on the right of women to eradicate sexist violence](#) (Diari Oficial de la Generalitat - Official Journal of the Government of Catalonia-, No. 5123, 2/5/2008), specifically Article 85 which states 'Protocols on coordinated action against sexist violence must include measures and mechanisms of support, coordination and cooperation aimed at public institutions and other agents involved, defining the formalities and succession of measures required to ensure their correct implementation'. It falls within the framework of the [Government Plan 2007-2010](#), which contains over three hundred key measures and specific commitments, including progress towards a new social contract between men and women that guarantees equality of opportunity and the eradication of sexist violence. This commitment is made under the first pivot of the Government Plan, on strengthening the welfare state for a fairer and more cohesive society.

The preparation of the *Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia* is also one of the commitments of the [Government of Catalonia's 2008-2011 Women's Policy Plan](#), headed by the Institut Català de les Dones (Catalan Institute for Women), and is specifically set out in Priority 6 on the comprehensive tackling of sexist violence. This Plan continues the work of the [Action and Development Plan for Women's Policies in Catalonia 2005-2007 and the Programme for an Integrated Response to Violence Against Women](#), which it includes. This programme has involved efforts to strengthen the stable interdepartmental and interdisciplinary circuit established to ensure the effectiveness of measures against sexist violence (prevention, detection, care and rehabilitation). The result is the *Framework Protocol and National Circuit for Coordinated Action against Sexist Violence* (Appendix 3).

The [Framework Protocol and National Circuit for Coordinated Action against Sexist Violence](#) is an agreed model which must be adapted to each area of action (health, justice, social services, etc.) and to each region. The proposed model will enable all forms of sexist violence to be tackled (physical, psychological, sexual, economic) wherever it may arise, as it should be adaptable to the specifics of each situation and in terms of the services and resources required.

The work of adapting and applying the Framework has thus produced a range of specific protocols (general and sector based), such as this Protocol. The healthcare system, via the professionals working in it, is ideally placed for the prevention and early detection of sexist violence, being, in many cases, the first point of contact with the women who suffer from it. The health services also have a unique advantage which we must exploit: the majority of women, at some point in their lives, make use of the health system. This protocol has therefore been drawn up on the basis that the role of the health services is of vital importance in the detection and diagnosis of the psychological and physical injuries caused by violence.

This Ministry of Health document has been prepared in accordance with the proposals of the Spanish Government's [Common Protocol on Health Measures to Combat Sexist Violence](#), which provides practical guidelines for healthcare staff on the provision of integrated care for maltreated women going to any healthcare centre. This protocol was coordinated by the Ministry of Health and Consumer Affairs and drawn up in agreement with the Autonomous Communities to unify and improve the care offered by health services across Spain.

Another antecedent is the document [Recommendations for the Healthcare of Women Victims of Violence](#) resulting from measures developed with regard to healthcare set out in the 2002-2004 Integrated Plan to Prevent Sexist Violence and Provide Care for Its Victims, recognising the work carried out by a range of institutions, local bodies, healthcare regions, providers, professional associations, scientific societies, associations, etc. in Catalonia and in the other autonomous communities, Europe and the rest of the world to establish protocols and carry out studies to tackle this problem. Reviewing all this material has been useful for formulating an approach to caring for women who suffer from violence or are at risk of doing so.

Finally, given the particularly alarming nature of violence within couples and families, both in terms of frequency and seriousness, this Protocol sets out the steps to be taken concerning this matter by all healthcare professionals. Sexist violence that may occur in other situations, such as at work, in social situations, in the community, or that related to other risk factors, is dealt with in other documents, referred to as operational documents, being prepared to complement this document. These documents will determine the focus of measures and the specific and proactive approach to be taken by healthcare workers to women who suffer from violence given the wide range of situations and needs affecting women and vulnerable groups and other factors and situations related to sexist violence. The main operational documents are the following:

- Pregnancy
- Drug addictions
- Mental health
- Sexual violence
- Female genital mutilation
- Immigration
- Children
- The elderly
- Disability
- HIV / Aids

# Aims

## Aims

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The aims of the Ministry of Health's proposed Protocol for dealing with sexist violence in the healthcare field in Catalonia in the context of families and couples are as follows:

- To provide healthcare professionals with a series of steps to follow to prevent and detect violence and provide care and rehabilitation for women who are suffering or have suffered from it and for women at risk, including steps for dealing with children and other dependents living with the woman who witness violence or are victims of it.
- To create and establish bases, mechanisms and circuits for appropriate action in cases of sexist violence.
- To unify the criteria of the institutions and healthcare areas involved in providing care for women who have suffered or are suffering violence or who are at risk, together with children or other dependent persons who may live with the women and be witnesses or victims of violence, so that coordinated joint action can be taken, paying due respect to the autonomy of those involved.

# Basic Concepts of Sexist Violence

## Definition

The [1993 Resolution of the United Nations General Assembly](#) defined sexist violence 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 in private life’.

Any act of violence involves the coercive exercise of power. It is used to oblige a person to do things against their will. In our society, sexist violence is undoubtedly an expression of men’s power over women. Where violence is used against a woman by a partner or former partner, two points must be considered in defining it: the repetition of violent acts and the aggressor’s dominant position, using violence to achieve control over the victim and obtain her submission.

To fully understand violence against women it is necessary to consider the influence of patriarchal culture (see definition of [patriarchy](#)) on women and on men. This culture, which is found in virtually all societies, is associated with the assignment of roles and stereotypes linked to gender.

All societies built on a patriarchal basis create certain expectations with regard to the fulfilment of gender roles. These roles are different and are valued unequally, they form a natural part of the cultural context in which they appear and are therefore accepted as normal by the members of the society. All societies define a range of social rewards and punishments that are used as control mechanisms to ensure that the assigned roles are maintained. Society thus has disciplinary rules built in to it, to which men, women and children must conform and which, explicitly or implicitly, establishes a strict hierarchy in precisely this order.

Nevertheless, as we know, any order can be changed. When it is perceived that a transgression of the assigned roles has occurred and that this hierarchy has therefore been broken, a range of punishments are called into play, referred to as [symbolic violence](#). This violence can occur at a general level, through the devaluation and criticism of any action that represents an infraction or breach of the established rules, or at a more specific level, stigmatising groups of women who question these rules or who wish to disregard them. This type of violence is not always explicit or visible, and frequently manifests itself in hidden ways, but it frequently forms the basis for legitimising more visible forms of violence. We refer then to violence which manifests itself more or less subtly and which is widely tolerated in society, given its atavistic roots and cultural acceptance, making it difficult to identify in spite of its prevalence.

A great deal of work has been done in the field of gender studies over the last few decades. The contribution of these studies, together with women’s experiences in the peace movement, have identified patriarchal thinking as a key issue in the analysis of the causes of sexist violence, whose aim is to prevent women achieving autonomy, thereby impeding the free development of societies.

Sexist violence is a product of the patriarchal society, the maximum expression of which is built around what we refer to as [sexism](#). [Law 5/2008 of 24 April on the right of women to eradicate sexist violence](#) uses the term ‘*sexist violence*’, understanding sexism to mean the imposition of a masculine model involving dominating and controlling behaviour and the abuse of power by men over women.

### “Article 3 - Concept of *sexist violence*”

For the purposes of this Law, *sexist violence* is that is perpetrated against women as a manifestation of discrimination and the situation of inequality in the framework of a system of power relations of men over women and which, produced by physical, economic or psychological means, including threats, intimidation and coercion, results in physical, sexual or psychological harm or suffering, whether it is produced in the public or private spheres.’

Sexist violence is, thus, structural and has many causes. Violence is not due to specific, pathological traits in particular individuals, but has structural traits as part of the cultural

definition of identities and the relationships between men and women. Sexist violence occurs in a society that maintains a system of gender relations that perpetuates men's superiority over women and assigns different attributes, roles and places according to gender.

Sexist violence is, furthermore, *instrumental*. Male power and female submission, as basic features of patriarchy, require a mechanism to enforce submission. Violence is thus a tool for consolidating this power relationship. Violence is not an end in itself but a tool of social domination and control, used, in this case, as a mechanism for maintaining male power and ensuring female submission. Thus the main risk factor for sexist violence is, precisely, the fact of being a woman. Male aggressors have learned that violence is the best way to achieve control and domination over women.

There is now much documentation to show that there are no psychological differences between victims and non-victims prior to the start of the violence, but rather that the psychological disorders and problems experienced by abused women are a result, not a cause, of the violence. This contradicts the statements of some commentators referring to pathologies such as hysteria or dependent personality disorder to explain why women remain in or return to abusive relationships.

Finally, we must not forget women whose personal characteristics or social or legal situation require special attention to meet their specific health needs. This particularly applies to women with a physical or mental disability, drug addicts, immigrants, socially excluded women, prostitutes, women in rural environments and the elderly. As such women are particularly vulnerable to violence; healthcare professionals must be especially vigilant.

## Forms of sexist violence

Violence has grave repercussions, both immediate and delayed, affecting physical, mental and social wellbeing, destroying dignity and self-esteem. It is thus an obstacle to achieving the goals of equality, development and peace; it violates human rights and basic freedoms, and impedes progress towards equality between men and women.

From a general perspective, violence can be defined as any injurious or destructive act or unnecessary omission by one person towards another. The main feature of this form of violence is abuse or aggression, i.e. the act or intention of injuring others. Within couples and families, it occurs in the context of an emotional relationship, making it more difficult to identify and more difficult for the victim to leave the situation. Violence against women, especially within couples and families, can take a variety of forms (the definitions quoted in italics below are taken from the text of [Law 5/2008 of 24 April on the right of women to eradicate sexist violence](#)):

*Physical violence.* Covers any act involving force against a woman's body, or failure to assist a woman, intentionally or negligently, with the result or risk of causing her physical injury or harm.

This usually consists of physical aggressions such as hitting, beating, cutting, stabbing, burning, etc. This form of violence presents the greatest level of risk to women, putting their physical integrity or even their lives in danger. It also includes any failure to assist a woman, intentionally or negligently, with the result or risk of causing her physical injury or harm.

*Psychological violence.* Covers any behaviour or intentional omission that produces a loss of esteem or suffering in a woman, by means of threats, humiliation, bullying, demands for obedience or submission, verbal coercion, insults, isolation or any other limitation of her freedom.

There is always a psychological and emotional component to any form of aggression. The effects of such violence are difficult to overcome, as it erodes women's self-esteem. Psychological violence is thus any attack against the integrity or dignity of another person:

- Constant undermining (for example: permanently criticising and humiliating).
- Threatening postures and gestures (for example: threatening violence or to take away the children).

- Restrictive behaviour (for example: controlling friendships, withholding money, limiting the woman's freedom to leave the home).
- Destructive behaviour (e.g. towards items of economic or sentimental value, or maltreatment of pets).
- Blaming the woman for the man's violent behaviour.

Sexual violence and abuse. Covers any act of a sexual nature without the consent of women, including exhibitionism, observation and imposition of sexual relations by means of violence, intimidation, abuse of the aggressor's position, or emotional manipulation, independently of whether the aggressor's relationship with the woman or minor is that of spouse, partner or family member, or is based on affection.

It refers to forcing sexual relations on the victim or the imposition of sexual behaviour perceived as degrading by the victim. This may include: rape, obliging the woman to perform certain sexual acts, forced prostitution, exacting reprisals for failure to satisfy, obliging the woman to have sex in front of the children or other people, and using sex to denigrate or start arguments.

Economic violence. Consists of the intentional and unjustified withdrawal of resources for the physical or psychological wellbeing of a woman, and/or her children, and limiting the availability of her own or shared resources within the family or couple.

It is a question of the establishment and maintenance of forced economic dependence. It may involve denying the woman's right to economic autonomy, preventing her from seeking or accepting paid work or obtaining access to information and education regarding these rights.

Sexist violence may occur in a range of environments, as defined in the text of [Law 5/2008 on the right of women to eradicate sexist violence](#) (reproduced below in italics):

*Violence within the couple. Consists of physical, psychological, sexual or economical violence exercised against a woman and perpetrated by the man who is or has been her husband or partner or by the person who has or has had similar affective relations.*

*Violence in the family. Consists of physical, sexual, psychological or economical violence exercised against women and minors in the heart of the family and perpetrated by members of the same family, in the framework of the affective relations and the ties of the family environment. This does not include violence exercised in the sphere of the couple, defined in the first paragraph.*

*Violence in the workplace Consists of physical, sexual, or psychological or violence that may occur in the workplace and during the working day, or outside the workplace and the working day if it is related to work, and may be of two types:*

- *Gender-related harassment: constitutes undesired behaviour related to the gender of a person on the occasion of access to paid employment, promotion in the workplace, occupation or training, which sets out to or produces the effect of an assault on the dignity of women and creates an environment that is intimidating, hostile, degrading, humiliating or offensive to them.*
- *Sexual harassment: constitutes any undesired verbal, non-verbal or physical behaviour of a sexual nature which sets out to or produces the effect of an assault on the dignity of women and to create an environment that is intimidating, hostile, degrading, humiliating, offensive or upsetting to them.*

*Violence in the social or community sphere. Covers the following cases:*

- *Sexual aggression. constitutes the use of physical and sexual violence exercised against women and minors determined by the premeditated use of sex as a weapon to demonstrate power and abuse it.*
- *Sexual harassment.*

**The spheres in which sexist violence may occur**

- *Trafficking and sexual exploitation of women and children.*
- *Female genital mutilation or the risk of suffering it. Includes any procedure that involves or could involve a full or partial elimination of female genitals or produces injury to them, even if there is express or tacit consent on the woman's part.*
- *Forced marriage.*
- *Violence deriving from armed conflict. Includes all forms of violence against women that may take place in these situations, such as murder, rape, sexual slavery, forced pregnancy, forced abortion, forced sterilisation, intentional infection with disease, torture or sexual abuse.*
- *Violence against the sexual and reproductive rights of women, such as selective abortion and forced sterilisation.*

*Any other comparable forms of violence that injure, or are likely to injure the dignity, personal safety or freedom of women.*

### The process of violence in the sphere of the couple

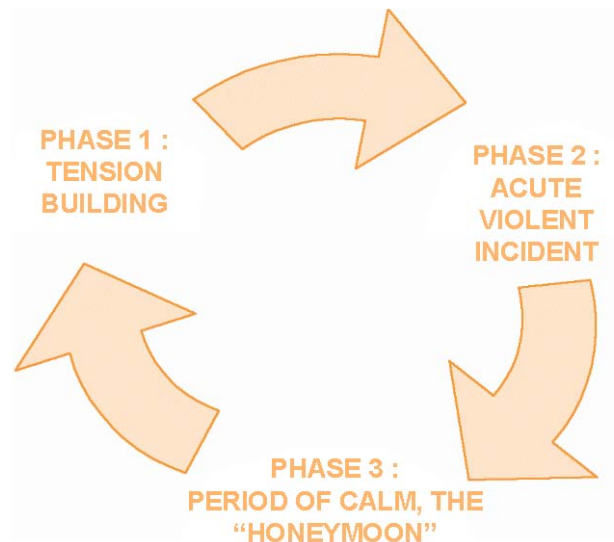
Violence by a partner (Figure 1), one of the most frequent forms, usually begins at the start of the relationship with psychologically abusive behaviour. Such behaviour is often restrictive or controlling, with the intention of undermining the woman's independence or capacity to make decisions, such as controlling what she wears, her telephone calls, friendships or relationships with family members.

The process of abuse frequently leads to increasing levels of violence, which may take place over a long period of time, and it is usually difficult for the victim to appreciate the situation in which she finds herself. Some writers have put forward the theory of the *Cycle of violence*<sup>1</sup> or *Spiral of violence*<sup>2</sup>, claiming that there are three stages to this syndrome: the tension-building phase, an acute violent incident and a period of calm or repentance, the honeymoon phase, characterised by *emotional manipulation*. As we point out below, the process of violence is a continual one, with the abuse never ending.

<sup>1</sup> Walker L. *The Battered Woman Syndrome*. New York: Springer; 1984.

<sup>2</sup> Garro E. *Apuntes sobre el proceso de la violencia*. In: CEMUJER. *En el camino de una vida sin violencia*. San Salvador: Malintzin; 1996. p. 15-21.

Figure 1. Cycle of violence



Source: Walker L. *The Battered Woman Syndrome*. New York: Springer; 1984.

### **Phase 1. Tension building**

In the early stages of a relationship physical violence is unlikely. Behaviour is good during this period. Both members of the couple show their best side. Later on in the relationship, the demands on it increase, together with the levels of stress. Aggressive behaviour is more common, usually directed towards objects rather than the partner (hitting doors, throwing objects, breaking things, etc.). Violence is then transferred from objects to the partner. Verbal and physical abuse may increase. The aggressor blames the woman for the abuse, finding motives to justify his aggressive behaviour. This makes the abuse difficult to identify and confuses the woman. The abused woman tries to modify her behaviour in order to avoid the violence. For example, obsessively cleaning the house, keeping the children quiet, breaking off contact with friends and family, etc. The aggressor increasingly controls the woman in an attempt to keep her ever more isolated.

### **Phase 2. Release of violence or acute incident**

The built-up tensions need to be released. The abuser chooses the time and place when the acute incident will take place, deliberately selecting which part of the body to hit, and how. The incident will release the abuser's tension and stress. If the police are involved, he will seem relaxed, while the woman appears confused and emotional as a result of the violence she has suffered. The more times the couple go through the cycle, the more violent it becomes.

### **Phase 3. Period of calm or repentance, the honeymoon phase**

This is a period of calm, without violence, with demonstrations of love and respect and emotional manipulation. The abuser may accept part of the blame for the abuse and lead his partner to believe that things will be different in the future. He behaves as if nothing had happened, or promises to seek help, that it will never happen again, etc. If there is no intervention and the relationship continues, it is very likely that the violence will escalate and become more severe. This phase only lasts a short time and the cycle is repeated.

The longer the cycle continues without being broken, the shorter the third phase will become. The more times the cycle is repeated, the less time it takes to recur, i.e. the cycle speeds up. Thus at the start of the relationship, the three stages of the cycle may take one or two years to complete. Ten years later, the same phases may be completed in a month or even less. If we analyse the three phases of violence, we can see that they will not stop by themselves, that the cycle is difficult to break, and that it can lead to fatal results. Although the cycle of violence is common in couples where physical violence occurs, it is not found in every case.

Recently another form of violent relationship has been identified, referred to as 'moderate forms of violence'<sup>3</sup>, where there is a constant atmosphere of anger and threats, which only occasionally spills over into physical aggression. This is more difficult to detect than more severe forms of abuse.

Throughout the course of the violence, women suffer a progressive loss of self-esteem and of hope that the situation will change, while submission to and fear of the aggressor increase. For him this is proof that the strategy works. All this makes it very difficult for the woman to break off the relationship. Thus, when a woman asks for help, she must always be given clear support to help her change her situation, and not blamed for her decisions. It is important that she understands that the violence will continue and will increase, and that she is not responsible for the aggressor's behaviour, in order to make her aware of the risks she is running.

## Scale and consequences

In 2008, 11 women in Catalonia<sup>4</sup> (-86 throughout Spain)<sup>5</sup> were killed by their partners, ex-partners or a family member, while 29,961 cases of gender violence<sup>6</sup> were reported (63,347 in Spain)<sup>7</sup>. It is estimated that these reports represent only 5% to 10% of the real number of cases of sexist violence.

The [Instituto de la Mujer \(Spanish Institute for Women's Affairs\)](#) carried out three major telephone surveys<sup>8</sup> on sexist violence in 1999, 2002 and 2006. The proportion of women 'technically' abused in each of these years (according to criteria defined by the research team) was 12.4%, 11.1% and 9.6% respectively. However, only 4.2%, 4.0% and 3.6% of these women defined themselves as abused. This difference in the numbers, according to the technical definition and the women's own definition, could be due to their failure to recognise some types of violent behaviour as abuse.

In the field of healthcare, some studies have found that between 20% and 48% of women attending mental health services or primary healthcare centres or who are treated in hospital casualty departments are the victims of violence.<sup>9,10,11</sup>

The fact that immigrant women are more at risk is due mainly to their precarious economic situations, legal invisibility and lack of support networks. The figures for the number of women killed by their partner or ex-partner per million of the population in Spain in 2008, broken down by country of origin, are also highly indicative: 14.60 per million foreign-born versus 1.87 per million Spanish-born women.<sup>12</sup> Factors common to many of these foreign-born women include a markedly patriarchal cultural background, lack of knowledge of the local language, irregular legal status, isolation, role changes, etc.

Unwanted pregnancies, miscarriages, sexually transmitted diseases and HIV, chronic abdominal pain, sterility and inability to negotiate the use of contraceptives or condoms are some of the ways women's vulnerability manifests itself in the context of sexual and reproductive health.

All these figures only give a guide to the extent of the problem, as this type of violence frequently takes place in secret and many women deny that they are victims. Too many women put up with a high degree of violence in their daily lives, both within and outside their relationships with their partners. It should be noted that the problem cuts across social class, religious, cultural and educational background, and that it impacts on other people living with the woman, such as the children.

Table 1 shows some of the potential consequences of violence for health:

<sup>3</sup> Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva: World Health Organisation; 2002.

<sup>4</sup> Institut Català de les Dones (Catalan Institute for Women), 2008.

<sup>5</sup> Instituto de la Mujer, 2008a.

<sup>6</sup> Women's Network; 2008.

<sup>7</sup> Instituto de la Mujer, 2008b.

<sup>8</sup> Instituto de la Mujer, 2008c and 2008d.

<sup>9</sup> Aguar-Fernández et al.; 2006.

<sup>10</sup> Usaola; 2001.

<sup>11</sup> Alonso et al., 2004.

<sup>12</sup> [http://www.migualdad.es/mujer/mujeres/cifras/violencia/muertes\\_tablas.htm](http://www.migualdad.es/mujer/mujeres/cifras/violencia/muertes_tablas.htm)

**Table 1.**  
Effects of violence on health

<b>FATAL</b>
<ul style="list-style-type: none"> <li>• Immediate death (murder or suicide)</li> <li>• Death due to delayed or chronic effects (injuries, suicide, HIV/AIDS, etc.)</li> </ul>
<b>PHYSICAL HEALTH</b>
<ul style="list-style-type: none"> <li>• Various injuries: contusions, trauma, wounds, burns, etc. to the extent of causing disability.</li> <li>• Functional deterioration</li> <li>• Non-specific physical symptoms (e.g. headaches)</li> <li>• Worsening subjective health</li> <li>• Obesity or extreme weight loss</li> </ul>
<b>CHRONIC DISORDERS</b>
<ul style="list-style-type: none"> <li>• Chronic pain</li> <li>• Irritable bowel syndrome</li> <li>• Other gastrointestinal disorders</li> <li>• Somatic complaints</li> <li>• Cardiovascular disorders</li> <li>• Metabolic or endocrine disorders</li> <li>• Failure to complete health treatments</li> <li>• Lack of interest in own wellbeing</li> <li>• Pelvic pain</li> </ul>
<b>SEXUAL AND REPRODUCTIVE HEALTH</b>
<ul style="list-style-type: none"> <li>• Due to forced sexual relations: loss of sexual appetite, menstrual disorders, sexually transmitted diseases including HIV/AIDS, vaginal bleeding and fibrosis, chronic pelvic pain, urinary infections, unwanted pregnancy, miscarriage, etc.</li> <li>• Due to violence during pregnancy: vaginal haemorrhaging, risk of miscarriage, high-risk pregnancy, premature birth, low birth weight, etc.</li> </ul>
<b>PSYCHOLOGICAL HEALTH</b>
<ul style="list-style-type: none"> <li>• Depression</li> <li>• Anxiety</li> <li>• Sleep disorders</li> <li>• Post-traumatic stress disorder</li> <li>• Eating behaviour disorders</li> <li>• Suicide attempts</li> <li>• Use and abuse of, and dependence on alcohol, drugs and psychotropic medications</li> </ul>
<b>SOCIAL HEALTH</b>
<ul style="list-style-type: none"> <li>• Social isolation</li> <li>• Job loss</li> <li>• Absenteeism from work</li> </ul>
<b>CHILDREN'S HEALTH</b>
<ul style="list-style-type: none"> <li>• Risk of affected general development</li> <li>• Feeling threatened</li> <li>• Difficulties learning or socialising</li> <li>• Violent behaviour towards peers</li> <li>• Increased frequency of psychosomatic disorders</li> <li>• Frequently victims of violence by their father</li> <li>• Transgenerational violence with high tolerance of situations of violence</li> <li>• Violence may also affect other dependents and people living with the woman</li> <li>• High risk behaviour such as drug and alcohol use</li> </ul>

# Health Service Measures

## Health Service Measures

The health services, in particular health professionals working in primary care teams, the Sexual and Reproductive Health Services Programme (PASSIR) and in specialist obstetrics and gynaecology, mental health, addiction or trauma units and hospital casualty departments are particularly well placed to prevent and detect sexist violence and provide care and rehabilitation for its victims. Health centres are accessible, have direct and continued contact with different groups of women and are staffed by multidisciplinary teams, all of which makes them the ideal place to identify women who are suffering violence, and to prevent and limit the effects of violence on women's health and wellbeing.

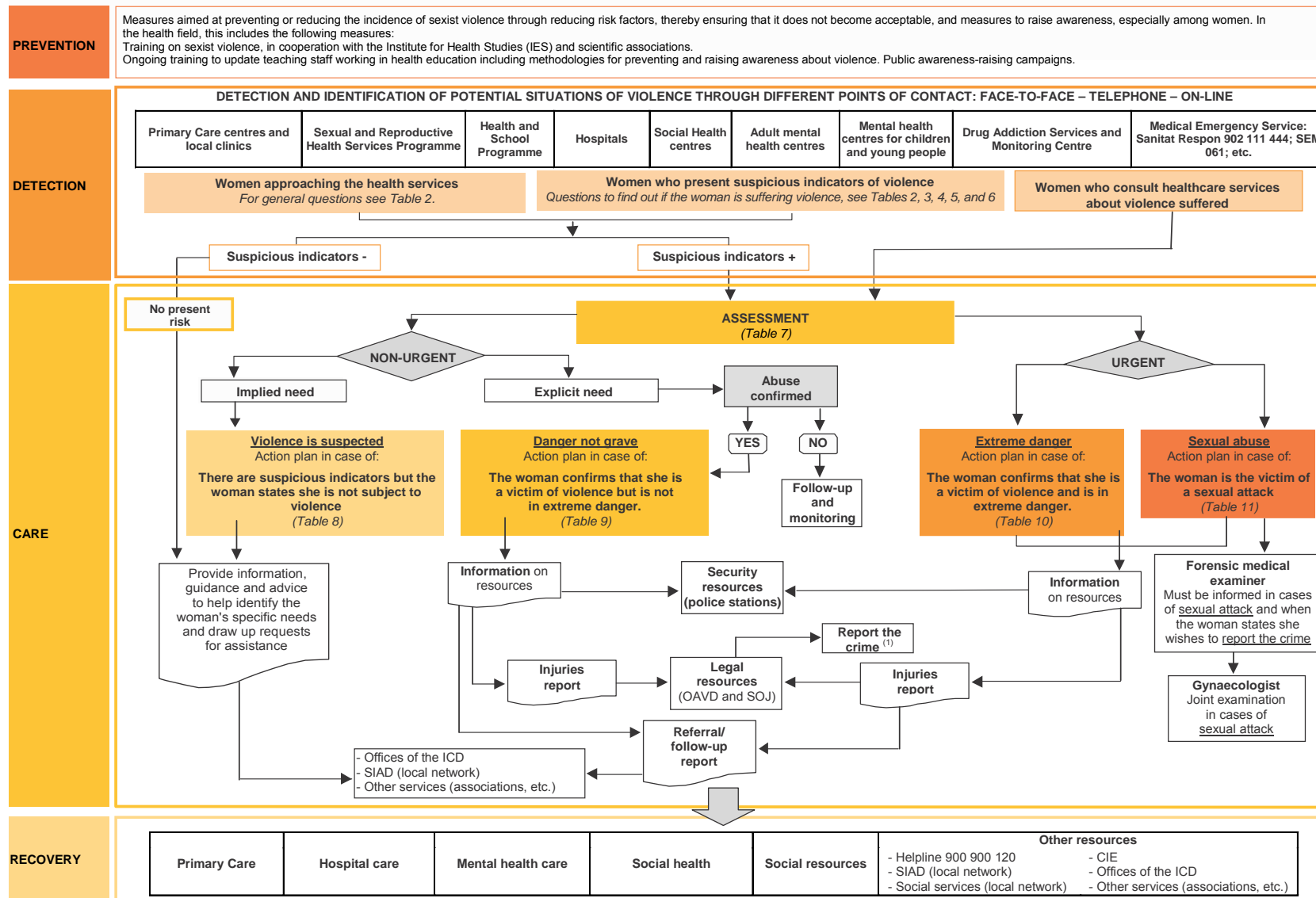
Constant vigilance is vital to detect signs that women using health services are, have been, or are at risk of being, in a violent situation.

Health service measures are structured as follows:

1. Prevention
2. Detection
  - Stages of the clinic interview
  - Indicators to aid detection
  - Assessment
3. Care and rehabilitation
  - Information about the problem
  - Work during the consultation and follow-up
  - Referral
  - Recording in medical records
  - Measures related to any children or other dependents
  - Issue, when necessary, the corresponding injury and medical reports.

The diagram below shows the measures adopted by the health services, focusing on violence perpetrated by the woman's partner or ex-partner or by other members of the family (Figure 2).

Figure 2. Diagram showing measures in the health service to coordinate action on sexist violence



<sup>(1)</sup> Official report procedure, Report to courts, application for protection order, etc.

Source: Adapted from: – Programme for an Integrated Response to Violence Against Women. Madrid: National Health System. Spanish Ministry of Health and Social Policy. Interregional Council. National Health System, 2007.  
 - Framework Protocol and National Circuit for Coordinated Action Against Sexist Violence. Barcelona. Institut Català de les Dones (Catalan Institute for Women), 2009

## Health Service Measures

### 1. Prevention

Prevention, according to Law 5/2008 of 24 April on the right of women to eradicate sexist violence, consists of those measures aimed at preventing or reducing the incidence of sexist violence through reducing risk factors, thereby ensuring that it does not become acceptable. It also involves measures to raise awareness, especially among women, that no form of violence is justifiable or tolerable. Preventive measures must take into account both situations where abuse has not yet occurred, in order to identify them, especially among the younger population, and situations where abuse has occurred to prevent it becoming persistent.

*Awareness raising* refers to all educational and communication measures aimed at producing a change in social consciousness that will eventually lead to the eradication of sexist violence.

In the healthcare field, this includes the following measures:

- A training programme on sexist violence, with the support of the Institute for Health Studies (IES).
- A draft plan for ongoing training to update teaching staff working in health education, including methodologies for preventing and raising awareness of violence.
- Activities to raise public awareness.

### 2. Detection

#### Stages of the clinic interview

In 1996 the World Health Organisation pointed out the importance of improving the health sector's methods for dealing with violence within the family through universal screening for women and children. It recommended regularly asking health service users if they have been subject to sexual or physical violence, and the creation of written protocols defining, for each specific field, the procedures to follow in order to identify victims of violence and provide an appropriate response.

There has traditionally been controversy in the health field regarding the usefulness of screening with regard to sexist violence perpetrated by the user's partner. There is, however, growing recognition of its value as an appropriate and effective means of identifying and responding to cases of violence, beyond those which are encountered at casualty departments or primary care centres.

We may not have sufficient evidence to recommend universal screening for sexist violence, but this does not mean that there is sufficient evidence for us *not* to recommend it<sup>13</sup>. The Canadian Task Force on Preventative Health Care<sup>14</sup> noted that 'although there is still insufficient evidence to recommend for or against the use of screening, its prevalence and the harm associated with domestic violence is sufficient reason to maintain high levels of vigilance during assessment of women patients'. Other medical organisations and bodies recommend screening or routine questioning within health services to identify possible cases of violence against women. The hidden nature of the problem of violence towards women, comparable to an iceberg<sup>15</sup>, leads us to consider screening as an effective method, as it allows us to uncover hidden cases of violence and help to break the silence, inhibitions and social tolerance surrounding the persons suffering from these situations. Other benefits of routine screening can be identified<sup>16</sup>: raising awareness about sexist violence among healthcare professionals and in the wider community; more pressure to increase the resources and training available to healthcare professionals; improved overall knowledge

<sup>13</sup> U.S. Preventive Services Task Force; 2004.

<sup>14</sup> MacMillan et al.; 2001.

<sup>15</sup> The iceberg metaphor applied to domestic violence highlights the fact that most of the victims are socially invisible: they are hidden below the water line by their own silence and by that of their social surroundings. (Gracia, 2002).

<sup>16</sup> Bradley et al.; 2002; Ramsay et al.; 2002; Jewkes; 2002.

about women's health issues; developing skills and more sensitive attitudes to the problem among health service professionals. All these potential benefits could contribute to coordinating measures aimed at identifying hidden cases of domestic violence perpetrated within the partnership or family, overcoming the silence, tolerance and social inhibitions surrounding the women that find themselves in these circumstances, and progressively melting the iceberg of violence against women. However, other commentators do not regard universal screening to be an effective method of detecting violence against women<sup>17</sup>.

In this protocol, therefore, we recommend constant vigilance to detect signs that women using health services are, have been, or are at risk of being, in a violent situation.

When a health professional suspects that a woman may be subjected to violence, the next step is to confirm or allay the suspicion. A clinical interview is therefore required.

Table 2 gives examples of general questions that may be used during the consultation to actively investigate whether there has been violence within the partnership or family. Table 3 gives some recommendations for the clinical interview when violence is suspected. Table 4 gives some examples of questions to ask in the event of such suspicions. Finally, Table 5 gives examples of questions for assessing the situation of the couple and the type of violence within it:

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**Table 2.**  
General questions to actively investigate for cases of violence

Depending on how well you know the woman and what level of trust exists, it may be necessary to begin by putting the questions in context with an introductory comment such as:

- Violence is a common problem in many women's lives and can be very serious. For that reason, I routinely ask all women who come to the clinic about this issue.
- You know that there is a lot of talk about violence these days; it is a common problem and can be very serious.
- A lot of women experience some sort of violence during their lives.

Then you can go on to explore general issues through more direct questions:

- How are things at home?
- What do you think is the cause of your illness or health problem?
- You seem a little nervous. Is something worrying you?
- Is some problem you are experiencing making you feel this way?
- Relationships between couples are sometimes violent. What happens when you have an argument at home? What are the arguments like? Do you ever fight physically?
- Have you experienced or do you ever experience psychological, physical or sexual violence from your partner? What type? If the answer is yes: Since when? How often does it happen?

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<sup>17</sup> Ramsay J, Richardson J, Carter YH, *et al.* "Should health professionals screen for domestic violence? Systematic review." *BMJ* 2002;325:314.

**Table 3.**  
Recommendations for  
the clinical interview  
when violence is  
suspected

- See the patient alone, assuring her that the interview is confidential.
  - Observe her moods and emotional state (through verbal and non-verbal language).
  - Help her to express her feelings.
  - Show empathy and listen actively to facilitate communication.
  - Tackle the issue of violence directly.
  - Clearly state that violence is never justifiable in human relationships.
  - Ensure that the woman does not feel to blame for the violence suffered.
  - Believe her without querying her interpretation of facts, without being judgemental, trying to alleviate her fear about having revealed the abuse.
  - Help her to think and order her ideas.
  - Make her aware of the risks and accept her decision.
  - Follow a logical sequence: from more general and indirect questions to more specific, direct questions.
  - Do not impose criteria or decisions. The woman must make her own decisions and decide the timing of her actions. Do not make her believe there are easy fixes.
  - Do not give her false hopes.
  - Do not criticise her attitude or lack of reaction with phrases such as: If you wanted it to end, you would leave.
  - Do not play down the feeling of being in danger she expresses.
  - Do not recommend relationship counselling or family mediation.
  - Do not prescribe drugs that diminish her capacity to react.
  - Do not adopt a paternalistic attitude.
-

**Table 4.**  
Questions when violence is suspected

- When suspicions are raised due to the medical history and background of the woman:
- I have had a look at your medical records and I have noticed a few things I would like to discuss with you. I see that... (Explain what you have found.) What do you think is the cause? What can you tell me about this? Do you think these things could be related?
  - In many cases women who have problems like yours, such as ... (Mention some of the major points identified.) ... are being treated violently by someone, for example, their partners. Is this happening to you?
- Where suspicions are raised by antecedents such as dyspareunia or pelvic pain:
- Have you ever been forced to have sex or to engage in sexual practices when you didn't want to?
- Where suspicions are aroused by physical injuries:
- This type of injury is often caused by being hit/punched... Is that what happened to you?
  - Does your partner or someone else use force against you? What sort? Since when?
  - Have you ever suffered a worse attack? (Beating, use of weapons, sexual aggression)
- Where suspicions are aroused by psychological symptoms or problems:
- I would like to know what you think about the symptoms that you have described to me (anxiety, nervousness, sadness, apathy, etc.): How long have you been feeling this way? What do you think is the cause? Is it related to any particular thing? How is your relationship with your partner?
  - Has anything happened lately in your life to make you worried or sad? Could there perhaps be some problem with your partner? With your children? A member of the family? At work?
  - You seem frightened, uneasy. What are you afraid of?
  - Do you have any problems seeing your friends or family? What is stopping you?

**Table 5.**  
Questions for assessing the situation and specific type of violence experienced

- Psychological violence**
- Does he often shout at you or talk to you in an authoritarian way?
  - Does he threaten to harm you, the children, other people or household pets?
  - Does he insult, ridicule or belittle you, when you are alone or in front of your children or other people?
  - Does he get jealous without any reason?
  - Does he stop you seeing your family or friends or make it hard for you to see them?
  - Does he blame you for everything that happens?
  - Does he control your money or make you account for your spending?
  - Does he stop you working or studying outside the home?
  - Does he threaten to take the children if you leave him?
  - Does he ignore your feelings or pretend you are not there, etc.?
- Physical violence**
- Does your partner push you or grab you?
  - Does your partner hit you, slap you or attack you in any other way?
- Sexual violence**
- Does your partner make you have sex when you don't want to?
  - Does he force you to take part in sexual practices that you don't like?

### Indicators to aid detection

A range of signs and symptoms can lead us to believe a woman may be a victim of sexist violence. It is important for all health professionals to be aware of them and to be vigilant during consultations, as detecting these signs will make it possible to intervene in situations of violence.

The most common form of abuse is psychological or emotional. Although it is less conspicuous at first sight, it can profoundly mark the physical and mental health of the women who are its victims. It is insidious in that it can take place over a long period of time and is repeatedly progressively destroys the woman's self-esteem, so that she often finds it difficult to identify herself as an *abused woman*. Even when the violence is physical, only a minority of women approach the health system with a specific complaint related to what has happened or is happening to them.

There is no consensus regarding the suspicious signs that can identify an abused woman who does not volunteer the information. This protocol recommends considering this possibility when carrying out differential diagnosis, paying special attention to the following aspects:

**Table 6.**  
Indicators to aid  
detection

<p><b>The woman's behavioural antecedents</b></p> <ul style="list-style-type: none"> <li>• She has been subjected to or has witnessed abuse in childhood (questions need to be asked about this matter).</li> <li>• Information on past or present situations involving abuse from relatives, friends and other professionals or institutions.</li> <li>• History of abuse of medication, especially psychotropic medication.</li> <li>• History of recourse to escape mechanisms: alcohol and drug abuse.</li> <li>• History of attempted suicide.</li> <li>• History of repeated accidents (at home, falls, while doing sport).</li> <li>• Eating disorders.</li> </ul> <p><b>Gynaeco-obstetric antecedents</b></p> <ul style="list-style-type: none"> <li>• Injuries to genitals, abdomen or breasts (especially during pregnancy).</li> <li>• Dyspareunia, pelvic pain and repeated genital infections.</li> <li>• Absence of birth control: unwanted or unaccepted pregnancy.</li> <li>• Delay in requesting prenatal care.</li> <li>• History of miscarriages or repeated abortions.</li> <li>• HIV / Aids</li> </ul> <p><b>Reasons for the consultation</b></p> <ul style="list-style-type: none"> <li>• There is no diagnosis that would explain the symptoms.</li> <li>• Constant somatic symptoms: especially chronic pain, gastro-intestinal disorders.</li> <li>• Constant psychological symptoms: sleep disorders, panic or distress attacks, depression and anxiety.</li> </ul>
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(Continued on following page)

**Table 6.**  
Indicators to aid  
detection  
(Continued from previous  
page)

<p><b>Patterns of health service usage</b></p> <ul style="list-style-type: none"> <li>• Very frequent visits or very frequent visits alternating with long periods of absence.</li> <li>• Failure to attend appointments or follow treatment.</li> <li>• The patient is always accompanied by a partner or another person during healthcare visits.</li> <li>• Repeated use of emergency services.</li> <li>• Frequent admission to hospital unexplained by diagnosis.</li> </ul> <p><b>Detection of injuries during the consultation</b></p> <ul style="list-style-type: none"> <li>• Delay in the demand for assistance for physical injuries.</li> <li>• Incongruity between the type of injury and the explanation of the reason.</li> <li>• Distribution of central lesions or lesions in areas normally hidden by clothing.</li> <li>• Genital lesions.</li> <li>• Suspicious bruises or contusions on areas: face and head, inner arms and legs.</li> <li>• Injuries in various stages of healing (violence over time)</li> <li>• Injuries defense (eg, inner forearm).</li> <li>• Lesions suspected extreme passivity: cigarette burns.</li> </ul> <p><b>Attitude and/or condition of the woman during the consultation</b></p> <ul style="list-style-type: none"> <li>• Signs of depression or listlessness with unexplained low self-esteem and guilt feeling.</li> <li>• Inexplicable attitude of fear or evasion and uneasiness.</li> <li>• Embarrassment, difficulty in communicating, avoiding eye contact.</li> <li>• Anxiety or distress, indignation which is out of place, aggression towards the healthcare professional attending her.</li> <li>• Isolation: lack of relationships with others.</li> <li>• Lack of attention to personal care.</li> <li>• Injuries are justified or dismissed as unimportant.</li> <li>• If the partner is present: she seeks approval or her answers reveal fear.</li> </ul> <p><b>Attitude of her partner</b></p> <ul style="list-style-type: none"> <li>• Insists on being present throughout the visit.</li> <li>• Monitors everything the woman says: he provides answers or interrupts her to correct or modify her version.</li> <li>• Displays excessive concern or care.</li> <li>• May be tense or even hostile or aggressive towards the woman or the healthcare professional.</li> </ul>
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### Assessment

Where there are positive indicators for suspecting violence a detailed assessment must be carried out. The assessment must help us to determine if we are dealing with a mere suspicion of violence, a case of violence which does not yet pose extreme health risks to the woman, or if we are dealing with a woman whose health, or even life, are in grave danger.

## Health Service Measures

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Tables have been published<sup>18</sup> for evaluating the risk to the woman depending on the type of violence. None of these tables are a substitute, however, for professional judgement, and, above all, the woman's perceptions. If the woman feels she is in danger, we must consider that she is in danger.

Currently, in the common context of the *Framework Protocol for Coordinated Action Against Sexist Violence*, there is an interdepartmental working group, headed by the Institut Català de les Dones (Catalan Institute for Women), which is working to establish a consensus on a tool to assess risk within the couple which is valid for all the areas which may be involved in dealing with cases of sexist violence.

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<sup>18</sup> Salber P, Taliaferro E. Reconocimiento y prevención de la violencia doméstica en el ámbito sanitario. Barcelona: Cedecs; 2000.

**Table 7.**  
ASSESSMENT  
INDICATORS

**BIOPSYCHOSOCIAL ASSESSMENT**

- Injuries and physical symptoms
- Family situation
- Financial situation, employment status and occupation
- Social support network
- Relationships

**ASSESSMENT OF THE VIOLENCE**

- Type, duration, frequency and intensity of the violence
- The aggressor's behaviour in the family and social context; has he behaved violently towards other family members or other people?
- Mechanisms used by the woman to adapt to the situation
- Current phase in the cycle of violence

**Safety evaluation and assessment of risk**

- It is important to determine whether the woman is in extreme danger or not. Extreme danger means there is a real and imminent threat to the life of the woman or her children. Indicators of extreme danger (this assessment must be carried out jointly with the woman):
  - Threats with weapons or the use of weapons
  - Threats or attempts to murder the woman or her children
  - Suicide threats or attempted suicide by the woman
  - Violence towards the children or other family members
  - Serious injuries, perhaps even requiring hospital treatment
  - Threats or persecution although the couple have separated
  - Increasing intensity or frequency of the violence
  - Violence during pregnancy
  - Repeated sexual abuse
  - Violent behaviour outside the home
  - Extreme jealousy, obsessive control of the daily activities of women (which was, or who is how much money you have).
  - Isolation growing.
  - Consumption of alcohol or drugs by the spouse, and consumption by women.
  - Reduction or absence of remorse expressed by the aggressor.
- The woman's own perception of the danger, both to herself and to other members of the family, must be taken into account. If she believes she is in danger, the situation is automatically defined as being one of extreme danger.
- Professional opinion to be given after the assessment (based on the interview and biopsychosocial assessment carried out)
- If a situation of danger is detected, ask the following questions:
  - Do you feel safe at home? Can you go home now?
  - Are your children safe? Where is the aggressor now?
  - Do your friends and family know? Would they help you?

## Health Service Measures

### 3. Care and rehabilitation

The role of health professionals is not limited to attending to and monitoring the women concerned, but also extends to their children, if they have any, and other dependents. It is therefore necessary to establish mechanisms for coordinating with the other services which could be involved.

Constant vigilance is vital to detect signs that women using health services are, have been, or are at risk of being, in a violent situation. Nor does the health service professionals' role end with the confirmation of suspected violence. There is important work to be done providing the woman with information, treatment and work in the consulting room, and making referrals, depending on the features of the case.

The treatment of the presumed aggressor must not put the safety of the woman and her dependents at risk. If the suspicion of violence is confirmed the aggressor may be offered the opportunity to go to an appropriate facility, if the area has a specific scheme for violent men. Measures aimed at the aggressor must take place after assessing the risk affecting the woman and it is very important for all details to be kept confidential.

The steps taken will vary according to whether the woman confirms or denies that the violence is taking place. Some of the possible situations and the guidelines to follow are set out below:

- There are suspicious indicators but the woman states she is not subject to violence (Table 8).
- The woman confirms that she is a victim of violence but is not in extreme danger (Table 9).
- The woman confirms that she is a victim of violence and is in extreme danger (Table 10).
- The woman is the victim of a sexual attack (Table 11).

The tables below summarise the main steps to be taken in each of the four situations which we have just described.

**Table 8.**  
Action Plan

#### There are suspicious indicators but the woman states she is not subject to violence

**NOTE IN THE PATIENT'S CLINICAL RECORD**  
that the woman is in a situation where violence is suspected at the consultation date.

*If there are suspicious indicators, the situation (suspected violence) must be discussed with the woman*, explaining why the indicators suggest that violence is taking place.

If, on being asked, the woman confirms that violence is taking place, assess her safety and proceed to the appropriate action plan (see Table 9 or 10 below), depending on whether she is in a situation of extreme danger or not. If she does not confirm that violence is taking place, the following steps must be taken:

- Record the date
- Record the agreed plan of action.

This record may be used as evidence in legal proceedings.

A Social Report may be written and included in the record. This report could be useful for future legal proceedings, if these take place, as it may provide social analysis and assessment of the violent situation.

***Work in the consulting room (follow-up)***

- **Comprehensive or interdisciplinary care.** Consider consulting all the staff involved (**with the woman's consent**) and drawing up a common treatment plan assigning responsibilities, tasks and follow-up actions to each professional.
- **Treatment of physical, psychological and emotional problems and addressing the social problems of the woman and/or her family which have been detected.**
- **Follow up appointments must be offered until it is confirmed that violence is or is not taking place: the woman must be helped, sympathetically, to recognise the violent situation she is in, and to take decisions.**
  - Emphasise situations that encourage the woman to feel in control of her own life.
  - Offer follow-up appointments for the health problems identified, in order not to lose contact with the patient.
  - Help the woman through the process of recognising the violent situation she is in, and to take decisions.
- **Try to offer her, if possible, the chance to get involved in group activities (women's groups in the centre or organised elsewhere in the area).**

***Referral*** (if deemed necessary and with the consent of the woman)

- **to social work staff** if psychosocial risks are detected.
- **to the appropriate resources for the woman's situation:** put the woman in touch with the services that you consider necessary in the network of women suffering sexist violence (Appendix 1), but not before the health team has drawn up an interdisciplinary work plan, studied the woman's particular circumstances and assessed the suitability of each service.

**Manage appointments with the service to which the patient is referred and coordinate action taken.**

***Measures related to any dependents living with the woman.***

If the woman has **dependent children**, the paediatric professional must be informed and the protocol relevant to children applied (risk assessment, action, referral, etc.).

The repercussions of the violence for **other dependent people living with the woman** must also be considered, and the necessary action taken or referrals made.

**Source:** Adapted from the *Common Protocol on Health Measures to Combat Gender Violence*. Madrid: Women's Health Observatory. Directorate-General of the Quality Agency. National Health System. Ministry of Health and Consumer Affairs. Commission against Gender Violence. National Health System Interregional Council, 2007.

## Health Service Measures

**Table 9.**  
Action Plan

<b>The woman confirms that she is a victim of violence but is not in extreme danger</b>	
<p><b>NOTE IN THE PATIENT'S CLINICAL RECORD</b> that the woman is in a situation where violence is occurring at the consultation date.</p> <ul style="list-style-type: none"> <li>Record the date</li> <li>Record the agreed plan of action.</li> </ul> <p>This record may be used as evidence in legal proceedings.</p> <p>A Social Report may be written and included in the record. This report could be useful for future legal proceedings, if these take place, as it may provide social analysis and assessment of the violent situation.</p> <p><b>ISSUE AN INJURY REPORT IF APPROPRIATE</b> There is a legal requirement to inform the authorities if there are injuries or other symptoms when violence is detected, remitting the injuries report and medical report to the courts. A copy must be made available to the woman and its implications explained to her. Strategies must also be established to ensure that this notification does not put the woman's life at risk or her children's.</p>	<p><i>It is necessary to discuss the situation with the woman</i> (who confirms that she is a victim of violence but is not in extreme danger) and to:</p> <ul style="list-style-type: none"> <li>Explain to her that violence is a crime and she has the right to report it.</li> <li>Inform her about her rights and those of any children she has.</li> <li>Explain to her how violent behaviour works (the cycle, consequences, etc.).</li> <li>Explain the repercussions of violence for her health and wellbeing and that of her family (especially children and dependents).</li> <li>Communicate messages of support: make it clear that she is not to blame, support her for having told someone about the violence, reassure her about confidentiality, respect her privacy, explain that other women have suffered the same thing, that there are people who can help.</li> </ul> <p><b>Work in the consulting room (follow-up)</b></p> <ul style="list-style-type: none"> <li><b>Comprehensive or interdisciplinary care.</b> Consider consulting all the staff involved (<b>with the woman's consent</b>) and drawing up a common treatment plan assigning responsibilities, tasks and follow-up actions to each professional.</li> <li><b>Treatment of physical, psychological and emotional problems and addressing the social problems of the woman and/or her family which have been detected.</b></li> <li><b>Establish a schedule of follow-up appointments to:</b> <ul style="list-style-type: none"> <li>Suggest or encourage the taking of decisions to bring about changes in the situation.</li> <li>Help the woman to face up to the situation.</li> <li>Prevent new violent incidents occurring.</li> </ul> </li> <li><b>Try to offer her, if possible, the chance to get involved in group activities (women's groups in the centre or organised elsewhere in the area).</b></li> </ul> <p><i>Referral</i> (if deemed necessary and with the consent of the woman)</p> <ul style="list-style-type: none"> <li><b>to social work staff</b> if psychosocial risks are detected.</li> <li><b>to the appropriate resources for the woman's situation:</b> put the woman in touch with the services that you consider necessary in the network of women suffering sexist violence (Appendix 1), but not before the health team has drawn up an interdisciplinary work plan, studied the woman's particular circumstances and assessed the suitability of each service.</li> </ul> <p><b>Manage appointments with the service to which the patient is referred and coordinate action taken.</b></p> <p><b>Measures related to any dependents living with the woman.</b> If the woman has <b>dependent children</b>, the paediatric professional must be informed and the protocol relevant to children applied (risk assessment, action, referral, etc.). The repercussions of the violence for <b>other dependent people living with the woman</b> must also be considered, and the necessary action taken or referrals made.</p>

**Source:** Adapted from the *Common Protocol on Health Measures to Combat Gender Violence*. Madrid: Women's Health Observatory. Directorate-General of the Quality Agency. National Health System. Ministry of Health and Consumer Affairs. Commission against Gender Violence. National Health System Interregional Council, 2007.

**Table 10.**  
Action Plan

<b>The woman confirms that she is a victim of violence and is in extreme danger</b>			
<p><b>NOTE IN THE PATIENT'S CLINICAL RECORD</b> that the woman is in a situation where violence is occurring at the consultation date.</p> <ul style="list-style-type: none"> <li>Record the date</li> <li>Record the agreed plan of action.</li> </ul> <p>This record may be used as evidence in legal proceedings.</p> <p>A Social Report may be written and included in the record. This report could be useful for future legal proceedings, if these take place, as it may provide social analysis and assessment of the violent situation.</p> <p><b>ISSUE INJURY REPORT AND MEDICAL REPORT</b> A copy of both documents must be made available to the woman and their implications explained to her. Strategies must also be established to ensure that these documents do not put the woman's life at risk or her children's.</p>	<p><b><i>It is necessary to discuss with the woman</i></b> the assessment of her situation, ensuring she is aware of the danger and explaining the options available, and to:</p> <ul style="list-style-type: none"> <li>Explain to her that violence is a crime and she has the right to report it.</li> <li>Inform her about her rights and those of any children she has.</li> <li>Communicate messages of support: make it clear that she is not to blame, support her for having told someone about the violence, reassure her about confidentiality, respect her privacy, explain that other women are suffering the same thing, that there are people who can help.</li> <li>Explain the danger she is in and the options available. Make sure she understands she is not alone.</li> </ul>		
	<p><b><i>Work in the consulting room (follow-up)</i></b></p> <ul style="list-style-type: none"> <li>Treatment of physical, psychological and emotional problems and addressing the social problems of the woman and/or her family which have been detected.</li> <li>Make sure she understands she is not alone.</li> <li>Explain the different options available and act on her decision.</li> <li>It is advisable to put her in contact with emergency social services staff, if available, or 24-hour emergency support services for abused women.</li> <li>Prepare a follow-up plan that is appropriate for the woman's situation in any of the three cases below. Consider consulting all the healthcare staff involved (<b>WITH THE WOMAN'S CONSENT</b>) and drawing up a common treatment plan assigning responsibilities, tasks and follow-up actions to each healthcare professional.</li> </ul>		
	<p>If she decides to leave the family home that day ↓</p>	<p>If she decides to go home ↓</p>	<p>If she has already left home and is still in extreme danger ↓</p>
	<ul style="list-style-type: none"> <li>Find out about her family background and what support is available to her: <ul style="list-style-type: none"> <li>The children: where they are and how they are.</li> <li>People available to provide support (family, friends, etc.).</li> <li>What documentation and money is she carrying?</li> </ul> </li> <li>If necessary, alert the emergency services attached to the network for care and rehabilitation of women subjected to sexist violence.</li> <li>Offer follow-up support (express interest in seeing her again, to know what is happening).</li> </ul>	<ul style="list-style-type: none"> <li>Organise another appointment to continue working on tackling obstacles to decision-making.</li> <li>Initiate any necessary mechanisms to protect children.</li> <li>Inform the woman about other support resources available via the network for care and rehabilitation of women subjected to sexist violence, such as women's information and advisory centres.</li> <li>Talk to her about the need to be alert and to organise somewhere safe for herself and her children, including things to consider if she has to leave home quickly.</li> </ul>	<ul style="list-style-type: none"> <li>Inform the woman about legal measures to restrain the aggressor, and if such orders have been applied for and not respected, advise her to report it to the relevant authority. Where possible it is advisable to produce a report in order to inform the authorities.</li> <li>Alert emergency services, if necessary.</li> </ul>
<p><b><i>Depending on her situation, put the woman in contact with the appropriate services in the network of women suffering sexist violence (Appendix 1), if you consider it necessary and with the woman's consent.</i></b> <b>Manage appointments with the service to which the patient is referred and coordinate action taken.</b></p>			
<p><b>Measures related to any dependents living with the woman.</b> If the woman has dependent children, the paediatric professional must be informed and the protocol relevant to children applied (risk assessment, action, referral, etc.). The repercussions of the violence for <b>other dependent people living with the woman</b> must also be considered, and the necessary action taken or referrals made.</p>			

Source: Adapted from the *Common Protocol on Health Measures to Combat Gender Violence*. Madrid: Women's Health Observatory. Directorate-General of the Quality Agency. National Health System. Ministry of Health and Consumer Affairs. Commission against Gender Violence. National Health System Interregional Council, 2007.

### Measures in case of sexual attack

A sexual attack, as a form of sexist violence, may take place in the wider community or within a couple or family. It refers to the use of physical and sexual violence exercised against women and minors and consists of the premeditated use of sex as a weapon to demonstrate power and abuse it.

The guidelines for cases involving sexual attacks or abuse and rape are included in a separate section due to the specific nature of such cases. A specific operational document on tackling these issues will also be available.

Sexual violence may be perpetrated by a partner or ex-partner, or by other men in the woman's family, social circle or community. In general, women seek advice when the aggressor is not the woman's partner, and only rarely when the aggressor is her partner. In these cases, the sexual violence usually remains hidden and is, therefore, difficult to detect.

Such acts are a crime against the woman's sexual liberty and the health measures to be taken by primary and community healthcare professionals or a hospital or non-hospital service dealing with a victim of sexual aggression must ensure physical, psychological and social assessment for the woman.

It is important to create an atmosphere that encourages communication, confidentiality and as much privacy as possible. If the victim wishes it, a person whom she trusts can stay with her. Do not ask compromising questions and only take down such information as the woman wishes to divulge. Inform her about the examinations you will carry out and their purpose, and explain what you are doing throughout.

Clearly in such cases it is vital to minimise the amount of psychological stress the woman must suffer after an attack. For this reason it is not only justified, but recommended, to carry out the gynaecological and medico-forensic assessment in a single examination, keeping the medical and forensic aspects separate, but trying to ensure no further examinations will be needed. There are no legal or ethical impediments to doing this, quite the opposite. In order to avoid multiple examinations and to coordinate the medical and legal aspects of the case, the relevant duty court must be called immediately to approve the attendance of the forensic doctor, or authorise the duty healthcare officer to take samples which may be required for legal purposes.<sup>19</sup>

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<sup>19</sup> For a criminal prosecution to take place, the victim or their legal representative must report the crime, or the case must be brought by the Public Prosecution Service (if the victim is a minor, incapacitated or otherwise unable to act on her own behalf, the action of the Public Prosecution Service is sufficient). Although the woman may not wish to prosecute at that precise moment, the facts must be communicated to the duty court so that the corresponding judicial procedures can be initiated and the necessary investigations and checks carried out in case the woman or any other competent legal authority wishes to prosecute in future.

Normally the measures to be carried out by the corresponding professionals are:

#### Clinical measures

- Emotional and psychological support.
- Clinical interview and examination.
- Request involvement of forensic medical service via the duty court, and cooperate on tasks to be carried out.
- Take samples from genitalia for sexually transmitted infections.
- Request blood analysis.
- Immediate treatment of any physical injuries.
- Treatment of and preventive measures against sexually transmitted infections, if necessary.
- Measures to prevent pregnancy.
- Issue injuries report.

#### Forensic measures

- Collect samples for legal purposes.<sup>20</sup>
- Locate and determine the seriousness of injuries (with photographs).
- Write forensic medical report for the court.

Table 11 gives details of the measures to be taken in cases of sexual attack.

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<sup>20</sup> The National Institute of Toxicology and Forensic Sciences and the Instituto de la Mujer (Spanish Institute for Women's Affairs), in collaboration with the Ministry of Justice's Centre for Legal Studies, has issued a kit for collecting samples in cases of sexual attack in a number of provinces and autonomous communities. It contains the tools necessary for correctly taking samples (swabs, nail clippers, comb, bags, labels, etc.). In addition to these tools, it also contains items to help improve the circumstances under which the examination must take place, in particular to ensure the privacy and dignity, which is most necessary in these cases in order to reduce the risk of re-victimisation.

## Health Service Measures

**Table 11.**  
Action Plan

<b>The woman is the victim of a sexual attack</b>	
<b>In the primary care centre or other non-hospital service</b>	Staff in the <b>primary healthcare centre or other non-hospital service</b> attending the victim of a sexual attack must ensure physical, psychological and social assessment for the woman. Consideration should also be given to the need to send the victim to hospital. She should not be cleaned up or any of her clothes changed. If fellatio has taken place, as far as possible ensure the patient does not ingest any liquids or food before being examined in hospital.
<b>In the hospital</b>	<p>Admission and support</p> <ul style="list-style-type: none"> <li>Assess the woman's visible injuries, emotional state and immediate needs: comfort, security, support and treatment plan.</li> <li>Inform the victim about the process, in particular how long it will take and who is involved in the treatment.</li> <li>Record the time the patient is admitted.</li> <li>Ensure she is supported by someone at all times through the examination and treatment process.</li> </ul>
	<p><b>Information entered in medical records</b></p> <ul style="list-style-type: none"> <li>Remember that this record may be used as evidence in legal proceedings.</li> <li>Transcribe the facts related by the woman with regard to the attack (date, time, location, type of sexual attack) and what she did between the attack and the examination (washing her self, food, drink or medication taken, etc.).</li> <li>Whether alcohol or other drugs have been consumed.</li> <li>Previous illnesses, operations, medication, etc.</li> <li>Antecedents of violence, if any.</li> <li>Gynaecological history: first period, nature of periods, date of last period, contraceptive methods used, last sexual intercourse.</li> </ul>
	<p><b>Contact forensic medicine service</b>, for joint examination with gynaecologist. Record forensic doctor's time of arrival.</p>
	<p><b>Contact the necessary professionals:</b> gynaecology, duty surgeon, infectious diseases, psychiatry and/or traumatology, social work.</p>
	<p><b>Emotional support, examination and treatment</b></p> <ul style="list-style-type: none"> <li>Emotional and psychological support</li> <li>Single interview conducted jointly by medical and forensic professionals</li> <li>Collection of physical and biological samples</li> <li>Therapeutic and preventive treatments</li> <li>Report to court</li> </ul> <p><b>Examination (general and gynaecological)</b></p> <p>External examination:</p> <ul style="list-style-type: none"> <li>Detail the location and seriousness of injuries (wounds, contusions, grazing, lacerations) or note if there are none. If there are injuries, it is advisable to take photographs, with the woman's consent.</li> <li>Take samples of semen, blood or other fluids from the skin using a sterile swab slightly moistened with distilled water. Store the samples in a tube which must be sealed, labelled and kept refrigerated (4-8 °C).</li> </ul> <p>Gynaecological examination:</p> <ul style="list-style-type: none"> <li>Vulvovaginal examination: Detail wounds, haematomas and contusions, or note if there are none.</li> <li>Take samples from vagina (or anus or mouth) using dry, sterile swabs, to test for semen. These must be stored in their sleeves without any form of preservative, refrigerated (4-8°C) and labelled. It is recommended to take at least two swabs.</li> <li>Wash the vagina (or anus or mouth) with 10cc of sterile physiological serum to collect any possible semen remnants. Store this in an appropriate sterile tube which must be sealed, labelled and kept refrigerated (4-8 °C). The vaginal washing must take place after samples have been taken for screening for sexually transmitted diseases.</li> <li>The sample labels must include the woman's name, the date and the professional's signature. The various samples must be placed in an envelope marked with the woman's name and sent to the duty court's forensic medicine service.</li> <li>Bimanual tactile examination: to determine uterine size, form, consistency and mobility, and the presence of adnexal masses or pain. An ultrasound scan may be necessary at a later stage.</li> </ul>

**Table 11.**

Action Plan

(Continued from previous page)

<p><b>In the hospital</b> (Continued)</p>	<p>Other evidence which may be collected for legal purposes:</p> <ul style="list-style-type: none"><li>• The woman's clothes at the time of the alleged attack: each item must be stored in a separate bag and labelled.</li><li>• Take anal and oral samples using swabs moistened with physiological serum if appropriate: store the swab in a tube which must be sealed and labelled.</li><li>• Collect nail clippings (for possible samples of the aggressor's skin).</li><li>• Collect pubic hair combings (for possible biological traces of the aggressor).</li></ul> <p><b>Analysis</b></p> <ul style="list-style-type: none"><li>• Check the woman's blood group and Rh.</li><li>• Test for toxic substances.</li><li>• Pregnancy test.</li><li>• Sexually transmitted diseases:<ul style="list-style-type: none"><li>- Culture for gonorrhoea and Chlamydia screening: immediately and after seven days.</li><li>- Syphilis: immediately and after six weeks.</li><li>- HIV: immediately, and after six weeks, four months and six months.</li><li>- Hepatitis B: immediately and after six weeks.</li></ul></li><li>• Cytological smear, also useful for detecting candidiasis (thrush) and trichomoniasis.</li></ul> <p><b>Treatment</b></p> <ul style="list-style-type: none"><li>• Treatment of physical injuries and psychological aftermath:<ul style="list-style-type: none"><li>- Physical traumatism: treat wounds and prevent infection, including tetanus vaccination, if necessary.</li><li>- Psychological traumatism: assess the patient's emotional state and, if necessary, refer to psychiatric or psychological services.</li></ul></li><li>• Prevention of sexually transmitted diseases:<ul style="list-style-type: none"><li>- Carry out preventive treatment for gonorrhoea, Chlamydia and syphilis, which may be incubating.</li><li>- The need for preventive treatment for HIV and/or the hepatitis B virus should be assessed on an individual basis.</li></ul></li><li>• Preventing pregnancy:<ul style="list-style-type: none"><li>- Explain that the likelihood of pregnancy in cases of sexual attack is very low, and it is preferable to wait. Nevertheless, the following options may be discussed with the woman:<ul style="list-style-type: none"><li>- Hormonal postcoital contraception.</li><li>- Wait for her next period or carry out a pregnancy test within two or three weeks. If she opts for this, inform her that, if pregnancy is confirmed, she will be able to have a legal abortion up to the fourteenth week.</li></ul></li></ul></li></ul> <p><b>Notifying the court</b></p> <ul style="list-style-type: none"><li>• Remit the injuries report and medical report to the duty court.</li><li>• Remit a copy to the woman's primary healthcare centre directly (not via the woman as this could compromise her safety).</li></ul> <p><b>Information and referral</b></p> <ul style="list-style-type: none"><li>• Inform the woman of the following points:<ul style="list-style-type: none"><li>- Sexual aggression is a crime and she has the right to report it.</li><li>- Discuss with her the repercussions for her physical and emotional health.</li><li>- Her rights and safety are protected by law and if she wishes she can apply for a protection order, the forms being available in the centre.</li><li>- Inform her about the network of social resources and services available to help women who have suffered violence.</li></ul></li><li>• Referral<ul style="list-style-type: none"><li>- Referral to and coordination with primary healthcare services and social services is important.</li><li>- It is vital to refer the woman to the network of women who have suffered sexist violence (Appendix 1) to ensure access to psychological, social and legal support services.</li></ul></li></ul> <p><b>Recommendations</b></p> <ul style="list-style-type: none"><li>• Do not have sexual intercourse before the next examination.</li><li>• Follow-up appointments for sexually transmitted diseases.</li></ul>
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# Appendix 1. Resources and Information and Care Services

## Appendix 1. Resources and Information and Care Services

### Institutional information and care services

#### Emergency telephone information lines

Helpline for Women Victims of Violence (24 hours)	900 900 120
Medical emergencies	061
Social emergencies	112
Mossos d'Esquadra (Catalan Police Force)	088
Crime Victims Helpline	900 121 884
Sanitat Respon (health services helpline)	902 111 444
Infància Respon (child helpline)	900 300 777
Citizen Information Helpline	012
Secretariat for Immigration	932 701 230
Ministry of Social Action and Citizenship information line	012

#### Programmes for specialised attention in mental health, gender violence and sexual abuse

Psychiatric and psychological attention:

- Sexual abuse unit. Sant Joan de Deu Hospital. Mental Health Services. Ctra. d'Esplugues, s/n. 08034 Barcelona
- Programme to Assist Women Suffering Abuse. Psychiatry Unit, Vall d'Hebron Hospital, Barcelona. Pg. de la Vall d'Hebron, 119-129. 08035 Barcelona
- Programme to Prevent and Treat the Psychological After-effects of Sexual Aggression Against Women. Psychiatry Service, Hospital Clínic, Barcelona Rosselló, 140, baixos. 08036 Barcelona
- Psychiatry Service, Santa Maria de Lleida Hospital Sexual maltreatment and abuse. Alcalde Rovira Roure, 44. 25198 Lleida
- Parc Sanitari Martí i Julià. Programme to Treat Aggressors. Dr. Castany, s/n. 17190 Salt
- Programme to Assist Women Suffering Abuse. Cornellà Mental Health Centre. Mossèn Andreu, 13 3a planta (edifici Can Moritz). 08940 Cornellà

#### Services to attend to women who are victims of sexual aggression

Servei d' Urgències ( Emergency Services) at the Hospital Clínic, Barcelona, is the city's central point for urgent medical attention following sexual aggression. There is a circuit and a protocol for attention.

C/ Villarreal, 170. 08036 Barcelona. Tel. 932 275 400. Fax 932 275 454.

E-mail: [webmaster@clinic.ub.es](mailto:webmaster@clinic.ub.es)

## Appendix 1. Resources and Information and Care Services

### Offices of Crime Victims Services (Ministry of Justice)

These are the main point of reference for information, contact, support and referral for anyone who is a victim of crime or who has applied for legal protection in cases of domestic and sexist violence. The services are free to victims of crime: providing any necessary information and helping the victim to gain access to help, specialist services and the security needed to ensure recovery. They also provide the support and emotional protection needed in crisis situations, following up legal action taken and facilitating access:

- C/ Venezuela, 74-76, 2a. 08019 Barcelona  
Tel. 900 121 884 (free); 933 030 049  
Fax 935 674 520  
Email: [victimabarcelona.dj@gencat.cat](mailto:victimabarcelona.dj@gencat.cat)
- Pg. Canalejas, 5. 17001 Girona  
Tel. 972 940 448  
Fax 972 940 454  
Email: [victimagir@gencat.cat](mailto:victimagir@gencat.cat)
- C/ Canyeret, 1, baixos. 25004 Lleida  
Tel. 973 725 505  
Fax 973 725 741  
Email: [victimalleida.dj@gencat.cat](mailto:victimalleida.dj@gencat.cat)
- Av. Lluís Companys, 10, 4a. 43005 Tarragona  
Tel. 977 920 108  
Fax 977 920 109  
Email: [victimatarragona.dj@gencat.cat](mailto:victimatarragona.dj@gencat.cat)
- C/ Àngel, 6, 4a. 43500 Tortosa  
Tel. 977 448 088  
Fax 977 448 089  
Email: [sgtebre.dj@gencat.cat](mailto:sgtebre.dj@gencat.cat)

### Where can cases of sexist violence be reported?

- At any station of the Mossos d'Esquadra (Catalan Police Force), Local Police, the Civil Guard or the National Police.
- To any duty court.

## Institut Català de les Dones (Catalan Institute for Women) Offices

The **Institut Català de les Dones** provides details of contacts, resources and attention and information services in Catalonia. Free services are also available for psychological attention and legal advice.

- **Barcelona**

Pl. Pere Coromines, 1. 08001 Barcelona. Tel. 935 531 672

- **Girona**

C/ Juli Garreta, 14, entresòl. 17002 Girona. Tel. 972 412 990. Fax 972 412 781

Open: from 9.00 am to 2.00 pm and on Tuesdays from 4.00 pm to 6.00 pm. In summer: from 8.00 am to 3.00 pm. Email: [icd.girona@gencat.net](mailto:icd.girona@gencat.net)

- **Lleida**

Av. del Segre, 5. 25007 Lleida. Tel. 973 703 600. Fax 973 703 607

Open: from 9.00 am to 2.00 pm and on Mondays from 4.00 pm to 6.00 pm. In summer: from 8.00 am to 3.00 pm. Email: [icd.lleida@gencat.net](mailto:icd.lleida@gencat.net)

- **Tarragona**

C/ Sant Francesc, 3. 43003 Tarragona. Tel. 977 241 304. Fax 977 211 262

Open: from 9.00 am to 2.00 pm and on Tuesdays from 4.00 pm to 6.00 pm. In summer: from 8.00 am to 3.00 pm. Email: [icd.tarragona@gencat.net](mailto:icd.tarragona@gencat.net)

- **Terres de l'Ebre**

Palau Abària. Montcada, 23. 43500 Tortosa. Tel. 977 441 234. Fax 977 510 592

Open: from 9.00 am to 2.00 pm and on Tuesdays from 4.00 pm to 6.00 pm. In summer: from 8.00 am to 3.00 pm. Email: [icd.terresebre@gencat.net](mailto:icd.terresebre@gencat.net)

- **Alt Pirineu and Aran**

Pau Casals, 14, entresòl. Tremp. Tel. 973 651 824

- **Central Catalonia**

Pl. Major, 37, 2a. 08500 Vic. Tel. 936 939 883. Fax 936 939 897

## Citizen Information Offices of the Ministry of Health

Health Regions Head Offices

- **Alt Pirineu and Aran Health Region**

Pl. Capdevila, 22, baixos (Tremp) Tel. 973 654 617

Email: [atencioalciutada.rspa@catsalut.cat](mailto:atencioalciutada.rspa@catsalut.cat)

- **Barcelona Health Region**

Edifici Mestral. Parc Sanitari Pere i Virgili (Barcelona) Tel. 902 011 115

Email: [atenciociudadana.rsb@catsalut.cat](mailto:atenciociudadana.rsb@catsalut.cat)

## Appendix 1. Resources and Information and Care Services

- **Catalunya Central Health Region**  
Muralla del Carme, 7, 4t (Manresa) Tel. 938 723 313  
Email: [atencioalciutada.rsc@catsalut.cat](mailto:atencioalciutada.rsc@catsalut.cat)
- **Girona Health Region**  
Carrer del Sol, 15 (Girona) Tel. 972 200 054  
Email: [atencioalciutada.rsgir@catsalut.cat](mailto:atencioalciutada.rsgir@catsalut.cat)
- **Lleida Health Region**  
Av. de l'Alcalde Rovira Roure, 2 (Lleida). Tel. 973 701 600  
Email: [atencioalciutada.rsle@catsalut.cat](mailto:atencioalciutada.rsle@catsalut.cat)
- **Camp de Tarragona Health Region**  
Av. de Maria Cristina, 54 (Tarragona) Tel. 977 224 151  
Email: [atencioalciutada.rstar@catsalut.cat](mailto:atencioalciutada.rstar@catsalut.cat)
- **Terres de l'Ebre Health Region**  
La Salle, 8 (Tortosa) Tel. 977 448 17  
Email: [atencioalciutada.rste@catsalut.cat](mailto:atencioalciutada.rste@catsalut.cat)

### Specialised Intervention Centres (CIE)

The CIE are specialised centres that offer information, care and resources geared to recovery for women (and their children) who have been affected by sexist violence, with the aim of helping them to get over their experience. Open: Monday to Friday, from 9.30 am to 2.00 pm and from 4.00 pm to 7.30 pm.

- **CIE Terres de l'Ebre**  
C/ Miquel Granell, 2, 1r - Edifici Zeus - 43870 Amposta - Tel. 977 700 168
- **CIE Baix Llobregat**  
C/ Pou de Sant Pere, 8 - 08980 Sant Feliu de Llobregat - Tel. 936 859 934
- **CIE Gironès**  
Pl. del Veïnat, 11, 3r - 17190 Salt - Tel. 972 406 555
- **CIE Tarragona**  
C/ Cristòfol Colom 28, 1r - 43007 Tarragona - Tel. 972 920 406

### Information and Assistance Services for Women

Municipal and county council Information and Assistance Services for Women prevent, detect and raise social awareness of sexist violence and provide assistance for its victims. The addresses and contact numbers of these centres can be found on the relevant municipal websites:

## BARCELONA

### **Badalona**

Centre d'Atenció a la Dona (Women's Services Centre - CAD)  
Baldoner Solà, 13-15. Baixos  
Tel. 93 483 29 68 i 93 483 29 64

### **Barcelona**

Punt d'informació i atenció a les dones de Ciutat Vella (Ciutat Vella Information and Assistance Services for Women)  
Erasmus Janer, 8  
Tel. 93 256 32 21

### **Barcelona**

Punt d'informació i atenció a les dones de Sants-Montjuïc (Sants Montjuïc Information and Assistance Services for Women)  
Pl. del Sortidor, 12  
Tel. 93 443 43 11

### **Barcelona**

Punt d'informació i atenció a les dones de Gràcia (Gràcia Information and Assistance Services for Women)  
Francisco Giner, 46  
Tel. 93 291 43 30

### **Barcelona**

Punt d'informació i atenció a les dones d'Horta-Guinardó (Horta Guinardó Information and Assistance Services for Women)  
Pl. Santes Creus, 8  
Tel. 93 420 00 08

### **Barcelona**

Punt d'informació i atenció a les dones de Nou Barris (Nou Barris Information and Assistance Services for Women)  
Doctor Pi i Molist, 133  
Tel. 291 68 67

### **Castellar del Vallès**

PADI - Servei d'Atenció i Informació a la Dona (Information and Assistance Services for Women)  
Pg. Tolrà, 1  
Tel. 93 714 40 40

### **Cerdanyola del Vallès**

Servei d'Informació i Atenció a les Dones (Information and Assistance Services for Women)  
Belles Arts, 19  
Tel. 93 592 16 47

### **Servei d'Atenció i Informació a les**

**Dones** (Information and Assistance Services for Women -SAID)  
Barberà del Vallès (Vallès Occidental)  
Pl. de la Vila, 1, baixos dreta  
Tel. 93 729 71 71 (extensió 266)

### **Barcelona**

Punt d'informació i atenció a les dones de l'Eixample (Eixample Information and Assistance Services for Women)  
Mallorca, 425  
Tel. 93 256 32 21

### **Barcelona**

Punt d'informació i atenció a les dones de Sàrria-Sant Gervasi (Sàrria Sant Gervasi Information and Assistance Services for Women)  
Brusi, 61  
Tel. 93 200 26 02

### **Barcelona**

Punt d'informació i atenció a les dones de Sant Andreu (Sant Andreu Information and Assistance Services for Women)  
Foradada, 36  
Tel. 93 345 70 16

### **Barcelona**

Punt d'informació i atenció a les dones de les Corts (Les Corts Information and Assistance Services for Women)  
Dolors Masferrer, 33  
Tel. 93 291 64 91

### **Barcelona**

Punt d'informació i atenció a les dones de Sant Martí (Sant Martí Information and Assistance Services for Women)  
Pallars, 277, 3er

### **Castelldefels**

Centre d'Informació i Recursos per a Dones (Women's Resource and Information Centre - CIRD)  
Pl. Joan XXIII, 8  
Tel. 93 636 41 44

### **Cornellà de Llobregat (Baix Llobregat)**

Centre d'Informació i Recursos per a les Dones (Women's Resource and Information Centre - CIRD)  
C/ Mossèn Jacint Verdaguer, 16-18  
Tel. 93 474 28 41

## Appendix 1. Resources and Information and Care Services

### **Esparguera**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Tomàs Cabeza (Patronat Parroquial), 2  
Tel. 93 708 02 10

### **Gavà**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Rambla Joaquim Vayreda, 31  
Tel. 93 263 91 00

### **Hospitalet de Llobregat**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Santa Eulàlia, 101  
Tel. 93 298 18 70

### **Igualada**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Santa Maria, 10, baixos  
Tel. 93 804 54 82

### **Manresa (Comarcal del Bages)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Muralla de Sant Domènec, 24  
Tel. 93 693 03 63

### **Martorell**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Lloselles, 66  
Tel. 93 773 51 93

### **Mataró (Comarcal Maresme)**

Servei de suport als serveis socials bàsics  
d'atenció a la violència (Women's Resource and  
Information Centre - CIRD)  
Pl. Miqueda Biada, 1  
Tel. 93 741 16 16

### **Molins de Rei**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
C/ Jacint Verdaguer (Ca n'Ametller), 95,bis  
Tel. 93 680 37 31

### **Esplugues del Llobregat**

Centre d'Informació i Recursos per a  
Dones (Women's Resource and  
Information Centre  
(CIRD)  
Sant Francesc Xavier, 1  
Tel. 93 371 33 50 (extension 190)

### **Granollers**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Portalet, 4, 4r  
Tel. 93 842 67 14

### **Igualada**

Equip d'Atenció a la Dona (Women's  
Services Team)  
Pl. de Sant Miquel, 5  
Tel. 93 805 15 85

### **Manlleu**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
C/ Baixa Cortada, 9  
Tel. 93 851 08 48

### **Manresa**

Punt d'informació i atenció a la dona  
Montserrat Roig (Montserrat Roig Women's  
Information and Services Point)  
Mel, 8, 1r  
Tel. 93 693 03 63

### **El Masnou**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Pg. Prat de la Riba, 16  
Tel. 93 555 81 04

### **Mataró**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Blai Parera, 6  
Tel. 93 702 28 12

### **Mollet del Vallès**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Àngel Guimerà, 15  
Tel. 93 570 77 47

**Pineda de Mar**

Casal de la dona (Women's Centre)  
C/ Barcelona, 35, entresol  
Tel. 93 764 19 43

**El Prat del Llobregat**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Cases d'en Puig (Pl. Agricultura), 4  
Tel. 93 379 00 50

**Ripollet**

Punt d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Montcada 77 (Office Llei de barris)  
Tel. 93 504 60 40

**Rubí**

Servei de la dona (Women's Service)  
Rambleta Joan Miró (Edifici RUBI+D)  
Tel. 93 581 39 00

**Sant Adrià de Besos**

Centre d'informació i atenció a les dones  
(Women's Information and Guidance Centre)  
C/ Escoles, 10, baixos  
Tel. 93 381 20 04

**Sant Boi de Llobregat**

Centre d'informació i atenció a les dones  
(Women's Information and Guidance Centre)  
Ebre, 27  
Tel. 93 635 12 00

**Sant Cugat del Vallés**

Punt d'assessorament Dona informació  
(Women's Counselling Information Point)  
Av. Gràcia, 50  
Tel. 93 565 70 00

**Sant Pere de Ribes**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Antoni Gaudí, 9-11  
Tel. 93 810 90 68

**Sant Vicenç dels Horts**

Servei d'atenció a les dones, "A prop teu"  
(Municipal Women's Services, 'by your side')  
Claverol (Dependències municipals), 6,  
1a planta  
Tel. 93 602 92 00

**Montcada i Reixac**

Oficina d'atenció a la dona (Women's  
Assistance Office)  
C/Casa de la Vila Major, 32  
Tel. 93 565 11 22

**Olesa de Montserrat**

La Teixidora, Centre d'informació i recursos  
per a dones ((Women's Information and  
Guidance Centre)  
C/ Cal Mané, Parc Municipal s/n  
Tel. 93 778 45 45

**Sabadell**

Centre d'atenció a la Dona (Women's  
Services Centre - CAD)  
C/ Vidal, 146  
Tel. 93 724 61 67

**Sant Andreu de la Barca**

Servei d'atenció i assessorament per a les  
dones (Information and Assistance  
Services for Women)  
Pl. Ajuntament, 1, 2a planta  
Tel. 93 635 64 02

**Santa Coloma de Gramenet**

Centre d'informació i recursos per a dones  
(Information and Assistance Services for  
Women)  
Pl. Montserrat Roig, 1  
Tel. 93 466 14 11

**Sant Feliu de Llobregat**

Servei d'informació i orientació a les dones  
(Information and Guidance Services for  
Women)  
Rectoria (Casa de cultura Can Ricart),4-6  
Tel. 93 685 80 02

**Sant Joan Despí**

Estem per tu, dona (We are her for you,  
woman)  
Av. Barcelona, 41  
Tel. 93 477 00 51

**Santa Perpètua de Mogoda**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for  
Women)  
Pau Picasso, 32  
Tel. 93 560 42 05

**Sitges**

Centre d'informació i atenció a les dones  
(Information and Assistance Services for  
Women)  
Davallada (Edifici Miramar), 12, baixos  
Tel. 93 811 31 80

## Appendix 1. Resources and Information and Care Services

### **Terrassa**

Servei de Polítiques de Gènere (Gender Policy Services)  
Nou de Sant Pere, 36  
Tel. 93 739 74 08

### **Vic**

Punt Dona (Women's Point)  
Pl. Don Miquel de Clarian, 3  
Tel. 93 889 34 76

### **Vilafranca del Penedès**

Dona Pla d'Igualtat (Women's Equality Plan)  
Hermenegild Clascar, 3  
Tel. 93 890 00 00

### **Vilafranca del Penedès**

Casal de les Dones (Women's Centre)  
Pl. de la Verema, 1, 1r  
Tel. 93 890 32 18

### **Vic**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Mestre Garriga, 12  
Tel. 650 54 07 32

### **Viladecans**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Av. De Luís Moré del Castillo, 18  
Tel. 93 637 33 22

### **Vilanova i la Geltrú**

Espai d'Equitat. Centre d'informació i recursos per a dones (Women's Information and Guidance Centre)  
C/ Col·legi, 29, local 11, baixos  
Tel. 93 816 90 02

## TARRAGONA

### **Amposta (Comarcal del Montsià)**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Jaume I, 2-4  
Tel. 977 70 74 96

### **El Vendrell (Comarcal del Baix Penedès)**

Servei d'Atenció a la Dona (Women's Assistance Services)  
Pl. Centre, 3  
Tel. 977 15 71 77

### **Gandesa (Comarcal de la Terra Alta)**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Bassa d'en Gaire, 1  
Tel. 977 42 00 18

### **Móra d'Ebre (Comarcal de la Ribera d'Ebre)**

Servei d'informació i atenció a les dones (Women's Centre - Information and Assistance Services for Women)  
Pl. Sant Roc, 2  
Tel. 977 40 18 51

### **Reus**

Casal de les Dones – Servei d'informació i atenció a les dones (Women's Centre - Information and Assistance Services for Women)  
Santa Teresa, 22, 1r  
Tel. 977 01 06 72

### **Cambrils**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Sant Pere (Centre Cívic Les Bases), 32  
Tel. 977 36 82 17

### **El Vendrell**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Quarter, 4  
Tel. 977 16 64 16

### **Montblanc (Comarcal de la Conca de Barberà)**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Sant Josep, 18  
Tel. 977 86 12 32

### **Reus (Comarcal del Baix Camp)**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Doctor Ferran, 8  
Tel. 977 32 71 55

### **Salou**

Servei d'informació i atenció a les dones (Information and Assistance Services for Women)  
Ebre, 11  
Tel. 977 30 92 06

**Tarragona**

Servei d'Informació i Atenció a les Dones  
(Information and Assistance Services for Women)

C/ de les Coques, 3  
Tel. 977 24 45 00

**Tortosa**

Servei d'informació i d'atenció a les dones  
(Information and Assistance Services for Women)

Doctor Ferran, 7, baixos  
Tel. 977 44 58 97

**Valls (Comarcal de l'Alt Camp)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Mossèn Martí, 3  
Tel. 977 60 42 58

**Tarragona**

Servei d'informació i atenció a les Dones  
(Information and Assistance Services for Women)

Pl. de la Font, 1  
Tel. 977 29 62 79

**Tortosa (Comarcal del Baix Ebre)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Barcelona, 152  
977 44 53 08

**Valls**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

C/ Muralla del Carme, 24, baixos  
Tel. 977 60 10 66

**GIRONA****Banyoles (Comarcal del Pla de l'Estany)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Pere Algius, 10, 1a planta  
Tel. 972 58 03 88

**Figueres**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Salvador Dalí, 107  
Tel. 972 03 23 11

**La Bisbal d'Empordà (Comarcal del Baix Empordà)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Pl. Joan Carreras i Dagas, s/n, baixos  
Tel. 972 64 23 10

**Olot (Comarcal de la Garrotxa)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Pl. Palau, 8  
Tel. 972 26 66 44

**Palafrugell**

Servei d'Informació i Atenció a les dones  
(Information and Assistance Services for Women)

Pals, 77  
Tel. 972 61 18 79

**Figueres (Comarcal de l'Alt Empordà)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Nou, 48  
Tel. 972 67 70 50

**Girona**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Joan Riglà, 16 (Edifici 100 Llars)  
Tel. 972 22 24 78

**Lloret de Mar**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Av. Vila de Tossa, s/n (Masia de Can Saragossa al parc de Can Xardó)  
Tel. 972 34 95 73

**Olot**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)

Tomàs de Lorenzana, 15  
972 26 01 52

**Ripoll (Comarcal del Ripollès)**

Servei d'Informació i Atenció a les Dones  
(Information and Assistance Services for Women)

Progrés, 22  
Tel. 972 70 32 11

## Appendix 1. Resources and Information and Care Services

### **Sta. Coloma de Farners**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Prat, 1, 1r  
Tel. 972 84 21 61 (extensió 400)

### **Salt (Comarcal Gironès)**

Servei d'Informació i Atenció a les Dones  
(Information and Assistance Services for Women)  
Àngel Guimerà, 106  
Tel. 972 20 19 62/ 972 23 51 05

### **Sant Feliu de Guíxols**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Pl. Salvador Espriu (Centre Cívic de Vilarta),  
s/n  
Tel. 972 82 01 01

## LLEIDA

### **Balaguer (Comarcal de la Noguera)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Pg. Àngel Guimerà, 28-30  
973 344 89 33

### **El Pont de Suert (Comarcal de l'Alta Ribagorça)**

Servei d'Informació i Atenció a les dones  
(Information and Assistance Services for Women)  
Av. Victoriano Muñoz, 48, 1a planta  
Tel. 973 690 353

### **Les Borges Blanques**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Av. Francesc Macià, 54  
Tel. 973 14 26 58

### **Mollerussa (Comarcal del Pla d'Urgell)**

Servei informació i atenció a les dones  
(Information and Assistance Services for Women)  
Prat de la Riba (Can Niubó), 1  
Tel. 973 71 13 13

### **Sort (Comarcal del Pallars Sobirà)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Mig, 9  
Tel. 973 62 01 07

### **Tàrrrega (Comarcal de l'Urgell)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Agoders, 16  
Tel. 973 50 07 07

### **Cervera**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Pg. Jaume Balmes, 3  
Tel. 973 53 13 00

### **La Seu d'Urgell (Comarcal d'Alt Urgell)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Pg. Joan Brudieu, 12  
Tel. 973 35 31 12

### **Lleida (Comarcal del Segrià)**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
Canyeret, s/n  
Tel. 973 05 48 00

### **Lleida**

Casal de la Dona (Women's Centre)  
Pl. Fanalets de Sant Jaume, s/n  
Tel. 973 700 461

### **Sort**

Servei d'informació i atenció a les dones  
(Information and Assistance Services for Women)  
C/ Pol i Aleu, 5  
Tel. 973 362 09 99

### **Tremp (Comarcal Pallars Jussà)**

Servei d'informació i atenció a les dones  
Pl. Soldevila, 18  
Tel. 973 65 01 87

**Tremp**  
Servei d'informació i atenció a les dones  
(Information and Assistance Services for  
Women)  
Pl. de la Creu (Centre Cívic Tarraquet, 1  
Tel. 973 65 00 05

**Vielha e Mijaran (Comarcal de la Vall  
d'Aran)**  
Servei d'atenció ara hemna  
Av. Garona, 33 baixi Palai de Géu  
Tel. 973 64 06 25

## Services for male aggressors

Services that offer information, counselling and assistance to male aggressors voluntarily attending them, and without court order.

- **Servei d'Atenció a Homes per a la promoció de relacions no violentes. Ajuntament de Barcelona (SAH) (Men's Assistance Services for the promotion of nonviolent relationships. Barcelona Town Council)**  
C/ Àlaba, 61, 1r, 08005 Barcelona (Fundació IReS)  
Tel.: 933 209 212 / 934 864 750, [sah@bcn.cat](mailto:sah@bcn.cat)
- **Servei d'Atenció a Homes que Maltracten, Àmbit de la Salut (SAHM-AS). Fundació IReS. (Men's Assistance Service, Health Sector. IReS Foundation)**  
C/ Àlaba, 61, 1r, 08005 Barcelona  
Tel.: 934 864 750, [sahm-as@iresweb.org](mailto:sahm-as@iresweb.org)
- **Programa d'Atenció i Reinserció per a Homes (ARHOM). Fundació AGI (Assistance and Rehabilitation Programme for Men. AGI Foundation)**  
C/ Pau Claris, 138, 6è 4a, 08009 Barcelona  
Tel.: 934 880 845
- **Unitat de psicoteràpia familiar i de gènere. Institut d'Assistència Sanitària, Parc Hospitalari Martí i Julià. (Family and Gender Therapy Unit. Health Assistance Institute, Martí i Julià Hospital Complex)**  
C/ Dr. Castany, s/n, 17190 Salt  
Tel.: 687 405 784
- **Pla Funcional Crisàlide. Centre de Salut Mental Adults del Segrià. Institut Català de la Salut (Crisàlide Funcional Plan. Segrià Adult Mental Health Centre. Catalan Health Institute)**  
C/ Alcalde Rovira Roure, 44, 25198 Lleida  
Tel.: 973 727 060, [crisalide@gss.scs.es](mailto:crisalide@gss.scs.es)

## **Appendix 2. Drawing Up the Protocol: a Participative Process**

## Appendix 2. Drawing Up the Protocol: a Participative Process

Violence directed against women is, unfortunately, a practice which goes back as far as the origins of patriarchal culture itself. However, the institutional struggle against such violence has only begun to take shape in recent years and it is only now that we can see a determination to develop a system of measures aimed at eradicating it.

So far we do not have a definition of the good practice needed to deal with the issue, one that takes into account the diversity of the victims' profiles, of the professionals involved, the services available and the locations affected. We can, therefore, say that we are now at the start of a journey, one which must, furthermore, be adapted to the specific circumstances of each case.

New strategies and approaches must be found to pursue the objectives which are set.

The *Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia. Framework Document* has been drawn up with the help of a large number of people. The Ministry of Health's Kyria group, which promotes projects geared to improvements in women's health, has been the main driving and coordinating force in the process of drawing up this document. Under Kyria's leadership and guidance the Protocol has been developed in a number of stages. Each of these stages has been worked on in a spirit of joint participation, so that expert knowledge can generate expert knowledge and the measures defined for the health regions, health services and healthcare professionals can constantly be adapted to the wide range of situations and events characterising everyday work in healthcare.

### Phase 1. Preliminary report

This was based on the national and international guidelines set out in the [Catalan Health Plan](#) and the [Framework Protocol and National Circuit for Coordinated Action Against Sexist Violence. The Common Protocol on Health Measures to Combat Gender Violence](#) was also used as a reference document and a review was conducted of existing protocols in different autonomous communities in Spain and the protocols in other regions and municipalities in Catalonia. Other documents were also reviewed, including the [Recommendations for the Healthcare of Women Victims of Violence](#) (2004), and a review was conducted of the bibliography giving scientific evidence recommending universal screening for sexist violence.

This work complements [Law 5/2008 of 24 April on the right of women to eradicate sexist violence](#), Article 85, and is part of the [2007-2010 Government Plan](#), Priority 1.

The commitment to prepare the *Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia* is included in the [Government of Catalonia's 2008-2011 Women's Policy Plan](#), drawn up on the initiative of the [Institut Català de les Dones](#) (Catalan Institute for Women), and is specifically set out in Priority 6 [on the comprehensive tackling of sexist violence](#). The programme continues the work of the [Action and Development Plan for Women's Policies in Catalonia 2005-2007](#) and the [Programme for an Integrated Response to Violence Against Women](#) which was part of it. This programme has involved efforts to strengthen the stable interdepartmental and interdisciplinary circuit established to ensure the effectiveness of measures against sexist violence (prevention, detection, care and rehabilitation). The result of this work is the [Framework Protocol and National Circuit for Coordinated Action Against Sexist Violence](#), which is a reference framework for other protocols which may be developed, such as the one presented here, or which are already being implemented, and is intended to establish a solid basis for a unified, coordinated and appropriate response to the different problems caused by sexist violence.

The preliminary report was drawn up based on a guideline project prepared by the promoting group with the technical and methodological assistance of experts in different units and healthcare regions of the Ministry of Health and Salut, institutions and other entities responsible for healthcare, healthcare professionals, professional organisations, associations representing members of the public, NGOs, local bodies and social agents. Professionals

## Appendix 2. Drawing Up the Protocol: a Participative Process

from various fields took part, mainly in revising the content and the definition of individual proposals for action in their own fields of work.

### Phase 2. Qualitative assessment with participative techniques

The preliminary document was subjected to an analytical assessment. It centred on assessment by approximately sixty healthcare professionals of the draft version of the protocol. The analysis was based on qualitative methods.

The healthcare professionals, who came from different fields, were invited to take part in a conference for work on and discussion of the protocol. Multi-disciplinary groups were set up. The analysis led to the reshaping of the design of the protocol and revealed the need to design operational tools adapted to the needs and special characteristics of the different healthcare situations and the wide range of cases they have to deal with.

### Phase 3. Making the protocol operative through participation

The results of the qualitative assessment, carried out through participative techniques with professionals, showed that one of the features most needed in a protocol for preventing and detecting sexist violence and care for women who have been subjected to it and help in their recovery is a set of guidelines for intervention adapted as far as possible to the characteristics of each person and each situation.

A number of *operational documents* are envisaged and the creation of health region circuits. They will serve as the basis for active work with the different profiles of the women attended. In this stage various measures are being undertaken to involve a wide range of people and services in its design and implementation. Its development will be based on different qualitative techniques through a process of participatory action research (IAP). This will make it possible to generate and establish a protocol for certain practices, taking the different social and healthcare situations in Catalonia as a starting point and final objective.

Different individuals, groups and services will play an active role in the design, implementation and assessment of the operational documents and the regional circuits. The participation is needed of individuals who are experts in the different profiles of women involved and the range of situations affecting them. The involvement of professionals from all over Catalonia is also needed, as they will have to implement the regional circuits and work with the operational documents. Lastly, women will be required to evaluate the circuits they have followed, as they will be the main beneficiaries.

### Structure of the Protocol:

***Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia.*** A document guaranteeing a unified generic approach to the phenomenon of sexist violence in the field of healthcare. Specific documents are needed to ensure the ongoing incorporation of the practices needed to respond to the many situations arising as a result of the diverse profiles of the women affected, the diversity of services, different inter-professional expertise, etc. The Protocol therefore consists of two types of document:

#### **The framework document**

This document is what we have called a framework document. It is a document which is intended to set out the main questions professionals must bear in mind when dealing with sexist violence.

The framework document's main aims are as follows:

1. To familiarise healthcare professionals with some of the main theoretical approaches to understanding sexist violence.

2. To make healthcare professionals aware of the importance of proactively tackling detection and intervention in cases where there may be sexist violence.
3. To offer common approaches to dealing with sexist violence through the healthcare system.

The framework document is presented as a global reference framework and starting point for understanding the operational documents, which set out the way in which measures are to be put into practice.

The framework document's main contributions are as follows:

- The definition of the common strategic lines of the *Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia*.
- A list of the main regulations governing measures to deal with violence against women.
- A definition of the basic concepts for understanding the phenomenon of sexist violence.
- A description of the main strategies determining measures by different healthcare services.
- A directory of resources and care services to tackle violence against women.
- A glossary of terms.
- Fact sheets addressed to healthcare professionals, providing a series of general guidelines for detecting and assessing cases of sexist violence, taking appropriate measures and monitoring the outcome.

### **Operational documents**

The operational documents are a collection of documents which complement this text and deal with women's specific needs. They determine the practical implementation of measures and of the specific proactive approach of the healthcare system to women who are victims of violence in view of the differences in their circumstances and needs.

The Protocol sets guidelines for healthcare professionals in the prevention and detection of sexist violence and care for and assistance in the recovery of women attending any healthcare facility who have experienced or are experiencing sexist violence, and those at risk of suffering it within the couple or the family. Cases of violence in these settings are common and have serious consequences in terms of psychological and physical harm. However, sexist violence can occur in other settings, such as the working, social or community environments, and in other forms which also harm, or are likely to harm, women's dignity, integrity and freedom. These matters are dealt with in the operational documents. Most of the documents deal with relationships within the couple and the family and the remainder with the other situations involved. All of them deal with the specific needs of women and other vulnerable groups and other situations related to sexist violence. The main operational documents are the following:

- Pregnancy
- Drug addictions
- Mental health
- Sexual violence
- Female genital mutilation
- Immigration
- Children

## Appendix 2. Drawing Up the Protocol: a Participative Process

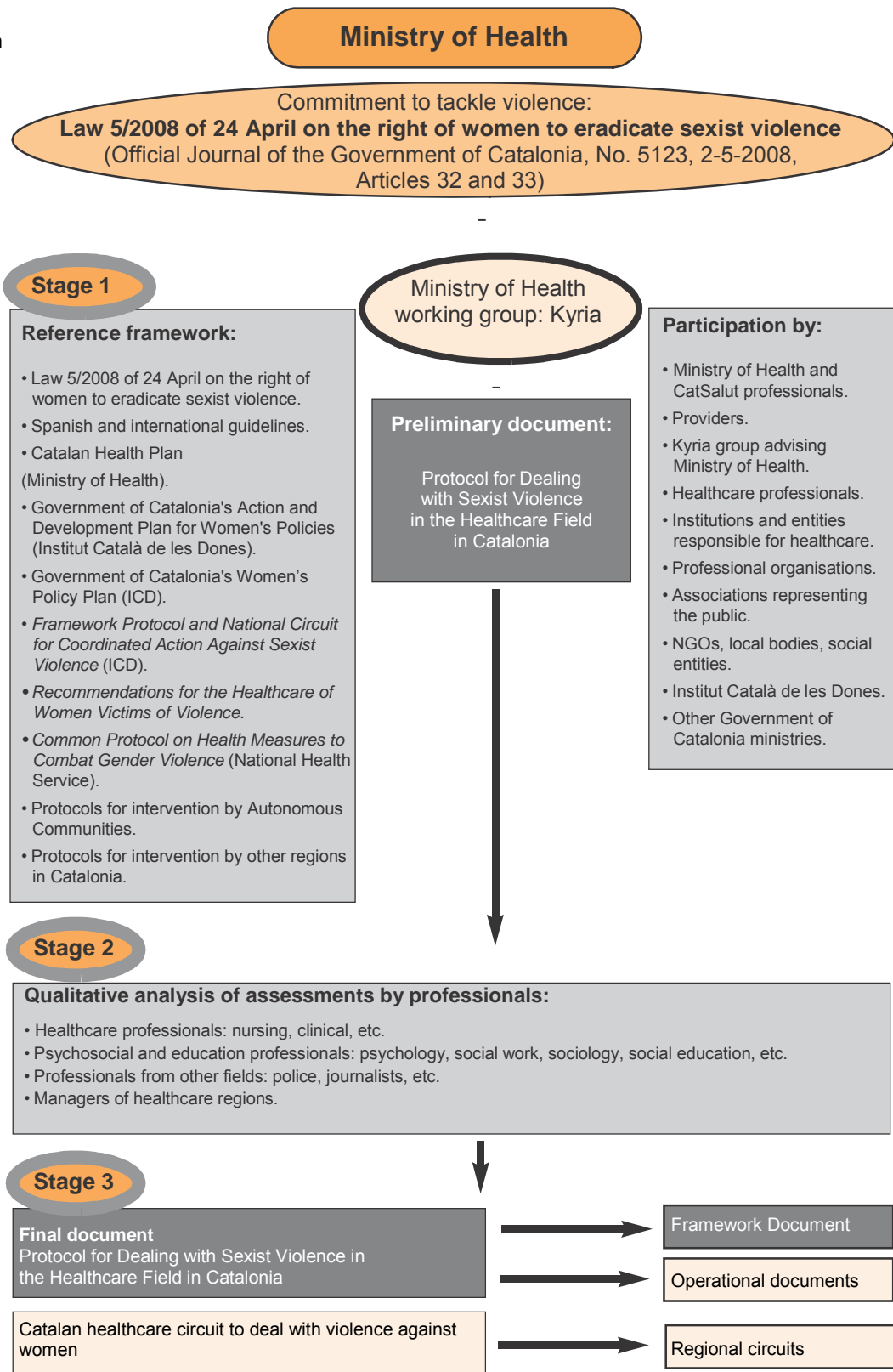
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- The elderly
- Disability
- HIV / Aids

Healthcare circuit to deal with violence against women. The circuits for dealing with the issue must be adapted to the situation in each region, so as to set up a network of networks in which each of the healthcare services in Catalonia can become an active node in a local and supra-regional network system. This network organisation must make it possible for local action to align with a generalised strategy to combat sexist violence, thus minimising the danger of re-victimisation. The circuit is thus organised in two types of network, the Catalan healthcare circuit and the circuits for each healthcare region: the different health regions should each have their own local health circuit, allowing them to assist women in this situation effectively and immediately, so that geographical location does not have a detrimental effect on them or on the professionals attending them. Local health circuits are envisaged corresponding to each region or more in line with Catalonia's health regions, although the final number and extent of such circuits will need to be determined according to the needs of each region. At present the city of Girona has a circuit as does the city of Barcelona. The latter, the Barcelona Circuit to combat violence against women, consists of ten coordinating circuits, one in each of the city's districts.

Figure 1 of this Appendix summarises the process by which this framework document was drawn up.

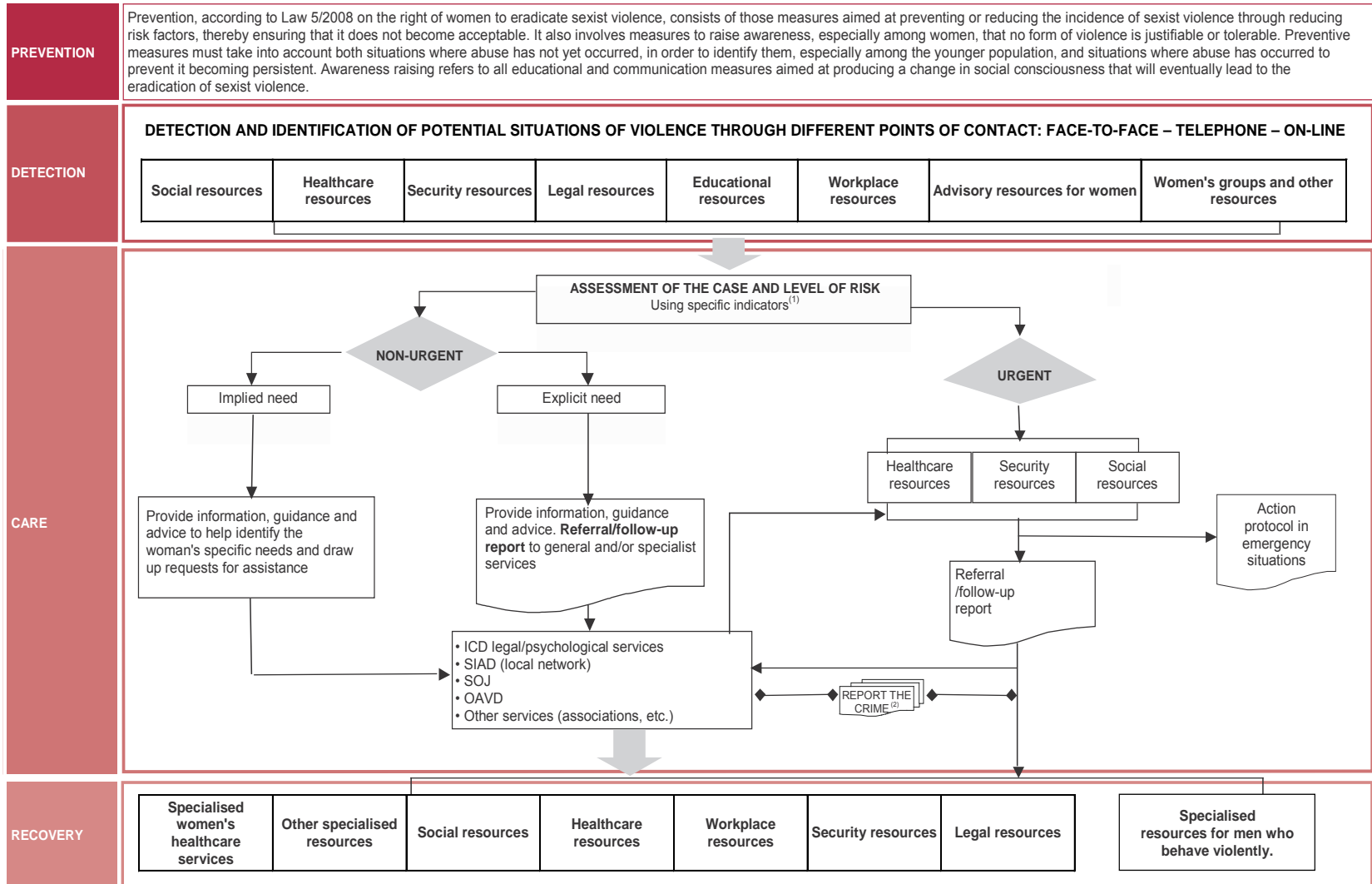
Figure 1. Summary of the process by which this framework document was drawn up



Source: own data

## **Appendix 3. National Circuit for Coordinated Action against Sexist Violence**

## NATIONAL CIRCUIT FOR COORDINATED ACTION AGAINST SEXIST VIOLENCE



<sup>(1)</sup> Indicators may vary considerably depending on the case.

<sup>(2)</sup> Official report procedure, Report to courts, application for protection order, etc. "Version: Phase 3, 30 April 2009"

# Appendix 4. Regulatory Framework

## Appendix 4. Regulatory Framework

A broad range of rights and measures to eradicate violence against women is contained in international, European, national and regional law. The most important regulations in each of these spheres are as follows:

### International Law

[1979 Convention on the Elimination of All Forms of Discrimination against Women \(CEDAW\) and 1999 Optional Protocol](#). The Convention's Optional Protocol, approved by the UN General Assembly on 6 October, coming into force on 22 December 2000, allows individual women, or groups of women, to submit claims of violations of rights, including gender violence. The broad legal base of this Protocol is extremely important as it enables specialist institutions and women's organisations to submit complaints to the Committee created under the Convention in order to investigate violations of women's rights when domestic remedies have been exhausted.

[1993 World Conference on Human Rights \(Vienna\)](#). The Conference Declaration stated that, 'The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights.' This is an advance, not only in beginning to acknowledge a broad range of concepts which could not previously be treated as rights, such as sexual and reproductive needs, but also in providing a review of all human rights from a gender point of view. A major change was introduced into human rights theory at Vienna when, on the initiative of women, it was accepted that human rights belong as much to the private sphere as the public, and can, therefore, be violated in both spheres. It recognises that sexist violence is a violation of human rights. This was a revolutionary change as previously the system of human rights was based on violations committed by the State in the public and social sphere. For the first time, the state could be held responsible for acts committed by private individuals in the private sphere. The Declaration also condemned ethnic cleansing, forced pregnancies and the systematic rape of women in situations of armed conflict.

[General Assembly Resolution 48/104 of 20 December 1993 \(Declaration on the Elimination of Violence against Women\)](#). This declaration, approved by the General Assembly of the United Nations on 20 December 1993, affirmed that violence against women constitutes a violation of their rights and fundamental freedoms. Violence against women is understood to encompass physical, sexual and psychological violence, including maltreatment, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation. The Declaration states that measures to prevent or redress violations must ensure that the re-victimization of women does not occur.

[Fourth World Conference on Women, Beijing \(1995\)](#). The Beijing Declaration and Platform for Action is the most comprehensive document produced by a United Nations conference on women's rights, as it incorporates the results of previous conferences and treaties, including the CEDAW and the Vienna Declaration. Paragraph 113 reiterated the Declaration on the elimination of sexist violence, which had defined *gender violence* for the first time: 'The term *violence against women* means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.'

[United Nations Commission on Human Rights Resolution 1997/44](#). This resolution calls on states to condemn violence against women and not invoke custom, tradition or practices in the name of religion to avoid their obligations to eliminate such violence, and to take action to eradicate violence in the family and in the community. It also reminds governments that their obligations under the Convention on the Elimination of All Forms of Discrimination against Women must be fully implemented with regard to violence against women.

## Appendix 4. Regulatory Framework

[Rome Statute of the International Criminal Court 1998](#). Under the Statute of the International Criminal Court, which was approved on 17 July 1998, the crimes falling under the court's jurisdiction include certain forms of gender violence. Crimes which can be directly linked to forms of gender violence include: measures intended to prevent births within the group fall within the definition of genocide; rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity, are classified as *crimes against humanity*; committing rape, sexual slavery, forced pregnancy, or any other form of sexual violence constituting a grave breach of the Vienna Conventions are included under *war crimes*.

[Review of the Beijing Platform for Action](#). When the Beijing Platform was approved, governments agreed to review it after five years. At a series of special sessions which took place in the General Assembly in New York in June 2000, known as *Beijing +5*, new specific commitments were made to advance the role of women and achieve equality between men and women.

[United Nations Human Rights Commission Resolution 2001/49 on the elimination of violence against women](#). This resolution reiterated many of the conclusions already stated in other United Nations documents. The resolution placed special emphasis on condemning gender violence in situations of armed conflict and the inclusion in the Rome Statute of the International Criminal Court of crimes linked to gender violence.

[Human Rights Commission Resolution 2002/52](#). This report, presented at the 2002 Plenary Committee, stated that 'the fact that the fundamental causes of all forms of violence against women and the girl-child are not fully understood is an obstacle to the measures applied to eliminate this violence'. The concept of *violence against women* needs to be accepted by society and the measures adopted to eradicate it need to have as wide a scope as possible.

### European Law

The issue of sexist violence has been addressed at various levels by both the Council of Europe and the European Union with the aim of introducing a range of protection measures: specific recommendations and resolutions, measures to be implemented through various action plans and programmes, and general provisions in conventions affecting their interpretation or the application of regulations.

[European Parliament Resolution A-44/1986](#) The European Parliament considered the grave problem of domestic violence for the first time in 1986, with this resolution on aggression against women, including sexual attacks, domestic violence and prostitution.

[European Parliament Resolution A 4-0250/1997](#), of 16 September 1997. This resolution, which led to a campaign for zero tolerance of violence against women, implemented in the European Union in 1999, stated that 'on the basis of the Universal Declaration of Human Rights, when Member States do not implement a proper policy preventing and incriminating violence against women, they are not complying with their international obligations under the Universal Declaration'.

[Recommendation of the European Commission to the Cologne Conference](#) (29 and 30 March 2000). We would highlight from the Cologne Conference those measures recommended by the European Commission to prevent gender-based violence, such as the immediate removal of the violent man from the common household and special measures needed to protect immigrant women.

[Recommendation of the Committee of Ministers on the protection of women against violence](#), 2002. This recommends action to combat violence through measures in fields including education and training, the media, and local, regional and urban planning.

[Directive 2002/73/EC of the European Parliament and Council](#), on equal treatment for men and women as regards access to employment, calls for comprehensive protection against sexual harassment, which is understood to fall within the generic concept of *gender-based violence*. Article 2.1 required member states to comply with this Directive by 5 October 2005.

[Decision No. 803/ 2004/EC of the European Parliament](#), of 21 April 2004, adopting a programme of Community action (2004 to 2008) to prevent and combat violence against children, young people and women and to protect victims and groups at risk (the [DAPHNE II](#) programme). The preamble to this decision states that violence of any type against women 'constitutes a breach of their right to life, safety, freedom, dignity and physical and emotional integrity and a serious threat to the physical health of the victims of such violence'. The aims and specific actions included in the Annex to this decision include express reference to the creation of sustainable multidisciplinary networks, training and the design of educational packages, the development and implementation of treatment and support programmes for victims and awareness-raising activities targeting specific audiences.

[European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950](#), and the corresponding Protocol (No. 12, 2000). This text, which is one of the most important international documents on the system for the protection of human rights, recognises above all the right to equal treatment without discrimination on the grounds of sex, stating that all humans are equal before the law with regards to any attempt against their life or liberty, that no one shall be subjected to torture or to inhuman or degrading treatment, and that personal dignity must be respected.

[4th European Ministerial Conference on Equality Between Women and Men](#). This Conference, held in Istanbul in 1997, urged member states to prepare an action plan to combat gender-based violence, the drawing up of which was entrusted to a group of specialists on the issue. Its basic aims were to identify the measures to be adopted, and to coordinate the institutions responsible for implementing them.

[Recommendation No. 1450 \(2000\)](#), urging the Council of Ministers to design a European programme to combat gender-based violence that would harmonise law and procedures and unify the current legal framework.

[Recommendation No. 5 \(2002\), on the protection of women against violence](#). This recommendation proposes a range of measures to guarantee that victims have access to effective legal protection.

## Spanish Law

[Spanish Constitution 1978](#). The Constitution advocates equality as one of the supreme values of the legal system (Article 1). Everyone has the right to life and to physical and moral integrity, and under no circumstances may be subjected to torture or to inhuman or degrading punishment or treatment (Article 15). These rights apply to all public authorities, who are obliged to adopt positive measures to ensure the rights are real and effective, and to remove obstacles to their full implementation. Articles 10.2 and 96 of the Constitution relate the interpretation of laws on human rights and fundamental freedoms to international treaties and agreements ratified by the Spanish state, stating that international treaties, once officially published in Spain, will form part of the internal legal system.

[Organic Law 11/2003, of 29 September, on citizen security, domestic violence and the social integration of foreigners](#); [Organic Law 15/2003, of 25 November, on reform of the Penal Code](#); and [Royal Decree 355/2004](#), creating a central register for the protection of the victims of domestic violence. These three laws were further complemented by Law 27/2003.

[Law 27/2003, of 31 July, regulating protection orders for victims of domestic violence](#). This law represented a new milestone in the measures adopted by the authorities to contribute to the eradication of this complex problem. It is a set of special precautionary measures without

## Appendix 4. Regulatory Framework

precedent in Spanish penal law, allowing the authorities to monitor certain types of conduct in order to eradicate domestic violence in all forms, towards all types of victim, direct or indirect.

[Practical Guide to Organic Law 1/2004 of 28 December on comprehensive measures to protect against gender violence](#) (Observatory on Domestic and Gender Violence of the General Council of the Judicial Power).

[Organic Law 1/2004 of 28 September on comprehensive measures to protect against gender violence](#). This was the first comprehensive law of this type in Europe, and covers preventive, educational, social, welfare, health and penal issues.

[Law 40/2007, of 4 December, on Social Security](#). Additional Provision 30 modifies Law 1/2004.

[Resolution JUI/3338/2003 of the Ministry of Justice and the Interior](#), of 30 October, publishing the Government of Catalonia Agreement of 21 October 2003 establishing the Ministry of Justice's Offices of Crime Victims Services as the point of coordination for protection orders for victims of domestic violence.

[Law 12/2007, of 11 October on social services in Catalonia](#). The new social services law is aimed at universalising social services to guarantee the social rights of the entire population.

[Programme for an integrated response to violence against women](#). These measures are intended to contribute to the prevention and eradication of violence, providing the necessary support for its victims and preventing aggressors from repeating the offence. This programme is one of the pivots of the 5th Action and Development Plan for Women's Policies in Catalonia (2005-2007).

[Organic Law 6/2006, of 19 July, reforming the Statute of Autonomy of Catalonia](#). The Statute establishes a range of competences attributed exclusively to the Government of Catalonia, including full responsibility for issues affecting women (Articles 19, 41 and 153).

[Law 5/2008 of 24 April on the right of women to eradicate sexist violence](#). Establishes the measures to be carried out by the public authorities in Catalonia to combat sexist violence and enables comprehensive action to be taken against all forms of this violence. The Law focuses on women as the subject of the law and on the consideration that sexist violence is a grave breach of their human rights and fundamental freedoms and an obstacle to full citizenship, autonomy and freedom.

[Law 10/2008, of 10 July, approving Volume IV of the Civil Code of Catalonia on inheritance](#). The Government of Catalonia has passed the Draft Law approving Volume IV of the Civil Code of Catalonia on inheritance. With the approval of this Draft Law the Government of Catalonia is harmonising and systematising Catalan legislation on this issue, at the same time making progress on the constitution and codification of a Catalan legal system.

[At local level](#), some municipalities in Catalonia have prepared specific plans and programmes against sexist violence. Meanwhile, many town councils, whether individually or collectively through county councils, have signed agreements with institutions and other bodies in order to establish a circuit to combat sexist violence, a network of emergency measures or, in the case of some councils, a circuit with a protocol for action in this area.

### Legislation in other autonomous communities

Other autonomous communities have drafted legislation on preventing sexist violence and providing comprehensive protection and treatment for women: These include [Castilla-la Mancha](#) (2001), [Navarra](#) (2002), [the Canaries](#) (2003), [Cantabria](#) (2004), [Madrid](#) (2005), [Aragon](#) (2007) and [Galicia](#) (2007).

## Appendix 5. Glossary

This section contains definitions of terms which have been used in this document, related to the principle of equality of opportunity, based mainly on legal definitions (in alphabetical order).

**Discrimination:** differentiation based on sex, race or ideas, distinctions, restrictions, exclusions, preferences and/or unequal, arbitrary, unjust or unreasonable practices in any field (educational, social, economic, employment, cultural, etc.) because of these differences, with the consequent prejudicial effects.

**Discrimination on sexist grounds:** discrimination that occurs when a person is treated differently on grounds of gender and not related to their aptitudes, competences or individual skills.<sup>21</sup> Any distinction, exclusion, restriction or preference made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women of fundamental freedoms in the political, economic, social, cultural, civil or any other field.<sup>22</sup>

**Equality of opportunity for men and women:** absence of gender-based obstacles or barriers to economic, political, cultural and social participation.

**Equality of treatment for men and women:** absence of all forms of gender discrimination, both direct and indirect.

**Gender:** a social and cultural construct defining the emotional, affective and intellectual characteristics and the behaviours that each society defines as 'belonging to' and 'natural to' women and men. Gender is learned, and can be taught, changed or manipulated.<sup>23</sup>

**Gender stereotype:** all those conventional, simplified, generalised and often mistaken attitudes, clichés, conceptions, opinions and images that as sign different characteristics, abilities and behaviours to women and men. They are simplistic and assume all people are the same.

**Sexist violence:** violence perpetrated against women by their partners, former partners or in other similar cases where there are emotional bonds, even if they are not living together. It also includes violence against the victim's children when this is linked to aggression against the mother.

**Patriarchy:** system of violent domination based on male hegemony (they hold the economic, political, religious, ideological and cultural power) and the oppression of women. Based on the simple fact of sexual dimorphism, a hierarchy is established with men at the top, and a dichotomy is established with different prejudices and conceptualisations for men and women. It is directed against all women, separating them from their culture to reduce them to a reproductive role (they only exist as mothers), thus taking power away from them and preventing equality. Patriarchy means the power of the father, producing androcentrism, sexism and discrimination. This term should not be thought of as the opposite of matriarchy, a historical-mythical idea bestowing power on mothers, of which no traces have survived in any culture in the form of a system of social, economic, ideological or political organisation.<sup>24</sup>

**Sex:** innate natural attribute based on physical, biological and anatomical differences between men and women. Sex classifies people according to their potential role in reproduction.

**Sexist violence:** Catalan Law 5/2008, which complements Organic Law 1/2004, while it maintains that the aggressor (the man) plays an active role and that the victim (the woman, including children and adolescents) is the passive subject, extends the definition of sexist violence to the following areas in its treatment of the aggressor and victim: a) partner, ex-partner or other similar cases where there are emotional bonds b) within the family c) in the

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<sup>21</sup> Óptima Programme. Instituto de la Mujer. Guía de desarrollo de acciones positivas; 2002.

<sup>22</sup> UN Convention of 18 December 1979.

<sup>23</sup> Barcelona Provincial Council Oficina Tècnica del Pla d'Igualtat.

<sup>24</sup> Simón; 1999.

workplace d) in social or community environments, and e) in other cases in which women's dignity, integrity and freedom are harmed, or are likely to be harmed.

**Symbolic violence:** mechanisms to impose and maintain power operating within and emanating from asymmetric social structures and rules, displayed by means of symbolic acts. Symbolic violence is inseparable from the concept of symbolic power. By *symbolic power* we mean the symbolic value placed by society on social manifestations, for example establishing which actions are more highly valued than others by a particular social group, which forms of social behaviour have greater prestige, etc.<sup>25</sup>

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<sup>25</sup> Bourdieu; 1998.

## Appendix 6. Bibliography

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- Aguar-Fernández M, Delgado-Sánchez A, Castellano-Arroyo M, Luna del Castillo J D. Prevalencia de malos tratos en mujeres que consultan al médico de familia. *Aten Primaria* 2006; 37:241-2.
- Alonso M, Bedoya JM, Cayuela A, Daurat M, Gómez M, Gentilhome D. Violència contra la dona. Resultats d'una enquesta hospitalària. *Progressos en Obstetrícia i Ginecologia* 2004; 47:511-20.
- American Medical Association, Council on Scientific Affairs. Violence against women: Relevance for medical practitioners. *Journal of the American Medical Women's Association* 1992; 267:3184-9.
- Bedoya MH, Bermúdez K, Goberna J, Kaplan A, Martínez C, Moreno J, Pérez JM, Xivillé M. Mutilació genital femenina: prevenció i atenció. Barcelona: Institut Català de la Salut; 2004.
- Bergh A. Screening for Family and Intimate Partner Violence: Recommendation Statement. *Ann Fam Med* 2004; 2:156-160.
- Bourdieu P. *La domination masculine*. Paris: Seuil; 1998.
- Bradley F, Smith M, Long J, et al. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *BMJ* 2002; 324:1-6.
- Chang JC, Decker M, Moracco KE, et al. What Happens When Health Care Providers Ask About Intimate Partner Violence? A Description of Consequences From the Perspectives of Female Survivors. *Journal of the American Medical Women's Association* 2003; 58:76-81.
- Cole T. Is domestic violence screening helpful? *Journal of the American Medical Women's Association* 2000; 284:551-3.
- Dones en xarxa. Catalunya va registrar 50 denúncies diàries per violència de gènere el 2007; 2008. Available at: [www.donesenxarxa.cat/spip.php?breve1836](http://www.donesenxarxa.cat/spip.php?breve1836).
- Garro E. Apuntes sobre el proceso de la violencia. In: CEMUJER. *En el camino de una vida sin violencia*. San Salvador: Malintzin; 1996. p 15-21.
- Gracia E, Herrero J. Acceptability of domestic violence against women in the European Union: a multilevel analysis. *Journal of Epidemiology and Community Health* 2006; 60:123-129.
- Gracia E. Las víctimas invisibles de la violencia familiar. El extraño iceberg de la violencia doméstica. Barcelona: Ediciones Paidós Ibérica; 2002.
- Gracia E. Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition. *J Epidemiol Community Health* 2004; 58:536-7.
- Gutmanis I, Beynon CH, Tutty L, Wathen CN, MacMillan HL. Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health* 2007;7-12.
- Hurley KF, Brown-Maher T, Campbell SG, Wallace T, Venugopal R, Bags D. Emergency department patients' opinions of screening for intimate partner violence among women. *Emergency Medicine Journal* 2005; 22:97-98.

## Appendix 6. Bibliography

- Institut Català de Dones. Violència masclista. Dones mortes; 2008. Available at : [www.gencat.net/icdona/docs/estadistica\\_violencia1.pdf](http://www.gencat.net/icdona/docs/estadistica_violencia1.pdf).
- Instituto de la Mujer. Denuncias por malos tratos producidos por la pareja o expareja, según relación con el/la autor/a; 2008b. Available at:
- Instituto de la Mujer. Guía de buenas prácticas para la implantación de acciones positivas en las empresas. Madrid: Instituto de la Mujer; 2000.
- Instituto de la Mujer. Mujeres muertas por violencia de género a manos de su pareja o expareja, según relación con el autor. Parejas en crisis. 1999-2007; 2008a. Available at: [www.mtas.es/mujer/mujeres/cifras/tablas/W805b.xls](http://www.mtas.es/mujer/mujeres/cifras/tablas/W805b.xls)
- Instituto de la Mujer. Porcentaje de Mujeres Maltratadas, según grupo de edad; 2008c. Available at: [www.mtas.es/mujer/mujeres/cifras/tablas/W595.xls](http://www.mtas.es/mujer/mujeres/cifras/tablas/W595.xls)
- Instituto de la Mujer. Porcentaje de Mujeres Maltratadas, según CC.AA; 2008d. Available at: [www.mtas.es/mujer/mujeres/cifras/tablas/W596.xls](http://www.mtas.es/mujer/mujeres/cifras/tablas/W596.xls)
- Jewkes R. Preventing domestic violence. *BMJ* 2002; 324:253-4.
- Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Ginebra: World Health Organization; 2002.
- Laing L, with Australian Domestic & Family Violence Clearinghouse. Routine screening for domestic violence in health services. Australian Domestic & Family Violence Clearinghouse; 2001.
- Langhinrichsen-Rohling J. Top 10 Greatest “Hits”: Important Findings and Future Directions for Intimate Partner Violence Research. *J Interpers Violence* 2005; 20:1008.
- MacMillan HL, Wathen CN, Canadian Task Force on Preventive Health Care. Prevention and treatment of violence against women: Systematic review & recommendations. CTFPHC Technical Report #01-4. London, ON: Canadian Task Force; 2001.
- MacMillan HL, Wathern CN, et al. Approaches to Screening for Intimate Partner Violence in Health Care Settings. *Journal of the American Medical Women’s Association*. 2006; 296:530-536.
- Mazza D, Lawrence JM, Roberts GL, Knowlden SM. What can we do about domestic violence? *MJA* 2000; 173:532-535.
- Nelson HD, Nygren P, McInerney Y, Klein J. Screening Women and Elderly Adults for Family and Intimate Partner Violence: A Review of the Evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2004; 140:387-396.
- Nelson HD, Nygren P, McInerney Y. Screening for Family and Intimate Partner Violence. Rockville: Systematic Evidence Review 28; 2004.
- New South West Health. Policy and procedures for identifying and responding to domestic violence. Sydney: NSW Health Department; 2003.
- Pla de salut de Catalunya a l’horitzó 2010. Departament de Salut. Generalitat de Catalunya; 2009. Available at: <http://www20.gencat.cat/portal/site/pla-salut>.

- Ramsay J, Richardson J, Carter YH, et al. Should health professionals screen for domestic violence? Systematic review. *BMJ* 2002;325:314.
- Rees, T. *Mainstreaming Equality in European Union*. Londres: Routledge; 1998.
- Rhodes KV, Levinson W. Interventions for intimate partner violence against women: clinical applications. *Journal of the American Medical Women's Association* 2003; 289:601-5.
- Richardson J, Coid J, Petruckevitch A, Chung WS, Moorey S, Feder G. Identifying domestic violence: cross sectional study in primary care. *BMJ* 2002; 324:274.
- Rohlf I. Violència contra la dona en la parella: freqüència i impacte en la salut física i psíquica. 2006 FIS. PI052516.
- Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. *Intimate Partner Violence Surveillance. Uniform Definitions and Recommended Data Elements*. Centers for Disease Control and Prevention. Atlanta; 2002.
- Simón E. *Democracia vital. Mujeres y hombres hacia la plena ciudadanía*, Madrid: Narcea; 1999.
- Taket A, Nurse J, Smith K, et al. Routinely asking women about domestic violence in health settings. *BMJ* 2003;327:673-6.
- Tamaia. *Vinculats: materials per treballar amb dones maltractades*. Barcelona: Barcelona Provincial Council. Oficina Tècnica del Pla d'Igualtat, 2000. 76 p. + 1 CD. (Guies metodològiques; 2).
- Tjaden P, Thoennes N. *Extent, Nature, and Consequences of Intimate Partner Violence*. Rockville: National Institute of Justice; 2000.
- United Nations Organisation. *Declaració sobre l'eliminació de la violència contra la dona*. Assemblea General de les Nacions Unides. 1993; A/RES/48/104.
- US Preventive Services Task Force. *Guide to Clinical Preventive Services*. 2a ed. Baltimore, MD: Wilkins and Wilkins; 1996.
- US Preventive Services Task Force. *Screening for Family and Intimate Partner Violence: Recommendation Statement*. *Ann Intern Med*. 2004; 140:382-386.
- US Preventive Services Task Force. *Screening for family and intimate partner violence: Recommendation statement*. *Ann Fam Med* 2004; 2:156-160.
- Usaola C. *Maltractament a la dona en la relació de parella. Factors relacionats implicats*. [Non-published doctoral dissertation]. Madrid: Universitat d'Alcalá de Henares; 2001.
- Walker L. *The battered woman syndrome*. New York: Springer; 1984.
- Wathen CN, MacMillan HL, Canadian Task Force on Preventive Health Care. *Prevention of violence against women. Recommendations statement from the Canadian Task Force on Preventive Health Care*. *CMAJ* 2003; 169:582-4.
- Webster J, Holt V. *Screening for Partner Violence: Direct Questioning or Self-Report?* *Obstet Gynecol* 2004; 103:299-303.

## Appendix 6. Bibliography

---

- Women's Health Observatory. Protocolo común para la actuación sanitaria ante la violencia de género. Madrid: Ministerio de Sanidad y Consumo; 2007.
- World Health Organisation. Violence against women. Geneva: World Health Organization; 1996. [www.mtas.es/mujer/mujeres/cifras/tablas/W300-2.xls](http://www.mtas.es/mujer/mujeres/cifras/tablas/W300-2.xls).



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Miret Montané, Marta	(PASSIR), Osona
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Monsó Lacruz, Carme	Barcelona Health Region
Moriana, Alícia	Lleida Basic healthcare area (ABS)
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Pérez Navarro, Rosa M.	Master Plan for Immigration
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Piñol Jave, Alba	Arnau de Vilanova Hospital, Lleida
Prat Puigpelat, Neus	Creación Positiva
Pujol Ribera, Enriqueta	Lleida Basic healthcare area (ABS)
Quer Manent, Dolors	Sexual and Reproductive Health Services Programme (PASSIR), Costa de Ponent
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Ribot Puig, Joaquina	Centres Management (Primary Healthcare)
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Santiñà Vila, Manel	Hospital Clínic, Barcelona
Serra Jubal, Joan	Institut Català de les Dones (Catalan Institute for Women)
Serratusell Salvado, Lúdia	Hospital Clínic, Barcelona
Solanas Bacardit, Gemma	Santa Maria Hospital, Lleida
Tarres Sabartes, Amalia	Ministry of Justice
Tomas Castillo, Immaculada	Manresa Basic Healthcare Area (ABS)
Valls Puente, Ester	Ministry of Social Action and Citizenship
Valls, Jordi	Torreforta -Tarragona Primary Healthcare Centre (CAP)
Vicario Rotger, Cristina	Subdirector General for Drug Dependence.
Vives Tribó, Antoni	Directorate-General for Public Health
	Santa Creu i Sant Pau Hospital
	Catalan Health Service.
	Institut d'Assistència Sanitària (Health Services Institute)



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