

## Partner violence against women and specialized care health professionals

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**Título:** Violencia de pareja hacia la mujer y profesionales de la salud especializados.

**Resumen:** La violencia de pareja hacia la mujer representa uno de los problemas de salud pública más relevantes. Causa graves consecuencias en la salud. Este estudio plantea detectar el nivel de conocimientos y las opiniones de los profesionales de atención especializada, conocer sus dificultades en la intervención y plantear propuestas de mejora. Para ello se realizó un estudio transversal, llevado a cabo en el Hospital Universitario Fundación Alcorcón, a través de una encuesta voluntaria y anónima. La recogida de datos se realizó en un Excel asociado a la plataforma utilizada. Para el análisis estadístico se utilizaron el SPSS 17 y el STATA 12. La tasa de respuesta total fue del 15%. El 31.5% de los profesionales conocían casos en su entorno; el 24.7% los detectaron en su trabajo. El 25.9% no hicieron nada, consideraron que no tenían la formación necesaria. El 82.5% pensaban que es un problema muy importante. El 50.9% creían que no hay consenso en la actuación; el 19% no sabían que existe un protocolo de actuación. Los profesionales encuestados necesitan formación para poder realizar sus competencias. Cada vez están más concienciados, tienen menos estereotipos y más herramientas de intervención, pero es necesario difundir los protocolos de actuación.

**Palabras clave:** Violencia de género; salud pública; apoyo a la formación; cuidado sanitario; violencia de pareja; mujer; servicios de salud para la mujer.

**Abstract:** Nowadays, partner violence against women is one of the main public health issues. Therefore, it has a severe impact in our health. Objectives: finding the degree of knowledge and thoughts of the specialised health care professionals, knowing the challenges they face when they have to take action as well as suggesting improvements. A transversal study was carried out at the *Hospital Universitario Fundación Alcorcón*, using a voluntary and anonymous survey. The data was collected in an excel file linked to the platform used to take the survey, and the statistical analysis was performed using SPSS 17 and STATA 12. The total response rate was 15%. Out of the 31.5% health care professionals that took the survey and knew about partner violence against women cases in their working environment, 24.7% said they detected them whilst working; on the other hand, 25.9% of them did not take any action as they considered they were not properly trained to act. Moreover, 82.5% of those who took the survey considered this to be a serious issue, whilst 50.9% said there was no consensus on action and 19% did not know about the action protocol. Health care professionals need training to conduct their skills in the field; they are increasingly becoming aware of this issue, they are less affected by the preconceptions that may condition their work and have more intervention tools; nevertheless, there is a need to spread action protocols.

**Keywords:** domestic violence; public Health; training support; delivery of Health Care; spouse abuse; women; women's Health services.

### Introduction

"The disadvantaged position of women in society is internationally recognized as both a breach of human rights and a barrier to broader social development" (World Health Organization, 2010, p. 1).

Partner violence against women is the most serious form of gender inequality. The mortality rate is alarming. In Spain, 906 women have been killed by their partner or former partner from 2002 to 2016 (Ministerio de Sanidad, Servicios Sociales e Igualdad – Spain, 2017a). Eight dependent children have been killed in 2014 and 2015 and 1 in 2016 (Ministerio de Sanidad, Servicios Sociales e Igualdad - Spain, 2017b). The extent of the problem is such that the Spanish Organic Law 8/2015, of 22 July, modifying the system of protection of children and adolescents, includes children as direct victims of gender-based violence (Moreno-Torres Sánchez, 2015).

Partner violence against women is defined 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" (United Nations, 1993); it is, therefore, violence against women for the mere fact of being women and it is perpetrated as an expression of discrimination against women due to the inferior position assigned to female sex in the society, the historical situation of inequality and the relationships of power of men over women (Spanish Law 5/2005, 2005; World Health Organization, 2005).

It is perpetrated within the family, at social and state level, and includes, among other forms, partner violence against women, sexual harassment in the working or educational environment, aggressions or sexual abuse, trafficking and sexual exploitation of women and girls, femicides, female genital mutilation, crimes committed in the name of honour and dowry-related, early and forced marriage, female infanticide or selective abortion of female fetuses (Spanish Law 1/2004, 2004; World Health Organization, 2005, p. 27).

Of all the ways mentioned, partner violence against women is the one that causes more preventable mortality. A woman is more likely to be injured, raped or killed by her partner or former partner than by another person (World Health Organization & Pan American Health Organization, 1998).

The results of a multi-country study carried out by the World Health Organization (WHO) to more than 24.000 women from 15 sites located in 11 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Montenegro, Thailand and the United Republic of Tanzania) have found that between 15% and 71% of all ever-partnered

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women have experienced physical or sexual violence by their intimate partner, with rates that vary from 24% and 53% in most of the sites studied (World Health Organization, 2005).

In Spain, according to data from the 2015 Macro-Survey on Violence against Women (de Miguel Luken, 2015), 12.5% of all women aged 16 years or older living in Spain claims to have suffered physical or sexual violence by their intimate partner or former partner in their lifetime. Specifically, 10.4% of women have suffered physical violence, 8.1% sexual violence, 25.4% psychological violence (i.e. preventing them from seeing other people or going to certain places), 21.9% emotional psychological violence (i.e. insults or threats) and 10.8% economic violence. Additionally, 85.2% of the victims of physical violence, 94% of the victims of sexual violence and 95.4% of the victims of emotional psychological violence states that violent acts usually occur more than once. On the other hand, 13% of them has been afraid of their partner or ex-partner at some point in their lives and 2.9% claims to have felt fear on an ongoing basis. Due to the methodological improvements introduced and the new questionnaire used, new cases of violence against women that had remained hidden before they have been brought to light.

For 20 years, the WHO (1996) considers that violence against women is a public health problem, which has recently defined as «a global health problem of epidemic proportions» (García-Moreno et al., 2013). Violence increases the poor perceived health and the risk of having some important health problems (Law 5/2005, 2005; García-Moreno et al., 2013; World Health Organization, 2005). These problems include, among others, direct physical injuries (bruises, wounds, fractures...), abdominal pain and gastrointestinal problems, chronic pain, joint problems, neurological disorders, accidental pregnancies, teenage pregnancies, miscarriages and abortions, late foetal death, low birthweight or prematurity, intrauterine haemorrhage, HIV and other sexually transmitted diseases, anxiety, depression, alcohol abuse, drugs or psychotropic drugs, eating disorders, post-traumatic stress disorder, disability and death (García-Moreno et al., 2013; World Health Organization, 1996). Additionally, less follow-up of the prevention activities, such as screening for cervical and breast cancer, has been observed in these women (García-Moreno et al., 2013, pp. 21-22).

In short, it is a risk factor for women's poor health, which makes them go to health centres more frequently. In the last year, 88% of these women went to their family physician for different reasons, 53% due to a specialised consultation and 35% to hospital emergencies. Only 4.8% of women have ever been asked if they suffered partner violence (World Health Organization, 2013, p. 1).

45% of them have decided to disclose their problem and to seek professional help. Psychiatric or psychology (29%), followed by health care (22%) and legal or social services (16% and 13%, respectively) were the most frequent services they used (de Miguel Luken, 2015).

According to several studies, health care professionals report experiencing difficulties to identify partner violence

against women and to take action on this (Arredondo Provecho et al., 2012, pp. 85-99; Pichiule et al., 2014). Apart from this, traditional beliefs, which consider that partner violence against women is a private matter (Valdés Sánchez, García Fernández & Sierra Díaz, 2016) or a social problem (Rodríguez-Bolaños, Márquez-Serrano & Kageyama-Escobar, 2005), and the biological approach of health care represent a major obstacle in understanding the problem.

A number of international agencies have on many occasions highlighted the need for an effective training of health professionals to address this health problem (García-Moreno et al., 2013; World Health Organization, 2005).

In Spain, the importance of training is included in the Spanish Organic Act 1/2004, of 28 December, on Integrated Protection Measures against Gender Violence (Cabrera Mercado & Carazo Liébana, 2010), at the national level, and in counterpart's laws at regional level. They include the incorporation of this training in the curricular areas of university studies and specialisation programs for social-health professions and of contents aimed at prevention, early detection, intervention and support to victims of this form of violence, as well as the development of awareness raising programs and ongoing training of health staff in order to foster the early diagnosis, care and rehabilitation of women in situations of gender-based violence.

Despite this need for training and awareness raising, which is key to providing an effective and quality response to such a complex problem, the literature on the degree of training and qualification of health care professionals in this field is relatively scarce. In this sense, the Community of Madrid has integrated it into the Annual Plan for Continuous Centralized Training. Also, the Community has published three guidelines for action, one specific for primary health care; another for specialised health care and a short one for emergency services.

The objective of this study was finding the degree of knowledge and thoughts about partner violence against women of the specialised health care professionals who work in a tertiary hospital of the Community of Madrid, knowing the organisational challenges they face when they have to take action as well as suggesting proposals to improve the early detection and the care for the people who suffer it.

## Method

### Procedure and participants

A transversal, descriptive study was conducted through a survey addressed to **1.569** professionals from the Hospital Universitario Fundación Alcorcón in the Community of Madrid. It was available from May to September 2016 and a monthly reminder was sent. A simple, voluntary and anonymous access link was distributed through the institutional email.

## Instruments

The questionnaire, used in previous studies (Arredondo-Provecho et al., 2012; Arredondo-Provecho, del Pliego-Pilo, Nadal-Rubio & Roy-Rodríguez, 2008), was taken from the one used in a similar study by Siendones et al. (2002). The changes were established through the consensus of several health professionals with training experience on partner violence against women to adapt it to the objectives of the study. It is shown in Annex 1.

It consists of 33 questions. The first 26 are aimed at answering the objectives proposed, the following 5 correspond to the sociodemographic data of the professionals surveyed and the last 2 have to do with training.

Within the first 26 questions, 3 of them are analyzed:

- A. The level of knowledge that professionals have on the subject. After 4 initial questions regarding the identified cases, the actions taken and whether or not they were aware of the resources of the hospital regarding their actions (questions 1-4), a knowledge test consisting of 10 questions is carried out (5-11, 14-16) assessing concepts, the importance of the problem, factors related to partner violence against women and legal aspects. Closed-ended questions with single answer to choose between 2 or more options and 2 open questions (5 and 8) are used
- B. The opinions and barriers of attitude that professionals identify when working in these cases. Guidelines for action (questions 18 and 19) and opinions (questions 12, 13, 17, 20, 21 and 22) against the partner violence against women are analyzed using closed-ended questions with several answers. Functions and how to raise colleague's awareness through open questions (23 and 24) are also assessed.
- C. Organizational barriers and proposals for improvement through open questions (25 and 26).

## Analysis of data

Data collection was carried out in an excel file linked to the platform used. The description of the qualitative variables was performed with *absolute and relative frequencies*. The quantitative ones are described by *mean and standard deviation, quartiles, minimum and maximum*. To analyse the differences in the answers between professionals with and without training, the *chi-square test or Fisher's exact test* are used. To compare the level of knowledge, the *non-parametric Mann-Whitney U test* is applied. The *95% confidence intervals* are calculated by the exact method. All tests are considered bilateral and statistically significant with *p-values less than .05*. The statistical analysis was performed using the programs SPSS 17 and STATA 12.

## Results

Out of 1,569 professionals, 235 persons from different fields completed the survey: 40% were graduates in nursing, midwives and physiotherapists; 32.8% doctors; 8.9% patient-

care technicians; 6% administrative assistants; 1.3% porters and 11.1% corresponded to other professional categories.

The overall response rate was 15%. By professional category, graduates (20.2%) and doctors (15.9%) had the highest percentage of response rates.

Regarding the sociodemographic data of the professionals surveyed, the distribution by sex was 81.5% of women compared to 18.5% of men. The *average* age was 41.9 with a *standard deviation* of 8.86, as shown in Table 1.

**Table 1.** Socio-demographic data of the professionals that completed the survey.

<b>Gender</b>	<b>Male</b>	43(18.5%)
	<b>Female</b>	190(81.5%)
<b>Marital Status</b>	<b>Married</b>	133(58.1%)
	<b>Other</b>	17 (7.4%)
	<b>Separated/Divorced</b>	21 (9.2%)
	<b>Single</b>	58 (25.3%)
<b>Occupational Group</b>	<b>Administrative Staff</b>	14 (6%)
	<b>Warden</b>	3 (1.3%)
	<b>Nurse/Midwife/Physiotherapist</b>	94 (40%)
	<b>Doctor</b>	77 (32.8%)
	<b>Other</b>	26 (11.1%)
	<b>Nursing assistant</b>	21 (8.9%)
<b>Age</b>	<b>Average ± Standard Deviation</b>	41.9 ± 8.86
	<b>Median (Interquartile Range)</b>	42 (37 - 48)
	<b>Range</b>	22 - 60
<b>Experience years</b>	<b>Average ± Standard Deviation</b>	17.8 ± 9.08
	<b>Median (Interquartile Range)</b>	19 (12 - 25)
	<b>Range</b>	0 - 48

Note: N = 235.

Concerning previous experiences, 31.5% of the professionals surveyed knew cases of partner violence against women in their environment, and 24.7% had detected some cases whilst working. Of these professionals, 52.3% had detected two or more cases. Their intervention after the detection was as follows: 25.9% did nothing, 24.1% initiated the action protocol established in the hospital, 39.7% referred the patient to another professional and 19% wrote a medical report.

Among the reasons they mention not to address the problem, the most frequent ones are considering that they do not have the required training (29.5%) or that the problem do not fall under their competences (5.1%).

79.8% had not been trained. Having received training was positively related to the level of knowledge, with a statistically significant difference ( $p = .003$ ), as shown in Figures 1 and 2.

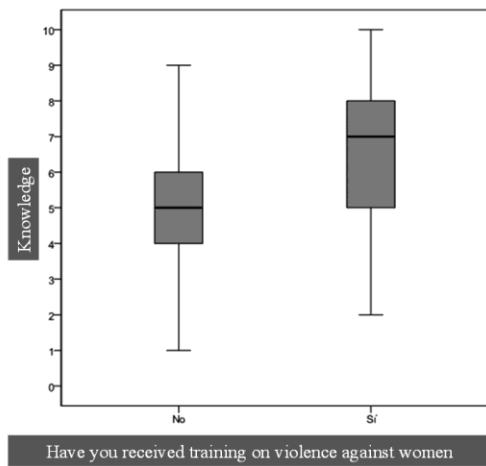


Figure 1. Training for Health Care Professionals on Violence Against Women.

On average, the knowledge degree was  $4.79 \pm DE 1.72$ . Out of the 10 questions that refer to the level of knowledge, only in two, Q-15 and Q-16, statistically significant differences were found between professional categories ( $p = .006$  and  $p = .012$  respectively), as shown in Table 2.

### Knowledge

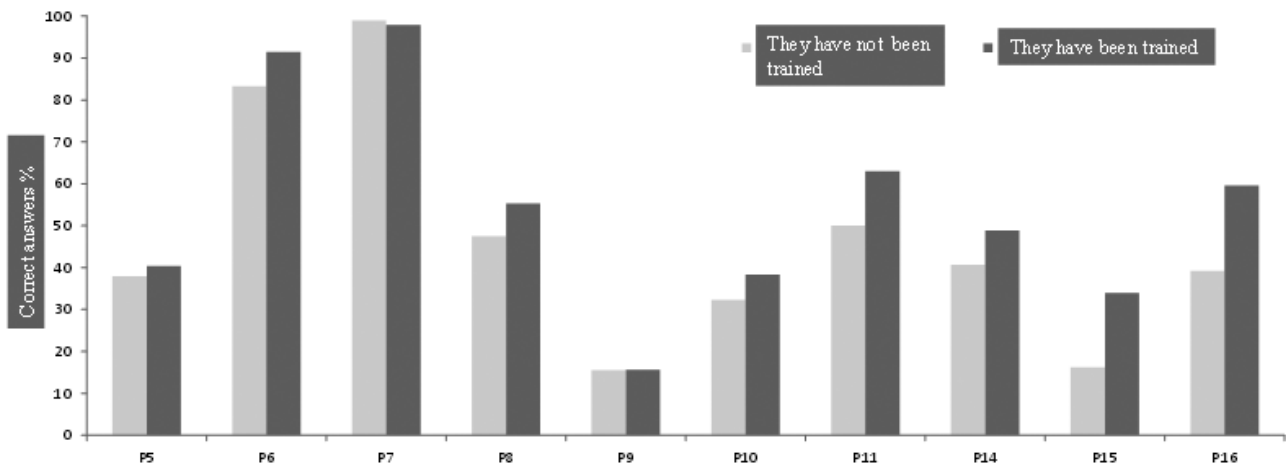


Figure 2. Impact of training of the health care professionals that completed the survey in their degree of knowledge.

Table 2. Knowledge Degree according to the Occupational Group.

	Total	Administrative Staff	Warden	Nurse/Midwife/Physiotherapist	Doctor	Other	Nursing Assit.	p-value
	235	14	3	94	77	26	21	
P5. There are differences	89 (38.4%)	6 (42.9%)	1 (33.3%)	41 (43.6%)	27 (36%)	12 (48%)	2 (9.5%)	.046
P5. They are similar	143 (61.6%)	8 (57.1%)	2 (66.7%)	53 (56.4%)	48 (64%)	13 (52%)	19 (90.5%)	
P6. Somehow/hardly frequent	36 (15.3%)	3 (21.4%)		15 (16%)	12 (15.6%)	5 (19.2%)	1 (4.8%)	.704
P6. Very frequent	199 (84.7%)	11 (78.6%)	3 (100%)	79 (84%)	65 (84.4%)	21 (80.8%)	20 (95.2%)	
P7. Communicated	3 (1.3%)			1 (1.1%)		1 (3.8%)	1 (4.8%)	.221
P7. Unnoticed	232 (98.7%)	14 (100%)	3 (100%)	93 (98.9%)	77 (100%)	25 (96.2%)	20 (95.2%)	
P8. No	118 (51.1%)	11 (78.6%)	1 (33.3%)	50 (53.8%)	22 (29.3%)	17 (68%)	17 (81%)	< .001
P8. Yes	113 (48.9%)	3 (21.4%)	2 (66.7%)	43 (46.2%)	53 (70.7%)	8 (32%)	4 (19%)	
P9. 10%-70%	186 (84.5%)	13 (92.9%)	2 (66.7%)	76 (84.4%)	58 (80.6%)	21 (91.3%)	16 (88.9%)	.629
P9. 70%-90%	34 (15.5%)	1 (7.1%)	1 (33.3%)	14 (15.6%)	14 (19.4%)	2 (8.7%)	2 (11.1%)	
P10.No	157 (66.8%)	11 (78.6%)	3 (100%)	58 (61.7%)	51 (66.2%)	19 (73.1%)	15 (71.4%)	.638

	Total	Administrative Staff	Warden	Nurse/Midwife/Physiotherapist	Doctor	Other	Nursing Assit.	<i>p-value</i>
Yes	78 (33.2%)	3 (21.4%)		36 (38.3%)	26 (33.8%)	7 (26.9%)	6 (28.6%)	
P11. High or low	111 (47.6%)	5 (35.7%)	1 (33.3%)	48 (51.6%)	37 (48.1%)	12 (48%)	8 (38.1%)	.791
Both the same	122 (52.4%)	9 (64.3%)	2 (66.7%)	45 (48.4%)	40 (51.9%)	13 (52%)	13 (61.9%)	
P14. Low sociocultural and socio-economical level	129 (57.8%)	7 (58.3%)	2 (66.7%)	50 (56.2%)	49 (65.3%)	9 (37.5%)	12 (60%)	.303
Is currently separating/divorcing	94 (42.2%)	5 (41.7%)	1 (33.3%)	39 (43.8%)	26 (34.7%)	15 (62.5%)	8 (40%)	
P15. No	187 (80.3%)	13 (92.9%)	1 (33.3%)	76 (81.7%)	60 (77.9%)	20 (80%)	17 (81%)	.371
Yes	46 (19.7%)	1 (7.1%)	2 (66.7%)	17 (18.3%)	17 (22.1%)	5 (20%)	4 (19%)	
P16. No	133 (56.8%)	12 (85.7%)	1 (33.3%)	47 (50%)	40 (51.9%)	19 (76%)	14 (66.7%)	<b>.021</b>
Yes	101 (43.2%)	2 (14.3%)	2 (66.7%)	47 (50%)	37 (48.1%)	6 (24%)	7 (33.3%)	
N	204	12	3	83	67	22	17	
Average ± Standard Deviation	4.79 ± 1.72	3.83 ± 1.75	5.67 ± 1.53	4.87 ± 1.68	4.96 ± 1.79	4.73 ± 1.52	4.41 ± 1.77	.387
Median (p25-p75)	5 (4 - 6)	3.5 (2.25 - 5.75)	6 (4 - 7)	5 (4 - 6)	4 (4 - 6)	4.5 (4 - 6)	4 (3 - 6)	
Range	1 - 9	1 - 6	4 - 7	1 - 9	1 - 9	2 - 8	2 - 7	

In their daily work, 36% of the health professionals did not normally adopt a wait-and-see approach to diagnose these cases, and 28.9% did not consider partner violence against women in patients with physical injuries as a differential diagnosis. The majority of the respondents think that this problem is very important (82.5%) or quite important (17.1%). For 98.7% of respondents, these cases go unnoticed and for 84.5% of them, 10 to 70% of the cases that come to the hospitals are not diagnosed there.

50.9% of the professionals surveyed believe that there is no consensus on the plan of action to follow by the professionals involved in the health care of these women. 49.4% were not aware that the Commission against violence existed in the hospital, and although 81% knew that there is a protocol, only 20.5% of them were aware of it.

Around 86.6% of health care professionals think that any

man may perpetrate violence against women and 80.8% of these professionals believe that this type of violence may affect any type of women. Nevertheless, there are still a lot of stereotypes regarding the victim and the abuser. Moreover, about 9% of the respondents believe that abused women do not have any higher education and 5.1% of the professionals that took the survey believe that they are housewives or immigrants. On the other hand, about 11.3% of those professionals believe that the abuser is a drinker, 1.7% states that he might be a drug user and .4% of the people that took the survey thinks that he is unemployed.

The majority of the people that took the survey (this is, about 97.8%) believe that cooperation between all the health care professionals is needed to solve this problem. The results per professional occupation can be found under table 3.

**Table 3.** Opinion according to each Occupational Group.

	Total	Administrative Staff	Warden	Nurse/Midwife/Physiotherapist	Doctor	Other	Nursing Assit.	<i>p-value</i>
	235	14	3	94	77	26	21	
P12. Housewives/ without higher education/ immigrants	45 (19.2%)	2 (14.3%)	1 (33.3%)	15 (16%)	19 (24.7%)	6 (24%)	2 (9.5%)	.445
Any type of women	189 (80.8%)	12 (85.7%)	2 (66.7%)	79 (84%)	58 (75.3%)	19 (76%)	19 (90.5%)	
P13. Drinker or drug user or unemployed	31 (13.4%)	4 (28.6%)		14 (14.9%)	6 (8%)	5 (20%)	2 (10%)	.256
As any other	200 (86.6%)	10 (71.4%)	3 (100%)	80 (85.1%)	69 (92%)	20 (80%)	18 (90%)	
P17. Something / unimportant	1 (.4%)			1 (1.1%)				1
Very important	233 (99.6%)	14 (100%)	3 (100%)	93 (98.9%)	77 (100%)	25 (100%)	21 (100%)	
P20. No	115 (50.9%)	4 (33.3%)	1 (33.3%)	49 (53.8%)	46 (60.5%)	10 (43.5%)	5 (23.8%)	<b>.031</b>
Yes	111 (49.1%)	8 (66.7%)	2 (66.7%)	42 (46.2%)	30 (39.5%)	13 (56.5%)	16 (76.2%)	
P21. Police or Judges or Psychologists or Social Workers or Health Care Professionals	5 (2.2%)			2 (2.1%)	2 (2.6%)	1 (4.2%)		.864
All	226 (97.8%)	13 (100%)	3 (100%)	92 (97.9%)	75 (97.4%)	23 (95.8%)	20 (100%)	
P22. Bad	185 (79.7%)	12 (85.7%)	1 (33.3%)	73 (78.5%)	64 (83.1%)	21 (87.5%)	14 (66.7%)	.177
Good	47 (20.3%)	2 (14.3%)	2 (66.7%)	20 (21.5%)	13 (16.9%)	3 (12.5%)	7 (33.3%)	

The main points that health care professionals consider to be crucial when assisting women who suffer violence are

the following: identify and detect possible cases at an early stage (44.7%), listen and provide reassurance and support to

the victims, as well as give information and advice, refer the cases to other health care professionals (16.2%), inform the authorities, report the cases (14%), coordinate with other healthcare professionals (9.8%), provide treatment both physically and psychologically (8.1%), establish a protocol to offer protection (6.4%), refer to social services (3%) and train the adequate professionals to train and treat these cases (2.6%) as well as educate children and teenagers to avoid this type of behaviour (2.1%).

These measures are to be taken as this is a health issue and health care professionals should be involved to treat it (23.8%); moreover, we, as professionals should be aware and be responsible of its consequences (18.3%), as this is an issue that may affect anyone and we have the moral obligation to face it (14.9%). Thus, this is a severe and common issue that requires change (14%) and in order to do so specific training is required (8.5%). Violence against women is a social scourge that nullifies the women and avoids her to show her worth in the male-dominated society we live in (7.7%); our actions as health care professionals can save lives (6.4%) as this is a severe social issue (5.1%) and thus we shall know the action protocol (3.4%), as well as the helplessness that women face and the number of preventable deaths (1.3%) that comes at a high cost (0.4%).

Around 42.5% of health care professionals believe that there are organizational or structural challenges in their workplace that do not allow to properly diagnose cases of violence against women, due to the high pressure to treat patients (35.3%), not knowing the action protocol and the lack of coordination between health care professionals (31.8%), as well as the lack of information and training (17.6%) and the resources available for these professionals (11.8%), lack of communication with the patient (3.55%), excessive paperwork (2.4%) and our overall passivity of our society regarding these issues (1.2%).

Health care professionals suggest to change the functional organisation and improve the detection protocols for cases of violence against women. In order to do so, several measures should be implemented, such as training (6.8%), more time available for each patient during the visits (5.1%), better overall conditions to improve patients' privacy without having to face their abuser (3.4%), more social workers, having a psychologist to help in these situations, more information on the procedure to follow and further interdisciplinary coordination (2.6%), as well as guidelines on how to proceed and coordinate health care professionals (1.7%), having enough personnel available (1.3%) and create a specific medical report and a Primary Care notification form when dealing with cases of violence against women.

## Discussion

Although violence against women is considered to be a major public health issue that has reached epidemic proportions and is a priority at an international level due to its impact both to the women who suffer from it and their surround-

ings, about 25.9% of health care professionals did not act when they detected such cases and 5.1% of those who answered the survey think it is not their job to do so. Earlier studies showed that violence against women increases the risk of poor health and worsens how it is seen, as well as showing that physical and psychological harm tends to appear both in the medium and long run (Lasheras Lozano et al., 2008; Montero et al., 2011; Polo Usaola et al., 2010; Ruiz-Jarabo Quemada & Blanco Prieto, 2004; Sanz-Barbero, Rey & Otero-García, 2014; Vives-Cases, Ruiz-Cantero, Escriba-Aguir & Miralles, 2011). Moreover, the more intense and the longer this violence is suffered, the worse these symptoms are (Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007). According to a study carried out by the Community of Madrid, out of the women that have suffered injuries due to this type of violence, 12.6% received medical care at the emergency room and refer to a higher morbidity and therefore higher usage of the health care resources (Lasheras Lozano et al., 2008; Montero et al., 2011; Vives-Cases et al., 2011).

In spite of the consequences that this issue has for the health care system, currently 79.8% of health care professionals have not been trained and, according to our study, those who were had therefore a wider knowledge on the topic. This result is similar to previous studies, in which out of all the respondents, 71.74% of them did not received any training on gender-based violence and 89.67% considered this training to be necessary (Carmona Franco & Pou Navarro, 2010; Coll-Vinent et al., 2008, p.; Elliott, Nerney, Jones & Friedmann, 2002; Ferrer Pérez, Bosch Fiol & Ramis Palmer, 2008; García Torrecillas, Torío Durántez, Lea Pereira, García Tirado & Aguilera Tejero, 2008). Higher levels on detecting cases of gender-based violence were shown in those health care professionals that were adequately trained, which came along their own confidence to be able to spot these type of situations (Coll-Vinent et al., 2008, p.; Elliott et al., 2002; Ferrer Pérez et al., 2008; García Torrecillas et al., 2008). According to the 98.7% of the respondents, gender-based violence goes unnoticed, as shown in previous studies (Arredondo Provecho et al., 2012, 2008; Pueyo, 2002; Rodríguez-Bolaños et al., 2005; Valdés Sánchez et al., 2016).

Healthcare professionals are becoming more aware of the importance of how they procedure when facing cases of violence against women and the pertinence of coordination with other professionals to treat these cases in an interdisciplinary way. The work for this professionals is less defined by stereotypes and they have more resources available to take action, but there is a need to spread action protocols so all health care professionals can apply them when assisting in these cases.

Moreover, health care professionals also claim that training is key to act adequately. Therefore, there is a need to keep creating continued training programs on specialised care for the surveyed professionals, as well as seminars and workshops that provide with action tools previously agreed by management on each health care centre. These action

tools could be implemented through practical sessions using simulation to encourage joint work amongst all health care professionals involved in assisting women who suffer this type of violence. Through a collaborative training perspective, an interdisciplinary point of view on the matter would be fostered to improve overall coordination when treating these cases. In fact, the health sector is ideal to contribute to prevention given its characteristic cross-sectional collaboration (Dirección General de la Mujer - Spain, 2016; Michau, Horn, Bank, Dutt & Zimmerman, 2015).

The *Estrategia madrileña contra la violencia de género (2016-2021)* [Madrid Framework against Gender-Based Violence] provides both training and implementing research initiatives to reinforce the *Red de Atención Integral para la Violencia de Género de la Comunidad de Madrid* (Dirección General de la Mujer, 2016) [Comprehensive Care Program towards victims of Gender-Based Violence of the Community of Madrid], which the main goal of offering an specific health response to each woman. This should be included in the study plan in Nursing, Medicine, Social Worker, Law and Psychology studies at a university level, and also implemented in the induction programs for new hospital workers and medical residents.

There is a need to spread the tools created to fight against this type of violence, both within the community and the hospital that took part in this survey, in order to unify how to act at a health-care level and to guarantee that all those women who suffer violence have access to comprehensive care. Improve coordination is key to not re-victimize these patients.

## References

- Arredondo Provecho, A. B., Broco-Barredo, M., Alcalá-Ponce de León, T., Rivera-Álvarez, A., Jiménez Trujillo, I., & Gallardo-Pino, C. (2012). Profesionales de atención primaria de Madrid y violencia de pareja hacia la mujer en el año 2012. *Revista Española de Salud Pública*, 86, 85-99.
- Arredondo Provecho, A. B., del Pliego-Pilo, G., Nadal-Rubio, M., & Roy-Rodríguez, R. (2008). Conocimientos y opiniones de los profesionales de la salud de atención especializada acerca de la violencia de género. *Enfermería Clínica*, 18(4), 175-182. [https://doi.org/10.1016/S1130-8621\(08\)72192-2](https://doi.org/10.1016/S1130-8621(08)72192-2)
- Asamblea de Madrid. (20 de diciembre de 2005). Ley 5/2005, de 20 de diciembre, integral contra la violencia de género de la Comunidad de Madrid. BOE: n.º. 52 de 2 de marzo de 2006. Recuperado a partir de <https://www.boe.es/boe/dias/2006/03/02/pdfs/A08515-08526.pdf>
- Cabrera Mercado, R., & Carazo Liébana, M. J. (2010). *Análisis de la legislación autonómica sobre violencia de género*. Madrid: Ministerio de Igualdad.
- Carmona Franco, A., & Pou Navarro, T. (2010). *Evaluación de la atención sanitaria especializada ante la violencia de género en las Islas Baleares*. Palma de Mallorca: Govern de les Illes Balears. Conselleria de Salut i Consum.
- Coll-Vinent, B., Echeverría, T., Farràs, Ú., Rodríguez, D., Millá, J., & Santinà, M. (2008). El personal sanitario no percibe la violencia doméstica como un problema de salud. *Gaceta Sanitaria*, 22, 7-10.
- Cortes Generales. (28 de diciembre de 2004). Ley Orgánica 1/2004, de 28 de diciembre, de Medidas de Protección Integral contra la Violencia de Género. BOE: n.º. 313 de 29 de diciembre de 2009. Recuperado a partir de <https://www.boe.es/buscar/pdf/2004/BOE-A-2004-21760-consolidado.pdf>
- de Miguel Luken, V. de. (2015). *Macroencuesta de violencia contra la mujer 2015*. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad, Centro de Publicaciones.
- Dirección General de la Mujer. (2016). *Estrategia madrileña contra la violencia de género*. Recuperado a partir de <http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadervalue1=filename%3DLIBRO+ESTRATEGIA+WEB.pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1352914249737&ssbinary=true>
- Elliott, L., Nerney, M., Jones, T., & Friedmann, P. D. (2002). Barriers to Screening for Domestic Violence. *Journal of General Internal Medicine*, 17(2), 112-116. <https://doi.org/10.1046/j.1525-1497.2002.10233.x>
- Ferrer Pérez, V. A., Bosch Fiol, E., & Ramis Palmer, M. C. (2008). La formación de los/as profesionales de la salud para afrontar la violencia contra las mujeres en la pareja. *Clínica y Salud*, 19, 59-81.
- García Torrecillas, J. M., Torío Duránte, J., Lea Pereira, M. del C., García Tirado, M. del C., & Aguilera Tejero, R. (2008). Detección de violencia contra la mujer en la consulta del médico de familia. *Atención Primaria*, 40(9), 455-461. <https://doi.org/10.1157/13126422>
- García-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Ginebra, Suiza: World Health Organization.
- Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors Influencing Identification of and Response to Intimate

Health care professionals and the overall society need to change their attitude towards this issue, that has an evitable loss of human lives and an incalculable cost. There is also a need to increase investment in innovative programs, encourage collaborations between researchers from different areas and work towards a leadership on the health care sector to “achieve a higher impact in primary prevention” (Michau et al., 2015). Last year, 44 lives were lost due to this type of violence and even though several initiatives have been implemented to improve the situation of all those women who suffer from it, we have to continue our work. There are new initiatives that promote interventions with men and young boys to change the perspective on masculinity that encourages violence (Jewkes, Flood, & Lang, 2014).

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- Partner Violence: A Survey of Physicians and Nurses. *BMC Public Health*, 7(1). <https://doi.org/10.1186/1471-2458-7-12>
- Jewkes, R., Flood, M., & Lang, J. (2014). From Work with Men and Boys to Changes of Social Norms and Reduction of Inequities in Gender Relations: A Conceptual Shift in Prevention of Violence Against Women and Girls. *The Lancet*, 385(9977), 1580-1589. [https://doi.org/10.1016/S0140-6736\(14\)61683-4](https://doi.org/10.1016/S0140-6736(14)61683-4)
- Lasheras Lozano, L., Pires Alcaide, M., Zorrilla Torras, B., Sánchez Gómez, L. M., Seoane Pascual, L., & Morant Ginestar, C. (2008). *Magnitud, impacto en salud y aproximación a los costes sanitarios de la violencia de pareja hacia las mujeres en la Comunidad de Madrid* (p. 56). Madrid: Consejería de Sanidad. Dirección General de Salud Pública.
- Méndez-Hernández, P., Valdez-Santiago, R., Viniestra-Velázquez, L., Rivera-Rivera, L., & Salmerón-Castro, J. (2003). Violencia contra la mujer: conocimiento y actitud del personal médico del Instituto Mexicano del Seguro Social, Morelos, México. *Salud Pública de México*, 45, 473-482.
- Michau, L., Horn, J., Bank, A., Dutt, M., & Zimmerman, C. (2015). Prevention of Violence Against Women and Girls: Lessons from Practice. *The Lancet*, 385(9978), 1672-1684. [https://doi.org/10.1016/S0140-6736\(14\)61797-9](https://doi.org/10.1016/S0140-6736(14)61797-9)
- Ministerio de Sanidad, Servicios Sociales e Igualdad. (2017b). Fichas de menores víctimas mortales. Recuperado 30 de marzo de 2017, a partir de <http://www.violenciagenero.msssi.gob.es/violenciaEnCifras/victimasMortales/fichaMenores/home.htm>
- Ministerio de Sanidad, Servicios Sociales e Igualdad. (2017a). Fichas de víctimas mortales por violencia de género. Recuperado 30 de marzo de 2017, a partir de <http://www.violenciagenero.msssi.gob.es/violenciaEnCifras/victimasMortales/fichaMujeres/home.htm>
- Montero, I., Ruiz-Perez, I., Martín-Baena, D., Talavera, M., Escribà-Aguir, V., & Vives-Cases, C. (2011). Violence Against Women from Different Relationship Contexts and Health Care Utilization in Spain. *Women's Health Issues*, 21(5), 400-406. <https://doi.org/10.1016/j.whi.2011.04.003>
- Moreno-Torres Sánchez, J. (2015). *Modificación del sistema de protección a la infancia y a la adolescencia. Guía para profesionales y agentes sociales*. Málaga: Save the Children. Recuperado a partir de [https://www.savethechildren.es/sites/default/files/imce/docs/modificacion\\_del\\_sistema\\_de\\_proteccion\\_a\\_la\\_infancia\\_y\\_a\\_la\\_adolescencia.pdf](https://www.savethechildren.es/sites/default/files/imce/docs/modificacion_del_sistema_de_proteccion_a_la_infancia_y_a_la_adolescencia.pdf)
- Organización de las Naciones Unidas. Declaración sobre la eliminación de la violencia contra la mujer, A/RES/48/104 § (1993). Recuperado a partir de <http://www.un.org/es/comun/docs/?symbol=A/RES/48/104>
- Organización Mundial de la Salud. (1996). Prevención de la violencia: una prioridad de salud pública. Resolución WHA49.25. Presentado en 49ª Asamblea Mundial de la Salud, Ginebra, Suiza. Recuperado a partir de [http://www.who.int/violence\\_injury\\_prevention/resources/publications/en/WHA4925\\_spa.pdf](http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_spa.pdf)
- Organización Mundial de la Salud. (2005). *Estudio multipaís de la OMS sobre salud de la mujer y violencia doméstica: primeros resultados sobre prevalencia, eventos relativos a la salud y respuestas de las mujeres a dicha violencia: resumen del informe*. Ginebra, Suiza: Organización Mundial de la Salud.
- Organización Mundial de la Salud. (2013). *Estimaciones mundiales y regionales de la violencia contra la mujer: prevalencia y efectos de la violencia conyugal y de la violencia sexual no conyugal en la salud*. Ginebra, Suiza: Departamento de Salud Reproductiva e Investigaciones Conexas. Recuperado a partir de [http://apps.who.int/iris/bitstream/10665/85243/1/WHO\\_RHR\\_HR\\_P\\_13.06\\_spa.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/85243/1/WHO_RHR_HR_P_13.06_spa.pdf?ua=1&ua=1)
- Organización Mundial de la Salud & Organización Panamericana de la Salud. (1998). Violencia contra la mujer. Un tema de salud prioritario. Washington. Recuperado a partir de [http://www.who.int/gender/violence/violencia\\_infopack1.pdf](http://www.who.int/gender/violence/violencia_infopack1.pdf)
- Organización Panamericana de la Salud. (2010). *Género y salud: una Guía Práctica para la Incorporación de la Perspectiva de Género en Salud*. Washington D. C.: Organización Panamericana de la Salud.
- Pichiule, M., Gandarillas, A., Ordoñez, M., Sonogo, M., Zorrilla, B., Pires, M., ... Polo, C. (2014). *Violencia de pareja hacia las mujeres: 3ª Encuesta para el estudio de la magnitud, tendencia e impacto en salud en la Comunidad de Madrid, 2014* (Documento Técnico de Salud Pública). Madrid: Consejería de Sanidad. Dirección General de Atención Primaria. Recuperado a partir de [http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DVP+M+19112014+definitivo+\\_2\\_.pdf&blobheadervalue2=language%3Des%26site%3DPortalSalud&blobkey=id&blobtable=MungoBlobs&blobwhere=1352861196413&ssbinary=true](http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DVP+M+19112014+definitivo+_2_.pdf&blobheadervalue2=language%3Des%26site%3DPortalSalud&blobkey=id&blobtable=MungoBlobs&blobwhere=1352861196413&ssbinary=true)
- Polo Usaola, C., Romero Claver, I., Pires Alcaide, M., García Delgado, C., Arredondo Provecho, A., Muñoz Cano, M., ... Molina Alen, E. (2010). *Guía de actuación especializada para abordar la violencia de pareja hacia las mujeres*. Madrid: Consejería de Sanidad. Dirección General de Coordinación de la Asistencia Sanitaria. Recuperado a partir de <http://www.madrid.org/bvirtual/BVCM017023.pdf>
- Pueyo, J. (2002). La actitud del personal sanitario ante el maltrato contra las mujeres. Presentado en Primeras Jornadas sobre violencia intrafamiliar, Zaragoza: Universidad de Zaragoza. Recuperado a partir de [http://www.unizar.es/sociologia\\_juridica/viointrafamiliar/pueyo.pdf](http://www.unizar.es/sociologia_juridica/viointrafamiliar/pueyo.pdf)
- Rodríguez-Bolaños, R. de los A., Márquez-Serrano, M., & Kageyama-Escobar, M. de la L. (2005). Violencia de género: actitud y conocimiento del personal de salud de Nicaragua. *Salud Pública de México*, 47, 134-144.
- Ruiz-Jarabo Quemada, C., & Blanco Prieto, P. (Eds.). (2004). Consecuencias de la violencia sobre la salud de las mujeres: la detección precoz en consulta. En *La violencia contra las mujeres: prevención y detección, cómo promover desde los servicios sanitarios relaciones autónomas, solidarias y gozosas* (pp. 103-117). Madrid: Díaz de Santos.
- Sanz-Barbero, B., Rey, L., & Otero-García, L. (2014). Estado de salud y violencia contra la mujer en la pareja. *Gaceta Sanitaria*, 28(2), 102-108. <https://doi.org/10.1016/j.gaceta.2013.08.004>
- Siendones Castillo, R., Perea-Milla López, E., Arjona Huertas, J. L., Agüera Urbano, C., Rubio Gallo, A., & Molina, M. (2002). Violencia doméstica y profesionales sanitarios: conocimientos, opiniones y barreras para la infradetección. *Emergencias*, 14(5), 224-232.
- Torres Macho, J., Fernández Salgado, F., Caballero Romero, A., Migueles Guerrero, C., Gómez Valencia, J., & Villalba Guijarro, N. (2013). *Violencia de pareja hacia las mujeres: guía breve de actuación en los servicios de urgencias hospitalarios* (Violencia de pareja hacia las mujeres) (p. 30). Madrid: Consejería de Sanidad. Dirección General de Coordinación de la Asistencia Sanitaria. Recuperado a partir de <http://www.madrid.org/bvirtual/BVCM017382.pdf>
- Valdés Sánchez, C. A., García Fernández, C., & Sierra Díaz, Á. (2016). Violencia de género: conocimientos y actitudes de las enfermeras en atención primaria. *Atención Primaria*, 48(10), 623-631. <https://doi.org/10.1016/j.aprim.2016.01.003>
- Vives-Cases, C., Ruiz-Cantero, M. T., Escribà-Aguir, V., & Miralles, J. J. (2011). The Effect of Intimate Partner Violence and Other Forms of Violence Against Women on Health. *Journal of Public Health*, 33(1), 15-21. <https://doi.org/10.1093/pubmed/fdq101>

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**Annex 1.**

Questionnaire on the awareness of specialised care professionals in Partner Violence Against Women modified from the one used in the study by Siendones Castillo R, et al. *Domestic violence and health care professionals*

1. Do you know any case of partner violence against women in your environment?

YES  NO

2. Have you ever identified any case of partner violence while you were working?

YES  NO

If so, how many cases have you seen in the last 3 months during your working hours? Number.....

How did you act?

Started protocol on abuse  Wrote a medical report  Referred to another professional  Did not do anything

In case you did not address the problem, which are the reasons?

I do not have the required training  I am worried I might be called to testify  It does not fall under my competence  I do not have enough time  
 Others.....

3. Were you aware of the existence of a Commission against Partner Violence Against Women in the hospital where you work?

YES, I was  NO, it is the first time I have heard of it

4. Is there an action protocol for the health care of these patients in the hospital where you work?  YES  NO

4.1. In case it exists, do you know it?  YES  NO

5. Do you think that the meanings of "partner violence against women", "abuse", and "gender-based violence" are the same or there are differences?

They are the same  There are differences (explain them) .....

6. In your opinion, partner violence against women in our society is a problem that occurs:

Very frequently  Quite frequently  Somewhat frequently  Infrequently

7. In your opinion, most patients suffering from it...

Talk about their situation  Go unnoticed

8. Do you know the meaning of the term "Iceberg" related to partner violence against women?

NO  YES (explain it)

9. Do you know what could be the percentage of cases that are NOT usually diagnosed?

10 – 30 %  30 – 50 %  50 – 70 %  70 – 90 %

10. Could you classify the types of partner violence against women by frequency? (1 for the most frequent and 3 for the least frequent)

Physical  Psychological  Sexual

11. Partner violence against women is more associated with the following social classes:

Upper  Lower  The same

12. In your opinion, women who suffer partner violence are usually:

Housewives  Uneducated women  Foreign nationals  
 Any type of woman

13. The abuser is usually a:

Drinker  Drug user  Unemployed  Regular man

14. Which of these three factors do you think that have more influence on the existence of partner violence against women in our environment?

Low sociocultural level  Going through separation/divorce proceedings  Low socioeconomic level

15. Do you know the legal repercussions that can result from not reporting an obvious case of partner violence against women?

YES  NO

16. Do you know the legal obligations of health professionals on the basis of a case of partner violence against women?

YES  NO

17. Do you think that the problem of partner violence against women is important?

Very important  Quite important  Something important  Unimportant

18. In your daily work, do you adopt a wait-and-see approach to diagnose these cases?

Always  Usually  Usually not  Never

19. At work, if there is a patient with physical injuries, do you consider the possibility of a case of partner violence against women as a differential diagnosis?

Always  Usually  Usually not  Never

20. Do you think that there is consensus about the actions to follow by all professionals involved in the care of women who suffer partner violence?

Always  Usually  Usually not  Never

21. When identifying and solving this problem, who should deal with the issue?

Police  Judges  Psychologists  Social workers  
 Health care professionals  All of the above

22. Which of these opinions do you think is more suited to the current situation of this problem, in relation to underdetection? (please choose an option):

A:  I believe that patients suffering from partner violence should insist more, have a firmer position and ask for more help from society.

B:  I believe that it is necessary to continue improving the systems of detection and coordination among the different institutions and professionals involved.

C:  These patients think that their problem has no solution and that society does not support them. I think they would need to change this misconception and should realise the possibilities they have.

D:  I believe that patients suffering from partner violence do not have yet the necessary means and they need more help.

23. What do you think are the main duties of hospital professionals when dealing with this problem?

24. If you wanted to change the behaviour of health care professionals by increasing their awareness, which 3 reasons would you give?

25. Do you think that there are organizational or structural problems in your work that prevent health care professionals from diagnosing these cases?

NO  YES, why?

26. If you could change the functional organization of your workplace, what would you do or change to improve the detection capability of women suffering from partner violence?

27. Occupational category to which you belong:

Nurse  Patient care technician  Doctor  Midwife  
 Physical therapist  Social worker  Porter  Administrative assistant  Other (please specify) .....

28. You work in:

Emergency department  Admission  Special services  Management  
 Consultation  Other (please specify) .....

29. Sex:

Male  Female

30. Age:

..... years of professional experience

31. Marital status:

Married  Single  Widowed  Separated-divorced  Others

32. Have you taken any training course on partner violence against women?

NO  YES

33. How many hours approximately? .....

Your answers will be confidential, but results may be publicly disseminated.

**Thank you very much for your participation.**