REVIVAL PROJECT

WP2

State of the Art

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CHAPTER I:

Best Practices for Combating Gender-Based Violence, within Europe

Dr. Mar Ramos, Dr. Nadia Morales, Dr. Lucia Cellerino

Vall d'Hebron Research Institute (VHIR)

1. Medical/Health Sector

Programs:

a) *Setting standards for the medical care of victims of gender violence. Germany.*
b) *Commission on Familiar and Gender Violence. Hospital Clínic de Barcelona. Spain.*
c) *Gender-Based Violence Protocol in the Medical Area in Catalonia. Spain.*
d) *A curriculum to improve hospital response to violence. Austria.*
e) *Health action on gender, violence, and life cycle (HAGVLC). Portugal.*
f) *Registration of FGM in hospitals. Belgium.*
g) *Model protocol medical care for women and girls FGM. Netherlands.*
h) *Brief guide of action in the hospital emergency services. Spain.*
i) *Institutional Protocol for health care for female victims of domestic abuse or sexual assault detected at health centers. Spain.*
j) *Institutional recommendations to response to Gender Violence in the psychological services. Evaluation of Psychological Services to Gender Violence against women. Spain.*
k) *Manual of good practices and recommendations of Psychological aspects for victims of gender-based violence. Spain.*

a) Setting standards for the medical care of victims of gender violence

Germany

Reducing the impact of sexual violence depends as much on the medical system as it does on the legal system, so it is important that hospitals and general medical practitioners should know how to detect whether their patients may be victims of it. A partnership of NGOs and university institutes therefore decided to develop and pilot a standard for treating violence victims.

It identified a systematic routine screening procedure to detect domestic violence victims in emergency rooms, and created an intervention model. This covers how to approach women, what the 'red flags' to look out for are, where to find information, what the law is and how to prepare documentation for use in court. It also took the needs of groups such as migrant women and women with disabilities into accounts.

The partners knew the need for different agencies to work together on this issue, and therefore also put effort into establishing multiagency networks involving anti-violence associations, medical organizations and associations of general practitioners.

The pilot trained 136 doctors in five areas of Germany, both urban and rural, and received very positive feedback from them. It was particularly successful in Berlin, where is continued with city funding after the end of the project. The project ran up against some reluctance from doctors to recognize the need to improve their treatment methods, but these doubts were overcome through personal contact backed up by the views of the medical associations. MIGG it is still under way in some of the pilot areas, with the financial support of the respective Land governments. If it is to be extended across the whole country, it will need to gain the support of the remaining Länder.

Dr. Brigitte Sellach, GesellschaftfürSozialwissenschaftliche Frauen- und Genderforschunge.V. (GSF e.V.) +49 69 55 51 83 sellach@gsfev.de

http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

b) Commission on Familiar and Gender Violence. Hospital Clínic de Barcelona

Spain

Health Institutions have a strategic role in addressing domestic and / or gender violence, since these are the places where new cases may be detected. In addition, health centers also are able to intervene and to access specific information, as well as the competence to act.

This Commission dates back to 1998, when a group of professionals from the hospital´s emergency department, who observed gender violence in their daily work, established a protocol to coordinate battered people assistance and to sensitize other hospital professionals. The current Commission was created 2000 to work with all types of patients who had suffered violence, whether women (more prevalent), men, minors or elder people.

This Commission is made up by a multidisciplinary team of medical, nursing and social work professionals and its main objectives are to stimulate the sensitivity and responsibility of health professionals in any situation of domestic or gender violence, to coordinate all the activity carried out in relation to this situation (welfare circuits, training and research, etc.), to analyze the abuse situation and its treatment, to encourage and stimulate the detection of cases of abuse, to design assistance circuits and develop action protocols with necessary information for their correct compliance, to evaluate the compliance of circuits and protocols, to form and disseminate new trends in this healthcare field, to coordinate and motivate the investigation in this area.

They created an information system in coordination with the health administration.

This Commission have written some guides and brochures for public dissemination, as well as videos, and have dissemination activities trough conferences and workshops.

Comisión de Violencia Intrafamiliar y de Género Hospital Clínic de Barcelona.

Dr. Manuel Satiñá

Calle Villaroel, 170. 08036.

https://www.hospitalclinic.org/es/el-clinic/comisiones-y-comites/comision-de-violencia-intrafamiliar-y-de-genero

c) Gender-Based Violence Protocol in the Medical Area in Catalonia.

Spain

This framework was born with the aim of becoming a practical tool to facilitate the intervention of professionals against gender-based violence, understanding the intervention as a broad concept that goes beyond the care and follow-up of extreme cases. The Department of Health is committed to developing the Protocol for the treatment of gender-based violence in the field of health in Catalonia, as well as a set of territorial circuits that should allow the effective application of the Protocol in the community. The main aims of this Protocol are to provide a set of guidelines for health professionals focused on prevention, detection, care and recovery of women who have suffered or suffer violence and those who are at risk of suffering it; as well as some intervention guidelines for their siblings who live with the women and that can be witnessing or suffering violence too; to create and establish the bases, mechanisms and circuits to carry out a correct action in cases of gender-based violence; to unify the institution's criteria and health services involved in the care of women who have suffered or suffer violence or who are at risk of suffering it, as well as their siblings, in order to act jointly coordinated and respecting the women's personal autonomy.
This action complies with Law 5/2008 of April 24, on the Right of Women to Eradicate Male Violence (DOGC no. 5123, 2-5-2008), specifically Article 85, which says that "The protocols for a coordinated intervention against gender-based violence must include a set of measures and mechanisms of support, coordination and cooperation intended for public institutions and other agents involved, which define the formalities and the succession of acts that must be followed to execute them correctly". This Protocol and the National Services for Intervention against gender based violence became a consensus model that must be adopted by every department and agency (health, justice, social

services, etc.) in each territory. The proposed model is a pioneer to addressing all forms of violence against women (physical, psychological, sexual, economic), in different areas and has the ability to adapt to specific situations and to the different services that must intervine. This Protocol will determine the orientation of the actions, the specific and proactive treatment of health care for women who suffer violence, taking care of the great heterogeneity, situations and specific needs, and taking into consideration vulnerable groups like pregnant women, drug abusers, mentally ill, victims of sexual violence, female genital mutilation, immigration, children and youth, old people, disabilities and HIV/ AIDS.

Departament de Salut. Generalitat de Catalunya.
http://salutweb.gencat.cat/ca/inici

http://salutweb.gencat.cat/web/.content/home/ambits_tematics/linies_dactuacio/model_assistencial/ordenacio_cartera_i_serveis_sanitaris/abordatge_de_la_violencia_masclista/documents/arxius/cast_femchist.pdf

d) A curriculum to improve hospital response to violence

Austria

In Austria, the first port of call for most women victims of domestic violence is their hospital or other healthcare centre. To improve their response to the issue, the City of Vienna created a curriculum on how to deal with victims of domestic violence. It comprises five modules covering the forms and effects of violence against women and children, securing evidence, legal issues and victim protection groups.

The curriculum was delivered for the first time in Vienna's SMZ Ost hospital in 2001and was later extended to five hospitals in all. Though it had to struggle to find enough time in the working day to deliver the curriculum, the project trained 880 healthcare workers, 70% of them nurses and the majority women. They were overwhelmingly positive about the benefits they gained. They expressed the wish that more doctors should also take the course.Participants were given a handy pocket checklist listing 10 steps to take when dealing with a violence victim.
The curriculum has long-term effects and the global approach adopted was to move from a preliminary analysis of the specific training needs of health personnel to the design of a training curriculum and the implementation of training activities. It has made hospital staff aware of domestic violence. Post-training questionnaires indicate that the training was considered by participants as a good opportunity to enhance their knowledge and skills in dealing with victims.

BeateWimmer-Puchinger, Prof. PhD and Alexandra Grasl, MA; Vienna Women's Health Programme +43 1 4000 - 87 167; beate.wimmer-puchinger@wien.gv.at / alexandra.grasl@wien.gv.at

http://eige.europa.eu/gender-based-violence/good-practices/austria/curriculum-improve-hospital-response-violence

e) Health action on gender, violence, and life cycle (HAGVLC)

Portugal

An integrated model of intervention on interpersonal violence cases in health settings.

In 2013, continuing the strategy adopted in 2008 by the Ministry of Health through the creation of the Health Action for Children and Youths at Risk (HACYR), an integrated model of intervention on interpersonal violence across lifecycle was created –Health action on gender, violence and lifecycle (HAGVLC).

Among other objectives, HAGVLC aims to prevent interpersonal violence, specifically domestic violence, stalking, dating violence, violence against elder people, vicarious violence and trafficking in human beings. HAGVLC is coordinated by the Directorate-General of Health.

In order to implement HAGVLS, multidisciplinary teams of prevention of violence against adults (TPVA) are being formed and trained, which have, among others, the competence of collecting and organizing statistics on violence cases attended in health settings (health centres and hospitals).

The goals are as follows: collecting and processing statistical data enabling knowledge and information systematization, promoting studies enabling the integration of knowledge gaps existing in matters of domestic and gender-based violence and updating essential information for determining the intensity of the phenomenon, developing statistical monitoring tools for domestic and gender-based violence, as well as for the management of the support network for victims.

A screening, evaluation and intervention protocol was created. This includes a clinical registration form on violence to be filled in by health professionals, which also attends to the data collection purpose. Questions about types and dynamics of violence, means and resources to face victimization, among others, are part of the process of the interview to be conducted with the victim. The

protocol contains information on psychosocial assessment, victimization assessment, physical examination, emotional state assessment, victim's change process, assessment and risk assessment.

Directorate-General of Health | Health Action for Children and Youths at Risk, Tel: +351 218430500

http://eige.europa.eu/gender-mainstreaming/good-practices/portugal/health-action-gender-violence-and-life-cycle-hagvlc

f) Registration of FGM in hospitals

Belgium

Pilot study for identifying adequate hospitals procedures in FGM cases.

In 2012, the Federal administration in charge of public health (FPS Health) organized awareness raising and training sessions in 18 hospitals in the country. In 2013, FPS Health launched monitoring of the registration of FGM in hospitals that had previously followed the mentioned training.

The aim of this pilot study was to assess whether existing registration procedures in hospitals are sufficient to ensure adequate recording of FGM cases. A number of cases were monitored for a period of 12 months. Ten hospitals were chosen for this monitoring study, the criterion for selection being to have previously followed a training session organized in 2012.

The results of the study show that the number of recorded FGM cases after awareness raising/training sessions is 2.5 times higher than the average of the previous years (1.6 times higher than in 2011), which seems to confirm the suspected under-registration in past years. The hypothesis that trained professionals will register FGM cases more systematically and accurately was confirmed. The study reveals clear links between information on FGM and how to deal with it (leaflets) and the correct implementation of existing registration instruments. Therefore, to improve the correct registration of FGM in hospitals, training and awareness sessions are the first steps to be implemented. Existing instruments (classification, leaflets) are adequate to ensure a proper registration if doctors in hospitals are properly trained.

SPF Santé publique, Sécurité de la ChaîneAlimentaire et Environnement – FPS PublicHeath dimitri.desantoine@sante.belgique.be

http://eige.europa.eu/gender-mainstreaming/good-practices/belgium/registration-fgm-hospitals

g) Model protocol medical care for women and girls with FGM

Netherlands

The Model protocol medical care for women and girls with FGM is a joint initiative of several medical professional organizations. It makes recommendations on how professionals can deliver medical, psychosocial and sexual care to girls and women who are victims of FGM. The protocol is aimed at prevention, urgent aid and long-term care. Statements are made on registration and reporting of (potential) cases of FGM.

KoninklijkeNederlandseOrganisatie van Verloskundigen (KNOV), 0031 30 282 31 00 www.knov.nlinfo@knov.nl

http://eige.europa.eu/gender-mainstreaming/good-practices/netherlands/model-protocol-medical-care-women-and-girls-fgm

h) Brief guide of action in the hospital emergency services

Spain

This guide pretends to give response to Hospital Emergency Services to partner violence against women.

Become part of the institutional project developed in Madrid Community for the area of primary care and specialized health care programs. This guide is created to distinguish it from other types of violence that produced inside and outside the family, this document will only be discussed of partner violence towards women (VPM).

Partner violence against women is considered a complex problem with repercussions on health and not as an intimate matter of the couple. The Hospital Emergency Services are, in many cases, the first contact that they have with the health system women who suffer situations of violence. Likewise, it is the Services that attend the most serious cases and complexity.

The Guide includes different important topics such as: Indicators of suspicion, signs and symptoms of violence in some vulnerable groups of women, attitudes or behaviors of the couple that can contribute to detect a situation of

mistreatment towards women, signs and symptoms in childhood that can make us suspect, recommendations on what to ask, assessment of the VPM situation, types of violence. Characteristics, vital risk assessment, signs of warning of serious risk in women, emergency intervention, measures to adopt(action in acute outburst of violence, acting in a life-threatening situation, activation of other resources, emergency protection protocol, security plan, ethical and legal aspects.

http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadervalue1=filename%3DGU%C3%8DA_BREVE_URGENCIAS.pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1352902656988&ssbinary=true

i) Institutional Protocol for health care for female victims of domestic abuse or sexual assault detected at health centers

Spain

The Department of Health and Osakidetza, within the framework of the IV Plan for the Equality of Women and Men in the Autonomous Community of the Basque Country (CAPV), Spain, have committed to mobilize all resources, especially human resources, in order to "detect cases of abuse as soon as possible, assist abused persons, and facilitate all the necessary steps so that the victim can receive comprehensive care (health, legal and social) as soon as possible." To promote and facilitate action in the area of abuse in childhood and adolescence, the Department of Health of the Basque Government and the Department of Social Action of the Provincial Council of Bizkaia published: "Abuse and neglect in childhood and adolescence: Attention to risk situations." The introduction of the Department of Health and Osakidetza is framed within the Interinstitutional Agreement for the Improvement of Attention to Female Victims of Domestic Abuse and Sexual Violence, including all efforts, commitments, and performances of the Basque Public Institutions.

The purpose of the protocol is to establish common guidelines for action in the Basque Country to ensure comprehensive health care for female victims of domestic abuse or sexual assault who go to a health center. In order to facilitate this attention, in both health and legal and social matters health personnel are presented with a tree of decisions/procedures to improve the health of the victim and benefit from the available social resources, and to allow for the relevant forensic and legal actions.

This guidelines for action against abuse in the domestic sphere is divided into types of action: acting in the face of abuse with evident physical or psychological injuries (acting in situations of physical or mental abuse without evident injuries), action against aggression or sexual abuse (acting against recent sexual assault or abuse (less than 72 hours, acting against aggression or sexual abuse not recent (more than 72 hours).

http://www.bizkaia.eus/Gizartekintza/Genero_Indarkeria/pdf/dokumentuak/protocolo_sanitario_2008.pdf?hash=8215004d08758bf3ce1796e52059eb0a

j) Institutional recommendations to response to Gender Violence in the psychological services. Evaluation of Psychological Services to Gender Violence against women.

Spain

The EMAKINDE, País Vasco Institute for Women.

In 2008, the materialization of the legal precept focuses on the evaluation of existing resources in the field of health care and specialized resources for psychological care that responds to situations of violence against women in the field of the Autonomous Community of the Basque Country (CAPV) and, as in previous studies, sought to assess the suitability of the available resources and understand their functioning and in context in order to contribute to their improvement. The result of the analysis of specialized psychological care resources is included in this report. It is structured into five chapters, the first of which presents the objectives and methodology used. The following two describe the context and scope of the resources analyzed, and the last three collect quantitative and qualitative results related to quality and suitability as well as the conclusions of the evaluation.

Focuses on three aspects: 1. Understanding the functioning of psychological care services in relation to violence against women. 2. Assessment of the quality of the service and the conditions under which it is provided. 3. Identification of areas for improvement.

The methodology used to prepare this report has been based on a multi-method strategy that combines quantitative techniques with qualitative methods of obtaining information. The compilation and analysis of the basic documentation (service guides, reports and reports) from the different institutions have been carried out, as well as the regulations regarding the actions of these institutions in the matter of domestic violence against women. Such guides, memories, regulations, etc., collect data on the scope of resources, operational processes, and assessment of the results of the activity carried out by the different institutions.

Interviews with people involved in the provision and organization of the different services: This is a process of in-depth, semi-structured interviews aimed at professionals from the different institutions under study. These interviews have allowed for the achievement of different objectives:

1. To know the services and resources that are available, for which the available documentation has been collected.

2. To know the forms of action of these institutions in a case of domestic abuse against women.

3. To know the opinion of the people who work with female victims of mistreatment and/or sexual violence, in terms of shortcomings, problems detected, and resources needed.

Questionnaires aimed at professionals of institutional psychological care programs: Information has been gathered from professionals who, within the framework of institutional programs, assist female victims of mistreatment of partners or ex-partners, in order to know their perception on the effectiveness of the institutional response in the resolution of the situation of violence, as well as the assessment they make of psychological care services. Thanks to the collaboration of the entities that manage these programs, a response has been obtained from 26 professionals working in this field.

http://www.bizkaia.eus/Gizartekintza/Genero_Indarkeria/pdf/dokumentuak/EvalPsic_c.pdf?hash=e88de394a313664cb9407d6edf83fe50

k) Manual of good practices and recommendations of Psychological aspects for victims of gender-based violence

Spain

This document is presented from the Official College of Psychologists of Spain.

The aim of the Manual is to give good practice recommendations that frame work with women, daughters and sons victims of gender-based violence on the one hand, and on the other, to collect a series of guidelines to work in any area of psychology, incorporating the gender approach.

It was prepared and agreed upon the Psychology and Gender Equality, General Council of Psychology of Spain.

This guide includes different aspects including:

- Recommendations for work with children victims of gender violence.
- Recommendations for work with female victims of gender violence.
- Self-care of the professionals that serve the victims of gender violence.
- Recommendations to incorporate the gender perspective and equality in the practice of psychology.

• Areas: Gender perspective in education - Gender perspective in the search for work - Perspective of gender in health.

https://www.cop.es/GT/MANUAL-BUENAS-PRACTICAS.pdf

2. Police/Lawyers/Government

Programs:

a) *Training for a multiagency approach. Slovakia.*
b) *Training the police to handle domestic violence. Luxemburg.*
c) *Police and administrative data. Sweden.*
d) *Standards for work with perpetrators. Germany*

a) Training for a multiagency approach

Slovakia

A monitoring exercise carried out in Košice in 2008 showed that public agency personnel working with women surviving domestic violence had no access to training. A course was therefore devised by the local women's NGO Fenestra with ministry support.

The course was delivered in four districts of the city. Thirty-six professionalspolice officers, social workers, health professionals, psychologists and lawyers working in these institutions attended specialized training workshops, which sensitized them to the subject of partner violence. The main topics covered were common myths related to intimate partner violence, its real causes and nature, the risk factors, the safety of women, who is responsible for violence against woman, and the health impact of partner violence on women and their children.

A manual was created describing in detail the competences and procedures of each support agency, and the course has inspired a similar project in another region of Slovakia, Prešov.

DušanaKarlovská, Fenestrao.z, +421 911 224 777; fenestra@fenestra.skdusana@fenestra.sk

http://eige.europa.eu/gender-based-violence/good-practices/slovakia/training-multiagency-approach

b) Training the police to handle domestic violence

Luxembourg

In 2003 Luxembourg adopted a law on domestic violence, which includes provisions to evict perpetrators of domestic violence from the family home. The law also established a nine-strong Cooperation Committee of Professionals on Fighting Violence, which brings together the actors concerned, i.e. the ministries, law courts, police and NGOs working on domestic violence.

Then NGOs and the Grand Duchy's police force have developed a special training module which is delivered to all new police officers as part of their basic training,and has also been delivered to existing officers during in-service training. This is accompanied by tools for police officers to use, such as guidance on writing reports for submission to the public prosecutor and an information card for victims and perpetrators.

One provision of the law is that perpetrators of domestic violence can be evicted from their homes for an initial period of 14 days, which the victim can apply to extend. The training has enabled the law to be implemented very smoothly, and only 1% of cases are problematic.

An exchange program with neighboring German Länder allows the respective police forces to compare notes on the best ways of dealing with domestic violence.

Kristin Schmit, Police Grand-Ducale, Direction de la Circonscription Régionale de Luxembourg+352 4997-4600 ; kristin.schmit@police.etat.lu

http://eige.europa.eu/gender-based-violence/good-practices/luxembourg/training-police-handle-domestic-violence

c) Police and administrative data

Sweden

Developing knowledge on VAW by collecting police and justice data on crime.

The National Council for Crime Prevention was given the task by the government to evaluate how the Action plan for combating men's violence against women, violence and oppression in the name of honour and violence in same-sex relationships was implemented.

The council's report was presented in December 2010. It showed that the plan had substantially increased awareness and knowledge about men's violence against women among professionals in many different areas. It also showed that the actual support for women who are victims of violence has improved, even if it still needed to be developed. The improved support had made more women motivated to report to the police when they were exposed to violence, but the report also indicated that the measures taken had not yet had any visible effects on the total number of women exposed to violence by men. Another problem with interpreting the effectiveness of the measures against violence towards women was that there was no information at all about how many women were exposed again once they had reported an incident to the police.

Swedish legislation has gone through major changes in recent years in order to strengthen the protection of women exposed to violence. Legislation concerning sexual offences has for example been extended and more acts are now included in rape crime. Legislation has also become gender neutral. In general, legislation, instructions etc. are good enough in order to make visible, prevent and take actions against men's violence against women. The main problems are rather the application of legislation, priorities and resources, ignorance, inability or lack of leadership in the work of the authorities. More knowledge, research and data are also available, even though data need to be extended and elaborated.

Jack Molin (contact person for official crime data), telephone 0046 8 527 58 419, jack.molin@bra.se

http://eige.europa.eu/gender-mainstreaming/good-practices/sweden/police-and-justicial-administrative-data

d) Standards for work with perpetrators

Germany

It is recognized that working with the perpetrators of domestic violence pays big dividends: correctly done, it can lead to real changes in behavior, and not only reduce the level of violence but also save public money in the long run.

Thirty-seven organizations working with violent men across Germany came together under the aegis of the Federal Association for Work with Perpetrators of Domestic Violence (BAG TäHG) to develop a standard for their work.

The standards were developed through a three-year process of consultation sponsored by the federal ministry. They were based not on theory alone, but on the evaluation of previous projects and on the experience of people working with the issue day to day. The results of this work were discussed with organizations providing counselling, help lines and women's shelters.

The standards are propagated through a 21-day training course for professionals nationwide. However, a shortage of public funding may limit their take-up.

BundesarbeitsgemeinschaftTäterarbeitHäuslicheGewalte.V. (BAG TäHG), (Federal Association for Work with Perpetrators of Domestic Violence), Office: +49 6341 55758-21 info@bag-taeterarbeit.de

http://eige.europa.eu/gender-based-violence/good-practices/germany/standards-work-perpetrators

3. General Population/Community-Based

Programs:

a) *Effective coordination between local agencies cuts repeat domestic violence 60%. United Kingdom.*
b) *Rape crisis network. Ireland.*
c) *My Secrets Cosmetics: hoax advertising campaign spreads the message against domestic violence. Netherlands.*
d) *A yearlong campaign against violence. France.*
e) *A training course for domestic abuse advisors. United Kingdom.*
f) *Telephone against gender violence. Spain.*
g) *Master's course in gender violence improves professional practice. Spain.*
h) *Good practices Guide: Cualifica- Avanza program. Spain.*

a) Effective coordination between local agencies cuts repeat domestic violence by 60%

United Kingdom

Multi-Agency Risk Assessment Conferences (MARACs) are meetings which bring together public and private organizations concerned with domestic abuse to discuss high-risk cases and formulate coordinated action plans. There are some 260 MARACs across England and Wales, partially funded by the government as part of its *Call to End against Women and Girls strategy*. They

process around 56,500 cases each year at a cost to the public purse of some £1.4 million (€1.7m).

The MARACs have been shown to reduce repeated abuse by 60%, and are extremely cost-effective, saving six euros of public spending for every euro they cost. They show that sharing information among agencies and following a simple action-planning system can speed things up and lead to more effective protection. An effective multi-agency response to high-risk domestic abuse is particularly effective in reducing repeat victimization and potentially lethal violence.

They take a partnership approach,and bring statutory and voluntary agencies together around the same table, to discuss the cases of individual high-risk victims, and formulate an action plan for each of them.

Laura Wilkinson, Co-ordinated Action Against Domestic Abuse (CAADA).

http://eige.europa.eu/gender-based-violence/good-practices/united-kingdom/effective-co-ordination-between-local-agencies-cuts-repeat-domestic-violence-60

b) Rape crisis network

Ireland

A secure online database on gender-based violence. The Rape Crisis Network Ireland (RCNI) database is a secure online database which allows authorized non-statutory sexual violence services in Ireland to record anonymized information on the specific needs and use of services by individual service users. The data allows the individual services and RCNI to generate a wide range of reports about the use of services at a local and national level, and the characteristics and situation of service users in relation to sexual violence. The system offers a unique data source as almost two thirds of this data relates to non-reported cases of sexual violence.

RCNI database, ClíonaSaidléar, director@rcni.ie, Rape Crisis Network Ireland

http://eige.europa.eu/gender-mainstreaming/good-practices/ireland/rape-crisis-network

c) My Secrets Cosmetics: hoax advertising campaign spreads the message against domestic violence

Netherlands

Dutch policy on domestic violence is based on addressing three of its causes: intergenerational transmission of the use of violence, invisibility of the use of violence and gender-related power differences between perpetrators and victims. Targeting the general public and victims of domestic violence, it tries to raise awareness of the issue, break the taboo that many women have on speaking out, and convey information on where to go for help. It works hand-in-hand with policies to improve early signaling by professionals and to improve the quality of shelters for battered women.

Every year, the government runs a media campaign against domestic violence, using radio, television and the internet. In 2010 it used an innovative tool: it launched a hoax range of cosmetics designed specifically to allow women to hide the injuries they sustain when they are battered. The products were branded *MySecret Cosmetics*, and were promoted using a make-believe television interview on a program called *Women & Business*. The interview lasted less than two minutes, but attracted so much attention that it merited an item three minutes long on the evening television news.

The campaign has had measurable effects. Phone calls for help increased by between 35% and 50%, and willingness to call rose from 50% to 59%. Knowledge of the available support centres and what to do in cases of domestic violence rose from 6% to 11% among the general public and from 10% to 21% among people already involved in episodes of domestic violence. Willingness to visit the website increased from 58% to 72% for the general public and from 63% to 76% for victims. During the campaign period, the campaign's website had 21,900 visits. This is reckoned to be very efficient, given that the campaign's total spend in 2010 was €505,000.

Mrs Jos Hallensleben, Ministerie van VeiligheidenJustitie, +31 70 370 79 11 j.hallensleben@minvenj.nl

http://eige.europa.eu/gender-based-violence/good-practices/netherlands/mysecrets-cosmetics-hoax-advertising-campaign-spreads-message-against-domestic-violence

d) A Year-LongCampaign Against Violence

France

Each year since 1977, the French government has nominated one social issue, proposed by an NGO, to receive special state support. The NGO selected can collect donations from the public, and also receives an allocation of free airtime on the national media. In 2010 that issue – the *Grande Cause Nationale* – was violence against women.

To capitalize on this special time-limited status, a coalition of 25 associations put together a year-long campaign. It used the full range of media channels: film, TV, radio, posters, press, seminars, conferences and public debate.The key message of the campaign was that victims of domestic violence should ring the helpline 3919, and the message evidently got though, because the number of calls doubled during campaign periods.

The campaign was accompanied by a new law (of 9th July 2010) which strengthened the protection of victims and children.At first, the approach to violence against women was a legal one, focusing on the definition and punishment of sexual violence, from rape (1980) to sexual harassment (1992). Legal measures then focused on violence within the couple, considering it as an aggravating circumstance (1994), on strengthening sanctions and on preventing repeat offending (2004-2006).

Ministère des Affaires Sociales et de la Santé (Ministry of Social Affairs and Health) Tel +33 01 40 56 60 00

http://eige.europa.eu/gender-based-violence/good-practices/france/year-long-campaign-against-violence

e) A training course for domestic abuse advisors

United Kingdom

Coordinated Action Against Domestic Abuse (CAADA) has developed a training course and professional qualification for independent domestic violence advisors (IDVAs), who work with victims at greatest risk of harm. The qualification is endorsed by the UK Home Office and accredited by the Open

College Network (OCN) at level 3. Since 2005, CAADA has trained over 1,700 IDVAs.

The course equips professionals with the skills to help victims of domestic abuse and their children and make them safer. The effectiveness of the IDVA approach is well documented: of the 2,500 victim cases analyzed in CAADA's 2012 report. A place of greater safety, 63% of victims reported that the abuse stopped after the intervention of an IDVA, and 71% of victims said they felt safer. The most significant reductions were in respect of sexual abuse. Victims also reported improvements in their wellbeing following the intervention of an IDVA: 69% said that their quality of life had improved and 77% were confident in how to access support in the future.

Co-ordinated Action Against Domestic Abuse (CAADA), 3rd Floor, Maxet House, 28 Baldwin Street, Bristol, BS1 1NG, UK; +44 117 317 8750; queries@caada.org.uk

http://eige.europa.eu/gender-based-violence/good-practices/united-kingdom/training-course-domestic-violence-advisors

f) Telephone against female violence

Spain

The 900 900 120 telephone number, which the Institut Català de les Dones (ICD) makes available to women in a situation of male violence, has attended a total of 9.756 calls in 2017. The 94.8% of the calls were related to intimate partner violence, 2.7% domestic violence, 2% community violence and 0.5% related to work. The 99.8% of the queries were women reporting psychological violence, while 36.8% for physical violence. The 70% of the calls are made by the woman, 27% by a relative or close person, and 2% by a professional. As for age, the line between 31 and 40 is the most frequent (40%). Second, calls made by people between 41 and 50 years old, (25.7%); and then people between 19 and 30 years old, who make 17.6% of the calls.

The 900 900 120 is a free and totally confidential service, which gives access to a team of professionals including lawyers, psychologist, social workers and medicine doctors, and that leads to the services of the Network of Comprehensive Intervention Against female violence . In extreme situations, the professionals who answer the calls, contact police and health emergency services. The telephone is able every day of the year and facilitates communication in 124 languages.

During 2015, the telephone against female violence attended 10,432 calls. In recent years, the number of calls made by family members and people close to the victim tend to increase.

Institut Català de les Dones.

Plaça de Pere Coromines, 1. 08001

http://dones.gencat.cat/ca/inici

http://web.gencat.cat/es/actualitat/detall/20160830_Telefon-contra-la-violencia-masclista

g) Master's course in gender violence improves professional practice

Spain

The launch in 2006 of the master's degree course on *Abuse and Gender Violence*. *A Multidisciplinary Vision* was not without problems, but it was pushed through by persistence on the part of the teaching staff. Since then it has grown to be one of the top-rated courses among students. The course takes a multidisciplinary approach, and considers the issue from the educational, psychological, sociological, medical, media, social assistance and judicial viewpoints. It also takes the effects of violence on groups of women such as women with disabilities, migrants, minors and teenagers into account and has won an award for this. The course consists of 10 obligatory curses plus an optional one involving 700 hours of research work. One of the keys to its success is that it uses an online platform, which allows students from all over the world – mainly Spain, but also the rest of Europe, America, and even one student from Asia – to take part. It also brings in expert professionals as trainers, meaning that it can attract high-level professionals such as judges, senators, policemen and psychologists as students, and that these can then apply what they learn in their working lives. This means it has a real impact on the way gender-based violence is dealt with by the various institutions. With an intake of between 220 and 370 students each year, the course has so far attracted 1,800 students from different areas of Spain and other countries.

http://portal.uned.es/portal/page?_pageid=93,1&_dad=portal&_schema=PORTAL

h) Good practices Guide: Cualifica- Avanza program

Spain

The Project is for the recovery of female victims of gender violence. It is based in the scope of the 2007 Innovative Projects subsidized by the Ministry of Labor and Social Affairs to implement the National Plan for Sensitization and Prevention of Gender Violence, which aims to strengthen the development of the Law Organic 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence, with special reference to the right to comprehensive social assistance. A sociological study has analyzed he personal, social and work trajectory of female victims of gender violence who have participated in the Cualifica Program. This has allowed us to design a comprehensive recovery process, which reflects the women who have managed to escape their situation in relation to violence or have utilized the resources that the IAM offers to women to escape violence.

The objective of the Andalusian Women's Institute when presenting this Guide is to make visible those actions, products and/or methodologies that are transferable to all the institutions that work with female victims of gender violence, which have been developed throughout the execution of the program "Qualifies Advances" for the Integral Recovery of Female Victims of Gender Violence. This Project is structured in four sections:

1) Regulatory context in which the Innovative Projects of the Ministry of Labor and Social Affairs are developed, whose main objective is to guarantee the right to Comprehensive Social Assistance.

2) Exhibition of Qualify Cualifica Program. We consider the program as a good practice in its entirety because it is an innovative project, a pioneer in the methodology of comprehensive intervention with female victims of gender violence in our autonomous community, has revealed itself as an effective program in achieving the objectives, and is efficient in it's use of resources.

3) Methodology used for the identification of specific good practices, detected through a process of analysis, training, and group work.

4) Good practices identified throughout the program, with respect to the tools designed and used, the methodology used to apply them, and a system of permanent internal and external coordination that has allowed decision making in an agile and effective manner, and the constitution of an intervention network among the services provided to the victims.

Identification of the successful practices resulting from the study:

- Process for the identification, location, and contact with the participants.
- Integrated Diagnosis for situational analysis and intervention planning.
- Comprehensive Intervention Itineraries from which all the actions to be developed are channeled.
- Strengthening of the Network of Resources for Attention to Victims of Gender Violence.
- Design and development of a computer application for the systematic collection of information.
- Portrait of the social and labor profile of the users.

- System of internal and external monitoring and coordination, which allows for an efficient work dynamic in the use of resources.

http://www.juntadeandalucia.es/export/drupaljda/29162.pdf

Chapter II:

What the scientific community says about good practices and new lines of intervention.

Suggestions for a local action plan

Robert Roche, Marc Brundelius, Pilar Escotorin

LIPA Group (Laboratory of Applied Prosocial Research)

Autonomous University of Barcelona.

Barcelona 15.03.18

Introduction

The contribution of this chapter is to review the advances of the scientific community and to propose an analysis of the protocols presented in the previous chapter, regarding its relevance and complement with REVIVAL.

We intend to provide a theoretical and application framework that strengthens the project, justifies its subsequent intervention and, above all, allows us to effectively adapt the project to the specific context of Catalonia.

Although the benefits of Prosociality and prosocial communication are studied in different contexts as a preventive of violence and as a repairer of aggression, we have not found studies that link prosocial behaviors with the interaction doctor-patient victim of gender violence. However, there are studies that develop the importance of training in social skills such as empathy for doctors and health personnel that deals with GV cases. In the first part of our chapter, we will present some relevant scientific studies that can provide current elements for the design of the project's training program.

1) State of Art: Arguments in favor of an encompassing communication model to shape relations between clinicians, nurses (and other specialists) and women victims of violence during their treatment in the emergency room

Marc Brundelius (LIPA-UAB)

As emergency room protocols for the treatment of and the communication with women victims of violence in Europe evolve, clinicians and nurses, but also psychologists, social workers as well as legal and law enforcement personnel are being prepared and advised regarding this topic.

a) Scientific findings

In order to understand the importance of a communication model which is designed to build trust relations with the women victims of violence, a look at a random selection of scientific articles is helpful:

Kulkarni et. al. (2012) identifies four thematic categories related to enhancing 'Intimate Partner Violence" in emergency departments: "empathy, supporting empowerment, individualizing care, maintaining ethical boundaries". They emphasize additional factors that interfered with quality services: "inadequate organizational resources, staff burnout, lack of training, and poor integration with other community resources",and conclude: "Respectful, empowering relationships are the centerpiece for quality IPV services."

Cortes et. al. (2015) studied how nurses in the emergency departments in Brasil deal with the topic and conclude that "Nurses must recognize their subjectivity and their empowerment as women to ensure that the relationship they establish with the users is based on dialogue and a permanent construction. They must also use communication and their social role in the health team.

Pytel et. al. (2009) comments the relations between nurses and patients in general in the way that "educating nurses about patient/visitor communication needs is the first step in enhancing how well nurses meet those needs." Their findings stress that "nurse and patient/visitor perceptions of important communication are similar. Patient and nurse importance differed significantly on only 2 communication needs: calm voice and social status (nurses rated these needs of higher importance than patients)".

b) Current protocols in hospital practice

Several projects in different European countries help implementing new concepts of how to approach women victims of violence in their first contact with health services when looking for help in the emergency departments of the Hospitals. The interpersonal communication of health personnel with these women is being emphasized as crucial. We reviewed two protocols produced and applied in Catalonia, where the project REVIVAL will be implemented:

The “Guide for assistance in cases of sexual violence” of the Hospital Clínic of Barcelona is a very detailed checklist of all medical and technical steps to take for different expert groups in charge of the women’s physical and psychological health. However, it does not specify guidance on interpersonal communication during these proceedings. While there are some hints for communication, it is not explained exactly how these can be obtained:

The interpersonal communication of doctors with the victims is not mentioned.

Social workers are advised to maintain a “warm and close” personal tone during the proceedings of admission of the patient, according to the protocol.

Nurses are advised to do an “evaluation of the emotional state of the patient. I case of agitation and or an important anxiety, the psychiatric evaluation is to be prioritized and Psychiatry to be informed.” The protocol does not explain how the nurses can communicate with her to calm her while the woman is not yet under the care of psychiatrists.

The protocol for the personnel of the Psychiatric Units emphasizes that the interview with the woman should be done listening empathically to the explanations of the victim, making sure that the woman can express her emotions about the trauma suffered. For instance: it is not being explained how it can be made sure that she has the trust to express this?

In other countries such guidelines are used, too, for instance in Germany, where the project MIGG (Medical Intervention in cases of violence against women, promoted by the German Ministry for Family, Elder people, Women and Youth) provides questions for the medical patient interview. Regarding the principles of communication the guide states:

“When a doctor has a suspicion that his or her patient could be a victim of domestic violence, then the women has to be approached by the doctor about this suspicion in a sensitive and empathetic way and in a protected space and in a private conversation”(…) and adds “Listen in an open way and without any prejudices.”

c) Conclusion

Whereas communication, as seen in the mentioned protocols, seems to be understood as a standard set of questions for an interview to obtain crucial information from the victim, there does not seem to exist an underlying model that determines how communication, i.e. interpersonal trust and empathy, is being established in the first place.

However, if the aim is to detect cases of domestic violence against women and to raise the numbers of reported cases, it is the general communication climate in the emergency department –not only with the doctors or nurses, but starting with the receptionist, or any other employee of the Hospital who the women comes into contact with- which determines whether or not she feels sufficiently comfortable (and comforted) to reveal her story.

Therefore, we conclude that there is a certain need for an encompassing communication model, a philosophy and way of thinking, which is internalized by all the team members and the organizational units of the Hospital, where women victims of violence are being attended. In REVIVAL, we suggest the Prosocial Quality Communication to be introduced as a pilot for such model.

Sources:

Comissió de Violència intrafamiliar i de Gènere (2012): Guía Assistencial de la Violència Sexual, Hospital Clínic de Barcelona, Barcelona

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Kulkarni, S. J., Bell, H., & Rhodes, D. M. (2012). Back to basics: Essential qualities of services for survivors of intimate partner violence. *Violence against women*, *18*(1), 85-101.

Pytel, C., Fielden, N. M., Meyer, K. H., & Albert, N. (2009). Nurse-patient/visitor communication in the emergency department. Journal of Emergency Nursing, 35(5), 406-411.

Zeitbild medical (2017): Gewalt gegen Frauen erkennen und helfen, München
(this guide is part of the material provided in the project MEDIZINISCHE INTERVENTION GEGEN GEWALT AN FRAUEN, MIGG (Medical Intervention in cases of violence against women, promoted by the German Ministry for Family, Elder people, Women and Youth)

2) Relevant studies on gender violence (GV) from the perspective of public health policies and the experience of health professionals in Catalonia

Summary made by Pilar Escotorin LIPA UAB

a) Cultural Considerations to apply REVIVAL: pink v/s lilac

In Spain and in the region of Catalonia, civil society organizations, the feminist and women's movement have been protagonists in making GV visible as a health problem in the political agendas. An example of this was the historic strike led by feminism on March 8, 2018, which managed to paralyze a large part of the country's services.

The movement of "lilac" color cannot be ignored as a resource that can favor the application of Revival. In the case of Catalonia, the pink color has highly negative connotations for the feminist movement, since it represents gender stereotypes that have been overcome. The name of the "Pink Room" of REVIVAL is not applicable to the Spanish context.

In this part we present the main conclusions of a doctoral thesis of our collaborator Dr. Kattia Rojas who developed three studies on gender violence from the perspective of public health policies and the experience of health professionals in Catalonia. We believe it will be very useful to review the state of progress of health care in the region provided to women victims of GV (Gender Violence) and to adapt the subsequent intervention and training design of the project to the local reality and the real progress that Catalonia has experienced in GV issues in the last years

Original version: Rojas, Kattia (2014) La violencia de género desde la perspectiva de las políticas públicas de salud y la experiencia de los profesionales de la salud. estudio comparativo entre Cataluña y Costa Rica. Tesis Doctoral. Barcelona: Universidad Autónoma de Barcelona[1]

In Catalonia, the healthcare sector plays a key role in the management of GV (Gender Violence) cases. Rojas (2014) presents a first study about the main barriers and facilitators of the GV approach in Catalonia; a second study was conducted, based on in-depth interviews with expert professionals, in order to identify the factors that facilitated or hindered the approach of GV to women. The third study provided elements that are necessary in the approach of the GV

[1] Complete thesis available in the following link
https://ddd.uab.cat/pub/tesis/2014/hdl_10803_283955/krl1de1.pdf

towards women such as the paradigmatic vision on gender, health and gender violence, the role of the network of social and health resources, sensitive training and the impact of work with the GV on women and self-care practices.

The results suggest that a greater use of the social and health resources of the network, training, professional satisfaction and a bio-psychosocial orientation have an impact on the attitude towards gender violence in health professionals.

Gender Violence against women is a kind of violence that is part of a patriarchal system; its cultural nature makes it transformable and manifests itself in different forms, with different actors and scenarios and in a variety of areas of women's social life. In addition, it must be addressed in the different populations that are affected by this violence as sons and daughters and aggressors.

Health professionals must deal with GV quite frequently, for which they do not feel adequately prepared, despite the official guidelines established in current legislation (Menéndez, Pérez, & Lorence, 2013)[2].

Violence against women is a reflection of pre-existing socio-cultural violence. It produces a bidirectional movement between society and the couple. Cantera (2004) proposes an open model to explain the phenomenon, and describes the victim of violence as someone who struggles to survive in a difficult environment and with a state of ambivalence between what she wants, believes, needs and what she perceives as socially appropriate. In this way, whoever establishes a professional relationship with the suffering person has a facilitating, proactive, preventive and community role (Cantera, 2004).

Summary of GV and Women's Health *• The consequences of gender violence are direct and indirect, both physical and psychological and are a risk factor in the health of women and their families.* ***• Public awareness through health policies and plans in different contexts has allowed the inclusion of the health sector as an instrument to act on the prevention and impact of gender-based violence on women****.* *• There is a distancing between programs and policies regarding the actions of health personnel and decision makers.* ***• Gender violence is a multi-causal problem, therefore the models of approach and prevention must contemplate socio-cultural, community, family and personal factors.*** *• The model of the GV approach to women requires a proactive, preventive and community system (****Kattia Rojas 2014, p.33)***

[2] To see the references, go to the original version, Spanish language https://ddd.uab.cat/pub/tesis/2014/hdl_10803_283955/krl1de1.pdf

b) **Professional Barriers to Health and Gender Violence** (Rojas, 2014, pp.33-35)

In most cases, it is the health professionals, especially those of Primary Care, who treat women and can help them break the silence of abuse. Therefore, it is necessary that women feel safe. Different studies, collected in a qualitative research review (Feder, Hutson, Ramsay, & Taket, 2006) **have indicated that women exposed to intimate partner violence value careful listening, confidentiality, care and not being judged by health professionals.**

These skills can be used at all three levels of the consultation: before the disclosure, when the problem of domestic violence has been revealed, in the immediate responses to the revelation of the problem and the responses in the later or follow-up interactions (Feder et al., 2006).

The barriers to an adequate approach persist in the health care of women exposed to gender violence. According to Nogueiras-García, Arechederra & Bonino (2005) in the detection of the problem, the role of socio-cultural factors such as myths and stereotypes about gender violence has a great weight, given that violence is naturalized and normalized in life, this make it difficult to identify women and men who suffer these bad situations.

Other factors are the context of the consultation, such as the lack of privacy and the shortage of time. Women victims of GV themselves also develop defense and survival mechanisms that make it difficult for them to recognize and assume to be victims of mistreatment.

At the level of the intervention, health personnel working with GV victims tend to wear out, since it is a work that engages at a subjective and emotional level (Lancman et al., 2009)

Some risks in this phase for health personnel are psychic contamination, over identification, management of frustration or burn out

Organizational barriers for professionals are: the pressure of care, the ignorance of procedures to be followed and the self-perception of the professional's competences (Arredondo-Provecho et al., 2012).

At the social level, the main barrier is the assessments that exist on the problem of gender violence (Coll-Vinent et al., 2008) and the level of knowledge and training that is sometimes insufficient.

At the individual level, a barrier is the lack of recognition of professionals from their own experience of violence (García et al., 2013)

c) Why do doctors not always ask their patients if they are victims of GV?

(Rojas 2014, 37-39)

Among the reasons why medical professionals and other health disciplines do not ask regularly about abuse, they have mentioned being overwhelmed, forgetting, being afraid to open the "Pandora's box" "(Sugg et al., 1999).

Needs of health professionals when working with the issue of GV towards women.

Importance of the relationship of trust and listening in the process of identification of the grievance, which makes a better professional preparation necessary (Gomes et al., 2013).

There is a consensus that the attitudes of listening, receiving, containing and deconstructing women are keys in the attention of the problem.

The education and knowledge about gender violence of health professionals is a necessity. Training is important and also to discuss the subject with the population. Health services can develop educational activities for that purpose (Moreira et al., 2008).

Although, health professionals who care for women recognize their responsibilities and roles, a supportive health system is necessary through interdisciplinary teams, information on resources, protection time and adequate training. (Chang et al., 2009).

The study of Goldblatt, Buchbinder, Eisikovits, & Arizon-Mesinger(2009) shows that in social workers the limits between personal and professional life are blurred and that the experiences influence their relationships and their gender identity, questioning their own relationships.

Lacman et al. (2009) addressed situations experienced by different health workers, such as feelings of helplessness in precarious situations and lack of knowledge of the efforts made.

Among the strategies that are developed to overcome the affectation with which health professionals have to mediate, are the creation of solidarity and protection networks with the population in order to reduce vulnerability, as well as learning to detect risks.

Coll-Vinnent et al. (2008) states that nurses were more sensitive to the problem and considered themselves more prepared than medical personnel. Ramsay et al. (2012) states that the knowledge that professionals have of medicine is basic. In such a way that both family doctors and practice nurses need a more comprehensive training on evaluation and intervention, including the availability of a local domestic violence service.

Summary on health professionals and GV

• Health professionals play a crucial role in identifying women who suffer gender violence at the three levels of health care, through promotion and prevention activities, identification and detection, intervention and tracing.

• The approach to the cycle of violence requires a professional that strengthens the affected person, that is proactive and prevents and works with community networks.

• The obstacles that hinder the detection and the approaching of the problem have been studied. Some obstacles detected are related to the lack of perception of gender violence as a health problem or the fear of addressing it. At the organizational level, there is a lack of time for visits to attend to women.

• Qualitative and quantitative studies highlight the perception of the lack of training in health professionals and the need to interact in a network and training in this aspect.

• Work with gender violence has consequences in the personal life of health professionals in aspects such as hypersensitivity to the issue, emotional exhaustion and fears of integrity.

d) Health trends In Catalonia in women's policies

- In Catalonia, there has been reached a consensus to define GV as: violence that is exercised against women in a specific way, differentiating itself from other forms of violence present in the policies and protocols of intervention.
- In the case of Catalonia, it is clarified that this subject is the woman, both in the policies and in the health plan and the protocols for action.
- In addition, the term “macho violence” is used more precisely in health policies and protocols, including partner violence and other types of violence against women, as well as areas beyond the family.

GV is a health problem that needs agreement between different actors in an effort to build an ecological approach to violence and health.

In Catalonia, it is necessary to develop sanitary actions with those who work in the area of violence against women, emphasizing the tasks of promotion and prevention of health. The effectiveness of the GV approach to women requires the participation of health personnel and different social institutions. One way to implement this trend is the continuity and updating of health protocols.

The work with aggressors is scarcely dealt with in the public policy and health plans of Catalonia. The lack of specific practices with the aggressors in areas of

prevention can respond to a dichotomous model of violence. Public policies of Catalonia contemplate the need for professional self-care when dealing with GV, however, specific sanitary actions are not developed in this regard.

e) Culture of collaboration: facilitators in the approach to GV from the perspective of health professionals in Catalonia

Sixteen interviews were carried out with experts in GV from different professional groups: Medicine, Nursing, Social Work, Psychology, who participate in the inter-institutional network of attention to women in Catalonia, with two years of experience.

The attention of the GV in Catalonia has its first approximations in the neighborhoods, with the help of town councils and social organizations.

Nou Barris neighborhood was a pioneer, a team that later was transformed for the whole city and was a city equipment. The experiences of the neighborhoods were concrete social and health practices in the approach of the GV. Feminist non-governmental organizations are important references in the training of professionals. The laws at the national level of Spain and in particular in the Autonomous Community of Catalonia are seen as a support for women and health professionals. They are considered as an achievement of social processes.

The main results of these interviews indicated that the common facilitators in working on GV are:

- the inter-institutional network with a common framework and the professional network
- a bio-psychosocial conception of health,
- a clear understanding of what is meant by violence and the gender paradigm in the model of intervention.
- Motivation, interest and satisfaction of health professionals with what is done.
- Given the impact of working on the issue of violence for health professionals, teamwork can mean a support space, therefore, teamwork as well as a network of communal and inter-institutional services works as a facilitator.
- A barrier in Catalonia is the lack of greater promotion and prevention and
- the lack of training in professional curricula

f) Preparation of profesionals:

The professionals of Catalonia have a favorable attitude to work on GV. Among the factors that explain this attitude are: training in the subject and the use of socio-health resources. A study was carried out, surveying 142 health professionals in Catalonia in areas such as Nursing, Social Work, Psychology, General Medicine and Family Medicine with performance in primary care of Public Health. According to the conclusions of Kattia Rojas,

regarding the consideration of the GV towards women, there is a high perception of it as a social problem, which is important, since as Herrero points out (2011) from the health point of view if the GV is not recognized as a problem, it is difficult for the professional to detect it in the consultation (Herrero, 2011).

From the results of this study (Rojas, 2014) it is clear that the greater the use of social network resources, the health professionals have more adequate support to provide the service to women, having an appropriate attitude to address the GV towards women in primary care. One of the barriers identified in qualitative studies has been the lack of awareness on the part of nurses about community resources (Yeung, Chowdhury, Malpass, & Feder, 2012)

It has also been detected that awareness and access to support services and other resources are a protective factor and a turning point for women to change their situation of violence (Chang et al., 2010).

The study by Arredondo-Provecho et al. (2012) points out that although there is a general knowledge of the importance of GV in health, professionals have not yet acquired sufficient tools to respond with solvency to specific cases.

Ramsay et al. (2012) identified that poor preparation persists in the general practices of physicians in primary care in the United Kingdom to respond to the needs of women suffering from GV and therefore, more complete training is required at the undergraduate and graduate levels and in explicit referral pathways to specialized GV services for women

The influence of professional satisfaction on Attitude towards GV is positive, some studies have addressed the personal implications in working with violence at the level of attrition, psychic contamination and over-identification (Lacman et al., 2009; Golbat; 2009)

g) Check list to facilitate the work of health centers on GV at all levels (Based on Rojas, 2014)

Given the experiences of good practices, the importance of multidisciplinary teams that address the problem is confirmed.

This research confirmed also the importance of including in the curriculum of disciplines such as Medicine, Nursing and other Public Health professions, specific training on how to prevent, detect and treat victims of gender violence.

It is important that health professionals are aware of the existence of the services that the community provides to women and to which services they can refer these women to and how they can support these services.

This research shows the importance of attitudes of health professionals and the impact of their own experiences in addressing GV towards women.

These conclusions have several practical implications for REVIVAL:

1. At the level of Public Policies and Social Planning

i. It is important to evaluate the results in the health system with qualitative as well as quantitative indicators.

ii. Incorporate into the health plans and health action protocols the different areas and forms of GV such as those forms of violence that are generated in the community, labor and social spheres that may have consequences for the health of women.

2. At the level of promotion and prevention

i. To find ways for health centers to be promoters of positive health models: Inform the population about the importance of preventing GV with their own social market campaigns.

ii. Inform the population what they can expect from the health system in their country when they suffer gender violence.

iii. Generate intervention projects that integrate children and young witnesses of gender violence in the field of primary care and mental health.

iv. Develop Research, knowledge and projects with aggressors

3. At the level of the relationship of the professionals with the network of socio-health resources

i. To Coordinate and facilitate the knowledge of the health professionals of the resources available in the community, those formal and informal.

ii.To provide a common frame of reference regarding GV through the training of professionals working in the network (Justice, Health, Education, Organizations, Police).

iii. Update, implement and systematically evaluate the action protocols with the participation of professionals from different institutions.

4. About the role of professionals

i. To include the bio-psychosocial vision in the Medicine curriculum, as well as the gender perspective in disciplines such as Psychology, Social Work and Nursing.

ii. Continuous training through workshops in the workplace of health professionals with specific contents in awareness, interpersonal skills and knowledge.

5. About the impact on personal life and the care of professionals

i. Organization of clinical sessions

ii. To promote from the health institutions appropriate resources when their collaborators need help or support in the tasks of attention to the GV.

iii. To promote work in interdisciplinary teams.

6. At the level of Public Policies and Social Planning

i. To evaluate the results in the health system with qualitative indicators as well as quantitative ones.

3) Proposal of a conceptual frame to elaborate an instrument of evaluation and intervention in REVIVAL[3]

Robert Roche, LIPA-UAB

An important age range to study the state of the art of partner violence is that between 12 and 35 years. Age that includes adolescents and young adults, which is very significant because of its extensiveness in age that allows both to know the possible origins of violence at an early age and to distinguish possible transitions between ages in development, from those origins.

Our intention in the REVIVAL Project, is to work for the prevention of interpersonal violence that includes the couple, where the relationships of power, of control, are emotionally very strong and that are, in the subjects, justified by an idealization of exclusivity that leads to accept the rational-mistaken conviction-of **possession of the other**.

It is enough to analyze the lyrics of the fashionable songs, centered on the passionate love to realize about this psychological dimension of **possessiveness of the other** also covered by an agreement - private contract of love - many times, endorsed by the social uses that are based on idealized models of cinema and the television series.

One of the studies that we are going to present, very recent, of 2017, gives us the opportunity to obtain a diagnose of the state of violence in young couples,

[3] ** We thank the authors of this study for their authorization to extract and use their results and conclusions. The texts are transcribed from the English version.

*** Note on bibliographical citations: we will detail the authors and year of publication of the various studies that endorse the aforementioned results, and reported by the authors of this meta-analysis. For full citations, go to the original article of the study presented and disclosed here.

**** Regarding the limits of the sample used in the various studies and the different methodologies, go to the original article.

with very important elements and details that allow us to advance in the objectives of our REVIVAL project.

We intend to develop programs that can be applied to groups available for education and training. Of course would be in the school environment, from primary to secondary school and even in the university.

Our experience in LIPA-UAB, since the 90s, for the development of programs for youth and adult education, contrasted in various European projects in both educational and health ambits, allows us to trust that the theoretical-applicative model of prosociality LIPA has a great potential to give content to a Program of Prosociality for the Prevention of Violence in Education (PVE) that we intend to elaborate.

The REVIVAL Project, in the partnership as a whole, has as main objective, the monitoring and improvement of the attention to victims of violence, whose visibility **only appears in health centers.** It is there where we will have to analyze what types of attention are given to the women affected by violence in the various European countries studied and with what quality of reception, communication and effectiveness health professionals apply.

The Good Practices that we will find, in REVIVAL will have a dissemination platform.

Rubio-Garay, F.; López-González, M.A .; Carrasco, M.A: Love, P.J. (2017)[4] perform, therefore, a very significant meta-analysis study, whose selection criteria were, apart from the age cited, that the subjects responded to the general population and did not have known psychiatric pathology, and that they had a relationship of courtship on the date of the completion of the study or at an earlier time.

The type of studies chosen should be primary works on the prevalence of

- **Physical violence**
- **Psychological or sexual committed (perpetration) and or suffered (victimization) in dating relationships (VRN)**

[4] *Rubio-Garay, F. ; López-González, M.A.; Carrasco, M.A: Amor, P.J. (2017) *Prevalencia de la violencia en el noviazgo: Una revisión sistemática*.Psychologist Papers, 2017, Vol 38 (2) pp 133-147

https://doi.org/10.23923/pap.psicol2017.2831

http://www.papelesdelpsicologo.es

http://www.psychologistpapers.com

The type of instruments to measure the results had to be validated instruments and with evidence of reliability. The type of designs: empirical studies with large samples (greater than 500 subjects).

In the aforementioned article they present a very useful table as behavioral indicators of violent behavior, according to the three types of violence that they categorize.

Forms of manifestation of violence in dating relationships: behavioral expressions.

*Rubio-Garay, F. ; López-González, M.A.; Carrasco, M.A: Amor, P.J. (2017) (4)

- **PHYSICAL VIOLENCE**
  - **Moderate physical violence**

Hitting, biting, slapping, shoving, scratching, kicking

  - **Severe physical violence**

Throwing objects, attacking with a weapon, strangling, burning, beating, etc.

  - **Homicide attempts / Homicide**

- **PSYCHOLOGICAL VIOLENCE**
  - **Verbal and/or dynamic manifestations of interpersonal harassment**

Insults, shouting, reproaches, criticisms, threats, intimidations and coercions, humiliations, ridiculing, provoking feelings of shame, etc

  - **Imposition of behaviors**

Social isolation, orders, abusive insistence, invasion of privacy, sabotage, etc.

  - **Attacks on property**

Destruction or damage of properties, objects or animals valued by the victim; denial or obstruction of access to money or other basic resources; etc

  - **Emotional manipulation of the victim**

Assignment of responsibility or blame; denial of the violence exercised, questioning of the mental health of the victim

- **SEXUAL VIOLENCE**
  - **Use of physical force**

Rape, attempted rape, physical coercion to have sexual relations

  - **Sexual abuse**

Under the influence of alcohol or drugs or by diminishing the mental capacity of the victim

  - **Infringement of the victim's freedom**

Psychological coercion to increase the number of sexual relations, imposition of unwanted or degrading sexual behavior, sabotage of contraceptive methods

From our point of view to turn this list of violent acts into a possible check list available for professionals, we propose that it should be combined with three possible new dimensions to include and argue, that they can affect the incidence and consequences in the development of the person:

- **Intensity,**
- **quantity and**
- **frequency**

Some results and conclusions of the study that we emphasize * (4)

- *Regarding age, the vast majority of studies show slightly higher rates of aggressive behavior in adolescents than in young adults, both in perpetration and victimization. This tendency for aggressive dating behaviors to decrease as age increases has been captured in a number of review studies (e.g., Capaldi, Knoble, Shortt, & Kim, 2012) . However, the consequences of violence tend to be much more severe at later ages despite being less frequent (González-Ortega et al., 2008).*
- *A significant part of the retrieved studies show a higher prevalence of psychological violence committed and suffered by women, in line with some previous review studies (Archer, 2000; Fiebert, 2004; Straus, 2008)*

Psychological violence, we know, is more invisible or less tangible than physical violence, but no less devastating. Can we infer that visible physical violence is always indicating, in addition, psychological violence? This would reinforce the need for all care and assistance protocols to register the underlying psychological aspects, since they are very important when it comes to the continuity of support and general prevention.

- *A very relevant finding is the existence of bidirectional violence in a significant number of the reviewed studies (e.g., Harned, 2001; Malik, Sorenson, & Aneshensel, 1997; Palmetto, Davidson, Breitbart, & Rickert, 2013; Rubio-Garay, López-González, Saúl, & Sánchez-Elvira- Paniagua, 2012; Straus, 2008; Straus & Ramírez, 2007). The analysis of the different studies seems to show that bidirectionality is more frequent in psychological aggressions*
- *In this sense, in the dynamic of a violent couple, both members can act as perpetrators and as victims, so when faced with aggressive behavior one responds with a defensive measure that is also violent (Lewis & Fremouw, 2001). However, it is also common for one partner to attack the other at one point in time and the other to respond aggressively at a different time and context (Palmetto et al., 2013).*
- *Thus, it is not possible to determine whether reciprocal aggressive interactions occur with the current partner or constitute a habitual pattern in relationships with other partners. In any case, it seems that regardless of who initiates the aggression, men use more dangerous forms of physical violence, and women suffer more severe physical and psychological harm (Archer, 2000, 2004; Harned, 2001; Jackson, 1999; Muñoz-Rivas, Graña, O'Leary, & González, 2007b).*

EXPLANATIONS FOR THE BIDERECTIONALITY

- *Various explanations have been put forward for two- way violence. For example, the theory of intergenerational transmission of violence (Lewis & Fremouw, 2001; Palmetto et al., 2013) suggests that victims might observe and learn (for example, from seeing violence between their parents) that the aggressors experience positive consequences with their actions and thus the victims employ similar violent strategies in their current or future partner relationships.*
- *Other authors propose that violence engenders violence, so some adolescents and young people are immersed in a culture of violence that leads to such behaviors (Jackson, 1999). The role of self-defense in bidirectional violence has also been postulated (Lewis & Fremouw, 2001), although self- defense strategies would only explain a limited percentage of this type of aggression (Straus, 2008).*
- *Finally, there have been other possible explanations such as revenge, i.e. jealousy, control, domination, and the deterioration of the relationship itself (Fernández-Fuertes & Fuertes, 2010; Follingstad, Wright, Lloyd, & Sebastian, 1991; Straus, 2008).*

From our point of view, it is important to know “the two way violence”, exercised at early ages, because it would indicate a capacity and learning for a later activity in relationships, for example in girls, afterwards women. There we could discriminate those that "defend themselves attacking" of those that apparently are only victims .

- *As for sexual violence, most of the studies indicate higher rates of male aggression and greater victimization among women, also in line with what has been reported in the literature (e.g., Corral, 2009; Foshee et al., 2009, Jackson, 1999)*

SOCIAL PROBLEM AND NEED TO IMPLEMENT PROGRAMS FOR PREVENTION

- *This suggests the need to explore the prevalence of this problem……. taking the couple as the unit of analysis rather than the respondents at the individual level. In any case, the review has shown that aggression in courtship, especially verbal and emotional, has a high prevalence, followed by sexual and physical aggression*

It is not easy to carry out this type of research on the relationships of the dyad in its natural habitat. The realization in the laboratory of communication exercises among them, could show some communication patterns. Ethically, we understand that these sessions should also be therapeutic learning for optimization.

- *It is, therefore, a serious social problem that has negative consequences on the overall health and interpersonal functioning of the victims and which, in the school context, translates into greater academic difficulties, lack of security, poor academic performance, lower educational attainment, dropping out of school, absenteeism, etc. (Banter & Cross, 2008; Centers for Disease Control and Prevention, 2012; Rubio-Garay, Carrasco, Amor, & López-González, 2015; Teten et al., 2009*).

- *This justifies the need to develop and implement programs of primary and secondary prevention of violence in educational institutions (Cornelius & Resseguie, 2007), since the average age of first dating relationships is 14-15 years (Viejo, 2014) and, at these ages, almost all adolescents are studying in secondary schools.*

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GOOD PRACTICES

- *The experience of a primary prevention program of DV (Domestic Violence) (Hernando, 2007), carried out with adolescents of a secondary education center in Huelva (Spain), showed a change in individual attitudes towards dating aggression, as well as greater knowledge and ability to detect situations of physical, psychological and sexual abuse, in addition to an increase in the abilities to deal with these types of situation.*
- *The results obtained by Hernando (2007) were in line with other studies that have evaluated the effectiveness of DV prevention programs in educational settings in cultural settings different from ours. These types of programs have shown positive short- and long-term effects in changing attitudes and behaviors with respect to violence, in changing traditional roles and gender stereotypes, in the development of communication skills, peaceful conflict resolution and problem solving, and improved self-esteem (see Cornelius & Resseguie, 2007; Leen et al., 2013, for a review).*

These studies justify the need to advance in intervention programs, as we intend in REVIVAL, to increase awareness and at the same time provide peaceful resources that counteract the compulsive immediacy of the violent response

4) Behavioral and attitudinal items for the study and prevention of violence in intimate partners.

Introduction

We present an extract of two articles by the authors that are cited, selecting the attitudinal or behavioral items, organized in different categories, which can be useful in our European REVIVAL Project, to optimize the prevention and coping of the cognitions, attitudes and behaviors that lead to violence.

ITEMS IN MEN

Who acts violently in intimate partner relations?

(Based in the study of (Dobash and Dobash and al. *)[5]

In the case of interpersonal violence, these are used as indicators of the wrongdoing of the victim, justify the "corrective" action of the perpetrator, and allow the sense of self to remain intact and untainted in ways that might otherwise accrue to one who perpetrates violence

The comments reflect notions that the men appeared to hold about themselves in relation to a woman partner, for example, men are in control, have authority, should be obeyed, and the like

Personal characteristics:

- Faults or defects in her or her family
- There are precise beliefs about the appropriate behaviors for women
- Violence is perpetrated for a high moral purpose such as

[5] - The research team included Rebecca Emerson Dobash, Russell P. Dobash, Kate Cavanagh, and Ruth Lewis.

- The 3-year study was completed in 2000 and the majority of offenders were sentenced in the 1990s. At the time of data collection, the approximate numbers of men and women in prison for murder in the separate jurisdictions was England/Wales: 3,000 men and 115 women, and Scotland: 500 men and 10 women.

- This is not to discount the possibility of an unsafe conviction, but we would argue that this is very unlikely in cases of intimate partner murder.

Dobash, R. E., Dobash, R. P., & Cavanagh, K. (2009). "Out of the blue": Men who murder an intimate partner. Feminist Criminology, 4,.194-225.

Dobash, R. E., Dobash, R. P., Cavanagh, K., & Medina-Ariza, J. (2007). Lethal and non-lethal violence against an intimate female partner: Comparing male murderers with non-lethal abusers. Violence Against Women, 13, 329-353.

the prevention of the “irresponsible” or “negligent” behavior of a spouse
- Inability to accept responsibility for
- Inability to feel remorse
- Inability to empathize with the victim

ITEMS IN MEN

Who murder an intimate partner

(Based in the study of Rebecca E. Dobash, Russell P. Dobash, Kate Cavanagh, and Ruth Lewis.* (5)

Interpersonal relationships:
- Had problems in intimate relationships
- Conflict
- History of serious, repeat violent abuse of the woman they kill
- Controlling behavior
- Jealousy and possessiveness
- Masculine possessiveness
- Sexual ownership
- Enforce rigid standards based on their beliefs about relationships between intimate partners.

Personal characteristics:
- Selective forgetting
- Lack of memory
- Contrite or cold and unemotional

Behaviors to justify
- A few completely deny the murder
- They deny agency and responsibility
- Diffusion or displacement of responsibility
- Blame in the victim
- Placing blame elsewhere: sad tales, adversity in childhood, victimization of the system: police, court
- Some justify and rationalize their behavior to avoid responsibility for it.
- Enhancing man self-esteem ?

The evidence presented here points to the **vital importance of including the study of violent men in the overall examination of intimate partner violence.** It also illustrates the utility of using qualitative materials from formal documents, such as the casefiles used in this analysis