Study on other forms of violence against women that threaten their capacity and right to reproduction and the approach and intervention of the local Administration in this area

forced abortion, forced sterilisation, forced contraception, surrogate pregnancy, crimes in the name of "honour"

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Plan de Recuperación, Transformación y Resiliencia

FEMP
FEDERACION ESPAÑOLA DE MUNICIPIOS Y PROVINCIAS

GOBIERNO DE ESPAÑA
MINISTERIO DE IGUALDAD
SECRETARÍA DE ESTADO DE IGUALDAD Y CONTRA LA VIOLENCIA DE GÉNERO
DELEGACIÓN DEL GOBIERNO CONTRA LA VIOLENCIA DE GÉNERO

Study on other forms of violence against women that threaten their capacity and right to reproduction and the approach and intervention of the local Administration in this area forced abortion, forced sterilisation, forced contraception, surrogate pregnancy, crimes in the name of "honour".

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List of abbreviations

AACC	Autonomous Communities
ATENPRO	Telephone Service for the Attention and Protection of Victims of Gender Violence
CAR	Refugee Reception Centres
CBC	Center for Bioethics and Culture
CEDAW	Committee on the Elimination of Discrimination against Women (CEDAW)
CESCR	Committee on Economic, Social and Cultural Rights
CETI	Temporary Stay Centres for Immigrants (CETI)
CNH	crimes committed in the name of so-called *honour*
CRC	Convention on the Rights of the Child
CREADE	Reception, Care and Referral Centres
CRPD	Convention/ Committee on the Rights of Persons with Disabilities
CRPD	UN Convention on the Rights of Persons with Disabilities
CRPD	Committee on the Rights of Persons with Disabilities
D.G.	Directorate General
DGRN	Directorate-General for the Registry and Notaries
DGVG	Government Office against Gender -based Violence
ECtHR	European Court of Human Rights (also known as the "Strasbourg Court")
ECtHR	European Court of Human Rights
EESC	European Economic and Social Committee
FASC	Forced abortion, forced sterilisation, forced contraception
FEMP	Spanish Federation of Municipalities and Provinces
FGM	Female Genital Mutilation
GBV	Gender-based violence

GC - GS	Gestational Carrier or Gestational Surrogate
GCJ	General Council of the Judiciary
HBV	Honour-based violence
HR	Human Rights
ICASM	International Coalition for the Abolition of Surrogate Motherhood
IOM	International Organisation for Migration
IP	International Protection
ISS	International Social Service
LA	Local authority
LE	Local entity
MISSM	Ministry of Inclusion, Social Security and Migration
NGO	Non-governmental Organisation
NNAS	National Network Against Surrogacy
SSGV	National Strategy to Combat Gender-Based Violence (2022-2025) (EEVM in Spanish)
OHCHR	Office of the High Commissioner for Human Rights
OIM	see IOM
PC	Penal Code
RAIEPP	International Academic Network on Prostitution and Pornography Studies
RTRP	Spanish Recovery, Transformation and Resilience Plan
RV	Reproductive Violence
SCS	Supreme Court Sentence
SDGs	Sustainable Development Goals
SECHR	Sentence of the European Court of Human Rights
PEIEMH	Strategic Plan for the Effective Equality of Women and Men (2022-2025)
SPGV	Spanish State Pact on Gender Violence
SRHR	Sexual and Reproductive Health and Rights
SSL	Spanish Sign Language

SV	Sexual violence
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
VAW	Violence Against Women
VGV	Victims of Gender-based Violence
VVAW	Victims of Violence against Women
WHO	World Health Organisation
WIDD	Women with Intellectual or Developmental Disabilities
WVGV	Woman/women Victim of Gender-based Violence
WVV	Woman/women Victim of (Gender-based)Violence

I. PRESENTATION AND INTRODUCTION

1. Presentation of the report

Object of study

The main objective of the *Study on other forms of violence against women that threaten their reproductive capacity and rights (forced abortion, forced sterilisation, forced contraception, surrogate pregnancy, crimes in the name of "honour") and the approach and intervention of the local administration in this area*, is to **improve the understanding of the lesser-known types of violence against women and to put forward proposals for action at the local level.**

The Spanish Federation of Municipalities and Provinces (FEMP) has conducted this research thanks to the Recovery, Transformation and Resilience Plan (RTRP) funding, which is supported by European Union Next Generation EU funds. The institutional funding framework is that of investment 4 of Component 22 of the RTRP, and has therefore been guided by the provisions of Royal Decree 1042/2021, which regulates the direct award of a grant to FEMP for this purpose[1] thanks to the promotion of the *Spain protects you against sexist violence Plan* (2021).

The study also contributes to the objectives of other public policy instruments, both to SDG5 of the United Nations *2030 Agenda for Sustainable Development* in Spain, and to the implementation of the Council of Europe Convention on preventing and combating violence against women and domestic violence (2011) in our country (the Istanbul Convention).

FEMP transversally promotes the principle of equal opportunities between women and men in all local policies, and actively works for the development and innovation of actions to eradicate violence against women as part of local equality policies.

[1] Royal Decree 1042/2021, of 23 November, which regulates the direct granting of a subsidy to the Spanish Federation of Municipalities and Provinces for the modernisation and expansion of care and protection mechanisms for victims of gender-based violence within the framework of the Recovery, Transformation and Resilience Plan, BOE no. 282, of 25 November 2021.

FEMP stresses, in line with the World Declaration on Women in Local Government (UCLG, 2021),[2] , that **local government plays a crucial role in guaranteeing women's reproductive rights** as a provider of services and acceptable living conditions.

Since 2004, FEMP has been responsible for the management of the **Telephone Service for the Attention and Protection of Victims of Gender Violence (ATENPRO)**[3] , which is run by the Government Delegation against Gender Violence (DGVG) (Ministry of Equality). **ATENPRO needs to be modernised in** order to optimise the services it provides in the fight against gender violence in all its forms and dimensions. This study aims to contribute to this objective by providing proposals for a comprehensive model of action that covers all forms of violence, including the lesser-known forms of violence, which in this case refer to reproductive violence (RV) and so-called "honour" crimes (CNH).

Hereafter, for ease of reading, abbreviations are often used (see List of abbreviations), thus **FASC** will be used for forced abortion, forced sterilisation, forced contraception; **GS will be used** for surrogacy; and **CNH will** be used for those referred to as crimes in the name of "honour".

Research team

The research has been developed by the Innovation and Public Policy area of RED2RED and has been carried out by a large interdisciplinary team of researchers: Clara Inés Guilló-Girard (direction), Cynthia Bartolomé Esteban, María Luisa Velasco Gisbert, Noemi Soriano García, Laura Nuño Gómez, Helena López Paredes, Josefa Fernández Camacho, Judith García Padilla, Amalia Cuesta García, Eva Álvarez Moreno; Ángela María Serrano Ruiz; and Esther Castellanos Torres; and in research support: Jaume Almendros Rodríguez, Daniel de Gracia Palomera, Jesús Barbero Quirós. The report has been translated by María Madrid Manzano and Clara Guilló.

2 Joint statement to the 65th session of the United Nations Commission on the Status of Women (CSW65) from the Global Taskforce of Local and Regional Governments (Access).

3 According to its current Protocol, ATENPRO, "pursues, as a fundamental objective, that the victim feels safe and accompanied during the process that allows her to regain control of her life, facilitating contact with a safe environment and enabling immediate intervention, with the mobilisation, if necessary, of the necessary care resources".

Together with this team, several entities and experts have provided valuable guidance to the work: ACCEM; Spanish Commission for Refugee Aid (CEAR); Alicia Márquez- Amaranta-Solidarity Foundation; Eva Menéndez Sebastián- UNHCR Spain; Rubia Naz- PakMir Pakistani Women's Association; Valeria Tosi; and Rebeca Tur Baraja. We thank all of them for their involvement in the project.

In addition, we would like to thank all the people and entities that generously participated in the surveys (Annex 1 and Annex 2) and interviews (Annex 3), and Joaquín Corcobado Romo and Gala Castellanos Poza from the Area of Citizenship and Social Rights of the Directorate General for Equality and Institutional Policy of FEMP for their coordination work.

Structure of the report

This report is divided into four blocks of content. The first part contains the Presentation of the report (chapter 1), the Introduction of the subject and the methodology used for its development (chapter 2).

The second part, from chapter 3 to chapter 13, establishes the *Situation Analysis*. Chapter 3 introduces the theme of violence against reproductive capacity and women's and girls' reproductive rights (RV). Chapters 4, 5, 6 and 7 focus on forced abortion, forced sterilisation and forced contraception (FASC) as specific forms of violence. Gestational surrogacy (GS) covers chapter 8, 9 and 10. Finally, crimes committed in the name of "honour" (CNH) or honour-based violence (HBV) are dealt with in Chapters 11 and 12. The development of these three themes begins with a description of the problem and its typology, followed by a description of the main groups of women affected and their needs. The institutional framework is followed by a mapping of experiences and an analysis of some concrete practices of interest.

The third part, *Recommendations and proposals for intervention*, brings together 4 chapters, which cover the recommendations drawn up for local action, the assessment carried out on the potential for improving ATENPRO services for RV and the CNHs and its future developments. Finally, a proposal for a comprehensive local intervention model on the violence targeted by the study (reproductive violence and crimes in the name of "honour") is provided in chapter 17.

The fourth part of the report presents the bibliography (chapter 18) and the list of annexes with complementary information.

2. Introduction

2.1. The existence of "other form of violence" against women

Violence against women (VAW) **is expressed in different and interrelated ways**. Some of these expressions are well known to society and there is considerable awareness of them. Examples of them are violence in intimate partner or ex-partner relationships (known in Spain as *gender-based violence*) [4] , sexual violence occurring in the public sphere (e.g., in entertainment venues) or the trafficking of women and girls for the purpose of sexual exploitation.

However, **there are other forms of violence that are little known,** to which public institutions have paid little attention until recently. The lack of knowledge is due to the normalisation and invisibility of the violence against women, which **warnings us to the institutional efforts that are still required to achieve equal societies between women and men**.

> The lack of information does not mean that its scope is lesser, nor that its consequences are milder. On the contrary, the invisibility of violence - in any of its forms - means that **the victims are more unprotected** and the aggressors enjoy **greater impunity**.

These forms of violence include so-called **crimes in the name of "honour"** (CNH) **and reproductive violence** (RV). With regard to the latter, the study focuses exclusively on **forced abortion, forced sterilisation and forced contraception** (FASC) and **surrogacy** (GS).

Although violence against women (VAW) is a *continuum* of interrelated violence (Kelly, 1988) and, any woman or girl can be a victim, the forms of violence we are concerned with **affect** mainly - but not exclusively - to **women with disabilities, women belonging to ethnic groups and diasporas from specific regions, and other women in situations of particular vulnerability**.

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[4] In Spain, this violence has been known as "gender violence" since the entry into force of Organic Law 1/2004, of 28 December, on Comprehensive Protection Measures against Gender Violence. This denomination was maintained in Royal Decree-Law 9/2018 on urgent measures for the development of the State Pact on Gender Violence, on 13 September 2018.

The latter would be the case for younger women, impoverished women, Roma women, women seeking international protection, or victims of sexual exploitation due to trafficking or prostitution.

It is for these reasons that the application of intersectionality (Crenshaw, 1989; Collins, 1990; Collins and Bilge, 2019) within the integrated gender approach is an essential condition for detecting and acting on these forms of violence.

In recent years, great advances have been made in the visibility of all forms of VAW, both in terms of improved social awareness and in the regulations that protect the rights of victims. Public policies aimed at its eradication and attention can definitely be improved. In this sense, **the institutional framework for action** against sexist violence in Spain, and in the European Union[5] is increasingly broader[6] but needs to be further developed.

A key instrument for institutional action is the **Council of Europe Convention on preventing and combating violence against women and domestic violence** (2011), better known as the **Istanbul Convention**[7] . Together with it, a future European Directive on combating violence against women and domestic violence is expected (proposal of the European Parliament and of the Council (COM/2022/105 final) year 2022).

Thus, the framework of this research is circumscribed by **the principles of the Istanbul Convention** which, according to the Council of Europe (2023) are:

- **Its foundations are**: to prevent violence, to protect victims and to bring legal actions against the aggressors; to raise awareness and to change people's mindsets by calling on all members of society, particularly men and boys, to change their attitudes.

[5] The European Institute for Gender Equality (EIGE) can be consulted for information on the regulatory and normative framework of the European Union on violence against women (access).
[6] An explanatory overview of the Spanish institutional framework can be found in the *Estrategia Estatal para combatir las violencias machistas 2022-2025* (Government Delegation against Gender Violence, 2022) (access).
[7] The Istanbul Convention is part of this institutional framework together with other instruments, e.g. the Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 5, 1950) and its Protocols, the Council of Europe Convention on Action against Trafficking in Human Beings (CETS No. 197, 2005) and the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (CETS No. 201, 2007).

- It is seen as a call for greater **equality between women and men,** as violence against women is deeply rooted in gender inequality in society and has been perpetuated through a **culture of tolerance and denial**.
- The term "women" **includes girls under the** age of 18.

Figure 1.Definitions: Article 3 of the Istanbul Convention

a) "Violence against women" shall mean a violation of human rights and a form of discrimination against women, and shall mean all acts of gender-based violence that involve or may cause harm or suffereing of a nature to women, physical, sexual, psycological or economic; including threats of such acts, coercion or arbitrary deprivation of liberty, in public or private life;

b) "Domestic violence" shall mean all act of physical, sexual, psychological or economic violence that occur in the family or at home or between former or current spouses or common-law partners, regardless of whether the perpetrator shares or has shared the same address as the victim;

c) "Gender" means the socially constructes roles, behavioura, activities and attributions that a specific society considers appropriate for women or men;

d) "Gender -based violence against women" shall mean any violence against a woman because she is a woman or that affects women disproportionately;

e) "Victim" shall mean any natural person who is subjected to the behaviors specified in sections a and b;

Source: Instrument of ratification of the Council of Europe Convention on preventing and combating violence against women and domestic violence, done in Istanbul on May 11, 2011.

- It is extensive in its definition of **forms of violence** (Article 3; see figure above). It covers those that are less known to society and indicates - together with the recommendations of its institutional follow-up mechanism, GREVIO[8] - that they must be **taken into account in policies at all levels.**

[8] Group of Experts on Combating Violence against Women and Domestic Violence (GREVIO). It is a body of independent experts First GREVIO Evaluation Report on Spain (2020); General Recommendation No. 1 on the digital dimension of violence against women (2021); Mid-term Horizontal Review of GREVIO baseline evaluation reports (2022).

- The Convention requires States Parties to **criminalise or punish the following conducts**[9] : domestic violence (physical, sexual, psychological or economic violence); harassment; sexual violence, including rape and sexual harassment; forced marriage; **"honour" crimes**; female genital mutilation; and **forced abortion and sterilisation**.
- It emphasises the **involvement of all relevant state agencies** and services in order to address violence in a coordinated manner. This means that agencies and NGOs should not act in isolation, but establish protocols for cooperation (Council of Europe, 2012:2).

The Istanbul Convention was **ratified by Spain**[10] **in 2014** and is therefore considered one the country's own legislation.

- Its entry into force **implies the alignment of regulations and public programmes across** the country. This is a process that is taking longer than desired. Its progressive implementation is entailing the **necessary updating of public policies to a more extensive and effective framework of intervention** on violence against women, that encompasses lesser-known forms of violence.

- For two decades, **Spain has stood out for its legislative initiative** on equality between women and men, the recognition of LGTBIQ+ rights and the fight against violence against women [11] . Today, while its policies are being updated to improve their alignment with the Istanbul Convention, more impetus is needed with regard to reproductive violence and crimes in the name of "honour". This is evident in the current institutional framework which, despite progress, does **not sufficiently reflect action on these violences**.
- As for recent impulses, we refer to the State Pact on Gender Violence (renewed on 25/11/2021)[12] , to the National Strategy to Combat Gender Violence 2022-2025 (SSGV), and to several recent legislative changes such as Royal Decree-Law 6/2022, of 29 March, adopting urgent measures within the framework of the National Plan of

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[9] It refers to other international instruments with regard to other forms of violence, such as trafficking in human beings and sexual exploitation.
[10] See: Instrument of ratification of the Council of Europe Convention on preventing and combating violence against women and domestic violence, done at Istanbul on May 11, 2011; BOE No. 137, 06/06/2014 (access).
[11] All regulations concerning equality and violence against women are compiled by the Official State Gazette in the *Equality Code* (access) and the *Code on Gender and Domestic Violence* (access) respectively.
[12] For a summary of the Pact, see the official DGVG website (access).

response to the economic and social consequences of the war in Ukraine[13] ; Organic Law 10/2022 of 6 September on the comprehensive guarantee of sexual freedom; Organic Law 1/2023 of 28 February amending Organic Law 2/2010 of 3 March on sexual and reproductive health and the voluntary interruption of pregnancy; and other regulations that have amended Organic Law 1/2004 of 28 December on Comprehensive Protection Measures against Gender Violence[14] .

Together with the Instrument of ratification of the Istanbul Convention (2014), Spain has the ***Spanish State Pact on Gender Violence (SPGV) (***renewed in 2022) and the ***National Strategy to Combat Gender Violence (SSGV) 2022-2025***, approved by the Council of Ministers held on November 22, 2022. According to the Ministry of Equality, this strategy is an instrument for planning and organising all public policies actions aimed at preventing and combating all forms of violence against women.

The SSGV 2022-2025 alludes to these *other forms* of VAW and therefore favours the promotion of new actions. In this way, thanks to the Istanbul Convention and other European initiatives subsequent to it, together with the SSGV and the instruments of some Autonomous Communities (AACC), **we have sufficient tools to be able to intervene more effectively** on *all forms* of violence, including those less visible to society, **and from all levels of administration**. This does not imply that specific strategies should be developed.

[13] It includes a unified model of accreditation of the status of victim of human trafficking or sexual exploitation and the Hotline "016" for Information and Legal Advice on Gender Violence, among other measures.
[14] See the institutional context of policy changes and reforms detailed in the SSGV 2022-2025.

2.2. Research Objectives

The objectives of the research have an **exploratory and descriptive nature,** given the lack of knowledge that exists about the forms of violence that concern us. It is a study that also has a **propositional character,** since recommendations and proposals are made for local intervention.

The objectives that were set for this diagnosis are as follows:

- **To describe the current** situation in Spain regarding the forms of violence against women that threaten their capacity and right to reproduction, including crimes in the name of "honour"; fundamentally in relation to the needs, situations and potential users of the ATENPRO service, and their children.
- To improve the existing knowledge on **the intervention and needs of local entities** on these forms of violence from an integral perspective.
- To **make proposals** for the approach and intervention on these forms of violence by local services; and for a possible itinerary offered by ATENPRO members (Local Entities).
- Contribute to the definition, organisation, design and development of **the platform** that will organise the attention and protection of all forms of VAW promoted by FEMP.
- Identify **guidelines for the training and care provided** by ATENPRO professionals.

2.3. Methodology

2.3.1. Methodological approach

This is an **exploratory and descriptive** study that has employed a mixed methodological approach (quantitative and qualitative) in relation to the use of data collection and analysis techniques.

The methodological triangulation (Denzin, 2017) is due to the different nature of the available data and the different objectives of the study. Thus, in addition to the search and analysis of secondary sources, we have employed surveys and semi-structured interviews.

- **The survey** has been used as a consultation technique under a distributive perspective to identify the experiences and opinions of expert organisations and local entities.

In terms of **statistical analysis,** the public sources that measure or register information on VAW are very limited, and in the case of the typologies we are concerned with, they are practically non-existent. Despite this, some questions from the Macro-survey on Violence against Women (DGVG, 2019) have been exploited. Likewise, other institutional sources have been consulted (such as the statistics of the continuous census, the statistics on voluntary interruptions of pregnancy, the national fertility survey, the register of the General Directorate of Spaniards Abroad and Consular Affairs, among others).

- The qualitative perspective focused on the study of experience and content analysis. It has been carried out through **documentary analysis** and **semi-structured interviews** with experts and technical staff who is related to victims from different perspectives and services.

The research **was carried out in three phases** from March to August 2023.

Phase I: literature review and survey

The first phase starts in March 2023. It focused on locating and analysing specialised secondary sources and searching for experts and local entities with relevant experience. The latter involved a first mapping of practices and the development of the necessary sampling frame for the surveys and interviews.

The surveys were conducted on-line through from May 26 to June 13, 2023. The **fieldwork with the LAs** was carried out thanks to the collaboration of FEMP, which sent an invitation letter by email with the survey link through its database. It was distributed to 7,410 local entities. In addition, an English version was sent to the Council of European Municipalities and Regions (CEMR) for distribution to its partners. A total of 288 responses were received, of which 9 were from European local authorities (UK, France and Belgium). Regarding the survey **of organisations and experts,** it was distributed through a similar procedure, directly from RED2RED from a sample frame of 150 references. A total of 108 responses were obtained.

In total, the following **5 questionnaires were** implemented:

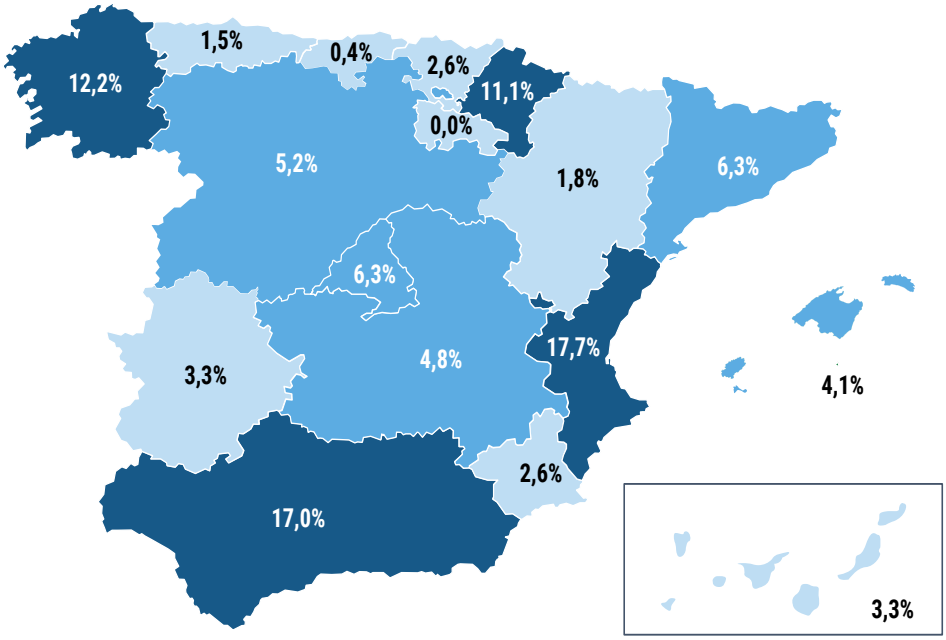
Table 1. Number of questionnaires carried out and responses obtained

Survey	Answers
To local authorities	**288**
• Spanish	279
• European	9
To Organisations and experts	**108**
• on Reproductive Violence	73
• on Surrogacy	17
• on Honour Crimes	18

Source: Own elaboration based on fieldwork

The distribution of the LEs in the **final sample by Autonomous Communities** can be seen graphically in the following Figure.

Figure 2. Distribution of the LEs participating in the survey (in Autonomous Communities) (% of total)



Red2Red (2023). Survey of local entities on other forms of violence against women.

The questionnaires were unevenly completed and not all questions were mandatory. Given the nature of the violence studied, almost all of the questions were open-ended and therefore it was a highly qualitative enquiry in its nature. At the same time, different services of the same local authority or NGO could answer the same questionnaire from different *expertise*. Therefore, the number of responses differs from the number of LEs (229) and organisations (49) participating in the surveys (see Annexes 1 and 2).

Phase II and III: experiences of interest (interviews) and relational analysis

The second phase of the research focused on the analysis of experiences of attention for victims of RV and CNH, mainly through semi-structured interviews. **A total of 17 interviews were conducted with 25 expert informants** (see Annex 3).

> Some interviews were individual and others had a triangulation character, so that several professionals took part. All of them had a prior informed consent and were audio/video recorded and transcribed. The average length was 2 hours and they were conducted between June and July 2023.

The main difficulties of the fieldwork have been related to the **lack of expert experience on the part of local entities and NGOs**. There are no public services specialised in these issues and there are few experiences from organised civil society as well as from the women's and feminist associative movement.

> In the case of RV, in general, local experiences are related to SV and GBV in the intimate partner/ex-partner environment and its reproductive consequences, but they lack the specificity of the Istanbul Convention. For this reason, we have relied more on the disability organisations - or women and disability - which do provide expert services and work in coordination with public services (in relation to RV). These are the organisations with the longest track record and *expertise* in RV. All women can benefit from it, whether they have a disability or not.

Seven practices of interest were identified, and **10 informants** participated in the analysis. Their profiles are described in Annex 3, and are as follows:

> (1) Support Service for Women and Girls with Disabilities Victims of Gender Violence of Cermi-Extremadura; (2) Psychosocial Rehabilitation Centre of San Fernando de Henares (CRPS); (3) Building Sexualities Project of the Los Realejos City Council - State Sexuality and Disability Association; (4) Alba Service of attention and accompaniment for deaf women of the CNSE; (5) Socio-legal support channel for women with cerebral paralysis victims of gender violence of the ASPACE Confederation; (6) The Madrid Plena Inclusión Women´s Observatory; (7) Specialised Assistance Units for women with disabilities who are victims of GBV of CODISA PREDIF Andalusia.

In the case of **surrogacy or surrogate pregnancy**, the profile of organisations and experts in the field in Spain focuses on denouncing and raising awareness of this practice, but not on

working with victims. For this reason, researchers who are in contact with victims abroad have interviewed.

> No formal organisations have been located in Spain or in the European Union that offer institutional support services for victims of GS, recognising them as such, as it is not recognised as a crime in many countries in our region and there is no major institutional development, in this respect. The work carried out has involved the study of secondary sources and of the care provided by experts to victims in other countries (see Annex 3).

Regarding violence conceptualised as **crimes in the name of so-called "honour"** (CNH), its approach in Spain is not addressed from this perspective. It is dealt with in a segmented manner, with respect to specific phenomena, and above all in relation to female genital mutilation (FGM) and forced marriages. This is due to the lack of specific regulations and institutional shortcomings regarding this violence.

> In parallel to this research, **FEMP was promoting another study that includes forced marriages and FGM**. Therefore, our research has focused on international experiences that work at the local level and have a solid trajectory in the attention of CNH victims. In addition to interviewing two Spanish experts, several practices were analysed (see chapter 12) from Germany, the UK, and Sweden.

Finally, in the absence of a more specific institutional framework on these *other forms of* violence, and given the lack of specificity of many of the experiences in Spain, it was decided to strengthen data collection from a **prospective approach**, which improved the quality of information and recommendations for action.

> For this reason, several interviews were carried out to assess the **potential for attention to other forms of violence in some consolidated services and institutional strategies** of VAW. In this way, the Government Delegation for Gender Violence (DGVG, Ministry of Equality), UNHCR Spain, the Spanish Red Cross, and Madrid City Council were consulted (see Annex 3).

The **last phase of the study** focused on the inter-relational analysis of the information and the elaboration of proposals, and recommendations for a local intervention model based on the data analysed and the information collected.

2.3.2. Working principles

The research has been carried out according to the following criteria:

- **Intersectional gender approach and feminist perspective,** as a critical and ethical theory. Recognising that people's experiences of gender differ according to their intersection with other variables of inequality, which imply multiple discriminations. Recognising the work and role of local women's organisations in promoting and developing equality policies.
- **Guarantee of rights and focus on the victim and her children**. Paying special attention to non-discrimination and situations of greater vulnerability: socio-economic, age, cultural, ethnic origin or racialisation, type of disability or administrative situation of foreigners.
- **Attention to the challenges indicated by GREVIO** in its recommendations and reports in relation to Spain on: evaluation (art.6 and 11), intersectionality (art.4.3), coordination (art.7), and effective enforcement of the due diligence obligation (art.5).
- **Specificity of the local equality policy,** taking into account LA's competences and the centrality of local realm in the life of the victims; as well as the differences that exist with respect to the territorial and political plurality in Spain, the size of habitat, and the rural character of some territorial entities.

II. DIAGNOSIS OF THE SITUATION

3. Violence against the capacity and right to reproduction

3.1. Characterisation and typologies

Almost two decades ago, the *Secretary-General's in-depth study on all forms of violence against women* (UN, 2006) concluded that **control over women's sexuality and reproductive capacity is one of the means by which male domination and the subordination of women are maintained** in our society and in all cultures.

> The UN established, in the first global study of its kind, that gender inequality between men and women transcends any individual action. Violence against women (VAW) implies that any exercise of violence, "by virtue of its punitive and controlling functions, also reinforces existing gender norms", so that any violence against women perpetuates such inequality (UN, 2006: paragraphs 72 and 73).

Violence against reproductive capacity and rights -or reproductive violence- (hereafter, RV) is a form of violence against women that refers to any form of **abuse, coercion, discrimination, exploitation or violence that threatens a person's reproductive autonomy** (UNFPA, 2021; 2022).

> In Spain, the SSGV 2022-2025 states that violence against women in the reproductive sphere "can be defined as any act based on gender-based discrimination that violates the integrity or self-determination of women in the area of sexual and reproductive health, their free decision on motherhood, its spacing and timing, including forced abortion and sterilisation" (DGVG, 2022: 50).

Reproductive autonomy refers to the capacity and exercise of contraception, pregnancy and the number of children one wants to have and when. It directly affects the capacity to enjoy a **satisfying and safe sex life**; this is an inseparable area of the **sexual and reproductive rights** (SRR) for all people and thus sexual and reproductive health (SRH).

3.2. Forms of RV

Based on the findings of our research, we consider that RV can be characterised around the following typology comprising **6 fundamental forms or typologies**[15] :

1. lack of attention to sexual and reproductive health;
2. obstacles or prohibition to contraception and to voluntary termination of pregnancy;
3. gynaecological and obstetric violence around childbirth;
4. harmful practices (e.g., child marriage, forced marriage; female genital mutilation; virginity inspection);
5. surrogacy or gestational surrogacy;
6. forced contraception, abortion and/or sterilisation for menstrual control and/or the prevention of the free exercise of motherhood.

This research focuses exclusively on the last two typologies. However, in order to understand the dimension and importance in which RV manifests itself, its main characteristics are - briefly – explained (there is an interrelationship between the different typologies of RV).

> **1-** The first form of RV refers to the **lack of attention to women's sexual and reproductive health.**

Such care should be provided by the public health system, **universally and free of charge**. It should be **provided to all people** regardless of their sexual identity and orientation, and should be provided throughout **life**.

It refers, fundamentally, to access to specialised public socio-health services, including those aimed at menstruation and syndromes related to menstruation; sexual and family planning information and counselling; care and prevention of sexually transmitted infections; and access to assisted reproduction treatments[16] .

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[15] Reproductive violence is an incipient area of research in the social studies, with a longer history in the field of health and by women's rights organisations. This means that, depending on the knowledge that is generated in the future, this typology may change and be expanded. For example, some of the experts consulted consider that some of the commercial practices that promote egg donation could be considered within this conceptualisation of RV.

[16] For an overview of the situation in Spain see the work of:State Family Planning Federation, et al. (2017). Deficiencies and inequity in sexual and reproductive health services in Spain. Online report (accessed); and the work of the Women for Health Association (AMS). 2017). Report " The gynecology services that women want (The gynaecology services that women want). Online document (access).

2- The second typology, although it can be considered part of the first, brings together several specific forms of particular relevance: on the one hand, **prohibition and/or obstacles to access contraception and voluntary termination of pregnancy** (VTP); and on the other hand, **forced pregnancy.**

Forced pregnancy is a human rights violation. The United Nations Population Fund (UNFPA) has repeatedly pointed out that all forms of modern contraception have a failure rate, that unintended pregnancies occur at all ages, and that health systems must ensure safe abortion. It is also a **manifestation of other forms of VAW**, such as harmful practices, sexual violence and intimate partner violence.

Forced pregnancy is especially worrying **when it happens to girls and adolescents** because it is usually an indicator of rape and sexual abuse. As the United Nations Children's Fund (UNICEF) points out, "in addition to the risks of pregnancy at an early age, there are the risks derived from the emotional impact of violence, blaming, silencing, lack of support when the abuse goes undetected. Pregnancy is thus a continuation of the abusive situation that gave rise to it. If it could not be told, or if it was silenced by the environment, the pregnancy will also be surrounded by concealment and stigma" (UNICEF 2018:17).

In our country, the difficulty of **access to contraception and abortion** has various causes[17] . There is a high variability in the guarantee of these rights in the territories covered by the Autonomous Communities[18] . The Spanish Society of Contraception (SEC, 2019), in one of its reports prior to the change in our current legislation, pointed out that the main causes are: difficulties of accessibility, financing and training of both professionals and users.

The current legislation that regulates these rights, *Organic Law 1/2023, of February 28, which modifies Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary termination of pregnancy* (together with *Organic Law 11/2015, of September 21, to strengthen the protection of minors and women with judicially modified capacity in the voluntary termination of pregnancy*), is too recent in its application and there is no data yet regarding its impact.

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[17] For data on the current situation see: L'Associació de Drets Sexuals i Reproductius (2020).Access to abortion in Spain: main barriers (access); L'Observatori de Drets Sexuals i Reproductius (2022) Violència institucional en el marc de Drets Sexuals I Reproductius. Eina de diagnosi de compliment de la diligència deguda (access); Spanish Contraception Society (SEC) (2019). Contraception Status Report, SSyRR, e IVE in Spain. Online document (access).

[18]The territorial organisation of Spain consists of three levels: the State or central organisation, the Autonomous Communities and the Local Entities. The territory is organised into 17 Autonomous Communities and the Autonomous Cities of Ceuta and Melilla. For information on how they work, see the Ministry of Territorial Policy (access).

Preamble II of the law highlights the **need to improve the protection and guarantee of rights related to sexual and reproductive health** in a comprehensive manner. With regard to abortion, it points out that the majority of abortions take place in private out-of-hospital centres (78.04% in 2020), which means that "we are a long way from being able to guarantee" this intervention in public centres.

With regard to impediments to **abortion**, it is important to note that the regulations regarding the time limits for free abortion (within the first 14 weeks of gestation) have been declared constitutional in Spain. The ruling of the Plenary of the Constitutional Court of May 9, 2023[19] reflects this and it has indicated "the obligation of public administrations to ensure the provision of voluntary interruption of pregnancy" as part of "that positive duty to ensure the effectiveness of fundamental rights". Furthermore, it highlights the importance of incorporating a gender perspective in health, educational and social policies for sexual and reproductive health.

3 - The third typology of RV is **gynaecological-obstetric violence or violence against women in childbirth care** [20] , which includes all inappropriate or unnecessary gynaecological or obstetric interventions on women in relation to childbirth (caesarean sections, episiotomies or unjustified instrumental deliveries).

In general, it tends to be defined as VAW "consisting of an action or omission that violates the health, reproductive and sexual rights of women, and covers the periods of gestation, childbirth, puerperium and reproductive cycles" (Guerrero-Sotelo, et al., 2019: 27). From a critical feminist perspective, it is considered an "appropriation of women's bodies and reproductive processes by health staff, which is expressed in a dehumanising treatment, in an abuse of medicalisation and a pathologisation of natural processes (...)" (Bellón-Sánchez, 2015:93).

In 2014, the World Health Organisation (WHO) already warned about its **global relevance**: "a growing body of research on women's experiences of pregnancy and, in particular, childbirth, paints an alarming picture". Furthermore, the WHO indicated that "adolescent women, unmarried women, women of low socio-economic status, women belonging to an ethnic

[19] See the ruling of the Plenary of the Constitutional Court: Sentence 44/2023, of May 9, 2023. Unconstitutionality appeal 4523-2010 (ECLI:ES:TC:2023:44), BOE No. 139, 12 June 2023, section of the Constitutional Court (access).
[20] This is the term used by the UN Committee on the Elimination of Discrimination against Women (CEDAW) in relation to these practices. The UN Special Rapporteur on violence against women, its causes and consequences (2019) notes that the term is not yet explicitly recognised in international human rights law, and therefore also uses "violence against women during childbirth".

minority, migrant women, women living with HIV, among others, are more likely to experience disrespectful and offensive treatment" (WHO, 2014: 1). This implies taking into account that there are women whose circumstances make them more vulnerable to such practices.

Likewise, the UN Special Rapporteur on violence against women, its causes and consequences, in its Report *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence* (2019), states that "this form of violence has been shown to be a widespread and systematic phenomenon".

In Spain, the **National Strategy against Gender Violence** (SSGV) 2022-205 mentions this practice and points out that there are no official statistics that allow us to analyse the real extent of this type of violence in our country. Spain has been reproved by the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) on three occasions for this type of VAW.

> The absence of national data, and the need to improve it, has been brought to the attention by the Committee (CEDAW/C/75/D/138/2018), which has urged to carry out studies and implement corrective measures (CEDAW/C/84/D/154/2020, Committee Opinion of March 7, 2023).

Throughout the national territory, different women's associations related to the field of women's health have denounced these RV practices (such as *El Parto es Nuestro* association and the *Obstetric Violence Observatory*). It should be noted that Law 17/2020, of December 22, amending Law 5/2008, on the right of women to eradicate gender-based violence in the Autonomous Community of Catalonia[21] was the first European law to recognise the existence of obstetric violence as gender-based violence. Since 2007, many countries in Latin America have legislated on obstetric violence in their VAW legislation (see Bellón Sánchez, 2015).

> 4- The fourth form of RV is related to **harmful practices** that have a particular impact on the sexual and reproductive health of girls, adolescents and women.

These practices include child marriage, forced marriage, female genital mutilation (FGM), breast ironing, and virginity testing. Many are considered as sexual violence and they are often

categorised as such[22] . They are also **deeply linked to crimes in the name of "honour" (**see chapter 11).

All countries have the obligation to **eliminate, prevent and protect** women from these practices. This is explicitly mentioned in various international human rights treaties, as well as in the Istanbul Convention, ratified by Spain in 2014. Along these lines, the United Nations High Commissioner for Human Rights (UNHCR) has reiterated the importance of "developing and endorsing comprehensive awareness programs to challenge and change cultural and social attitudes, traditions and customs that are the underlying cause of forms of conduct that perpetuate harmful practices" (UNHCR, sf).

In relation to **virginity testing**, the WHO has established that it is a form of gender discrimination and is an **unscientific, ineffective and humiliating practice** that constitutes a violation of women's human rights. Given its prevalence in Spain and its relationship with CNH, it was considered of interest to delve deeper into its characteristics.

Inspection of the vagina for the hymen[23] is based on the belief that the appearance of the female genitalia can reveal whether sexual (vaginal) intercourse has taken place. It is carried out by key individuals in the community or through health professionals who have been assigned "expert" knowledge in the field.

> Such tests, which **lack scientific validity**, can cause pain, induce painful and unnecessary surgeries[24] , and have harmful social consequences for girls and women in

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[22] Law 5/2008, of 24 April, on the right of women to eradicate male violence. published in: DOGC, no. 5123, of 08/05/2008, and BOE, no. 131, of 30/05/2008 (access). Art4. d) Obstetric violence and violation of sexual and reproductive rights: this consists of preventing or hindering access to truthful information, necessary for autonomous and informed decision-making. It can affect different areas of physical and mental health, including sexual and reproductive health, and can prevent or hinder women from making decisions about their sexual practices and preferences, and about their reproduction and the conditions in which it is carried out, in accordance with the assumptions included in the applicable sectoral legislation. It includes forced sterilisation, forced pregnancy, the impediment of abortion in the legally established cases and the difficulty in accessing contraceptive methods, methods for the prevention of sexually transmitted infections and HIV, and assisted reproduction methods, as well as gynaecological and obstetric practices that do not respect women's decisions, bodies, health and emotional processes.

[22] In the National Strategy for Sexual and Reproductive Health it is in fact stated thus: "Sexual violence encompasses coerced sex of any kind, including the use of physical force, attempts to obtain coerced sex, assault by means of sexual organs, sexual harassment including sexual humiliation, forced marriage or cohabitation including child marriage, forced prostitution and the commercialisation and trafficking of girls and women, forced abortions and forced pregnancies, denial of the right to use contraception or to take measures to protect against infection, and acts of violence affecting the sexual integrity of women such as female genital mutilation and virginity inspections. These aggressions are deeply rooted in gender inequalities and power relations, and are one of the most heartbreaking manifestations of it" (Ministry of Health, Social Policy and Equality, 2011:53).

case of a negative interpretation (not "being a virgin"). They are therefore **linked to violence or crimes in the name of "honour"**.

In 2018, **the United Nations made a global call**[25] **for all governments to prohibit this practice and to work with the communities where it is carried out to eradicate it**. In Spain, this prohibition has yet to be implemented; it is not included in the ENSSR, the SSGV, nor in current legislation.

> According to the ***Declaration to Eliminate Virginity Testing*** (WHO, UN Women, OHCHR, 2018:7), "*virginity* is not a medical or scientific term, but a social, cultural and religious concept that reflects gender discrimination against women and girls; (...) it is based on the stereotype that female sexuality should be reduced to marriage. This notion is harmful to women and girls globally"; and therefore "governments, health professionals and communities must act to eliminate this practice".
>
> It has also highlighted that, for many women, "it has negative short- and long-term physical, psychological and social consequences, such as anxiety, depression and post-traumatic stress disorder. In extreme cases, women or girls may attempt suicide or be killed in the name of *honour*" (WHO, UN Women, OHCHR, 2018:5).

5- The fifth type of RV is surrogacy **or gestational surrogacy** (SG).

This form of reproductive violence refers to the **set of procedures by** which a woman ends up carrying one or more embryos (has a pregnancy), resulting from the fertilisation of her own egg or the transfer of embryos, and gives birth to one or more children for a firm, for another person or for a couple.

In GS, such procedures **go beyond pregnancy and childbirth**. They involves the commercial practices of client recruitment, the location of the gestational mother (*altruistic* or commercial), the agreements or contracts between the parties, the medical and logistical procedures necessary prior to achieving conception and to hormonally prepare the gestational mother, and also throughout the pregnancy or pregnancies (including spontaneous abortions and forced

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[23] The hymen is an elastic membrane that some women have, not all of them are born with it, and if they have it, it can be broken accidentally or when practising certain sports. It has nothing to do with "virginity" or the absence of sexual intercourse, which, in fact, goes beyond vaginal penetration.

[24] Surgical interventions under the name of "hymen reconstruction" (hymenoplasty), recreate a membrane to partially cover the vagina and try to ensure that bleeding will occur at future virginity tests or at the first vaginal penetrative intercourse in marriage.

[25] This is a multi-agency appeal: World Health Organization, UN Human Rights Office, UN Women, "Eliminating virginity testing - An interagency statement" (access); (access the press release in English).

abortions), during childbirth and postpartum, as well as the transfer and registration of the children born, and the management of the situation of abandonment or care of those children who are rejected by the purchasing party. **In Spain it is an illegal practice**. It is one of the forms that this research explores (see chapters 8, 9 and 10).

> -6- The sixth typology of VR involves the control of menstruation and the prevention of the free exercise of motherhood through **forced sterilisation, forced abortion and/or forced contraception** (FASC).

It is a form of VAW that is suffered to a **greater extent by women with disabilities and women with mental illness,** although not exclusively.

Coercive contraception and sterilisation are practices strongly associated with **stereotypes about motherhood and sexuality** that are conceived under ableism and racist notions and thus affect many more women. Forced abortion can occur under the same premises, but it can also be an indicator of a more complex phenomenon: gender-biased sex selection; which is seen as a form of discrimination against women and a manifestation of violence against mothers and girls.

FASC can also be an **indicator of the presence of other forms of VAW,** mainly sexual violence and intimate partner/ex-partner violence.

Although **this study focuses on the last two typologies,** it is important to highlight that all of them are framed in the violation of sexual **and reproductive rights**[26] (SRR).

3.3. Sexual and reproductive rights

SRHR are part of the holistic notion of human health and are therefore included in the Sustainable Development Goals (SDGs) of the United Nations **2030 Agenda** (2015). Their protection and promotion is the responsibility of all institutions.

> UNFPA defines **good sexual and reproductive health** as a state of general physical, mental and social well-being in all matters relating to the reproductive system. It includes the capacity to have a satisfying and safe sex life and to have children, and the freedom to decide whether, when and how often to have sex.

[26] For more information on SRHR see the work of UNFPA (accessed). A compilation infographic on SRHR is available on their website (accessed).

SRHR are protected as **fundamental human rights** in the international agreements of the *Global Programme of Action*[27] of the International Conference on Population and Development held in Cairo in 1994 (ICPD)[28] , whose commitments were renewed at the Nairobi Summit in 2019 (ICPD+25), and in the *Beijing Declaration and Platform for Action* adopted at the 1995 World Conference on Women, renewed at its successive UN follow-up international summits.

SRHR is frequently explained through the ***Charter on sexual and reproductive rights***, such as that promoted by the International Planned Parenthood Federation (IPPF), which contains the following 10 articles (FPFE, 2010)[29] :

1. Right to equality
2. Right to sexual autonomy
3. Right to liberty and bodily integrity
4. The right to decide on reproductive choices
5. Right to information
6. Right to sexual education
7. Right to sexual and reproductive health care and protection
8. Right to privacy and confidentiality
9. Right to choose between different ways of living together
10. Right to participation and freedom of opinion

The **violations of rights committed** against women **in this area** were highlighted almost two decades ago in the final report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (OHCHR, 2006)[30] (in line with the statements of the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination against Women (CEDAW) (see chapter 6).

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[27] The ICPD "called for ensuring that all people have access to comprehensive reproductive health care, including voluntary family planning, safe pregnancy and delivery services, and the prevention and treatment of sexually transmitted infections. It also recognized that reproductive health and women's empowerment are interdependent, and both are necessary for social progress. The Programme of Action affirmed that: "The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on the basis of sex, are priority objectives of the international community" (United Nations, n.d.).
ICPD: access to the text of the conference.

[28] Two special sessions of the United Nations General Assembly were held in 1999 and 2014 to assess the implementation of the 1994 ICPD and take measures to strengthen it.

[29] Sexual rights, specifically, have also been taken up more concretely in an expanded charter; see International Planned Parenthood Federation (IPPF), 2010.

[30] See United Nations General Assembly, Note by the Secretary-General (2006) The right of everyone to the enjoyment of the highest attainable standard of physical and mental health of 13 September 2006 A/61/338 (accessed).

In this sense, the OHCHR recalls that women's sexual and reproductive health "is related to multiple human rights, such as the right to life, the right not to be tortured, the right to health, the right to privacy, the right to education and the prohibition of discrimination. This means that states have an obligation to respect, protect and fulfil rights related to women's sexual and reproductive health" (2023).

Violations of women's reproductive self-determination constitute **very serious crimes under** international humanitarian law. In this sense, the Rome Statute of the International Criminal Court[31] (1998; in force since 2002) defines rape, sexual slavery, forced prostitution, forced pregnancy, forced sterilisation and other forms of sexual violence as crimes against humanity and war crimes for the first time in this framework. The Rome Statute determines that these crimes are on a par with the most heinous international crimes, constituting in many cases torture and genocide.

3.4. Linking RV to other forms of violence

Reproductive violence **has its own specificity**; however, it is often an **indicator of other VAW**, especially the presence of harmful practices, sexual violence and intimate partner violence.

Harmful practices refer primarily, as explained in the previous section, to child marriage, forced marriage, FGM and virginity testing. Most of these practices tend to be conceptualised as "sexual violence". A number of them will be referred to in more detail in Chapter 11.

In order to be perpetrated, **sexual violence** often requires the specific exercise of reproductive violence, given that pregnancies can be an indicator of rape and can hinder the continued exercise of abuse over girls, adolescents and women victims. Thus, victims of sexual exploitation in any of its forms are victims of RV as a consequence of the above. This refers to the situation of women in prostitution, in the pornography industry and other commercial by-products, and especially those women in situations of trafficking, both for sexual exploitation and labour exploitation[32] .

Within **gender-based intimate partner/ex-partner violence**, reproduction is another dimension of abuse along with physical, psychological, sexual and economic abuse. In

[31] Instrument of Ratification of the Rome Statute of the International Criminal Court, done at Rome on July 17, 1998. BOE no. 126, of May 17, 2002 (access).
[32] See in this regard the study promoted by FEMP(2023) on sexual violence.

reproduction, therefore, there is also control by the abuser. This is done both by forcing the use of contraception, abortion or sterilisation to prevent future pregnancies and, on the contrary, by preventing the victim from accessing or using family planning methods, causing forced pregnancies. Although intimate partner/ex-partner violence has been the most studied form of VAW, the reproductive dimension has been little explored, so there is little data available.

Sexual, physical and psychological violence by a man who is - or has been - a woman's partner can have **serious reproductive consequences**: it can cause miscarriages because of fear and stress or because of the aggressions themselves; it can cause damage to the woman and the foetus; and it can produce pregnancies resulting from rape.

There are few possibilities for exploitation of the **Macro-survey on Violence against Women** 2019 (DGVG); however, a statistical exploitation has been carried out exploring some of the consequences of the violence suffered, specifically, miscarriage which can be seen as a consequence analogous to forced abortion. The results obtained are explained below[33] .

In the **2019 Macro-survey, miscarriage** appears as a possible consequence of sexual violence by women's current or former partners, as well as by people other than partners (e.g., male family members).

According to the 2019 data, miscarriages due to current partners are practically non-existent among the women responding to the survey (4 cases). This does not mean that this type of violence does not exist, but that it is very likely that, if it does happen, the current partner has become a partner from the past and is therefore not counted in this category. This is supported by the finding that miscarriages are somewhat more frequent (n=53) when asked if they were caused by past partners.

Due to the number of cases, no significant differences can be seen according to age or country of birth. However, the proportion of cases among nationalities

[33] For people other than current or former partner, male perpetrators of sexual violence were filtered by behaviours that may result in an unwanted pregnancy. Thus, considering other types of non-partner sexual violence, the responses to question M3P2 and the items were analysed:
- Has forced you to have sexual intercourse by threatening you, holding you down or hurting you in any way.
By sexual intercourse we mean vaginal or anal penetration with a penis or objects, or oral sex.
-Has forced you to have sex when you were unable to refuse because you were under the influence of alcohol or drugs.
- You have had unwanted sex because you were afraid of what the person might do to you if you refused.
-Has forced you to have sex when you did not want to.
- Has forced to you to perform some other sexual practices that I have not already mentioned.

other than Spanish appears to be higher, as do cases among those currently aged 30-49. These conjectures should be taken as mere hypotheses to be explored in future surveys.

The vast majority of the cases found are not recent, with 79% (41 cases out of 52) occurring more than 4 years ago. This seems to reinforce the idea that women who have suffered a miscarriage due to intimate partner violence are no longer in a relationship with the aggressor.

Regarding access to health services in cases of miscarriages, we found the following situation:

- 19 of the respondents (35.85% of the total) had to stay in hospital,
- the same number (35.85% of the total) received medical care from medical services, such as medical consultations or nursing, but did not require hospitalisation.
- 7 people (13.21% of the total) say they have not needed health care,
- 6 people (11.32% of the total) felt that they should have received it, but did not.

The data on miscarriages caused by other people outside the couple also show limited cases. Specifically, 10 cases were recorded, which precludes a more detailed analysis by age or country of birth.

Based on the data collected, the total number of reported miscarriages is 67. Of these, 4 of the cases (approximately 5.97%) are miscarriages related to past partners. 53 of the cases (approximately 79.10%) are linked to the current partner, while the remaining 10 cases are from outside the couple.

In total, 222 women out of the 9568 women asked about sexual violence stated that they had suffered one of the assaults that could lead to an unwanted pregnancy. This constitutes 2.3%. Again, there are no significant differences by age or country of birth. The sample is small.

When asked whether these sexual incidents occurred before or after the woman's 15th birthday, 35% (78 cases out of 222) reported that they occurred before and 18% (40 cases out of 222) reported that they occurred both before and after the woman's 15th birthday. In total, 53.1% (118 cases out of 222) of

the women who experienced any of these sexual violences stated that they happened before the age of 15.

It would be interesting if **future editions of the Macro-survey could include questions on RV** and the relationship between sexual and intimate partner violence, and the sexual and reproductive health of victims.

In general, according to the latest available report of the **Macro-survey on Violence against Women** (2019), the picture on the use of health care is perturbing. 80.6% of women who have suffered physical or sexual violence by a current partner and 60.3% of those who have suffered such violence by a past partner state that they **did not seek health services**, which contributes to the lack of registration. However, "this should not be interpreted as a lack of severity in the violence suffered and its consequences, since most forced sexual relations do not produce physical injuries" (DGVG, 2019).

4. FASC: Forced abortion, forced sterilisation, forced contraception

4.1. Starting perspective

Non-voluntary, coercive or forced abortion, sterilisation and contraception (FASC) are forms of violence that represent a **violation of** women's **SRHR** and a **practice of subjugation and annulment of will that transcends the right to maternity.**

The Report of the UN Special Rapporteur on violence against women, its causes and consequences, *Human rights-based approach to abuse and violence against women in reproductive health services, with a focus on childbirth care and obstetric violence* (OHCHR, 2019) notes that forced sterilisation and forced abortion are medical treatments that are **practised worldwide without informed consent**.

> The Rapporteur's Report indicates that they are **practised by health professionals for a variety of reasons**, for example, in the **so-called best interests** of women or based on the belief that certain women belonging to minority groups, such as Gypsy/Roma women, indigenous women, women with disabilities or women living with HIV, are not " are not "worthy" of procreation, are unable to make responsible decisions about contraception, are not fit to be "good mothers" or are not advisable to have offspring (OHCHR, 2019).

Coercive contraceptive use occurs for the same reasons and has similar consequences (Mertus and Heller, 1992; Sparrow, 2011; Benson, 2014). While access to family planning methods must be guaranteed by public health policies, their use as a tool to control women's bodies must also be prevented. Therefore, one cannot ignore the historical context of coercive practices related to contraception, especially those targeting disadvantaged groups.

"These practices fall along a spectrum, ranging from extreme, overt and intentional instances of involuntary sterilization to more subtle attempts to influence women's contraceptive

decision making by providing financial incentives or taking other steps to unduly encourage choice of a specific method (...) (Benson, 2014)[34] .

These *medical interventions* have been analysed by the CEDAW and regional international human rights courts and have been established as **forms of gender-based violence against women** that can cause physical and psychological harm and may even constitute torture or cruel, inhuman or degrading treatment.

Research on the subject indicates that **FASC occurs worldwide**, including in North America (Stern, 2005; Murray, et al., 2019; Kluchin, 2017; Volscho, 2010) and in the European Union (Patel, 2017; Stejskalová and Szilvasi, 206; Albert and Szilvasi, 2017). In Western countries, although they are no longer part of mass public programmes, forced sterilisation is **still carried out on vulnerable women** (mostly women with disabilities), mainly through coercion and lack of information, and therefore without consent.

> FASC can occur through **lack of information or informed consent** or through the use of **threats or coercion, psychological violence or** physical **aggression.**
>
> **There is hardly any data on the situation in Spain on the FASC**, given that it has not yet been consolidated as an object of research. In fact, it is a subject that has not received the social recognition it deserves and is not sufficiently visible. In this sense, it is interesting to note the existence of international research projects[35] that allow us to consider future lines of research. However, in recent years there has been some very interesting research on the violation of the SRHR of **women with disabilities, the results of which allow us to draw lessons for all girls and women**.

Perpetrators of FASC are often the male partners of the victims and therefore it is associated with gender-based intimate partner violence. However, in other cases, such as with women with disabilities, **it is also perpetrated by family members and care institutions**. Furthermore, the execution of such practices (especially in the case of sterilisations) requires the direct participation of medical services and therefore they **involve health professionals**. In the case of women with other vulnerabilities, perpetrators may be broader figures.

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[34] The author refers mainly to the United States of America (USA), and especially to the phenomenon of the subdermal implant contraceptive Northplant and other similar brands, although it had a global impact because it occurred in multiple countries.

[35] The *Sterilization and Social Justice Lab* in the USA is a case in point. It has recovered the history of eugenic sterilisation and denounces its consequences and current practices.

4.2. Forced abortion

4.2.1. Approach to the problem

Forced abortion is the unwanted termination of a pregnancy through the use of specific drugs or a medical procedure, depending on the week of gestation. In other words, abortion can be pharmacological or surgical.

> In Organic Law 2/2010 of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy, forced abortion is defined as a "Form of violence against women in the reproductive sphere that consists of performing an abortion on a woman without her prior and informed consent, with the exception of the cases referred to in article 9.2.b) of Law 41/2002 of November 14".

Any woman who is a victim of intimate partner/ex-partner violence may be subject to coercive abortion, as well as women in prostitution and trafficking - both for sexual exploitation and labour, and victims of sexual violence in general. Women in vulnerable situations, such as women with disabilities, mental illness, in prison, HIV-positive women and pregnant adolescents, may also be subject to coerced abortion.

> The case of women who are victims of intimate partner/ex-partner GBV has been considered in point 3.4., although miscarriage (as a consequence of an assault or the violence itself) is not the same phenomenon as forced abortion.

In addition, women from cultural backgrounds where male preference persists and **sex selection practices** prevail through **selective abortion** are at risk. Special attention will be paid to this issue given the invisibility of this problem in Spain.

Regardless of the cause that coercively terminates a pregnancy, it is important to consider that forced abortions **can occur in both safe and unsafe health care settings**.

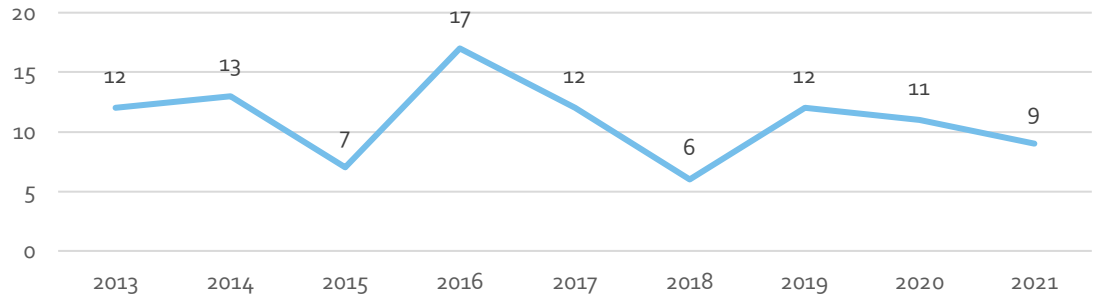
> **Unsafe abortion** occurs when a pregnancy is terminated by people who lack the necessary skills, or in an environment that does not meet minimum medical standards, or both (WHO, 2021).
>
> According to the WHO data, "between 4.7 per cent and 13.2 per cent of maternal deaths are due to unsafe abortion each year. In developed regions, an estimated 30 deaths occur for every 100,000 unsafe abortions" (2021). According to 2012 data projections, 7 million women in developing countries are treated in hospital for complications caused

by unsafe abortion (WHO, 2021). The extent of forced abortion data compared to voluntary terminations in unsafe settings is unknown.

Available data on the prevalence of the problem are very insufficient. **Statistics on termination of pregnancy** are based on the voluntary nature of the act (abortion) and judicial statistics are not very specific. Other surveys on fertility, health and violence do not include RV.

Data on the **crime of forced abortion** from the Ministry of Justice (Central Register of Convicted) are not disaggregated by sex; it shows a scarce record of the phenomenon (see graph below).

Graph 1. Statistics on convicted abortion offenders 2013-2021. Units: infractions



Own elaboration. Source: INE's use of the Central Register of Convicted (Ministry of Justice).

In general, **the number of convictions** for abortion is insignificant and it is not possible to go deeper into the issue. In 2021, there was only 1 prison sentence (see table below).

Table 2. Abortion (offence): prison sentences by length of sentence (2012-2021). Units: Penalties

	2021	2020	2019	2018	2017	2016	2015	2014	2013
From 0 to 2 years	1	4	1	3	7	3	0	4	4
Over 2 to 5 years	0	0	3	0	1	0	0	0	0
More than 5 years	0	2	1	1	1	2	3	1	2

Source: INE, 2023 (from the Central Register of Convicted of the Ministry of Justice).

The reasons for voluntary abortion are diverse, in some cases very complex. In Spain, they are framed within the right to the free termination of pregnancy in a system of weeks-time limits.

It is impossible to know whether they are caused by RV (biased sex selection, or any other type or coercion); in any case, **the prohibition of abortion is considered ineffective and counterproductive.**

The National Health System anticipates an information procedure for pregnant women to make informed decisions, but **there is no specific protocol for the detection and identification of reproductive violence** (the protocol for gender violence - in the partner/ex-partner sphere - is applied according to the level of awareness and training of each health staff).

The data on abortion in Spain are monitored by the General Directorate of Public Health of the Ministry of Health. It is carried out through an epidemiological surveillance system whereby each abortion performed is recorded by the medical staff responsible for notifying the health authority of the Autonomous Community, where the intervention is carried out, who in turn enter the data in the corresponding application[36] . The information referring to the pregnant woman and the centre where the abortion is performed is considered confidential and its statistical use is very limited. In Spain, abortion is mainly carried out **in private facilities**.

The identified reasons for the abortion remain constant over time (2012-2021); they are (for the latest year available, 2021) as follows: at the request of the woman 90.98%; serious risk to the life or health of the pregnant woman 5.58%; risk of serious foetal anomalies 3.12%; *foetal anomalies incompatible with life* or extremely serious and incurable disease 0.29%; and various reasons 0.03%.

Abortion occurs all throughout a woman's fertile life, although the greatest number of abortions are registered between **the ages of 20 and 34** (62.8 per cent according to the Ministry of Health (2021).

In 2021, 67.15% of the abortions were performed on women with **Spanish nationality**. 74.15% had a European nationality (including Spanish). Data indicate that 5.03% of resident women were from Africa, 18.4% from Central America, the Caribbean or South America, and 2% from an Asian country.

[36] See the procedure in detail in the methodology of the Ministry of Health's statistical data on promotion and prevention (access).

According to data from the yearbook of the Ministry of Health (2021), **72.4% of abortions were performed at 8 weeks' gestation or less** and in private out-of-hospital health centres (almost 8 out of 10). These abortions **can hardly be related to** a sex-selective practice, since it is not feasible to know the sex of the foetus. More than 89% of the reported pharmacological abortions in 2020 were performed during the first 8 weeks of gestation; of these, 70.62% were performed in out-of-hospital health centres (Directorate General of Public Health, 2022).

In general, **multiple screening tests** (blood tests of the pregnant woman combined with ultrasound), which make it possible to determine the sex of the foetus, are performed from the tenth week of gestation onwards. They are -therefore- usually made **at the end of the first trimester of pregnancy and the beginning of the second trimester**. Thus, in order to proceed to a selective abortion, it would be more appropriate - in any case - to speak of possible abortions produced between nine and fourteen weeks of gestation (or more). In Spain, these represent 22.4% of the abortions performed (year 2021). 5.1% of abortions are performed at 15 weeks and more.

There is no relationship between the method of termination of pregnancy and selective or forced abortion. In Spain as a whole, 62.3% of abortions were surgical; 36.9% were pharmacological; and for the rest (0.8%) no information is collected or another method was used (D.G. de Salud Pública, 2022).

4.2.2. Selective abortion as a practice of sex selection

Harmful cultural practices that impose a preference for the birth of boys over girls promote **coercive abortions** when prenatal sex analysis (by ultrasound or other prenatal screening tests) detects a "female" foetus (XX chromosomes in the 23rd pair).

> While in the context of the present research it is considered a practice strongly linked to forced abortion, sex selection may take place before pregnancy (with sperm sorting for in vitro fertilisation), or after birth (i.e., infanticide or child neglection). The latter is evidenced by excess mortality among baby-girls and little girls and/or persistent abandonment of baby girls.

The European Parliament, in its *Resolution of 8 October 2013 on Gendercide* (2016) considers this practice as a **crime and human rights violation** that contributes to violence against women and can be framed as such under the Istanbul Convention.

4.2.2.1. Description of the phenomenon

UNFPA (2020) estimates that about 140 million women are "missing" worldwide, as a result of son preference. Births to women that do not occur sum almost **1.2 million per year** worldwide.

> According to World Bank data (Anukriti et al., 2021) the annual number of sex-selective abortions increased from almost zero in the late 1970s to 1.6 million per year between 2005 and 2010 worldwide (in Bongaarts and Guilmoto, 2015). Although India and China account for the majority of sex-selective abortions, sex-selective birth ratios have been documented in a wide range of countries, including Asian populations in the United States, Canada, the United Kingdom, Greece **and Spain**.

Data on the **masculinity index at birth** allow for a quantitative approximation of the problem[37].

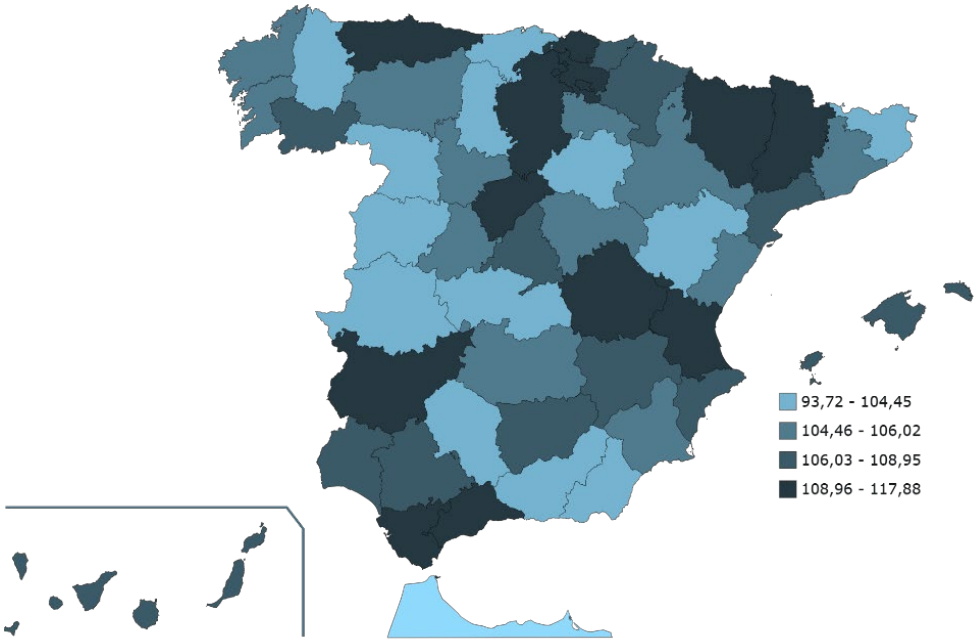
As a population constant, there is an approximate proportion of babies born/assigned "boys": between 102 and 106 babies for every 100 babies born/assigned "girls". Therefore, when there is a marked asymmetry, it is considered a sign that sex selection may be taking place. Some of the countries with such imbalances are (UNFPA, 2020; for 2017 data):

- China 114.3
- India 109.8
- Nepal 107.3
- Republic of Korea 105.6
- Singapore 106.5
- Vietnam 112.2
- Armenia 111.7
- Azerbaijan 113.4
- Georgia 106,5
- Albania 108.3
- Montenegro 107.2

In Spain, there are no data on this issue. Potentially, given the persistence of this harmful practice in some countries, it **could be affecting women from some diaspora communities or descendent from some communities** who hold such values, (as is the case in other countries in Europe and North America) (UNFPA, 2020).

[37] Early death of girls in early childhood is also an indicator used.

Figure 3.Male birth ratio by province (year 2021). Units: number of males for every 100 females (%).



Source: National Institute of Statistics, 2023

In our country, **the male ratio at birth** (see Figure above) shows, for the year 2021, a percentage of 106.7 boys born/assigned for every 100 girls (INE, 2023). In other words, a number within the population regularity. However, **some provinces are very asymmetrical**.

The provinces that exceed this reference are the following ten:

- Ceuta 117.88
- Cuenca 114,52
- Badajoz 110.88
- Valencia/València 110,42
- Burgos 110.02
- Cadiz 109.95
- Segovia 109.31
- Malaga 109.29
- Araba/Álava 109,28
- Lleida 109,24
- Asturias 109.23
- Huesca 109.18
- Bizkaia 109.06
- Huelva 108.95
- Balears, Illes 108,50
- Santa Cruz de Tenerife 108.36
- Albacete 108.05
- Seville 107.49
- Madrid 107.41
- Alicante/Alacant 107.05

In an analysis of our country compared with Italy, researchers from the University of Modena - Braglia and Nicolini (2018) - looked at the evolution of the masculinity index at birth and its possible relationship with selective infanticide.

In the **absence of a convincing explanation for the increase observed in recent** years, both authors consider that recent progress in foetal sex determination **may be related to selective abortions of female foetuses,** but they also advance other explanatory hypotheses:

- The sex of the baby could be selected at the moment of conception, for example, by means of sex selection in in vitro fertilisation. However, these methods are not legal in Spain for non-medical reasons.
- There has been a selective voluntary abortion, once it has been possible to determine the sex of the baby.
- If mothers who are pregnant with girls take less care of themselves, girls may suffer more frequent late foetal deaths.
- Despite similar numbers of boys and girls being born, girls would have a higher probability of not being officially registered, or even registered as boys.
- Migrant families pregnant with girls would be more likely to leave Spain before giving birth, for example, by returning to their country of origin.

Whatever the way in which the expected balance is manipulated, what is clear is that prenatal sex selection **is a manifestation of the low status of women and girls in society**.

In Spain, some diasporas from Asia (mainly, but not only, from India), and within these some ethno-religious groups, carry out this practice:

> "(...) they follow up pregnancies from very early on (...), in many cases they undergo selective abortions, but not only when the baby is a girl, but also when the family already has two [male] children (...) there is an ideal model that was promoted by the Indian government during the 1970s or so, which is the model of the perfect family: father, mother, a son and a daughter. So that was very popular, (...) there was a lot of pressure for that to be the ideal family model, (...) Of course, how do you achieve that, yes, sometimes it can be natural, but sometimes it is through selective abortion processes. Of course, in some cases they are pressured by their husbands, but in other

cases the social pressure they feel is so great that sometimes the husbands don't even find out about the pregnancy" (interview with expert).

4.2.2.2. Causes and consequences

Sex-selective abortion is a form of RV that occurs in contexts where the gender social structure assigns the male population a **social position of greater value to the detriment of girls**, who are considered a burden or even a liability. As the *State of World Population 2020 report* notes, she may be seen as a burden, an obstacle that blights the future of the family (UNFPA, 2020)[38]. It occurs primarily in patrilineal and patrilocal societies where girls and women are dependent on men.

In this context, **women are coerced into abortion**. The *failure* to provide a male partner to her husband's family may undermine her social, political and economic status (both the family's and her own). This can mean exclusion, marginalisation, divorce or repudiation from the family group (both husband's and her own), as well as facing physical violence if she refuses the abortion. It is for these reasons - fear and social coercion- that abortion may be planned or sought by the pregnant woman herself.

> **Preference for sons** does not necessarily imply gender-biased sex selection. Such a preference is not a violation of human rights, "however, (...) it is embedded in a web of social relations that reflect, generate and reproduce gender stereotypes. What does constitute a human rights violation is the perpetuation of stereotypes, especially those that dictate that the masculine is superior to the feminine and that result in the subordination of women to men and girls to boys" (UNFPA, 2020: 45).

As different studies explain, this preference **is common in countries** in East Asia, South Asia, the Middle East and North Africa. " Sons are preferred because they have a higher wage-earning capacity (especially in agrarian economies), they continue the family line and they usually take responsibility for care of parents in illness and old age. There are also specific local reasons for son preference: in India, the expense of the dowry; and in South Korea and China, deep-rooted Confucian values and patriarchal family systems" (Hesketh and Xing, 2011:1374). The denial of women's rights to inheritance and land ownership is a determining factor in male preference.

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[38] The report highlights that "She may die as a result of this neglect or more deliberate acts, all of which amount to postnatal sex selection" (UNFPA, 2020:42), and that "the mortality rate for girls is higher than for boys, suggesting that the care they receive is influenced by discrimination" (Ibid., p. 45).

In some cases, the previous number and sex of children may play a role. Thus, couples may not select the sex of the first child, "then may resort to sex-selective abortions if they had a girl child first" (UNFPA, 2020: 52). Policies limiting the number of children and (smaller) family size are also determinant. UNFPA reports that currently "about a quarter of parents with two daughters may choice to gender-biased sex selection to avoid having a third girl"[39] .

The social consequences of this population asymmetry are numerous and severe (Hesketh and Xing, 2006; Das Gupta, et al., 2003; UNFPA, 2020); among them, it encourages prostitution and trafficking of women for sexual exploitation and forced marriages, and increases child marriages of girls (Tucker, et al., 2005; Dandona, et al., 2006; UNDOC, 2020).

The Council of Europe also denounces that this phenomenon has harmful consequences, including demographic imbalances, an increase in crime and social unrest, and an increased risk of human rights violations, such as trafficking for marriage or sexual exploitation (EC Parliamentary Assembly, 2010).

In some countries, sex selection has been outlawed and, to a lesser extent, the underlying problem of patriarchal son preference has been addressed. In China, India and South Korea, laws **prohibiting foetal sex determination and selective abortion** exist, although with very uneven strength (Hesketh and Xing, 2011). Similarly, other countries such as the Republic of Korea and Vietnam, have banned the revelation of foetal sex before birth in public facilities. Efforts have also been made to **raise awareness through** campaigns on gender equality and the advantages of having daughters, although cultural change is slow and public policies would need to be intensified.

Although there may be laws prohibiting abortion as a sex-selective measure, in many cases it can be avoided by clandestine procedures; putting women's health at risk again. Ultimately, the preference for a male child **affects women's sexual and reproductive lives**, and has repercussions for their health and survival.

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[39] Information accessed 04/07/2023 on the UNFA website: SWOP Report 2020 | United Nations Population Fund (unfpa.org) from the report "State of World Population 2020. Against My Will. Challenging practices that harm women and girls and impede equality" (UNFPA, 2020).

In general, what influences to a greater extent for the change of values and behaviour of the population is the **improvement of the legal and social status of women**.

> Overall, laws and policies aimed at ending sex-selective abortion have not been very effective. In the case of abortion bans, "are often ineffective and also violate reproductive rights, such as access to safe abortion" (UNFPA, 2020: 60). The UN therefore notes that the solution is likely to lie in "changes in social norms" (2020:57).

The 2011 UN Interagency Statement (OHCHR, UNFPA, UNICEF, UN Women and WHO), *Preventing Gender-Biased Sex Selection,* considers that "they should be pursued in approaches that move away from condemnation and coercion, encourage positive behaviour change and help women and girls without compromising their reproductive rights" (UNFPA, 2020:62).

4.3. Forced or coercive sterilisation

Forced sterilisation requires a surgical intervention (tubal ligation, removal of the fallopian tubes, etc.). It is a particularly worrying form of violence because of its impact on health and its irreversibility.

> The definition in Organic Law 2/2010 of March 3, on sexual and reproductive health and the voluntary termination of pregnancy is as follows: "A form of violence against women in the reproductive sphere that consists of the practice of a surgical intervention whose purpose or result is to terminate a woman's capacity to reproduce naturally without her prior informed consent or understanding of the procedure".

Its practice affects, above all, women with disabilities and women with mental illnesses. It is therefore **directly related to eugenic beliefs and the existence of discriminatory, enabling and racist behaviour and attitudes**.

> The first time this mass practice was publicly considered was at the Nuremberg trial (1945-1946) after the Second World War, in relation to the treatment of many women and men through sterilisation programmes promoting Nazi eugenic policy, but it has occurred before that.

In the case of women with disabilities, menstrual control is one of the wrong motivations for seeking sterilisation.

Certainly, menstruation is also affected in the reproductive sphere, an issue that goes beyond the scope of this research, but needs to be pointed out. As UNFPA points out, **social and**

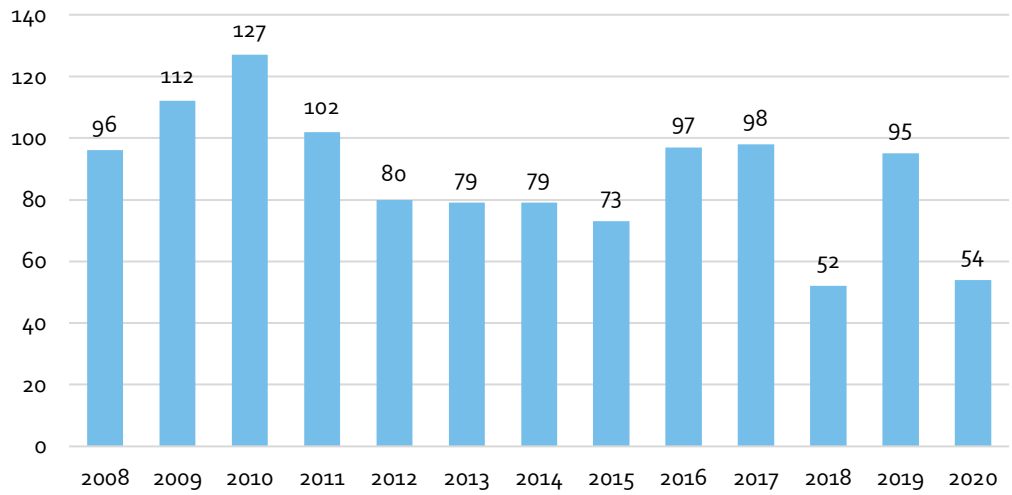
cultural stigmas about menstruation discriminate and provoke violence against women (2022). These include: exclusion from public life, barriers to opportunities, and barriers to sanitation and health.

> Menstruation in girls is (wrongly) interpreted as maturity and **implies greater vulnerability to sexual violence,** child and forced marriages.
>
> In addition, **people with non-binary gender identities**, such as transgender men "often face additional barriers to obtaining information or supplies to manage menstruation safely, including potential threats to their safety and well-being" (UNFPA, 2022).
>
> In addition, it has been noted that economic violence causes menstrual poverty, among other harms (Bartolomé Esteban, et al., 2023).

Despite the **legal prohibition of forced sterilisation** in some countries, it remains, even though it has been recognised as a **human rights violation** by the UN Human Rights Council and Committee against Torture, and even despite the guidelines issued by the International Federation of Gynaecology and Obstetrics, where it is defined as an "act of violence" (CRPD, 2014).

As with the rest of women victims of RV, **we do not have sufficient data** on forced sterilisations. According to data provided by the General Council of the Judiciary (CGPJ) to the media Newtral.es (2021), between 2008 and 2020, 1,144 decisions on forced sterilisation were registered in Spain.

Graph 2. Sterilisation processes for people with disabilities in Spain (2008-2020).



Source: Newtral.es (2021) based on CGPJ data.

The national fertility survey (2018 edition) indicated that, of the 55% of women using a contraceptive method, **9.2% of women had used tubal ligation sterilisation (**INE, 2019).

> The majority of women who have used this method **are aged 40 or older** (83.4%), so one could assume that their desires for offspring have been fulfilled or partially fulfilled. But this is speculation, since **there is no way to consider coercion in the choice of method**. 0.5% of ligation was reported by women under 30 years of age and 16% by women between 30 and 39 years of age. It is in both age groups that epidemiological surveillance should be increased the most.

As for women with disabilities, there is a long social and even legal history of **forced sterilisation** (CRPD, 2014). In Spain, organisations such as the CERMI Women's Foundation (FCM, 2018) have denounced these situations in the 2017 *Human Rights Report*, and the Monograph *Putting an end to the forced sterilisation of women and girls with disabilities*.

The study on *Sexual violence of women with intellectual disabilities (*Castellanos-Torres, 2020b) highlighted the **lack of knowledge** among the victims themselves about their own sterilisation. The research showed that women lacked a correct explanation of how pregnancy occurs or how to prevent it, and those who had some involvement in contraception had little understanding of its implications. Recent studies have shown that, with appropriate care and support, women with intellectual disabilities can avoid unwanted pregnancies without sterilisation (Meera Roy, 2010; Castellanos-Torres, 2020; 2023), which has many negative effects (see 4.5. Consequences of FASC).

4.4. Forced contraception

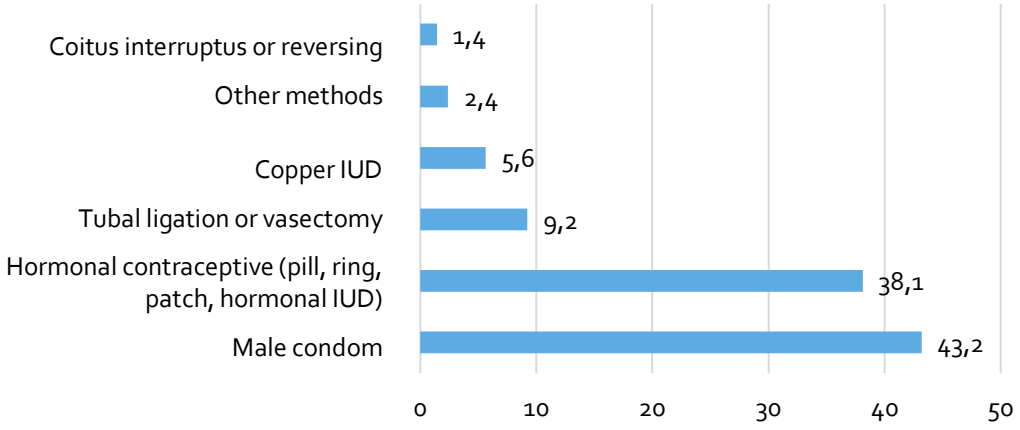
Forced contraception involves a temporary menstrual or birth control procedure to prevent pregnancy from occurring or to control the frequency and flow of menstruation; for example, using IUD intrauterine devices, subdermal implants, or other oral or injected contraceptives.

> In the definition section of the Organic Law 2/2010 of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy, forced contraception is defined as a "Form of violence against women in the reproductive sphere that it consists of medical intervention by any means, including medication, which has similar consequences to forced sterilisation".

Contraceptive methods have different side effects and not all of them are suitable for every woman, so they are not necessarily 100% safe. They have **consequences on the physical and psychological health** of women that they must assess from their reproductive autonomy. They are reversible methods in the sense that they can be removed and the victim can interrupt their use at some point

There are no statistical data that allow us to discriminate the **motivations for contraceptive use, or whether there is any indication of coercion in this regard**. In Spain, the aforementioned national fertility survey (2018) allows us to assess only the presence of different contraceptive methods (see graph below).

Graph 3.Women using a contraceptive method: percentage by type (year 2018)



Source: INE, 2019. National fertility survey.

Women **use different contraceptives according to their age group** (see table below). Of these, 43.2% referred in the survey to condoms and 38.1% to some type of hormonal contraceptive. Several contraceptives require the intervention of a health professional, including the IUD (used by 5.6% of women) and tubal ligation (9.2%).

Table 3.Women using a contraceptive method: percentage by type and age group (2018)

Method	Total	Age group				
		< 30 years	From 30 to 39 years old	From 40 to 49 years old	50 and over	Total
Hormonal contraception	38,1	40,2	30,0	24,4	5,3	100
Copper IUD	5,6	10,9	30,9	45,6	12,6	100
Condom or male condom	43,2	29,1	30,7	31,8	8,4	100
Tubal ligation	9,2	0,5	16,0	55,4	28,0	100
Other methods	3,9	20,4	34,1	36,7	8,8	100
Total	100					

Source: INE, 2019. National fertility survey.

It has been pointed out that the fertility survey of the General Directorate of Population Statistics "needs to improve its gender sensitivity as well as include the diversity of biological, socio-economic and structural factors that condition fertility, and to explore deeper into the differential elements that generate gender inequalities and biases" (Pérez-Corral and Danet-Danet, 2022). To this, it can be added the need to assess coercive aspects and reproductive violence in order to improve the future availability of data.

4.5. Consequences of the FASC

The CEDAW Committee in its General Recommendation number 21 *Equality in marriage and family relations* (1994) warned that coercive practices revealed in forced pregnancy, abortion or sterilisation **have serious consequences for women**. In this sense, reproductive violence has a clear impact on women's lives due to the great health risks it represents.

In relation to the **link between sexual violence and reproductive violence**, it is considered that the most serious and long-lasting consequences occur in the psychological sphere, with emotional disturbances and psychological disorders for girls and women survivors.

> Sexual violence can lead to sexually transmitted infections, ranging from candidiasis, gonorrhoea, syphilis, herpes to HIV or hepatitis (STIs). In addition, physical injuries can lead to gynaecological problems (irritation, fibroids, infections, bleeding, vaginal pain, etc.), as well as other reproductive problems such as unwanted pregnancy, miscarriage, unsafe abortion, bleeding, cervical lacerations, intra-abdominal injuries, uterine

perforations, infections, impaired reproductive health (infertility), complications during pregnancy and childbirth, and even death (Kefauver, 2021). As the SEXPOL Foundation points out, it may also involve sexual desire dysfunctions such as desire disorder, aversion to sex and vaginismus, among others.

In relation to the specific consequences of reproductive violence, the following issues need to be considered. Note that in the section on forced abortion, those relating to **selective abortion** as a practice of sex selection as RV have already been specifically pointed out.

According to the International Federation of Gynaecology and Obstetrics (IFGO), **miscarriage** is a traumatic event that can cause pain, anxiety, depression and even symptoms of post-traumatic stress disorder (PTSD).

In addition, the performance of an abortion requires essential **post-intervention care** for women. The absence of such care can seriously affect the mental and physical health of the victims.

As noted above, if forced abortions are performed **in unsafe settings**, they present numerous risks, the most common being incomplete abortion, severe haemorrhage, infection, uterine perforation, peritonitis, and damage to the vagina and uterus (WHO, 2021). This can affect future pregnancies, cause infertility and ultimately lead to the death of the woman.

In addition to the **inability to reproduce**, sterilisation can lead to **early onset of menopause, osteoporosis and cardiovascular disease**, especially if it is performed before a girl has menstruated or during puberty.

Along with the above, it is considered that forced sterilisation can **increase the vulnerability** of girls, adolescents or young women with disabilities to **sexual assault and rape** (Fundación Cermi Mujeres, 2018; Peláez et al. 2009). The same risk occurs with the rest of women who present other vulnerabilities.

This reproductive violence has other specific consequences on women's mental and physical health, as well as on their social environment. In this sense, it has been pointed out that it has **disabling consequences** such as: other physical injuries, setbacks or difficulties in development, alterations and disorders of sleep, eating or sphincter control, sexually transmitted infections or the development of psychosocial disability, including ailments such as insecurity, mistrust, inhibition problems and fears, isolation, self-harm, aggression, conflict

with family and friends, substance abuse, mood disorders, anxiety or post-traumatic stress (Fundación Cermi Mujeres, 2018).

For example, the macro-study on the consequences suffered by rural and indigenous women victims of forced sterilisations in Peru (IAMAMC, 2016) revealed **consequences on the sexual and reproductive autonomy of these women, as well as on their physical and economic autonomy.** Negative consequences on emotional well-being (depression, rupture of affective-sexual relationships, abandonment, loss of self-esteem, physical and mental weakening) and damage to their family environment (sadness, impoverishment, abandonment, migration, lack of protection, loneliness, helplessness, loss of emotional ties, suicides) are indicated.

The results of the research on women with disabilities who are victims of RV emphasise that it must be considered that involuntary, coercive and/or forced sterilisation should **not be analysed solely from the perspective of motherhood.** This would reduce the violation of a human right to a stereotype, that is, that women are reproductive devices.

Authors such as María Laura Serra (2016) point out that this situation must be analysed and discussed, being necessary to differentiate the reasons why these practices have been developed on girls and women. In this case, **what is destroyed is the present or future will; the possibility of making decisions regarding their life plan and the objectification of the body,** achieving full submission.

> It is therefore an intrusion into her body, a violation of her human rights, including her physical integrity; equal recognition as a person before the law; the right to health; the right to information; the right to privacy; the right to decide about the number and spacing of children; the right to found a family; the right not to be discriminated against; and the right to self-determination over her own body (Serra, 2016).

Finally, another general consequence among victims of any form of reproductive violence is **silence and lack of reparation**.

In this sense, women whose reproductive rights have been violated **are invisible and do not have guaranteed access to reporting** for a variety of reasons (Open Society Foundations, 2011), among them:

- **Victims are unaware of their situation and/or their rights**. They are unaware of the actions they can take against the instigators and medical staff who took part in the process. In the case of sterilisation, "it can take years for a woman to realise that she

has been sterilised if there was no consent form or if she was asked to sign it without being able to read it or if the procedure was not explained to her" (OSF, 2011:7).

- Victims **lack effective legal recourse to obtain** reparation or compensation. In the case of sterilisation, it is noted that, even if it is illegal if "women do not feel that their government will respond to their reports of involuntary sterilisation, they may not seek justice" (Ibid.).
- Victims **feel ashamed and fear social stigma**. There are women who "wish to keep their situation secret. They wish to avoid social stigma and emotional consequences" (Ibid.).

5. FASC: women victims and their needs

While reproductive violence can affect any woman throughout her life, **some specific groups are more affected** by FASC. Women who experience intimate partner violence, impoverished women and women in situations of sexual exploitation are **frequent victims of** reproductive violence (UNFPA 2018, 2021, 2022; GREVIO, 2020).

Similarly, both indigenous women and women from ethnic minorities (especially Roma) have historically suffered from the same practices. Women in prison and women living with HIV are also **more vulnerable groups**.

However, it is **women with disabilities** who represent the most extensively affected group on whom RV has been exercised as they are in a situation of greater vulnerability, especially women with intellectual or developmental disabilities (WIDD) and women with mental illnesses.

It is important to note that, although not addressed in this research, **transgender people** are affected by the practice of forced sterilisation and are a vulnerable group that also needs to be protected and redressed.

> This is reflected in the European Parliament resolution of June 24, 2021 on Sexual and reproductive health and rights in the EU in the context of women's health (2020/2215(INI)) (paragraph 21), which refers to the judgement of the European Court of Human Rights in the case of A.P. Garçon and Nicot VS. France, which recognised that the obligation to sterilise imposed by a Member State as a precondition for legal gender recognition procedures constituted a **violation of the European Convention on Human Rights** (right to respect for private and family life) (SECHR of April 6, 2017, Transgender identity and change of marital status).

5.1. Women with disabilities and women with mental illness

As the approach promoted by the WHO points out, disability does not only refer to a person's own health condition, but is the result of the interaction between certain conditions (psychological and/or physical) and a series of environmental and personal factors. In other words, **the social context can be responsible for generating a disabling environment**. In this sense, the UN warns that persons with disabilities are at greater risk of having their fundamental rights violated.

> Along these lines, General Comment No. 3 of the UN Committee on the Rights of Persons with Disabilities (CRPD) (2016) emphasises that **stereotypes based on gender and disability** often lead to structural or systemic discrimination, in particular with regard to sexual and reproductive health and rights.

In Spain, according to data from the Survey on Disability, Personal Autonomy and Dependency Situations (EDAD) (INE, 2020), there are about 4 million people with disabilities, of whom approximately **2.5 million are women**. This represents 60% of the population with disabilities. Despite being the majority, they face greater barriers due to the intersection of gender with disability and multiple discriminations[40] .

Violence against women with disabilities can be structural and the consequence of discriminatory legislation (UN, 2006). It involves violence in the form of physical force, legal coercion, economic coercion, intimidation, psychological manipulation, deception and misinformation, and in which the absence of free and informed consent is a key component (OHCHR, 2012). In other words, it **goes beyond reproductive violence**.

> The study *Women, disability and gender-based violence* (Castellanos-Torres, 2020a) has highlighted **numerous forms of violence** against women with disabilities: physical, psychological, sexual or financial in nature, including abandonment, social isolation, confinement, humiliation, arrest, denial of health care, forced sterilisation and forced psychiatric treatment.

[40] For example, in the case of access to employment, the unemployment rate is higher than that of men (INE, 2021). In addition, 64.7% of women with disabilities are considered inactive, with the consequences this has for their economic autonomy, a fundamental factor for getting out of situations of abuse and violence.

Many of these situations occur **within family relationships**, including physical violence and sexual violence at the hands of known men with family ties. They can also occur **within care institutions** (OHCR, 2020).

> Women with disabilities are **exposed to specific forms of violence** and, in addition, to the same forms of violence as other women, in which they have a **higher incidence**. In this regard, data from the Macro-survey on Violence against Women (DGVG, 2019) show that 40.4% of women with disabilities have experienced **some form of intimate partner violence** compared to 31.9% of women without disabilities.

On the other hand, it is essential to bear in mind that **violence is the cause of multiple disabilities** in women, and also in their children (born in conditions of violence). According to the report promoted by CERMI Mujeres (Castellanos-Torres *et al*, 2022) on the situation of women with disabilities:

- 40% have experienced sexual harassment at some point in their lives.
- 42% were exposed to sexual violence in childhood when they were under the age of 15, perpetrated by perpetrators other than intimate partners.
- 14% of survivors of non-partner sexual violence developed disability as a result of this violence.
- 23% of women say that their disability is a consequence of physical or sexual violence against them by their partners.

Women with mental illness and women with disabilities are therefore **particularly vulnerable to reproductive violence**.

The *Report on the Human Rights of Women with Disabilities, 2022 (*Fundación Cermi Mujeres, 2023) has warned about situations of **discrimination, violence, infantilism and prejudice** when going for a gynaecological check-up. According to the report, 22% have 'never' or 'almost never' went to a check-up, 4% of the women did not know if they had undergone a sterilisation process, and another 4% stated that they had undergone sterilisation without having all the necessary information.

For their part, Moreno-Hernández and Pérez de la Merced (2022), in their *research on the situation of women with intellectual and developmental disabilities in relation to their sexual and*

reproductive rights for Plena Inclusion, Spain, pointed out that there is a considerable gap between knowledge of rights and the exercise of these rights.

> This qualitative study revealed that "a large majority do not enjoy reproductive autonomy, as they have not chosen to use the contraceptives they use" and "almost all women with WIDD do not know whether they can become pregnant or not" (2022:36). The study also identified that "only a small proportion have received information through adapted materials" (2022:38) and there was "poor accessibility and training of sexual and reproductive health service personnel" (Moreno-Hernández and Pérez de la Merced,2022).

Stigma and misconceptions about disability and sexuality have a profound negative impact on women's lives. They lead to disempowerment and infantilisation. They are not considered as targets for counselling and information services and are often "asexualised".

> As a result, many girls and young women with disabilities lack the basic knowledge and support needed to **protect themselves from sexual abuse, unwanted pregnancies and sexually transmitted infections**, and are not equipped with the tools to make informed decisions about their own bodies, health and lives (Alcedo Rodríguez, et al, 2006; Altundağ S, Çalbayram NÇ, 2016; Cruz Pérez, 2004; Castellanos-Torres, 2020b).

The most frequent stereotypes are related to the following ideas (Vazquez and Castro, 2018: 28-29):

- "They are like minors": it is society that infantilises.
- "They are asexual": sexual development is no different from non-disabled people.
- "They have less sexual interest and are not sexually adventurous": this idea is the result of distorted social beliefs of infantilisation and the belief that they are asexual people.
- "They are not desired people": desire is an individual power over which society cannot decide.
- "They do not need sex education": all people have the right to know, accept and live their own sexuality with satisfaction.
- "More sex education = more sexual desire": more sex education = better management of sexual desire.

- "They have oversexualised behaviours": this false belief is determined by the need to discriminate between behaviours appropriate to public or private spaces.
- "There is no sexual diversity among people with disabilities": a demystification process towards diversity is necessary to take into account the whole population.
- "They cannot make decisions regarding their sexuality": the responsibility for one's own body and the decision of intimacy, autonomous or interpersonal, is individual.
- "Persons with disabilities cannot be perpetrators of sexual violence": anyone who believes they have power over the sexuality of another person can be an aggressor. There are known cases of sexual violence against girls and women with disabilities by peers with disabilities, especially in residential or institutional settings.
- "They are not at risk of experiencing sexual violence": there is data showing that it can occur 2 to 10 times more often than in people without disabilities (Paola Rivera, 2008).

Paradoxically, FASC is being carried out to a greater extent against the most autonomous WIDD; those who would be able to manage their sexuality and motherhood with the appropriate affective-sexual education and the necessary support. Sometimes, according to several of the experts interviewed, the family may have made sterilisation or forced contraception a condition for the victim in order to allow her to have affective-sexual relations.

There are several causes of FASC against women with disabilities: on the one hand, there are the **systematic eugenic** ones, which limit the right to reproduction; and on the other hand, the **reasons that drive most families and institutions**, which are fundamentally two:

- **To control menstruation in order** to facilitate self-care.

  Menstruation requires basic body hygiene care and, as with sexuality, women and girls with disabilities (especially intellectual and/or psychosocial) generally lack adequate information about menstruation, and this inaccessibility is doubled in poor settings (Serra, 2016). Menstruation for women with disabilities continues to be surrounded by silence, taboos and stigma (Shah, Norlin, Logsdon and Samson-Fang, 2005).

  > International organisations such as OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO (2014) denounce that menstrual control should not be used as a pretext for contraceptive sterilisation.

- **To prevent pregnancies**. This is based on the discriminatory stereotype that a woman with a disability is incapable of carrying out the roles associated with motherhood.

  It should also be noted that there are important debates about **the exercise of the right to motherhood by women with intellectual disabilities** (Castellanos-Torres, 2023). The **myths and stereotypes** range from the refusal to offer them information about contraceptives to suggesting sterilisation. They are considered irresponsible and incapable of adequately caring for their children (Cruz, 2004; Castellanos-Torres, 2023)[41] .

  Paradoxically, FASC sometimes contributes to **making sexual aggression invisible**, since pregnancy is sometimes the only sign that helps to detect this situation. In this sense, as Laura Serra (2016) points out, this reasoning is extremely cruel given that it seems that it does not matter if a rape is committed, as long as there is no pregnancy.

In general, the disempowerment of women with disabilities with regard to their SRHR is most severe **when their lives are organised primarily through institutions** that deny them the full exercise of their autonomy and privacy, whether intentionally or unintentionally.

The European study on **violence experienced in institutions** (Holla and Smits, 2018), has highlighted this fact. Sterilisation of women with disabilities in institutions as a means to cover up sexual abuse (or to prepare for what is seen as inevitable sexual abuse) has been recorded in institutions around the world.

> As noted by the United Nations Deputy High Commissioner for Human Rights, "Institutions, such as long-term care homes, orphanages, and psychiatric institutions, may also expose women and girls with disabilities to particular risks due to their seclusion. (...) [They] may lack access to a functional report mechanism for mental, physical, or sexual abuse or violence, particularly when they have communication or intellectual impairments. They may be ignored, disbelieved, or misunderstood, which is conducive to systematic and continuing violence" (OHCHR, 2020).

[41] As Castellanos-Torres (2020b) explains, these practices are part of a more widespread pattern. Denial also includes exclusion from appropriate reproductive health care and sexual health screening, restrictions on contraceptive choice, a tendency to suppress menstruation, poor management of pregnancy and childbirth, selective or forced abortions, and denial of the right to exercise motherhood.

5.2. Other women affected by FASC

5.2.1. Women victims of sexual exploitation

Reproductive violence is exercised together with **sexual violence**, as it is part of the total control of the female body necessary to abuse it and intervene in its consequences.

Therefore, girls and women victims of sexual exploitation, those in prostitution, in the sex industry, in any of its commercial variants, including sex tourism, as well as victims of trafficking for sexual exploitation, and victims of trafficking for labour exploitation are also victims of RV (Mora, 2007; García Medina, 2017).[42]

Those responsible for RV against these women are multiple, depending on the type of sexual violence. Thus, in addition to the abusers themselves, there are those responsible for the sex industry to which the victims are linked, the figure of the male or female pimp, members of the exploitation and trafficking networks, and male clients. Along with the above, there is the responsibility of the health professionals involved in such practices whose collaboration is necessary, and the public authorities who fail to ensure due diligence in the protection of victims.

> From a sociological approach, these practices are considered male privileges whereby men gain individual or group access to the bodies of women who do not want them, which outside of prostitution they would gain through explicit violence or intimidation (Ranea, 2018)[43] .

The **prostitution and sexual exploitation of trafficked persons** has serious effects on women's health. Even in situations where local prostitution has not been induced these women and girls still suffer physical and psychological abuse and violence at all levels and should be considered victims (Médicos del Mundo, 2012).

> Although there are no systematic records, there is plenty evidence that such practices lead to unwanted pregnancies and **frequent unsafe abortions**.

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[42] In this case, labour exploitation of women requires that no pregnancies occur. In addition, there is a strong link between labour exploitation and sexual violence (harassment, assault or rape) towards the victims.

[43] According to Ranea (2018:3), "In the patriarchal sociosexual imaginary, male sexuality is represented as a physiological "need", that is, as a bodily "need". This imaginary that essentialises masculinity has been one of the great legitimisers of sexual violence because it fictionalises masculine sexuality as a "need" and even places it in the realm of instincts that must be satisfied in one way or another".

On the other hand, it is assumed, without much foundation, that prostituted women take care and protection measures. However, when they are recruited at a young age, they do not always have knowledge about contraception and prevention of infectious or venereal diseases. In extreme cases, women who experience such violence have been found to be more prone to cervical cancer (Ruffa and Chejter, 2010).

Studies on foreign migrant women in prostitution indicate that, although they may receive some attention from a biomedical approach (focused on STI control), other consequences on the psycho-social health of these women are not taken into account (Ríos, 2014).

Likewise, the Association of Women for Health (AMS) indicates that **unhealthy sexuality has consequences for any woman**, with particular severity for those in prostitution or trafficking situations. In addition to the physical health effects mentioned above, the psychological and emotional consequences range from post-traumatic stress (with repetitive and torturing memories), to high rates of depression and anxiety problems, anguish, fears, phobias, lack of self-esteem, etc. "Suicides or suicide attempts are also very frequent and they are 40 times more likely to be murdered. Prostituted women are subjected to a much greater extent to threats, mistreatment, rape, abuse, torture and multiple humiliations and degradations" (Muruaga, 2023).

Finally, the analysis of the quality of life of women in prostitution in terms of their "**social health**" has rarely been analysed. The few approximations speak of fears related to spatial and temporal conditions that restrict their social ties and relationships, the perception of social segregation and isolation, reservations and/or restrictions in access to social and health services, and the effects of administrative irregularity in the cases of migrant or trafficked women (Pinedo, 2008).

5.2.2. Women migrants, refugees and applicants for international protection

According to census data, the immigrant population in Spain represents 11.68% of the total (INE, 2022). They account for 2,778,214 men and 2,764,718 women. Registered migrant women are **11.42% of all women** living in our country.

For many women and non-binary people, gender-based violence is one of the **reasons for fleeing their countries**. In addition, sexual and reproductive violence often occurs in contexts

of persecution and armed conflict situations, as well as in **the processes of escape from them** and in **unsafe transit contexts**.

Therefore, **migrant** girls and women **and** women **seeking international protection and refugees**[44] are in a situation of special vulnerability of **FASC.**

> People who migrate "are not inherently vulnerable, nor do they lack resilience or agency" (OHCHR-GMG, 2018:5). Migrants may find themselves in different situations of vulnerability "as a result of the situations that force them to leave their country of origin, the circumstances in which they travel or the conditions they face upon arrival, or because of personal characteristics such as their age, gender identity, race, disability or health status" (Ibid.).

In Spain, if a woman has suffered **gender-based persecution** by the authorities of her country or by a third-party agent (partner, family, community or others), without having received protection from the authorities, she may be **eligible for refugee status or subsidiary protection**[45] , as established by the international and EU normative framework[46] .

> *"Refugee status may be granted to women victims of gender-based violence who, owing to a well-founded fear of being persecuted for reasons of gender, membership of a particular social group or sexual orientation, are outside their country of origin and are unable or, owing to such fear, unwilling to avail themselves of the protection of that country. Therefore, if she has suffered persecution, either by the authorities of her country or by a third-party agent without having received protection from those authorities, on gender-based grounds, she may be eligible for refugee status. These grounds may include,* ***but are not limited to****: physical or psychological violence by a partner or former partner, sexual assault or abuse,* ***forced sterilisation or abortion****, female genital mutilation or risk of female genital mutilation, forced marriage and trafficking in women and girls. (DGVG, n.d.;* emphasis added*).*

It is important to point out that not all women have access to international protection in Spain. **Access to protection** has been collapsing for years and the Spanish protection system as a

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[44] (access).

[45] This applies to third country nationals (non-EU nationals) and stateless women.

[46] See: Article 14 of the Universal Declaration of Human Rights and the 1951 Geneva Convention and its protocol (New York Protocol, 1967); in the EU it is enshrined in Articles 18 and 19 of the Charter of Fundamental Rights of the European Union and regulated by the Common European Asylum System (CEAS), which comprises the Dublin Regulation and three specific Directives; as well as the EU's New Migration Pact on Asylum (2020). In Spain, see Law 12/2009, of 30 October, regulating the right to asylum and subsidiary protection (B.O.E. no. 263, of 31/10/2009.

whole has shortcomings[47] that hinder the adequate protection of women and girls. **There is not even a register of gender-based refugee applications**, which means that the issue cannot be adequately monitored.

In 2022, Spain became **the country with the third highest demand for international protection in the entire European Union**[48] **,** (64,219 applications from men and **54,623 from women**) (Ministry of the Interior, 2023). It was the **fifth EU country that granted the most temporary protection permits** in 2022 (161,037 granted to people displaced by Russia's invasion of Ukraine[49]) (Ministry of the Interior, 2023).

However, **recognition rates are far behind the EU average** (16.5% compared to 38.5%). From a gender perspective, the recognition rate of **women (11.59%)**[50] **is 6.3 points lower than that of men (**17.90%) (according to data from the Ministry of the Interior, 2023).

> The top ten **nationalities of origin of** applicants for international protection in Spain in 2022 were: Venezuela, Colombia, Peru, Morocco, Honduras, Nicaragua, Mali, Afghanistan, El Salvador and Cuba. Those with a favourable decision were: Mali, Afghanistan, Ukraine, Syria and Colombia. The main nationalities with subsidiary protection[51] were: Venezuela, Colombia, Peru, Panama and Chile.

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[47] Complaints by specialised NGOs have been constant, especially since 2018 about the shortcomings of the Spanish system (see for example CEAR's annual reports). In June 2023, 23 specialised NGOs filed a complaint with the European Commission denouncing the collapse of the asylum application appointment system in Spain (Europa Press, 2023). The entities are: Andalucía Acoge, Asociación Atalaya Intercultural, Asociación Claver, Asociación Loiola Etxea, Comisión Española de Ayuda al Refugiado (CEAR), Centro Padre Lasa, CESAL, Coordinadora de Barrios, Creando Huellas, Fundación Ellacuría, Fundació Migra Studium, Fundación Red Íncola, San Juan del Castillo Foundation - Pueblos Unidos center, MPDL, La Merced, Progestión, Provivienda, Red Acoge, SJM, SJM Almería, SJM Valencia, Sercade.

[48] According to Eurostat data (2023): Germany received a quarter (25 %) of asylum applications, followed by France (16 %), Spain (12 %), Austria (11 %) and Italy (9 %). 117,945 asylum applications were registered in Spain; 118,842 applications for international protection according to the Avance trimestral de datos de protección internacional acumulada a 31 de diciembre de 2022 (Subsecretaría del Interior, Dirección General de Política Interior del Ministerio del Interior, 2023).

[49] In application of the Temporary Protection Directive 2001/55/EC of 4 March 2022, which guarantees the right to temporary protection of the right of residence for persons with disabilities.
The beneficiaries are entitled to reside, work and have access to social benefits.

[50] Data by sex show: favourable decisions: 4,444 women; humanitarian reasons: 11,517 women; recognition of stateless status: 91 women (mainly from the unrecognised Sahara). Data as of 31/12/2022 (Subsecretaría del Interior, Dirección General de Política Interior del Ministerio del Interior, 2023).

[51] The right to subsidiary protection is granted to foreign nationals and stateless persons who, without qualifying for asylum or being recognised as refugees, but with respect to whom there are serious reasons to believe that if they were to return to their country of origin in the case of nationals, or to their country of former habitual residence in the case of stateless persons, they would face a real risk of suffering any of the serious harm referred to in Law 12/2009 of 30 October 2009 on the Right to Asylum and Subsidiary Protection, and who cannot or, because of the said right, cannot be recognised as refugees, would face a real risk of suffering any of the serious harm provided for in Law 12/2009, of 30 October, regulating the Right of Asylum and Subsidiary Protection, and who are unable or,

These data do **not reflect the actual number of people eligible for protection,** both because of the deficiencies in access to the application and because of the under-demand of many victims who consider Spain to be a transit country.

> Indeed, our country **is a transit route** (to the rest of the UE) **and not just a destination**. This means that many women are here temporarily because the country they would like to reach is another[52] . This may mean that they find themselves in an **administratively irregular situation** (undocumented migrants).

Regarding displacement, **girls** (accompanied and unaccompanied) **and women who migrate through routes that are not safe**[53] , do so in highly vulnerable conditions and are frequent victims of sexual and reproductive violence, among others.

> It should also be considered that several of the routes that reach Spanish territory are considered among **the most dangerous in the world**: due to the number of deaths involved in their transit (the Mediterranean and the route to the Canary Islands) and because most of the countries they cross until they reach the Spanish border are not safe (women's human rights are not guaranteed, nor is the non-refoulement principle) (ECRE, 2019; IOM, 2022; 2023; Walking Borders, 2022, 2023.).

In Spain, no official data is collected on the type of violence suffered by female asylum seekers, nor is there any record of VAW (and its typology) as a motivation for applying for international protection in our country. Therefore, there is a significant lack of institutional knowledge on the subject.

As for data of **foreign women in general,** they are taken into account in the study of the prevalence of VAW through the Macro-survey on Violence against Women (DGVG, 2019). The Macro-survey data show that foreign-born women are particularly vulnerable to violence:

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because of such risk, unwilling to avail themselves of the protection of the country concerned, provided that none of the grounds for exclusion or refusal set out in the said Law exist (Ministry of the Interior, n.f.).

[52] The regulation of the right to asylum in Europe implies that when arriving in a "safe country" one must apply for international protection there, otherwise the applicant would be returned to the first safe country (Regulation (EU) No 604/2013 of the European Parliament and of the Council of June 26, 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (Dublin III).

[53] See the UN Global Compact for Safe, Orderly and Regular Migration (GCM) (A/RES/73/195 adopted in Marrakesh in 2018), which is the first intergovernmental agreement on the subject.

- Almost 46% have suffered intimated partner/expartner violence: 45.6% psychological violence and 24.7% physical or sexual violence, 40.3% controlling violence and 34.9% emotional violence.
- 15.7% have suffered physical violence outside the couple.
- 9.8% suffered at least one episode of sexual violence perpetrated by a person other than their partner.
- More than 44% have been victims of sexual harassment at some point in their lives and 19.3% say they have experienced repeated harassment.

The study carried out by AIETI (2020) shows that migrant women **benefit less from the** financial support provided to combat GBV. They have **greater difficulties in accessing protection and exercising their rights** if they are undocumented, if they are dependent on their husband or in a situation of trafficking and smuggling. The majority of GBV murders are committed by Spaniards, even when the victim is a foreigner. Foreign women are also the **main victims of sexual exploitation** (trafficking and prostitution).

With regard to **the presence of FASC**, throughout the fieldwork, the organisations and experts consulted have highlighted the existence of both **abortions and forced pregnancies** among migrant women trying to reach Spain, often as a result of the sexual violence to which they are subjected in **transit territories**.

In some cases, some pregnancies may be intentional, but as the organisations report, most are not terminated due to lack of information and access to sexual and reproductive health services, which prevents them from adopting contraceptive measures, including abortion. It has also been pointed out that in some cases pregnancies are carried to term under the belief that they could favour the pregnant mother regarding the non-expulsion from the national territory.

Women in an irregular administrative situation -or awaiting an administrative decision on their residence status in Spain- and unaccompanied minors (UM) are in a particular vulnerability.

Thus, we found that girls and women of migrant origin who have been v**ictims of FASC in their countries of origin - or in their transit to Spain** - have not received attention for it, nor have they been recognised as RV as a specific gender-based violence.

All of the above does not exclude the fact that violence has occurred or **is occurring in our country as well**.

Displacement implies changes in people's gender roles and this entails **psychosocial stress in process of inclusion in the host society**. Likewise, it often implies the loss of social and cultural structures of reference, and possibly family structures, thus **increasing the risk of gender-based violence** (IOM, 2020).

> In 2022, the Union of Family Associations (UNAF) denounced that in Spain **migrant women are not accessing SRH care resources**: "the presence of these women in specialised care services and resources is anecdotal, we estimate that it only reaches 0.1%, which shows that the vast majority of women do not have access and that the resources do not reach them" (UNAF, 2022).

As we have already pointed out, most of the figures available on international protection in Spain do not include the sex variable and the gender perspective. This deficit extends to the entire **International Reception and Temporary Protection System** (ITPRS)[54] and the data available on it.

> At present (as of March 31, 2023) 18,181 women (52% of a total of 34,725 persons)[55] were receiving the services and benefits of the International Reception and Temporary Protection System, in any of its modalities; 29% of them being minors (OPI, 2023b). The following Figure shows their distribution in the ITPRS by Autonomous Community. Most of the women registered in the system were in Andalusia (20%), Catalonia (16%), Madrid (11%), Valencia (10%) and Castile and Leon (9%) (OPI, 2023b).

According to the information available in the Data System of the Programme for Immigrant Refugees and Asylum Seekers (SIRIA), the main **countries of origin** of the women registered are: Ukraine 58%, Colombia 10%, Venezuela 9%, Afghanistan, 6%, Syria 3%, Peru 3%, Georgia

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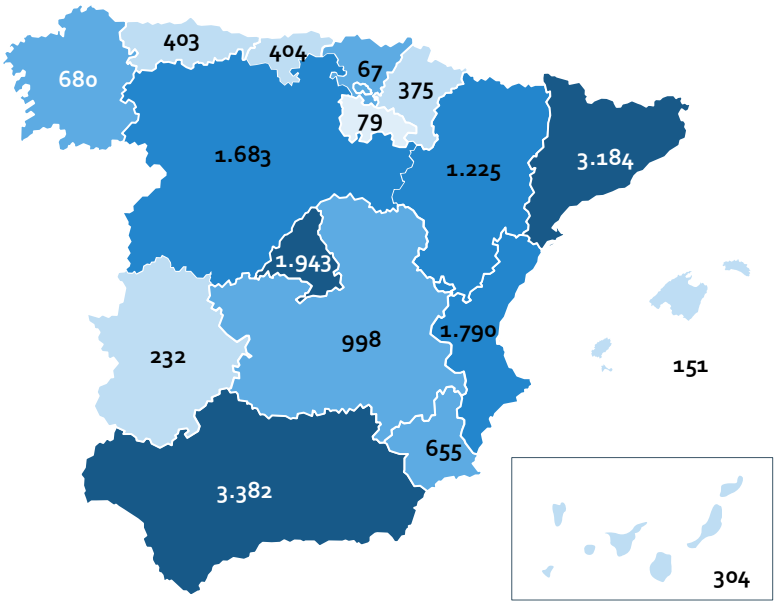
[54] While applications for international protection are managed by the Asylum and Refuge Office (OAR) of the Ministry of Interior, ITPRS is the responsibility of the Ministry of Inclusion, Social Security and Migration (MISSM), which implements it through various NGOs. It has a network of centres and resources distributed throughout the national territory, both publicly owned and centres managed by third sector entities (MISSM, 2023). The system is developed through individualised itineraries of different types of benefits and services.

[55] The persons covered by the Reception System have submitted an application for international protection are beneficiaries of international protection in Spain; or are applicants for or beneficiaries of statelessness or statelessness status in Spain.

temporary protection, and lack sufficient financial means, (they do not exceed the individual monthly amount of the guaranteed income provided for in Law 19/2021, of December 20, which establishes the Minimum Living Income).

2%, with 1% nationals from Russia, Morocco, Honduras and El Salvador; below 1% are the remaining nationals (OPI, 2023b).

Figure 4. Distribution of the number of women beneficiaries of international protection in the Reception System by Autonomous Community. Total stays. National total at 31/3/2023.



Source: OPI (2023) from SIRIA

(*) Ceuta: 3 women.

The MISSM has started to collect some data from the NGOs that take part in the management of the Reception System. Thus, some data are starting to be collected on **gender-based violence** suffered by (women) beneficiaries in the Reception System, but it is not public yet.

No data is collected on women who, for various reasons, are not in the system but are beneficiaries of international protection by the Spanish state; nor on those who are in the relocation or resettlement programmes.

The project for the implementation of the **Protocol of Action on Gender Violence** of the Ministry of Inclusion, Social Security and Migration and UNHCR, which is developed together with several NGOs, has recorded some data regarding the detection and identification of GBV in the system. According to this information (CEAR, 2023b), at least 90 cases were detected in the first half of 2022 alone.

The data indicate that the perpetrators were close to the victims: either their current partner (69%) or ex-partner (31%). In 49% of the situations, they lived in the same place.

In 80% of the cases the women had at least one minor in their care (at least 139 children were affected by these assaults). **These data do not include reproductive violence nor CNH**. The project is currently working on expanding the types of VAW to be detected, in order to come closer to all those covered by the Istanbul Convention.

As part of the fieldwork for this study, the NGO ACCEM, which helps women refugees, migrants and women in a situation or at risk of social exclusion, has compiled data on cases identified from 2019 to May 2023. In total, **23 women** were identified as **victims of FASC and other violence** (reproductive and gender-based), including cases of forced marriages. This is a great underestimation, as only visible cases or those verbalised by the victims have been recorded.

The profile of the victims assisted by ACCEM is that of women mostly of reproductive age (between 20-37 years old), half of them with minor children. Most of them suffered this violence some time ago in their country of origin. The main reason for coming to our country was precisely to flee from the situation of gender violence they were going through and which made them fear for their physical integrity and that of their children.

5.2.3. Roma women and women from other ethnic groups

In Spain, there is a lack of studies and statistics disaggregated by ethnic origin or racialisation that would bring us closer to the possible prevalence of FASC victims in these groups of women.

FASC has systematically targeted **women from indigenous/indigenous** or **aboriginal peoples** and **ethnic minorities** - such as **Roma women** - as "population control measures" with the aim of limiting the growth of certain populations under racist and discriminatory ideological premises.

Currently, **practices of subtle coercion** (under the notion of "one's own good") **together with threats** (for example, with the loss of - or impossibility of accessing - social, economic or food benefits) have been reported as well as some cases of violence, although they have not been registered in Spain.

A paradigmatic case is the allegations of **indigenous and peasant women** sterilised during the 1990s in Peru through the National Sexual and Reproductive Health and Family Planning Programme implemented by the Fujimori government (IAMAMC, 2016; Amnesty International, 2019).

However, **these practices continue to occur** in the world nowadays. Forced sterilisation is of particular concern, as noted by international organisations such as the Special Rapporteur on the Rights of Indigenous Peoples of the Inter-American Commission on Human Rights (IACHR)[56] . For example, in 2019 it warned of reports of forced sterilisations against indigenous women in Canada, which are "a flagrant expression of violence and discrimination based on both their gender and their ethnicity" (IACHR, 2019).

Within the European Union, the situation of Roma women is of particular concern. Some of the countries where there has been a recent high-profile public alert in this regard are Slovakia[57] and the Czech Republic (Amnesty International, 2013; 2021; Albert and Szilvasi, 2017).

In the Czech Republic, an investigation by the Ombudsman in 2009 was followed by a public apology from the State to the victims and compensations for those who were affected between 1966 and 2012. In Slovakia, something similar happened in 2021, for cases that occurred between 1966 and 2004[58] . Hungary is another country where such practices have been denounced[59] (Open Society Foundations, 2011; Koldinská, 2009).

There are no data in Spain in this regard, although there have been no contemporary state campaigns against the Roma population comparable to the two previous cases. Roma women in our country may suffer RV like women in the rest of the population, but in their case, it occurs at the intersection of other axes of oppression and inequality that are not only affected by gender, such as **antigypsyism/antiromanism and lack of resources.** All of this hinders the visibility of this violence.

According to the information provided by the experts consulted, the types of FASC most frequently reported by Roma victims are **"recommended" sterilisation and contraception.** This RV is not usually carried out by the partner or ex-partner, but by the health system itself (public and private); it is a clear symptom of **institutional violence reproduced by health professionals**.

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[56] There are several declarations and reports of this Office of the Rapporteur of the Organisation of American States (OAS) where this concern is mentioned (access).
[57] See for example: Judgment of the European Court of Human Rights, November 2011 on Case V.C. v. Slovakia (no. 18968/07) (access). Slovakia (no. 18968/07) (access);
[58] Access to the Slovak Government website.
[59] See UN Committee on the Elimination of Discrimination against Women, CEDAW/C/36/D/4/2004, August 29, 2006 (accessed).

> Paternalism, high pharmacology and anti-romanism are both present in the lives of Roma women, affecting their SRHR and the experience of motherhood through cultural judgement regarding the *appropriate* number of children they should have, the age of their first pregnancy and the time distance in which pregnancies should occur.

In the research by Asensio et al. (2019), which compares attitudes and experiences in relation to contraception in the Roma and non-Roma population in Spain, it became clear that **the Roma population is more traditional in its conception of the family**. This could be one of the reasons why they have more children than the non-Roma population. This **preference is interpreted in a racist way** by some health and social care professionals.

In our discussion with the experts, it became clear that too many young Roma women (aged 18-35) are treated with contraceptives without being informed of all the consequences. In many cases, they have not been requested by themselves, but have been *recommended* or prescribed because they are young, live in poverty or it has been assumed that they are not free to decide about the sexual relations they have. In other words, **the "recommendation" functions as a subtle coercion** that implies their acceptance because they are unable - afraid or unpowered- to question medical decisions, and because they trust the health system.

Another of the situations revealed in our fieldwork, and which Roma women suffer most from, is **total or partial sterilisation** (mainly tubal ligation). This is not perceived as *violence* by many Roma women, but as a recommendation which, however, does not coincide with their wishes or preferences. It is therefore reported that this action is often initially consented to - but not sufficiently informed - and that it is carried out on Roma women at a younger age on the basis of the cultural judgement of health professionals about the number of children they already had.

> One of the recurrent examples mentioned in the research is, after a second caesarean section, telling the patient woman that she *should have* a tubal ligation, because in the third caesarean section it would not be possible to perform the operation and it would be too dangerous for her life (and that of the future baby). However, health recommendations permit up to three caesarean sections.

Again, comparative research by Asencio et al. (2019), which surveyed more than 800 people (women and men from two Roma and non-Roma neighbourhoods in Barcelona), found that **Roma women were more likely to use tubal ligation and the contraceptive implant** than non-Roma women, and that Roma men were more likely to use coitus interruptus.

Regarding information on contraceptive methods, the study showed that Roma women **are more familiar with the IUD, the contraceptive injection and the tubal occlusion than non-Roma women**, and they are less familiar with the male condom. Roma men are less familiar with the female condom than non-Roma men. Therefore, a careful analysis of these situations from a gender perspective in public sexual and reproductive health policies also seems necessary.

5.3. Needs of women victims of FASC

5.3.1. Common needs

Throughout the research we have tried to distinguish what needs victims of FASC may have by paying attention to their different profiles. It is important to underline that little knowledge is available on this type of reproductive violence and **more research** is needed, **especially through the experiences of the victims themselves**.

Both, literature and the organisations and experts consulted refer to a set of specific needs of victims of FASC and RV in general. Notwithstanding that all underlined that all victims of VAW **have common needs that indicate to comprehensiveness (regarding the protection of all their rights) and universal and cultural accessibility.** Given that this is shared by all forms of violence, it is developed in the chapter on Proposals and Recommendations for Intervention (see chapter 15).

First of all, the **specific damage suffered and its consequences** must be taken into account (see point 4.5) so the following should be considered:

- **Need for awareness**: Victims are unaware of key SRHR and are often characterised by very poor access to gynaecological and obstetric health services and sexual and menstrual health information and counselling.
- In general, **many taboos persist** in the area of sexuality, human reproduction, menstruation and the women's body. For many women, these are topics that are **embarrassing**. Issues they **lack confidence** and comfort on. In many cases, they are not even aware of the violence they have suffered.
- **Credibility and recognition**. The persistence of stereotypes about sexuality, ableism and ethnic-racial discrimination (among others), influence the consideration of

victims' testimonies. In addition, when awareness is delayed, it is influenced by the time that has passed since the aggressions, so that victims believe that they will not be recognised as such.

> (...) she had experienced situations of abuse by her father, and what this woman did, was at the time, to go to the area social worker, who did not give her much credibility because, since she has mental health problems... she did not give much credibility to the discourse of what she said (E3).

> The story of a woman with a physical disability will be more credible than that of a woman with a mental disorder or a woman with an intellectual disability, because of the existing myths about these disabilities (E7).

- **De-homogenisation**. In the case of disability, it is pointed out that there are often social care professionals, police and judicial officers who tend to understand disability in a homogenous way, without taking into account the different types of disability that exist and the differences between them.

  The same would be true for Roma/gypsy women and women from different diasporas who are lumped into the category of "immigrant" without taking into account the differences in social and religious values and customs that affect their experiences.

- **Information on resources**. Victims of FASC need information that is accessible, clear, simple and adapted to the characteristics of the different profiles of the targeted women. According to WHO (2022), this care should be provided confidentially, without discrimination and without the threat of criminal prosecution or other punitive measures[60] . The last one is very important because there is a tendency to blame or criminalise women victims of RV.
- **Understanding and communication supports**: Women facing specific communication needs have feelings of incomprehension, especially if their communication supports are inadequate.

  For example, hearing impaired and deaf women may require, in addition to SSL interpreters, communication mediators; others may need deaf-blind

[60] General Comment No. 36, paragraph 8: Article 6 of the International Covenant on Civil and Political Rights, on the right to life. Geneva, United Nations Human Rights Committee (124th session), 2018 (CCPR/C/GC/36).

mediators. Some WIDD and women with cerebral paralysis may need speech therapists.

In addition to the above, pictograms representing different forms of violence and SRHR are useful for victims as a whole.

In the case of certain diasporas and communities, there is a need for leadership figures regarding mediation and cultural interpretation; who can *translate* the experiences and meanings given to a situation[61] . Also, when a problem occurs, the victims can have access to trained members of its own community who can facilitate the attention and the resources.

- Victims **need to be attended by staff trained** in RV and FASC, but also with regard to the specific needs of the groups of women who are their main victims.
- The experience of the LEs and experts (NGOs and researchers) categorically points out that training for the FASC in SRHR, health and gender equality and VAW are an essential requirement.
- Recovery process involves **specialised referral procedures**. This implies a coordinated work between health services and expert organisations (for highly vulnerable women and other concomitant violence such as SV, FGM, sexual exploitation, forced marriages, etc.).
- Victims require **gynaecological and medical examinations** to detect damage and health consequences of the violence they have suffered. They require **psychological and psychiatric** support with long-term monitoring. They may often require reparative surgeries and lengthy drug treatment (see the section on *Consequences of FASC*).
- It is necessary to carefully **assess the link between sterilisation and sexual assault;** especially against women with disabilities and victims of sexual exploitation.
- On the **needs for access to justice**, it is also necessary to ensure the perspective of intersectionality and universality. These remedies may include adequate, effective

[61] One of the experts explained it in the following way: "there are women who come with their daughters when they consider that they are developing at too early an age, their period comes too early and then that is going to *impede* their growth (...) They go to the health centre to try to *treat* this development. In India, for example, they are given that kind of treatment; here they are not, because it is understood as something normal (...) here the doctors tell them that they don't understand what the problem is (...) These mediators try to explain to them [the professionals] the context in which this is a problem for them (...)", they contribute to the coping of the situation." (interview).

and prompt reparation in the form of restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition[62] .

- These forms of RV are primarily addressed through criminal law, but without giving due emphasis to the **need to engage in prevention, protection and compensation** (GREVIO, 2020).
- Procedures (evidentiary activity, communications, examinations) should be adapted or supported for women with disabilities and members of diasporas.
- In the case of women with disabilities, when they are deprived of legal capacity, the barriers in the justice system are almost insurmountable. Even when reporting abuse, victims are often not perceived as credible (Holla, Juultje and Smits, José, 2018; Castellanos-Torres, 2020b). In this regard, already CRPD General Comment No. 3 (2016) warns about **the lack of awareness and harmful stereotypes on the part of the civil service, the judiciary, the prosecution or the police**. Lack of understanding and lack of recognition discourages reporting, and results in impunity and invisibility (Castellanos-Torres, 2020b).
- Violations of the sexual and reproductive rights of women with disabilities often occur because their right to exercise **legal capacity** was first violated. When sterilisation is performed, the will of women with disabilities is not taken into account if their right to legal capacity has been restricted (Serra, 2016).
- Barriers to access to justice for victims of RV can also arise in situations of **legal uncertainty**, such as those faced by: migrant women in an irregular administrative situation, pending resolution of their IP petition, women in situations of prostitution or trafficking for sexual exploitation or labour exploitation.
- **Symbolic reparation**. FASC - and VAW in general - is not included in symbolic acts of awareness-raising, denunciation and reparation on VAW.

Some of the interviewees have criticised the institutional act of forgiveness to the victims that was made when the change of article 156 of the Penal Code on forced sterilisations of women with disabilities was approved. It was considered insufficient and did not make restitution for the harm done to these sterilised women.

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[62] General Comment No. 22 on the right to sexual and reproductive health, paragraph 64 (article 12 of the International Covenant on Economic, Social and Cultural Rights). Geneva, United Nations Committee on Economic, Social and Cultural Rights, 2016 (E/C/12/GC/22).

- **Links and support**. The characteristics of FASC mean that women have been largely isolated in their victimisation. In most cases there is a direct link between the abuse and the social isolation and lack of social network. Bonding and friendship with others are required.

5.3.2. Specific needs according to profiles

With regard to the specific needs of **some groups**, the following has been collected throughout the research:

- **Women with disabilities**: they require significant dehomogenisation as a group; each disability has its own characteristics.
    - Families and caregivers need to understand that overprotection can become another form of violence. They need to know what violence against women with disabilities is, as well as RV in particular; they need to identify how to contribute to the victims' recovery.
    - In many cases, families and caregiving institutions have been the perpetrators of RV, requiring awareness of the harm done and avenues through which to make reparations to victims.
- **Roma women**: They need to know their rights as patients and citizens; they need to know how to identify the consequences of the FASC they have experienced. They also need support to identify possible discriminatory an anti-Roma attitudes (e.g., behind medical recommendations that are not neutral). This means that they need counselling on discrimination.
- **Migrant, asylum-seekers, refugee women**: They need an adaptation of the intervention in a more precise intercultural framework, which does not re-victimise them and which makes services accessible through cultural interpreters, which goes beyond the language barrier.
    - They may also require more **resources for family reconciliation** to ensure their access to care processes due to the lack of other support nearby.
    - Many women are vulnerable because of their administrative situation and therefore need **support in the regularisation** (or IP procedures) they are undergoing or need to initiate.

- Depending on their country of origin, they may be required to **learn Spanish** (and the co-official language of the Autonomous Community where they live).
- **SRHR is practically absent from the Reception System** and from the processes of inclusion which affects prevention, detection/identification and care. They represent a group with particular difficulties in finding out about the resources available for help in terms of equality and VAW (in general). They also face barriers of trust with certain services and professionals to whom they could verbalise the violence they have suffered.
- In addition, they may face situations of certain **institutional isolation**, which is why it is necessary to work specifically in these places. We mean (above all) forced isolation (e.g.: CIE) or limited isolation because they depend on institutional resources (e.g.: CETI of Ceuta and Melilla, CAR or CREADE).

6. FASC: regulatory and institutional framework

6.1. International and European context

6.1.1. General starting framework

Forced contraception, forced sterilisation and forced abortion are specific violations of **sexual and reproductive health and rights** (SRHR) and **fundamental rights** (Patel, 2019) such as: the right to health[63], the right to information[64], the right to liberty and security of the person[65], and the right to equality and non-discrimination[66].

> **Forced sterilisation** has been widely denounced as a human rights violation equivalent to torture and a particularly pernicious form of gender-based violence (UNFPA, 2018).
>
> **Forced abortion is** a violation of the right to be free from torture and cruel, inhuman and degrading treatment and punishment, including the right to physical and mental integrity[67] (WHO). In this regard, the WHO notes that:
>
> "States should prevent and prosecute forced abortions by public officials and private agents, especially when performed on women with disabilities or in accordance with coercive family planning laws and policies, as well as in the context of conflict"[68].

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[63] Collected by the international instrument of the UNs: the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC).

[64] Guaranteed by the International Covenant on Civil and Political Rights and the CRPD.

[65] Present in the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[66] Convention on the Elimination of All Forms of Discrimination against Women; International Covenant on Economic, Social and Cultural Rights; Convention on the Rights of Persons with Disabilities; International Covenant on Civil and Political Rights.

[67] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN, 1987)

[68] See in this regard: General Comment No. 28: Article 3 of the International Covenant on Civil and Political Rights, concerning the equal rights of men and women. New York (NY), United Nations Human Rights Committee, 2000 (CCPR/C/21/Rev.1/Add.10); Report of the United Nations Working Group on the issue of discrimination against women in law and in practice to the Human Rights Council. New York (NY), UN General Assembly, 2016 (A/HRC/32/44); Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. Report to the Human Rights Council. New York (NY), United Nations General Assembly, 2013 (A/HRC/22/53); General Comment No. 3: Article 6: Women and girls with disabilities. Geneva, United Nations Committee on the Rights of Persons with Disabilities, 2016 (CRPD/C/GC/3); Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Report to the Human Rights Council. United Nations, 2008 (A/HRC/7/3); Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report to the General Assembly. United Nations, 2009 (A/64/272).

> The protection of victims requires according to WHO (2022:10) that, within the right to non-discrimination and equality, States take measures to prevent the imposition of forced abortion, in particular on women and girls from groups that are especially vulnerable.

The **Declaration on the Elimination of Violence against Women** (Vienna World Conference on Human Rights, 1993) defines violence against women for the first time in an international body as a human rights problem; in its article 1, it explicitly includes in this definition the violence we are concerned with: **the practice of forced sterilisation and abortion, the coercive/forced use of contraceptives, female infanticide and prenatal sex selection**.

> Despite having been highlighted three decades ago, their inclusion by UN member states in their policies to combat VAW has been very uneven.

The Committee on Economic, Social and Cultural Rights of the United Nations Economic and Social Council (2016), in **General Comment No. 22 on the right to sexual and reproductive health** (article 12 of the International Covenant on Economic, Social and Cultural Rights) states that **sexual and reproductive health and rights are human rights**.

> They are not only integral to the right to health, but are **necessary for the enjoyment of many other human rights,** including the rights to life, freedom from torture and ill-treatment, freedom from discrimination, equal recognition before the law, respect for family life, education and work. They are therefore **universal and inalienable, indivisible, interdependent and interrelated**. States must ensure the availability, accessibility, acceptability and quality of facilities, goods, information and services related to sexual and reproductive health and rights.

The Committee on the Elimination of Discrimination against Women (CEDAW, 2017) in **General Recommendation No. 35 on gender-based violence against women**, states -specifically- that:

> "Violations of women's sexual and reproductive health and rights, such as forced sterilisation, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, and abuse and ill-treatment of women and girls seeking sexual and reproductive health information, goods and services, **are forms of gender-based violence** that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment" (paragraph 18. Emphasis added).

Within RV, it should be noted that **selective abortions as a sex-selective practice** are also considered a violation of human rights. This was made clear during the United Nations International Conference on Population and Development in Cairo (1994), and is specifically referred to in the 2011 United Nations inter-agency declaration (OHCHR, UNFPA, UNICEF, UN Women and WHO), *Prevention of gender-biased sex selection.* In the European context, it should be noted that this issue has been of particular importance (see next section).

All these international mandates must be implemented taking into consideration, in addition, **the Sustainable Development Goals of the 2030 Agenda,** and more specifically Goal 3 (Health and well-being), Goal 5 (Gender equality) and Goal 10 (Reducing inequalities) from the dual approach of gender and disability.

6.1.2. European context

FASC is listed as one of the forms of expression of **violence against women** in the Council of Europe Convention on preventing and combating violence against women and domestic violence (2011). Known as the **Istanbul Convention**, it was ratified by Spain and has been in force since August 1,2014.

> Alongside it, there is the so-called Warsaw Convention, the Council of Europe Convention on Action against Trafficking in Human Beings (Council of Europe Convention No. 197), done at Warsaw on May 16, 2005.

Forced abortion and forced sterilisation are offences under Article 39 of the Convention:

> *Article 39. Forced abortion and sterilisation*
> *Parties shall adopt such legislative or other measures as may be necessary to establish as a criminal offence, when committed intentionally:*
>
> *(a) Performing an abortion on a woman without her prior informed consent;*
>
> *(b) Performing a surgical intervention that has the purpose or effect of terminating a woman's capacity to reproduce naturally without her prior informed consent or understanding of the procedure.*

Forced **sterilisation** is still legal in 13 EU countries[69] and a legislative initiative is being promoted on the basis of the European Parliament Resolution of December 13, 2022 towards equal rights for persons with disabilities (2022/2026(INI))[70] .

Regarding **prenatal sex selection**, the Parliamentary Assembly of the Council of Europe in its 2010 Resolution condemned this practice as a gender inequality phenomenon that reinforces a climate of violence against women.

> This document analysed the situation in several European countries, and considered that the European instrument that regulates this situation is the 1997 *European Convention for the Protection of Human Rights and Dignity of the Human Being in relation to the Application of Biology and Medicine*, also known as the "Oviedo Convention", ratified by Spain in 1999[71] .
>
> The European Parliament (2016) in its Resolution entitled *Gendercide: where are the missing women*, stresses that *gendercide*[72] **is a crime and a serious violation of human rights** that requires effective means to combat and eliminate all the root causes that lead to patriarchal culture; considers such pressure on women a form of physical or psychological violence by the Council of Europe Convention on preventing and combating violence against women and domestic violence and by the Beijing Declaration and Platform; and urges governments to react to this phenomenon.

Finally, also at the European level, it is necessary to refer to the **European Parliament Resolution of June 24, 2021 on the situation of sexual and reproductive health and rights in the European Union,** in the context of women's health, as it refers to the eradication of FASC.

> The Resolution starts from the description of the worrying situation in European countries (the *Report on the situation of sexual and reproductive health and rights in the*

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[69] Portugal, Finland, Bulgaria, Croatia, Malta, Czech Republic, Cyprus, Denmark, Estonia, Hungary, Latvia, Lithuania and Slovakia.

[70] European Parliament resolution of December 13, 2022 towards equal rights for persons with disabilities (2022/2026(INI)) (access)

[71] Article 14. Non-selection of sex. The use of techniques of medical assistance to procreation for the purpose of choosing the sex of the person to be born shall not be permitted, except in cases where this is necessary to avoid a serious hereditary sex-linked disease.

[72] The European Parliament uses "gendercide" as a gender-neutral term referring to the large-scale, systematic and deliberate targeted killing of persons (men or women) belonging to a particular sex, which is a growing but under-reported problem in some countries, with lethal consequences, and in the above-mentioned Resolution specifically studies the causes, trends, consequences and methods to combat sex selection practices, which can also take the forms of infanticide and gender-based violence.

European Union in the framework of Women's Health 2021)[73] ; where the **negative impact that Covid-19** has had on women's sexual and reproductive health care systems is pointed out.

Among other issues, it **indexes the absence of statistical data** and concerns about the **added barriers, intersectional discrimination and violence** in access to health care faced by "marginalised individuals and groups, including ethnic or religious minorities, migrants, people from disadvantaged socio-economic backgrounds, people without health insurance, people living in rural areas, people with disabilities, LGBTIQ people, victims of violence, etc.". This is a consequence of "laws and policies that allow for coercive sexual and reproductive health practices and failure to ensure reasonable accommodation in access to quality care and information".

Point 1 of the Resolution refers to **non-discrimination**[74] **and the responsibility of Member States to safeguard the right of all persons to** "*make their own informed choices regarding sexual and reproductive health and rights, to ensure the right to physical integrity and personal autonomy, equality and non-discrimination and to provide the means for everyone to enjoy sexual and reproductive health and rights*".

It stresses reproductive and sexual health as an essential component of good health, calling on member states to provide **quality and accessible health services** in point 9, specifically mentioning access to such services for women with disabilities, victims of sexual and gender-based violence. It also stresses that prior consent must be given in all medical interventions related to sexual and reproductive health and rights.

Point 17 of the Resolution explicitly refers to women with disabilities, where it "expresses its deep concern that women and girls with disabilities are too often **denied access to sexual and reproductive health facilities and informed consent to contraceptive use and even face the risk of forced sterilisation**; calls on Member States to implement legislative measures to protect the physical integrity, freedom of choice and self-determination in relation to the sexual and reproductive lives of persons with disabilities" (emphasis added).

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[73] From the Committee on Women's Rights and Gender Equality (2021). V. blb.

[74] Point 1 refers to: age, sex, gender, race, ethnicity, class, caste, religion or belief, marital or socio-economic status, disability, HIV (or STI) status, national or social origin, legal or immigration status, language, sexual orientation or gender identity.

Finally, mention should be made of the **Proposal for a Directive of the European Parliament and of the Council on combating violence against women and domestic violence** (COM/2022/105 final) of 2022, which covers (among many other forms of violence) forced abortion and forced sterilisation (paragraph 4).

> RV is explicitly mentioned, in relation to the specialised support services to provide support that should be in place (paragraph 46)
>
> Regarding this Proposal, advocating for a holistic treatment of violence, the European Women's Lobby has pointed out the importance of considering within the notion of "**forced abortion**", the denial of safe and legal abortion care and forced sterilisation as a violation of women's sexual and reproductive rights, as well as forced marriages. This is stated in the *Study on the Proposal for a Directive - COM (2022) 105 final - of the European Commission on violence against women* (Freixes, 2022).

In fact, in the study of the process of **transposing this Directive into Spanish law**, the recommendations of the Economic and Social Council have been taken into account, which promotes the inclusion in the law of what is known as "**gynaecological and obstetric violence" and also surrogacy**. Although this legislation is in a process of transformation.

6.2. Rights of women with disabilities

Special attention should be paid to the international normative reference that protects women with disabilities, as they are the **main ones affected by FASC**.

The fundamental rights framework is the United Nations **Convention on the Rights of Persons with Disabilities** (2006), which entered into force in Spain in 2008, makes explicit reference to multiple discrimination against women and girls with disabilities, through Article 6 and other provisions[75] .

> The articles are directly or indirectly related to the protection and promotion of their sexual and reproductive rights. If women with disabilities are not recognised

[75] Article 6 makes direct reference to women with disabilities, noting the need for states to recognise that women and girls with disabilities are subject to multiple forms of discrimination and to take measures to ensure their full and equal enjoyment of all human rights and fundamental freedoms. Other related provisions include Article 12 on equal recognition before the law; Article 16 on protection from exploitation, violence and abuse; and Articles 23 and 25 on respect for home and family and health, respectively.

as equal before the law and do not have the right to exercise their legal capacity[76], it is difficult for them to exercise other human rights and fundamental freedoms. In particular, Article 16 Protection from exploitation, violence and abuse refers to protection both within and outside the home, and points to the need for appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and carers.

In addition, the rights of women with disabilities are also recognised in **CEDAW**, Article 12 of which states that States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

General Comment No. 3 of the UN Committee on the Rights of Persons with Disabilities in 2016 identified three main areas of concern regarding the protection of the human rights of women with disabilities: 1. violence; 2. sexual and reproductive health and rights; 3. discrimination.

> The Committee highlighted the persistence of violence against women and girls with disabilities, including sexual violence and abuse, forced sterilisation, female genital mutilation, and sexual and economic exploitation. It noted that their decisions **are superseded by those made by third parties** including legal representatives, service providers, guardians and family members, thus violating their rights under article 12 of the CRPD.
>
> All women with disabilities **should be able to exercise their legal capacity** autonomously, making their own decisions, with support if desired, about medical and/or therapeutic treatment. Restricting or withdrawing legal capacity can facilitate certain interventions such as forced sterilisation; consequently, it is essential to recognise the legal capacity of women with disabilities on an equal basis with others, as well as the right to start a family and access family support services on a regular basis.

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[76] This is why Law 8/2021, of June 2, which reforms civil and procedural legislation to support people with disabilities in the exercise of their legal capacity, this law has meant that Spain, 15 years after the Convention, complies with article 12, placing little emphasis on the will of the person.
It is therefore necessary to change from a system such as the one in force until now in our legal system, in which substitution predominates in decision-making affecting people with disabilities, to one based on respect for the will and preferences of the person who, as a general rule, will be in charge of making his or her own decisions. This is fundamental when analysing the relationship between sterilisation and judicial incapacitation.

This perspective has been further evidenced by the report of the **UN Special Rapporteur on the Rights of Persons with Disabilities** addressing sexual and reproductive health and rights of girls and young women with disabilities (2017). The *report of the Special Rapporteur on the rights of persons with disabilities* (2017), highlights that women face significant challenges while making autonomous decisions regarding their reproductive and sexual health, and are regularly exposed to violence, abuse and harmful practices, including forced sterilisation, forced abortion and forced contraception. Recalls that States have an obligation to invest in the sexual and reproductive health and rights of girls and young women with disabilities, and to end all forms of violence against them.

The **European Parliament resolution of November 30, 2017** on the implementation of the European Disability Strategy (2017/2127(INI)) "recognises that women with disabilities, especially intellectual disabilities, are more exposed to gender-based violence, sexual harassment or other types of abuse; further recognises that their dependency status may prevent them from identifying or reporting abuse; stresses the need to continue to address the implementation of the European Disability Strategy, which provides for preventive measures aimed at avoiding all types of abuse and providing high quality, accessible and tailored support to victims of violence."

Finally, the **opinion of the European Economic and Social Committee** on *the situation of women with disabilities*, of an exploratory nature, requested by the European Parliament (April 3, 2018. 2018/C 367/04), mentions as a specific observation sexual and reproductive health and rights, including respect for the home and the family.

6.3. Spanish regulatory framework

6.3.1. State regulation

Spain has ratified all the key treaties on human rights, women's rights and the rights of persons with disabilities. They belong to our legal acquis[77]. They establish the obligation to act with due diligence against all forms of violence against women.

[77] Given the specificity of the matter at hand, we will not go into detail in this section on the regulatory framework in Spain on VAW in all its dimensions. For example, the SSGV 2022-2025, which compiles this framework and updates it in detail, can be consulted at the Government Delegation against Gender Violence (access).

Regarding references to FASC, it is necessary to start again from the **Istanbul Convention**, which was ratified by Spain in 2014 and has been in force since then. Its **article 39** refers specifically to forced abortion and forced sterilisation (explained in the previous point).

In a non-explicit way, FASC can be contemplated -as an area of harm- of intimate partner/ex-partner violence (if the man is the perpetrator) according to **Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence.** As already noted, this is a reductionist approach to the specific typology of reproductive violence.

Together with the Istanbul Convention, in the state framework, the FASC is mainly included in the **Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy** (Organic Law 2-2010 on SHR); above all thanks to the **Organic Law 1/2023, of February 28, which modifies the Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy.**

> Organic Law 1/2023 of February 28, which amends Organic Law 2/2010 of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy, considers **violence in the reproductive sphere** to be "any act based on gender-based discrimination that violates the integrity or free choice of women in the area of sexual and reproductive health, their free decision on motherhood, its spacing and timing" (Article 2.7).

The law **explicitly adds FASC** as a form of violence within the legal definitions (Article 2) and incorporates a Title III on Protection and guarantee of sexual and reproductive rights, where in its Chapter III on Measures of prevention and response to forms of violence against women in the area of sexual and reproductive health, it incorporates Article 31 on the actions of public administrations, which must detect and prevent such violence. That is:

> *Article 2. Definitions.*
>
> *(...) 8. Forced sterilisation: A form of reproductive violence against women which consists of the performance of a surgical intervention intended to terminate or having the effect of terminating a woman's capacity to reproduce naturally without her prior informed consent or understanding of the procedure.*
>
> *9. Forced contraception: A form of reproductive violence against women consisting of medical intervention by any means, including medication, which has similar consequences to forced sterilisation.*
>
> *10. Forced abortion: Form of violence against women in the reproductive sphere that consists of*

performing an abortion on a woman without her prior and informed consent, with the exception of the cases referred to in article 9.2.b) of Law 41/2002, of November 14".

Article 31. Action against forced abortion, forced sterilisation and forced contraception

1. The public authorities shall ensure that actions enabling cases of forced abortion, forced contraception and forced sterilisation are avoided, with special attention to women with disabilities.

2. The public administrations, within the scope of their powers, shall promote sexual and reproductive health programmes aimed at women with disabilities, which shall include measures for the prevention and detection of the forms of reproductive violence referred to in this article, for which purpose the specific training necessary for professional specialisation shall be provided.

Furthermore, Article 2 of the Organic Law 2-2010 on SHR guides the public authorities on the notion of **health that must be guaranteed to citizens with regard to SRHR**:

- **Sexual health**: The general state of physical, mental and social well-being, which requires an **environment free of coercion, discrimination and violence**, and not merely the absence of disease or illness, in all matters relating to a person's sexuality.
- **Reproductive health**: The general state of physical, mental and social well-being, and not merely the absence of disease or illness, in all matters relating to reproduction.

For both cases, Article 2 considers that it is also "a **comprehensive approach** to analyse and respond to the needs of the population, as well as to guarantee **the right to health and reproductive rights**". It would therefore allow for action on RV in all its forms.

This orientation is reinforced in Chapter II Protection and guarantee of sexual and reproductive rights in the gynaecological and obstetric field (Articles 26-30), covering principles of action, research and data collection, training and protocol development.

Organic Law 10/2022, of September 6, on the Guarantee of Sexual Freedom refers to the inclusion in Art. 32 of the right to comprehensive, specialised and accessible support, to personal assistance, as a resource available to women with disabilities with the aim of strengthening their autonomy in all legal proceedings, protection and support measures and services for victims. It is important to re-emphasise that it is women with disabilities who are the main victims of FASC.

From a punitive approach, **Organic Law 10/1995, of November 23, 1995 of the Penal Code** includes several manifestations of RV.

In the Spanish **Penal Code, non-consensual abortion** is explicitly included together with other crimes against freedom, torture and against moral integrity, sexual freedom and sexual indemnity; specifically in its Title II On abortion. This Title invalidates consent obtained "by means of violence, threat or deception" and takes into account unsafe abortions:

> *Article 144.*
> *Whoever causes the abortion of a woman, without her consent, shall be punished with a prison sentence of four to eight years and special disqualification to exercise any health profession, or to provide services of any kind in gynaecological clinics, establishments or surgeries, public or private, for a period of three to ten years.*
> *The same penalties shall be imposed on anyone who performs the abortion having obtained the consent of the woman by means of violence, threat or deception.*
> *Article 145a.*
> *1. Anyone who performs an abortion in the cases contemplated by law shall be punished with a fine of six to twelve months and special disqualification from providing services of any kind in gynaecological clinics, establishments or surgeries, whether public or private, for a period of between six months and two years:*
> *a) Without the required prior opinions;*
> *b) Outside an accredited public or private centre or establishment. In this case, the judge may impose the sentence in its upper half.*
> *2. In any case, the judge or court shall impose the penalties provided for in this article in the upper half when the abortion has been carried out after the 22nd week of gestation.*
> *3. Pregnant women shall not be punished under this provision.*

With regard to sterilisation, it should be noted that, in Spain, **forced sterilisation** of **women with disabilities** was legal until December 2020, when it was finally prohibited by **Organic Law 2/2020 of December 16, amending the Criminal Code to eradicate forced or non-consensual sterilisation of persons with disabilities who are judicially incapacitated**[78] .

> Before this legislative change, such sterilisations were allowed under the original article 156 of the Organic Law 10/1995, of November 23, 1995, of the Penal Code, as they could be carried out after a judicial incapacitation. Nowadays, no judge has been able to authorise forced sterilisation of women with disabilities; however, many victims have been left behind.

[78] BOE No. 328 of 17 December 2020, pages 115646 to 115649 (access).

The current Organic Law 2/2020 has a single Article to delete the paragraph referred to has been a historic milestone in which the organised movement of women with disabilities has been advocating for years for our country to be in line with the UN Convention.

With regard to **selective abortion as a practice of sex selection** of the baby, the association of this practice with RV does not appear explicitly in our regulatory framework, but it is worth remembering that it can be found in article 2.7, as part of the definition of reproductive violence, of Organic Law 1/2023, of February 28, which modifies Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy.

Spain ratified in 1999 the aforementioned **European Convention for the Protection of Human Rights and Dignity of the Human Being in relation to the application of Biology and Medicine** (Oviedo, 1997). We belong to the group of countries among which pre-implantation genetic diagnosis is legal and sex selection is only allowed for medical reasons. In Law 14/2006, of May26, on Assisted Human Reproduction, and by which sex selection or genetic manipulation for non-therapeutic or unauthorised therapeutic purposes is considered a very serious offence.

Finally, with regard to other **women in a situation of special vulnerability** to RV, there are different instruments of protection under the notion of VAW.

Victims of FGM, women in prostitution and women victims of trafficking for sexual exploitation have specific protection tools[79] (see in this respect the aforementioned FEMP study, 2023) on which the indicators on FASC (and GS) can be improved.

In the specific case of **migrant women, refugees and asylum seekers,** their protection against male violence is generally insufficient.

The legislation on foreigners contains two specific provisions to protect women who suffer gender-based violence[80] , in addition to those resulting from the protection against the crime of human trafficking.

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[79] Organic Law 10/1995, of November23, of the Criminal Code establishes the criminalisation of the crime of genital mutilation in article 149.2 of the Criminal Code (see specialised regulations and protocols on the DGVG website. The offence of trafficking in human beings is defined in article 177 bis (see specialised regulations and protocols on the DGVG website).

[80] Women who arrive in Spain in a process of family reunification obtain a residence permit dependent on that of their spouse, making its renewal conditional on the maintenance of the marital bond. In the case of situations of gender-based violence, Organic Law 4/2000 in Article 19.2 and RD 557/2011 (regulations for the application of the

The Immigration Law comprises two specific provisions to protect foreign women who suffer from GBV.

- Women who arrive in Spain in a process of family reunification obtain a residence permit dependent on that of their husband, making its renewal conditional on the maintenance of the marital bond. However, women facing GBV can access to an independent authorisation in cases where a protection order has been issued (Organic Law 4/2000 in Article 19.2 and RD 557/2011 (regulation on the application of the law on foreigners) in Article 59.2).
- Secondly, residence and work permits are provided for women who suffer gender violence (first provisional, once a protection order has been issued; permanent, once the aggressor has been convicted). In order to ensure that women in an irregular migratory situation are not discouraged by this circumstance (for fear of a sanctioning procedure being initiated for irregular stay), sanctioning proceedings are paralysed when a police report is filed for IPV or SV (see the regulations in relation to Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence; and Organic Law 10/2022, of September 6, on comprehensive guarantees of sexual freedom).

As far as refugee women are concerned, Article 7 of **Law 12/2009, which regulates the right to asylum and subsidiary protection,** defines the grounds of persecution that give rise to the recognition of refugee status, **expressly** including **gender-based persecution** (as explained in previous sections).

In this regard, it should be noted that the Regulation governing[81] the International Reception and Temporary Protection System also **explicitly refers to violence against women** in:

law on foreigners) in Article 59.2, in relation to family reunification, allow the reunited woman to access an independent authorisation in cases where a protection order is issued. Secondly, residence and work authorisations are provided for women who suffer gender violence, provisional once a protection order is issued and permanent once the aggressor is convicted. In order to ensure that women in an irregular administrative situation are not deterred by this circumstance for fear of a sanctioning procedure being initiated for irregular residence, sanctioning proceedings are paralysed when a report of gender-based violence is filed.

[81] Royal Decree 220/2022, of March 29, approving the regulations governing the reception system for international protection (B.O.E. no. 76, of 30/03/2022).

- recognition of vulnerability[82] (art.2);
- the general principles for action[83] (art.6);
- the reception pathway (art.11)[84] ;
- the right to "receive comprehensive care for recovery from violence, if any, suffered prior to or in the context of displacement" (art.12);
- the guiding principles (art.26), which state: (f) "The prevention of harassment and acts of gender-based violence, including sexual violence and harassment";
- the characteristics of the Reception Centres (art.29); which must have focal points for "prevention, detection and coordination of actions" of VAW and protocols for action;
- in the training of system staff (art.30).

The practical application of the Regulation in the System will mean an improvement in guaranteeing the gender perspective and the protection of women with international protection system in Spain.

In general, **it can be foreseen that the protection for victims of FASC will be similar to that which exists for GBV**, i.e., the current model will be extended to all forms of violence against *all women* that are included in the institutional framework for combating VAW.

This is reflected in the institutional efforts to fully develop the Istanbul Convention and the extension of services included in the *Reference Catalogue of policies and services on violence against women in accordance with international human rights standards*

[82] This includes, among others, minors, elderly persons, persons with disabilities, persons with serious illnesses, pregnant women, single parents with minor children, victims of human trafficking, victims of any manifestation of violence against women, persons belonging to ethnic or national groups subject to discrimination, persons with mental health problems, LGTBI+ persons or other persons who have suffered torture, rape or any serious form of psychological, physical or sexual violence, which are distinct from torture.

[83] Article 6.c) Incorporate a human rights, gender and intersectionality approach in all programmes, measures and actions carried out, including the recognition of discrimination and violence that specifically affects women and the prevention of and attention to violations of the human rights of LGTBI+ people and people because of their national or ethnic origin.

[84] Regarding the proposal for referral to places for people in situations of vulnerability, to other resources or centres not included in the reception system. It is stated that "In order to guarantee effective care and protection in the cases indicated above and, in particular, in cases of victims of human trafficking, of any manifestation of violence against women, or who have suffered torture, rape or other serious forms of psychological, physical or sexual violence, the protocols and mechanisms for inter-institutional coordination and referral that are established for this purpose shall be applied".

approved by the Sectoral Conference on Equality, at its plenary meeting held on July 22, 2022 in Tenerife.

6.3.2. Regional references (AACC)

With regard to the situation of FASC in the different Autonomous Communities, in their legislation on violence against women, there are different types of regulations in which abortion and forced sterilisation are present as **forms of violence against women**.

Four autonomous communities: Andalusia, Catalonia, Valencia and La Rioja, **expressly name** forced sterilisation as a form of gender-based violence:

- In **Andalusia**, Article 3 of Law 13/2007, of November 26, on measures for the prevention and comprehensive protection against gender-based violence, includes among the types of violence:

  > f) Violence against women's sexual and reproductive rights, understood as actions that restrict the free exercise of their right to sexual or reproductive health, that deny their freedom to enjoy a full and safe sexual life, the right to decide, the right to exercise their maternity and the right to be **free from forced sterilisation**.

- In **Catalonia**, Article 5 of *Law 5/2008, of April 24, on the right of women to eradicate gender-based violence*, in its article 5, related to the areas of gender-based violence, establishes:

  > f) Violence arising from armed conflict: includes all forms of violence against women that occur in these situations, such as murder, rape, sexual slavery, forced pregnancy, forced abortion, **forced sterilisation**, intentional infection with disease, torture or sexual abuse.
  >
  > g) Violence against women's sexual and reproductive rights, such as selective abortions and forced sterilisations.

- *Law 7/2012, of November 23, comprehensive law against violence against women in the **Valencian Community in*** its article 3 point 8 expressly mentions sterilisation as one of the manifestations of violence against women in the following way:

  > 8. **Abortion and forced sterilisation**: the performance of an abortion without her free, prior and informed consent, and of sterilisation or surgical intervention intended to

> terminate or resulting in the termination of a woman's capacity to reproduce naturally, without her prior and informed consent or understanding of the procedure.

- Article 5 of Law 11/2022, of September 20, against Gender Violence in **La Rioja,** on the forms and manifestations of gender violence, expressly states the following in point 2.f)

> f) Violence against the sexual and reproductive rights of women and girls, understood as actions that restrict the free exercise of their right to sexual or reproductive health, that deny their freedom to enjoy a full and safe sexual life, the right to decide, the right to exercise their maternity and the right to be free from **forced sterilisation**.

Other ACs, although they do not specifically mention forced sterilisation, include generic references in their regulations:

- In the case of Murcia and the Canary Islands, they respectively name in their regulations the **medical procedure without consent**. See Article 40.2 of Law 7/2007, of April 4, for Equality between Women and Men, and Protection against Gender Violence in the **Region of Murcia** and in the **Canary Islands**, Law 16/2003, of April 8, on Prevention and Integral Protection of Women against Gender Violence, modified by Law 1/2017, of March 17, amending Law 16/2003, of April 8, on Prevention and Integral Protection of Women against Gender Violence, which in its Article 3. 2. indicates violence against women's sexual and reproductive rights, understood as the performance of an abortion on a woman without her prior and informed consent or the surgical intervention whose aim is to put an end to her reproductive capacity.
- In Aragón, Cantabria, Castilla la Mancha and the Basque Country, their respective regulations cover **"*Violence against women's sexual and reproductive rights*" *in* a generic way**.

> In **Aragon,** Law 4/2007, of March 22, on Prevention and Comprehensive Protection of Women Victims of Violence in Aragon, Article 2 mentions violence against sexual and reproductive rights. In **Cantabria,** Law 1/2004, of April 1, Integral for the Prevention of Violence against Women and the Protection of its Victims, in Article 3. In *Law 4/2018, of October 8, for a Society Free of Gender Violence in* ***Castilla-La Mancha***, Article 4 recognises manifestations of violence that are related to reproductive violence.

Likewise, in the **Basque Country,** Law 4/2005, of February 12, for the Equality of Women and Men, modified by Law 1/2022, of March 3, on the second modification of the Law for the Equality of Women and Men, states in Article 50.3 that: "Violence against women constitutes gender-based violence: intimate partner violence, domestic violence, sexual violence, femicide, trafficking in women and girls, sexual exploitation, female genital mutilation, forced marriages and other harmful traditional practices, coercion or arbitrary deprivation of liberty, torture, institutional violence, harassment, political gender violence, gender-based violence, violence against women and girls, sexual violence against women and girls, sexual exploitation and violence against women and girls, gender-based political violence, digital violence and **violence** in social networks, **obstetric violence, violation of sexual and reproductive rights, as well as any other form of violence that harms or is likely to harm the dignity, integrity or freedom of women and girls that is provided for in international treaties, in the Spanish Criminal Code or in state or autonomous community regulations.** (...)".

- In Castilla y León, Galicia and Navarra, forced sterilisation could be included in the non-specific mention of "any other form of violence" that appears in its articles.

  Law 13/2010 of December 9, 2010 against gender-based violence in **Castilla y León, in** Article 2; in **Galicia,** Law 11/2007 of July 27, 2007 for the prevention and comprehensive treatment of gender-based violence, in Article 3.

  In **Navarre,** the Foral Law 14/2015, of April 10, to act against violence against women, considers "Any other form of violence that harms or is likely to harm the dignity, integrity or freedom of women that is provided for in international treaties, in the Spanish Penal Code or in state or foral regulations".

- Both in **Extremadura** and **Asturias** their regulations do not include this type of reproductive violence as a form of gender-based violence in their definitions -article 4 and article 2, respectively-, which are similar to the concept of gender-based violence established in the *Integral Law 1/2004.*
- Finally, in the case of the **Balearic Islands,** Article 65 of its legislation does not include forced sterilisation in its definitions, but it does, for example, include Female Genital

Mutilation (FGM), as does *Law 5/2005 against gender violence in the* ***Community of Madrid***, which expressly mentions FGM in its article.

A review of regional legislation on violence against women and the inclusion -or not- in its definitions of reproductive violence, specifically forced sterilisation, shows a very heterogeneous scenario, which can lead to **disparate results in the attention to victims and generate territorial inequalities.** Thus, as the GREVIO Report (2020) refers, there are noticeable differences in terms of the scope of regional legislation, **the provision of services and the funding allocated**.

6.3.3. Other institutional references

The III Strategic Plan for the Effective Equality of Women and Men 2022-2025 (PEIEMH) is the key public policy to promote equal opportunities between women and men in Spain, aimed to promote the fundamental rights of women in our country.

Within the PEIEMH, reproductive violence is **partially covered**, both in **Axis 3 "Lives free of male violence"** and in **Axis 4 "A country with rights for all"**.

Axis 3 on male violence appears within Line MV.1 Institutional framework: consolidating the frameworks of institutional obligations in the face of the different forms of male violence, the elimination of inadequate or unnecessary gynaecological and obstetric interventions is included among the priorities. Defining and responding to violence in the sexual and reproductive sphere, as well as inappropriate or unnecessary gynaecological and obstetric interventions in the framework of the reform of the Organic Law 2/2010 of March 3, on sexual and reproductive health and interruption of pregnancy is also referred to in MV.1.1.3. Measures 349, 350 and 351.

Axis 4 A country with rights for all, considers in turn the RV in Line DEM.2. Health, sexual and reproductive rights: incorporating gender equality and the voice of women in public health policies, and guaranteeing rights, and specifically in the points:

- DEM.2.2. Guarantee sexual and reproductive health and rights for all women.
- DEM.2.2.1 Propose and approve the reform of Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary termination of pregnancy to guarantee the effective exercise of recognised rights and legislate against violence in the sexual and reproductive sphere, for the elimination of

inappropriate or unnecessary gynaecological and obstetric interventions, and against reproductive exploitation, all through a participatory process (measure 518).

- DEM.2.2.3. Guarantee universal access to sexual and reproductive health services, and especially to contraceptive methods, emergency contraception and termination of pregnancy for all women in the National Health System.

Together with the PEIEMH, the framework for institutional action on FASC has a dual nature. On the one hand, we find references to **public policies on** sexual and reproductive **health and,** on the other hand, to **action on violence against women**.

In relation to the first area, at state level, with regard to sexual and reproductive health care, there is the ***National Strategy for Sexual and Reproductive Health* (NSSRH) (**2011), for which the Ministry of Health is responsible. Likewise, there are the actions of the Women's **Health Observatory** of the General Directorate of Public Health, which works on the development of common lines of action to reduce gender inequalities in health, including in the area of sexual and reproductive health.

The NSSRH develops 4 strategic lines: health promotion, health care, training of professionals and research, innovation and good practices. FASC is not specified in the NSSRH, with the exception of "forced abortions and pregnancies" linked to sexual violence and its approach as part of a comprehensive sexual health policy. Greater emphasis is placed on the relationship between gender-based violence and sexual and reproductive health.

The conceptual framework of **the NSSRH belongs to an institutional framework that is more than a decade older** than the current one; its approaches are not aligned with the Istanbul Convention nor with Organic Law 10/2022 of September 6, on the comprehensive guarantee of sexual freedom, nor with Organic Law 1/2023 of February 28, which amends Organic Law 2/2010 of March 3 on sexual and reproductive health and the voluntary interruption of pregnancy. The NSSRH Operational Plan 2019-2020 also makes no reference to FASC.

It should be stressed, however, that among the **cross-cutting aspects** included in the NSSRH, the **active participation of women** in the process itself is highlighted, as well as the **accessibility** of information. Attention to disability is also one of them.

In this sense, as part of the NSSRH, the aim was to achieve the objective "to ensure adequate care for women with disabilities. To provide the necessary structural means and information to enable them to exercise their right to decide freely and responsibly the number of children they want, the spacing between them and the satisfactory way to carry it out", as well as to facilitate their participation in the process.

The NSSRH recommends facilitating accessibility, having protocols tailored to the specific needs of women with disabilities, promoting their resilience and autonomy, designing specific programmes for them, and creating meeting points with women who are or have been in the same situation.

In the same way that in the field of *gender violence* there is a heterogeneous framework of action at regional level, in the specific case of sexual and reproductive health the same thing happens, that is to say, we find a panorama of institutional action that shows territorial variability and this can lead to inequities in health care.

The situation of **women with disabilities and attention to SRHR** is particularly relevant, as they are the main victims of FASC. According to the study by Castellanos-Torres (2023), in the different autonomous regions there are four types of situations with the following differences with respect to women with disabilities:

- those that have included the **specifics of sexual and reproductive health care for women with disabilities in their** public policies, such as Andalusia[85] , Canary Islands[86], Valencian Community[87] .
- ACs that have developed specific **regulatory frameworks** related to maternity and sexual and reproductive health, such as Aragón[88] , Navarra[89] , Castilla la Mancha[90] and Cataluña[91] .
- ACs that have developed general Health Plans/Strategies, but in which **there is no express mention of women with disabilities in the area of sexual and reproductive**

[85] These include the accessibility of gynaecological consultations.
[86] Programme for Affective-Sexual and Reproductive Health Care (PASRH)
[87] Sexual and Reproductive Health Strategy of the Valencian Community 2017-2021.
[88] Article 71 of Law 7/2018, of June 28, on equal opportunities between women and men in Aragon obliges the powers of the Autonomous Community of Aragon to protect *maternity*.
[89] Regional Decree 103/2016, of November 16, which establishes the organisation of health services in the field of sexual and reproductive health.
[90] Law 12/2010 of November 18, 2010 on equality between women and men in Castile-La Mancha.
[91] Portfolio of Services of the Sexual and Reproductive Health Care Units to Support Primary Care published in 2007 by the Department of Health of the Generalitat of Catalonia.

health, as is the case of Asturias[92] , Castilla y León, Extremadura, Galicia, Basque Country[93] , Balearic Islands[94] and La Rioja[95] .

In the Aligned Strategies Plan (*Plan Estrategias Alineadas)* de la Rioja 2021-2024, maternity and sexuality is mentioned in point 15, in relation to the training of midwives in the sexual and reproductive health protocols, in addition to promoting maternal education.

A mixed situation, is the case of Cantabria II Action Plan: Women's Health (2008-2011). In action area 2, related to Sexual Health, there is a direct objective for women with disabilities*: To promote the recognition of the right to sexuality of women with disabilities.*

- Autonomous Communities that have **specific strategies/plans for people with disabilities**, such as the Community of Madrid[96] and the Region of Murcia.[97]

With regard to the institutional framework concerning **violence against women**, it is necessary to refer to the **State Pact on Gender Violence** (SPGV) (2017, extended on November 25, 2022)[98] .

Approved by the plenary of the Congress of Deputies, it is the key institutional reference in Spain together with the State Strategy to combat Sexist Violence 2022-2025 (SSGV). In the Consolidated Document of the SPGV (DGVG, 2019), references to forced abortion and sterilisation appear in the axis 2. Improving the institutional response: coordination, Networking, within point 2.6:

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[92] Strategy for pregnancy, childbirth, neonatal and breastfeeding care in Asturias. It contains guidelines for good practice in normal childbirth and neonatal care, as well as good practice in pregnancy and puerperium. There is no mention of disability.

[93] It has a Strategic Health Framework 2021-2024 that includes a section dedicated to sexual and reproductive health that promotes informed and healthy sexuality, with a gender perspective and respect for diversity.

[94] Plan for Humanisation in the field of Health 2022-2027

[95] Aligned Strategies Plan of la Rioja 2021-2024, aimed at professionals to share health strategies. Maternity and sexuality is mentioned in point 15, in relation to the training of midwives in the agreed sexual and reproductive health protocols, in addition to promoting maternal education.

[96] The Madrid Strategy for the Care of People with Disabilities 2018-2022, in its measure 41 establishes: "Develop a sexuality and disability programme to provide sex education, information and support in all biopsychosocial, affective and emotional aspects of users, including training and information for families and professionals of all categories of the centres of the Social Care Agency of Madrid".

[97] Regional Action Plan for Persons with Disabilities, 2003.

[98] The Pact envisages extending the provisions of Organic Law 1/2004 on Comprehensive Protection Measures against Gender Violence and making a number of amendments. These amendments are based on the Istanbul Convention and the recommendations of its monitoring mechanism GREVIO, as well as General Recommendation No. 19 and General Recommendation No. 35 of the CEDAW and the recommendations of the UN Human Rights Council on the issue of discrimination against women in law and in practice. The change in legislation has not yet been implemented.

The Parliamentary Groups subscribing to this Report note the need to: To declare that physical, psychological and sexual violence, including rape, female genital mutilation, forced marriage, sexual harassment and gender-based harassment, ***forced abortion and forced sterilisation are also forms of violence against women in*** *accordance with the Istanbul Convention, even in cases where the relationship required for the application of the LO 1/2004 does not exist with the aggressor. Therefore, the care and recovery, with the recognition of specific rights of women victims of any act of violence contemplated in the Istanbul Convention, and not provided for in LO 1/2004,* ***will be governed by the specific and comprehensive laws*** *that are issued for the purpose of adapting the need for intervention and protection to each type of violence.* ***Until this regulatory development takes place, other forms of gender violence recognised in the Istanbul Convention will receive preventive and statistical treatment within the framework of LO 1/2004****. Likewise, the criminal response in these cases will be governed by the provisions of the Penal Code and criminal laws.*

In any case, with the approval of the **Reference Catalogue of Policies and Services on Violence Against Women in Accordance with International Human Rights Standards** within the Resolution of 16 March 2023, of the Secretary of State for Equality and against Gender Violence, which publishes the Agreement of the Sectoral Conference on Equality of 3 March 2023, approving the joint multiannual plan on violence against women (2023-2027), "all forms of violence against women" are addressed from various areas of the Pact.

These areas of the Pact relate to:

- Area 1. Preventing and raising awareness of all forms of violence against women
- Area 2. Comprehensive social assistance and reparation
- Sub-area 2.1. Specialised services for support, assistance and comprehensive recovery. Action 2.1.02. Free, accessible, safe and confidential comprehensive care and recovery services that guarantee the privacy and dignity of the victim, for victims of all forms of violence against women. Action 2.1.03. Specialised comprehensive care and recovery services for children and other children and adolescents under their guardianship or care and custody of women victims of all forms of violence against women.

- Sub-area 2.3. Health services action 2.3.01. The public health system will be promoted to guarantee victims of all forms of violence against women. Including free of charge (action 2.3.03).
- Area 3. Protection and access to justice
- Sub-area 3.1. Protection and action 3.1.02. The promotion of compulsory training, as well as the provision of protocols for action, to deal with all manifestations of violence against women.
- Sub-area 3.2. Access to justice for all manifestations of violence against women

The State Strategy to Combat Gender Violence (SSGV) 2022-2025 mentions, for the first time in the Spanish policy, some of the most invisible and least known forms of violence. However, their presence is uneven within the expected lines of action and measures. One of the innovative elements of the Strategy is that it addresses to **all forms of violence against women**.

Reproductive violence" is mentioned in the diagnosis of the situation, although no data is provided on the national level and, moreover, specifically in relation to women with disabilities. They are taken into account in the Contextualisation section, citing forced abortion and sterilisation as part of this type of violence, along with the commercial exploitation of women's bodies (in relation to surrogacy).

Likewise, the Strategy focuses on reproductive violence as part of the attention to sexual violence. Within the package of measures, RV is included in:

- **Axis 2 on Awareness-raising, prevention and detection** of different forms of gender-based violence, within Line 2.1. Broadening the view of all forms of violence and all victims and survivors: improving knowledge of all manifestations of gender-based violence. And specifically with regard to the measures:
  - Action 63. Conduct studies on forced sterilisation as a form of violence against women.
  - Action 66. Publication of research on the incidence of inappropriate and unnecessary gynaecological interventions in gynaecological-obstetric, perinatal and reproductive health practice in public and private health centres.

- Apart from that, there are several measures related to awareness raising and prevention in the field of reproductive rights (Actions 87, 137, 138).

- **Axis 3 on Protection, security, care and comprehensive reparation**, within Line 3.6. Guaranteeing individual and comprehensive reparation, in Measure 233. Guaranteeing protection of the right of all victims to therapeutic, social and sexual and reproductive health treatment.

Finally, as regards the **regional framework for the eradication of male violence**, as stated in the First Evaluation Report on Spain by GREVIO (2020), there are great differences between the Autonomous Communities. Especially in the implementation of public policies as set out in the Istanbul Convention.

> Despite the various coordination measures adopted at institutional level, comparable levels of protection and support are not guaranteed for the different forms of gender-based violence to which women and, in particular, women with disabilities may be exposed. This is particularly relevant in the case of forms of violence that occur outside the sphere of the partner and ex-partner, such as VAW with disabilities in the family environment or by carers.

The GREVIO Report warns that few autonomous communities offer specialised services for victims of sexual assault and rape[99] , and there are even fewer specialised support services for women at risk of reproductive violence.

> It points out that public policies and resources for dealing with VAW in our country have been directed mainly at the context of the partner or ex-partner, in line with the concept of gender-based violence set out in the Comprehensive Law 1/2004, with less action being taken in relation to the other forms of violence.
>
> Given the lack of comprehensive policies to address these other forms of violence, **the institutional response at regional level has been uneven**, lacking a perspective focused on victims and lacking inter-institutional coordination. This situation becomes more palpable when it comes to facilitating interaction between the set of professionals involved in dealing with RV. In the same way, data collection, awareness-raising and

[99] CIMASCAM in Madrid's Community, AMUVI (association) in Andalusia, Crisis centre in Asturias and the one in Madrid City Council. According to the GREVIO report (2020), of the 17 Autonomous Communities, only seven have a specialised service for victims of sexual assault and rape, leaving a large part of Spain and rural areas in particular unattended.

training for professionals on these other forms of violence seems to be more limited (GREVIO, 2020).

The GREVIO Report (2020) identifies as fundamental tasks for public policy: **investment in services to address reproductive violence**, counselling, long-term psychological support and victim-centred care sensitive to the traumatic experiences.

7. FASC: mapping of care for women victims

7.1. The intervention of the LEs

7.1.1. Local actions on VAW

The local entities (LE) (also mentioned as local authorities, LA) that have taken part in the research survey have **different backgrounds in dealing with violence against women** (VAW). They represent all the Autonomous Communities in the country. The territorial distribution of those participating in the survey can be consulted in the methodology (chapter 2).

> There are pioneering local councils with actions on equality since 1980 and also local entities that started their policies more recently, mainly thanks to the SPGV. According to the data collected in the survey, the beginning of the actions is -on average- in 2005.

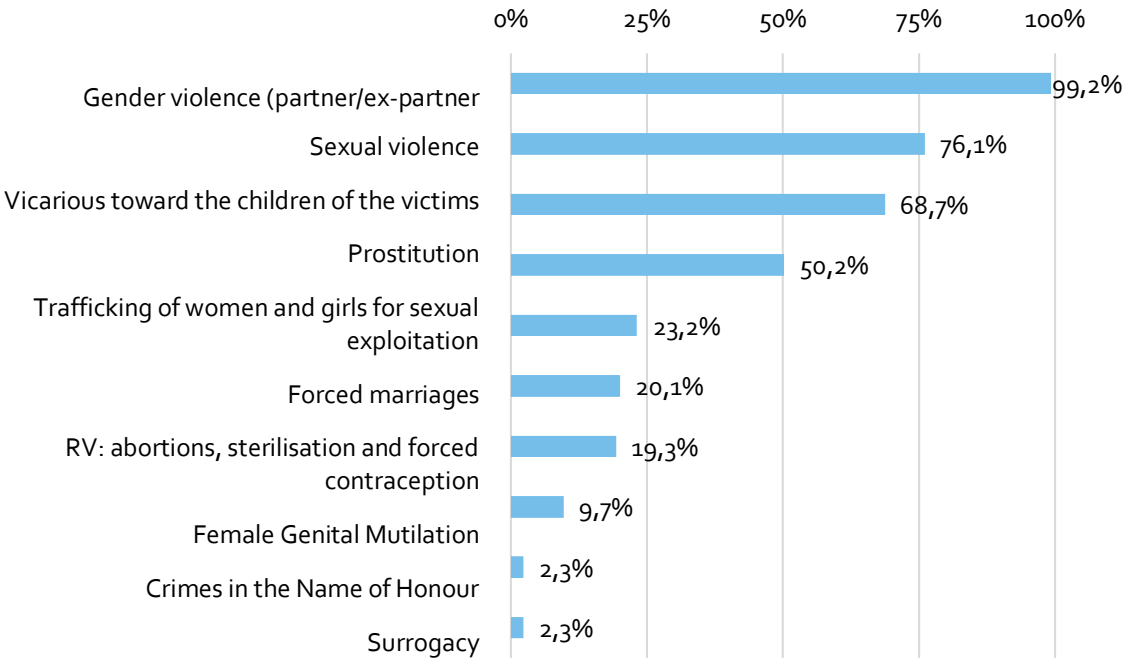
Regardless of the time they have been active, the LEs **have focused their work on the violence that have had greater knowledge and institutional visibility** in their territorial framework: men's violence against women in intimate partner/ex-partner relationships.

> It is possible to distinguish between the LEs that - throughout their work - have knowledge about different forms of violence (see graph 4) and the fact of providing care services to victims of such violence (graph 5), which focuses mainly on intimate partner violence and sexual violence.

Actions on violence, both victim care and other types (awareness, prevention, coordination...) are carried out, both, from the (local government) areas of equality and from the social services, particularly when the former are not equipped with human resources, or do not yet exist.

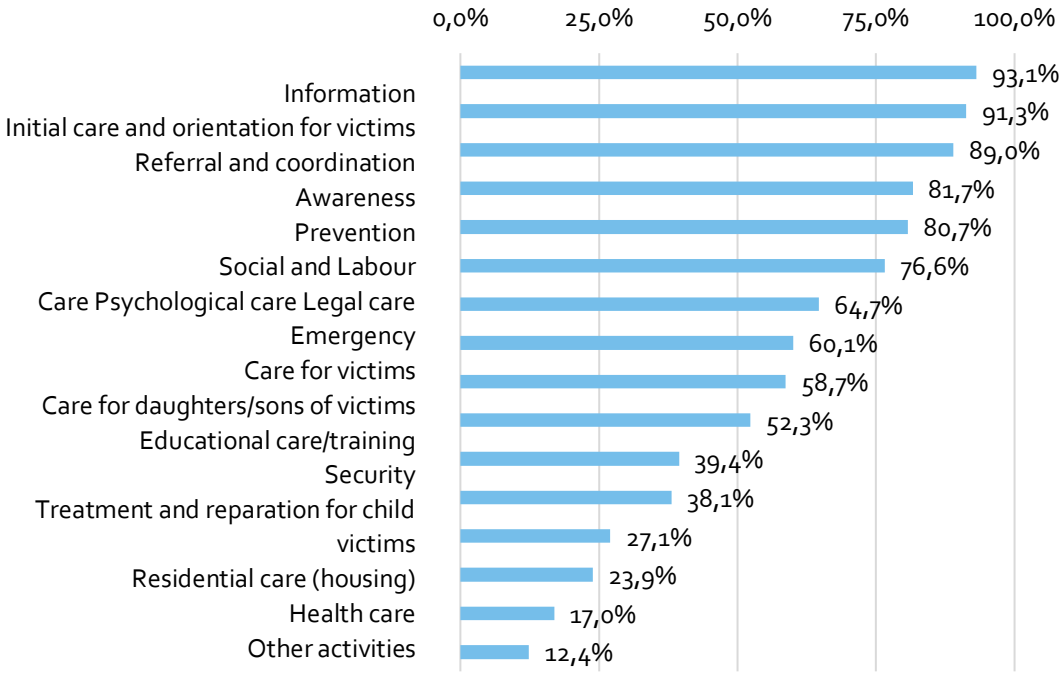
91.4% of the LAs have some kind of direct care for victims (see graph 5). **89.2% of the entities surveyed were part of ATENPRO.**

Graph 4.LAs: violence that has been known in the development of the work in the local authority



Red2Red, 2023. Survey of local entities on other forms of violence against women. N= 259

Graph 5. LAs: current actions taken with victims of violence (in general)



Red2Red, 2023. Survey of local entities on other forms of violence against women. N= 218

Only **63% of local authorities have a** specific **budget for** local action on VAW. Even fewer entities **- 48% - develop their work on the basis of strategic** (local or regional) **planning**. However, plans for action are very diverse and some are not specific to VAW, but to equal opportunities. Thus, references range from plans against gender-based violence or different VAW, or plans for equal opportunities between women and men, to references to VIOGEN, the SPGV or strategic plans for social services.

In terms of local VAW policy **coordination mechanisms**, the LEs have a variety of resources: victim care protocols, institutional coordination protocols and monitoring bureaus or protocols. However, their use differs from one type of violence to another (see Table 4). IPV and SV are the types of violence with the highest number of procedures in local entities. FGM, forced marriages and prostitution, are the types of violence with the fewest attention and coordination protocols (see Data Table 4).

In general, there is **greater systematisation in victim care procedures** (care protocols). There is some institutional coordination of resources and agencies; and there is little coordination in the monitoring of the phenomenon and the evolution of cases in the medium and long term.

Table 4.LAs: availability of protocols on violence against women

	Victim care protocol	Coordination protocol	Monitoring bureau or mechanism
GBV partner/ ex-partner	82,8%	81,6%	73,9%
Vicar (children)	56,1%	58,8%	52,3%
Sexual Violence	58,8%	53,7%	46,2%
Prostitution	26,2%	24,4%	17,2%
Trafficking for sexual exploitation	24,8%	17,3%	16,2%
FGM or forced marriages	16,2%	17,5%	12,8%

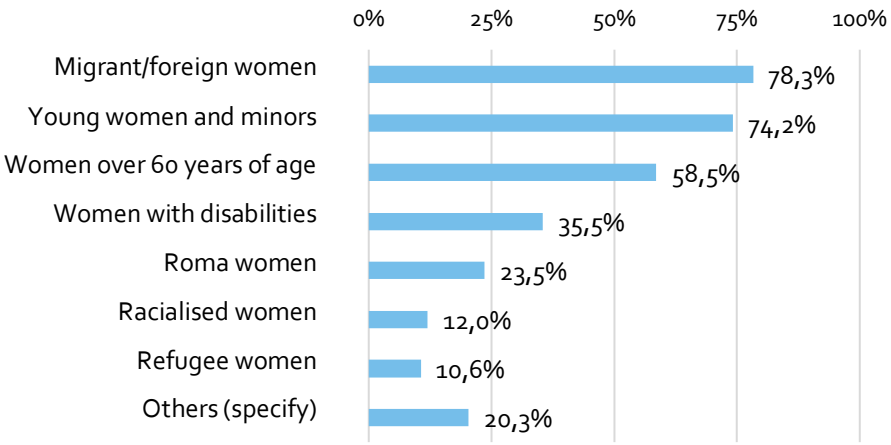
Red2Red, 2023. Survey of local entities on other forms of violence against women.

Vulnerability to violence, and the sense of being a victim or not, is different for each woman and is built in a socio-relational way (Guilló Girard, 2018). This depends on different factors, including other situations of discrimination - in addition to gender - that women face; for example, according to their age, (dis)ability, ethnicity, racialisation, social class, etc.

A diversity perspective in daily work helps to make women more visible from a plural approach and to better individualise the processes of care according to their needs. In this sense, the LEs were asked about the profiles of women who attended in their services.

The **diversity of women's groups** is present in all the LEs (see graph 6), however, the application of intersectionality is still absent in almost 30% of the local areas or services.

Graph 6.LEs: groups of women or vulnerabilities are most present in the entity's current work approach



Red2Red, 2023. Survey of local entities on other forms of violence against women.

In general, the **assessment of the integration of the intersectional gender approach** in the work of the LEs shows a high self-appreciation in their performance. On a scale of four levels (0-3), 24.2% consider that they apply it completely; 46% position themselves level 2 (quite), and the rest of the LEs are positioned in little (level 1) 24.2% and 5.6% in zero (level 0).

7.1.2. LEs: Experiences of care in FASC

29% of LEs' staff who responded to the survey did not know what forced abortion, sterilisation and contraception (FASC) was.

71% say they are aware of the characteristics of this reproductive violence (RV). However, only 18.5% of all these professionals claim to have learned about it in the development of their work at the local level.

> 9% of the technical staff who responded to the survey stated that they deploy some type of actions regarding FASC, although associated with SV or IPV. In other words, the cases that are currently detected by the LEs are not specifically referred to the particularity of FASC. It is a **very little visible violence for the staff** of public resources.

Because of this context, **there are no specific protocols for the care of FASC victims**; nor is there a distinction between emergency and general care.

around 2% of the LEs do consider that attention to RV is included in their protocols for victim care and institutional coordination of GBV. As it is assimilated to the consequences of IPV and SV.

In general, the position of the LEs in this sense is summarised by the following qualitative contribution to the survey: "all women victims of male violence are attended to, whatever the form of violence. All the resources of the service are available to all victims, regardless of the type of violence experienced".

No **specialised resources** other than those assimilated to the typology of women's centres, *violence attention points* or sexual violence centres have been identified in the sample. The LEs consider that these are the key devices in case of FASC. When cases of VAW (as currently understood by the LEs) have been detected, they have worked under the approach of coordination and referral, either with local or supralocal resources.

With regard to the **work carried out with local resources,** there are four different operating logics in the LEs:

1. The first and most frequent is that of professionals who attend and refer to the **general equality resources** in their municipalities (women's centres or services, women's information office, etc.).
2. Secondly, those that incorporate in their attention and referral the specific care services for **violence against women** in any of its forms, in order to provide the most comprehensive care.
3. Thirdly, and to a lesser extent, those who refer to the **local health centre** for advice. In this line, and more specifically, only two of the LEs expressly indicate the **referral** to the Centres and/or Programmes of **Sexual and Reproductive Care.**
4. Fourthly, on a residual basis, victims are referred to **social services**.

Regarding the **resources with which they coordinate**, they mainly do so with the area of equality and the local women's information centres, and the gender violence comprehensive care teams themselves. In addition to it, they work with social services in the area, primary and specialised health care centres, SRH centres, the local police and, to a lesser extent, with youth services and educational centres. There is other resources Les referred to, such as Courts, Public Prosecutor's Office, ACs equality bodies, VIOGEN teams, the Office of Assistance to Victims of Crime, as well as the associative network (NGOs and women's organisations).

Regarding **supra-local** resources for FASC cases, these are mainly from the **health sector** (health centres and hospitals, or NGOs such as, for example, Medicos del Mundo) and also specific **sexual and reproductive health** units. In addition, specialised VAW and sexual violence services are also mentioned when these are not available locally.

Interesting experiences

Local experiences **focus on the promotion of SRHR and the prevention of sexual and gender-based violence**. No specialised actions in FASC have been detected in the exploration, but there are practices that include them. Thus, the following experiences have been considered:

The LEs have implemented sexual and reproductive health programmes, originally aimed (1980s) mainly at adolescents and young people, with the focus on the promotion of sexual health - family planning - through municipal health centres and sex education in schools. From the youth councils and under different names, "youth counselling" services were created (affective-sexual counselling, infosex, etc.).

Current practices include the Sexual and Reproductive Health Programme *Healthy and pleasurable experiences of sexual diversities of* the **Madrid City Council** [100] within the framework of the Strategy "Madrid, a healthy city, 2020-2023". It aims to promote SRHR, the prevention of unplanned/unwanted pregnancies and difficulties associated with sexualities (STIs, sexual dysfunctions, discrimination and sexual and gender-based violence). Open to all citizens, the "preferred target population" is people under 25 years of age and people in situations of social vulnerability (including *people with functional diversity*). It includes work with professionals in the fields of education, health and social mediation who work with these groups. It does not expressly address RV but it does develop specific objectives for the prevention and care of sexual violence.

Since 2014, **Barcelona City Council has** had a *Shared Strategy for Sexual and Reproductive Health* (SSSRH)[101] , which is a participatory framework for action based on multiple agent alliances to promote the protection, respect and guarantee of SRHR. The mapping of health assets mentions the Programmes for the prevention of abusive relationships in women and girls with disabilities, and takes into consideration

[100] Madrid City Council (access).
[101] Barcelona City Council (access).

the vulnerability of persons with disabilities.

The municipality of **Los Realejos** (Santa Cruz de Tenerife) has been working since 1998 through the Municipal Plan for Affective Sexual Education[102] to encourage the population to live their affective and sexual relationships in a positive, responsible and non-discriminatory way. Since 2013 it has been developing the project "Construyendo sexualidades" (Building sexualities) with the Canary Islands Sexuality and Disability Association.

7.2. Specialised organisations: FASC attention

7.2.1. Characteristics of the organisations

A total of 73 responses were received to the survey of organisations and experts, although the lack of practical experience regarding the victims' attention has shown that very few organisations have specialised resources in RV.

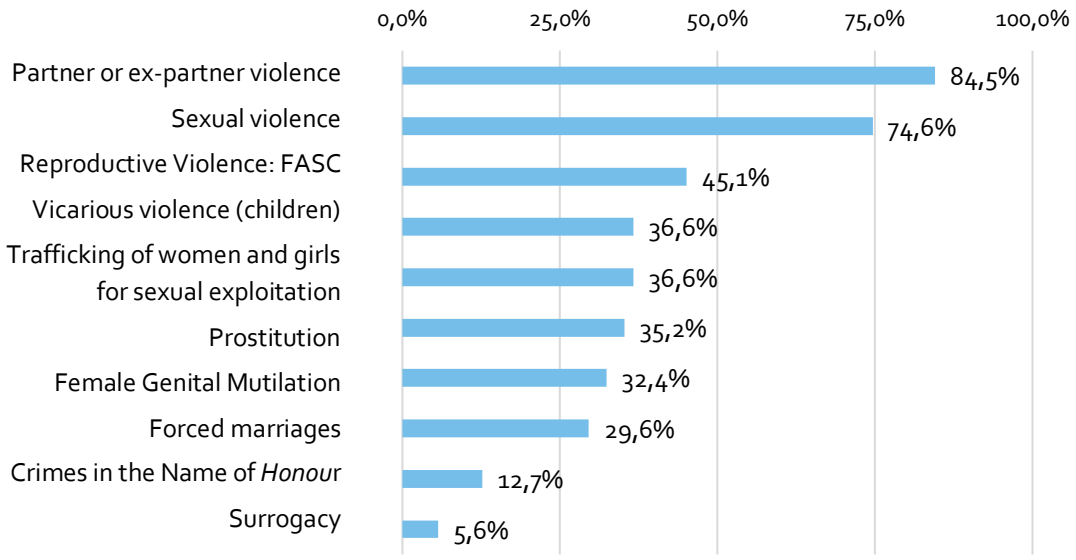
94.4% had some kind of care service for women victims of violence. 7.9% provide some kind of local service related to ATENPRO.

The scope of action of the organisations is diverse, both in terms of the **type of territorial action** they carry out (state 42.3%, autonomous 32.4%, provincial 15.5% and local 19.7%), and in terms of the type of male violence they address in their actions.

As in the case of the LEs, the focus is mainly on intimate **partner violence and sexual violence** (in its different expressions) and, due to the presence of expert entities on disability, some of them provide attention for women with disabilities who are victims of FASC (see graph 7).

Graph 7.Organisational experience in types of VAW

[102] Los Realejos City Council (access).

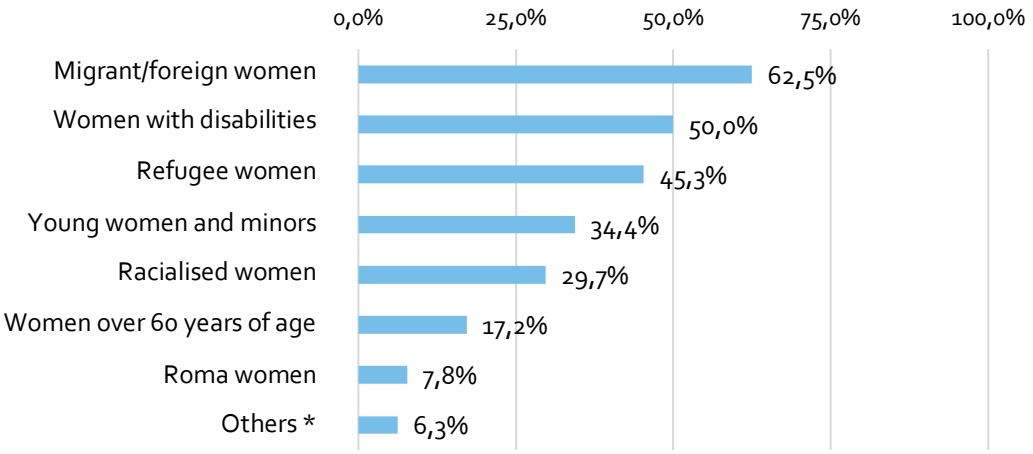


Red2Red, 2023. Survey of experts and organisations on reproductive violence (N=73)

The self-perception of the degree of **integration of intersectionality** in the gender approach employed by the organisation is quite positive. 50% of the respondents grade it high, 35.9% *quite a lot* and 14.1% valued it as little integration.

The diversity of women's groups and the presence of vulnerable women is clear. The **groups of women or vulnerabilities** that are most present in their current work are shown in the graph below.

Graph 8.Specialised organisations: groups of women or vulnerabilities most present in their current work



Red2Red, 2023. Survey of experts and organisations on reproductive violence (N=73)

Note: (*) women and girls with disabilities in rural areas; women with mental health problems; women in social exclusion; deaf migrant and refugee women with disabilities.

7.2.2. Attention to FASC

Only **28.7% of the specialised organisations reported an expert knowledge or developing some kind of action in the** field of FASC (21 organisations out of 73).

> These are mainly entities from the disability movement/ or women with disabilities associations. However, there were also organisations with expertise in gender and health, migrant and refugee rights and human rights. Their main *expertise* is, as in the case of the LEs, in the attention to GBV; therefore, attention to cases of RV is often - but not exclusively - detected from the identification of IPV or SV violence to which it is related.

Considering that **the main victims of FASC are women with disabilities**, the experts in the field report that few direct cases come in, although most of them suspect many forced sterilisations or abortions.

> One difficulty in the subsequent qualitative fieldwork was the secrecy and even reticence of some of the experts during the field exploration, as the practice of sterilisation has given rise to different positions and controversy, even within the disability movement itself.

The organisations participating in the survey **do not keep records of the cases of FASC detected, nor do they measure** prevalence among their clients/patients. In this sense, some the organisations indicate that they attend to between 1 and 20 women per year. The subjective perception of the organisations is that perhaps more than half of the women - over 50 years old - could be sterilised and almost all young women with disabilities could have experienced forced contraception.

Concerning the **type of activities carried out, there is no standard typology of services**. In general, prevention, information, awareness-raising, referral and coordination activities are carried out, and in some cases direct care: counselling, psychological care and legal assistance to victims.

> Among the experiences implemented, **socio-legal support** for women victims with cerebral paralysis stands out, as it has been distinguished that there are more cases of

sexual abuse and forced sterilisations in women with cerebral paralysis than in men[103] . The existence of interdisciplinary units to assist women with disabilities victims of GBV has also been reported. These units provide psychosocial support, information, accompaniment and counselling to deal with situations of violence, its consequences and the prevention of new episodes.

Within the victims' attention procedures, **emergency care is not distinguished**. However, according to the experience of the organisations, **a crisis situation** in FASC victims would be related to several situations:

- **Health**; regarding side effects of the practices to which they are subjected or lack of adequate medical follow-up or lack of restorative gynaecological care.
- **Security**; in relation to times when third parties plan to target the victim with FASC action.
- **Communicative**; due to the lack of means or support to communicate directly with the victim; especially in the case of women with disabilities with high support needs.

With regard to care procedures, **there are no standard protocols**. It was considered (in the survey and by some experts) that protocols should be similar to those in place for IPV, in the sense of covering the same resources. However, it was also pointed out that **in order to facilitate the victims' request for help and the formulation of demands,** it is necessary to take into account several issues:

- Permanent information on SRHR.
- Guarantee of universal accessibility (physical, cognitive and cultural).
- Credibility of the victim (breaking the stereotype about the victim's disability, cultural background, anti-gypsyism/ antiromanism, etc.).
- Effective communication and consent for intervention. Have communication supports (e.g., speech therapists), cultural mediation (e.g., anthropologists), or other resources for direct communication with victims rather than through other third parties.
- Always be aware of the shame and taboos associated with GBV.

[103] The communication barriers encountered by women with cerebral paralysis, most of whom have dysarthria (difficulty in articulating words), mean that they are not understood in contexts outside their personal circle. To ensure two-way communication, augmentative communication is used.

- Respect for the victim's own time frame for intervention, as there is not enough *expertise* in standardised procedures for women victims.

In relation to **care protocols, or institutional coordination and/or monitoring bureau or protocols** on RV, there is no indication of their existence, with the exception of two entities that are in the process of developing them.

> One, regarding the referral of FASC cases from the public services to specialised entities, and another regarding guidelines for health professionals aimed at guaranteeing free and informed consent by the woman before sterilisation.

In relation to **coordination with other local resources** (public or private), they do not work with resources specialised in FASC because they do not exist or they are *the* resource. Other general resources they coordinate with are either gender violence or disability resources.

> At the local level, work is carried out within the network of specialised care centres for VAW that correspond to their Autonomous Community, in relation to the women's, women's and disability associations, and also in coordination with the r victims of sexual aggression centres.

In the case of **women seeking international protection**, it is worth mentioning the incipient existence of the Protocol of Action on Gender Violence of the Ministry of Inclusion, Social Security and Migration and UNHCR. Its application is being carried out through an implementation project that is being developed together with various NGOs. However, it does not - for the moment - include reproductive violence in any of its forms.

> In spite of this, the consideration of migrant women as *victims of GBV* - regardless of its typology - would allow them to access the resources and services provided and to improve their protection by the Spanish State. In the same way, protocols tend to be used for the detection and action on other forms of violence[104] , such as those related to FGM, forced marriages and trafficking for sexual exploitation[105] .
>
> Through the Gender-Based Violence Unit of the Ministry of Inclusion, it is possible to apply for a place within the assistance program to asylum seekers, beneficiaries of international protection, statelessness and temporary protection. It is specific for

[104] See the DGVG website for a compilation of detection and action tools.
[105] See the studies promoted by FEMP in this respect (2023).

victims/survivors of GBV. Through these territorial Units, it is possible to access an emergency place, without the need to file a police report.

Interesting experiences

Women with disabilities and disability advocacy organisations have a long history of promoting women's SRHR, including maternity support and work on sterilisations of women with disabilities.

Numerous **SRHR** practices have been identified in the fieldwork, some of which are information and awareness-raising, others are care practices. The following are a sample of interest:

In relation to organisations at **national level**, it is necessary to refer to: Fundación CERMI Mujeres, Plena Inclusión Spain, Sexuality and Disability Association, Spanish Association for Sexual Health, Mental Health Spain Confederation, Liber Association of Decision Support Entities, ASPACE Confederation, CEMUDIS (Confederation of Women with Disabilities), Federation of Midwives, ONCE Foundation, State Confederation of Deaf People (CNSE), Autism Spain Confederation, CEPAMA, Committee for the Promotion and Support of Autistic Women, National Association for Sexual Health and Disability.

In general, at the **regional level**, the references are those of: Plena inclusión Madrid, Plena inclusión Comunidad Valenciana, Plena inclusión Extremadura, Plena inclusión Castilla y León, Plena inclusión Murcia, Plena inclusión La Rioja, Foundation APROCOR (Madrid) CERMI Región Murcia (Women's Commission), CERMI Andalucía (Women's Commission),CERMI Madrid (Women's Commission), CERMI Valencian Community, CERMI Castilla la Mancha, CERMI Extremadura, Down Catalunya, ACADAR Association of Women with Disabilities Galicia, Luna Andalucía Federation of associations for the promotion of women with disabilities, FAMDISA Federation of Associations of women with disabilities in Andalucía, AMUDIS Association of Women with Disabilities in Castilla y León, A LA PAR Foundation(Madrid), FESORD Valencian Community, CODISA PREDIF Andalusia, CoordiCanarias (Coordinator of people with physical disabilities of the Canary Island).

In terms of local experiences, the following have been considered of interest: Amanixer - Aragonese Association of Women with Disabilities (Zaragoza), Associació Dones No Estandars (Barcelona), AFANIAS

Madrid, APSA (Alicante), Fundació Vicki Bernadet (Barcelona and Zaragoza), Xarxa dones amb discapacitat (Valencia), AFAEMO, Association of family and friends of people with mental disorders in Moratalaz (Madrid), Más Mujer-Association of women with physical and organic disabilities of the Region of Murcia, Peace and Good Association (Seville and Huelva), Functional Sexuality (Valencia), GORABIDE Vizcaína association in favour of people with intellectual disabilities, ASPAYM Madrid, COCEMFE Alicante, AFEMAGRA Mental Health Granada, AFESOL Association of Families and People with Illness (Málaga), Sphere Foundation (Madrid).

On the other hand, in the case of migrant women, asylum seekers and refugees, it is worth highlighting the existence of protocols for detecting different types of intimate partner/ex-partner violence and other forms of violence by several NGOs, as well as different actions to raise awareness and protect the SRHR of migrant and refugee women in Spain.

Organisations such as ACCEM and CEAR have protocols for detection and prevention and care procedures. In the case of **ACCEM**, they are aimed at professionals, volunteers and users. Regarding care, the identified case is monitored by an interdisciplinary team, for which a social report is used as a tool for collecting information and monitoring. In 2021, the legal service for international protection prepared training materials on gender-based violence with the aim of broadening the vision and conception of violence that women can suffer as a result of being women in order to improve the detection and attention to the needs of international protection for gender-based reasons.

A collaboration practice has also been established between ACCEM and Médicos del Mundo in the Canary Islands, whereby, when a case of sexual violence (especially FGM) is detected, a report is drawn up by Médicos del Mundo which can be used to help the application for international protection.

ACCEM has developed an agreement with the Crisis Centre for Victims of Sexual Assault in Asturias to offer cultural interpretation and translation services in cases of IPV. The interpreters are also cultural mediators with gender perspective training thanks to another ACCEM programme "mediators in equality".

UNHCR has led the **Seed Project** for the implementation of the Protocol of Action on Gender Violence of the **Ministry of Inclusion, Social Security and Migration** with the collaboration of MISSI itself and

the NGOs that are part of SAPIT. Its conclusions foresee the extension to all forms of VAW.

In the field of sexual and reproductive health, the "Salud entre culturas" programme of the **Ramón y Cajal Hospital in Madrid** stands out, whose **"Salud Entre Mujeres"** line seeks to create a culturally and linguistically adapted health education space. It works on SRHR, including violence, among other activities, and offers a "transcultural psychology" service.

Farmamundi's RAISA Project is developed in collaboration with **the Barcelona City Council**, which promotes access to the health system and provides care for migrant women in the field of health and SRHR, as well as for the prevention and eradication of violence.

Along the same lines, the campaign "YOU MATTER. Your sexuality is important" aimed at migrant women from **UNAF**.

7.3. Analysis of interviewed practices

As explained above, **action on FASC is not very specific** in Spain, with the exception of some organisations working with women with disabilities.

Most of the experiences that exist in our country are carried out by non-governmental organisations in the field of disability and some public health resources (mental health or sexual and reproductive health services). The services specialised in equality and VAW are not leading this type actions.

> As explained in the methodology, the 7 practices that have been analysed provide expertise - above all - in the work on VAW and disability. Although not all of them focus on FASC (given the lack of specialised practices), they do provide a better understanding of the characteristics of care for RV when it is associated with GBV and VAW. Above all, they allow us to develop criteria for action and universal accessibility that can be transferred to care for **all women**.

Information provided in the questionnaires and other experts consulted has also been taken into account. The list of informants can be found in Annex 3.

7.3.1. Summary of experiences

Experience 1: SAVIEX: Support Service for Women and Girls with Disabilities Victims of Gender Violence in Extremadura (Cermi Extremadura)

- Saviex was created in 2021 as a result of one of the results of the Study on the situation of violence against women with disabilities in Extremadura (Cermi Extremadura, 2020).
- It is implemented by the Committee of Entities Representing People with Disabilities of Extremadura (CERMI Extremadura) thanks to the support of the Regional Government of Extremadura - with funds from the Spanish State Pact on Gender Violence - managed by the Department of Equality.
- Although they do not work to detect cases of RV, they work with its suspicion. Especially in the case of care for women who have been sexually assaulted by family members.
- Saviex has a specialised staff who works as a reference professional for women and girls with disabilities, as well as for the different agencies and resources that intervene during the process of recovering from violence.
- The intervention is articulated in a model of personal support that responds to the specific needs derived from the type of disability and other individual factors, for inclusive, accessible and effective care in situations of VAW.
- The women's care components of the service are carried out by means of detection (through collaboration and referral) from various specialised resources aimed at eradicating gender violence[106] . It considers coordination procedures after the referral of cases with the different professionals.
- In the protocol, a personalised intervention is implemented from the moment the woman, voluntarily, makes contact via email, mobile phone or in person. Once the relevant care and accompaniment has been provided, a follow-up is carried out through telephone calls.

[106] Equality and Gender Violence Offices of the Junta de Extremadura network; non-governmental organisations (NGOs) and associations that assist women victims of gender violence and/or people with disabilities; state security forces and legal professionals (lawyers, judiciary and public prosecutors).

- It also collaborates with other resources involved in prevention and awareness-raising. It carries out training actions on GBV for personal assistance professionals with an intersectional perspective. Transfers knowledge and good practices on care for women with different types of disabilities to other resources. The actions promoted (2022 and 2023) have been aimed at institutional and technical collaboration, dissemination, awareness raising and prevention in conferences, events and seminars[107] .
- These actions include training for police, legal and social agents on communication in the taking of testimony from women and girls with disabilities; and also, on accessible information from the police and judicial system.

Experience 2: Psychosocial Rehabilitation Centre San Fernando De Henares (CRPS)

- The CRPS San Fernando de Henares is part of the devices of the Public Network of Social Care for people with severe and long-lasting mental illness at the Community of Madrid.
- It has a multidisciplinary team that, from an individualised approach, focused on the rehabilitation and recovery of the person, works to favour the creation and strengthening of support that promotes the participation of users in socio-community resources in their environment, under the same conditions as any other citizen.
- The team consists of 1 director, 3 psychologists, 1 social worker, 1 occupational therapist, 3 educators, 1 administrative assistant and 1 part-time cleaning staff.
- They have different information, education and skills training programmes that are carried out both at the centre and in the person's own socio-community environment. Activities is also developed with family members or people close to the patients.
- The CRPS was inaugurated in 2004 and is currently designed for the care of 90 people. 40% are women. They are all referred from the Mental Health Centre of the Hospital del Henares, and include the municipalities of Coslada, San Fernando de Henares, Mejorada del Campo, Velilla de San Antonio and Loeches, through the Commission for Referral to Resources and Case Monitoring.

[107] Saviex carries out a wide range of awareness-raising and prevention work. Various types of training activities are carried out: "Love without labels" workshop. Dismantling myths of romantic love; Workshops "I love myself, I take care of myself. Women and disability"; Group workshops on prevention against gender violence. "Women and disability. Towards a positive vision"; Workshops "Love without labels. Diversity and respect".

- Among other commissions and coordination bodies, the incorporation since 2011 of the local roundtables against gender violence in Coslada and San Fernando de Henares stands out.
- The CRPS is a pioneer in working from a gender perspective. It stands out because of: its participation in several research projects and publication[108], the interventions within the Municipal Points against GBV in the area, and its great development of group programmes for the detection, prevention and intervention in sexuality, gender violence, sexual violence, among others. This includes accompaniment for women victims of GBV and groups with men to work on alternative masculinities.

Experience 3: Project "Construyendo Sexualidades" (Building Sexualities) of the City Council of Los Realejos and the Association Sexuality and Disability.

- "Construyendo Sexualidades"[109] is a project that has been running for a decade by the Municipal Plan for Affective Sexual Education of the Town Council of Los Realejos (Santa Cruz de Tenerife), which it develops together with the Asociación Sexualidad y Discapacidad Canarias (Canary Islands Sexuality and Disability Association). It has the collaboration of the Caja Canarias Foundation, Obra Social "la Caixa" and the Government of the Canary Islands.
- The project aims to respond to needs in the affective-emotional and socio-relational dimensions of different groups at risk of social exclusion or dependency. It is aimed at improving the quality of life of people with disabilities and/or rare diseases in the town and the surrounding area, focusing on care, education and the provision of support for their sexuality. A counselling service has been created in which the services provided are those derived by the project when cases of RV are detected either from the health or social or educational fields.
- During the years of implementation of the project and the workshops carried out, situations of RV have been detected, and for this reason, coordination has been set up with the local resources for their attention, mainly with the social workers of the area.

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[108] See, (2010) Prevalence of gender-based violence in women with severe mental disorder, Guide to care for abused women with serious mental disorders (access).
[109] Access to the information leaflet.

- In this decade, it has achieved to train more than 4,000 people, including people with disabilities, their families, professionals and volunteers in the field, through transversal activities.

Experience 4: "Alba Service" for the care and accompaniment of deaf women. State Confederation of Deaf People (CNSE).

- Alba is an information platform[110] funded by the DGVG, the Ministry of Social Rights and 2030 Agenda, Mutua Madrileña Foundation and the ONCE Foundation.
- It offers a contact point for assistance and information in sign language or in writing about GBV. It activates a service accessible in sign language to assist and accompany hearing-impaired and deaf women and their environment (families, professionals, etc.) on how to act -or where to go- in a situation of GBV. They have not attended deaf women who are victims of RV as such, but they do consider that many of the victims have suffered it.
- They can be contacted in different ways: via e-mail, video call and chat. Due to the diversity of deaf women, not all of them are sign language users or oral language users, some are bilingual. The professionals adjust to the needs of the target group including other intersectional factors such as: age, territoriality, having additional disabilities such as deaf-blindness, etc.
- They work with the CNSE associative network in the different territories, who are the ones who provide the resources to attend the victim (support with formalities, police reports, all the necessary procedures) with sign language interpreters or with communication mediators, or both at the same time, instantly so that they can go to any appropriate resource.
- They attend to both victims and families, external professionals and professionals from its own network, as there is often a lack of training on how to intervene with deaf women.
- It ensures confidentiality and this facilitates access to the service. Sometimes deaf WVV do not want to go to the federations because the deaf community can be small in some areas and they feel embarrassed. The Alba Service refers them to the most

[110] Alba Service: https://cnse.es/proyectoalba/.

appropriate resource, either by mediating with the federation to facilitate accompaniment or to the resource they need.

Experience 5: Socio-legal support channel for women with cerebral paralysis who are victims of gender violence. ASPACE Confederation

- In 2020, the ASPACE Confederation launched the channel with the aim of providing socio-legal support to women with cerebral paralysis who are victims of GBV and SV, although an extensive service is provided to all forms of VAW.
- It arises due to the specific needs of women with cerebral paralysis and other related disabilities and their families, who face a situation of special vulnerability that increases their lack of protection from violence.
- The service is part of the ASPACE Confederation's legal advice service, within the "ASPACE for your rights" programme, which works on four main lines of action: specialised training on rights and disability in the main areas of daily life of people with cerebral palsy, political advocacy, the cross-cutting approach to rights in the ASPACE associative movement, and legal advice.
- The channel is online, by telephone and in person. Contact is made via WhatsApp at 661 347 869, to which you can send your messages from Monday to Friday from 9:00 to 17:00. These hours are limited due to the limited funding available at the moment. Contact with legal advice can also be made by e-mail. The channel is staffed by 2 lawyers specialised in VAW.
- The women assisted receive information and legal support in order to exercise their rights and, if necessary, they are referred to GBV services for psychological counselling or for the allocation of shelter or housing.

Experience 6: Women's Observatory. Plena Inclusion Madrid

- It is a working group created in 2010, being the first Observatory of the associative movement of intellectual disabilities in Spain, with the aim of working for the full equality of women with intellectual or developmental disabilities (WIDD) and the aim to raise awareness in society about the causes that perpetuate their social disadvantage.

- Women with and without intellectual disabilities, including support staff, from 17 organisations of Plena Inclusión Madrid participate in the Observatory. Its agenda includes issues such as the fight against gender violence, the eradication of forced sterilisation, maternity or gynaecological health.
- It is configured as a space for the participation of WIDD together with support professionals to promote their rights, guarantee their full inclusion and carry out awareness-raising, training and visibility actions aimed at their empowerment. WIDD represent themselves and the entities promoting their active participation.
- They have filmed 4 short audio-visuals to raise awareness of the barriers faced by women with intellectual disabilities and the support they need to enjoy full citizenship. All of them have addressed the GBV they suffer in its different expressions[111] .
- The professionals who take part in the Observatory are staff of local organisations in the region of Madrid. They work in specific resources for the care of people with intellectual disabilities who are members of the federation of "Plena Inclusion" Madrid. These organisations do not have specific resources of attention to women victims of RV, but they do detect them continuously in the development of their work, because the WIDD themselves express it. In this sense, they carry out group interventions, especially psychological care for the recovery of the victims (grief, resilience, ...) and they work with the families so that they can understand the situation of the victims.
- Empowerment and training group work is carried out both with WIDD in general and with those who have experienced RV in particular. Issues related to their sexuality, body knowledge, SRHR, and support for the recognition and expression of the RV they have experienced are addressed.
- The Observatory works on access to gynaecological health as part of the promotion of the SRH of WIDD and their rights.
- The *group of mothers of mutual support* is another of the actions promoted. It is made up of WIDD who are mothers sharing their experiences. Some of these mothers have also suffered some form of GBV.

[111] In the field of dissemination, the following documentaries produced by the Women's Observatory stand out: También Somos Mujeres **(**2011). Access; It wasn't me that was the problem **(2017).** Access; As far as possible (2022) Access; It's my right (2023) Access.

Experience 7: Specialised Assistance Units for women with disabilities who are victims of gender violence in the community. Confederation of Organisations of People with Physical and Organic Disabilities of Andalusia (CODISA PREDIF Andalucía).

- CODISA PREDIF Andalucía launched this service in 2015, which serves women with all types of disabilities. The care is provided through the Specialised Assistance Units, where psychosocial care, information, accompaniment and counselling are offered to deal with situations of violence, its after-effects and the prevention of new episodes.
- It includes support for administrative, police and judicial procedures, areas in which women with disabilities usually encounter barriers that make it difficult for them to report and recover. They also carry out prevention work through group intervention, through the development of women's empowerment groups.
- There are two ways for women to access the units: directly at the initiative of the victims, or through referral by professionals from a member organisation, where the user is taking part in one of its services or programmes. The staff of the entities also contact the CODISA PREDIF units when they detect a situation of violence or suspect it, in order to seek advice. In this way, the service has a preventive feature. They are also referred by professionals from other resources of the local or regional public network of attention to WVGV.
- The service has a virtual office and has a face-to-face service in offices in all provinces (except Almeria). Each unit has a reference technician; at regional level there is a multidisciplinary team formed by: 1 social worker, 1 psychologist and 1 social educator. The team is trained and specialised in the needs of women with disabilities, their conditions of vulnerability and the presence of differential risks with respect to the rest of the female population.

7.3.2. Lessons learned and challenges in victims' care

The results obtained from the interviews conducted to analyse the 7 practices is described below. Besides, some of the results of the surveys (to LEs and to expert organisations) are also referred to, as they are mostly aligned with these experiences and they contribute to reinforce consensus among professionals on how RV is approached.

7.3.2.1. Screening for violence and access to care

All the experiences have highlighted the importance of the diffusion or dissemination about the existing services to facilitate victims' access to specialised care.

The practices identified use different **dissemination strategies**, such as:

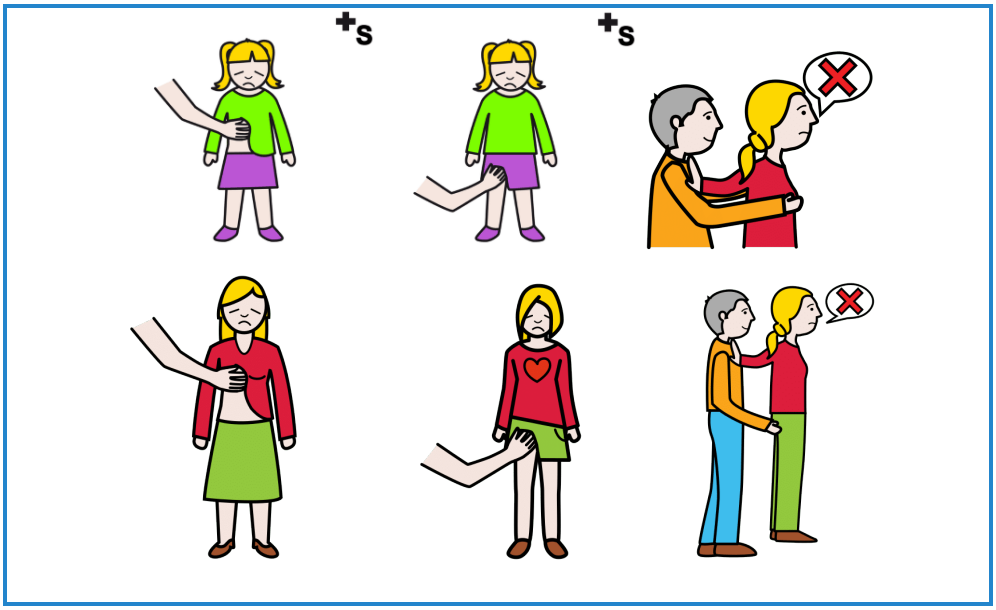
- In SAVIEX, it is done through the media, both written media and radio programmes and Extremadura channel (both in news and specific programmes or reports). Interviews have been conducted for the media. An information leaflet has been distributed in pharmacies: 380 in the province of Badajoz and 290 in Cáceres, turning apothecaries into SAVIEX points.
- The project "Construyendo Sexualidades" is disseminated within the framework of the Municipal Sexual Affective Education Plan of the Los Realejos City Council and on the informative website of the association Sexualidad y Discapacidad.
- CSNE's "Alba Service" has an informative website and carries out internal dissemination.
- CODISA PREDIF's Specific Care Units for women with disabilities use multi-diffusion: posters with a QR in Purple Points, distribution of posters in health centres, social services, educational centres, etc., as well as in member entities; social networks; meetings, conferences and forums.
- In Confederación ASPACE it is disseminated internally, to members and federations, through social networks and the media, as well as in the awareness-raising actions themselves (both with legal operators and with educational and health resources).

This requires making violence (in this case, RV) clearly visible in all the organisations' **information and communication media**, which are still too limited to express women's experiences of abuse.

> *Women with cerebral paralysis who use tablets or notebooks with pictograms to communicate or to support their communication, as they did not include a page of pictograms related to violence. So how are they going to express to you what is happening to them? (E5)*

Some examples of pictograms on sexual abuse of girls and women can be seen in the Figure below:

Figure 5. Pictograms-SAAC on sexual violence against women and girls



Source: Aragonese Augmentative and Alternative Communication Portal (ARASAAC),

Training and awareness-raising activities are carried out **with and for the women themselves**, both to raise awareness of their own victimisation and to find out about the existence of help resources.

These activities are essential; through them, the women VGV learn a framework of **new meanings for experiences they did not know how to name**, and identify a place where they can resolve doubts and be oriented for the first time.

- The existence of **specific listening places** - such as the WIDD groups - where there is a **safe and trusting climate, as** well as all the specific training on topics such as: their sexuality, affectivity, motherhood, sexual and reproductive health, sexual and reproductive rights, and RV is fundamental.

  Above all, we detect this in the training sessions, mainly where you generate safe scenarios where sometimes these issues have not been raised because they have not come up in their daily conversations (E3).

- These prior awareness-raising activities **help women to identify** situations of violence, including RV. In many cases, a prior link has been created with a professional they trust, which **facilitates the intervention**.

  Women with cerebral paralysis have a very damaged self-concept, because of the fact that they are dependent for everything. And as you work on their

empowerment, women start to express their demands regarding the violence they are suffering (E5).

- Staff requires an **attitude of observation and listening** that allows them to hypothesise about different forms of violence to which participants may be exposed.

  When it comes to RV, women with cerebral paralysis don't know, they don't have the tools to identify that this type of violence is taking place, so when they arrive at the [ASPACE] Channel, it has already happened. Reproductive violence is linked to other violence, usually sexual violence. Often what sexual aggressors do is: "if I sterilise her, I have a greater chance of continuing the violence without a trace", That is to say that forced sterilisation is usually an initial step to carry out sexual violence later on. In these cases, the intervention is aimed at making them aware of what has happened and giving them the tools to be able to defend themselves against sexual violence (E5).

Thus, those who come to the services for help have been - or are - participants in different trainings on empowerment, rights or prevention of different forms of VAW.

Furthermore, depending on the type of disability, **the exchange with** the ***personal assistants***[112] **and the work within the families** is often indispensable in the detection process, particularly in the case of women with multiple disabilities[113] , cerebral paralysis and WIDD.

The barriers are sometimes the families and so we have to work on psycho-education (...), so that they understand that they are people with a sexuality who obviously have rights and that this has to take precedence over the decisions of each family member (E2P2).

In addition to this, complementary activities are developed **with other professionals**, so that they can detect cases of violence and contribute to the dissemination of resources.

In this sense, the results of our research suggest that action **towards own resources** (within the institution, the LEs or the NGO) is essential, as well as **participation in** professional **exchange**

[112] For example, in CODISA PREDIF, training on violence is given to personal assistants who can act as agents for detecting situations of violence and transferring the situation to the corresponding services.

[113] "Multi-disability is a severe disability of multiple expression, where two or more disabilities are associated, such as motor disability, intellectual disability, sensory disability or fragile health, which can be severe or profound. It causes an extreme restriction of aspects and possibilities of perception, expression, emotions and relationships. People with multiple disabilities experience delayed development and often require a high level of support and care in their daily lives". (Maita, 2023).

or associative **networks**. These activities would include **awareness-raising and training for other professionals.**

Regarding this issue, the **lack of** basic **training** on FASC specifically, has been identified as an **obstacle to detection/ identification**; including professionals in the own field of VAW and in the health sector, as well as among SRHR promotion staff.

The professional teams do not have the training to respond. If they are asked questions (...) they don't know how to deal with a situation of reproductive violence. So, if I don't have training or I don't know how to go about it, I don't ask, lest they ask me a question or ask me back and I have no information (E3).

For the identification of RV, the experiences analysed tend to use a **set of specific and non-specific indicators,** which are generally associated with VAW given the interrelationship with RV[114] . The guidelines and main indicators used for the detection of FASC inside the analysed experiences are:

- The women's **direct explanation.**
- **Expression of suspicion from other** professionals or people in the environment (friends, volunteer staff, work environment, etc.).
- Medical reports.
- **Mood swings,** symptoms related to depression, disruptive behaviour.
- **Type of medication** such as tranquillisers or anxiolytics, whether they know what they take them for, whether it is a demand from them and whether they really need psychological care rather than medication. Paying attention to mental health and psychopharmacology is key. Prescribed drugs need to be checked.
- Eating disorders, especially in WIDD.
- **Reading and body analysis**. The case of adult WIDD who are dressed or dress in a very infantilised way. Or the case of a young woman who gains weight suddenly as a result of an early menopause or contraception.
- **Early menopause that does not correspond with age**. In this case it should be confirmed by hormone analysis and/or vaginal ultrasound whether it is due to menopause following sterilisation.

[114] See and Vazquez and Castro (2018) for a list of indicators for detecting sexual violence at different life stages against women with disabilities (v.bibl.).

- **Not menstruating**. It must also be considered that not all women with disabilities have menstruation due to different pathologies. It is common for families or institutions to choose a contraceptive method without the informed consent of the women, which in many cases leaves them without a menstrual cycle for most of their lives.
- **Hospital admissions or non-specific surgical interventions**. There is suspicion if a woman is not able to recount exactly what happened, or what the intervention consisted of.
- **Consider the hypothesis of sexual violence** and apply available screening tools; assessing it as a consequence or a condition for RV.

  Explore with women **whether they have suffered abuse in childhood,** as this is also linked and important to evidence that this type of SV is linked to RV. At the same time, special attention should be paid to situations of legal incapacitation, which is now called *being subject to support measures*. Check whether her guardian or support person is her abuser.

When FASC is suspected, **simple and direct questions are often asked** about situations that may have led to reproductive violence:

- in **medical consultations attended by** women accompanied by support persons, or by trained health professionals.
- in **social care for women** with disabilities in intake and follow-up interviews. The questions are direct questions with closed, simple, easy, straightforward and straightforward answers and nothing is taken for granted. **Two examples have been provided**:
  - **Example 1**: A woman who comes to a service because she has become pregnant after having suffered SV and says that she had an abortion or it appears in the medical report, you can ask her directly: but did you want to have the baby or did you want to have an abortion?
  - **Example 2**: A woman victim of SV who comes to a centre for victims of sexual violence and who may be asked questions such as: "What is the best way to respond to sexual violence?
    - do you know your sexual and reproductive rights?

- Do you know about contraceptive methods and what information do you have about them?
- Is she using or has she used any contraceptive method up to this point? What is it? What information does she have about it: length, protection against STIs, contraindications and side effects, etc. ...? Or does she just have the one she has been given? Because if the woman does not know about the main contraceptive methods, we may have to suspect that she may be sterilised.
- Do you recall recent surgery and what type of surgery?

> When you ask women who are currently undergoing certain contraceptive treatments, whether oral or patches, the message they have been told about why they have had tubal ligation is because it was the best treatment. And of course, there is no scientific evidence. It's all unrealistic, because they were told that it's for calcium or they were told that it's for epileptic seizures. In other words, how can you say that this treatment is contradictory or why do you prescribe some that are irreversible? No, when there are no studies (E3).

7.3.2.2. Care pathways and procedures

Care and accompaniment of victims.

All attention to RV victims should depend **on their communication support needs**. It should prioritise the understanding of the situation of violence experienced by themselves. This would be the first starting point of any care pathway: **universal accessibility**.

Confederación ASPACE practice of the socio-legal support channel for women with cerebral paralysis of is an example of this: the **centrality that accessibility must have in the attention** to these women. In the case of this socio-legal support channel, care is considered as follows:

- Any woman with sufficient literacy skills can write WhatsApp messages (or emails).

- Communication with professionals can be by audio and video recording, which allows for repeated listening and speech therapists. This is particularly useful for women with varying degrees of dysarthria[115] .

  This could be adapted to the case of interpreters and cultural mediators for women of foreign origin with a limited level of Spanish (or co-official language).

- Augmentative and alternative communication systems can be used in a complementary way - partially or totally - as required[116] (SAAC), as well as having professional technical support: speech therapists, SSL interpreter, communicative mediators. This could be extended to interpreters of other languages or cultural mediators in the case of other victim profiles.

Throughout the entire care itinerary, it is kept in mind that the **interlocutor is always the woman herself -** and in cases where this is necessary, with the technical support of professional figures.

This aspect is decisive for the reception phase of the victim and, as far as possible, **this support should** be **planned and anticipated.** Ideally, it should be provided by the service itself free of charge as part of their rights.

The **reception phase** is key to establishing the link between the professional and the woman victim of GBV. It should be supported by a systematised procedure that guides the professional's actions (a protocol). This usually includes: introducing oneself, observing and actively listening to the woman's history, giving credibility to what she expresses, containing her distress, using a script of questions for the interview that allows for a good record of each attention.

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[115] Dysarthria is a motor speech performance disorder. The muscles of the mouth, face and respiratory system may become weak, move slowly or not at all after a stroke or other brain injury. It is quite common in people with cerebral paralysis.

[116] Augmentative and Alternative Communication Systems (AACS) are forms of expression different from spoken language that aim to augment and/or compensate for the communication and language difficulties of many people with difficulties in this area. SAACs are not exclusive of spoken language, but are a complementary form of expression. They include the use of pictograms, signed language or communication support products such as notebook or technological tablets or PCs with special programmes, Braille, easy reading, pictograms, easily accessible multimedia devices, oral communication support systems and sign language, tactile communication systems and other devices that enable communication. See some of the systems available at: Article 4 of Royal Decree 674/2023 of July 18, approving the Regulations on the conditions of use of Spanish sign language and means of oral communication support for deaf, hearing impaired and deafblind people (access); Law 6/2022, of March 31, amending the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion, approved by Royal Legislative Decree 1/2013, of November 29, to establish and regulate cognitive accessibility and its conditions of requirement and application (access).

Emphasis is placed on women victims **being protagonists in their processes** and decision-making throughout recovery.

> *It is important to know how to differentiate that the needs sometimes perceived by professional teams do not always match or coincide with the demands expressed by women or girls with disabilities or rare diseases themselves. And that has to do with the fact that sometimes we take the permission not to ask them, but to assume that we take them for granted... so I think my priority would be this, because we are going to ask them, we are going to generate scenarios and we are going to see the answers. (E3)*

The focus **should not be on police reporting,** which in the case of RV it is very unlikely.

> The practices of the organisations show that one of the aspects that is first explained to the victims is, precisely, that **a report procedure will not be carried out until they decide to do so**; that if they do so, the expectations and guarantees of the process will be explained to them.
>
> It is up to the victim to decide when and how she wants to report, if at all. Priority is always given to a psychological approach that empowers them to make a report, and there is always legal support in the process.

According to the professionals interviewed, the reporting process is greatly complicated when either the SV or the RV, or both, occur in the immediate family environment. In the case of women with disabilities, it would involve reporting to the victim's main source of daily support, on which she depends.

> *When it is the case of the family, women have a feeling of being helpless, they themselves tend to be taken in by the family, much more so than if it were their partner or ex-partner. This is accentuated by the fact that they also have such a high level of physical and communicative dependence, it is like: "if my family disappears, I am alone in the world". E4*

> *The first premise is the lack of knowledge they have about their bodies and not only about anatomy, but also about physiology (...) They are not aware and have internalised the idea that their bodies do not belong to them, nor that they can make decisions about their bodies, nor that their opinion will be considered, to the point that ugly things have happened, that there have been situations of violence. (E3)*

The physical integrity and safety of women is the only criterion of exceptionality that should guide professional action in the field of VAW, and this extends to cases of RV. In general, the practices analysed identify "reporting" as an action resulting from a process of social intervention.

> *"Once the woman has made progress with the psychologist, she returns to the legal approach and she decides. The itinerary we follow is: I put you in a safe place, that is to say, this social approach and accompaniment for the exit; then the psychological approach for recovery; and finally, the legal approach if the woman decides to do so". E5*

The protocols that exist in GBV and SV state that when a woman verbalises that she is suffering violence, an *emergency plan* is implemented directly and the protocols that exist according to the risk (which do not exist in the case of RV, but those of SV are applied) are followed.

> If the risk is very high and the woman decides to do so, she is accompanied to file a report. And if the risk is low, we work on understanding the situation and accompanying her in her decision making through information and appropriate counselling.

In the **coordination and referral phase**, after assessing the personal safety/integrity situation, depending on the risk, the necessary social resources are put in place and, if necessary, the woman is removed from the environment where the violence is occurring or has occurred.

In case of **urgency or emergency**, a search is made for a housing resource that is adapted to the circumstances and needs of the victim within the public resources.

> In the case of women with disabilities, as the answer is generally that they do not exist (because they are not accessible), an emergency accommodation resource is set up within the organisations' associative network.

Once this emergency resource has been set up, psychological counselling begins which, once again, given the lack of training in disability (or harmful practices) of the human resources of public resources, is not adapted to victims of RV.

The victim's recovery process (some organisations have called it "**accompanied reconstruction")**, focuses on individual empowerment; also, through psychological care and group activities.

The work approach of the groups responds to the notion of "**collective empowerment**", through heterogeneous groups of women, made up of five or six women, focusing on secondary

prevention: deconstructing false ideas about the violence they have suffered, eliminating self-blame, training in affective-sexual education.

> *Hearing other people's testimonies is also healing and beneficial to them, the bottom line is that they need answers as to why and for what reason they have been acted upon in this way (E3).*

Resources, infrastructure and coordination

A comprehensive perspective in care implies a multidisciplinary **human resource**. In the practices analysed, the fundamental resources available are professionals in the fields of: psychology, social work, law, social education and communication mediation (in different specialities depending on the disability, speech therapy, SSL, deaf-blindness, etc.).

> Access to sexologists, midwives, nurses, gynaecologists, GPs and psychiatrists is also essential. However, many of these human resources are accessible **only through coordination and networking**.
>
> An important characteristic of care, especially for WIDD, is **continuity in the designated or referral professional.**

In terms of **care infrastructures**, it must be taken into account: decentralised mechanisms, online response platforms, telephone and mobile applications (for tablets and smartphones) as well as mobile (itinerant) teams that go to where the victims are.

> In this way, **the teams travel to** attend women within their municipalities or to other municipalities, creating itinerant teams and facilitating access and attention to the local resources available. These must meet **minimum requirements**: privacy and security.

For the interviewed organisations, **coordination is one of the major challenges** on which the quality of care depends. This was also expressed by the LEs and experts in the different surveys.

Thus, one of the unanimous demands is to be able to **establish stable and coordinated work** between health services, VAW resources and disability (or other) organisations with the aim of providing adequate care for women who may be exposed to any type of violence.

> The same can be extended to organisations representing - or with expertise in - other groups, which, as indicated in chapter 4, would be: associations or NGOs providing care for Roma women, migrant women, asylum seekers for or beneficiaries of international protection and refugees, victims of sexual exploitation and transgender people.

In general, LEs and organisations have focused their assessment of their experience in coordination **on GBV and to a lesser extent on SV**.

Their assessment **is positive**. There is a consolidated trajectory of cooperative interventions and monitoring of cases; despite the fact that the persistence of malpractice by some members of the State security forces and bodies has been detected[117] with respect to police reports.

> *Normally we have a very good coordination with the resources in the area that deal with violence and so, generally speaking, we coordinate with the psychologists or the social workers at the Violence Point and if she agrees, then we coordinate with them. On occasion, a colleague has even carried out joint interventions (E1).*

Examples of coordination between resources or services include:

- CODISA PREDIF holds regular meetings with the provincial coordinators of the Andalusian Women's Institute, thanks to which the *Protocol for Specialised Assistance to Women with Disabilities Victims of* Gender *Violence (*IAM, 2021) was drawn up. This protocol uses an agreed model report that establishes the referral procedure.
- The member organisations of "Plena Inclusion" Madrid coordinate with both the regional federation itself and with the sexual and reproductive health centres of the Community of Madrid, where they highlight the support work of the nursing professionals in the centres.
- The CNSE has a collaboration agreement with the *Women in ON Mode Programme*, where they are referred for job search. It is an initiative of *Inserta Empleo* and Fundación ONCE to promote employability and entrepreneurship.
- In the care of minors, CNSE refers to the ANAR Foundation, with whom they have a collaboration agreement. Plena Inclusión Madrid uses its network through the *Madres con Mayúsculas Programme*, which is aimed at supporting and accompanying mothers with intellectual disabilities and their children.

[117] One of the several examples that have emerged in the fieldwork exemplifies the typical situation: the case of a victim who "goes to a police station to report and the police officer tells her that what is happening to her is not violence, when his role is to welcome the woman so that she can file a report and it is not his role to assess whether or not this is violence". In this sense, they underline the feeling of frustration and impotence as professionals who have advised the police to file a police report.

However, it is important to note that this coordination is costly, because it **requires a lot of time** and persistence, especially when a **culture of networking** is not yet in place.

> *"There is a question of lack of time, of demand, of professional overload of all the services (...) is to facilitate spaces and places, I think that would be one of the keys, wouldn't it? And time to do it. Primary Social Care is overwhelmed. Mental health? It's complicated. I think that perseverance is important (...) I try to coordinate myself, they don't answer me, but I always come back to collaboration and help, don't I? Let's see, we need you, but we can also help you (anonymised interview).*

Networks and stable spaces for coordination are fundamental in the analysed experiences.

Its main obstacle is the lack of human resources, which means that whoever is available tends to prioritise direct attention over coordination, which, in the medium term, is detrimental to the quality of the intervention. This lack of resources also means that coordination may be limited to emergency situations.

Both in the experiences and in the surveys carried out (see points 6.1. and 6.2.), those who provide a more critical perspective state that, in practice, there are **obstacles to coordinated work**.

In this regard, the following issues have been identified for consideration:

- **Lack of updating and consultation**. Some coordination protocols are used as a means of resolving doubts, but are not reviewed before and during coordination. Sometimes they are too long and complex, too many reports are required, and there is excessive bureaucratisation. In some cases, it is pointed out that staff training and information exchange processes between services need to be improved.
- Coordination is more costly in **small and rural municipalities,** as well as in those that do not have their own resources. It implies that specialised services are centralised in the capital of the province (including shelters), which generates territorial inequality in the attention to victims.
- All the interviewees identified the biggest problems in the functioning of coordination with the **judicial sphere**. In the case of women with disabilities, this is determined by: the lack of knowledge and myths about sexuality and motherhood, the scarcity of adequate resources to testify with the necessary communication support, and the lack of credibility towards the victims.

- **Lack of accessibility** of VAW care resources and communication barriers due to not guaranteeing universality.
- **Lack of specificity**, because general protocols on care for victims of GBV do not usually take into account the specific needs of women with disabilities, and therefore do not identify other forms of violence that particularly affect them, such as RV.
- Lack of guidelines for **emergency situations**, such as COVID19, where there were no protocols in place and several services were paralysed.

Both LEs and expert organisations agree on a number of **general** coordination **challenges**. These are listed in the table below.

Table 5. Main challenges regarding RV according to Les and expert organisations

LEs	Expert organisations
Review and *debureaucratisation*	Insufficient resources
Specific training for professionals	Improving detection mechanisms
Allocation of competences and sufficient provision of materials and human resources	Disability and intersectionality perspective
Inaccessibility to common databases to apply for grants	Inclusive and accessible services for victims
Risk of secondary victimisation	Targeting resources according to women's needs
Improving crisis care	Consolidating inter-agency coordination beyond the emergency
	Changes in the political and institutional context

To conclude, it is essential to consider the key ideas about the **challenges ahead and the keys to sustainability** that characterise the practices analysed. In this way, the informants have identified the following eight challenges to be addressed in their work:

- *Challenge 1: Establish real inter-institutional coordination and consolidate it around the FASC, with specific protocols.*
- *Challenge 2: Incorporate the cross-cutting perspective of disability and interculturality as the backbone of the gender and intersectionality approach.*
    - Consider the heterogeneity of disabilities and not the single treatment of *disability*, as each type has its specificities and specific needs for care, as

well as the notion of multi-disability faced by many women with disabilities.

- *Challenge 3: Put women victims of RV and their rights at the centre.*
- *Challenge 4: Design inclusive and universally accessible services for all victims of RV.*
- *Challenge 5: Raise awareness and visibility of the different forms of RV that exist and specifically FASC in order to make progress in detection.*
    - Emphasise that it is a type of violence that mainly affects women with disabilities.
- *Challenge 6: Establish adequate mechanisms for the detection of RV.*
    - They are working to incorporate the detection of RV in sexual and reproductive health services, centres for the care of victims of violence against women, as well as services for victims of other types of violence. To meet this challenge, training for professionals is required.
- *Challenge 7: To ensure that women who are victims of RV seek help from the resources of the Integral Network for Gender Violence that exist in all the Autonomous Communities.*

7.3.2.3. Prevention and awareness-raising actions

Prevention actions **aimed at women** focus on two types of actions: on the one hand, through **empowerment groups for women**, providing a safe and trusting space where many issues related to self-determination, sexuality, SRHR can be addressed; and, on the other hand, through **specific trainings** working on these same contents (see previous point).

> *In the reproductive health groups and all that, we do work when the midwife comes and explains very well what contraceptive methods there are, what each one is for, how to use them (E2).*

All the practices analysed carry out awareness-raising activities aimed at the **families** of girls and women with disabilities, either through individualised information and counselling work or through training or awareness-raising actions on issues related to sexuality and affective-sexual education.

> *A father came to one of the talks and said to me "I've already solved this issue, we had my daughter's tubes tied when she was 20 years old, so I've already solved this" ... I thought to myself what you think you've solved, but here we are going to talk about*

sexuality. After the talk, this father came up to me and changed the discourse, "Wow, it's true, an intervention has been done on a woman's body without consulting her, without informing her, without asking for her collaboration, without considering her" (E3).

With regard to other **agents and institutions**, they work with State Security Forces and Corps in the field of SRH, students of health and social science disciplines and legal operators.

All experiences analysed are committed to movements in defence of women's rights and the rights of people with disabilities and mental illness. Therefore, they carry out multiple awareness-raising actions aimed at **society in general through**: talks in schools, participation in different conferences or meeting and through awareness-raising campaigns.

Figure 6. Info dissemination of informative talk. SAVIEX -CERMI Extremadura

Source: HOY Solidario[118]

Figure 7. Info dissemination of specialised training. CODISA PREDIF Andalusia

Source: Twitter CODISA-Predif[119]

In all the actions, the work of **breaking myths** about women with disabilities is important, as well as giving a **positive image** of women with disabilities, raising awareness of the violence they suffer and, above all, launching the idea in society that women with disabilities "are not eternal children" and can exercise their sexual and reproductive rights.

They all point out that **it is not possible to talk about "them" without counting on "them"**, which is why in their awareness-raising actions they

[118] HOY Solidario. Access
[119] Twitter CODISA-Predif. Access

provide the appropriate support so that women with disabilities themselves are the protagonists, for example, by giving training or telling their own testimonies.

8. Gestational surrogacy or surrogate pregnancy

8.1. Characterisation of surrogacy or surrogate motherhood

8.1.1. Key dimensions and aspects

Surrogacy or gestational surrogacy (GS) is a form of **reproductive exploitation of women** and therefore a form of violence against women (VAW). It is illegal in Spain and the European Commission has clearly established the link between this practice and trafficking in women for the purpose of exploitation.

> GS refers to the set of procedures by which a woman ends up carrying one or more embryos (has a pregnancy), resulting from the fertilisation of her own egg or the transfer of embryos, and gives birth to one or more children for a firm, for another person or for a couple.

Although there is a **deep debate on the regulation** of this practice under the principles of altruism (Regalado Torres, 2017; Piña Sempertegui, 2019; Zegarra Vásquez, 2022) it transcends the agreement between individuals with personal ties (previous or not), being a practice that is characterised by its commercial development worldwide (Balaguer, 2017; Marrades Puig, 2017; Serrano Ruíz-Calderón, 2017; Salazar Benítez, 2018; Guerra Palmero, 2018).

> GS is a very specific type of VAW, which **tends to entail other forms of RV** such as obstetric violence and forced abortion, and which, in addition, may constitute an **international crime** as it affects women who could be subjects of international protection in our country given its link to trafficking for the purpose of exploitation.

GS violates fundamental rights recognised both at state and international level: such as the right to life, the right to physical integrity, the right to freedom of decision (which despite of being the main argument in favour of GS, is totally subordinated to the wishes of the legal principals or to the very effectiveness of the GS contract in certain cases), the right to health, patient autonomy, sexual and reproductive rights, freedom of movement and the right to dignity and, in the case of children born, their right to know their origin and identity (Lamm, 2012; Regalado Torres, 2017).

The European Commission (2020) recognises that **human trafficking through** surrogacy is a form of exploitation; an emerging pattern to which women and girls are particularly vulnerable. Victims of trafficking for other forms of exploitation (including GS) would represent 18% of all victims of trafficking according to the European Commission (2020).

The experts consulted in the research have underlined that **GS is - fundamentally - a form of commercial RV**, which implies paying attention to the ways in which capitalism as an economic system blend with patriarchy to formulate specific forms of violence against women (González López; López Paredes; Nuño Gómez; Trejo Pulido). Both are seen as interdependent systems of oppression.

> In addition to GS, this is also the case of sexual exploitation in prostitution and others derived from the sex industry. These are forms of violence that, from a contemporary perspective, cannot be understood without understanding the intersection between capitalism and patriarchy (Fernández-Martorel, 2018).
>
> The neoliberal capitalist model has found in GS an opportunity for profit through the need of two parties. On the one hand, the intended parents who have no possibility of having offspring naturally and who desperately seek, sometimes due to social and family pressure, any way to have a child with the same DNA as their own. On the other hand, women in vulnerable situations find economic resources that could alleviate their vulnerability (Szygendowska, 2021).

In spite of this, **the characteristics of GS are little known** by society as a whole, which, in general, is stereotyped by the marketing companies that hide the consequences for pregnant mothers and cover up the situations of coercion and violence to which they are often subjected. This results in **the normalisation of the practice and the invisibility of abuse**.

> Thus, it is **a form of violence against women that is not recognised as such** in many places and by many agents. Certainly, from an international perspective, there are different approaches to this practice, mostly rooted in the society and legislation of different countries.

Despite the reasons why women initially consent to this practice is **access to an income**, it is estimated that expectant mothers would only earn 0.9% of the global turnover. The estimated global turnover of GS is around 6 million dollars a year, which is why some experts speak of **reproductive pimping** (Nuño Gómez, 2016; Trejo Pulido, 2017),

Lack of recognition determines, of course, the regulations in this respect, but it also does the degree of social and institutional awareness. In this sense, a **perspective far from women's rights and their experiences** is often used, and the focus is placed on the process of giving birth to a son or daughter desired by the purchasing party. Gestation becomes a *minor* mean to this end and the pregnant mother is **dehumanised.** This perspective of invisibility is favoured by the social debate on the rights of recognition of gestated minors and, therefore, by the interests of the people who choice this practice to have a baby.

In this way, the **physical integrity and health of the surrogate mothers whose bodies are indispensable are subordinated**; they are the ones who suffer the continuous violation or even the total loss of their rights during, before and after gestation. As explained in chapter 2 *Violence against capacity and the right to reproduction*, surrogacy comprises a **complex set of commercial, health and administrative practices** that involve a continuum of violation of fundamental rights for the women who are victims of surrogacy and that goes beyond the gestation itself.

The feminist perspective helps to understand how patriarchal notions of women minimise ovulation, embryo implantation, pregnancy, childbirth and postpartum. Society as a whole, the health care system and women themselves **undervalue women's role in reproduction, its value and its costs**.

Researchers such as Fernández-Martorel (2018) point out that all these processes are relegated as secondary, "automatic" events. As a whole, they would represent a natural process where all **psychological and emotional, physiological and social sub-processes are completely minimised in women's lives**.

> All of these are obviated and simplified around the notion of "gestation", which is conceived as a "basic function" for any woman, which is of little relevance. In contrast, technology (the masculine sphere par excellence) takes centre stage. The technique of assisted reproduction (*in vitro* fertilisation), together with the administrative act of registering the baby with the State, occupies the narratives of what GS consists of; and women, who are the only ones who can make it all possible, are conceptualised as passive subjects, bearers of the products "boy" / "girl" (Fernández-Martorel, 2023).

> "In the case of surrogacy, the **analogies with the production process *of baby factories*[120]** are evident and the commodification of pregnant women cannot be seen as an advance in freedom, but rather as a regression towards slavery" (Guerra Palmero, 2018: 49). It is therefore necessary to adopt an **intersectional approach** in the study of GS and to put an end to the commodification of women's bodies in this and other fields (Guerra Palmero, 2018).

With regard to the **different denominations** given to GS, these depend on the aspect to be highlighted - and also on the ethical assessment made - and are known as: surrogacy, surrogate motherhood, surrogate womb, surrogate motherhood, gestational carrier, etc. (Comité de Bioética de España, 2018). Although the feminist movement prefers to focus on the notion of commercial gestation or commercial motherhood in order to put the spotlight on firms (which are the ones that promote this practice and develop violent practices against pregnant women).

> It is thus emphasised that **life processes can neither be surrogated nor substituted**, whereas "surrogate womb" refers only to a part of the body (as if the whole organism as a whole were not involved) and is less respectful of the pregnant women (who are not mere wombs) (Nuño Gómez, 2023).

Within the discussion on terminology, the **most common terms** are the notions of *surrogacy*, surrogate *motherhood* or *gestational carrier,* which are used as euphemisms for this complex practice.

> Regarding the first term, it would be correct to speak of a surrogate *mother* - instead of a surrogate *womb* - since it is not only the womb that is contracted, but the woman in her entirety to carry out a gestation that the intended parents cannot or do not wish to carry out. "Nor does it seem correct to speak of 'surrogate motherhood' since from the biological and genetic perspective, motherhood is not replaceable: either there is genetic motherhood (the mother who provides the egg) or there is physiological motherhood (the gestational mother)" (Comité de Bioética de España, 2018: 9).

[120] UNESCO used the term "baby factory" in 2006 to refer to clandestine centres in Nigeria where human traffickers lured or abducted young women with unwanted pregnancies or women who were raped until they became pregnant and then sold the babies (Holguín, 2020).

In this regard, the WHO has noted that a surrogate "is a woman who carries a pregnancy with an agreement that she will deliver the baby to the intended parents. The gametes may originate from the intended parents and/or third parties" (2010).

GS tends to be presented in a reductionist way in three parts: (1) the pregnant woman, (2) the intended or commissioning parent(s) and (3) the baby or babies born through this practice. Depending on the relationships between the parties and the variables involved, there are different modalities of GS which are represented as follows (see table 6):

Table 6. Current surrogacy modalities

Variable	Types of GS
Remuneration agreement	Altruistic GS: the pregnant woman does not receive payment for it, although there may be compensation for expenses, damages or loss of income derived from the gestation process. Commercial or lucrative GS: (the most commonly practised) the pregnant woman obtains a financial remuneration that is greater than the compensation for the expenses and inconvenience suffered by the gestation.
Origin of the baby's genetic endowment	Gestational or full GS: the pregnant woman provides "only" the gestational capacity of the uterus. Through this technique, the rights to the baby born are renounced. There are 3 possible situations: • Gametes from both intended parents are used. • Both gametes come from donor or donated embryos. • One of the parents provides a gamete while the other comes from donation. Traditional or partial GS: the pregnant woman also provides the egg, which is usually not manipulated (this practice is almost out of use).
Affective or family relationship with the pregnant woman	Intrafamilial GS: if the pregnant woman belongs to the family of the intended parents (mother, sister, daughter, aunt, etc.). In this case, the baby will have a double bond with the pregnant woman: the one derived from the gestation and the one of legal filiation. GS extrafamilial: if the pregnant woman has no family relationship with the intended parents.
Conditions of delivery of the baby	GS with waiver before birth: the pregnant woman waives maternity before the birth of the baby, so that after the birth the baby will be handed over. This is the usual form of commercial GS. GS without waiver before birth: it can be agreed with the pregnant woman that she will not resign beforehand and that she can decide in the days following the birth whether she will finally give up the baby.
Territory	National GS: Intentional parents carry out GS in the same country where they reside.

Variable	Types of GS
	International GS: intended parents go to a country other than their country of residence for GS.

Under this triangular conception, **the other figures in the process are largely invisible, but they are just as relevant** to the understanding of the key dimensions of the problem:

- **The company or recruiting firm** of the pregnant women and the marketer of the practice (if not the same), their procedures and practices and the economic benefit they derive.
- **The *clinics* and health professionals** involved in the process of hormonal preparation and treatments for the implantation and gestation of the embryo and the rest of the health care for the mother, including interruptions of pregnancy, miscarriages, childbirth and postpartum (if covered).
- **Institutional agents** of administrative and public/legal registration of the babies accepted by the purchasing party. This implies the state where the expectant mother lives and the state where the purchasers live.
- **Children who are rejected,** and therefore their later lives.
- **Institutions** that take care of rejected children.

We must also consider in the debate **the rights of children born by GS** (Balaguer, 2017) and their future rights to know their gestating mother[121] .

> Surrogacy is, by its very nature, a breeding ground for exploitation, abuse and trafficking, and not only in developing countries. In the United States, a network of lawyers who had created an inventory of unborn babies to sell for $100,000 using GS was dismantled in 2015 (Practitioners for Ethics, 2015: 9).

8.1.2. Prevalence of the problem

There are no specific **statistical records** on the phenomenon, making it difficult to quantify the true scope and dimensions of this form of VAW.

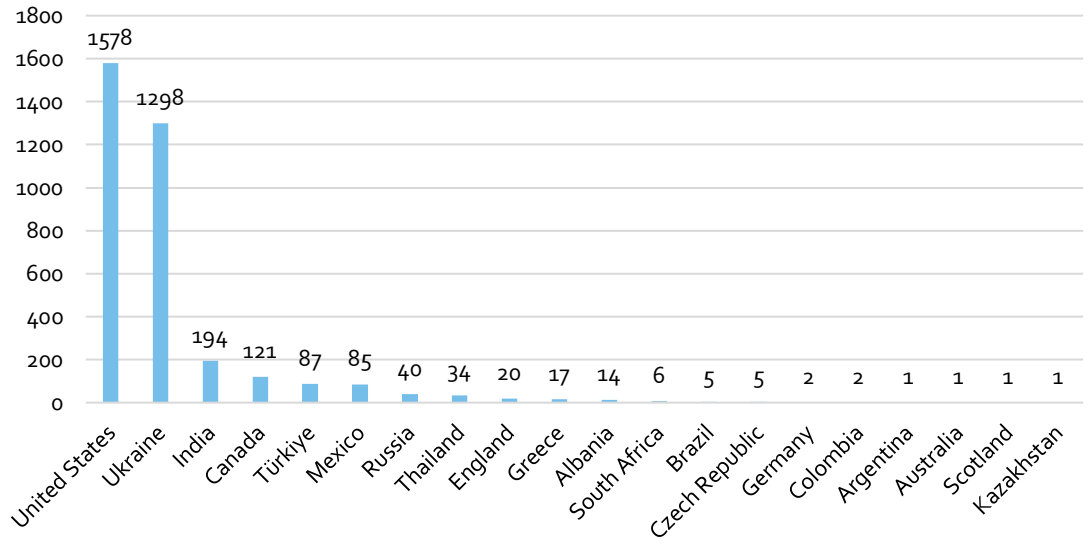
[121] In 2020, the Spanish Bioethics Committee drafted a report recommending the modification of article 5.5 of the Law on Assisted Human Reproduction to eliminate anonymity in gamete donation. Spain was one of the few European countries, along with France and Italy, that still maintained it.

A quantitative approach to the problem is usually made through embassies and consulate registrations. In this way, **embassies and consulates** and other registry procedures can identify the number of children who are registered[122] by Spanish nationals, as well as their countries of birth. This allows us to an approximation of the problem. However, this is a **partial and biased vision**, as it focuses on minors - in this case in relation to their civil registration - and not on the **real number of women who are victims** of GS in any of its forms.

> The data provided by the Ministry of Foreign Affairs, in response to the consultation carried out in this research, indicate that **between 2010 and 2022, 3,512 applications for the registration** of babies born by GS **would have been made** at Spanish consulates in different countries.

Regarding the **countries of origin**, the United States (US) with 1,578 applications (44.9% of the total) and Ukraine with 1,298 (37.0%) are the two places where the largest number of applications have been made in the period 2010-2022, although there are more countries as can be seen in the graph below.

Graph 9.Applications submitted to Spanish consular offices for the registration of children born through surrogacy techniques by country (2010-2022)



Source: Ministry of Foreign Affairs (data requested 2023).

[122] As part of this research, a request was made to the Ministry of Foreign Affairs and the DGVG for current data on applications for registration of babies in the civil registries of Spanish consulates. The Ministry of Foreign Affairs -via transparency portal- provided in July 2023 the available data on the "number of applications filed in Spanish consular offices between 2010 and 2022 for the registration of minors born through surrogacy techniques", while the DGVG -via email- replied that it does not have any data in this regard.

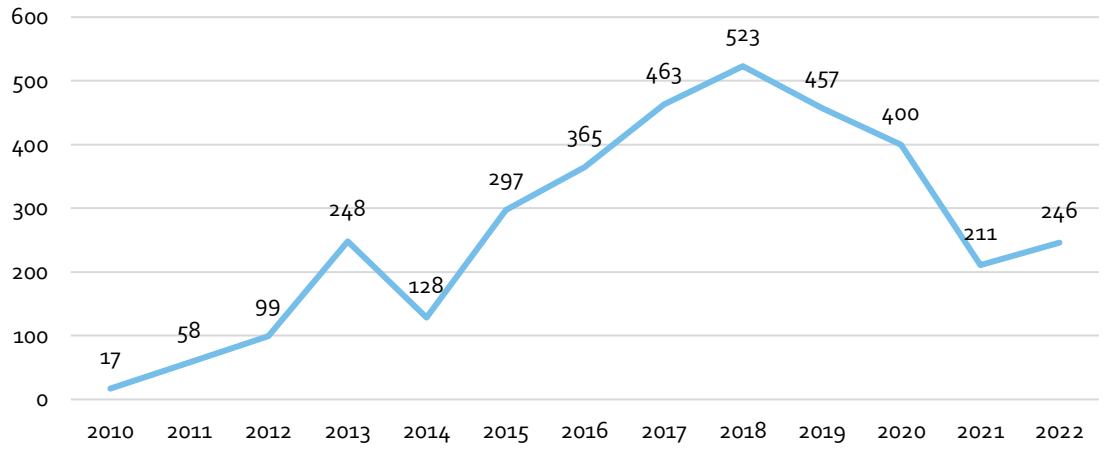
The difference in the number of applications **in the USA and Ukraine compared to the rest of the countries is high** and is related, fundamentally, with the legislation of each territory and also with the cost or price of the "service" offered by the different companies.

> However, these data only show a small part of the reality and it is difficult to quantify the total number of Spanish nationals who have had children through GS. Many choose to register these babies directly upon arrival in Spain, in the Central Civil Registry, where no data related to the pregnancy is recorded. There is, therefore, a probable underestimation of the phenomenon.

It should be noted that the decrease in the number of applications for registration at consulates from 2019 onwards indicates that **more and more babies are being registered directly in Spain.**

> One explanation that fits with this hypothesis is that, in 2019 *the Instruction of February 18, 2019, of the Directorate General of Registries and Notaries, on updating the registry regime of the filiation of those born through surrogacy*, considers that civil registrations in consulates can only be made in cases in which there is a final judgment of the judicial authority of the country concerned, was issued in this regard.

Graph 10. Evolution of the number of applications to register babies born by GS at Spanish consulates by year (2010-2022)[123]



Source: Ministry of Foreign Affairs requested via the transparency law (requested data 2023).

[123] The data for 2013 presents a peak due to the fact that the number of applications made at the Spanish consulate in New Delhi (Asia) between 2010 and 2013 is counted in this year, which amounts to a total of 90 applications, as these data are not available broken down by year.

The coalitions of feminist NGOs that monitor the phenomenon (such as CIAMS, Stop Surrogacy Now or RECAV), which warn about the violation of the human rights of pregnant mothers, point out that in the absence of a register or quantification of the number of women affected, it is very difficult to measure the problem.

8.2. Women victims and the consequences of this VR

Most of the literature focuses on the bioethical and legal debate on GS (Regalado Torres, 2017; Albert Márquez, 2017; Aparisi Miralles, 2017; Casciano, 2018; López, de Montalvo, Alonso, Bellver, Cadena, de los Reyes, Fernández, Jouve, López, Nombela, Romero, and Serrano, 2018; Piña Sempertegui, 2019; Zegarra Vásquez, 2022). There is hardly any research focused on women's experiences as surrogate mothers, so women who are victims of reproductive violence (RV) and their needs are still very little known.

8.2.1. Characteristics of women victims

There is a consensus among researchers and experts on GS that it is **women in a situation of** socioeconomic **vulnerability who** put their bodies at the service of commercial GS (Pande, 2014; Aparisi Miralles, 2017; Albert Márquez, 2017; Abell-Selby, 2019; Nuño Gómez, 2020; Pardo Mirando, 2023). This occurs **in any country** and especially in those societies or cultural contexts in which the subordination of women to men persists in a more notable way, where women are especially unprotected against the instrumentalisation of their bodies and the consequent use of their bodies for other people's purposes (Aparisi Miralles, 2017; Nuño Gómez, 2020).

> The victims are young women of reproductive age, between 25 and 35 years old, who have usually been mothers before, characteristics that are intended to ensure the viability of the pregnancy. They are generally uneducated women with little or no job opportunities. They are generally unemployed or have precarious jobs in the informal economy (E8).

Some studies indicate that less than 4% are women with a university education and more than 40% are unemployed and/or receiving social benefits (Trejo Pulido, 2017).

These are therefore women in a **situation of extreme vulnerability** who have little or no economic resources. In fact, the most common reason for women to become involved in GS is economic (Casciano, 2018).

> This decision is made by the couple if the woman is married. In this sense, **the husband of the victim** may have a fundamental role in decision-making, above the pregnant woman herself, who can often find herself in a role of emotional, social and legal subordination to her husband that limits her autonomy or even in a situation of gender violence (Pande, 2014; Aparisi Miralles, 2017; Albert Márquez, 2017; Abell-Selby, 2019; Nuño Gómez, 2020; Pardo Mirando, 2023). Likewise, as the European Commission points out, she may be a trafficked woman for the purpose of reproductive exploitation.

The ultimate goal for pregnant women is to **improve their socio-economic status and be able to support their families** (Abell-Selby, 2019). For example, that their children are educated and freed from poverty (Pande 2014; Abell-Selby, 2019).

> One fact that some studies point out is that pregnant women who already had children before undergoing GS have not had the economic capacity to feed themselves adequately during their previous pregnancies, whereas during surrogacy this situation changes, as the wellbeing of the baby is contingent on the health of the woman who is carrying the child. This gives an idea of the impact that the arrival of income has on their lives (Pande 2014; Abell-Selby, 2019).

Victims **start from a situation of asymmetry** (cultural, economic, ...) between the pregnant woman and the commissioning parents, which puts the violation of women's autonomy and rights at greater risk (Aparisi Miralles, 2017; Casciano, 2018; Abell-Selby, 2019).

> Carrying a baby for other people implies a process that transcends gestation. It cannot be considered a free decision when the pregnant woman is in a situation of vulnerability, because she lacks sufficient autonomy to exercise her right to freedom if she is in a position of inequality (Aparisi Miralles, 2017; López Rodríguez, 2017; Casciano, 2018; Gonzalez López, 2019; Szygendowska, 2021).
>
> Intended parents who travel to other countries - usually developing countries - to carry out GS do not face the same social and economic difficulties as surrogate mothers. They do not take into account the costs and implications of surrogacy for these women, reproducing the **physical and structural vulnerability** of these women.

Research such as Amrita Pande's (2014) in India describes how the **process of 'recruitment' of** pregnant **women takes place** and in particular how some women justify the decision to become pregnant by adopting a new *moral code*, sometimes religious, and putting aside their personal beliefs, around altruism. The influence of social inequality on GS for Indian women has also been investigated (Abell-Selby, 2019), concluding that women are exploited or not depending on their socio-economic class.

> The selection process of the surrogate mother by companies and intended parents is associated with a multitude of tests and criteria, which tends to include racial criteria on the selection of the surrogate mother (Practitioners for Ethics, 2015).

It is common for pregnant women to **misunderstand the implications of the situation** they face. GS exposes pregnant women to situations that increase their vulnerability due to a process in which they lose their voice and are subjugated to the **rules of an** often-abusive **contract.**

> In almost all cases, women have **difficulty understanding a contract** that is usually in English or in a language that is not their native language. Even in their own language, they are confronted with legal language whose characteristics and implications go beyond the initial understanding of the text (as with anyone outside the field of law). The lack of education and counselling in the contract signing process not only limits these women's future opportunities, but also hinders their capacity to negotiate with intended parents about the agreement (Abell-Selby, 2019).

Expectant mothers are **relegated to dependent roles**, from which they have to take orders from intended parents and business-related medical personnel (Pande 2014; Abell-Selby, 2019).

> This situation even implies that some victims take on this role as pregnant mothers **confined in gestational residency centres** (Pande, 2014; Abell-Selby, 2019). In other words, confinement can be part of the GS process, especially at the end of pregnancy, which implies the isolation of the victim from her family and emotional support environment (Fernández-Martorel, 2023).
>
> While in non-commercial pregnancies the priority is usually the health of the pregnant mother, in commercial pregnancies the well-being of the unborn child is prioritised (see López, De Montalvo, Alonso, Bellver, Cadena, de los Reyes, Fernández, Jouve,

Nombela, Romero and Serrano, 2018). The GS process relegates **the physical integrity and health of pregnant women** victims to a **secondary position** compared to those of the foetus, so that they see their rights suspended during the gestation period, sometimes being unable to make reproductive decisions such as having a vaginal birth versus a caesarean section, despite the former being the most appropriate for the health of the latter (Pande, 2014; Aparisi Miralles, 2017; Abell-Selby, 2019; Nuño Gómez, 2020).

It is common for the surrogate mother to carry several embryos because it lowers the cost of the second baby for the purchasing party; this increases the **risk of multiple pregnancies and multiple births** for the victims (Practitioners for Ethics, 2015).

This dehumanisation is accentuated when, by contract, abortion is requested if the foetus suffers from Down Syndrome or other genetic characteristics not desired by the parents; or when **the abortion** of one of the foetuses **is imposed** in the case of multiple pregnancies, as a condition for receiving the agreed money, without taking into account the effects this may have on the mother or the unborn babies (Lamm, 2012; Regalado Torres, 2017).

Undoubtedly, debates regarding free self-determination are an aspect susceptible to criticism in GS processes, since the apparent freedom of decision is conditioned by the economic-social circumstances surrounding the pregnant woman (Regalado Torres, 2017).

8.2.2. Consequences of surrogacy

Social and legislative debates on GS are usually established around the **patrimonial relationship of providing a service** and not from the perspective of women's rights. From the first approach, surrogacy develops a practice of commodification of women's bodies. It allows people with economic capacity to feel entitled to buy a baby (Szygendowska, 2021; Nuño Gómez, 2020) and the reproductive exploitation of vulnerable women offers this possibility. The first consequence is therefore the **normalisation of this form of violence**.

GS **contributes to the undervaluing of women's bodies and their role in human reproduction, its costs and social implications**. It is a violation of the fundamental rights of women and of the children who come to life in this way. The objectification, instrumentalisation and depersonalisation of the pregnant mother are effects and characteristics that are inherent, constitutive and inherent to GS (Casciano, 2018).

A particularly relevant consequence is the promotion of trafficking. Since the link between GS and **trafficking in human beings for the purpose of exploitation and trafficking in minors** has been identified.

> "The commodification of human beings and the exploitation of needy people in developing countries are only the most serious manifestations of this figure. The profile of the countries that supply and those that demand this type of gestation reinforces the idea that surrogacy constitutes a vehicle for the exploitation of women" (Pardo Miranda, 2023: 8).

The **consequences of the pregnancy process** that victims have to face are mainly physical and psychological, but also social and economic.

Although many pregnant women initially see GS as an opportunity to gain survival capacity - in the context of the feminisation of poverty and the counter-geographies of globalisation (Sassen, 2003) - the truth is that **GS reinforces inequalities and increases women's vulnerability** (Aparisi Miralles, 2017; López Rodríguez, 2017; Casciano, 2018; Gonzalez López, 2019; Szygendowska, 2021).

> Expectant mothers themselves **minimise their reproductive work and underestimate the impact** it has on their lives. **They underestimate the physical, psychological, social and economic costs** involved in the processes of "unsuccessful" pregnancy or along the way.

The physical consequences of GS on pregnant women, both during the process and afterwards, have an impact on women's **bodily autonomy and health** (Abell-Selby, 2019).

Prior to pregnancy, all women undergo medical tests and hormone treatments. These differ depending on whether fertilisation of the egg itself is required, and insemination is carried out later, or whether an embryo is implanted.

> The use of drugs to prepare the pregnant mother to receive the transferred embryos exposes her to an **increased risk of increased intracranial pressure** (Center for Bioethics and Culture [CBC], n.d.).
>
> It is critical to understand that the process leading to pregnancy in GS **differs from spontaneous conception and that there are important medical details** until gestation is established. Hormonal treatment that triggers ovulation in women has **significant risks to their health** (Farhud, Zokaei, Keykhaei, & Yeganeh, 2019; Trejo Pulido, 2017) such as negative obstetric outcomes, vascular problems compared to spontaneous pregnancy (Wu, Sharma, Mehta, Chew-Graham, Lundberg, Nerenberg,

Graham, Chappell, Kadam, Jordan, & Mamas, 2022; Udell, Lu, & Redelmeier, 2017) or severe long-term mental health impairment (Vikström, Josefsson, Bladh, & Sydsjö, 2015).

During pregnancy, women face various changes and health risks. Pregnancy inevitably brings with it physical changes such as weight gain, swelling, appetite changes, increased urination, hormonal changes, back pain or nausea, among others, which generally affect all pregnant women. Some of these consequences, such as weight gain, the appearance of stretch marks or possible scarring from childbirth or planned births and terminations, do not disappear after childbirth.

There are **complications that can occur in any pregnancy**, such as embolisms, iron deficiency anaemia, haemorrhages, gestational diabetes, arterial hypertension, eclampsia, hyperemesis gravidarum, spontaneous abortion, placenta previa, placental abruption, premature labour, depression and anxiety or even death, to which must be added the problems that the foetus may present (The Ministry of Health and Consumer Affairs, 2005). In addition, "giving birth to a child that is genetically not one's own entails a greater risk of serious complications such as pre-eclampsia" (Trejo Pulido, 2021: 49).

In the case of GS pregnancies, the particular conditions of conception, gestation and delivery established in the contracts expose pregnant women to a **very aggressive process for their physical and mental health** and entails risks for the babies, as it is a "highly medicalised, technified, controlled and alienated" pregnancy (Trejo Pulido, 2021: 49).

Women pregnant with a donor egg have **more than three times the risk of developing** pregnancy-induced **hypertension** and pre-eclampsia (CBC, n.d.).

Cases of deaths of pregnant mothers have also been documented (CBC, n.d.).

It is common for multiple embryos to be transferred at each attempt, which together with the overhormonation to which women are subjected, has the consequent increased likelihood of **multiple pregnancies, associated with a higher risk of maternal and perinatal complications**, such as gestational diabetes, foetal growth restriction and pre-eclampsia, as well as premature birth (CBC, n.d.).

In this situation, **the surrogate mother has no voice** and it is the contracting party who decides whether to carry out selective abortions or to carry out the gestation of 2 or 3 babies, and whether she wants to keep all the children or not. They also have no say in the delivery, which in most cases is programmed and induced, often by caesarean section.

During GS, amniocentesis or other invasive genetic tests, which are risky and painful, are common to ensure the genetic integrity of the pregnant woman and to rule out the risk of malformations or certain genetic anomalies (Lamm, 2012; Regalado Torres, 2017; Trejo Pulido, 2021; Profesionales por la ética, 2015). If a problem is detected, the woman is subjected to an abortion (Lamm, 2012; Regalado Torres, 2017; Trejo Pulido, 2021; Profesionales por la ética, 2015). This could constitute another form of reproductive violence as it could constitute a situation of forced abortion (see Chapter 4.2).

> Due to the consequences of GS, there have been cases where pregnant women have been forced to reinvest the money they receive in their physical and emotional recovery and/or to compensate for their postpartum sick leave status, as in many of the countries where GS takes place, women lack some basic rights such as maternity leave (E8).

Regarding delivery and postpartum, in GS there is a **very high percentage of induced and caesarean deliveries (**CBC, n.d.; Trejo Pulido, 2021), at the request of the commissioning party so that they can attend the birth and avoid other risks for the baby during vaginal delivery or by decision of the clinic, to maximise the number of births they perform per day (Trejo Pulido, 2021), circumstances that increase the likelihood of longer hospital stays (CBC, n.d.).

> Caesarean sections that are performed as a last resort, out of business necessity, without regard for the pregnant woman constitute a clear manifestation of **obstetric violence**, along with other medical practices that are performed during gestation without the consent of the pregnant woman. In addition, **caesarean sections carry serious risks** (Olza, 2018; National Guideline Alliance, 2021) including heavy bleeding, infection, longer recovery compared to vaginal delivery, and the **likelihood of complications in future pregnancies** (National Library of Medicine, 2021).

In relation to the postpartum period, a normal vaginal delivery of a single baby tends to last 6 weeks, in the case of GS where delivery tends to be by caesarean section and multiple births are frequent, pregnant women do not usually receive medical or psychological care during the **entire postpartum recovery period**.

> Pregnant mothers suffer from the **absence and neglect of** both the commissioning party and the intermediaries or clinics that have carried out the process, which do not assume any responsibility for the woman's health after the birth of the baby (Trejo Pulido, 2021).

In terms of **physical consequences for the baby**, children born through GS are more likely to have **low or very low birth weight**, and there is a 4 to 5-fold increase in **stillbirths** in pregnancies carried out through assisted reproductive technologies (CBC, n.d.).

> Babies who have suffered health consequences in the birth process, who have malformations or other characteristics not desired by the purchasing party are usually rejected (Lamm, 2012; Regalado Torres, 2017; Professionals for Ethics, 2015. There is a lack of studies on the situation of children who are abandoned.
>
> The particular conditions of surrogate pregnancies, which, as noted, are associated with a higher likelihood of multiple pregnancies, can lead to **preterm births**, with consequent **risks for premature babies** such as cerebral paralysis, learning difficulties, slow language development, behavioural difficulties, chronic lung disease and developmental delays (Trejo Pulido, 2021).

The **psychological consequences** of the GS process for expectant mothers are diverse.

> "The sale or surrogacy of one's own body ultimately involves the whole person, and the **psychological consequences** of GS are obvious. There is increasing scientific evidence regarding the bonds that are created between mother and baby during pregnancy, yet some would have society believe that a surrogate is something aseptic, with no psychological consequences for either the mother or the child" (Professionals for Ethics, 2015:6).

In many cases, pregnant women **require psychological support** (Professionals for ethics, 2015; Aparisi Miralles, 2017; Nuño Gómez, 2020; Trejo Pulido, 2021). Particularly noteworthy are the **risks to the mental health of pregnant mothers** after childbirth and separation of the new-born (Professionals for ethics, 2015; Aparisi Miralles, 2017).

> Some studies on the emotional state of surrogate mothers show that they have **high levels of depression during pregnancy and postpartum** (Lamba, Jadva, Kadam, & Golombok, 2018; Ahmari, Tashi, Mehran, Eskandari, & Dadkhah, 2014). During pregnancy the surrogate mother's concerns may be various such as suffering a *miscarriage* after experiencing physical pain in the In Vitro Fertilisation process; anxiety about possible health problems of the baby or malformations; insecurity about how to inform her own children/daughters or family members about the situation; religious and economic conflicts related to surrogacy; or fear of birth complications and recovery in the event of a caesarean section, among others (Ahmari, Tashi, Mehran, Eskandari, & Dadkhah, 2014; Taebi, Masoudi, & Ahmadi, 2020).

In the postpartum period, although women are aware of the baby's delivery from the beginning and are contractually forbidden to establish a sentimental bond with the baby they are carrying, in more than 10% of cases they need **intense psychological support to overcome the separation (**Aparisi Miralles, 2017).

In commercial practices where the commissioning mothers and fathers maintain close contact with the pregnant mother, this contact tends to disappear -suddenly or progressively- after the birth of the baby. Once the birth occurs, the woman is *discarded*, "she becomes an unnecessary, annoying and amortised element, in market terms, and feels the full weight of exploitation, of separation from the baby, of the commodification of pregnancy and of the vested interests of a commercial transaction that involved whole persons rather than products for sale and purchase" (Practitioners for Ethics, 2015:7).

> When the contracting party achieves what it was aiming for, which is to obtain the baby or babies, any kind of investment to ensure the physical and mental health of the pregnant mother is considered by the intermediary companies and clinics as a loss, since the product has already been delivered (E8).

In addition to the above, according to epigenetics researchers, prenatal factors can negatively or positively affect the genetic development of the human being, therefore, **surrogacy presents a challenge in this field because of the impact on the health of the foetus** (Tan, 2020).

In addition, victims face **other personal consequences**. **Loss of social and family support networks** is another consequence faced by some pregnant women.

In some countries, such as India, the line that divides GS and sex work in the social imaginary is very thin, which is why pregnant women often hide this reality from their close environment, distancing themselves from family and friends during surrogacy (Abell-Selby, 2019; Trejo Pulido, 2021).

Many women who have been away from their environment during pregnancy and return after childbirth to their communities - where they head the household and carry most of the household responsibilities - face social stigma for having done so (Abell-Selby, 2019; Trejo Pulido, 2021). There is still very little information on what kind of stigma women face as a result of having been or being a pregnant mother.

Another lesser-known aspect is the **violation of the right to privacy, freedom of movement and the right to make decisions.**

> Surrogate mothers can be monitored according to their contracts 24 hours a day, 7 days a week by the intermediary companies and/or by the persons accessing this practice (E8).

There are also cases in which they are forbidden to have sexual relations, or suffer strong restrictions on the control of social relations, even being forced to separate from their families (Trejo Pulido, 2021).

Finally, it should be noted that the lack of understanding of the processes involved in GS can lead to the **criminalisation of pregnant women**, which can be interpreted as a possible specific consequence of this form of RV (Nuño Gómez, 2020).

An example of this occurred in Cambodia, where GS was banned in 2016 and more than 60 women were imprisoned on charges of gestational surrogacy. The usual practice in these cases was to release the gestational mothers on bail, with the obligation to carry the pregnancy to term and raise the baby as their own until the child came of age (Nuño Gómez, 2020). The experts consulted have pointed out that in Spain caution should be exercised, as article 221 of the Spanish Penal Code (SPC) could lead to the criminalisation of the pregnant mother.

For all of the above reasons, the institutional approach to GS in Spain is to consider it as reproductive violence. **Legalising GS implies the dehumanisation of women and babies**, who become parties to a sales contract, commodities. It implies a violation of the rights of the most vulnerable women and contributes to increasing the existing inequality gap between countries (Regalado Torres, 2017; Nuño Gómez, 2020; Szygendowska, 2021).

8.2.3. Needs of women victims of GS

Among the interviewed experts there are some experiences of care for victims of GS, through which they explain their needs. They agree that **access to victims is complex**, as women subjected to reproductive exploitation do not report exploitation. When they do, these women run the risk of being treated as perpetrators of a crime. In addition, there is no specialised support for victims of such violence.

In addition to the common needs of victims of RV, survivors of GS **have multiple needs** that may vary according to the individual circumstances of each woman, but in general terms the most common are:

- **Economic resources:** the economic situation can be diverse and depends largely on the surrogate mother's country, but in general, women who agree to gestate for others do so for economic reasons, as Nuria González López (E8), a lawyer specialising in human rights, argues[124] .

  > A common feature is the economic emergency situation of the woman herself or someone close to her, which, for example, in the case of women from the USA or Canada, may be to pay for medical expenses for an illness or, in the case of women from developing countries, it may be an attempt to escape from a situation of extreme need. In any case, almost all of them face an exceptional situation of vulnerability (E8).

- **Medical and psychological care:** pregnant women need regular medical check-ups and prenatal care to ensure their well-being and that of the baby during pregnancy, childbirth and especially in the postpartum period. They also require psychological and emotional care, as they may experience different emotions during the process. For this reason, as Helena López (2023), midwife and women's health expert[125] points out, access to health care, specialised obstetric care and quality mental health services is essential throughout the pregnancy process, distinguishing the following needs according to the moment:
  - Before pregnancy:

    In processes in which hormonal treatment is carried out, as is the case with GS, the woman should have received **social and health support and full information on the possible side effects** of ovarian stimulation using hormones before undergoing the process.

  - During pregnancy:

    Pregnancy care is a crucial part of the continuum of women's reproductive health care, as stated by the World Health Organisation (WHO, 2016) and

[124] Nuria González López is a lawyer and expert in Human Rights (HR), author of Vientres de alquiler (2019) and La Mala Gente (2021). Currently, among other work, she provides support services and legal advice to surrogate mothers. She has participated in the study as a collaborating expert (González, 2023).
[125] Helena López Paredes is a nurse (Universidad Europea de Madrid, Spain) and midwife (University of East Anglia, England), expert in health and women, currently working as an international midwifery consultant for the United Nations. She has participated in the study as a collaborating expert (López, 2023).

in line with the Sustainable Development Goals (SDGs) strategy[126] that aims to ensure the well-being and healthy lives of pregnant women. They provide a platform for important functions including health promotion, screening, diagnosis, and disease prevention.

In the case of maternal or foetal impairment, the multidisciplinary team must intervene jointly, bringing together different disciplines to achieve a satisfactory outcome (Gómez, Seva, Hellín, Roldán, Paredes, Iglesia, Ruíz and Navarro, 2022).

The surrogate mother may well need the specific support of a **midwife specialised in mental health** during the gestational stage to detect warning signs and symptoms for referral and work with the multidisciplinary team.

- During childbirth:

  The woman **will need prior counselling** on how the birth of the baby may unfold so that she can make fully informed decisions, which may be seen as a challenge to the woman's autonomy.

  The literature shows that childbirth can be a satisfying but also traumatic experience for the mother, which is why women require individualised care **attending to their physical, emotional and psychosocial needs** (Rodríguez-Almagro, Hernández-Martínez, Rodríguez-Almagro, Quirós-García, Martínez-Galiano and Gómez-Salgado, 2019).

- In the postpartum period:

  The postnatal period is defined as the time from the birth of the baby until six weeks after birth. The new adaptation and hormonal changes make it a **time of great vulnerability** for women, who need close medical and psychological care. Conversely, mothers state that there is an intense focus on women's health during pregnancy, but not so in the postpartum period (Tully, Stuebe and Verbiest, 2017).

[126] The Agenda for Sustainable Development or *2030 Agenda* (UN, 2015) is a sustainable development strategy consisting of 17 Sustainable Development Goals (SDGs) that were agreed by the United Nations (UN) with the support of member countries.

- **Legal and/or legal support:** Abuse and exploitation underlie most GS processes; exploitation and violence are in the nature of the contract. When we speak of abusive practices in the context of surrogacy, we are referring to the countless additional problems that pregnant women and babies can face in the context of these arrangements.

  Pregnant women, therefore, need protection that guarantees their rights.

  Surrogate mothers become mere objects during the surrogacy process, to the point of losing all their rights. All decisions from the beginning of the surrogacy process until the birth and delivery of the baby are made by the commissioning party, by contract, often **without medical criteria**.

  It is also important to assist **pregnant women who do not want to give up the baby**. This is a rare situation, because the extreme economic need that pushes women to gestate for other people is incompatible with assuming an additional family burden (E8).

In addition to the circumstances described above, **there are other problems** - some already mentioned - that pregnant women face and for which they may present **other needs**: such as obstetric violence - which may include medical malpractice, forced caesarean section, unwanted invasive tests, forced and/or selective abortions, etc.; non-payment of agreed payments; unilateral breach of contract by the commissioning party; abandonment of the woman with the baby; forced confinement of mothers in "flats" or maternity homes; among others.

9. GS: regulatory and institutional framework

9.1. International framework and European framework

9.1.1. General framework

Surrogacy violates women's bodily and reproductive integrity and autonomy. It turns children into an object of exchange, affecting their identity rights, and pregnant women are reduced to gestating bodies. This form of violence violates **the fundamental rights of women** who often find themselves in situations of economic deprivation and in countries whose political and economic contexts tend to be characterised by a lack of rights and opportunities.

No international instrument specifically regulates surrogacy (Nuño Gómez, 2020). In the European framework, although it is not explicitly included as such in the Istanbul Convention, its Article 3 allows this type of VAW to be covered (see chapter 9.1.2) and the Parliament has shown concern regarding the extension of this violence. The Spanish institutional framework explicitly prohibits this practice.

The United Nations (UN) **has international human rights instruments** that contain similar references, although not all of them specifically address GS (Nuño Gómez, 2020). These include the *Convention on the Elimination of All Forms of Discrimination against Women (*CEDAW), the *United Nations Convention against Slavery*, the *International Convention on the Rights of the Child* (CRC) and the Optional Protocol thereto, and the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption.

> CEDAW, in one of its reports[127], is concerned about surrogate mothers and requests that, through technical support from the Office of the UN High Commissioner for Human Rights, standards be brought in line with international human rights standards.
>
> The CRC (UN, 1989) - ratified by Spain and in force since 1991 - in Article 35 states that States Parties shall take all appropriate national, bilateral and multilateral measures to

[127] The Committee considered the sixth periodic report of Cambodia (CEDAW/C/KHM/6) at its 1730th and 1731st meetings (see CEDAW/C/SR.1730 and CEDAW/C/SR.1731), on October 29, 2019. The list of issues and questions of the pre-session working group is contained in CEDAW/C/KHM/Q/6, and the responses of Cambodia are contained in CEDAW/C/KHM/Q/6/Add.1.

prevent the abduction of, the sale of or traffic in children for any purpose. Furthermore, the CRC expressly recognises the responsibility of States Parties in guaranteeing the right to identity of girls and boys - Articles 7 and 8 - aspects that are violated in GS.

The *Optional Protocol*[128] *to the* Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (UN, 2000) - ratified by Spain in 2002 - aims to reinforce articles 34 and 35 of the CRC and **provide greater protection for children** from sexual exploitation, sexual abuse and the sale or trafficking of children. Although it does not specifically mention the particular situation of children who are nations by GS, in Article 2:

> *Sale of children means any act or transaction whereby a child is transferred by one person or group of persons to another for remuneration or any other consideration.*

Of particular relevance is the Report of the UN Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material (2018), which includes a "**study on surrogacy and the sale of children**" and makes recommendations for effective prevention and prohibition of the sale of children.

This report by the Special Rapporteur[129] (UN, 2018) finds "**discrimination against women by virtue of the instrumentalisation of their bodies** for cultural, political, economic or other purposes **unacceptable**" and encourages other UN mechanisms and entities to investigate GS and its impact on women's rights with the aim of developing a human rights-based normative framework. It further notes that "nothing in this report should be interpreted as limiting women's decision-making autonomy or sexual and reproductive health rights" (UN, 2018: 4. Emphasis added).

The Rapporteurship commissioned the NGO International Social Service - ISS - to develop international principles and standards governing GS contracts in accordance with human rights and children's rights standards. This recommendation, called "Principles for the Protection of the Rights of Children Born through Surrogacy" -

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[128] The Optional Protocols to the Convention on the Rights of the Child are an instrument of the United Nations General Assembly that reinforce the standards contained in the Convention.

[129] The European Economic and Social Committee -CESE- agrees with the Special Rapporteur of the United Nations Human Rights Council showing concern "about the increase in so-called surrogacy" and states that it "agrees with the expression expressed by the European Parliament which considers it a form of reproductive exploitation that violates the dignity of women. It therefore considers that this practice - when it is a legal transaction involving profit or benefit for either party, including advertising - should be considered as a form of violence against women and should be considered on the same level as sexual exploitation". (CESE, 2022: 3.12).

known as the "**Verona Principles**" - (ISS, 2021) aims to protect the rights of children born through surrogacy. It has 18 principles which are:

- Principle 1: Human dignity
- Principle 2: The child as an independent rights-holder
- Principle 3: The right of the child to non-discrimination
- Principle 4: The child's right to health
- Principle 5: Pre-surrogacy protection
- Principle 6: Best interests of the child
- Principle 7: Surrogate Consent
- Principle 8: Prospective parents' consent
- Principle 9: Consent of persons providing human reproductive material
- Principle 10: Legal filiation and parental responsibility
- Principle 11: Protection of Identity and Access to Origins
- Principle 12: Notification, registration and certification of births
- Principle 13: Prevention of statelessness
- Principle 14. Prevention and prohibition of the sale, exploitation and trafficking of children
- Principle 15: Transparency in financial matters
- Principle 16: Intermediaries
- Principle 17: Responding to unexpected events in surrogacy arrangements
- Principle 18: Cooperation between states, regions and local authorities

It highlights principle 7, which refers to the consent of the pregnant woman, stating (ISS, 2021):

> *7.1. Confidence in the integrity of the circumstances surrounding her surrogacy arrangement is of great importance to the rights of the child. The surrogate mother must be able to make independent and informed decisions, free from exploitation and coercion.*
>
> *7.2. Free and informed decision-making in all legal, social, financial and medical matters by the surrogate mother should be supported prior to surrogacy arrangements, throughout the pregnancy and after delivery.*

Conditions must be established and guaranteed to enable the surrogate mother to exercise her self-determination. Surrogacy should only be permitted when the surrogate mother, inter alia:

a. is of legal age

b. has experienced, as an adult, at least one previous birth that was not a surrogacy arrangement;

c. is competent and has the cognitive capacity to make decisions, give consent and exercise autonomy and self-determination.

Despite the aforementioned Special Rapporteur's considerations on pregnant women (UN, 2018) and the fact that the ISS report (2021) makes it explicit that **the Verona Principles do not imply an endorsement of GS**, both documents focus exclusively on the rights of the child born through GS and **lack a gendered approach** that addresses the rights of pregnant women and encourages an analysis of their socio-economic situation or the circumstances and reasons that have led them to expose themselves to surrogacy.

Different **international feminist organisations, and within Spain, have criticised the Verona Principles**. Thus, the International Coalition for the Abolition of Surrogacy - ICAS- (2022) considers that, under the pretext of protecting the rights of children born through GS, they tend to **promote the international regulation** of this practice. It has drawn up an 8-point critique comprising the following ideas:

1. would support the international reproductive exploitation industry.
2. an attempt to decriminalise surrogacy,
3. a strategy to pit women's rights against children's rights,
4. a "low cost" conception of human dignity,
5. omits the issue of the dignity of women hired as surrogate mothers,
6. contains a biased concept of the best interests of the child,
7. implies a superficial approach and instrumentalisation of the concept of consent,
8. is based on the social construction of the belief in the right to have children.

Regarding the **legal regulation that exists in the countries**, we find different situations (González, Guerrero, Hernández, Holgado, Ingelmo, Justo, Lázaro, López, Lucas, Martín, Mateos and Mateos, 2021; Nuño Gómez, 2023):

- Countries that **allow both altruistic and commercial** GS, such as Ukraine, Russia, India and some US states. It should be noted, however, that in federal states such as the United States and Mexico, regulation varies widely from state to state.
- Countries that **only allow altruistic** GS. This is the most common regulatory model among European countries that allow this practice, such as the United Kingdom, Greece and Portugal.
- Countries that **prohibit GS in any of its forms**, also present in European countries such as Spain, Italy and France, among others.
- Countries that are in **legal limbo** because it is not reflected in any sense. International framework.

In general, international law is **far from focusing on the protection of women** from this practice, and focuses primarily on the rights of the unborn child.

It is interesting to note the practice of GS in the USA and Canada, two of the three main international destinations for Spaniards, of which the following can be highlighted:

- **USA**: the most flexible territory, although the legislation depends on the state where gestational surrogacy takes place. On the one hand, it is considered a criminal offence in New York, Arizona, and Michigan and is prohibited and the contract is void in Kansas, Louisiana, Nebraska and Indiana. On the other hand, it is permitted for any family model (heterosexual, homosexual or single persons) in Florida, California, Arkansas, Delaware, New Hampshire, Nevada and Illinois. In other states where it is allowed, certain requirements are imposed: Texas requires a judge's approval; in Tennessee both partners must contribute their gametes; Utah states that intended parents must be married and the gestating woman cannot be the egg donor; New Jersey does not allow commercial gestation and parents have only 3 days to claim maternity rights; and Vermont requires a post-delivery court judgment (Cáceres Lara, 2019).
- **Canada**: the practice is legal - Assisted *Human Reproduction Act*[130] *(S.C. 2004, c. 2)* - for any type of family (heterosexual couples, homosexual couples and single persons) but only altruistic GS is allowed. The pregnant woman must also be over 21 years of age and have had at least one child prior to gestation. Legal paternity of the baby is obtained through the approval of a judge (Cáceres Lara, 2019).

[130] *Assisted Human Reproduction Act* of Canada. Access

Legislation in Central and South America varies. Not all countries include GS in their regulations. Some examples of countries where GS is included are:

- **Argentina:** as Cáceres Lara (2018) points out, GS is not regulated and so far the judiciary has ruled on several cases. However, several legislative proposals have been presented, such as the *Regulation of the Solidarity Gestation Technique 5700-D-2016*[131] or *Bill 5759-D-2016*[132] , which consider altruistic (or solidarity) GS. Other initiatives are *Bill 3202-2017*[133] which amends some articles of the Civil and Commercial Code to include surrogacy, and *Bill 3765-D-2017*[134] which establishes the need for judicial authorisation for gestational surrogacy.
- **Brazil:** The law does not consider this practice, but it is considered in section VII of *Resolution CFM nº 1.957 / 2010*[135] of the Federal Medicine Council). It contemplates GS in the altruistic modality and in cases in which there is a medical problem that prevents or contraindicates the intended mother (who will be the genetic donor) from carrying out the pregnancy. Among the conditions imposed, it is established that the pregnant women must be relatives (up to the second degree) of the genetic donor woman - intrafamilial GS -, the rest of the cases are subject to the authorisation of the Regional Council of Medicine.
- **Colombia:** GS in the commercial modality is prohibited and the Draft Statutory Law considers controls to prevent it. According to *Draft Bill 88 of 2017*[136] , "Ley Lucía", altruistic GS was considered in cases of natural impossibility to procreate.
- **Mexico:** There is no specific law regulating surrogacy and it depends on each state. In some states, such as Querétaro, Cohahuila or San Luis Potosi, it is explicitly prohibited. In Tabasco (Civil Code) - which limits access to GS only to Mexican citizens - and Sinaloa (Family Code of the state), on the other hand, it is allowed in cases where there is a physical impossibility or medical contraindication for the intended mother to carry out the gestation (Cáceres Lara, 2019). In Mexico DF, the proposed law favourable to

[131] Argentina's *Solidarity Gestation Technique Regulation 5700-D-2016.* Access
[132] *Draft Bill 5759-D-2016* of Argentina. Access
[133] Draft Law 3202-2017 of Argentina. Access
[134] Draft Bill 3765-D-2017 of Argentina. Access
[135] *Resolution CFM nº 1.957 / 2010* of Brazil. Access
[136] *Bill No. 88 of 2017 Senate "Whereby assisted human reproduction, procreation with scientific assistance and other provisions are regulated -Law Lucia-"* of Venezuela.

GS focuses on ensuring filiation rights for intended parents (Hernández and Santiago, 2011).

- **Uruguay:** allows GS only if the intended mother is unable to gestate her own embryo due to a medical impediment (chapter IV of *law 19.167*[137]). This incapacity must be recognised by the medical team, which will prepare a report for Honorary Commission on Assisted Human Reproduction, the body in charge of assessing whether the established conditions are met. In this case, a woman or couple will be allowed to resort to intrafamilial altruistic GS and agree with a relative (up to the second degree of consanguinity) on the implantation and gestation of their own embryo - understanding as their own that which is formed by at least one gamete of the couple or by the ovum in the case of single women- (Cáceres Lara, 2019).

Beyond Latin American countries, **other countries** with GS legislation are:

- **Australia:** only altruistic GS is allowed and the conditions depend on the states. It is the only country where the pregnant woman is considered the mother, so after delivery she has the right to keep the baby if she so wishes. It is generally only allowed for heterosexual couples. In states such as Queensland, Tasmania and New South Wales it is also allowed for homosexual couples. In addition, in Queensland and New South Wales, it is also available to unmarried people if they can prove their inability to gestate (Cáceres Lara, 2019).
- **Georgia:** only married heterosexual couples are allowed in cases where the intended mother does not have a uterus. Other criteria include that the pregnant woman must be no older than 35, have had at least one child of her own before and be of medium-high socio-economic status. The baby will be registered by the intended parents, without the need for the consent of the pregnant mother. And in the particular case of Spanish couples, in order for the Spanish consulate to recognise paternal filiation, the father must provide his sperm (El Mundo Newspaper, 2023).
- **India:** it used to allow both types of GS contracts (commercial or altruistic), being one of the main destinations for this practice. But like other Asian countries, it abandoned - in 2016, with the passing of the *Surrogacy (Regulation) Bill, 2016*[138] - the commercial modality in favour of foreigners, and currently the country's legislation only allows

[137] *Law 19.167* of Uruguay. Access
[138] *Surrogacy (Regulation) Bill*, 2016 of India. Access

altruistic surrogacy in cases of infertile heterosexual couples of Indian nationalities (El Mundo Newspaper, 2023).

- **South Africa:** allows the altruistic modality - according to the Children's Act 38 of 2005 - and to persons resident in the country, whether a single person or a couple, requiring that the gametes used be from at least one of them. In addition, it is established that the person or couple, intended parents, cannot have a child for reasons that are permanent and irreversible (Cáceres Lara, 2019).
- **Thailand:** was one of the main destinations for surrogacy until 2015 when it changed its legislation. The current law only allows surrogacy for heterosexual couples and nationals (El Mundo Newspaper, 2023).

The **absence of a common international framework, the diversity of criteria and the opposition of some countries** - such as the USA, among others - to recognise the CEDAW and the CRC, create a context that places both pregnant women and pregnant minors in a position of extreme vulnerability with regard to the violation of their rights (Nuño Gómez, 2020).

9.1.2. European context

In the **European context**, the reference standard in the fight against male violence, the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) - ratified by Spain in 2014 - does not mention GS as a form of violence against women, but as has already been explained, Article 3 covers all forms of violence against women. This is due to the multiple expressions that VAW has and that institutions are slow to reach in the development of their institutional action.

Within this framework, **the European Parliament** has been the only supranational institution that has clearly shown a position against the regulation of GS (Nuño Gómez, 2020). The *European Parliament Resolution* of December 17, 2015 on the Annual Report on Human Rights and Democracy in the World (2014) and the European Union's policy on the matter (2015/2229(INI)), considers in the framework of women's and girls' rights the following:

> *"Condemns the practice of surrogacy, which is contrary to the human dignity of women, as their bodies and reproductive functions are used as a commodity; considers that this practice, which involves the exploitation of reproductive functions and the use of the body for financial or other purposes, particularly in the case of vulnerable women in developing*

countries, should be prohibited and calls for it to be urgently examined under human rights instruments" (European Parliament, 2017: 115).

Other institutions, such as the **European Court of Human Rights** (ECtHR), have shown greater ambivalence on the issue by not expressly regulating GS or assisted human reproduction. The ECtHR refers to the national legislation of each state, which allows a very wide margin in its treatment and consideration (Nuño Gómez, 2020).

> The ECtHR itself de facto recognises the absence of consensus in Europe and tends to consider that in these cases the child's right to identity prevails on the basis of Article 8 *European Convention for the Protection of Human Rights and Fundamental Freedoms*[139] (hereinafter the European Convention on Human Rights). This was first stated in 2014 and subsequently in other judgments.

With regard to the **national regulations of European countries**, there is a disparity in the regulation of GS. Among the countries that allow this practice, Ukraine is particularly relevant as it is the second destination where most Spaniards go to carry out GS. Other "destination countries" for Spaniards include: Russia, England and Greece.

- **Ukraine**: before the war it was the main destination in Europe for people resorting to this practice. It allows GS in any form only for married heterosexual couples[140] and in cases where the intended mother is medically unfit to carry her own child. In Ukraine, moreover, the gestating woman must be anonymous and cannot claim maternity, so she has no rights or duties over the baby she gestated (González, Guerrero, Hernández, et al., 2021).

However, the war has not stopped the reproductive exploitation of Ukrainian women and the main GS clinic in the country - BioTexCom - continues to operate despite the invasion. After the outbreak of the war, BioTexCom moved to a bunker, although the safety guarantees they offer for pregnant women and babies are unknown[141] .

- **Russia**: allows altruistic or commercial GS, only for heterosexual couples - such as Ukraine - and in cases where the intended mother is medically unable to carry her own child. The intended mother cannot provide her eggs, and must be between 20-35 years

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[139] European Convention for the Protection of Human Rights and Fundamental Freedoms. Access
[140] Ukraine prohibits same-sex marriage and therefore, because they cannot meet the requirement of being married, same-sex couples cannot have recourse to GS (González, Guerrero, Hernández, et al., 2021).
[141] Martin, A. (2023). *War has not stopped the use of surrogacy in Ukraine*. El País. Access

old, have had at least one previous child of her own, and undergo a physical and emotional examination. In addition, if the pregnant woman is married, she must have her husband's prior consent (González, Guerrero, Hernández, et al., 2021).

- **United Kingdom**: only altruistic mode is allowed for couples (homosexual or heterosexual) and excludes single persons. From the birth of the baby, the intended parents have 6 months to apply for paternity or it will be considered the legal child of the gestating woman. In addition, at least one of the partners must be resident in the UK to apply for the support of a surrogate mother. For this reason, the UK is an under-used destination for foreign nationals. GS in the UK is also little used by British people themselves, who frequently opt for India because they would not find British women who would consent to be surrogate mothers.
- **Greece**: Commercial gestational surrogacy is prohibited; only heterosexual couples and single women who are unable to gestate their own children are allowed to do so altruistically, a situation that the intended mother must justify with a certificate of infertility. The gestating woman cannot provide her eggs and the process must have the consent of a judge.
- **Portugal:** in 2017, Law 25/2016 came into force, which established the conditions for the application of GS, and which would be repealed by the country's Constitutional Court on the grounds that it violated various principles and rights, including the repentance of the surrogate mother. At the end of 2021, after several years of debate, the current Law 26/2021 on surrogacy was passed. This law allows heterosexual couples or female couples to access altruistic surrogacy only in cases where the woman does not have a uterus or has an irreversible injury or clinical situation that prevents her from having a pregnancy. One of the special features of this measure is that the pregnant woman has a period of 20 days after giving birth to decide whether or not she wishes to give up the baby. Despite the approval of the law, only one process has been registered since its entry into force.

On the other hand, other European countries such as **Sweden, Germany and especially France and Italy** have taken a stand against the regulation of RV.

- **France:** GS is an illegal practice under the French Civil and Penal Code, particularly prohibited by Law 94-653 of July 29, 1994. This law introduces Article 16-7 of the French Civil Code, which establishes the nullity of any agreement on gestation on

behalf of another person and the PC, in Article 227-14, establishes prison sentences and fines for those who intermediate between people who want to have a baby through this practice and the woman who is going to gestate it. In addition, French jurisprudence has been very clear in proclaiming the nullity of these practices, going so far as to deny the registration of surrogate babies born outside French borders. In 2014, de facto, there are two well-known judgments of the ECtHR[142] in which the French state was condemned for not registering two minors born by GS in the USA (González, Guerrero, Hernández, et al., 2021).

- **Italy:** GS is prohibited and its practice is punishable by severe legal penalties. Law No. 40 of February 19, 2004, in Article 4.3, prohibits the use of heterologous medically assisted procreation - as in the case of GS - and in Article 12.6 imposes very high financial fines and prison sentences for the use of "surrogate mothers" (González, Guerrero, Hernández, et al., 2021).

In 2015, the ECtHR[143] also intervened in the **Italian authorities' refusal to register a baby born by GS**. The couple's registration as parents was carried out, in the first instance, in accordance with Russian law - where the GS process took place - but they were subsequently charged with alteration of civil status, falsehood and violation of the law on adoption, "insofar as notable falsehoods were accredited in the account of the facts, and they were denied recognition of the filiation established abroad" (Consejo General del Poder Judicial [CGPJ], 2016).

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[142] ECHR June 26, 2014: this ECtHR judgment establishes the doctrine on two similar cases previously decided under French law. In both cases, a couple of French nationality appealed to the GS (the first after several failed attempts at in vitro fertilisation and the second due to fertility problems) in two different states of the USA. In both cases, the French authorities refuse to register the birth.
The ECtHR states that the non-recognition of the relationship of filiation between babies born by GS abroad and the couples who resort to this practice in French law is not limited to the situation of the intended parents, but also affects that of the children, "whose right to respect for private life, which implies that everyone can establish the substance of his or her identity, including his or her filiation, is significantly affected" (CGPJ, 2016: 8). Thus, the ECtHR considers that there is a situation of legal uncertainty as to whether the children can have their French nationality recognised and be able to inherit from the appellant spouses, an uncertainty that is even more pronounced if one of the partners has participated in the begetting of the baby.
In the conclusion it states that "by hindering the French Court of Cassation both the recognition and the establishment of his filiation link with his biological father (since it does not even allow it to recognise him as a child or to adopt him)" (CGPJ, 2016: 8) the French State has exceeded the limits of its discretionary margin, and has ignored the children's right to privacy, in violation of art. 8 of the European Convention on Human Rights.
[143] ECHR January 27, 2015: a couple of Italian nationality appeals, after several unsuccessful attempts at in vitro fertilisation, to the GS in Russia, where the pregnant woman gave her written consent for the baby to be registered as the child of the Italian intended parents.
The Court again found a breach of Article 8 of the European Convention on Human Rights, in this case by the Italian authorities, by removing the child from the parents, since after living together for more than six months, the three of them constituted a "de facto" family nucleus.

The Italian authorities not only did not recognise the filiation but, after 6 months of cohabitation, placed the child under the guardianship of an institution, preventing mutual contact, as well as handing him over to a foster family.

Recently, by order of the government delegation in Milan, the mayor of the city has been asked to stop the registration of babies of same-sex couples born abroad through surrogacy (El Mundo Newspaper, 2023).

9.2. Spanish regulatory framework

9.2.1. State regulation

In Spain since 1988, *Law 35/1988*[144] *, of November 22, on assisted reproduction techniques* -article 10- considers the surrogacy contract null and void and is a practice that **is not allowed in any of its modalities**, an aspect that is maintained in the subsequent and current *Law 14/2006*[145] *, of May 26, on assisted human reproduction techniques*. Article 10 on surrogacy specifically states:

> *1. A contract by which it is agreed to carry a child, with or without payment, by a woman who renounces maternal filiation in favour of the contracting party or a third party, shall be null and void as of right.*
>
> *2. The parentage of children born through surrogacy shall be determined by birth.*
>
> *3. The possible claim of paternity against the biological father shall remain unaffected, in accordance with the general rules.*

Furthermore, according to Article 221 of the *Penal Code*[146] the surrender of the baby is a criminal offence:

> *1. Those who, through financial compensation, hand over a child, descendant or any minor to another person, even if there is no relationship of filiation or kinship, avoiding the legal procedures of guardianship, foster care or adoption, with the aim of establishing a relationship similar to that of filiation, shall be punished with a prison sentence of between one and five years and special disqualification from*

[144] Law 35/1988 of November 22, 1988 on Assisted Reproduction Techniques. Access
[145] Law 14/2006, of May 26, on assisted human reproduction techniques. Access
[146] Organic Law 10/1995, of November 23, on the Criminal Code. Access

exercising the right of parental authority, guardianship, curatorship or guardianship for a period of between four and 10 years.

2. The person who receives the child and the intermediary shall be punished with the same penalty, even if the delivery of the child has been produced in a foreign country.

3. If the offences are committed using nurseries, schools or other premises or establishments where children are taken in, the guilty parties shall be sentenced to special disqualification from exercising the aforementioned activities for a period of two to six years, and the temporary or permanent closure of the establishments may be ordered. In the case of temporary closure, the term may not exceed five years.

However, feminist experts and researchers consider that there is a **risk of criminalisation**. They point out that this article of the Criminal Code places the parents of interest on the same level as the pregnant woman, who is also considered the perpetrator of the crime, and does not take into account either the situation of vulnerability faced by the majority of women who agree to gestate for others or the hierarchical relationships that are established during the gestation process and which relegate pregnant women to a subordinate position.

In our country, the role of the **Spanish Bioethics Committee**[147] should be highlighted within the national framework. In its *Report on the ethical and legal aspects of surrogacy*, the position of the majority of the Committee's members is expressed, which "understands that *any surrogacy contract entails exploitation of the woman* and harm to the best interests of the child" (López et al., 2018:86) and formulates three criteria that should guide a legislative reform:

- Principle of minimum intervention: the reform should be geared towards achieving the effective nullity of contracts of GS, also applicable to those concluded abroad. To this end, consideration should be given to the sanctioning of agencies dedicated to intermediation and, if they are not effective in preventing GS, recourse should be had to other legal measures to reinforce compliance.

[147] Created in compliance with Law 14/2007, of July 3, on Biomedical Research as a "collegiate, independent, consultative body on matters related to the ethical and social implications of Biomedicine and Health Sciences", attached to the Ministry of Health.

- Universal ban on international surrogacy: adoption of measures aimed at banning international surrogacy contracts.
- Safe transition: the Committee recognises that during the drafting of the reform it is likely that an indeterminate number of Spanish persons will be immersed in GS processes, a situation that must be taken into account in the transition towards an effective regulation so as not to leave children born as a result of these processes unprotected. To this end, the Committee proposes guaranteeing their filiation abroad in accordance with the doctrine established by the Supreme Court (SC).

As for the **public policies** implemented, they lack sufficient specificity.

The *National Strategic Plan against Trafficking and Exploitation of Human Beings* (2021-2023)[148], in the general framework, states that trafficking in human beings - as a predicate offence - encompasses all known forms of exploitation - the final offence - particularly pointing out GS. In the face of this "serious criminal phenomenon", it states the **need for a multidisciplinary and comprehensive approach** that contributes to establishing lines of action in both the public and private spheres, including the third sector.

The[149] *SSGV 2022-2025*, in line with the Istanbul Convention, states that it is necessary to **broaden the focus of analysis of violence against women in the area of sexual and reproductive rights** and that there is a commitment to address serious violations of reproductive rights that are manifestations of violence against women, such as GS (DGVG, 2022).

> The SSGV 2022-2025 recognises that **some forms of sexual violence may constitute international crimes** [150] and is particularly concerned about transnational sexual violence such as "trafficking in women and girls for sexual exploitation, child, early and forced marriage, **commercial surrogacy, and** female genital mutilation (FGM)".
>
> According to the SSGV, violence against women in the area of sexual and reproductive rights includes acts that, based on gender-based discrimination, violate **the integrity or self-determination of women** in the area of sexual and reproductive health, their

[148] National Strategic Plan against Trafficking and Exploitation of Human Beings (2021-2023). Access
[149] National Strategy to Combat Gender Violence -SSGV- (2022-2025). Access
[150] According to *CEDAW Recommendation No. 35*, "inter alia, crimes against humanity and war crimes such as rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilisation or any other form of sexual violence of comparable gravity, in accordance with Articles 7(1)(g), 8(2)(b)(xxii) and 8(2)(e)(vi) of the Rome Statute of the International Criminal Court". Access

free decision on motherhood, its spacing and timing, including forced abortion and forced sterilisation.

Among the different forms of violence in the reproductive sphere, according to the SSGV 2022-2025 "**forced pregnancy**" in relation to the commercial exploitation of women through GS (or surrogacy) deserves special attention since "this type of violence materialises the reproductive exploitation of women's bodies for commercial purposes, and may suffer situations related to lack of full informed consent, coercion and arbitrary deprivation of liberty" (DGVG, 2023: 48).

The SSGV 2022-2025 **does not include specific actions** on this form of violence as the draft bill amending the Organic Law 2/2010 on sexual and reproductive health was in the pipeline at the time of drafting and approval of the Strategy.

The reform of Organic Law 2/2010 or "Abortion Law" - *Organic Law 1/2023*[151] , of February 28, which amends Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary termination of pregnancy - shows that although GS is illegal in Spain (according to the aforementioned Law 14/2006) it continues to take place under the protection of the various international regulations. Therefore, **GS should be recognised as "a serious form of reproductive violence"** and measures should be taken to prevent and prosecute its practice. De facto, this reform incorporates **Article 32. Prevention of surrogacy or surrogate pregnancy**:

> Article 32. Prevention of surrogacy or surrogate pregnancy:
>
> 1.Gestation by surrogacy or substitution is a null and void contract, according to Law 14/2006, of May 26, on assisted human reproduction techniques, whereby gestation is agreed, with or without a price, by a woman who renounces maternal filiation in favour of the contracting party or a third party.
>
> 2. Information shall be promoted, through institutional campaigns, on the illegality of such conduct, as well as the full nullity of the contract by which gestation is agreed, with or without price, by a woman who renounces maternal filiation in favour of the contracting party or a third party.

[151] Organic Law 1/2023, of February 28, which amends Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary termination of pregnancy. Access

Article 32 is integrated into Chapter III on measures of prevention and response to forms of violence against women in the area of sexual and reproductive health in Title III on the "Protection and guarantee of sexual and reproductive rights" which is incorporated into Law 1/2023. In the same Title III, Chapters 1 and 2 on institutional responsibility and the protection and guarantee of sexual and reproductive rights in the gynaecological-obstetric field, respectively, are also considered.

In addition, Law 1/2023 introduces in **Article 7 bis, on reproductive health care**, that public health services will guarantee: an anti-discriminatory and intersectional approach in their intervention; access to information on reproductive rights, public benefits and health coverage during pregnancy, childbirth and puerperium; the provision of assistance, emotional support and mental health accompaniment to women who require it during the postpartum period or in the case of perinatal death; and the specialised provision of psychological or sexological care with a gender perspective, among other precepts.

This regulation establishes in Article 11 the elaboration of the State Strategy for Sexual and Reproductive Health[152] and in Article 30 it is considered that this Strategy "will include a section on prevention, detection and integral intervention for the guarantee of sexual and reproductive rights in the gynaecological and obstetric sphere".

However, despite the express prohibition of GS by Spanish law, **filiation of children born through this practice has been granted**.

Our legal system considers that nullity only affects the contract, a matter that is resolved once filiation has been achieved, but does not provide for a criminal offence for buying and selling babies (Nuño Gómez, 2020).

Proof of this, the Supreme Court Judgment (SCS) *5375/2016 (*CGPJ, 2016) refers to two previous judgments of the ECtHR - ECtHR June 26, 2014 and ECtHR January 27, 2015 - in relation to GS and the recognition of parentage in two cases decided in European countries (see 9.1.2. European Institutional Framework).

The SCS 5375/2016 points out that in both judgments it is stated that Article 8 of the European Convention on Human Rights has been violated. **In neither of these cases is**

[152] The National Strategy for Sexual and Reproductive Health (2011) makes no mention of GS, although it does state that "one of the basic rights of women in reproductive health is the right to information and to decide freely", rights that are violated during GS processes. Access

the right to maternity protection discussed, what is under debate is the viability of the registration of filiation "arising from a maternity contract" (CGPJ, 2016: 9).

Both cases take place in a different legal context from the Spanish one, noting in SCS 5375/2016 that in Spain "the possibility of adopting the minors or of inquiring into biological paternity mitigates the possible abandonment in which they may find themselves by preventing their access to the Civil Registry as children of the surrogate parents" (CGPJ, 2016: 9).

In these matters, the SCS highlights the importance **given in both judgments to the need to protect the situation created**. If there is family cohabitation between the intended parents and the children, the latter must be protected, especially if one of the "surrogate parents" is also the biological mother or father. "What is being done is to opt for a "lesser evil": to maintain the consequences of a situation which is contrary to national law (cohabitation resulting from surrogacy) because it is in the interests of the child (keeping him or her in the "de facto" family unit). And this, regardless of the provisions of private international law, obviously also integrated into Spanish law" (CGPJ, 2016: 9).

Thus, **in Spain "we find ourselves in a real legal limbo in** which legislation, the Public Prosecutor's Office and the jurisprudence of the Supreme Court disallow the validity of contracts, but the General Directorate of Registries and Notaries, belonging to the Ministry of Justice, the different marketing companies and the principals ignore the same" (Nuño Gómez, 2020: 66).

In this sense, the most controversial measure (Nuño Gómez, 2020) is the *Instruction of 5 October 2010, of the Directorate General of the Registry and Notaries, on the registry regime of parentage of those born through surrogacy* -DGRN- which allows the possibility of registering in the Spanish Civil Registry a relationship of parentage declared by a foreign court, which enables the cross-border continuity of a relationship of parentage that implies parental responsibilities. Even if this relationship of filiation is produced by GS.

The purpose of the DGRN Instruction is:

> In order to provide **full legal protection for the best interests of the minor**, as well as other interests present in cases of surrogacy, it is necessary to establish the criteria that determine the conditions of access to the Spanish Civil Registry

> of those born abroad through this assisted reproduction technique (DGRN, 2010 : 1).

The *Instruction of February 18, 2019*, of the DGRN, on updating the registry system for the filiation of children born through surrogacy, requires a firm ruling from the judicial authorities of the country where the GS is carried out for the registration of the child.

On the other hand, it is worth mentioning that there have been different proposals in favour of the legalisation of GS. The last one was presented by the Ciudadanos Parliamentary Group on April 14, 2023, under the name *Proposición de Ley reguladora del derecho a la gestación por sustitución (Proposed Law regulating the right to surrogacy)*[153] . This bill advocates permitting altruistic surrogacy and has met with a majority opposed to regularisation, which is why it will most likely not go ahead. The political party that presented this proposal did not obtain parliamentary representation for the following XV Spanish legislature.

9.2.2. Regional references

The review of regional legislation shows a **diverse scenario, with only one specific mention of** GS. It is for this reason that the search has been extended to precepts that may indirectly allude to this form of violence against women.

In this sense, the findings show that several **ACs present a broad definition of violence** against women -in line with the Istanbul Convention- and that, although they do not explicitly mention it, they **could include GS when referring generically to** "violence against sexual and reproductive rights", such as: Andalusia, Aragon, Canary Islands, Cantabria, Castilla-La Mancha, Catalonia and La Rioja.

On the other hand, the Balearic Islands and the Basque Country, although they do not mention GS or consider violence against reproductive rights among the forms of GBV, like the previous ACs, make reference to these among the general principles.

It should be noted that Aragon is the **only autonomous community that explicitly mentions GS in its regulations.** It does so in the *IV Strategic Plan for the prevention and eradication of violence against women in Aragon*[154] (2018-2021) through the following measure:

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[153] For more information see *Proposed Law regulating the right to surrogacy*. Access

[154] Consult the *IV Strategic Plan for the prevention and eradication of violence against women in Aragon*. Access

Action 1.1.1.1.6: Carry out awareness-raising actions against the reproductive exploitation of women and surrogacy, in order to make society aware of the negative effects of these practices for all women.

In the other ACs - Asturias, Castile and Leon, Valencia, Extremadura, Galicia, Madrid, Murcia and Navarre - the regulations on VAW have a narrower focus on violence and its manifestations, as they generally follow the state definition of gender-based violence established in *Law 1/2004*[155] and there is little presence of the typology of reproductive violence.

[155] See *Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence*. Access

10.GS: mapping and experiences of action

10.1. Survey for local authorities and expert organisations

10.1.1. Participants' profile

The participation data from the survey are very low in both cases, since in Spain **there are no organisations with experience in caring for victims** of this type of violence. For this reason, the fieldwork was complemented with semi-structured interviews (see Annex 3); besides, international literature on the subject was strengthened.

Regarding the **survey**, a double consultation has been carried out on the actions on GS and the experience in the care of women victims of GS; on the one hand, to local entities (LEs) or authorities (LAs) and on the other hand, to organisations and experts.

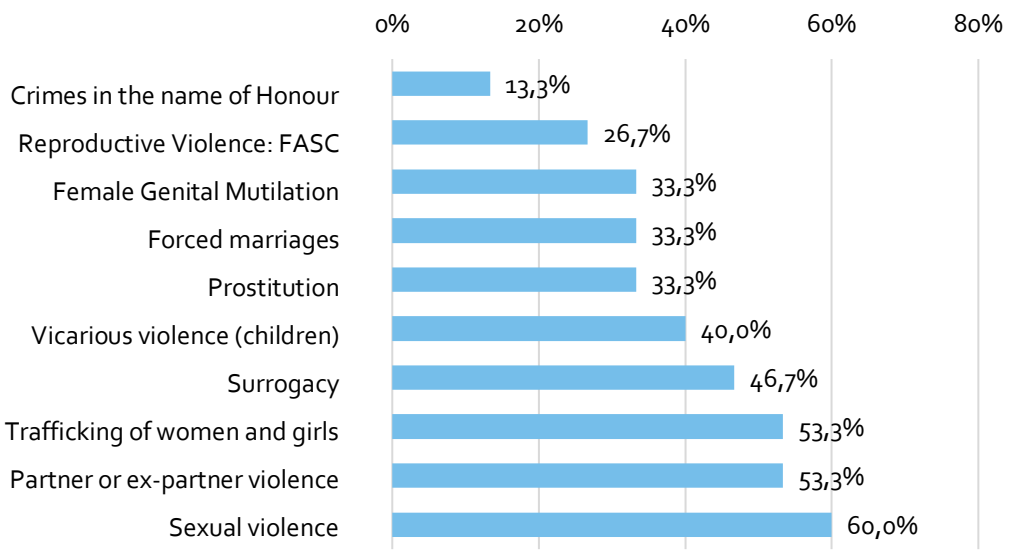
Of the 279 **LEs** that completed the questionnaire, only 6 reported having known about GS in the course of their work and only 4 LEs answered questions about surrogacy. Only 3 of them (municipalities) reported having some experience of this form of RV, but they either do not specify it or refer to awareness-raising activities to publicise the existence of this type of VAW and raise awareness in society.

The participating LEs generally consider the application of intersectionality to be high. And that their work with the main groups of vulnerable women is with women with disabilities.

In the second case, the participation of 17 **organisations and experts** from universities, associations, foundations, and o feminist and women's organisations has been obtained. They represent a wide range of *expertise in* the academic, health, legal, psychological and advocay fields, among others.

As for the **organisations accessed**, their territorial scope is mainly national (85.7% of them), but also ACs (7.1%), provincial (7.1%) and local (14.3%). 87.5% of these organisations have expert knowledge and/or experience in caring for women victims of VAW in its different forms (see graph), although 46.7% indicate that their knowledge of GS is mainly theoretical.

Graph 11.Areas of knowledge and/or intervention of the expert entities (survey)



Source: Red2Red, 2023. Survey for expert organisations on other forms of violence against women

70% of the organisations consider that the application of the intersectional gender approach in their work is high, and 30% *quite a lot*. As for the most vulnerable women who are present in their actions, they indicated that these are migrant/foreign women (around 80% of the organisations), racialised women (50%) or refugee women (40%) and also young women and minors (70%).

The field of *expertise* of the people who participated in the survey was diverse, there were professionals in the field of psychology and academics, advocated and/or teachers standing out slightly.

10.1.2. Activities in the field of GS

The organisations and experts consulted and who took part in the survey indicated that, given that GS is illegal in Spain, **there are no specialised resources for dealing with** this form of violence or its victims. They also stated that they were unaware of the existence of care protocols, institutional coordination and/or monitoring bureaus, roundtables or protocols for this form of violence that have been promoted by other types of organisations. In any case, neither the LEs nor the organisations or experts consulted have attended victims of GS in Spain.

If the focus is on **possible victims of GS who may arrive in Spain**, the intervention protocol to be followed with them could be similar to that followed with women

> victims of trafficking or prostitution. In addition, it should be taken into account that, being migrant women, they may present some obstacles in accessing resources: not knowing the resources and services available to them in our country; not knowing where to go for help; language or cultural barriers; distrust of the administration - especially women from developing countries or countries with high levels of corruption-, among others (E8).

The LEs do not see any particularity in the **attention to women victims of GS** and argue that it should be equal to that provided to other VAW victims, in the sense of extending the same rights and resources.

> In general, all the experts consulted agree on the importance of incorporating GS into **international development cooperation policies.** In their opinion, countries that prohibit GS in their territory, such as Spain, have the **moral and ethical obligation to promote and finance international cooperation programmes** that protect the most vulnerable women in whose countries where GS is carried out, providing them with certain resources such as education or material and financial resources that enable them to defend themselves from the exploitation of their bodies.

Actions on GS in Spain focus, as has already been pointed out, on **actions to raise awareness** among citizens and public institutions.

Awareness-raising is mainly carried out through feminist organisations and organisations. Thanks to them, manifestos, talks, training, demonstrations, collection of signatures, and dissemination materials in the press and online media have been developed.

- These actions are addressed in general to the whole society, but in particular to people who have opted to GS (parents-buying party) or plan to do so, and to public administrations.
- They are usually carried out in coordination with other feminist organisations both in Spain and internationally, such as CIAMS (ICAS), No somos Vasijas (We are not Vessels, la Red Estatal contra el Alquiler de Vientres (State Network against the rent of Womb), Stop Vientres de Alquiler (Stop Wombs for Rent) l'Escola AC, etc.

Some interesting experiences at the international and national level are highlighted below.

10.1. Interesting experiences

In the international sphere, the following organisations are noteworthy for their work in observing, studying, denouncing and raising awareness of GS:

The **International Coalition for the Abolition of Surrogacy** [156] -ICAS- is an international association that promotes women's rights from a feminist perspective. Its main objective is to "contribute to the adoption and implementation of legislation and public policies promoting the abolition of surrogacy at national, European and international level"[157] .

It is made up of numerous organisations from different countries, including the following Spanish organisations: State Network against surrogacy; We are not vessels; Federation of Associations of Separated and Divorced Women; Commission for the investigation of mistreatment of women; Stop Bellies for Rent; Young Women Federation; FAC Feminists to Congress; and Feminist Politics Forum. Stop Surrogacy Now[158] is an international organisation - associated with the Centre for Bioethics and Culture (CBC) - that brings together organisations and professionals from various fields and backgrounds who oppose the reproductive exploitation of women and the trafficking of children through GS. By signing the Declaration, the member organisations express their concern about the social, human, economic, legal and cultural aspects of surrogacy. In the *Stop Surrogacy Now Declaration* [159] they urge the collaboration of the world's national governments and leaders of the international community to end GS.

As explained above, it has not been possible to access experiences of intervention with surrogate mothers in the **context of the LEs in Spain**; however, some examples of awareness-raising and sensitisation practices related to the issue promoted by local governments have been located:

An example of institutional commitment and local agreement is the action of the **Municipal Women's Council together with the Department of Social Welfare of**

[156] International Coalition for the Abolition of Surrogate Motherhood -ICAS-. Access
[157] ICAS Statutes. Access
[158] Stop Surrogacy Now. Access
[159] Stop Surrogacy Now Statement. Access

the City Council of Marín (Pontevedra). They held a meeting in November 2018 on the occasion of the commemoration of 25N, International Day for the Elimination of Violence against Women. In addition to establishing the awards for local intervention against gender-based violence, these bodies decided to express a public agreement against the regulation of surrogacy[160] .

The City Council of Mérida collaborated in the talk-debate [161] "Surrogacy vs. Surrogacy: a critical look" held in 2015 and which aimed to expose the *regulationist* position versus the abolitionist one. The City Council and the Lugo Provincial Council, as part of the "Women with strength" programme of activities to commemorate 8M in 2019, participated in the public presentation of the book "*Vientres de Alquiler*" by Nuria González, exploring the reality of GS by addressing the legal situation, the practice and the consequences that it has on pregnant women.

The Provincial Council of Pontevedra, as part of its online courses on equality, offers a training course on "Surrogacy: reproductive exploitation and feminisation of poverty".

At the end of 2017, the Seville City Council organised the II Autumn Feminist Cycle which, among other activities, included reflection sessions [162] on GS/Wombs for rent.

Regarding the work of **feminist and women's associations**, 3 organisations stand out: the **National Network Against Surrogacy (NNAS)**[163] , We are not vessels and Stop Wombs for Rent.

NNAS was founded by a group of organisations and activists who came together to fight against GS and defend women's collective rights. Currently, NNAS has more than 150 feminist organisations from all over Spain.

In addition, there are three other organisations specialised in denouncing and raising awareness: We are not Vessels [164] , Stop Wombs for Rent [165] (SWR) and the International Academic

[160] Vigo Lighthouse, 2018. Marín rejects the regulation on surrogacy and demands the abolition of prostitution. Access
[161] Talk-debate: Surrogacy vs. Surrogacy: a critical view. Access
[162] II Autumn Feminist Cycle. Access
[163] State Network Against Surrogacy (IANSPP). Access
[164] We are not vessels. Access
[165] Stop Surrogacy for Hire (SWR). Access

Network for Studies on Prostitution and Pornography (IANSPP).

As for "**No somos vasijas" (We are not vessels)**, it is a platform formed with the aim of preventing possible attempts to regulate GS in Spain. **Stop Vientres de Alquiler (**Stop Wombs for Rent) is a feminist outreach project whose main objective is to promote knowledge and raise social awareness about surrogacy as a form of violence against women and a contemporary practice of reproductive exploitation and sale of babies.

There are also examples of local initiatives by feminist associations, such as the following. The **feminist association Marea Violeta Jerez** organised in 2019, with the collaboration of Stop Vientres de Alquiler (Stop Wombs for Rent), the dissemination day "Explotación reproductiva y mercado de bebés" (Reproductive exploitation and the baby market). The **Association of Women for Health** (AWH), in commemoration of May 28 - International Day of Action for Women's Health - and with the collaboration of the Madrid City Council, held the conference "Maternities" in which, among other topics, issues related to violence around maternity were addressed and in particular the feminist philosopher Ana de Miguel spoke on "The new neoliberal maternity: surrogate wombs".

Several **public universities** have also carried out actions (congresses, conferences and seminars) on surrogacy that could be replicated by local governments; some examples are:

The conference organised by the **Universidad Nacional de Educación a Distancia** (UNED) in March 2023, which was given by the anthropologist Mercedes Fernández-Martorell under the name *Encargar humanos* [166] (ordering humans).

Carlos III University of Madrid has offered an open seminar since 2020, in which, for example, the political scientist and feminist Laura Nuño has taken part[167] .

Another example is the International Congress "Theoretical and legal debates: reproductive exploitation and commercial pregnancy" [168] organized by the RAIEPP in 2022, among other actions in the academic field.

[166] Conference "Commissioning humans". Access
[167] Seminar "Maternidades S.A.: The surrogacy business". Access
[168] International Congress "Theoretical and Legal Debates: Reproductive Exploitation and Commercial Gestation". Access

11. Violence or crimes committed in the name of so-called "honour"

11.1. Problem description and typologies

Crimes committed in the name of so-called "honour" (CNH) are a type of violence against women (VAW) comprising a **broad continuum of mechanisms** used to control women and girls with varying levels of severity (Mayeda, Vijaykumar and Chesney-Lind, 2018), **the most extreme expression of which is murder** (*honour killing*). In the framework of the European Union, they are included in the Istanbul Convention, which guides the action of public authorities in the fight against VAW.

Although its victims are **mainly women**, as they are the ones who are most affected by the notion of "honour", it also affects non-binary people and the LGTBIQ+ community in general.

> Rather than CNH, some institutions and authors consider it more appropriately to be designated as "honour-based **violence**" (HBV) (see Mayeda & Vijaykumar, 2016) or "honour-related **violence and oppression**" (as does the Swedish Gender Equality Agency). This is because **coercive practices are broader** than the more extreme examples of crimes, which focus on punishment for the restoration of "honour". For the time being, the Istanbul Convention calls them CNH.
>
> According to the European Parliamentary Research Service (2015: 2), the connotation of "crime" is also criticised because it disguises the premeditated nature of the crime or places too much emphasis on "honour", so it may in some ways validate the motive for the crime (Welchman and Hossain, 2005). Some alternatives suggested by the EPRS are "femicide" or "shame killings".

An infraction or violation "of honour" is a complex notion, key to patriarchal societies, which refers to different **moral, religious and cultural values in relation to the expected behaviour of the female members** of a group: a family (nuclear or extended), a community or a religious or another affiliation (e.g., tribe, ethnic group, clan, etc.), always according to prevailing gender roles.

> Thus, as Mayeda and Vijaykumar (2016:354) point out, "an honour-based family system rests upon socially constructed understandings of rigid femininity and masculinity, and under such systems, women's and girls' purported sexual purity is central to the family's reputation".

This has the following implications:

- The women's behaviour **would affect the group as a whole**, so that their interests and needs would be subordinated to those of the group, as their transgressions put the "honour" of the group at risk.
- For this reason, women are subject to **close family and community control**, especially of their sexual behaviour (e.g., virginity or fidelity) and attitudes (e.g., modesty, modesty, modesty, righteousness).
- Control includes**, among other things**: monitoring of the places they can be alone or accompanied as well as the use and timetable to access them; the people they can interact with, especially men; the way they dress; the activities they can carry out (leisure, professional or other); the prioritisation of family needs, etc.
- It could also involve **harmful practices** such as virginity testing, FGM and forced marriages, which are also considered SV and RV.
- **It requires** women **to be kept away from comments**, rumours or gossip that would function as patriarchal control mechanisms (Sen, 2005). In diasporic contexts, rumours may reach the family's country of origin, "leading to a macro level of oppression crossing international lines" (Mayeda & Vijaykumar, 2016: 357).
- This control is **exercised by both men and women**; together they result in a context of oppression.

Behaviours or situations that **may constitute an injury "to honour" include**: non-decent attitudes, clothing or career choices, not being heterosexual, having a non-binary or different gender identity than the one assigned, relating to males outside the family, reporting incidents of domestic abuse or GBV, not following religious precepts, refusing to enter into an arranged marriage, dowry disputes, refusing FGM of daughters or early marriage, seeking divorce, adultery, having premarital affairs, not being a virgin or becoming pregnant outside of

marriage. Furthermore, rape victims may even be seen as "causing" their own violence (Stenger and Jones 2019).

Therefore, when there is a perceived **potential for risk or an affectation of 'honour'** (*shame*), a **corrective action** (*restoration) is required*; the degree of severity of it will vary according to the family and context.

The modes of expression of HBV or CNH, **its typologies, are various**:

- emotional punishments or sanctions,
- loss of personal freedoms,
- restrictions on freedom of movement,
- restrictions on contact with men,
- verbal and psychological violence,
- community isolation and ostracism,
- corrective removal or abduction to the country of origin or country of reference of the diaspora,
- corrective removal or abduction to a third country to reside with other family members,
- being held at home against one's will or abducted,
- non-lethal physical abuse,
- acid attacks,
- corrective rape,
- forced abortion,
- suicide inducement,
- murder.

The incidence of HBV or CNH appears to be decreasing when...

- the notion of "honour" is transformed. Certain socio-cultural changes occur that affect women in particular (related to marriage, dowry, and in general the social situation of women and non-binary people);
- social tolerance of violence freely exercised by family members decreases (loses legitimacy);

- the state strengthens the protection of citizens in general, and women in particular, and it improves the effectiveness of civil law (impunity is lost). Also, the rights of women and LGTBIQ+ persons are promoted and protected (gender equality is advanced).

11.2. Characteristics and needs of victims

11.2.1. Main groups affected

According to Stenger and Jones (2019), in communities susceptible to HBV, weak legal protection and inadequate access to victim information often make women vulnerable.

> Although CNH are associated with geographies far from Spain, it is true that the notion of "honour" and its correction or punishment are **present in all cultures**, albeit in different ways, as the term can vary in its connotations. Although these crimes have been mostly associated with Islam, they also occur in Hindu, Sikh, Druze, Christian and Jewish communities (EPRS, 2015).

In Europe there are practices that have (almost) disappeared and others that survive unnoticed by the majority of society. For example, some of those that survive are corrective rape of lesbian women or corrective therapy for LGTBIQ+ persons; others have lost legitimacy, such as adultery-related murders.

In this sense, it is necessary to point out that, **in Spain, Francoism** in the dictatorial period meant the establishment of a symbolic and legal order that promoted action against women in the name of "honour" (Cenarro Lagunas, 2018; Noblet, 2021).

> Along these lines, Noblet (2021:164-165), points out that "The civil code and the penal code are formed in order to establish the crime of adultery with a differentiated treatment according to the sex of the perpetrator, to suppress almost all sentencing in the case of a crime of honour against a daughter or a wife, and to punish with prison sentences women who have had an abortion (...). It is clear, then, that after 1939, behind the father and the responsible husband, the all-powerful *pater familias*, who guarantees (and holds) the collective honour, hid more often than before (and less discreetly). (...) In the years 194 and 1950, it was more a question of a "head of the family" than a "father of the family".

The notion of "honour" is therefore not so far removed from **our own cultural references.**

Today, CNH refer to both *harmful practices* and customs derived from patriarchal values which, in their most notorious expressions, are **more prevalent in some regions of the world** than in others. Measurements are insufficient or lacking in many countries, so quantitative data must be taken from an approximate perspective.

According to available research and data from international agencies, there is a higher prevalence in the **Indian subcontinent of Asia, North Africa, the Middle East and among diasporas from these areas** living in other parts of the world, including of course Europe and therefore **Spain**.

Diasporas refer both to economic **migrants** and to the entire population seeking or benefiting from **international protection** in Spain (see point 5.2.2.).

- The fact that CNH are present among the common forms of VAW in some regions **does not mean that the entire indigenous population is exposed to them or is a perpetrator**.
- The perpetration of CNH is sometimes related only to membership of (sometimes minority) groups in certain areas, religious expressions, specific clans, and also to specific family values. In addition, their practice may vary according to their **rural or urban origin.**
- For all these reasons, it is preferable to **avoid generalisations and stereotypes** that can affect the entire population of certain nationalities, thus inducing **discrimination, racism and xenophobia**. This also leads to the alienation of potential victims from care resources.

With regard to the **expression of some specific forms of violence**, the following data are known.

- On **FGM**, according to UNFPA (2020b) it has affected at least 200 million girls and women and is practised in communities around the world (but mainly in sub-Saharan Africa and the Arab States):
    - In Africa: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania,

Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Zambia.

- Asia: India, Indonesia, Malaysia, Pakistan and Sri Lanka.
- Middle East: United Arab Emirates, Oman, Yemen, Iraq and the State of Palestine.
- Eastern Europe: Georgia and the Russian Federation.
- South America: Colombia, Panama, Ecuador and Peru.

Ethnicity is the most relevant factor for the prevalence of FGM, which goes beyond socio-economic class and educational level, although there are exceptions in relation to the urban or rural origin of the population (UNFPA, 2020b).

- Regarding child marriage[169] , although it occurs worldwide, the countries where the practice is most prevalent (well over 50% of the female child population) are: Niger, Central African Republic, Chad, Bangladesh and Burkina Faso. In global terms, India, China, Pakistan, Afghanistan and Iran are countries where the practice is widely entrenched. High prevalence countries where there has been a noticeable decline in the practice are: Bangladesh, Ethiopia, India, Indonesia, Armenia, Esuatini (formerly Swaziland), Maldives, Rwanda and Tunisia (UNICEF, 2021).

The number of children worldwide is estimated at 765 million. Although it affects both boys and girls, girls are more affected and the consequences are more severe. According to the Girls Not Brides global alliance, 12 million girls and adolescents are married before the age of 18 every year.

- It is not always possible to clearly differentiate data on forced child marriages or unions from those **involving women aged 18 and over**. Their extent is global and should not be assimilated to arranged marriages or marriages of convenience, although the latter can become forced if they are not allowed to be dissolved (see the different relationships for example in Naz Ali Kousar, 2023).

There are still few studies on its prevalence in Europe (see the research promoted by FEMP on the subject, 2023). The Work network on forced marriages in Spain (2023) indicates the importance of its practice among communities and ethnic groups in

[169] Refers to any type of formal marriage or informal union in which one or both parties are under the age of 18 (UNICEF

China, India, Pakistan, Turkey, Iran, Afghanistan, Bangladesh, Iraq, Morocco, Senegal, Gambia, among others.

- Regarding **virginity testing** (see chapter 3), according to the Declaration to Eliminate Virginity Tests (WHO, UN Women, OHCHR, 2018:7), countries where this practice has been documented include: Afghanistan, Brazil, Egypt, India, Indonesia, Iran, Iraq, Jamaica, Jordan, Libya, Malawi, Morocco, the Occupied Palestinian Territories, South Africa, Sri Lanka, Swaziland, Turkey, the United Kingdom, Zimbabwe, Belgium, Canada, the Netherlands, Sweden and Spain.

  In Spain **it is due to the presence of diasporas**, but it also refers to the **Roma population**. In our country it tends to be exacerbated in the Spanish Roma community in reference to ritual virginity examinations as part of the celebratory acts associated with marriage or partnership.

  The experts consulted on the subject point out that virginity testing **is not something that characterises the Romany People** but that it was a practice "acquired" from its "promotion" at the court of the Catholic Monarchs, who wanted to encourage Christian morality among women. The Roma people are diverse and the test (*prueba del pañuelo*/ handkerchief test) is not widespread. Experts point out than in Spain it is in disuse and is only performed when there is free acceptance by the bride. It is certainly associated with the patriarchal notion of "pride", although nowadays it is considered that there would be no possibility of "dishonour", since if the test is given, it happens when the woman decides it and the result would not contradict the expectation.

- As for "**feminicides or honour killings**" or killings in the name of "honour", there is an underestimation of their incidence as quantification is generally very poor. Their objective would be the restoration of family "honour".

  Most are reportedly in the Middle East and South Asia. The WHO estimated (2012) that globally there were around 5,000 killings each year in the name of "honour". However, as Valcárcel points out, "these figures could swell considerably taking into account unreported cases and the lack of official national and international statistics" (2020:59).

In Spain - where there is no official measurement of the prevalence of CNH as such - it could be estimated that **there are groups of women who may be facing a higher risk**. We refer to girls and women from diasporas where the survival and prevalence of CNH in their countries of origin

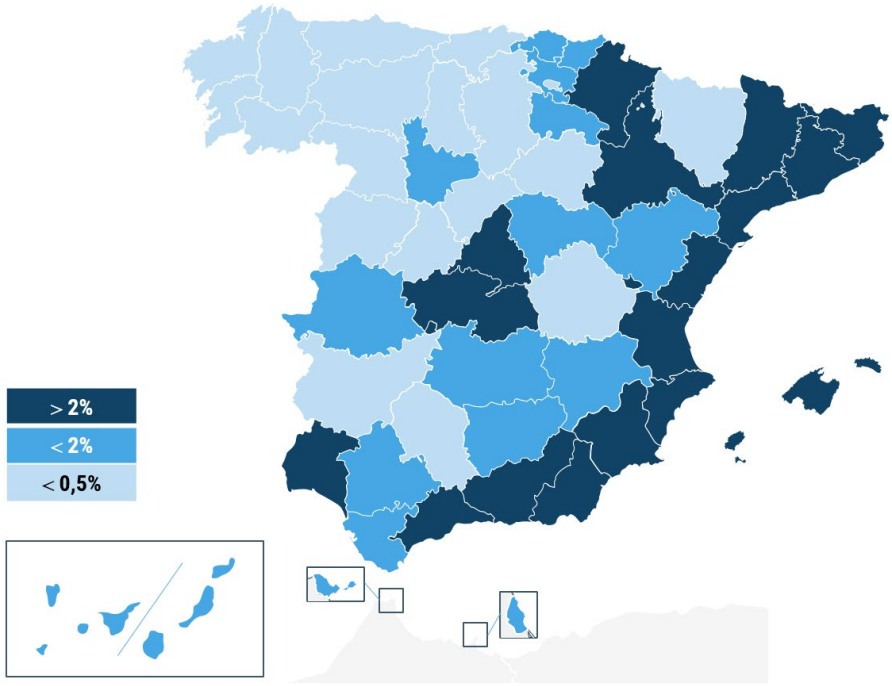
is higher. This does not exclude the native Spanish population, but it places them at a lower risk of HBV.

Based on this fact, and focusing on the population of migrant origin, an **analysis** has been made **of the census** according to the **female population by country of birth**, assessing the most numerous nationalities in our country.

The following criteria were used:

- The division into provinces has been considered because it is more useful for local action on the phenomenon.
- The presence of the set of nationalities with a prevalence of CNH has been assessed with respect to the total registered female population (%). The key is not the nationality but the weight of the female population at risk.
- Many of the nationalities have very little presence in Spain, which is why a regional approach is of greater interest in considering the phenomenon. In this way, the following origins have been considered:
    - Africa: Gambia, Mali, Morocco, Algeria, Sudan and South Sudan.
    - Asia - Indian subcontinent: India, Pakistan and Bangladesh.
    - Middle East: Egypt, Saudi Arabia, United Arab Emirates, Iraq, Iran, Jordan, Kuwait, Lebanon, Qatar, Yemen, Syria and Turkey.
- In order to assess the **degree of vulnerability to CNHs**, this criterion has been established:
    - high vulnerability: if the population exceeds 2% of the total number of women;
    - medium vulnerability: when the population weight is 0.5% to 2%,
    - low vulnerability: when the female population is less than 0.5%.

Figure 8. Map of potential vulnerability (*) to CNH in Spain (by provinces). % of foreign women** out of the total female population.



Prepared by the authors. INE (2023) Statistical use of the population register.
Notes:
(*): High: 2% - 15%; Medium: < 2%; Low Vulnerability: < 0.5%.
(**): The Gambia, Mali, Morocco, Algeria, Sudan, South Sudan, India, Pakistan, Bangladesh, Turkey, Egypt, Saudi Arabia, United Arab Emirates, Iraq, Iran, Jordan, Kuwait, Lebanon, Qatar, Yemen, Syria

From an autonomous community perspective, where there is a greater presence of these female populations is in Catalonia, Madrid, Andalusia, the Valencian Community, the Balearic Islands and Navarre.

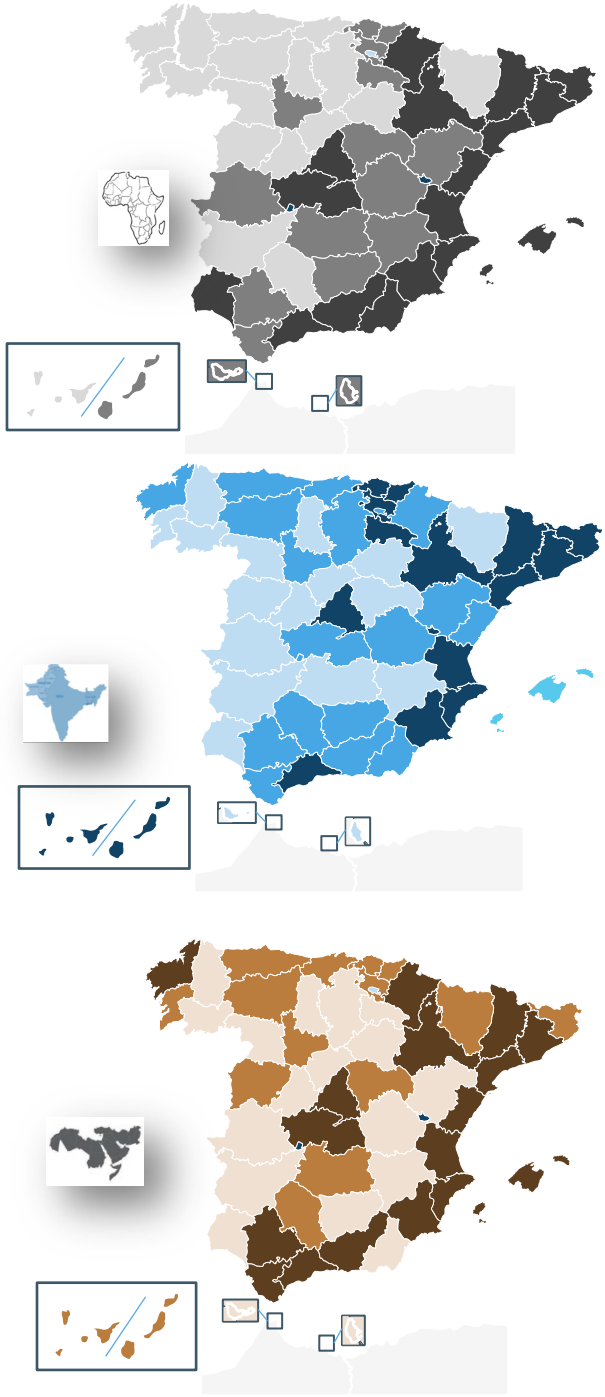
A more detailed look from the perspective of the origin together with the province shows us that the population weight varies according to the continent of origin, therefor results change. The following Figures show these differences.

Regarding the **African origin**, it is necessary to consider its presence in all the provinces of Catalonia, Valencia and the Balearic Islands, as well as in Murcia, Madrid, Malaga, Huelva, Granada, Almeria, Navarre, Zaragoza and Toledo.

As for women of Asian origin - in relation to the **Indian subconscious** (Bangladesh, India and Pakistan) the provinces to pay more attention to the female population would be: all the Canary Islands, the Balearic Islands and all the provinces of Catalonia and the Basque Country, together with Murcia, Alicante, Valencia, Madrid, Malaga, Zaragoza and La Rioja.

With regard to women from **Middle** Eastern countries, these would be found residing in the provinces of: Barcelona, Tarragona, Lleida, Madrid, Cadiz, Malaga, Granada Seville, all the provinces of the Valencian Community and the Balearic Islands, as well as Toledo, Murcia, Navarra, Zaragoza and La Coruña.

Figure 9. Maps of potential vulnerability (*) to CNH in Spain, by provinces and by region of origin of women (Africa; Indian subcontinent; Middle East). % of registered women (by country of birth**) out of the total female population.



Prepared by the authors. INE (2023) Statistical use of the population register.
Notes:
(*): High Vulnerability: 2% - 15%; Medium Vulnerability: < 2%; Low Vulnerability: < 0.5%.
(**): Gambia, Mali, Morocco, Algeria, Sudan, South Sudan, India, Pakistan, Bangladesh, Turkey, Egypt, Saudi Arabia, United Arab Emirates, Iraq, Iran, Jordan, Kuwait, Lebanon, Qatar, Yemen, Syria

On the other hand, in the **surveys and interviews with expert individuals and organisations**, some specific profiles of women who have come to different social care resources have been mentioned.

Firstly, reference has been made to **women seeking international protection** in Spain.

- In this sense, young and middle-aged women (between 20 and 45 years old), with little education and significant difficulties with the language (Spanish), generally with dependent minors and who in many cases have come alone to Spain fleeing gender-based violence and seeking asylum due to gender-based persecution, have been identified as victims of CNH. They come mainly from Afghanistan, Iran, Pakistan, former Soviet republics (not specified) and countries in sub-Saharan Africa and the Maghreb (not determined in the surveys), as well as Honduras, Peru and Colombia.
- The profile of women applying for **international protection** in Spain and its **link to** gender-based **international protection** has been described in chapter 5 (FASC: women victims and their needs).

Secondly, Spanish **Roma/Gypsy women** have been mentioned, despite the fact that they are not a population usually considered within the HBV.

Throughout the fieldwork, surveys and interviews, it has been pointed out that some Roma women could be a population facing risks comparable to those of the CNH. There is a lack of social research to be able to assess the situation among the Roma, but no international organisation has assimilated the notion of "honour" to this ethnic minority.

However, it is interesting to consider that certain solutions to expressions of gender-based violence require attention to some cultural traits (such as the weight of the family and the presence of relevant community prescribers). Given that the Roma population is the majority ethnic minority in Spain (and in the European Union), it is worth considering the information gathered and also assessing the **information gaps that exist about the needs of Roma women in relation to** family pressure and VAW.

- Based on the experience of some social services and GBV care resources, it has been assessed that some Roma women experience coercion and threats **from their direct and extended families in relation to** some transgressive female behaviours: e.g., out of expectation behaviour, or seeking solution outside the family or community conflict resolution procedures.

- With regard to these **behaviours,** reference was made to: the woman's break-up (separation or divorce) of her relationship for *impermissible* reasons, infidelity, requesting custody of the children after a non-consensual separation, police report of GBV or non-payment of alimony/support after separation or divorce from her ex-partner, and police reports of a sexual assault committed by a Roma man from the community.
- These victims **lived experiences** such as: threats, intimidation, physical assault, rape, disownment, social isolation, loss of custody (access to their children) and banishment. The threats were extended to their offspring (sons and daughters) or their direct family (father, mother, siblings and other relatives). They also experienced the warning of being responsible for provoking a (serious) conflict between families (*war*), with potentially dire consequences for all family members. All these consequences (experienced or feared) were named by these clients as "ruin" (l*a ruina*) in the eyes of professionals.
- As a result, many of the victims **would have changed their decisions** in the face of a report, the break-up or abandonment of the partner, the cession of custody, the waiver of maintenance, etc. As a result, their rights would have been violated.
- Some informants have also alluded to the *handkerchief test* as a harmful practice.

The perception of the professionals who have worked on these care cases is that, in such situations, **women who transgressed** norms outside of what was tolerated by their own and/or their partner's families **were punished**, because - in such cases - the moral values upheld by family relationships took precedence over the individual rights of the women. This is a characteristic feature of -all- patriarchal societies. These professionals felt that they lacked sufficient **tools to guarantee their rights, their accompaniment and support, and also their safety.**

On the other hand, the organisations that represent and defend the rights of the Roma population in Spain consider that the term CNH and "honour killings" **do not correspond to the cultural practices of the Roma people**.

Along these lines, the Fundación Secretariado Gitano (Gypsy Secretary Foundation)) and the National Federation of Roma Women's Associations 'Kamira' have pointed out that the

reference to ethnicity in sexist crimes "damages the image of Roma as a community, perpetuating prejudices and stereotypes"[170] .

The study by Duque Sánchez, Khalfaoui Larrañaga and Valls Carol (hereafter, Duque Sánchez et al., 2023) *Violencia de género en la población gitana* promoted by the DGVG does not have among its objectives the analysis of other VAW and the family role; but it shows, nevertheless, the importance of families within the Roma community.

- The aforementioned study is based on the recognition of the diversity in the role played by families (some facilitating and others perpetuating VAW), as is the case with non-Roma women. It does not therefore determine that there is a specific model of family response to GBV.
- It is mentioned that "some [victims] say that they did not report for fear of reprisals against their family" (2023:30).
- We believe that this fear could also occur in small and/or rural contexts where families are closely linked through marriages; where, in addition, the community has a rigid role as an overseer of gender and social norms.
    - In this sense, Franco and Guilló point out that a victim of GBV in rural areas (in Spain) runs the risk of not having support and of ostracism when "she does not have the legitimacy granted by the community to count on help for something that is not collectively approved" (2012:231)[171] (in relation, for example, to the legitimacy of separating from the abuser but not resorting to filing a police report).
    - It has been considered that these victims would also express "the importance of not involving the families they belong to in conflicts, and at the same time solving the problems - expressly including a situation of gender-based violence - within the family (...) In the relationship with the family it is totally decisive *not to worry them, not to cause them displeasure, to avoid embarrassing them*" (Guilló Girard, et al., 2010: 476).

[170] See FSG and Kamira (2014). Joint Communiqué. Online document (access)
[171] See, for example: FADEMUR (2020). Women victims of gender-based violence in the rural world. Ministry of Equality-DGVG; or Folia Consultores (2010). Gender violence in the small municipalities of Spain, Madrid: Ministry of Health, Social Policy and Equality. DGVG.

- Duque Sánchez et al. (2023), show that sometimes Roma women decide "not to go to the police or to institutions that offer help" for fear of "the consequences of going to the police, either because they are not sure of the treatment they will receive or because of reprisals afterwards" (2023: 33). It is important to remember that Roma people have historically been persecuted and discriminated against (and still are). Furthermore, reporting increases the risk of aggression when it is not accompanied by the adequate deployment of security measures for the victim (any victim, any violence) adapted to her/his protection needs.
- The aforementioned research also shows cases in which there is support from both the family and the aggressor's family; and the importance of prestigious figures (older Roma men and women) who act as mediators in these cases (2023:31) and that of evangelical pastors (2023:33) is also mentioned.
- In line with other existing research, the lack of information, mistrust, fear of not being believed or understood and the general absence of Roma professionals are identified as influencing factors that keep Roma/Gypsy women away from support institutions.

There is a need to improve knowledge about VAW faced by Roma/Gypsy women and their experiences surrounding them.

11.2.2. Victims' needs

From a rights-based approach, and in the same way as for victims of RV, the needs of victims of CNH are the same as **those of any other victim of VAW** (see points 5.3. and 8.3. of this report).

> These refer to: information, counselling, psycho-social support, legal accompaniment, residential care, security-protection, health care, psychological and psychiatric care, specialised care for their children, alternative social links or network to the aggressor environment and reparation.

On the other hand, and as has been pointed out with regard to RV, victims of CNH, depending on the typology they face, **will also have more specific needs** due to the characteristics of the violence and the profiles of the groups of women most affected by it.

Throughout the fieldwork, reference has been made to issues such as the following:

- Access and rapid response to gender-based international protection and refuge.

- **Cultural interpretation** services that go beyond translation and service mediation; that are oriented towards support in social accompaniment and the relationship with care resources.
- The presence of **professional** women of **their ethnicity or from the same background** (but not from their immediate circle because it may be perceived as a threat) is considered necessary.
- Guidance and information processes that guarantee **anonymity**.
- **Understanding**; victims/survivors need specialised care where the complexity of their experiences is accurately and empathetically understood, transcending cultural biases:
- the role of family networks, the notion of loyalty, shame, the internal struggle between values and cultural mandates, the sense of betrayal of the family, isolation and loneliness.
- They also need to feel understood in the characteristics of the community of their neighbourhood or municipality of residence, and the relationship that exists between it and others in other localities.
- A much more accurate **assessment of risk and security resources** for their protection than is currently the case. Among others, it is necessary to assess issues such as:
    - community risks and different perpetrators;
    - protection in the country of origin, to them if they return and to family members who are there and are threatened;
    - cultural practices that affect them are frequently disseminated through international channels that reach their communities in Spain, as the CEDAW points out, it is necessary to adopt adequate measures to contain such dissemination;
    - forced relocation with family members to another Autonomous Community;
    - the international transfer or abduction of victims;
    - the international mediation required for their rescue and return to Spain;
    - the needs of their children and the risks they face;
    - the characteristics of crisis or emergency situations.

- Victims are considered to have particular difficulties in accessing **support for economic autonomy**, sometimes because of their undocumented situation and/or dependence on family networks or partners. Rapidity of response is vital.
- They require a **supportive social network**, but:
    - face greater **barriers to accessing women's groups**, sometimes due to discrimination (racism, xenophobia or antigypsyism/antiromanism) from local women's associations in their municipalities.
    - There are few groups of women survivors who have been **persecuted on the basis of their gender**.
    - There are few **safe spaces for social inclusion** (intercultural and gender-sensitive), which allow them to build new relationships (leisure, sport, cultural, etc.).
- **Accompaniment is long-term**, and sometimes lifelong, because perpetrators are always a potential risk and there are multiple perpetrators (sometimes in several countries). The recovery process for this type of violence is more complex and much slower than for GBV and SV.
- SV and RV is present in some expressions of CNH, so victims must be guaranteed access to **SRHR remedies**.
- Victims **may find it difficult to seek help or report** mainly due to a lack of knowledge of their rights and available resources; and in relation to the latter, also because they have not yet developed a sense of their own victimisation as **the context of oppression they experience is highly normalised** and its breakdown causes them moral conflict. **Their access to justice** must be **facilitated**, as most of these crimes are often not reported, even when they are brought to the attention of the police (RSEP, 2015).

> "A lot of listening and interpretation of their life history is needed, many are not identified as honour killings. It is very important to listen to them in order to be able to make a proper identification" (interview with expert).

There is a need to improve knowledge about the needs of victims through victim-centred research.

11.3. Regulatory and institutional framework

11.3.1. International and European context

The CNHs fall within the scope of **fundamental human rights** and violence against women. In this way, reference would be made to standard instruments of UN international law already mentioned in other chapters of the study, such as:

- Universal Declaration of Human Rights (1948).
- International Covenant on Economic, Social and Cultural Rights and the Covenant on Civil and Political Rights (1966) and General Comment No. 28 of the Human Rights Committee which states that "cultural tradition should not be accepted as a defence in cases of *honour* crimes".
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).
- Convention on the Rights of the Child (1990)
- International Conferences on Women (from Mexico 1975 to Beijing 1995); in particular the Beijing Platform for Action and its indicators and subsequent follow-up summits.
- Declaration on the Elimination of Violence against Women (1993), which explicitly mentions "honour killings" as a form of VAW.
- Unesco Universal Declaration on Cultural Diversity (2001), condemns violence arising from cultural practices.
- UN General Assembly Resolution 57/179 "Towards the elimination of crimes against women committed in the name of honour" (2002), and Resolution 58/147 on "Elimination of domestic violence against women", which urged states "not to invoke any custom, tradition or religious consideration to avoid their obligation to eliminate violence against women" (2003).
- The 2006 Report of the Secretary-General on the In-depth study on all forms of violence against women (A/61/122/Add.1) led to the adoption of several important resolutions: three of them on "intensification of efforts to eliminate all forms of violence against women" (61/143 in 2007; 62/133 in 2008; and 65/187 in 2010).

- Convention on the Elimination of All Forms of Discrimination against Women. CEDAW (1979).

With regard to **CEDAW**, as a global reference instrument for the eradication of VAW in all its forms, it is worth mentioning some of **its recommendations** that broaden the notion of violence, so that the CNH begin to be more visible in the UN as a whole and the obligations of states:

- General Recommendation No. 19: Violence against women (1992).
- General Recommendation No. 28 on core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women (2010).
- General Recommendation No. 35 on gender-based violence against women, updating General Recommendation No. 19 (2017).
- General Recommendation No. 31 of the Committee and General Comment No. 18 of the Committee on the Rights of the Child "on harmful practices", adopted jointly in 2014):

- It warns about **States' obligations** in certain forms of violence: FGM, child or forced marriage, polygamy, and **"honour"** crimes.
- It describes **the oppression** that girls are subjected to and the macho beliefs that cause it; and determines that (emphasis added):
    - "are **acts of violence** that are committed disproportionately, but not exclusively, against girls and women because family members believe that a certain **alleged, subjective or actual** behaviour will bring dishonour to the family or community" (para. 29). (para. 29).
    - "Rather than being perceived as criminal acts against women, "honour" **crimes are often condoned by the community as a** means **of preserving or restoring** the integrity of their cultural, traditional, customary or religious norms after alleged transgressions. In some contexts, national legislation or its practical application, or lack thereof, allows for the defence of honour to be **presented as an exonerating or mitigating circumstance** for perpetrators of such crimes, resulting in reduced penalties or impunity. In addition, the formation of criminal cases may be hampered by the reluctance of persons with knowledge of the case to provide corroborating evidence" (paragraph 30).

- In light of this, it recalls the obligation of States to act **diligently**, in a **holistic and coordinated manner** (vertically and horizontally) among all public institutions and to promote the **rights of women and girls and their empowerment**.
- In addition, it also focuses on:
  - "the obligation to take all appropriate measures, including temporary **special measures** (art. 4(1) [172] to modify socio-cultural patterns of conduct)" (para. 31).
  - "ensure that an **independent monitoring mechanism** is put in place to track progress" (paragraph 35).
  - "The regular and comprehensive collection, analysis, dissemination and use of **quantitative and qualitative data**" (paragraph 37).
  - Certain professionals "are in a unique position to identify potential or actual victims of harmful practices (...) [the] rules of confidentiality which may conflict with their obligation to report (...) This obstacle needs to be overcome with specific regulations introducing mandatory reporting of such incidents" (paragraph 49).
  - Work with the community to deconstruct the supposed benefits of harmful practices and find alternatives to the expression of the cultural values that represent them (paragraph 59).

In terms of the EU framework, the key reference is of course the **Council of Europe Convention on preventing and combating violence against women** (2011), the *Istanbul Convention*.

The Istanbul Convention was preceded and followed by a number of significant **institutional actions**; thus, it is necessary to outline:

- The 2004, Stockholm Platform for Action to Combat Honour Based Violence in Europe, which resulted in a number of recommendations to EU Member States.
- Funds and various funding programmes such as: Progress, Daphne, Rights, Equality and Citizenship Programme, ESF, ESF+, NextGeneration-EU.

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[172] General Recommendation No. 25 of the Committee on the Elimination of Discrimination against Women (CEDAW) on the right to education
Women, para. 38.

- Resolutions 1327 (2003) and 1681 (2009), and Recommendation 1881 (2009), which addressed "honour" crimes. These resolutions call for urgent action to be taken and for immigration laws to be amended to make the threat of honour crimes sufficient grounds for a residence permit or asylum. They also call for the enforcement of laws that punish "honour" crimes, excluding honour as a mitigating factor or defence in criminal proceedings (...)" (EPRS, 2015).
- The European Parliament's 2011 Resolution on the face of female poverty in the EU, in which it urges Member States to take the necessary measures to eliminate "honour" crimes.
- The European Parliament's resolution of April 5, 2011 on the new framework for combating violence against women alerted to the existing deficits and specifically referred to "honour" killings and other "honour" crimes, urging the Commission to take more decisive action.
- Directive 2012/29/EU of the European Parliament and of the Council of October 25, 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA, identifies "crimes in the name of honour" as VAW (paragraph 17).
- The March 2012 Resolution on Gender Equality in the EU - 2011, underlines that the Member States' EU Victims' Package must include actions and resources to combat CNH.
- Parliament's legislative initiative resolution of February 25, 2014, with recommendations to the Commission on combating violence against women, made special mention of "honour" crimes.

As for the **Istanbul Convention**, crimes in the name of "honour" are covered in its preamble, in the definition of VAW (Art. 3), in the general obligations of states (Art. 12. 5. *The Parties shall ensure that culture, custom, religion, tradition or so-called "honour" shall not be regarded as justifying acts of violence falling within the scope of this Convention*) and explicitly in **Article 42:**

> Art.42. Unacceptable justification for criminal offences, including offences allegedly committed in the name of "honour".
>
> 1. Parties shall take the necessary legislative or other measures to ensure that, in criminal proceedings instituted for the commission of an act of violence falling within the scope of this Convention, culture, custom, religion, tradition or alleged "honour" shall not be considered as a

> justification for such acts. This includes, in particular, allegations that the victim has transgressed cultural, religious, social or traditional norms or customs relating to appropriate behaviour.
>
> 2. Parties shall take the necessary legislative or other measures to ensure that the encouragement by any person of a child to commit any of the acts referred to in paragraph 1 does not diminish the criminal responsibility of that person in relation to the acts committed.

The Council of Europe (European Council, 2023) considered, in drafting the Istanbul Convention, that CNH "are generally offences that have long been part of the criminal law landscape of Council of Europe member states", and that the difference was **the intentionality**, "they are committed to pursue an objective other than or in addition to the immediate effect of the offence" (the restoration of the family's "honour"). Thus, "in order to take account of this aspect, the drafters of the Convention **abandoned the original idea of introducing a separate criminal offence** for so-called "honour crimes" and agreed to prohibit any attempt to justify criminal behaviour on the basis of culture, custom, religion, tradition or so-called "honour""; this is the reason for Article 42.

Furthermore, **Article 53** of the Convention introduces restraining and protection orders for all forms of violence, including CNH. Similarly, victims of CNH are extended all the remedies and services referred to in the Victim Support Convention (see Articles 22 and 24).

It also stresses the importance for States to consider the **balance between** ex officio **reporting** and the protection of the population at risk and the **necessary confidentiality** required to **provide support** to these victims (Articles 27 and 28); as well as improving their protection (Article 51) and guaranteeing the right to **international protection** for victims (Articles 60 and 61).

The **evaluation reports of GREVIO**, the monitoring mechanism of the Istanbul Convention, have highlighted the remaining challenges in the implementation of the Convention. Thus, the following should be considered in the current institutional context:

- Only four GREVIO baseline evaluation reports, notably those of Albania, Italy, Portugal and Turkey, have addressed article 42 of the convention:
    - make modifications to ensure that not only the perpetrator of the crime but also the members of the family council who made the decision to carry out the murder are charged with the crime;

    - call for the dismantling of the concept that the *honour* and prestige of the man or family are intrinsically associated with the conduct or presumed conduct of the women associated with them;
    - The training of judicial professionals and the monitoring of judicial practices;
    - have an impact on data collection
- Spain is not among these countries, nor are CNH mentioned in the Shadow Platform Report to GREVIO 2018.
- GREVIO has *strongly* encouraged/encouraged signatory parties to integrate the perspective of action on CNH in the design, implementation, monitoring and evaluation of policies to prevent and combat VAW in the *baseline assessment reports* on Albania, Andorra, Belgium, Italy, Portugal, Spain and Turkey (2020:48).

Finally, it should be noted that the Parliamentary Assembly of the **Council of Europe** adopted **Resolution 2395 (2021) Strengthening the fight against so-called "honour" crimes**, which calls on the member states of the Council of Europe:

- It refers to the signing and full implementation of the Istanbul Convention.
- It calls for improving and strengthening care for victims of CNH and its adequate funding.
- Indicates the importance of providing adequate care for LGBTI victims.
- Strengthen asylum and international protection policies.
- Improve awareness-raising activities.

In spite of the existing international framework, **CNHs are still not punishable in many countries** and when they are, penalties have tended - until recently - to be erroneously softened by the existence of cultural beliefs or motives as mitigating circumstances. This results in a patriarchal interpretation of violence and a re-victimisation of women victims of violence.

The SURGIR Foundation notes that "Several explanations can be given for this shameful indulgence: inappropriate laws, the complicity of judges and public authorities, and also a lack of witnesses because people keep quiet for fear of reprisals" (Bernard, 2012:13). There is still a need for **more forceful institutional action** and a more extensive understanding of the complexity in which this form of VAW is expressed (Saldaña 2016; Szygendowska, 2017).

11.3.2. Spanish regulatory framework

In our country, the current regulatory framework refers to the Istanbul Convention (ratified in 2014); together with this, almost all (but not all) manifestations of CNH are included as crimes in **Organic Law 10/1995, of November 23, of the Criminal Code** and would be grounds for granting international protection on gender grounds in our country according to **Law 12/2009, of October 30, regulating the right to asylum and subsidiary protection.**

There is no specific notion of "honour crime" or "honour-based violence" **in our state legislation**. It would be necessary to review our legal practice. On the other hand, many of the expressions of HBV are not easily punishable in our legal framework, for example, the "oppressive framework" experienced by the victims.

As stated in the SPGV (2019; renewed 2022) "the care and recovery, with recognition of the specific rights of women victims of any act of violence contemplated in the Istanbul Convention, and not provided for in the LO 1/2004, will be governed by the specific and comprehensive laws that are issued for the purpose of adapting the need for intervention and protection to each type of violence. Until this regulatory development takes place, other forms of gender violence recognised in the Istanbul Convention will receive preventive and statistical treatment within the framework of LO 1/2004. Likewise, the criminal response in these cases will be governed by the provisions of the Criminal Code and criminal law.

Several of the manifestations of CNH would be considered "family violence", which is regulated in the Spanish Penal Code in **Article 173.2.** Other typologies specifically refer to more explicit crimes of VAW, such as forced marriage, FGM, gender-based intimate partner violence, reproductive violence or sexual violence, which are referred to, in addition to the Criminal Code, in Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence and Organic Law 10/2022, of September 6, on comprehensive guarantee of sexual freedom.

The offences related to CNH **would involve at least the aggravating circumstance of kinship and gender** (among other possible ones), which are included in Chapter IV On the circumstances that aggravate criminal responsibility and Chapter V On the mixed circumstance of kinship of the Criminal Code.

The introduction of the gender aggravating circumstance in our legal framework took place thanks to the Istanbul Convention and is produced through Organic Law 1/2015 of March 30,

which modifies the Penal Code, which among others modifies the 4th circumstance of Article **22, which** considers the aggravating circumstance of gender for reasons of discrimination:

> "22. 4. Committing the offence for racist, anti-Semitic, anti-Roma or other types of discrimination based on the ideology, religion or beliefs of the victim, the ethnic group, race or nation to which they belong, their sex, age, sexual or gender orientation or identity, reasons of gender, aporophobia or social exclusion, the illness they suffer from or their disability, regardless of whether these conditions or circumstances are actually present in the person who is the object of the conduct".

And **Article 23,** with regard to kinship, states that:

> "It is a circumstance that may mitigate or aggravate responsibility, depending on the nature, motives and effects of the offence, to be or to have been the offender's spouse or person who is or has been linked in a stable manner by a similar relationship of affection, or to be an ascendant, descendant or sibling by nature or adoption of the offender or of his or her spouse or partner".

In addition to the above-mentioned loopholes, it is important to note the difficulty of prosecuting these crimes when they are committed abroad.

For their part, **the SPGV and the SSGV 2022-2025** allude to all forms of VAW, and point out in their diagnoses of the state of the issue the existence of CNH and the concern for *honour killings.* Likewise, their actions address all forms of violence and all women, but are clearly not specific to VAW, and there is a lack of a specialised and concrete public policy strategy.

With regard to the frameworks of action of the Autonomous Communities, the diversity of autonomous regulations reflects an unequal presence of the phenomena that characterise the CHN. Forced marriages and FGM are included in many legislations and territorial strategic plans, as well as other forms of abuse that are often associated with the cause of "honour". Similarly, all legislation refers to the Istanbul Convention and thus would cover the main phenomena of VAW referred to therein, including CNH (in Article 3). However, under the notion of "crimes in the name of honour" as such, there are few ACs that use it or refer extensively to its manifestations. The key exceptions are the following:

- Andalusia, in Law 13/2007, of November 26, on measures for the prevention and comprehensive protection against gender-based violence:

> Article 3. Concept, typology and manifestations of gender violence: (...). 4. For the purposes of the provisions of this Law, the following manifestations, among others, shall be considered acts

of gender violence: (...) k) Violence arising from the application of cultural traditions that violate women's rights, such as honour crimes, dowry crimes, extrajudicial executions, executions or punishments for adultery or honour rapes.

- Canary Islands, in Law 16/2003, of April 8, on Prevention and Integral Protection of Women against Gender Violence:

Article 3. Forms of gender-based violence. i) Femicide: homicides or murders committed within the context of intimate partner or ex-partner, as well as other crimes that reveal that the basis of the violence is gender-based discrimination, understood as, among others, homicides or murders linked to sexual violence or carried out in the context of prostitution and trafficking in women, as well as those related to the infanticide of girls or carried out for reasons of honour or dowry.

- Catalonia, in Law 17/2020, of December 22, amending Law 5/2008, on the right of women to eradicate gender-based violence:

Art.5, Violence in the social or community sphere: (...) "g) Feminicides: gender-based murders and homicides of women, inducements to suicide and suicides as a consequence of pressure and violence towards women. (...) j) Restrictions or deprivations of women's freedom, or of access to public or private spaces, or to work, training, sports, religious or leisure activities, as well as restrictions on the free expression of their sexual orientation or gender expression and identity, or their aesthetic, political or religious expression.

- Navarra, in the Foral Law 3/2018, of April 19, for the modification of the Foral Law 14/2015, of April 10, to act against violence against women:

Article 3. Definition and manifestations of violence against women (...)2. c) Femicide: homicides committed in the context of intimate partner or ex-partner, as well as other crimes that reveal that the basis of violence is gender-based discrimination, understood as murder linked to sexual violence, murder in the context of prostitution and trafficking in women, honour killings, female infanticide and dowry deaths.

- La Rioja, in Law 11/2022, of September 20, against Gender Violence in La Rioja:

Forms and manifestations of gender-based violence (...) 1.k) Violence arising from the application of cultural traditions that violate the rights of women and girls, such as honour killings, dowry crimes, extrajudicial killings, executions or punishments for adultery or honour rape, virginity tests or any other cultural practices that violate the dignity or privacy of women and girls.

12. CNH: Relevant experiences

12.1. Results of the surveys of LEs and organisations

12.1.1. The intervention of local authorities

Of the 279 LEs that responded to the survey on RV and CNH[173] , **100% said they knew** -in general- the characteristics of violence understood as CNH, but only 8 municipalities -**2.8%- indicated to carry out** specific **actions** regarding it. In the response of the LEs there is a differentiation, as the survey itself stated, between forced marriages, FGM and the generic category of CNH. Local actions on VAW (chapter 7) describes the characteristics of local intervention on VAW in general. 89.2% of the respondents are members of ATENPRO.

The local entities that claim to carry out CNH actions are in the provinces of Valencia, Toledo, Cuenca, Cáceres, Barcelona, Granada, Valladolid and Madrid. **None of them refers to a specialised approach** to "honour", but to the fact that its manifestations (aggressions, threats, return to the country of origin, forced marriages, etc.) are known by local teams and the detection and care of victims is part of the usual procedures of attention to VAW. Of these, only 3 LE incorporate these forms of violence into the existing protocol or protocols of institutional coordination.

Regardless of the above, the participating LEs did **not considered the inclusion of the CNHs as part of the local** VAW **monitoring roundtables or bureaus.**

According to the answers obtained, **there are no resources that are identified as "specialised"** (local or supra-local) -different- to those available for GBV or male violence. It is to these resources where women, their daughters and sons are referred or attended to.

The **main barriers that are perceived** by the LEs, with respect to the action with the victims, are language barriers, mainly due to the lack of availability of interpreters.

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[173] The characteristics of theLEs are explained in the methodology (chapter 2; their distribution by Autonomous Regions) and are also described in point 7.1.1. concerning the FASC, but which is introduced by the description of local action in general.

Challenges in coordinating cases of violence involving CNH focus on the safety of victims, and specialised health care together with educational institutions. In general, the experience of local coordination is assessed as very positive and is grounded in GBV care procedures.

In the collection of information through the survey, no experiences of interest have been identified that could be established as a good practice. It should be recalled that the study excludes CNH related to FGM and forced marriages (of which there are numerous references in Spain) as a parallel investigation is being carried out by FEMP itself.

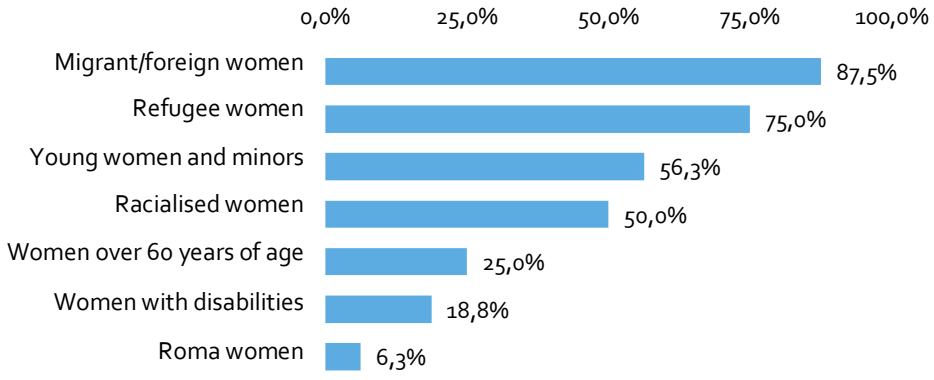
12.1.2. The intervention of organisations and experts

The survey of organisations and experts - focused exclusively on CNH - obtained **18 responses** (from NGOs and universities), most of them from professionals working with women in different fields: psychosocial, health and in the field of the rights of women of foreign origin (although not exclusively). Also, by some researchers in the field.

Their work was mostly **national-wide** (70.6%) and provincial (23.5%), and to a lesser extent local (5.9%) or regional (5.9%). Only 2 organisations were linked to ATENPRO.

The experience in mainstreaming the intersectional gender approach is high in the majority: 68.8% considered that they applied it totally and 25% quite a lot. The women's groups that are most present in their current work are those related to the different diasporas (see graph below):

Graph 12.CNH: most vulnerable groups of women present in the work of the organisations



Red2Red, 2023. Survey of individuals and organisations with expertise on CNH (N=18)

Of the 18 organisations, 11 had experience in working on forced marriages and 8 on FGM, but only **6 organisations** considered that they had experience in "honour killings" (29.4% of the

total responses). Only 2 worked in relation to a protocol of action regarding male violence or gender-based violence. These organisations were all **in the field of international protection** (IP) and social inclusion of refugees and migrants.

The experiences that have been collected in the survey **do not correspond to specific projects on CNH,** but rather the actions - with respect to their manifestations - are part of the attention to people who are users of their NGOs.

These **activities are part of their international reception programmes** and are carried out by interdisciplinary teams:

- Sensitisation and awareness-raising.
- Legal advice and accompaniment (IP and administrative situation).
- Psychological care and emotional support.
- Promoting women's support and empowerment networks.
- Attention to gender violence in its different manifestations.
- Support for social inclusion processes.
- In some cases, it would also involve social research.

In general, the resources for women victims are residential and care facilities. In terms of ownership, some (the minority) are their own. In general, they are residential resources managed by the SAPIT network. In terms of care for violence, NGOs do have specialised human resources and also work in coordination with the local and regional network for victims of gender-based violence, including the law enforcement and security forces[174].

> "We have reception centres and shared flats for the reception phase and interdisciplinary accompaniment throughout the whole process of applying for international protection" (comments to the survey).

> "We have rented housing specifically for women, provided by local administrations and religious entities (they belong to the places financed by the Ministry)".

> "We provide individual and group care and referrals to specialised gender-based violence resources" (open comments to the survey).

[174] Urban Guard, Municipal or Local Police, Regional Police forces, National Police Corps, Civil Guard.

Along with the above, the NGOs point to other women's associations and associations representing certain diasporas or nationalities, as well as international organisations (such as IOM, UNHCR, UNHCR, USA, UNICEF, IRCT, among others).

The experience of the expert organisations in **relation to coordination** is positive, although coordination with resources and institutions poses challenges in the cases of CNH; primarily:

- identification of the problem and awareness of its importance;
- the security measures required for women and children;
- a greater intercultural and gender focus;
- better trained human resources for prevention and detection;
- knowledge of the cultural environment of the countries of origin;
- understand women's fears, the notion of "shame", "betrayal", "loyalty";
- and speed of response.

In terms of **preventing future victimisation** with CNH survivors, it is felt that action depends, to a large extent, on more agile institutional responses:

- Short deadlines for the resolution of IP applications .
- Accompaniment in social integration and health, psychological and educational support.
- Economic autonomy.

In terms of prevention and awareness-raising work, this would differentiate between action towards other agents and institutions and towards society in general. With regard to the former, the improvement of training on this violence and transversal training in the intercultural and gender approach have been pointed out.

With regard to raising awareness in **local society**, the organisations surveyed consider that the following issues need to be addressed:

- to raise awareness that not all countries and the world respect women's rights and that women who transgress, according to the social norms of their environment, are often punished with different practices ranging from isolation to attacks on their physical integrity or rape by family members.

- Intercultural and gender issues, types of violence that are part of gender-based violence.
- not to make it invisible and not to consider it as something exclusively linked to culture or religion.
- As I said before, these should be continuous actions, informing and making visible

In both actions, **women's and feminist associations** are seen as facilitators as well as support resources for the victims themselves.

> "They are spaces for leisure, networking, integration, conciliation, support in care, referents..." (comments to the survey).

As for other **associations related to the origin**, ethnicity or culture of the victims' families, work should be done at the community level to raise awareness of women's fundamental rights. In this regard, it has been pointed out that many victims prefer not to have any contact with their diaspora, because they perceive it as a security risk.

> "Women who have suffered crimes do not usually want to relate to people from their culture or family members...because of the risk they may run in relation to their location, the information they may give to their social environment" (open comments to the survey).

In terms of **experiences of interest** developed by some organisations, the following entities have been highlighted: Accem, CEAR, CER-Migracions (Autonomous University of Barcelona), Amaranta Solidarity Foundation and the Wassu Gambia Kafo Foundation.

12.2. Analysis of international practices consulted

The first 'honour' crime to be recognised as such in the EU was the murder of Fadime Sahindal in 2002, which also led the Swedish police to reopen the case of her boyfriend's murder three years earlier (EPRS, 2015:6). Cases have been reported in France, Sweden, Germany, the Netherlands, Belgium, Italy and the United Kingdom (which is no longer a member of the Union). The UK is considered to have the highest number of cases, not least because it has vastly improved mechanisms for accessing reporting and measuring prevalence in recent years.

Within the European Union, Germany, the United Kingdom and Sweden are particularly known as countries where CNH are of public concern with regard to VAW. They are established multicultural societies and the women's movement has actively worked for public policies for their eradication. Denmark, Switzerland and the Netherlands are states where the authorities have also implemented actions of great interest, although they are not covered in this study.

The aim of this section is not to carry out comparative research, nor to present a detailed analysis of the situation in these countries. The aim of this section is more humble and more precise. Given the lack of information on local experiences in Spain we have sought examples of care resources that can serve as *models* and from which to draw lessons for local action. In this way, a description of these practices is given, briefly contextualising the different approaches used.

12.2.1. Experiences from Germany and the UK

As the researcher Ercan (2014) explains, Germany and the UK have different solutions to the same problem. While in the UK the debate focused on the gender dimension and is addressed by VAW, in Germany it has been considered as a more culturally specific crime with less attention from feminism and more from multiculturalism.

12.2.1.1. United Kingdom

The UK has improved **legal protection** for victims of harmful practices and *Honour-Based Abuse* (*HBA*) under the VAW approach in recent years. This legal framework has recently been

reinforced in 2023[175] together with the improvement of the prevalence study through **national statistics** on VAW (from 2020).

In 2007, the police unit specialised in violence against women and girls (*Association of Chief Police Officers Honour Based Violence Working Group*) was created with special units ("community safety units"). The State Prosecutor's Office has had a specific strategy since 2008. This includes extradition requests to prevent crimes from going unpunished if the victim flees abroad or is abducted to return to their country of origin (Fundación SURGIR, 2012); there is a specialised institutional website on the subject (mainly aimed at young people) and a national support and consultation line (telephone).

> According to some of the organisations based in the UK that provide specialised services to victims/survivors, the cases identified as CNH represent the tip of the iceberg given the difficulties in reporting; furthermore, although statistics have improved, they do not take into account the large number of women and girls who are taken abroad and do not return to the UK.

Since 2015, a **National Day of** *Memory for Britain's Lost Women* (*Day of Memory for Britain's Lost Women*) has been celebrated in the United Kingdom (UK) on July 14. The date coincides with the paradigmatic case, which opened the social and legal debate, of Shafilea Ahmed, born in Bradford and murdered in Warrington in 2003 at the hands of her parents of Pakistani origin. It is her birthday.

Specialised resources are managed and implemented by NGOs. These are mostly (especially the pioneer) organisations, associations or foundations, created by women who have had first-hand experience with CNH; they are funded by government agencies, mostly state agencies and other non-profit organisations with more resources.

Some of the NGOs[176] whose work can serve as an example of good practice are:

- **IKWRO** (Iranian and Kurdish Women's Rights Organisation): Represents women and girls at risk of honour-based violence from any community in the Middle East, North Africa and Afghanistan. They have taken part in the research as informants.
- **Karma Nirvana**: Runs the *National Honour Based Abuse Helpline* for people threatened by this kind of violence. The organisation estimates that currently, in one in five cases, the victim is a man.

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[175] See The Code for Crown Prosecutors (accessed).

[176] Other organisations listed as specialist resources by the UK police can be found on their website (access).

- **Halo Project**: Initiated in 2011 in response to the need for services for racialised black and minority ethnic women and girls who are victims of domestic and sexual abuse and violence.
- **Henna Foundation:** It was also a recognised entity in this field supporting Muslim women and girls, but ceased its activity in mid-2022.

The characteristics of UK practices of interest are briefly explained below. It should be noted, in all cases, that:

- all services are anonymous and confidential,
- are provided by qualified HBV professionals.
- Mediation with families is never carried out, although this may vary depending on the legislation on working with children under 16 years of age, which depends on the public child protection services.

Experience 1: HALO PROJECT

- **NGO:** (access)
- **Type of service provided:** consists of a specialised support centre to provide information, counselling and personalised advocacy to women and girls at risk (of sexual and domestic abuse, forced marriages, honour crimes, FGM), survivors and professionals. Services provided include:
  - Search for safe shelter or emergency shelter and community support.
  - Awareness-raising programmes through Halo-Hubs in partnership with universities.
  - Training of professionals and advice to NGOs (with various guides and manuals to support link).
  - Independent review of domestic homicides and support for collective reports to the police.
  - Participation forum to give victims a voice.
  - Advocacy.
  - Emergency telephone number.

- **Functioning of the resource:** Registered national charity founded in 2011. Receives government funding. It is staffed by women only. Since 2014 operates a network of Halo-Hubs across the country.

  It works from a basic 6-module methodology to recognise abuse, understand its impact on children, know where to seek help and feel safe. It is complemented by therapies to reduce stress and anxiety, English language courses, financial support and employability support. Accredited in 2022 with the national quality standard "Women's aid".

- **Criteria or principles for action**: Empowerment of survivors to break the cycle of abuse and recover from trauma. Awareness raising and education of future generations. For a society free of cultural violence (forced marriages, honour killings and FGM) against black and minority women.
- **Results to highlight:** They have supported over 3,000 women from over 49 different ethnicities by helping them move from a situation of unsustainable violence to a life free from abuse. They have trained over 3,000 professionals from various fields: care, police, education and the justice system. They were the driving force behind the 2020 'super police complaint' by the Centre for Women's Justice (CWJ), which alleged that law enforcement agencies were failing to respond adequately to domestic abuse cases, which is considered to be at the root of social change in the UK.

Experience 2: IKWRO

- **NGO**: Iranian and Kurdish Women's Rights Organisation (access)
- **Type of service provided**: comprehensive interdisciplinary assistance. Resources include:
  - Free counselling, psychological care and legal defence provided by specialised professionals (women).
  - They offer their services in several languages (Kurdish, Farsi, Arabic, Dari, Pashto, Turkish and English), based on an email request for help. The professionals travel to the victim's location for confidential face-to-face counselling.
  - They deal with cases of forced marriage, child marriage, marital captivity, FGM, virginity testing and hymenoplasty, Sharia courts, etc.

- Shelter: safe and specialised accommodation for young and single women.
- Training and emotional support for women and girls to help them understand their rights.
- Collaboration with educational organisations, helping them to access English language classes, education, training and employment opportunities.
- Counselling and training for public and voluntary sector professionals to better understand the needs of victims, the types of abuse they experience and to learn about good practice in prevention and support services.
- Awareness raising with campaigns to raise awareness and improve laws and policies to address all forms of "honour" based abuse and other harmful practices.
- True Honour *Awards*: *True Honour Awards* are held annually to recognise individuals and organisations that work on VAW. They commemorate the women killed each year.
- They network and participate in local VAW roundtables as part of their coordination and advocacy procedures.

- **Operation of the resource**: Registered charity founded in 2002. Beneficiaries are women and girls from the Middle East, North Africa and Afghanistan living in the UK, who have experienced or are at risk of all forms of 'honour' based abuse (including; forced marriage, child marriage and female genital mutilation (FGM), or domestic abuse).
- **Principles of action**: human rights, gender approach and interculturality. Networking. Empathy. No victim without response. No limit to the time allocated to care. Networking and coordination in local and national spaces.
- Results to highlight: In 2022 they served more than 2,200 women and girls. They develop awareness-raising **campaigns** with high community impact. They have a very high level of implementation in at-risk communities due to word of mouth, respect for confidentiality and a permanent individualised response over time. The average length of care for a client is 4 years.

Experience 3: Karma Nirvana

- **NGO:** (access)

- **Type of service provided**: National *Honour Based Abuse Helpline* for victim counselling, training for professionals, awareness raising and advocacy and social research. Main resources:
    - Raising public awareness with campaigns against honour-based abuse (girls, women and men).
    - Victim support, empowerment and training by phone and email; legal and welfare counselling and temporary accommodation. The victim can call or ask to be called.
    - Advice to other professionals working on or facing CNH cases.
    - Face-to-face and virtual training programme for frontline professionals (police, social workers, teachers, health professionals, etc.).
    - Knowledge production: reports for reflection; generation of own data (with quarterly statistics from 2019); analysis of other information from external partners.
    - Awareness-raising and advocacy campaigns.
- **Operation of the resource**: Registered national charity with government funding (Home Office and Ministry of Justice) founded in 1993. It is considered to be the first British NGO specialising in the care of victims/survivors of honour-based abuse. It serves both foreign nationals living in the country and British nationals living abroad. In 2008, the Helpline was launched. It networks with other NGOs such as the Esmée Foundation and The Henry Smith Charity.
- **Principles of action**: Teamwork. Active listening, guaranteeing confidentiality, respect and empathy with the victim. Reaction by seeking solutions according to each individual situation and channelling attention within the team or to other external services, including opinion leaders.
- **Results to be highlighted**: It has the recognition of the "Helplines Standard" quality mark. Between 2022-23 the HelpLine has received more than 120,000 calls (45% of professionals) dedicating almost 1,300 hours and have assisted 2,540 victims (536 with experience or threat of forced marriage, 210 of them girls). Between 2021 and 2022 they have trained 6,712 professionals in 108 virtual sessions.

12.2.1.2. Germany

In Germany, CNH are presented in aggravating terms and are considered murder, and are of particular concern in the regulations concerning the rights of girls and adolescents. Some "Länder" (federal states) are more active than others in awareness-raising, prevention and victim care policies (Fundación SURGIR, 2012).

The German Association of Women Lawyers reports in the public media[177] that in the case law, CNH are classified in a different social context than femicides caused by domestic violence and are punished with a different severity, as they are seen as a problem particularly linked to ethnic or religious minorities.

This consideration has opened a heated debate that has spread to courts, parliaments, the media, and the German public sphere in general, as some advocate that the families where these crimes occur should leave the country, which fits into the migration policy debate and has been diagnosed as a failure of multiculturalism in the country (Ercan, 2015)[178] .

Accessible information on figures on the incidence of honour killings in Germany is very disparate. A 2011 study by the Max Planck Institute[179] estimated the number of honour killings in Germany at around 12 per year. However, it is also considered by specialised NGOs to be vastly underestimated.

There are also grassroots organisations that develop victim services. Concern about CNHs intensified after Hatun Sürücü, a 23-year-old Turkish-Kurdish girl, was murdered by her brother in Berlin in 2005 because she wanted to become independent and break away from family rules by refusing a forced marriage.

Some of the organisations with the longest track records are:

- **Terre des Femmes (TDF):** Germany's largest women's rights organisation with more than 2000 members.
- **Papatya**: intercultural NGO that counsels and protects girls and women victims of honour crimes. They have participated as informants in the study.

Details of these experiences are given below.

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[177] As in Deutsche Welle (DW), the international news broadcaster in Germany (access).
[178] Ercan, Selen (2015). Creating and Sustaining Evidence for "Faliles Multiculturalism". The case of "Honor Killing" in Germany. Journal of American Behavuiral Scientist, 59, (6): 658-678. 15/04/2015 (accessed).
[179] Kasselt, J. (2011). Honour Killings in Germany. Executive Summary. Max Plank Institute (accessed)

Experience 4: TERRE DES FEMMES

- **NGO: (**access)
- **Type of Service provided**: no longer operates as a counselling centre but as a women's and girls' rights awareness organisation in VAW with a specific section on HBV. Provides:
    - Awareness-raising and information projects on discrimination, exploitation, abuse, persecution of women and girls. These include: the school theatre project: "My heart belongs to me - against forced and early marriages" and the "White Week" project in Berlin schools to work on prevention with young people and to offer specific help.
    - Awareness-raising, especially among the media
    - Research and dissemination of statistics on affected women and girl victims in Germany
    - Advocacy for the improvement of legislation and public policies.
    - Networking with other organisations and supporting self-help projects for victims.
- **Functioning of the resource**: German non-profit NGO, headquartered in Berlin, with an international presence. Since its foundation in 1981, it has more than 40 years of experience in awareness-raising, campaigning, press and public relations, networking and lobbying at national, regional and international level. Until 2019, it had its own counselling centre, where 200-300 women and girls a year were assisted.

  It is organised in advocacy working groups. It is financed by donations from individuals, as well as EU and other state-sponsored initiatives.

- **Principles of action**: defence of all violations of women's human rights. Networking and coordination at local and state level. Advocates for: equal rights before the law, self-determination in sexuality and life decisions, and freedom from role restrictions and all forms of violence.
- **Results to highlight**: It associates more than 2,000 members. It was involved in the preparation of reports: "Forced marriages in Germany" (2011), which found 3,443 victims of forced marriages in 2008; and "Honour killings in Germany 1996-2005" (2011) which examined 78 cases. It established that in Germany there were 12 cases

per year registered by the judiciary. In 2022 their school survey identified 1,847 cases of HBV.

Experience 5: PAPATYA

- **NGO: (**access)
- **Type of service provided**: crisis centre with face-to-face and online comprehensive care by expert professionals.
    - Provides a crisis care service assisting girls and women (mostly refugees or migrants) in a safe place (secret address in or outside Berlin) who are at risk or need to flee their families because of: family violence, threat or reality of forced marriage, strict family controls (oppression), sexual violence and other similar issues.
    - They support girls and young women in planning their own lives and in dealing with their families.
    - They offer a free telematic/presential counselling window (SIBEL) in several languages (German, English, Kurdish, Arabic, Farsi and Turkish) with guarantees of anonymity and confidentiality.
    - They advise professionals and individuals who want to help affected victims.
    - They also pay attention to the cases of girls and women held abroad so that they can return to Germany.
- **Functioning of the resource**: NGO founded in 2004. Its core funding comes from the Land of Berlin. The crisis centre Papatya is funded by the Department for Education, Youth and Family (Senatsverwaltung für Bildung, Jugend und Familie). The online counselling service SIBEL is in turn funded by the Department of Health, Care and Equality (Berliner Senatsverwaltung für Gesundheit, Pflege und Gleichstellung), together with the Brandenburg State Office of Social Affairs (Landesamt für Soziales und Versorgung des Landes Brandenburg).
- **Principles of action**: feminism, interculturalism. The young people are accompanied 24 hours a day after their acceptance/entry into the centre. They work in close cooperation with the Youth Office (Jugendamt), Jobcenter) and other public institutions. Networking with all kinds of social and feminist organisations for coordination and for local and state advocacy.

- **Results to highlight**: Since its inception they have helped more than 2000 girls and young women. Between 2002 and 2019 it has won several awards and prizes: Berlin prevention Prize State Commission against violence; German Federal Service Cross (Bundesverdeninstkreuz) and Lothar-Kreyssig-Peace-Prize Foundation of the Protestant Church Group Magdeburg.

12.2.2. The particular case of Sweden

Sweden is one of the EU member states that has been concerned about VAW for the longest time, since the honour killings of Sara Abed Ali in 1996, Pela Atroshi in 1999 and Fadime Sahindal in 2002.

According to the Swedish Agency for Youth and Civil Society already in 2009, around 70,000 women and men living in the country reported that they were under family pressure and at risk of being forced to marry against their will. Ten years later, the Swedish police authority started a specific monitoring of honour-related crimes and, by November 2021, 4,500 alleged crimes had been registered.

Although a **National Team** with Competence in dealing with honour crimes already existed since 2005, it was in 2018 through a **State Regulatory Charter**, and as part of its gender equality policies, that the Swedish Government mandated the provincial administrations to strengthen preventive work on men's violence against women, the design of regional action plans and the promotion of cooperation between relevant actors.

In this way, **the development of resource centres** for people who have been victims of violence by family members was promoted, with a special focus on honour-related violence and oppression, where they can go for support, advice and counselling.

As of October 1, 2022, the **National Centre against Honour-related Violence and Oppression** was established to replace the National Team. **Legislative development** in the country has run in parallel, and two recent milestones can be identified:

- From July 1, 2020: regulations on child marriage offences and travel bans for people vulnerable to abuse abroad and on grounds of honour came into force as a basis for increased penalties.
- From June 1, 2022: Oppression or crime based on honour in all its manifestations is recognised as a criminal offence. Persons found guilty can be sentenced to between 1-

and 6-years imprisonment. Apart from that a foreigner convicted of an honour crime also runs the risk of being deported from Sweden, depending on his or her ties to Swedish society.

- Criminal actions that may constitute **oppression in the name of honour** refer to the penalty provision in Chapter 4 of the Swedish Penal Code (among the crimes against liberty and peace), and may include assault, unlawful threats, sexual harassment and criminal damage, as well as breach of restraining orders.
- Someone who has subjected a person to assault, threats or ill-treatment can be sentenced to harsher penalties (than those in the Penal Code) if there is an honour motive behind the crime.
- In cases of more serious crimes such as murder, rape or FGM, it is not intended that they will be dealt with under the heading of honour crimes, but will be treated separately as a serious crime against the integrity of women.
- For the courts to increase the penalty for an offence, it is sufficient that one of the motives for the offence is honour. Therefore, the preservation or restoration of honour need not have been the sole or main motive for the offence.
- One difference between the aggravating circumstance and the new offence of honour-based oppression is that the regulation of the new offence allows the police and prosecutors to investigate more effectively those where honour has been a motive. Specifying this ensures that the question of whether there was an honour motive behind the crime is considered throughout the investigation and documented.

Experience 6: National Centre Against Honour-Related Violence and Oppression

- **Entity: National Centre against Honour-related Violence and Oppression (NCH;** Hedersfortryck in Swedish) is the key public care structure in the country. Its activity is branched out into provincial divisions or County Administrative Boards. (access)
- **Type of service provided**: it has different lines of work, some aimed at administrations and others at citizens, such as:
    - Coordination of public agencies and services (such as: Social Services, Education Services, Police and Taxation and Health Care), in order to detect signs of vulnerability in potential victims, possible risks and red flags for honour-based crimes from these areas and to comply with the new regulations.

- Support to municipalities and regions to monitor and evaluate their actions in this area.
- Helpline or Helpline for citizen care professionals and volunteers by receiving phone calls from all over the country.
- Additional guidance on the difficulties of these professionals in providing support and protection to vulnerable people.
- Information material and campaigns on legal protection for victims in different languages.
- Generation of quarterly statistics on the use of the helpline.
- Compilation and dissemination of knowledge on honour crimes through research and proven experience (e.g., Guides and Reports).

- **Criteria or principles for action**: its mission is to support and contribute to strategic, preventive and knowledge-based work against honour-related violence and oppression at national, regional and local levels.

  Part of the research and follow-up actions are carried out in a network with other public authorities (Victims of Crime Agency, the National Board of Health and Welfare, the Police Agency and the Public Prosecutor's Office) and Universities, and in the longer term with local NGOs.

- **Functioning**: Established in 2005, inter-regional coordination was mandated by the Swedish government in 2020 and relies mainly on the call service (which had already existed since 2014). During 2021 and 2022, the Centre coordinated a joint mission of information and guidance authorities in the field. This mission has since become permanent.

  Funding is organised from the allocation of surplus funds from the county administrative boards in each county and supplemented by additional funding from the Swedish Government (the Regulation Charter increases by 2023 from SEK 10 million to SEK 15 million state budget).

- **Results**: Since 2022, 21 counties have been able to report specific data. The joint institutional mission coordinated by the National Centre has generated:
  - Information targeted at almost 600,000 potential victims and almost 750,000 professionals. The majority of calls to the helpline come from social service

professionals. This is followed by calls from educational staff (schools and colleges).

- Very significant increase in the number of visits to the website www.hedersfortryck.se and to social media where information is disseminated, including a Guidance Guide for practitioners.
- A pioneering survey on forced marriages and abductions in a CNH context was conducted in 2019. Cases of abducted persons were found in 43 of the 192 municipalities surveyed. A total of 199 affected persons were identified (86% of them minors).
- The year 2022 saw the publication of the National Team's research "To make the invisible visible. A socio-economic analysis of honour-related violence and oppression" was published. It proposes procedures for comprehensive care, detection and action.
- In 2023 it published the "Final report of the agency-wide mission on information and guidance in the work against honour-related crimes" which is divided into two parts. On the one hand, new legislation and legal protection against honour-related violence and oppression. On the other hand, a guide for social service, health care, school system and police staff on how to prevent and respond to HBV.

Some of the **characteristics of this national resource** in CNH care are discussed in more detail below.

The NCH is geographically located in Östergötland County, and from there a **steering operational group at national management level** coordinates the networked activity of the other provincial resource centres, although these have been progressively incorporated. The first counties that started operations with financial support from the Swedish government were called "pilot counties", followed by "the new counties" and those that have just joined in June 2023 are called "Group 3 counties".

As of 2014, a call-in **helpline was** set up at the NCH, staffed by a multidisciplinary team with cutting-edge expertise and knowledge on HBV, whose attention can refer to different professional profiles for more specialised attention (such as police officers, sociologists and researchers).

Calls are received from people at risk of human rights violations, mainly girls and young women exposed to many different types of violence, blackmail, rape, restraint and

control, victims of various perpetrators (usually parents, brothers or other relatives) in a family environment that supports these behaviours or allows them by arguing collective values about concepts such as honour, dishonour or shame, and from which they control the behaviours, bodies and sexuality of the women in their community.

The NCH also provides **methodological support** and deals mainly with the many queries from professionals in the social services or educational field.

In these cases, they are guided on how to assess threats or risks, how to intervene and how to care for and relocate victims if necessary.

Part of its activity focuses on **data generation and knowledge production**.

The NCH generates quarterly statistics[180] and issues Annual Activity Reports, also compiling what the other resources in the counties do by providing them with a common recording and monitoring methodology. As a specialised centre, it is described in more detail at the end of this section.

Alongside the National Centre and the structure of dependent resource centres, there are **other public authorities** whose activity also contributes to the prevention of or response to HBV. Between 2021 and 2022 they all formed an institutional partnership in the so-called **Joint Mission for Information and Guidance in the work against honour-related crimes**[181] . These are:

- The **Agency for Victims of Crime** (Brottsoffermyndigheten). It is attached to the Ministry of Justice and has four areas of work: compensation for criminal damages (it decides and pays compensation contributing to the reparation of the damage); the claim to the perpetrators so that they take responsibility for the damage caused; the provision of a Fund for financing projects to improve the knowledge of the problem, the treatment of victims and support for witnesses (the Fund is fed by various contributions, but above all by a special fee paid by the perpetrators); and the Centre for information-dissemination of the results of research and events for the transfer of knowledge in the field, with special governmental allocations.

[180] The most recent statistics are for the quarter March-June 2023, referring to indicators such as: types of calls, average number of vulnerable people per case, cases handled per month, distribution by gender, type of violence to which they have been exposed, profile of the abuser, profile of the caller and cases per county (access).
[181] Östergötland County Administrative Board (2023). Final report of the authority's joint mission on information and guidance in the work against honour-related crimes (access).

- The **National Board of Health and Welfare** has a Social Welfare Committee which, in the specific case of CNH, can apply for a ban on girls travelling abroad to prevent them from being subjected by their relatives to FGM or forced marriages, applications which are submitted to an administrative court, and which even in certain urgent cases can take the form of a temporary restraining order.
- The **Police Agency and the Prosecutor's Office,** whose mission is to protect the public and to enforce the relevant legislation.
- The **Swedish National Agency for Education as a** cooperation agency.
- The **Consular and Civil Legal Affairs Unit** of the Ministry of Foreign Affairs, which has a consultative role.

13. Conclusions

This research has been developed under an **exploratory approach through methodological triangulation**. In addition to an analysis of secondary sources, 5 surveys have been used to reach 288 local entities (LEs) and 108 organisations specialised in VAW or care for vulnerable groups throughout Spain, and some in Europe. Interviews were also carried out with the participation of **25 expert informants** and **13 practices of interest** for the local level were described.

The result of the work shows an overwhelming reality on which it is necessary to improve knowledge and data production, as well as comprehensive care for these victims of *other forms* of violence against women: RV and HBV.

Violence against women (VAW) is a social, political, economic and public health problem (UN, 2006). However, not all forms of VAW are equally visible to society, nor to the women who suffer from it, given its extensive degree of normalisation in their lives. It has been noted:

- This report suggests paying particular attention to the **following six manifestations of RV**: 1. lack of attention to sexual and reproductive health; 2. barriers or prohibition to contraception and voluntary termination of pregnancy; 3. gynaecological and obstetric violence around childbirth; 4. harmful practices (e.g. child marriage, forced marriage; female genital mutilation; virginity inspection); 5. surrogacy or surrogate pregnancy; and 6. contraception and voluntary termination of pregnancy. harmful practices (e.g., child marriage, forced marriage; female genital mutilation; virginity inspection); 5. surrogacy or gestational surrogacy; and 6. forced contraception, abortion and/or sterilisation for menstrual control and/or the impediment of free exercise of motherhood. The research has focused only on the last two typologies and has explored some harmful practices in relation to CNH. However, all of them find their framework of understanding in the notion of SRHR and gender-based violence.
- Forced abortion, forced sterilisation, forced contraception (FASC) and surrogacy are forms of violence against women that violate their reproductive capacity and rights. This reproductive violence (RV) is one of the least known to society.
- Women's sexual and reproductive health (SRHR) and rights (SRR) are still **very little present in public agendas,** even in health and gender equality agendas. However, their

attention is key both to guaranteeing the wellbeing of half of the population and to detecting many of the forms of violence to which women and girls are still subjected.

- RV **has a specificity of its own**, and is exercised by different actors in various forms: by couples, by families, by institutions and professionals, and also by criminal networks and other commercial actors.
- **Honour-based violence** (HBV) or so-called crimes in the name of "honour" (**CNH**) are related to other forms of violence such as SV and RV, but their very specificity means that victims face a context of **permanent oppression** that is accompanied by harmful practices and violence of varying severity, up to its most extreme expression: femicide.

On the other hand, research has shown that the reproductive dimension is an **expression of harm from other types of** VAW.

- RV is concomitant with sexual violence, violence in intimate partner/ex-partner relationships, and CNH, among others. They are deeply interrelated. Therefore, **the detection of one should lead to hypothesising the presence of both forms of RV and HBV**.

As the United Nations pointed out almost two decades ago, "Male violence against women is generated by sociocultural attitudes and cultures of violence in all parts of the world, and especially by norms concerning the control of women's reproduction and sexuality" (UN, 2006:27; para. 57).

- FASC encompasses practices that go beyond the violation of the right to maternity and involve the **subjugation of women**.
- Within forced abortion, its relationship with **selective abortion as a sex-selective practice in Spain** has been explored. The available data point to a phenomenon of discrimination that occurs in our country and to which attention should be paid. Especially in Ceuta and the provinces of Cuenca, Badajoz, Valencia, Burgos, Cádiz, Segovia, Málaga, Asturias, Huesca and Vizcaya, which have more than 109 boys for every 100 girls born, which is an indicator of population asymmetry.

All women can be victims of RV, but specific groups face situations that make them much more vulnerable. In general, groups of women who hold discriminatory, eugenic and enabling beliefs are at risk of FASC.

- Women with disabilities, especially WIDD, multiple disabilities and cerebral paralysis, are the most affected.
- Roma women and women from ethnic minorities, as well as migrant women in unsafe transits, or at risk of social exclusion, women seeking international protection and women from some diasporas.
- Alongside them are women in confinement or certain isolation (prison, internment centres for foreign nationals, clinics or hospitals); women with mental illness, HIV and other pathologies; and transgender people who may undergo sterilisation prior to reassignment.
- Of course, victims of gender-based violence (GBV), sexual violence (SV) and sexual and labour exploitation face the reproductive consequences of such violence. In many cases, as in the case of women with disabilities, sterilisation masks the sexual abuse to which they are subjected.

The needs of victims of RV are common to those of all VAW and the violation of their rights means that their reparation needs require the same care services; however, sexual and reproductive health services (gynaecology, midwifery, obstetrics, sexology) play a central role in the comprehensive recovery of women.

Women facing HBV have the same needs, in addition to confidentiality, cultural understanding and protection. The notion of safety transcends the forms that are currently available. To repair the damage and guarantee the rights of CNH victims, it is necessary to improve detection indicators, to study, design and implement protection strategies, to incorporate the international dimension into action on victims and to combat racism and xenophobia in a cross-cutting manner. Likewise, the linking of policies to combat VAW should reinforce their coordination with policies for international protection and social inclusion of migrant populations.

The profile of the main women affected by RV and CNH implies - inevitably - **ensuring** women's **universal and cultural accessibility** to all resources and working from an **intersectional gender approach**.

- It is very important in this sense to **dehomogenise** the group of women with disabilities and to address in a specific way the different disabilities, which have different demands.

- The same applies to **migrant** women **and their descendants.** It is necessary to point out that the reception or support processes they need are different depending on how they enter the country and above all on the type of violence they suffer. For example, victims of harmful practices or forced abortions due to prenatal sex selection do not usually have family support (a situation that victims of GS may also face); those who arrive in Spain for family reunification are afraid to denounce their partners in case they are expelled back to their country (they are unaware of the right that protects them); the same happens with HBV who face multiple perpetrators among their family members.
- In general, these are groups of women who are characterised by: facing the absence of emotional support networks and resources; being unaware of the fundamental rights of women in Spain; having experienced violence and lack of protection by civil servants and security forces in their countries of origin or in transit countries, or both. This extends to the experiences of Roma women.

The institutional framework for combating GBV needs further development and specificity in Spain. It is insufficient. As for RV, it defends SRHR as part of the fundamental rights (to health, information, freedom, security, equality and non-discrimination, among others) and a life free of violence for all women.

- SRHR are explicitly stated in the Declaration on the Elimination of Violence against Women (1993) and are alluded to in numerous recommendations and comments in other international human rights instruments, including: CEDAW General Recommendation 35 *on gender-based violence against women, as well as* the framework on the rights of persons with disabilities and specifically women with disabilities (CRPD) and children's rights.
- In the European context, Article 39 of the Council of Europe Convention on preventing and combating violence against women and domestic violence (2011), known as the Istanbul Convention, refers to forced abortion and forced sterilisation.
- The Parliamentary Assembly of the Council of Europe has condemned prenatal sex selection as a phenomenon that reinforces VAW; and the European Parliament considers it to be *gendercide* and a violation of fundamental rights.

- Likewise, different resolutions of the European Parliament have shown their concern for the situation of SRH and SRR of women and women with disabilities, explicitly referring to the eradication of this violence.
- The Proposal for a European Directive on combating violence against women and domestic violence, which is expected to be adopted imminently, also refers to the eradication of forced abortion and forced sterilisation. It also calls for improved action on VAW or CNH.
- The normative review of GS is particularly characterised by an absence of international consensus. In this regard, the lack of international normative recognition of this practice as a form of RV is noted.

All of this has been included in **our national framework**, mainly through the ratification of the Istanbul Convention in 2014.

- The development of more recent regulations has given more attention to RV. Thus, we have LOSSRIVE (art.2 and art.31) and Organic Law 1/2023, of February 28, which modifies Organic Law 2/2010, of March 3, on sexual and reproductive health and the voluntary interruption of pregnancy. It defines violence in the reproductive sphere, FASC, and provides public authorities with sufficient references to work towards guaranteeing women's SRR at any administrative level.
- The Penal Code (1995) covers offences relating to most expressions of HBV, but does not easily cover some expressions. It would be interesting to see the possibilities of adapting the British and Swedish models to the Spanish context.
- The PC specifically covers non-consensual abortion and forced sterilisation. The latter was legal against women with disabilities (or legally incapacitated women) until the arrival of Organic Law 2/2020, of December 16, amending the Criminal Code to eradicate forced or non-consensual sterilisation of persons with disabilities who are judicially incapacitated.
- Although Law 12/2009 of October 30, 2009, regulating the Right of Asylum and Subsidiary Protection, embraces the protection of women for reasons of gender, the RV and the CNH are not made explicit; neither is the Regulation governing the International and Temporary Protection Reception System (but it does allude to VAW).

- The SSGV 2022-2025 is the normative reference that recognises manifestations of violence more broadly, but they do not appear specifically in the measures that develop it. The same applies to the SPGV.

Our institutional framework **is not very explicit** (for RV and HBV) in relation to the strategies and plans that order public policies, whose references are important, but too generic.

- There are references to FASCin: the PEIEMH, (Axes 3 and 4); the PECVG (Axis 2, improving institutional response); the SSGV (2022-2025) (Diagnosis and Axis 2 Awareness raising, prevention and detection and Axis 3 Protection, security, care and reparation). The ENSRR (2011) refers to pregnancies and forced abortions in relation to sexual violence.
- The references to GS are very specific, they are found: in Law 35/1988 and subsequent Law 14/2006; in article 221 of the Criminal Code; in the National Strategic Plan against Trafficking and Exploitation of Human Beings (2021-2023); in the SSGV 2022-2025; and in Law 1/2023 which modifies Organic Law 2/2010. However, there are other references that conflict with the recognition of GS in the aforementioned legislation, such as the Instruction of October 5, 2010, which allows for the filiation of babies born by GS outside our borders.
- The regional framework is very uneven, as pointed out in the GREVIO report (2020). It is not very explicit in its normative references and there are considerable differences in the services and resources that are available from one territory to another.

The mapping of the attention to RV has demonstrated the interest of the LEs to intervene in all types of VAW, but also their lack of knowledge about it.

- Less than 25% of local entities consider that they fully apply the intersectional gender approach in their work on VAW, which makes it difficult to identify victims, especially the lesser-known forms.
- 29% of the LEs do not know what the FASC consists of. Only 18.5% have had direct contact with the RV in the course of their work.
- With some exceptions, there is a lack of specialised resources for RV, both at local and supra-local level. Care is mainly provided through specialised GBV services, or in their absence those related to SRHR (in general).

- The experiences analysed focus on the promotion of SRHR and their relationship with SV and HBV. Organisations that support and defend women with disabilities are the organisations with the most experience and resources in dealing with FASC.
- The success of these practices lies in training, coordination, ensuring universal accessibility, as well as adaptability to the individual situations of each user and to each type of disability.
- Local organisations and entities have very little experience of working with CNHs, with the exception of forced marriages and FGM (which are not part of this study). In general, organisations defending migrant women and those specialising in the right to international protection have the most experience in working with victims.

Any intervention on RV or CNH must be based on alignment with the principles and actions set out in the Istanbul Convention.

- The response to RVs and CNH corresponds to all spheres of **institutional responsibility** (prevention, protection, assistance, reparation to victims and promotion of justice) which is based on the guarantee and effective recognition of the rights of all victims. In other words, it responds to the notion of due diligence.
- **Economic resources** are essential for the care of victims, among other things to ensure the stability of care staff and to support the incorporation of new professional profiles, which are not currently present in VAW care and are necessary.
- Sexual and reproductive health strategies, together with strategic plans on combating VAW, and plans for international protection and social inclusion of vulnerable populations, should systematically consider screening for RV and CNH in a cross-cutting manner.

Although violence against women is a complex problem that requires a clearly multidisciplinary approach, **the strategic role of health care must be** emphasised (Ruffa and Chejter, 2010).

- Health care not only facilitates the availability of preventive treatments to reduce specific risks associated with violence, but also fulfils a legitimising and facilitating function, as it comes from the health system and is public, free and socially recognised. On the other hand, the availability of health professionals for women in a climate of privacy where victims can report the situations they face in confidence, and the

availability of a system of resources spread throughout the territory and increasingly sensitised, with protocols for alerts and coordinated reaction with other services, are key (Ruffa and Chejter, 2010). For this to be the case, it is essential to work with an intersectional gender perspective and under the principles of universal and cultural accessibility.

- In this context, **the key areas for the detection of RV are**: health services, both primary care services (nursing, medicine, midwife, social work unit) and those specialised in mental health, gynaecology and obstetrics. Likewise, equality resources, those focused on comprehensive psychosocial care, are the ones that will favour the victim's recovery.
- **The key areas for the detection of HBV/CNH** are, along with health care, education, given that they have a significant impact on the adolescent and youth population; as well as those that promote the reception and social inclusion of vulnerable or foreign populations.
- **Empowerment, antigypsyism/antiromanism, racism and xenophobia** are barriers that hinder and impede access to and use of resources for victims of RV and HRV. It is necessary to work from the consideration of the **intersectional gender approach** as an essential condition to guarantee the rights of victims.

There is a need to **improve knowledge** about lesser-known forms of violence, especially by empowering women survivors.

- There is also a need to improve the recording of victims and crimes, as well as the measurement of prevalence in various ways and through multiple - harmonised - instruments, because reproductive violence and violence in the name of so-called "honour" crimes are characterised by their multidimensionality.
- There are different strategies for this, from improving registration and institutional surveys to the use of big data. Specific proposals are made in this regard.

Taking into consideration the conclusions reached in the Diagnosis, this report develops a third part of **recommendations and proposals**.

- They are divided into three types: on the one hand, those related to the **production of knowledge**, which are essential for the prevention and improvement of interventions; on the other hand, those related to **comprehensive care** for victims in this area; and finally, those that specifically allude to the **functioning of ATENPRO** and its future

holistic development, as an instrument that is fundamental in the coordination and provision of services for women in many municipalities in Spain, especially the smallest and most rural ones. They form part of the following chapters.

- The recommendations for intervention and proposals for a **local model of action** are based on the needs detected in the diagnosis, the coordination challenges identified throughout the practices studied and the experiences analysed. Both the lack of data and the lack of a more specific and consolidated institutional framework make *protocolisation* difficult, so the suggestions of this work should be taken as **a model open to debate, experimentation and modification**.

LEs are leading public administrations in addressing equality between women and men, including "ending sexual harassment and all forms of violence against women and girls, as well as a commitment to guarantee sexual and reproductive rights, including women's right to sexual autonomy, and to ensure equal participation in politics and decision-making in all spheres of life" (UCLG, 2021: 1).

- Local equality resources are basic services for citizens (Guilló, et al., 2022); however, international unions of municipalities warn of the risk of losing these resources in the face of democratic setbacks. Hence the importance of expressing firm institutional commitments together with the planning of actions and budgets that materialise these commitments towards lesser-known forms of violence, such as reproductive violence and crimes in the name of "honour".
- As the *World Declaration on Women in Local Government* (UCLG, 2021:5) states: Local and regional governments are at the forefront of putting in place mechanisms to guarantee sexual, reproductive, health and other rights. A broad coalition needs to be put in place, with women leaders and allies from local and regional governments, parliamentarians and civil society, feminist, grassroots, activist and community organisations, to defend the rights of all girls and women in their diversity and end impunity for all forms of gender discrimination, ensuring that this is at the top of the agenda of elections, policies and all relevant forums.

III. RECOMMENDATIONS AND PROPOSALS FOR INTERVENTION

14. Proposals to improve knowledge and use of *Big data*

14.1. Improving knowledge production

One of the research findings relates to the **information deficits regarding** the collection of data on types of VAW and the lack of data available on some groups who, as in the case of women with disabilities and women from some diasporas, face these specific forms of violence.

In this way, it is essential to advance in the field of knowledge from different perspectives, both quantitative and qualitative. It should not be forgotten that **this is one of the obligations of the States**, not only in the Istanbul Convention, but also in all the resolutions included in the CEDAW recommendations.

First, access to existing data needs to be improved:

- it is essential to **improve access to current sources and databases** related to RV and CNH crimes; openly and with all data disaggregated by sex.
- Full disaggregation is not always available in public information. Some crimes, such as presumed childbirth and altered paternity, related to RV, are grouped together with other crimes in the same field, making it difficult to analyse in detail and to understand the magnitude and specific characteristics of these forms of violence. It is crucial to work on a more precise disaggregation.

In a cross-cutting manner, the importance of considering **diversity as a requirement for** population **analysis is** underlined:

- **Demographic analysis** can improve the detection of groups at greater risk of suffering such violence, for example, by considering the variables present in the profiles of the most vulnerable groups of women, such as: disability (according to type of disability), age, origin and nationality, ethnicity (beyond the Roma population), sexual orientation, habitat (rural/urban), and economic situation, among others. Different statistics, from the municipal census to the labour force survey, can provide interesting data, although not all of them are available at the local level.

- Likewise, the use of diverse **socio-demographic variables** in the design of the survey samples should allow for **statistical exploitation** from an **intersectional** gender approach.
- It should be remembered that Organic Law 5/2018, of December 28, on the reform of Organic Law 6/1985, of July 1, on the Judiciary, on urgent measures in application of the State Pact on gender-based violence specifies that the statistical information obtained must be disaggregated with a disability indicator for the victims. Our regulatory framework therefore emphasises the disaggregation with a disability indicator of the information collected on the victims.
- With regard to origin, the socio-cultural differences between the different countries must be taken into account, with particular emphasis on the socio-economic situation and the rights that pregnant women have or do not have in their countries.

The results of this analysis can be of great use in **directing prevention and awareness-raising efforts** towards the most vulnerable groups and towards the public service professionals who have the most contact with them in their daily lives.

Similarly, there is a need for **better record-keeping and further research**:

- Design new registers and modify the registers and procedures for quantification of victims of crime (and other types), in order to properly size up the persons who are victims of RV. For example, those relating to:
- Statistics on the foreign population seeking international protection, refugees, beneficiaries of subsidiary protection, displaced persons and stateless persons.
- Victims of gender-based violence.
- Victims of sexual violence.
- Victims of trafficking for sexual exploitation.
- Transgender people undergoing gender reassignment in surgical procedures.
- Women with disabilities victims of forced sterilisations.
- Registers of births and registrations abroad; Statistics on the acquisition of Spanish nationality by residents.
- State Database on Persons with Assessment of the Degree of Disability.

- Statistics of the Comprehensive Monitoring System for Gender Violence Cases (VioGen System).
- Domestic Violence Statistics.
- 016-Phone Service for Information and Legal Advice on VAW.
- ATENPRO Service.
- Optimise the measurement of prevalence:
- Surveys measuring the **prevalence** of specific forms of RV and CNH as types of violence against women require their own instruments.
- **Adaptation or inclusion of** relevant **modules** in other available surveys, such as: Macro-survey on Violence against Women; European Survey on Gender Violence; Fertility Survey; Spanish National Health Survey; National Health Survey on the Roma Population; Survey on Disability, Personal Autonomy and Dependency Situations; Survey on Sexual and Reproductive Health; as well as surveys on the population of foreign origin in Spain (among others).
- **Prevalence studies** in small and rural municipalities.
- To go deeper into **specific topics**, such as:
    - The impact of recent legislative reforms on improving the protection of women with disabilities from RV.
    - The link between FASC and the sexual and labour exploitation of women.
    - The relationship between RV and sexual violence against women.
    - The relationship between harmful practices against women and RV, specifically: forced abortions in relation to prenatal sex selection, virginity testing and hymenoplasty.
    - International protection of victims of RV.
    - The RV that affects migrant and refugee women in displacement, transit and reception processes.
    - Forced sterilisation and gender reassignment of transgender men.
    - FASC and menstrual management.
    - RV in the case of women in isolation and semi-isolation (psychiatric clinics and centres, care institutions, prisons, CIE, etc.).

- Promote research from **professional and scientific associations** related to sexual and reproductive health (sexology, gynaecology, midwifery, nursing, psychology) and from other disciplines such as social sciences (anthropology, sociology, social work, law, criminology) and public safety (police sciences).
- Involve **NGOs** with women's programmes[182] in data collection to improve knowledge about the problem and how to improve intervention. For example, through working groups or thematic commissions.
- In organisations of the disability **movement,** conduct surveys and studies among families with daughters on sexuality, reproductive rights and RV.
- In **organisations specialising** in the inclusion of people of migrant and Roma origin or descent, include RV and CNH within the areas of study on VAW.
- Promote the opening of research lines on RV and CHN in **universities and** public and private **research centres.**
- Promote data collection **from health resources** at all levels of public care.
- Facilitate **community (local) health programmes** to specifically record reproductive violence according to its typologies, and specifically those affecting the most vulnerable population:
    - FASC
    - Selective abortion as a practice of sex selection
    - Harmful practices: virginity testing, hymenoplasty, FGM, etc.
    - Surrogacy
- Involve **private health service providers** in the production and collection of information on RV.

The orderly compilation and accessibility to the public is a requirement for transparency, but also an instrument to provide information for the diagnosis of the situation for those LEs that cannot produce their own studies.

- **A centralised database would be needed** to collect and organise research, reports and statistics related to such violence.

[182] Including transgender people who are victims of RV.

- Given the institutional development and consolidation of the DGVG website[183] which contains a statistical portal, it would be of interest to include it in this platform, as well as to link it with the Ministry of Inclusion, Social Security and Migration, the Ministry of the Interior and the Women's Health Observatory of the Ministry of Health.
- The development of a global web platform at the **municipal level, from FEMP,** would favour the exploitation of statistical data with a unique value for the detection of violence, the implementation of action measures and their evaluation.

Finally, a complementary strategy to consider is the **evaluation of existing**, current and future **interventions.**

- In addition to updating data on the user or target population, the data will allow for the adaptation and improvement of prevention and victim support strategies with the aim of creating safer environments in the future.
- In this line, the importance of using the **potential of the ATENPRO service** for the production of local information has been pointed out, which requires improving its data collection and exploitation system.

14.2. Big data tools

The production of knowledge is inseparable from strategies for **prevention and** early **intervention** of these phenomena. The use of the internet and Big Data is also employed in this field for this purpose.

Firstly, the importance of **monitoring social media and digital platforms is** highlighted.

- Using Big Data techniques, it is possible to analyse these interactions to identify attitudes, opinions and trends related to violence against women (Xue et al., 2019).
- Analysis based on messages collected from platforms such as Twitter, Facebook, Instagram and web newspapers offers insight into perceptions and stereotypes related to these forms of violence.
- Data collection can help detect emerging issues, allowing for the customisation of awareness campaigns (Capobianchi, Muratore & Villante, 2023).

[183] DGVG website. Access

Secondly, it is proposed to explore the development of **predictive models as a tool for prevention and intervention**.

- Using machine learning algorithms based on historical data, geographic areas or population groups at higher risk of reproductive violence or honour crimes can be identified. An example of real use is presented by González-Prieto et al. in the article "Machine learning for risk assessment in gender-based crime", where a machine learning model for violence prevention is developed using a dataset of more than 40,000 people who were victims of gender-based crime in the United States. With 80% accuracy, the model was able to predict the risk of victimisation by taking into account various factors such as age, race/ethnicity, socio-economic status, history of violence, substance abuse, mental health and the victim's social environment. This tool was used to identify women at higher risk of gender-based crime and provide them with interventions such as counselling, guidance and financial support.

Thirdly, the creation of an **online Data Collection Platform**, as envisaged by FEMP in relation to ATENPRO, as a holistic tool to address VAW in all its forms, is considered of particular relevance.

- This platform would enable the collection and centralisation of information on documented cases, stakeholder profiles, and legal and ethical issues. The collection would allow for detailed, evidence-based analysis, thus informing informed decision-making.
- One example is the *National Network to End Domestic Violence* (NNEDV) in the USA, which works to prevent domestic violence, help victims and provide information. NNEDV has a web portal that provides information on domestic violence as well as resources for victims. It is a platform that aims to provide specific information, offering different resources ranging from prevention to data collection.

As a diagnostic tool, the establishment of **online Anonymous Consultation and Report Platforms** is also suggested.

- These platforms would give people the possibility to confidentially report cases or suspicions of RV and CNH (or other VAW). By using Big Data techniques to analyse the data collected, statistics on the incidence of these crimes could be generated, enabling the design of more effective preventive policies.

- Platforms such as RAINN (Rape, Abuse & Incest National Network) or the National Domestic Violence Hotline, both from the United States, are not only a channel for reporting, but also a source of information that provides detailed statistics on the profile of victims, perpetrators of sexual violence and the people helped by these platforms.

The use of Big Data in **raising awareness** of reproductive violence and honour crimes can significantly enrich strategies to address these issues.

- One of the key measures is the creation of **targeted awareness campaigns tailored to different population groups and contexts.** By harnessing data collected through Big Data, a more accurate understanding of the needs and experiences of affected people can be gained. These campaigns can use a variety of media, including social media, to reach a wider audience and generate greater impact.
- In this context, following the recommendations of works such as "Deepening the use of techniques associated with Big Data in the fight against violence against women" (2020), it is suggested that it is important to **improve institutional presence** on platforms such as Twitter, Instagram or YouTube, in order to take advantage of the reach and participation of the audience.
- The **use of awareness-raising slogans** in communications can be a strategy to increase reach. Words and hashtags such as #NiUnaMenos, #ViolenciaDeGénero and #ViolenciaMachista have become symbols of the fight against gender-based violence, and using them in future campaigns focusing on reproductive violence or honour crimes could build on the relevance they already have.
- Big Data could be of great help in identifying the **target population** for these campaigns and also in selecting **dates** where this dissemination could have a greater reach, such as March 8, International Women's Day and other anniversaries (see below for recommendations on awareness-raising).

Another strategy to address this violence is to create **online spaces where people can share their experiences, opinions and proposals**.

- These digital spaces would allow for greater interaction between society and experts, promoting the generation of solutions that are more focused on the real needs of those affected. The United Nations Women (2023) report "Disasters, Crises and

Violence Against Women" highlights the importance of promoting access to and use of the Internet, especially among women, to provide tools to seek help and resources for victims of gender-based violence, thus strengthening protection and support for those in need.

15. Proposals for intervention

15.1. Strengthen the institutional framework of "other violence".

All violence against women is combated through institutional frameworks that promote equality between women and men, in any sphere of society. Therefore, strengthening laws and policies based on a commitment to human rights and gender equality will help to eliminate the causes of VAW, in any of its expressions.

In relation to an *ideal institutional framework*, the results of the surveys and interviews point to a series of proposals to improve the current situation that are aligned with the recommendations of international organisations and are aimed at giving visibility and specificity within the characteristics of the Istanbul Convention.

These are the following considerations:

- Ensure that **child and adolescent protection** frameworks appropriately address RV and CNH, not only from a girls' and young women's safety perspective, but also from a specialised care approach.
- That the **normative frameworks** that protect women's rights (including the penal framework) in matters of VAW and health incorporate RV explicitly and alluding to its different typologies, and that the necessary improvements are incorporated into the Spanish legal framework to consider all the aggravating factors and manifestations involved in violence in the name of honour or CNH. Local entities can transfer the same to their **gender ordinances**.
- Considering the participation of the groups affected by this violence so that they can contribute their expertise: communities with a prevalence of CNH, entities in the field of disability or specific to women with disabilities, as well as other groups especially vulnerable to RV, including transgender people and the LGTBIQ+ group in general.
- That the implementation and evaluation of the **PEIEMH** and the current **SSGV** 2022-2025 and the **SPGV** incorporate concrete measures on RV (in particular with regard to GS and FASC) and VNH.

- **The mainstreaming of the disability perspective** and **intersectionality** in general should also be incorporated, as this contributes to making lesser-known forms of violence more visible.
- That the evaluation of the current **ENSSR** and the future Strategy include concrete measures for the prevention, care and reparation of Rape, with specific actions for women with disabilities and other groups in situations of special vulnerability. Special attention should also be paid to the intersection between HIV and its reproductive expression.
- Public policies on **disability** should incorporate a gender perspective, including specific measures for the prevention, care and reparation of RV and also with regard to the expressions of CNH that could affect women with disabilities to a greater extent.

In the particular case of GS, the experts consider that **international recognition as a form of reproductive exploitation** - which would allow it to be treated in the same way as other manifestations of RV - and the consideration of resorting to this practice to have babies as **trafficking in human beings,** should be promoted.

As this violence can constitute an international crime and is a violation of human rights, organisations and experts are calling for the creation of an **international convention** to prohibit, prosecute and punish the practice transnationally. There are a number of proposals in this regard, of which the following stand out:

- The International Feminist Convention for the Abolition of Surrogacy[184] developed by FCAS(2020).
- The ***Declaration for the Global Abolition of Surrogacy*** **or Casablanca Declaration**[185] (2023). It annexes a proposal for an International Convention and a number of recommendations to States:
- Prohibit surrogacy on its territory.
- Deny any legal value to contracts and recognition of parentage.
- Sanction natural and legal persons acting as intermediaries.

[184] International Feminist Convention for the Abolition of Surrogate Motherhood. Access
[185] Declaration for the global abolition of surrogacy or the Casablanca Declaration. Access

- Prosecute persons who resort to surrogacy on its territory and nationals who resort to surrogacy outside its territory.
- To act in favour of the implementation of a global prohibition legal instrument.

With regard to **violence based on "honour"** (VBH) or crimes in the name of "honour" (CNH), it is necessary to design adapted care itineraries, accessible from a cultural perspective, and with expert qualification on the part of professionals. Generalist attention from GBV is not adapted to the needs of the victims and does not have the necessary human resources; together with this, the protection of victims is deficient and not very specific to their risks. It is necessary to study the potential of the Swedish and British models for Spain.

The above recommendations refer primarily to the state framework, but in the case of **other levels of public administration**, they are equally transferable with respect to their particular policy instruments.

> Thus, at **the local level,** we would refer to institutional plans and municipal ordinances in relation to equality and violence against women and in relation to health in general and SRH in particular, as well as attention to disability.
>
> It can therefore be transferred to local equality and gender-based violence plans, community health, sexuality and SRHR plans, and other local instruments relating to groups of women highly vulnerable to Rape and practices related to so-called "honour" crimes (such as plans for social inclusion, international protection, development cooperation, and plans for children, adolescents and youth).

15.2. Comprehensive and coordinated care

15.2.1. Rights and comprehensive Care

The survey of local entities, given their lack of experience in dealing with RV and HRV, provided very little information on the needs of victims and their children.

However, both expert organisations and the different local care services consider that all women victims of male violence have similar needs, insofar as their fundamental rights are violated, and therefore, they consider that the needs of the victims - of any male violence - must always be attended to in relation to **the notion of comprehensiveness and universality**, that is to say: **attending to all the rights that correspond to them and to their full reparation.**

According to the consultation with LEs, organisations and experts, the notion of comprehensiveness or integrity refers to the **centrality of the rights** of the victims (their children).

> This issue corresponds to the model of care for victims of GBV promoted by Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against Gender Violence, which was reinforced thanks to the SPGV and Organic Law 10/2022, of September 6, on the comprehensive guarantee of sexual freedom; which in turn were based on the **Istanbul Convention.** The Istanbul Convention places "the rights of the victim at the centre of all measures" (art.7.2.).

In this way, the results of the fieldwork allude to considering all the **care and comprehensive reparation needs** that are expected in the care of victims of GBV:

- information and guidance;
- of security, protection, and guarantees of non-repetition;
- sexual and reproductive health;
- mental health;
- physical health;
- social care, housing, education, childcare or dependent persons;

  > In the case of housing, it is important to bear in mind that many women with disabilities require adapted housing and in many cases the presence of personal assistants to carry out daily activities. For this reason, it is necessary to ensure the existence of different resources such as supervised housing or independent living with personal assistance. Women victims of Rape Victims with disabilities have the right to leave the aggressor family environment with adequate support.

- The age limit for children who can live with their mothers in some housing resources (up to the age of 18) is a barrier for some women who need to protect them even though they are of legal age.
- peer-to-peer encounter, through group intervention with women for their personal and social empowerment.
- of social inclusion and participation;

- economic autonomy (in terms of employment, training for employment and/or access to monetary or other support);
- support needs of their family members or people close to them.
- and needs that allude to other dimensions of integral reparation in terms of restitution, compensation, rehabilitation or satisfaction;

Comprehensive models of care would be responsible for responding to the needs of VAW victims.

> These models are usually articulated either in comprehensive services or in (coordinated) referral resources; and usually cover: information; initial care and orientation for victims; initial care and orientation for family members; legal care; judicial accompaniment; emergency care for victims; security-protection; social care and economic autonomy; residential care (housing); educational care/training; health care; psychological care; care for victims' children; treatment and reparation for victims' children; social links or network; and others. Ideally, they **should be extensible** for women victims of RV and CNH taking into account **their specific needs** (see points 5.3., 8.3. and 11.1.2).

In order to work on the needs of the victims, it has been repeatedly pointed out that there must be an **individualised** care **plan** for each woman, which takes into account intersectionality with other inequalities and provides a cross-cutting and coordinated response. The recommendations and proposals in this respect can be found in the second part of this Report, but they have also been alluded to in the description of the needs of those affected.

Specialised support should offer victims **personalised support taking into account** their specific needs and **independently of any** police **report**[186] .

- The specialists emphasised that the needs of victims **will vary** according to their **personal and life situation**, and must therefore be addressed on the basis of **individualised care**.

[186] As stated in the Proposal for a Directive of the European Parliament and of the Council on combating violence against women and domestic violence (access) Strasbourg, 8.3.2022 COM (2022) 105 final 2022/0066(COD).

- Needs **are modified or transformed** depending on the moment in time. That is, whether it is a crisis or emergency context, coping with leaving the context of violence, awareness of a past event, or a long-term recovery process. The needs of victims and their children **evolve over time**.

Finally, it should be noted that there is hardly any mention of the specific needs of **the children** of female victims, who can also be subjected to this male violence through practices of vicarious violence. Therefore, reference is made to the need for specialised resources for minors in terms of mental health and educational support.

15.2.2. Universal accessibility

The second element that has been unanimously pointed out in the fieldwork, in line with the literature and the institutional framework, is universal accessibility to care resources.

The results of the research indicate that the following should be considered:

- Accessibility **is a necessity for all people**, with or without disabilities, but for the latter it is essential.

  > **It is a requirement** to be able to understand the information provided and to ensure free decision-making and consent to procedures by - all - women VVAW.

- It presupposes *universal design or design for all people*, but also requires appropriate forms of individualised **assistance and support**, technical devices and assistive technologies.
- With regard to the **facilitator**, this would be a basic resource in terms of facilitating physical, sensory or cognitive accessibility and in terms of mediation and cultural interpretation, depending on the profile of the victim. It is neutral and does not speak on behalf of the person supported or on behalf of the care resource; it does not influence the decisions or outcomes of decision-making.
- Guaranteeing accessibility for women with disabilities is an **obligation of the public authorities in accordance** with the UN CRPD (2006) ratified by Spain in 2007[187] . It is also **regulated by**:

[187] See the Instrument of Ratification of the Convention on the Rights of Persons with Disabilities, done in New York on December 13, 2006. BOE No. 96 of April 21, 2008.

- the General Law on the Rights of Persons with Disabilities and their Social Inclusion, approved by Royal Legislative Decree 1/2013, of November 29;
- Law 6/2022, of March 31, amending the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion, approved by Royal Legislative Decree 1/2013, of November 29, to establish and regulate cognitive accessibility and its conditions of requirement and application;
- Royal Decree 193/2023 of March 21, which regulates the basic conditions of accessibility and non-discrimination for people with disabilities for access to and use of goods and services available to the public[188] ;
- Royal Decree 674/2023, of July 18, approving the Regulations on the conditions of use of Spanish sign language and means of support for oral communication for deaf, hearing impaired and deaf-blind people.

- According to this normative framework, **disability mainstreaming should be a principle of all public policy**.
- It is also essential to guarantee the rights of some women of migrant origin or descent, especially when Spanish[189] is not their mother tongue.

Accessibility requires working with an **intersectionality** approach and the prevention of discrimination. Let us not forget that this form of RL is present to a much greater extent in the lives of women with disabilities, women with mental illness, women from certain diasporas or descendants of diasporas, and Roma women. The same is true for the characteristics of women HBV. In this way, the principles of the Istanbul Convention have often been pointed out in the fieldwork that....

> "measures to protect the rights of victims shall be ensured **without discrimination** based in particular on sex, gender, race, colour, language, religion, political or other opinion, national or social origin, membership of a national minority, property, birth, sexual orientation, gender identity, age, health status, disability, marital status, migrant or refugee status, or any other status" (art.4.3. Emphasis added).

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[188] Which will necessarily be complemented by the rule transposing Directive (EU) 2019/882 of the European Parliament and of the Council of April 17, 2019 on accessibility requirements for products and services (OJEU No. 151 of June 7, 2019).

[189] Or the language that is co-official in the relevant Autonomous Community where the care is to be provided. The Spanish Constitution establishes in Article 3 that Castilian is the official language of the State and that the other Spanish languages are also official in their respective Autonomous Communities: Catalan in Catalonia and the Balearic Islands, Valencian in the Valencian Community; Basque in the Basque Country and Basque-speaking areas of Navarre; and Galician in Galicia.

15.3. Principles of care and intervention with victims

As stated in the Istanbul Convention, the principles of care should aim to **guarantee the fundamental rights** of victims, and therefore be based on: gender mainstreaming, universal accessibility and prevention of discrimination.

According to the *Reference Catalogue of policies and services on violence against women in accordance with international human rights standards* approved by the Sectoral Conference on Equality (2022) (hereinafter, the Catalogue), institutions and bodies "will act with respect and support for the decisions of the victims, reinforcing their autonomy and freedom of decision, self-esteem, protecting their safety and confidentiality as a priority".

According to the GREVIO reports on the implementation of the Istanbul Convention (2020; 2022), interventions with victims[190] will be based on:

- Universal accessibility; victims' rights and protection; prevention of secondary victimisation; the relationship between victims, perpetrators, children and their wider social environment; empowerment and economic independence; and addressing the specific needs of vulnerable persons, including children.
- Timeliness and adequacy of information (art.19) in accessible languages.
- The temporal evolution of demand, differentiating between short and medium term (art.22) specialised services.
- Multi-agency cooperation (art.9), in which Spain must improve by incorporating specialised organisations in policy development (art.19).

Likewise, the CRPD Committee Observations linked to SRHR and UNFPA's (2018) recommendations on reproductive violence on young women and women with disabilities point out that the following guidelines for **programme implementation** should be taken into account:

- Effective identification of needs and referrals required.
- Accessible, quality, rights-based services.
- Assessment of the accessibility of resources (identification of obstacles, physical, sensory, cognitive and economic).

[190] See GREVIO (2022). Mid-term Horizontal Review of GREVIO baseline evaluation reports. Online document.

- Linking with sexual and reproductive health and health resources in addition to violence.
- In terms of service delivery, emphasis should be placed on:
  - Gender-sensitive understanding of violence against women.
  - Specific support for women with disabilities.
  - Specific intercultural mediation support.
  - Covering: justice and security; social services for protection, rehabilitation and accompaniment; psychological health, equality and social inclusion; and SRHR (contraceptive information, commodities and services; maternal and new-born health; comprehensive sexuality education and information; information, testing and treatment for sexually transmitted infections, including HIV).
  - That women are included in institutional settings (as is the case for many women with disabilities).

In addition, throughout the research, **the informants emphasised** the following elements (most of which are already included in the Istanbul Convention):

- Ensuring **comprehension and accessibility** in communication.
- **Culturally relevant care** for Roma women and women from other ethnic-racial backgrounds, and women of foreign origin; regardless of their administrative status as foreigners; with special attention to language barriers.
- **Listening and accompanying the woman's** emotional outpouring about: her history of violence, her discomfort, her emotions and her grief.
- Giving **credibility and hope** by promoting resilience in victims.
- Put **self-determination** at the centre; avoid paternalistic, protectionist or infantilising attitudes. Encourage both individual and collective empowerment, both of which are equally important.
- Prevent re-victimisation or **secondary victimisation** by institutions due to inadequate application of protocols or procedures, inappropriate attitudes or lack of training.
- **Prevent future victimisation** of RV and other violence.
- **Participation and social inclusion**, a key principle of action is to facilitate the development of emotional networks of support and assistance.

- **Improve risk assessment and adapt protective measures.**

15.4. Indicators to facilitate detection

Specialised indicators need to be developed to assist in the detection of lesser-known violence. Depending on the production of expert knowledge and the development of studies, indicators will improve.

In relation to forced contraception, forced sterilisation and forced abortion, as well as acting through active listening to identify these experiences in women's accounts as a form of violence against women, some elements of interest for detection have been pointed out.

In this way, the following FASC indicators to be considered have been identified throughout the study on an exploratory basis:

- Being a woman with an intellectual or developmental disability.
- Being a woman with cerebral paralysis.
- Have multiple disabilities (e.g., deaf-blindness).
- Being an adolescent or young woman with a disability.
- Being a woman with a severe mental disorder.
- Institutionalised living.
- Have a high degree of dependency and high support needs to carry out activities of daily living.
- User of augmentative and alternative or other types of communication.
- Be subject to support measures according to Law 8/2021, of June 2, reforming civil and procedural legislation to support persons with disabilities in the exercise of their legal capacity (formerly known as judicial incapacitation).
- Living with the family without autonomy, inactivity at work, without friends or outside of associative or support networks.
- Having pregnancies that are not carried to term and coming from diasporas originating from countries where selective abortion is practised.
- Being a Roma woman with two or more children.
- Being a transgender man who has undergone gender reassignment surgery.
- Being a victim of sexual violence; gender-based violence or sexual or labour exploitation.

- Women at risk or in a situation of social exclusion.
- Symptoms to consider: displaying very low self-esteem and self-concept; depression; disruptive behaviours; changes in psychopharmacology; eating disorders; abrupt body changes.
- Early or premature menopause.
- Absence of menstruation.
- Hospital admissions or non-specific surgical interventions.

See also the examples provided in the analysis of experiences in dealing with FASC (point 6.3.2.1.). Also, consider the consequences of FASC and GS as warning indicators (see point 4.5. and point 8.2.2.2, respectively).

In the case of GS, the organisations and experts state that the characteristics of the experiences to which pregnant women may have been subjected are similar to those of victims of trafficking or sexual exploitation. In this sense, they point out some GS indicators to which attention should be paid:

- Being a young migrant woman (<35 years old) with children
- Being a woman with low socio-economic status -low level of education and unemployed or in the informal economy-.
- Being a woman with psychological problems such as alienation or depersonalisation
- Being a woman with a specific medical record: previous pregnancies, hormone treatment, certain tests...
- Having had a pregnancy that has not been adequately followed up medically
- Pregnancy concealment

In addition to the above, detection could be facilitated by:

- Specific listening spaces/ women's groups based on a safe and trusting climate
- Specific training spaces on: sexuality, affectivity, maternity, SRH, SRD, RV, VAW, which enable professionals to identify situations of abuse and risk. Hence the need and importance of the existence of these spaces, as spaces for the detection of RV.

- Include pictograms related to these and other RV in augmentative and alternative communication systems in the case of women who communicate through these systems or use them as communication support.
- Spaces for psychosocial intervention with the families of women with disabilities.

In any case, the available protocols should be activated in the event of: the direct account of women, the expression of suspicion by other professionals, the direct concern of people in the environment or witnesses (friends, volunteers, work environment, etc.), and the presence of medical reports.

Indicators for detecting so-called "honour" crimes need to be improved. Each typology varies somewhat, in general, according to the information collected:

- Some social isolation and lack of socio-affective networks outside the family.
- The victim's life - in her daily life - has several features of community and family control that prevent her from developing a normal social, educational or professional life.
- Violence increases the scale of its expressions (e.g., from restriction of movement, to verbal violence, isolation, etc.).
- Threats are made about relocation with other family members (either to a third country or to the country of origin).
- Death threats.
- Imminent travel or holidays.

15.5. Ensuring access to resources/services

As pointed out in chapter 4 on the needs of women victims of FASC, resources for victims - of **any kind of violence -** must be distinguished by **their comprehensiveness and universality** (point 4.4.1.). This point explains what universal accessibility consists of, which must characterise all public resources.

Furthermore, as stated in Article 18(4) of the Istanbul Convention, access to remedies and the provision of services **shall not depend on the willingness of victims to take legal action** or to testify against the perpetrator(s) of the crime.

Based on these two considerations, **recommendations for facilitating access to resources or services** for victims of RV would address the following issues:

- Ensure **accessibility and individualisation** of specific communication supports for women (depending on their type of disability and their support needs or background). For example, via email, via video call or video call with chat included, as well as virtual help desks. They can be key for women who live in rural environments or have mobility problems or face situations of social isolation. Also, in the case of migrant women with language barriers.
- Dissemination campaigns about existing resources for victims and about RV on **social media and in the media**; preferably with the participation of women who represent the main groups of those affected.
- Promote the dissemination in **networks of women's associations and women's groups** that are particularly vulnerable or support them.
- **Enhance the visibility** of information in health and emergency resources, pharmacies and private health care, educational and leisure centres.
- Carry out awareness-raising actions both with **legal operators, international protection, educational and health environments**, on existing resources to enhance detection and referral.

15.6. Facilitating the accreditation of victims

For the recognition of victims and their accreditation, in the case of RV, a model should be assimilated to that of victims of gender-based violence and other typologies; for example, through a specialised report from the equality services, or social services together with the relevant references to health reports; in addition to the police report.

In any case, it has been pointed out that the following aspects should be considered:

- Reporting should never be a prerequisite for the recognition of these victims.
- The judicial system does not provide for precautionary measures for the victims of these RV, so this element cannot be taken into account for their accreditation either.
- In addition to the testimony of the victim herself before specialised services, a gynaecological report could be provided, showing that the woman has undergone

forced sterilisation or contraception and the physical and psychological consequences this has had on the woman. Together with a complementary psychological and/or psychiatric report that evidences the trauma derived from this RV.

- It would be of interest to consider having access to the clinical records of the victims of sterilisations, so that the procedure can be reviewed by FASC and to check how the woman's informed consent was carried out and whether there are guarantees that her decision was respected or whether procedural errors or flawed consent were detected. It would be necessary to involve the Public Prosecutor's Office.
- Consideration could be given to allowing institutions or families who regret having sterilised their daughters, aware and motivated by the need to provide for their recovery and reparation, to testify (e.g., by notarised affidavit or otherwise) to facilitate accreditation.
- It is necessary to design models - and test them - to try to unify future reports from municipal social services or equality services, in order to accredit the status of a victim of RV and a victim of CNH.
- Decriminalise women who act as surrogate mothers and facilitate their identification as victims of RV. Since they have been subjected to reproductive exploitation, as with any other violence, justice and reparation must be ensured for them, and it is especially important in this case that they are treated as victims and not legislatively equated with those who commit the crime[191] .

15.7. Enhancing comprehensiveness and coordination

All informants, as well as the results of all surveys, have indicated that the **design of specialised instruments or protocols** on RV and CNH is required.

> The creation of such a protocol for prevention, care, accompaniment, recovery and reparation for victims should be done in a participatory manner with women's associations that represent and serve the groups most vulnerable to such violence.

Similarly, the importance of **updating existing protocols** that address other specific forms of violence to ensure adequate intervention on the reproductive dimension of other types of

[191] Referring to Article 221.1. of the PC

abuse has been pointed out: SV, GBV, trafficking for sexual exploitation, forced marriages, child marriage, FGM, etc. (see point 3.4).

Together with the above, and from a perspective of preventing RV, the creation of two other instruments is considered necessary. On the one hand, an **institutional protocol on respectful, consensual contraception, accessible** to all women. On the other hand, the updating of procedures for access to abortion in order to **improve the detection of forced abortions** and to guarantee that the decision is free and informed without interference from third parties, without affecting any right and provision of abortion for women[192] .

A number of proposals have been made regarding these tools:

- It would target **SRH** professionals, but also **primary care professionals**.
- Special attention should be given to **women with disabilities**, due to the higher prevalence of RV among them, and informed and accompanied consent should be at the centre of interventions to prevent non-consensual sterilisations.
- Special attention should also be given to **economically vulnerable migrant women from** countries where GS is legal.
- Raise awareness of **forced contraception** as a more subtle and less perceived form of RV related to menstrual control.
- For the prevention of **selective abortions**, it is recalled that all States have an obligation to put in place measures to prevent female infanticide through prenatal sex selection and to ensure that these injustices are addressed without exposing women to the risk of death or serious injury if they are denied access to required services, such as safe abortions within a legal framework or other health services (WHO, 2011).
- It is proposed to follow the recommendations of the UN Interagency Statement on *Preventing Gender-Biased Sex Selection* (OHCHR, UNFPA, UNICEF, UN Women and WHO, 2011), which, among other issues, emphasises:
- involve commitments on the **ethical use of** relevant prenatal diagnostic **technologies** through health professional associations.
- The WHO (2011), insists that medical technologies (such as amniocentesis or ultrasonography) should not be demonised, because they are not the root of the

[192] As the

problem. Banning them can be ineffective and even harmful to women's health. Only, they should be regulated for proper use by appropriately qualified professionals.

- Raise awareness of **women's** and girls' **rights,** promote and implement **positive action measures** to improve their situation.
- Support advocacy and **awareness-raising** activities, such as social awareness campaigns, that stimulate discussion and debate in order to strengthen and broaden consensus around the concept of equal value for girls and boys.

In addition to the above protocols, some of the proposals that have been gathered from the analysis of the interviews to promote comprehensive care and coordination are as follows:

- There is a need to involve **private** service providers in the attention to disability and sexual and reproductive health services.
- Existing coordination spaces for other health-related violence need to be strengthened by incorporating new areas.
- It is necessary to make room for **new professional profiles** in the roundtables and spaces for combating VAW.
- The strategies most conducive to **individual empowerment** are those that work on self-esteem, social skills and personal concerns along with feminist awareness. Women are victims of violence because they are women. In this sense, collective empowerment is a condition for individual empowerment to be sustainable and to prevent future victimisation.
- **Collective empowerment,** in women's groups, is very positive for victims, not only as therapeutic spaces, but also as spaces for meeting, active participation, self-representation and leadership, by sharing with other women what has happened to them and knowing that other women have also suffered from RV.
- All protocols should work to create sustainable and long-lasting **social support networks** for victims.
- In the case of women with disabilities, and WIDD in particular, it is essential to leave the private, family and domestic environment.
- Social support networks require **medium to long-term approaches**. They are built on mutual trust and exchange in activities; activities that have a cost and require a budget.

They are emotional bonds that cannot be forced and require a lot of time and professional resources for dynamization and care of the spaces.

15.8. Sufficient human and material resources

15.8.1. Professional profiles

Multidisciplinary teams are key to the care of victims of *little-known* violence. Recommendations in this regard point to the following **professional profiles**:

- **Care/intervention** professionals: psychologists[193], social workers, lawyers, social educators.
- Professionals who ensure accessibility in **communication and** cognitive **understanding**: professional facilitator, sign language interpreter, communicative mediator, speech therapist and cultural mediator or interpreter (preferably anthropologists).
- This includes **professional support** figures for women with disabilities, personal assistants[194], with training in gender-based violence. For example, if a victim with cerebral paralysis or a high dependency needs to leave her home, she needs personal assistance.
- Facilitators must also be present for access to justice and for the necessary adaptations during the police and judicial process and not only for social and health care.
- Regarding RV, **primary health care and sexual and reproductive health** professionals: midwives, sexologists, gynaecologists, nurses.

There is ambivalence and diversity of opinion as to whether the professional figures in integrated social care should be **women or men.**

However, the importance of always having female figures available, especially in the first steps of the reception process and the first phases of the intervention, has been

[193] It has been pointed out, in the case of care for deaf women, that it would be preferable for the psychologist to be deaf.

[194] Personal assistance refers to the human support provided through an employment relationship to a person with a disability (client) in order to enable her/him to lead an independent life. It is the user who determines how and when the services will be provided.

unanimously pointed out. There is a finding - at least in RV - that in general, women victims feel more confident and bond better if the professional is a woman.

It is considered essential to increase the budget for VAW programmes and to provide resources for the care of women in RV, above all to provide job stability for the staff, to expand it and to guarantee continuity of care.

15.8.2. Continuing education and training

With regard to the training that professionals should have, the following is proposed:

- Intersectional gender training.
- Institutional framework exists on VAW.
- Existing national and international regulations on crimes in the name of honour.
- National and international regulations on SRHR and reproductive violence, including surrogacy.
- Basic notions of sexuality, sexual and reproductive health and sexual and reproductive rights.
- The situation of women's SRHR, and in particular: women with disabilities, Roma women, women from diasporas with prevalence of harmful practices, migrants, refugees and young women.
- Training on disability and violence against women with disabilities
- Training on reproductive exploitation: particularly on how the GS industry works from a feminist and human rights perspective
- Knowledge of the legal, bioethical, health and social issues involved in GS
- Appropriate treatment and care guidelines for women and girls with disabilities, according to type of disability.
- Augmentative and alternative communication systems and their individualisation.
- Profile of women victims of RV, needs and consequences
- Profile of women victims of CNH, needs and consequences
- Functioning of specialised resources and provision of care.

- Principles and criteria for psychosocial, health and safety intervention on VAW. And in particular:
- Trauma and bereavement treatment.
- Training on resilience, understood as the way to be able to rebuild after an unwanted and traumatic situation.
- Prevention and awareness-raising on new victimisation.
- Possible remedial action.

15.8.3. Care infrastructures

As for the infrastructures that are necessary for the intervention, these have been considered from the actions of the specialised services in the field of equality and against GBV. Both in the surveys and in the interviews, the following recommendations were made:

- It is not so important that there are care "offices"; in general, LEs and organisations have limited infrastructures and little budget for their adaptation. The importance lies in the **flexibility of care and mobility**: that is to say that the care team of the resource or service is close to the victims, and not the other way round.
- **Spaces with a minimum of requirements**: intimate and friendly to welcome women victims, in a safe and trusting atmosphere.
- There must be adequate spaces for childcare.
- **Innovative** virtual spaces and **applications (Apps)** to improve the accessibility of resources and communication for women with disabilities or other communication needs.
- **Universal accessibility** to all resources (physical and virtual: face-to-face or not), services and programmes specialising in care for women victims of any type of violence.

15.9. Reparations for victims

Reparation for victims refers to restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition[195]. In this regard, a number of recommendations have been made and are set out below:

On reproductive violence: FASC

- Compensation to victims is seen as very positive, as has been the case in other countries, such as Sweden in cases of sterilisation of women with disabilities or the Czech Republic in the case of sterilised Roma women.
- At the institutional level, from the judicial and health sectors, it has been considered important to **issue circulars** that recognise these massive RV, which have been carried out mainly against WIDD. It is also important to value more visible action by the **Attorney General's Office** and its specialised areas (violence against women, people with disabilities and the elderly, hate crimes and discrimination).
- Carry out **symbolic reparation** actions, such as commemorations and tributes to victims of RV.
- Address measures to **ensure non-repetition**, accompanying legislative change with regard to sterilisations of women with disabilities. For example, adjusting the informed consent procedure so that there is no possibility of vitiating it as may be happening (according to the results of the fieldwork), and allocating resources to ensure that it is carried out in an accessible manner and with the necessary communication supports.
- Possibility of carrying out **small restorative acts** in individualised intervention plans.
- For example, one family regrets having sterilised their disabled daughter in the past.
- Consider the **civil liability of professionals** involved, especially in the health sector, who have performed sterilisation or coerced abortion (in its different forms) at the decision of the family and without informed consent.

[195] See for example, (Sordo Ruz, 2021) where these terms are explained in detail.

- Promote institutional public apologies (e.g., from medical or social work professional bodies) that include acknowledgement of the facts and moral acceptance of responsibility for past actions.
- To focus on the victim's rehabilitation dimension by prioritising **mental health** care.
- Psychological work on trauma, grief and the impact of RV on psychological and emotional health.
- Facilitate the right to outrage and anger. Many victims become aware of RV after a considerable time has passed. In the case of women with disabilities, victims are aware that in general it has been their families who have exercised this RV, but also professionals from the disability organisations they attend as users. In this sense, the importance of their being able to express their anger and discomfort as part of their reparation process is underlined.
- Rehabilitate desire and the right to pleasure; especially in sterilised women, which does not change the fact that they can live their sexuality in a full and satisfying way.

In addition to this, in the particular case of **GS the recommendations** also state:

- Dealing psychologically with the trauma and grief experienced by the separation from the baby
- Work on the feelings of guilt that some victims have about the surrender of the baby.
- Establish international measures to allow, in the event that expectant mothers wish to recover their children, the restitution of the maternity and filiation of the babies.

Concerning so-called "honour" crimes

- Study the compensation and recovery funds proposed in the Swedish model, based on part of the penalties imposed on offenders.
- Establish a national day of remembrance for victims.
- Addressing the SRH consequences of violence.
- Facilitate the change of identity for the protection of victims, including relocation to another safe EU country without risky family ties for those affected.

15.10. Empowering associations and the women's movement

Regarding the role of women's associations, the feminist movement and other civil society organisations, the proposals that have been put forward are fairly unanimous for all the forms of violence studied, both for the FASC and GS as RV, as well as for the CNHs.

The recommendations are mainly aimed at **coordinated and joint work** with public administrations and between the organisations themselves; they are as follows:

- Strengthen the participatory governance of VAW policies.
- Facilitate the participation of women's associations and the women's movement in existing institutional spaces (or those to be created), e.g., local coordination bureau, working groups, etc.
- Collaborate in the production of knowledge and the registration and identification of cases of violence.
- Encourage joint awareness-raising campaigns.
- Act jointly for the dissemination of available resources.
- Collaboration with specific associations of women who are victims of VAW and the CNHs and their associative support networks.
- Establish synergies and alliances to increase political advocacy in relation to lesser-known male violence.
- Organise joint forums, meetings and conferences to raise awareness in society.
- Favour accessibility and intersectionality in the design of its activities, programmes, activities or resources.
- Include in their speeches, campaigns, manifestos the visibility of RV and CHNs and have women victims represented in these actions.
- Working together to make lesser-known forms of violence visible on anniversaries, such as: March8, International Working Women's Day; November 25, International Day for the Elimination of Violence against Women; February 14, European Sexual Health Day; September 4, World Sexual Health Day; December 3, Day for the Rights of Persons with Disabilities; April 8, International Roma Day; June 20, World Refugee Day, etc.

15.11. Preventing and raising awareness

The proposals have been directed towards three distinct target groups, women victims, institutional actors and other actors of action, and local society in general.

In all of them, the need to put the women who are victims of violence at the centre of the actions has been underlined:

- To encourage **women themselves to be the referents and protagonists** in awareness-raising actions; to make their fundamental rights and reproductive rights visible, contributing to a positive image of women, which will help to break down existing myths in the social imaginary.

The following considerations have been noted with regard to awareness-raising and prevention of RV:

- Develop specific **information materials**:
- Develop materials with SAAC for different cultural sensitivities and disabilities.
- Innovate in digital and social media formats.
- Elaboration and dissemination of guides, brochures, posters on RV in different formats accessible to all women (easy reading, pictograms, Braille, video interpretation, multiple languages...) aimed at providing information to women on RV, what it is, how to detect it, where to ask for help, rights, etc. ....
- Ensure universal accessibility of all campaigns.
- **Involve real victims** during campaigns, showing their diversity so that other women can identify themselves, because if they are not present in prevention actions, it will be difficult for them to reach the intervention.
- Promote **women's groups**, training and professional accompaniment, for the knowledge of their rights, VAW, SRHR, RV, harmful practices and CHNs.
- Develop **peer-to-peer** training programmes for trainers or groups of women's **rights advocates**, SRHR or similar.
- Promote **sexual and affective-sexual education** from childhood and throughout adulthood.

- Work with the families of women with disabilities who are victims of FASC on their SRHR.
- Work **with communities and from the** cultural **communities** of victims where harmful practices against women persist, on SRHR and specifically on practices of control and oppression associated with GBV.

With regard to the last point, it is worth bearing in mind what the CEDAW (2014) General Recommendation No. 31 of the Committee and General Comment No. 18 of the Committee on the Rights of the Child "on harmful practices", regarding **the challenges of raising awareness with and in communities where CNH is prevalent**:

> "An underlying challenge to be addressed is the possible perception that harmful practices have beneficial effects for the victim and members of his or her family and community. Consequently, any approach that focuses solely on changing individual behaviours has considerable limitations. Rather, a broad-based and holistic collective or community approach is needed. Interventions that are respectful of cultural particularities and that reinforce human rights and enable practising communities to collectively explore and agree on alternative ways to realise their values and honour or celebrate their traditions without causing harm or infringing on the human rights of women and children can lead to the large-scale and sustainable elimination of harmful practices and the collective adoption of new social norms. Public manifestations of a collective commitment to alternative practices can strengthen their long-term sustainability. The active participation of community leaders is crucial in this regard" (para. 59).

With regard to **institutional actors**, these recommendations have been taken up:

- **Make RV visible** as a type of VAW in all possible forums, raising awareness of its consequences and interrelationship with other forms of violence.
- Actions aimed at **political staff and agents and professionals**: from the field of health, SRH, students of Health Sciences and Social Sciences disciplines, legal operators and law enforcement and security forces, professionals of resources for the care of women victims of gender-based violence.
- The amendment of Article 156 of the Criminal Code, which makes sterilisation illegal in 2020 with the approval of Organic Law 2/2020, of December 16, amending the Criminal Code for the eradication of forced or non-consensual sterilisation, is still recent and unknown, and has not permeated other actors beyond the disability movement. This indicates the urgent need to **disseminate, train and raise awareness**

among different actors so that it does not remain a mere formal change but transcends into an effective one.

- Raising awareness among professionals of the resources, services and programmes of **specific care for people with disabilities**, who are unaware of the real consequences of this kind of RL and the violation of rights that it implies. In the past, many of these professionals may have been *accomplices* through ignorance, advising families of this type of forced practices.
- Organisations and associations: develop **internal positions** on sexuality, privacy and intimacy protocols, as well as protocols for the prevention of violence within entities and care resources (especially with people with disabilities and groups that have to reside or stay in institutional resources).
- **Development and** dissemination of materials: guides, brochures with recommendations, good practice manuals, platforms, applications, etc., as well as raising awareness of institutions, organisations and LEs of reference in the field of care for RV and CNH.

Finally, in relation to social awareness, and specifically local society, the following community awareness-raising actions are proposed:

- Promote the visibility of local women's associations and the feminist movement, which alert and raise awareness of this violence.
- Take advantage of anniversaries and commemoration events to dedicate them periodically to RV or include RV and CHNs in awareness-raising themes; both in the media and in social media.
- Work with local health and care providers to raise awareness of reproductive violence typologies and protocols for detection, reporting and intervention, including pharmacies.
- Include specific working groups on RV and CHN in the local VAW roundtables.
- Sensitise communities by working to create leadership for change as prescribers or figures of respect within the community to eradicate harmful practices, community control over women and gender stereotypes based on a notion of women as inferior.

16. Recommendations regarding ATENPRO

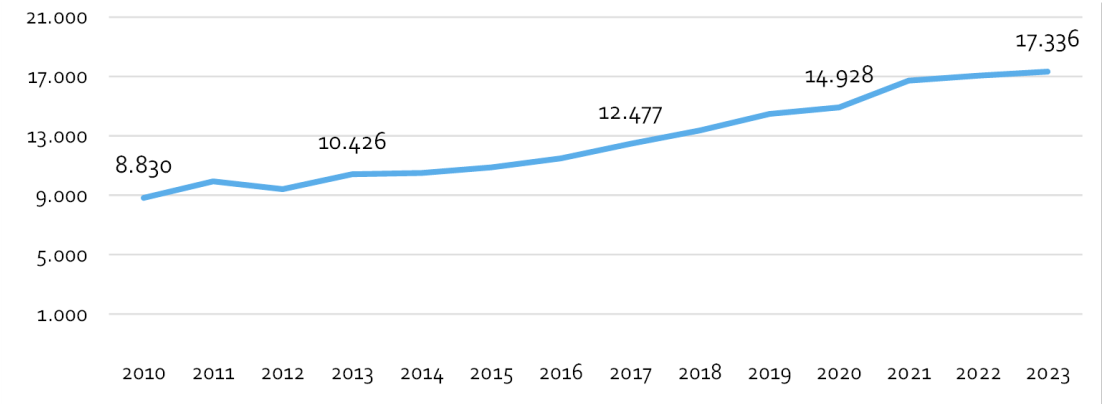
16.1. Introduction to the service

The Spanish Federation of Municipalities and Provinces (FEMP) is the most widely established association of local entities at national level[196] . One of its statutory aims and objectives is to raise awareness of the situation of women in local government. In Spain FEMP is considered "an instrument of undoubted public utility to complete the care and protection of victims of violence against women"[197] .

Since 2004, FEMP has been responsible for the management of the Attention and Protection Telephone Service for (female) Victims of Gender Violence (ATENPRO)[198]. The updating of its action protocol in July 2023, has renamed the service as ***Telephone Service for the Care and Protection of Victims of Violence against Women***. It is funded and own by the Ministry of Equality (DGVG).

Present data (31/05/2023) show there were a total of **17,336 active users** of the service (DGVG, 2023). Since its launch, demand has increased steadily. The graph below shows the evolution of the number of beneficiaries.

Graph 13. ATENPRO: evolution of the number of active beneficiaries (2010-2023)



Source: DGVG-FEMP (2023). DGVG statistical portal (updated 2023/09/29).

[196] It reaches more than 95% of the Spanish population in the more than 7,239 Municipalities, 39 Provincial Councils and 10 Island Councils and Island Councils that it groups together (see Royal Decree 1042/2021 of 23 November).
[197] As recognised by Royal Decree 1042/2021 of November 23.
[198] Full description available at DGVG web (access).

Together with ATENPRO, FEMP provides other **services to local authorities to strengthen its actions against gender violence,** among them:

- support for the local implementation of the SPGV;
- development of guides and materials;
- a Training Platform for LEs;
- Dissemination of activities, conferences and other actions;
- Participation in international networks of local governments:

ATENPRO is a **key resource within the comprehensive recovery process** of VVAW. Thus, its **specific objectives** are:

a) To provide care, security and tranquillity to service-users and, by extension, to their circle of relatives. It offers information and advice through interpersonal communication with specialised professionals 24 hours a day, 365 days a year.
b) To enhance the self-esteem and quality of life of the users, helping to create a social support network in their usual environment and encouraging them to maintain, in complete safety, contact with the social environment.
c) Ensure immediate and adequate attention to emergency situations, providing security and mobilising appropriate resources.
d) Active follow-up through regular contact with the Care Centre.

Its characteristics are as follows:

- Registration for the service is managed through the local council's Equality or Social Services.
- The **Care Centre** is run by an NGO, currently the Spanish Red Cross.
- The service includes **programmed preventive actions** within an individualised monitoring system.
- It is based on the use of mobile telephone **communication and telelocation technologies**
- It is accessible for women with **hearing impairment** (SOTA Module) via an application installed on the terminal and allows contact with the Service Centre through text messages correspondence.

- The device is similar to a mobile phone; it has notifications: acoustic, light, graphic and vibration (customisable). The alarm can be activated by a physical button (easily accessible side button). It has appropriate buttons in size, contrast and colour combination, as well as an adapted, simplified and customisable menu design.

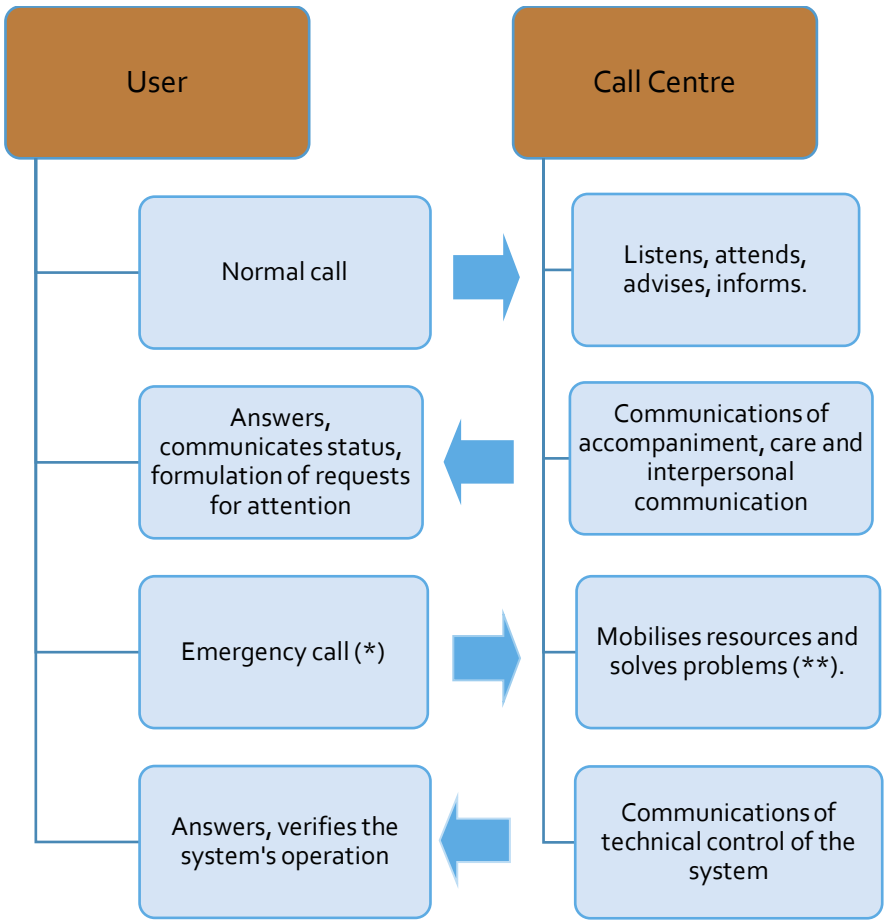
In the context of its application and, above all, after the entry into force of the Istanbul Convention, ATENPRO **needed to be updated**. The funds and motivation were obtained thanks to Royal Decree 1042/2021, of November 23, which regulates the direct granting of a funding to FEMP for the modernisation and expansion of care and protection mechanisms for victims of male violence within the framework of the RTRP financed by the European Union-NextGenerationEU (modified by Royal Decree 194/2023, of March 21).

- In addition to the progressive increase in the demand for the service, the explanatory memorandum *of* Royal Decree 1042/2021 points out the need to advance in modernisation and digitisation and to respond to all forms of VAW as required by the Istanbul Convention. As we have already explained in the *Introduction* to this report, this is one of the reasons for this research.
- This modernisation is part of the Plan ***Spain protects you against gender-based violence***, which is part of investment 4 of Component 22 of the PRTR, which includes among its measures: extending and making comprehensive care services accessible to all potential victims, as well as minimising the digital divide that affects the current service.
- **The investment includes**: improving the technical requirements of telephone devices; extending their coverage; reducing their size and weight; increasing battery life; and new functionalities to improve accessibility for people with hearing or speech disabilities and low vision.
- In addition, the **planned actions** include: external alarm buttons accessible to women with reduced mobility, automatic inactivity alerts on the mobile terminal, smartwatches, a communication channel with the Control Centre via chat, a Service website, the creation of a computer application that incorporates all the information on users and LAs, and an assessment of the Big Data analysis of the Service.

As part of this process, the Service's Action Protocol **has been updated** to July 2023, changing its reference from "victims of gender-based violence" to "victims of violence against women".

- **The Protocol** is the instrument that contains ATENPRO's operating procedures for all actors involved. It covers:
    - The description of the Service and its objectives; the types of registration (ordinary and extraordinary); the access requirements; the relationship between the management of social services on the one hand, and the entity providing the Service on the other; the length of the Service; the procedures for cancellation; the information provided to users; the action to be taken when users change their municipality; the description of the Service's operations; the monitoring of the case by the social services centres; and the communications to the Autonomous Communities and the cities of Ceuta and Melilla.
    - It includes several annexes: on the operating rules (I); the procedures for processing applications for registration (II); the procedures for assessing continuity (III); the procedure for deregistration (IV); the application forms, which include different forms (V); and the application for membership of the LAs to ATENPRO (VI).
    - The basic **operating scheme is** summarised in the following Figure:

Figure 10. ATENPRO scheme (July 2023).



Source: Ministry of Equality-FEMP (2023)

Note: (*) Emergency calls: (1) psychosocial care; (2) pre-alarms for proximity of aggressor or potentially dangerous situation; (3) alarm for assault

(**) Level 1: verbal response; Level 2: mobilisation of resources as established with the LAs (health care, crisis centre, Local Police, 112 emergency service, National Police, Civil Guard, Autonomous Police, or others); Level 3: transfer of the user to a specialised centre.

16.2. Assessments and proposals

The main characteristics of ATENPRO have been assessed from different perspectives (throughout the fieldwork, surveys, interviews with experts and the study of care practices). Based on the information provided, the following proposals have been formulated; many of them are suggested directly by the LAs and organisations participating in the study.

16.2.1. Functioning and operation of the Service

The requirements for access to the Service need a certain flexibility insofar as the victims of RV and victims of CNH have - for the moment - difficulties to be recognised as VAW.

As it has already been explained throughout the research, these are forms of violence against which there is no tendency to resort to the judicial and police system; therefore, the vast majority of those who have been victimised have not pressed charges and their attackers have not been convicted (so they lack such documents). At the same time, there is no practice in public services or NGO services of drawing up support reports that could serve as administrative accreditation of these forms of violence, so that victims do not have access to a legitimate administrative document. As long as these forms of violence were recognised in local VAW services and social services, this would facilitate procedures of recognition.

> The possibility that, exceptionally, the DGVG may consider certain applications as extraordinary, may favour the access of these victims to the Service.

As for the access requirements that are currently considered in the Action Protocol, there are also difficulties. In addition to the lack of an official recognition (as a victim), there are two other barriers. First, " not living with the aggressor who has abused you " is sometimes hard to fulfil. In the case of this type of violence an "aggressor" does not necessarily has to be a single person but, for example, a family or institutional environment for women with disabilities, or a community environment for victims of CNH.

> After experiencing RV, victims with disabilities continue to live with the family that perpetrated the violence. Women have few opportunities to leave the family environment, for different reasons: they are financially dependent and care-dependent, they are their main support network and there is a bond of affection. Those who live in residential settings (institutions) are dependent on the professionals who were perpetrators. Accessible alternative housing can be difficult and time-consuming to arrange.
>
> Regarding GS, (usually) it is not a form of intimate partner violence, but a form of reproductive exploitation by strangers (e.g., firms) or, in some cases, community members.

On the other hand, "participating in specialised comprehensive care and recovery programmes" may be difficult for these victims, because they are often not in place or, if they exist, are not always accessible to them for various reasons. However, they may be taking part in other more generalised VAW services or health treatments.

No barriers to accessing the service through *extraordinary applications* or extraordinary discharges have been identified.

In terms of **service standards**, flexibility may be required. For example, a woman with a severe mental disorder may exhibit disruptive behaviour of some kind that leads to non-compliance with the rules.

In terms of **testing the operation of** the terminal, this should be adapted to different disabilities.

The characteristics of these violences have an impact on various aspects of the management by the social or equality services and the service-provider entity (as foreseen in the Action Protocol in its current format). The following points might be considered:

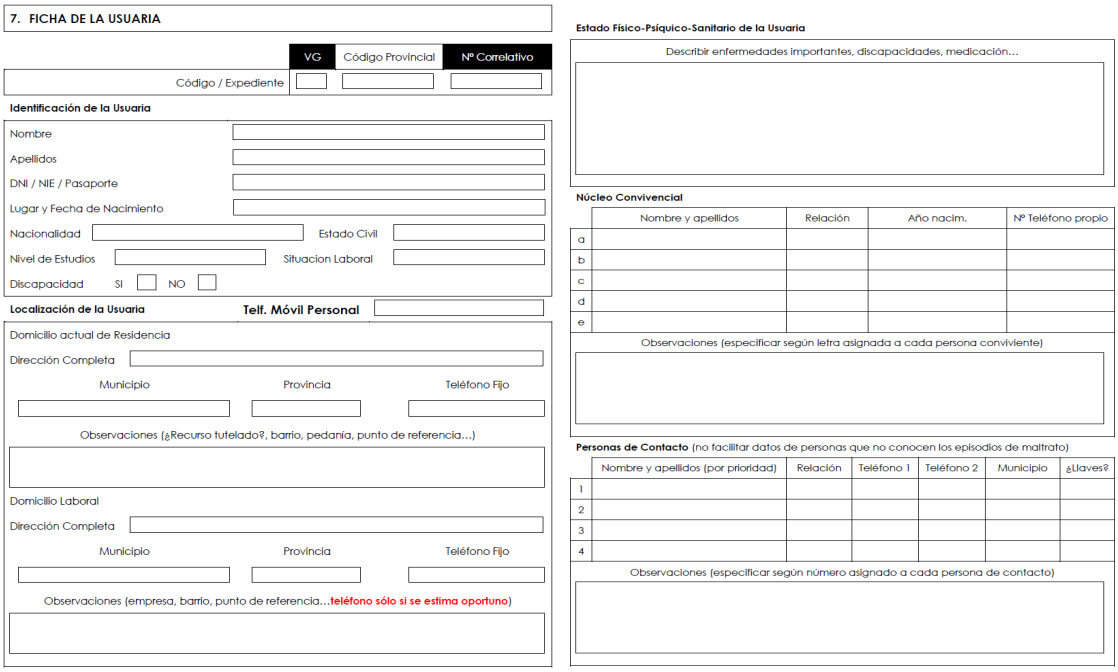
- it would be necessary to **increase or reinforce specialised resources** and areas of attention, at least those of SRH, attention to disabilities, cultural mediation and interpretation, and international protection and social inclusion. They also have an impact on the **Service's operations**.
- It is considered that there may be barriers in relation to communication with users, from the very basic information about the Service to the set of communications that develop it (calls and interactions with the Care Centre). This is due to the criteria already discussed throughout the research on universal accessibility and cultural adaptation required by the main profiles of victims of RV and CHN. See recommendations in relation to principles of care and access to resources).
- With regard to **information for users**, it is considered essential to develop materials with pictograms that favour intercultural understanding and cover the needs of WIDD, as well as minors. This would also involve translation into different languages, including the rare languages of ethnic minorities within some nationalities in which harmful practices persist and which are not the majority languages of the foreign population in Spain.
- The **frequency of** follow-up **contacts** and its characteristics should be adapted and individualised in order to fulfil a real preventive function. Communicative support should be foreseen.

- It was highly appreciated that ATENPRO has a **successive extension** in its provision, generally up to a maximum of 10 years, precisely because lesser-known violence is characterised by long-term consequences.
- With regard to the withdrawals or deregistration from the service, it has also been considered that certain adaptations are needed with regard to the notion of "repeated non-compliance".
- Most of the interviewees emphasise that in the case of women with disabilities who are victims of RV, it must be ensured that the voluntary leave is the woman's decision and that there is no manipulation by the family or environment. Also, in the case of victims of GS, it must be ensured that the decision is free from external pressure.
- In the case of **sterilisations and coercive abortions**, these are irreversible forms of violence, and therefore, key aspects should be considered such as: to what extent they have they found a support or if they have overcome the mourning of the whole process.
- In the case of CNH victims and victims of GS, given their profiles, their international mobility is possible; therefore, it would be of interest to foresee **collaboration agreements with similar services** in other countries in order to provide the greatest security to victims and give continuity to their recovery processes.
- With regard to emergency care procedures, there is little knowledge of the typology of the *crisis situations* the victims of RV and CNHs may face. The first proposal, therefore, is to generate more specialised knowledge on this issue and, above all, to make the procedures more flexible in practice. It would therefore be of interest to establish a specific working group on this issue in the follow-up of ATENPRO.
- The overall assessment of emergency calls and the levels of responses that are foreseen in the Service are considered adequate (see Figure 8). However, it should be emphasised that the different types of aggression (other than SV or GBV) mean that the emergency contexts do not resemble other more familiar VAW.

Finally, it has been considered that the main system's management tool (user/beneficiary registration form), has a lot of potential for its improvement, in general and for their adaptation to the RVs and the CNHs.

- These files, are forms implemented through Excel spreadsheets. They are based on open writing fields. This involves the massive storage of qualitative information that makes it impossible to be statistically analysed. This hinders the production of knowledge, the monitoring of the diverse and multiple forms of violence faced by the users, the monitoring of their evolution, the specific access to specialised services, as well as the evaluation of the service itself.
- It has been pointed out that the development of a platform with more closed registration forms, based on exclusive and exhaustive categories (with few open fields) could contribute to solving these deficits. It was also suggested that the platform could host annexed documentation, videos and audios of the users themselves. This would facilitate intervention and follow-up, as well as access from the specialised staff (speech therapists, communication mediators, interpreters and cultural mediators, etc.).

Figure 11. Extract from the User Form (beneficiary file) - ATENPRO Action Protocol.



7. FICHA DE LA USUARIA

VG | Código Provincial | Nº Correlativo

Código / Expediente

Identificación de la Usuaria

Nombre
Apellidos
DNI / NIE / Pasaporte
Lugar y Fecha de Nacimiento
Nacionalidad | Estado Civil
Nivel de Estudios | Situacion Laboral
Discapacidad SI NO

Localización de la Usuaria | Telf. Móvil Personal

Domicilio actual de Residencia
Dirección Completa
Municipio | Provincia | Teléfono Fijo
Observaciones (¿Recurso tutelado?, barrio, pedanía, punto de referencia...)

Domicilio Laboral
Dirección Completa
Municipio | Provincia | Teléfono Fijo
Observaciones (empresa, barrio, punto de referencia...teléfono sólo si se estima oportuno)

Estado Físico-Psíquico-Sanitario de la Usuaria

Describir enfermedades importantes, discapacidades, medicación...

Núcleo Convivencial

	Nombre y apellidos	Relación	Año nacim.	Nº Teléfono propio
a				
b				
c				
d				
e				

Observaciones (especificar según letra asignada a cada persona conviviente)

Personas de Contacto (no facilitar datos de personas que no conocen los episodios de maltrato)

	Nombre y apellidos (por prioridad)	Relación	Teléfono 1	Teléfono 2	Municipio	¿Llaves?
1						
2						
3						
4						

Observaciones (especificar según número asignado a cada persona de contacto)

Source: Ministry of Equality-FEMP (2023:44-45).

- On the other hand, these forms, as data collection sheets do not include - none of them - the **typologies of violence** referred to in the RV (in its multiple forms) nor the CNH (in its various expressions). There are no fields to identify them, nor to describe their

consequences or the needs of the victims. This weakness would be best addressed by the changes noted above.

- It would be necessary to collect information at least in relation to:
  - Regarding the section of the *victim's fact sheet*, the following should be recorded: the type of disability suffered by the woman and not only its presence; the specific ethnic origins and cultural or religious backgrounds; the languages they speak; and the relationship with diasporas and relatives in the country of origin (for example, to assess the risk of abduction or relocation).
  - In the *physical, psychological and health status* of the victim, it is necessary to make explicit reference to SRH, regardless of the VAW she is facing.
  - In relation to the user's living arrangements, the type of cohabitation with relatives and the extended family is very important as it is the presence of second-degree family networks, which is relevant for the CNHs. This also applies to other types of cohabitation that women with disabilities face as living in institutionalised care settings.
  - As for the **aggressor's data section**, it must be taken into account that they may be multiple or have a community dimension, and therefore it is necessary to describe more precisely what is the victim's environment; what type of presence the community has in the victim's local area and in other nearby municipalities, in order to better assess her safety.
  - Regarding **risk assessment**, RV and CNH face a significant lack of knowledge about when communities, families or institutions could carry out an aggression. In any case, it is recommended to review the recommendations made on *victim identification procedures* in the previous chapter in order to assess their inclusion in the data collection forms.
  - The **history of aggression** is also not adapted to the violence we are referring to; the types of abuse do not include any of the RV and none of the potential aggressions that fall within the notion of HBV.
  - With regard to **the emergency resources record**, it is vital to specify its accessibility and cultural adaptability. In addition, it must be stated those related to sexual and reproductive health as well as communication facilitators, cultural interpreters and translators.

16.2.2. On interpersonal communication and accompaniment

The recommendations collected that should guide the personal communication and accompaniment of victims for the professionals of ATENPRO Service are:

- **Ask the victim** which form of communication she wants to use. Telephone communication can be a barrier, so video conferencing offers closeness, not only with verbal language but also with body language.
- **Facilitating the video call**, which favours understanding and bonding with the professional. It is suitable for deaf women, but also for women with other disabilities. It has been **recommended the revision of the SOTA Service for deaf women,** which is slower and less accessible than desirable.
- As far as possible, especially in the case of WIDD, **it should always be the same ATENPRO professional** or, where appropriate, two reference professionals. Their recovery processes are slower, as are their communication processes and the assimilation of the RV suffered. There will be more setbacks than progress.
- WIDD need **cognitive accessibility criteria**. Brief explanations, clear and simple language.
- It is important to **ensure the understanding** of the information and the reason for the interactions (particularly if they are WIDDs and women with negative experiences with institutions). Due to social desirability and acquiescence, they may claim to understand the practitioner but they may not.
- **Encourage empowerment**. Avoid overprotective, paternalistic attitudes, continuously encourage self-determination and self-representation.

16.2.3. On the evaluation of achievements

Finally, some proposals have also emerged on how to assess the results of the interventions carried out by the ATENPRO Service, **some of the** suggested **evaluation indicators** are:

- Qualitative indicators:
  - Degree of stability in behaviour.
  - Increment of self-esteem.
  - Improvement of health and health perception

- Whether, during care, the frequency of follow-up calls has increased or decreased and an explanation of the reasons for this.
- Autonomy obtained and support received.
- Extent to which the social support network has increased.
- Overcoming grief and the trauma of the whole process.
- Other forms of violence that have been detected and actions taken.

- Quantitative indicators:
  - Number of actions taken to resolve crisis situations.
  - Number of follow-ups calls that have been made.
  - Average length of follow-up calls.
  - Number of calls per crisis situation and type of crisis dealt with.
  - Number of unsuccessful calls and reason.
  - Number of referrals to other resources and type of resources.
  - Number of supports received.

- User satisfaction: usefulness, quality, accessibility of the service and care, women's own perception of their own progress and proposals for improving the service.

17. Proposal for a local intervention model

The elaboration of the following proposal has taken into consideration, in addition to the information gathered throughout the research, the "Reference Catalogue of policies and services on violence against women in accordance with international human rights standards" approved by the Sectoral Conference on Equality, at its plenary meeting held on July 22, 2022 in Tenerife (hereinafter referred to as "the Catalogue").

> This Catalogue is included in the Resolution of March 16, 2023, of the Secretary of State for Equality and against Gender Violence, which publishes the Agreement of the Sectorial Conference on Equality of March 3, 2023, that approves the joint multiannual plan on violence against women (2023-2027)[199] .

Besides, this local model **is guided by three key institutional references**: the Istanbul Convention, the laws and regulations in force and the thematic strategic plans and resolutions of the Sectoral Conference on Equality[200] .

> These references point to the fundamental aspects that should guide the work of any public administration with regard to VAW in Spain. In addition, there are specific recommendations from the monitoring mechanism for the application of the Istanbul Convention to our country (by the GREVIO Committee), and others made by international organisations such as the CEDAW and the CRPD, to which the research has referred to in the relevant chapters (see institutional frameworks at each of the forms of violence studied).

[199] Published in BOE No. 67, Monday March 20, 2023 (access).

[200] With regard to the resolutions of the Sectoral Conference on Equality, these agreements reflect the convergence of the Autonomous Regions and the National Government on the framework for joint action that should exist in our country to guarantee the stability and permanence of public policies and services in the area of violence against women. They are also derived from current legislation and the Spanish State Pact on Gender Violence (updated on November 25, 2021).

17.1. Prevention

17.1.1. Secondary prevention: early identification and local diagnosis

Diagnoses, in terms of research, improves knowledge about VAW. They are essential for the design and evaluation of public policies. Recommendations in this regard have been made in chapter 14.

In relation to measures and **instruments** for a local diagnosis of these *other forms of violence* among women, there are complementary ways to do it:

- Through specific **regular studies at the** local level.
- Within other studies on the forms of VAW that persist, including typologies of RV and the ways in which CNH manifests itself; **asking women directly about its prevalence in surveys**.
- Assessing the **presence and characteristics of the resident population** with respect to the groups and profiles considered most vulnerable.
- Including **new** data **recording fields** in existing instruments.

Along with the above, it is important to look at the local resources where **information** can **start to be recorded and collected**, such as different municipal services (health, SRH, VAW, disabilities' care, Roma population, migrant and refugee population, etc.), as well as private health or disabilities' care providers, and local NGOs.

- **Women's organisations and NGOs** are privileged spaces for the detection and registration of cases.

In terms of early detection, **protocols for the detection and identification** of different types of VAW (including those for the prevention of suicidal behaviour) establish a system of "referral and coordination flows" [201] to facilitate the detection and referral of these cases to comprehensive VAW services.

[201] As stated in the aforementioned Catalogue.

- As indicated above, in Spain we do not yet have this type of tool for the FASC, the GS or the CHNs. However, until they are implemented, **the key professionals of reference would be those from the specialised VAW available resources.**
- The **areas to which detection and identification refer** are very numerous and all necessary: education, healthcare (family medicine, paediatrics, nursing, midwifery, social work, emergencies, mental health and gynaecology), network of Social Services centres, and residential centres (day centres for the homeless or those at risk of social exclusion, disability-related centres, day centres for the elderly, centres for international protection and the inclusion of migrants) and *family meeting points*[202] .
- For the detection of the FASC it is necessary to consider resources providing care for women with disabilities (day centres, occupational centres, special employment centres, work insertion programmes, residential homes, sheltered housing, among others, and associative networks).
- With regard to surrogacy, key detection places could be public officers at municipal census and civil registry offices, as well as paediatric and child care services, primary care, or gynaecology and obstetrics services.
- For the detection of CHN victims: SRH resources, education centres, inclusion services and gender diversity resources.

It would be necessary for professionals to be familiar with a series of warning or risk indicators (although there is a lack of sufficient information for these indicators to be exhaustive):

- An **initial interview** should be carried out to gain a better understanding of the woman's situation. See the recommendations on the detection of violence in the previous chapter.

[202] Note that the Catalogue explicitly mentions the following: "In relation to the mentions of family meeting points in this Catalogue it is indicated that after the reforms brought about by Organic Law 8/2021, of June 4, on the comprehensive protection of children and adolescents against violence and Law 8/2021, of June 2, reforming civil and procedural legislation to support people with disabilities in the exercise of their legal capacity, the minor children of women victims of gender violence should not be referred to these points. However, and given that there are still cases of referral to these centres and that they intervene in civil proceedings that may be caused by situations of gender violence, it is considered necessary to mention them in the Catalogue in order to guarantee the effective detection, from the perspective of gender and childhood, and the referral of cases of violence against women, as well as those cases in which the minor children are also direct victims of gender violence against their mothers, to the specialised comprehensive care services provided for in this Catalogue" (page 41823).

- In conducting the *screening interview* with women, guidelines of safety, privacy and trust, as well as universal and cultural accessibility, should be taken into account.

It is imperative to remember that there is a need to improve knowledge about RV and CNH for the proper assessment of the risk that women and their children are facing; in this regard, the following issues need to be considered:

- A local working group should be established to focus on the safety of these victims; led by the law enforcement and security forces.
- RV and CNH is often an indicator of other forms of violence, so the risks are multiple.
- RV can involve institutional and family perpetrators.
- Perpetrators could be in Spain, but also in other countries.
- In the case of GS, the victims may also be victims of trafficking networks; the coercion figures are varied, including individuals from the community or national and international firms protected by trade agreements.
- In the case of violence related to CNH or HBV, in addition to family environments, the community risk should be assessed.

17.1.2. Education and awareness-raising

In terms of **awareness-raising and sensitisation**, campaigns should be conducted - and their impact evaluated. Campaigns that "pay attention to the causes, especially the direct link between inequality and violence and gender stereotypes, and men's responsibility for their eradication"[203] .

At the local level, the principles of accessibility and universality should be ensured[204] .

- Campaigning has to consider cognitive, physical, sensory and cultural accessibility.
- The continuity of the campaigns should be annual, which means that local advertising must be accessible to the most vulnerable population to these forms of violence.
- In addition, it would be interesting to consider **the most diversified media possible**, such as: downloadable brochures and guides in different formats (easy reading,

[203] As stated in the Catalogue under "Information, awareness-raising and sensitisation".
[204] According to Royal Legislative Decree 1/2013, of November 29, approving the Consolidated Text of the General Law on the Rights of Persons with Disabilities and their Social Inclusion.

pictograms, Braille, explanatory videos with video interpretation or in short/documentary format, subtitled, with simple and clear messages featuring the women themselves and their testimonies, as well as those of family members, professionals in the field of sexual and reproductive health, as well as the judiciary, etc.).

- It is necessary to **make these campaigns visible at the community level**. This implies going beyond the usual resources and jointly committing to the use of other public places: sports, leisure, neighbourhood networks, local businesses, transport, pharmacies, etc.
- Impacts can be multiplied on **significant dates and** international **anniversaries** (see recommendations on awareness-raising and sensitisation).
- Local media and institutional communication should follow basic recommendations on existing good practices on **non-sexist and inclusive language**[205] , representing the diversity and intersectionality of victims.

With regard to RV - and also in CNH due to its relation to harmful practices - awareness-raising, SRHR education and affective-sexual education should be considered essential at all **educational stages.**

Considering the core competences of local authorities, it would be necessary to contemplate:

- content should be available in nursery schools, schools and institutes and non-formal education spaces (e.g., sports, leisure and free time). Along the same lines, training in this area should be guaranteed for parents' associations, school councils, Education Inspection Services or consultative and/or advisory bodies[206] .
- cultural, recreational and social welfare activities for all ages[207] which are privileged community settings for social intervention and the promotion of fundamental rights.

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[205] For example, the Guide on gender and disability for journalists by FCPED, CODIP and COCEMFE (access), the Guide on Inclusive Communication by the Barcelona City Council (access), the Guide on Equal treatment, media and the Roma community by FSG (access) or the Guide on Media and refugees by UNHCR (access).
[206] For example, with these possible contents: women's rights, self-esteem, self-concept and knowledge of the body, sexual orientations and gender identities, SRD, menstruation and SRH care, preparation for gynaecological visits, contraception, good treatment in affective-sexual relationships, VAW, harmful practices.
[207] This "Catalogue" refers to adult education, technical courses, activities and workshops linked to artistic, cultural, specialised disciplines, sports, leisure and free time activities, etc.

With regard to the **training of professionals**, each area requires tailor-made, quality training processes and materials provided by specialists.

In accordance with the Resolution of March 16, 2023, of the Secretary of State for Equality and against Gender Violence, this training must be included in the selective processes for the recruitment of personnel, and therefore the programmes must be updated for all forms of violence.

- It should be "**mandatory, initial and ongoing**" and should serve to ensure "gender-sensitive, diligent, appropriate and respectful action for the victim in the face of any form of violence against women".
- At the local level, these updates should be taken into account in plans for further training and new recruitment.
- The main **professional profiles** to which this training is addressed are:
  - Professionals in areas related to prevention and detection: health staff and in particular SRH, equality, social services, staff with public service functions.
  - Professionals who intervene directly with victims of violence: legal operators, police, emergency services, specialised services for the care and recovery of victims of all forms of VAW, community social services, specialised social services of the child and adolescent protection system, and employment services.
  - Professionals working with vulnerable populations: promotion of Roma rights, attention to disabilities, social inclusion of migrants and international protection, women in prostitution, victims of trafficking for sexual exploitation and labour exploitation.

Finally, in the field of awareness-raising, the **exchange of good practices and networking**, the use of platforms and resources of FEMP and other territorial federations, contribute positively to improving the capacity of local resources.

Together with these, it is recommended to review the existing networks and practices collected in the study (see the specific chapters on the analysis of practices of interest for each violence).

17.2. Comprehensive care

17.2.1. Comprehensive social assistance and reparation

Throughout the research, emphasis has been placed on the characteristics of comprehensive care and universal and cultural accessibility (see chapter 15). Given the characteristics of victims of RV and CNH, accessibility is a prerequisite to ensure care for victims.

Note that the notion of "victims" also refers to girls and adolescents, not just adult women.

The *Catalogue* indicates a series of resources or services that must comply with a series of characteristics, which can be extended to guarantee adequate care for RV and CNH. The following should be taken into account:

Characteristics of the services:

- accessibility and universal design, both the service itself and its environment;
- free of charge, including that of professional communication support services (communication mediation, cultural mediation, speech therapy, translation and interpreting);
- safe and avoid re-victimisation;
- confidential, guaranteeing the privacy and dignity of the victim, children and minors in the care of women victims, as well as other child and adolescent victims and young victims.

In addition to the above, the Catalogue indicates that, in order to assure **effective access** for all victims, and with special reference to those living in rural areas, the following must be ensured:

- universal accessibility of translation and interpreting services.
- management of safe transport services for women.
- support for family reconciliation and care of minor children or other dependent and elderly people.

Similarly, comprehensive assistance should include:

- personal assistance for women with disabilities;

- adaptations to the specific needs of certain groups of women[208] .
- With regard to **health services,** it will be promoted that the Public Health System guarantees free health services for victims of all forms of violence against women and their children, regardless of their administrative situation. Here it is essential to remember that SRH services must be at the centre of attention.

Type of service provision

Victims must be guaranteed access to **health services,** aid/subsides and benefits for **economic autonomy and employment, comprehensive reparation** services and specialised **support, assistance and recovery services**. The Catalogue indicates that "specific protocols for care, health action and multisectoral response" should be drawn up. At the time of the development of this research, **such protocols have not been drawn up** by the public health system.

The table below lists the services included in the Catalogue and their basic benefits with respect to this assistance, to which all victims are entitled:

[208] The Catalogue refers to the needs of rural victims and to the "adaptation of specialised services to the specific needs of young women, older women, women with disabilities, women with addiction problems, mental health problems, homeless women or women at risk of social exclusion, in order to facilitate access to them and guarantee information, advice, care and appropriate psychological, social and legal accompaniment under equal conditions" (page 41824-41825).

Table 7. Basic services and benefits of Comprehensive Social Assistance and Reparation (Reference Catalogue of Policies and Services on Violence against Women 2022)

Aim	Services
Information, advice and guidance	• Information on rights and resources available to victims, their children and family members or close associates, if applicable. • Emergency psychological care to ensure emotional containment or accompaniment. • Legal guidance.
Comprehensive care and recovery	• Social, psychological and other emergency care and intervention 24 hours a day • Legal advice and monitoring of the steps and claims in judicial and administrative processes undertaken by victims to claim their rights. • Secure temporary accommodation, both emergency and long-term. • Personal assistance for women with disabilities
Specialised comprehensive care and recovery for minors (*)	• Social and psychological care and accompaniment in the process of comprehensive recovery of the victims' children. • Specialised care for girls • Schooling and early school leaving prevention and action • Financial aid and benefits, such as those for maintenance and educational needs, and scholarships and grants for university studies in the case of young adults.

Economic autonomy and employment	• Aids/subsidies and benefits (**):
	  ○ emergency situations;
	  ○ due to lack of economic autonomy and unemployment;
	  ○ to housing (purchase and rental).
	• Employment services (job placement and training and job placement programmes)

Health	• Health care, with special attention to mental health, through psychiatric and psychological care until full recovery.
Comprehensive repair	• Supplementary aid by way of compensation and reparation for the specificity or severity of the sequelae • Financing of sanitary treatment not covered but necessary for repair • Support services for the families and emotional environment of murdered women (***) • Social and symbolic reparation (tributes, acts of recognition, public dissemination actions, collective commitment, etc.).

Aim	Services
	• Reintegration and prevention of recidivism of convicted persons (****)

Source: Based on the Catalogue approved by the Sectorial Conference on Equality (Tenerife, July 22,2022).
Notes:
(*) refers to children and other children and adolescents under the guardianship or custody of women victims, as well as children and adolescents who are victims of violence, especially orphans.
(**) contributing to their economic autonomy and emancipation from violent relationships by promoting their compatibility and prioritising their access to them
(***) in order to inform them of their rights and accompany them in the procedure, as well as to facilitate their access to pensions and orphan's benefits, burial assistance, repatriation, scholarships and preferential psychological support, among others, without prejudice to the provisions of the protocols and services for the case of feminicides already in place in the Autonomous Regions.
(****) The Catalogue refers to convictions for crimes related to gender-based violence and crimes against sexual freedom, but could be extended to other forms of violence against women.

Finally, with regard to reparation, local entities would have greater competence for actions related to the rehabilitation and symbolic reparation of victims (see recommendations in this regard in chapter 15.2.9).

17.2.2. Protection and access to justice

Police and judicial facilities should be **friendly, safe and accessible** for all VAW. The care of minors should be carried out by reference persons specialised in gender and childhood. Likewise, communication support professionals should be taken into account from the very beginning.

With regard to protection, the study has highlighted the need to prioritise the production of information on the security needs of RVs and CNHs, which are currently **insufficiently known**.

- It is unavoidable to remember that safety is a necessity for those who file a report or are facing an ex officio report, as well as for those who do not file a report or who abandon a criminal procedure. In any case, the safety of victims should be linked to the development of a ***personalised safety plan*** (PSP)[209] .

[209] The PSP mainly refers to: Always carrying a mobile phone; Making safe use of new information and communication technologies and social networks; Personal self-protection measures in general for all victims; Planning an escape routine in case of a new aggression attempt; Self-protection measures in case of a new aggression only when the victim has minors in her care; Self-protection measures only in case the aggressor has left the home; Self-protection measures only in the workplace; Self-protection measures only when the victim has minors in her care; Self-protection measures only when the aggressor has left the home; Self-protection measures only in the workplace; Self-protection measures only when the victim has minors in her care; Self-protection measures only when the aggressor has left the home; Self-protection measures only in the workplace.

- The actions of the law enforcement and security forces must be **connected to social services and specialised care through** different actions: procedures for collecting reports, procedures for investigating crimes, protection mechanisms and ATENPRO (or other similar mechanisms of the Autonomous Regions through local entities).
- The VIOGEN system[210] of the Ministry of the Interior does not take into account the specific nature of this type of violence. Therefore, specialised care services **should provide for other types of coordination** with the law enforcement and security forces acting at the local level in order to be able to provide the relevant information on the victim and her environment. This is essential to ensure the effectiveness of the police assessment of the risk and its evolution.

In relation to justice, legal aid - for any form of VAW - must be guaranteed from the moment prior to the filing of the report.

- In the care system in Spain, the **Office for Victim Assistance (OAV)**[211] , plays a key role. The OAV should have staff trained in specific forms of violence (FASC, GS and CNH) and work in coordination with the available specialised network.
- In general, it should be made easier for victims to intervene in court proceedings from the places where they are formally living or receiving assistance; efforts should be made to **avoid unnecessary travel**.
- On the other hand, it is necessary to make available to the victims who demand it - at any stage of the procedure - **accompaniment in the judicial process, as well as** non-visibility and non-confrontation with the accused party[212] ; which in the case of the victims of the violence we are dealing with is especially relevant.
- The **Comprehensive Forensic Assessment Units or similar systems** in each Autonomous Community should be accessible to all women, in all judicial districts, 24 hours a day, 7 days a week. AA. should be accessible to all women, in all judicial districts, 24 hours a day, 7 days a week.

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[210] The Integral Monitoring System in cases of Gender Violence (VioGen System), of the Secretary of State for Security of the Ministry of the Interior, was put into operation on July 26, 2007, in compliance with the provisions of Organic Law 1/2004, of December 28, on Integral Protection Measures against Gender Violence. The evolution of VioGen is to contemplate all forms of violence against women.

[211] There should be a minimum of one in each province or specific territorial division of the Autonomous Communities.

[212] Victim-specific rooms in court buildings, and the technological means for videoconference testimony and relevant communication supports should therefore be promoted.

- This implies having teams with adequate specialisation in the types of violence for which we are responsible, and as soon as institutionally possible, with specific protocols for action. For victims of violence against women, it implies showing special sensitivity to the situation of the victims and the potential risks of re-victimisation.
- In the case of RV, it would be necessary to extend the reference to cases of sexual violence, to the FASC and GS, which is made in the Catalogue, where it points out the importance of access to **forensic and gynaecology and sexology services**, 24/7 hours, in sufficient number and trained. Also, psychological assistance if required.

- In the case of foreign women victims of GBV, procedures for **international protection** and their recognition as refugees must be put in place and expedited.
- It is important to include **procedures for the involvement of** the Autonomous Regions and the National Government (in cases of feminicide and other serious manifestations of violence). In this sense, local authorities can also play a role in promoting or demanding such actions before supra-local administrations, or, if necessary, lead the legal intervention in cooperation with the Public Prosecutor's Office and with the representation of the victim's family.

17.3. Coordination and protocols

The centrality of the victim's rights and their autonomy is what shapes all institutional intervention on VAW.

- Regardless of its ownership and sphere of competence, the intervention must be conceived from the point of view of **comprehensiveness, universality and accessibility,** as well as efficiency and effectiveness, which implies **preventing the re-victimisation** or secondary victimisation of the women who are assisted.
- The most effective way is to **work in coordination through a reference body and instrument**, i.e., **a protocol** (or protocols) that helps to organise intervention procedures and coordination between actors, as it provides for referral between actors and resources.

As the Catalogue points out, institutional coordination and collaboration contributes to "preventing feminicides as a priority, also eliminating possible duplication, minimising the risk of re-victimisation and, in any case, guaranteeing comprehensive, personalised, specialised, agile and immediate action".

17.3.1. Coordination and collaboration bodies

At the local level, the starting point is the consideration that **overall coordination** should be carried out by the body, service or area responsible for attention to VAW within the local authority sphere of promoting and guaranteeing equality between women and men in local government.

- Its functions also include promoting the actions foreseen in relation to detection, prevention, protection, access to justice and comprehensive assistance, including reparation.
- Its function would be to promote the implementation and monitoring of the protocol and **sectoral protocols** in the necessary areas (such as: education, health, socio-assistance, police, judicial, lawyers and solicitors, training-labour, etc.).

The local body may consist of a **council, coordination board** or similar body covering the relevant territorial scope (municipal, county, provincial, insular, etc.).

- Representation should be multidisciplinary and include professionals from all areas involved in prevention, protection and assistance to victims, as well as civil society organisations and associations involved in addressing situations of violence against women. In the case of RV and the CNH, this implies **extending participation to all professional figures** involved in care (see previous point).
- Depending on local characteristics, the judiciary/courts may have representation.
- Likewise, a coordination mechanism must be guaranteed with the relevant ACs department responsible for equality and VAW, and with the Coordination Unit or the Violence against Women Unit of the Government Delegation or Subdelegation in the territory. For example, through a stable mechanism of information on the calls and minutes of meetings, or the participation of the relevant supra-local representatives.
- If they are not part of the municipal coordinating body, **coordination with** women's **associations**, entities of the feminist associative movement and non-governmental

organisations that work directly in relation to RV and VAW and their most vulnerable populations should be foreseen. Ideally, however, they should actively participate in the existing local body.

- The operating procedure of this body should include the organising of **Crisis Committees, or working groups** with similar functions, for exceptional situations to improve the institutional response.
- There will always be a crisis committee in the case of feminicides, which should be coordinated or added to the one set up by the Autonomous Community together with the DGVG[213] .
- Finally, among the areas and professionals that take part in the local coordination space, the **exchange and dissemination of good practices**, sectoral protocols, guides and resource maps is an important component to take into account within the coordination. See the previous comments on networking with regard to prevention.

Supra-local action is a determining factor in promoting cross-cutting action on violence, both in terms of funding and in terms of consolidating the institutional framework of reference.

- In this sense, from the local sphere, it is necessary to take a **perspective of constant updating on** the future development of public policies in relation to reproductive violence in the scope of the National Government and the Autonomous Communities. In all of them, the principle of coordination with local entities applies, fundamentally through FEMP (and similar associations in the different autonomous territories).

17.3.2. Analogue protocols and tools

Ideally, there should be a protocol in each Autonomous Communities that organises and facilitates the inter-institutional coordination of actions and networking in the area of VAW[214] , which specifically contemplates RV and CNH. Moreover, these forms of violence should be explicitly included in other protocols, as they are concomitant to other forms of expression of gender-based violence.

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[213] In this respect, the Catalogue states that "Representatives of all regional and/or local institutions with competence in the area of violence against women, together with the judiciary and the public prosecutor's office in the territory, will be encouraged to attend these meetings" (p. 41830).

[214] The regional protocols are updated according to the regulations in force. Their compilation can be consulted in the regional equality bodies with competence in the area of violence against women and on the website of the Government Delegation against Gender Violence.

Despite the lack of a more comprehensive institutional framework, local action can be broadly developed. Local equality policy has always provided pioneering and inspiring examples of public policies for other supra-local levels[215], also with regard to male violence. This is why this *model* or set of guidelines has been proposed for its development at the local level.

Certainly, both the lack of data and the lack of a consolidated institutional framework make *protocolisation* difficult, so this proposal should be taken as **a model open to debate, experimentation and modification.**

Any protocol must be based on **principles of action**; they have been set out in detail (see chapter 15) in the chapter on proposals for intervention. In general, they refer to: the centrality of rights, the autonomy of the victim and universal accessibility (with the necessary technical supports).

Intervention with the victim and her children must always be individualised and articulated on the basis of a **personalised care plan**[216].

As explained throughout the chapter, in terms of **intervention pathways and procedures** in situations of RV and CNH, the competences and responsibilities of the institutions are determined by the rights of the victims and the guarantee to the services in the Catalogue (2022).

With regard to the proposals referred to throughout this report, once again, they are experimental in nature and open to discussion. The following diagram graphically summarises a basic intervention model.

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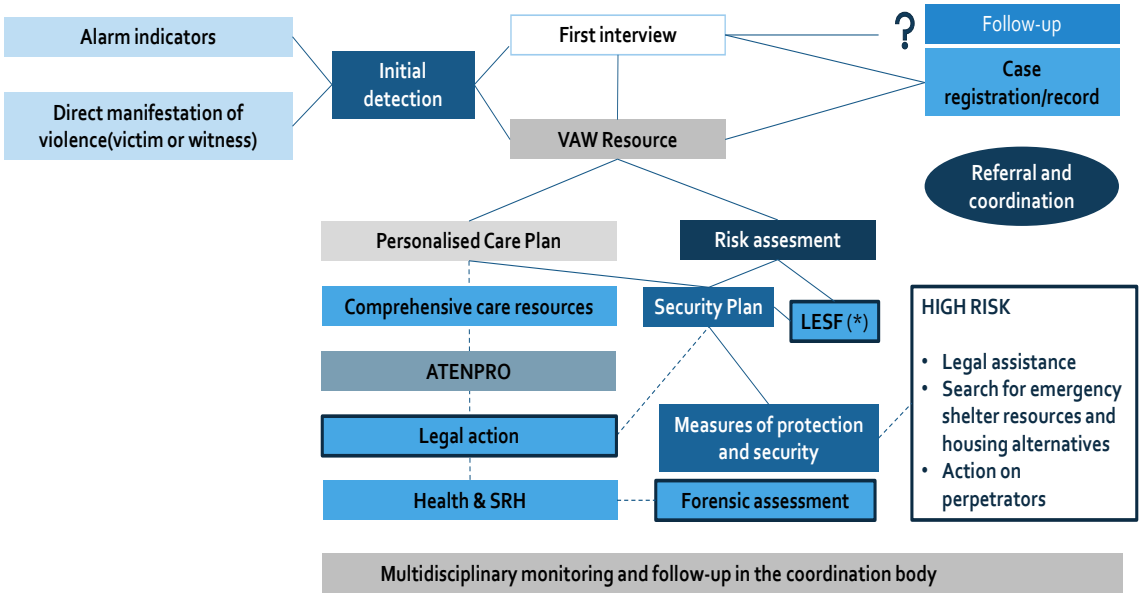
215 See for example the action of FEMP and other associations of municipalities and provinces in Spain, which have proposed local models of action and protocols on equality and violence against women (Guilló, et al. 2022).

216 There are general guidelines and some implementation models proposed by some Autonomous Regions, see: DGVG (2014). Proposal of guidelines for comprehensive and individualized intervention with women victims of gender violence, their sons and daughters and other dependents Online document (access); DGVG(2012?) Common proposal to improve institutional coordination and implement a personalized care plan for victims of gender violence. Online document (access). Directorate General for Women (2017). Personalized Care Plan Manual for victims of gender violence. Edition with care guidelines for women with disabilities. Department of Family and Equal Opportunities - Autonomous Community of the Region of Murcia. Online document (access).

Figure 12. Outline of a basic action model (proposal)



(*) Law enforcement and security forces

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Annex 1. Local authorities participating in the survey

The survey allowed for both anonymous responses and organisational identification. There were 229 identified local entities (which were not anonymous responses), all of which we thank for their participation:

City of Edinburgh Council, Scotland, United Kingdom

Consejo de la Región Mediterránea de los Pirineos de Occitania, Francia (Conseil Région Occitanie Pyrénées Méditerranée, France)

Agrupación Servicios Sociales Zona Básica de Artajona (Artajona, Larraga, Berbinzana y Miranda De Arga)

Ajuntament d' Almoines

Ajuntament de Alcalà de Xivert-Alcossebre

Ajuntament de Carcaixent

Ajuntament de Cornellà De Llobregat

Ajuntament de Foios

Ajuntament de Llorenç del Penedes

Ajuntament de Mutxamel

Ajuntament de Paiporta

Ajuntament de Sant Boi de Llobregat

Ajuntament de Sant Just Desvern

Ajuntament de Sot de Chera

Ajuntament de Tàrrega

Ajuntament de Vallirana

Ajuntament de Viladecans

Ajuntament de Vilanova De Segrià

Ajuntament de Vilobí d'Onyar

Ajuntament del Poble Nou de Benitatxell

Ajuntament d'Oliva

Ajuntamiento de Yecora

Ayuntamiento de Ablitas

Ayuntamiento de Adeje

Ayuntamiento de Alaior

Ayuntamiento de Alcalá de Henares

Ayuntamiento de Alcantarilla

Ayuntamiento de Alcobendas

Ayuntamiento de Alcoy

Ayuntamiento de Alcublas

Ayuntamiento de Aldeire

Ayuntamiento de Alfondeguilla

Ayuntamiento de Alhaurin de la Torre

Ayuntamiento de Alhendin

Ayuntamiento de Alicante

Ayuntamiento de Aller

Ayuntamiento de Allo

Ayuntamiento de Almedinilla

Ayuntamiento de Almensilla

Ayuntamiento de Almería

Ayuntamiento de Almodóvar del Rio

Ayuntamiento de Alzira

Ayuntamiento de Amescoa Baja

Ayuntamiento de Andosilla

Ayuntamiento de Andújar

Ayuntamiento de Ansoáin

Ayuntamiento de Antequera

Ayuntamiento de Arantza, Bera, Etxalar, Igantzi y Lesaka

Ayuntamiento de Aras de los Olmos

Ayuntamiento de Ares

Ayuntamiento de Arrecife

Ayuntamiento de Arriate

Ayuntamiento de Aspe

Ayuntamiento de Barcelona

Ayuntamiento de Baztan

Ayuntamiento de Beas de Segura

Ayuntamiento de Becerreá

Ayuntamiento de Benasque

Ayuntamiento de Benetússer

Ayuntamiento de Berriozar

Ayuntamiento de Betanzos

Ayuntamiento de Betera

Ayuntamiento de Bétera

Ayuntamiento de Burjassot

Ayuntamiento de Burlada

Ayuntamiento de Cáceres

Ayuntamiento de Cacin

Ayuntamiento de Calatayud

Ayuntamiento de Calzada de Calatrava

Ayuntamiento de Camas

Ayuntamiento de Cangas

Ayuntamiento de Carboneras

Ayuntamiento de Cartagena

Ayuntamiento de Cartaya

Ayuntamiento de Casares de Las Hurdes

Ayuntamiento de Castelló de la Plana

Ayuntamiento de Castilleja del Campo

Ayuntamiento de Cendea de Olza, Belascoain, Bidaurreta, Etxauri y Valle de Ollo

Ayuntamiento de Cenes de la Vega

Ayuntamiento de Cerdanyola del Vallès

Ayuntamiento de Ceutí

Ayuntamiento de Chantada

Ayuntamiento de Cieza

Ayuntamiento de Córdoba

Ayuntamiento de Corella

Ayuntamiento de Cubo de Tierra del Vino

Ayuntamiento de Dos Hermanas

Ayuntamiento de El Castillo de las Guardas

Ayuntamiento de El Real de la Jara

Ayuntamiento de El Sauzal

Ayuntamiento de Enguera

Ayuntamiento de Escalona

Ayuntamiento de Firgas

Ayuntamiento de Fuenlabrada

Ayuntamiento de Fuente del Arco

Ayuntamiento de Gandía

Ayuntamiento de Gijón

Ayuntamiento de Gotarrendura

Ayuntamiento de Guarroman

Ayuntamiento de Hermisende

Ayuntamiento de Ingenio

Ayuntamiento de Iniesta

Ayuntamiento de Junciana

Ayuntamiento de La Algaba

Ayuntamiento de Larva

ayuntamiento de las palmas de gran canaria

Ayuntamiento de Las Torres de Cotillas

Ayuntamiento de Lena

Ayuntamiento de Los Arcos

Ayuntamiento de Lupión

Ayuntamiento de Málaga

Ayuntamiento de Malpartida de Cáceres

Ayuntamiento de Mandayona

Ayuntamiento de Manises

Ayuntamiento de Marchena

Ayuntamiento de Marratxí

Ayuntamiento de Moguer

Ayuntamiento de Monforte de Lemos

Ayuntamiento de Monóvar
Ayuntamiento de Montanejos
Ayuntamiento de Moral de Calatrava
Ayuntamiento de Noreña
Ayuntamiento de Numancia de la Sagra
Ayuntamiento de O Carballiño
Ayuntamiento de Órgiva.
Ayuntamiento de Orkoien
Ayuntamiento de Paiporta
Ayuntamiento de Peñaranda de Bracmonte
Ayuntamiento de Peñarroya-Pueblonuevo
Ayuntamiento de Peñíscola
Ayuntamiento de Pezuela de Las Torres
Ayuntamiento de Pinos Genil
Ayuntamiento de Pollença
Ayuntamiento de Puebla de Cazalla
Ayuntamiento de Puente de Genave
Ayuntamiento de Puertomingalvo
Ayuntamiento de Pulianas
Ayuntamiento de Quart De Poblet
Ayuntamiento de Quintanilla Del Olmo
Ayuntamiento de Ribaforada
Ayuntamiento de Roda de Berà
Ayuntamiento de Sa Pobla
Ayuntamiento de San Esteban del Valle
Ayuntamiento de San Fernando
Ayuntamiento de San Fernando de Henares
Ayuntamiento de San Isidro
Ayuntamiento de San Sebastián de los Reyes
Ayuntamiento de Sant Antoni de Portmany
Ayuntamiento de Sant Joan Despí
Ayuntamiento de Santa Maria del Camí
Ayuntamiento de Santa Susanna
Ayuntamiento de Sardón de Duero
Ayuntamiento de Sax
Ayuntamiento de Segorbe
Ayuntamiento de Serradilla
Ayuntamiento de Siero
Ayuntamiento de Soto del Real
Ayuntamiento de Tafalla
Ayuntamiento de Tíjola
Ayuntamiento de Torrecillas de la Tiesa
Ayuntamiento de Torrevieja
Ayuntamiento de Totana
Ayuntamiento de Úbeda
Ayuntamiento de Utrera
Ayuntamiento de Valladolid
Ayuntamiento de Vilalba
Ayuntamiento de Villanueva de Gallego
Ayuntamiento de Villar del Arzobispo
Ayuntamiento de Villava
Ayuntamiento de Villavicosa De Odon
Ayuntamiento de Zamora
Ayuntamiento de Zumárraga
Ayuntamiento del Valle de Aranguren
Ayuntamiento del Valle de Yerri
Ayuntamientode de Peal de Becerro
Centro Comarcal de Información a la Mujer de Arquillos-Castellar-Chiclana de Segura-Montizon-Navas de San Juan y Sorihuela del Guadalimar
Centro de la Mujer Ayuntamiento de Calera y Chozas
Centro de la Mujer Ayuntamiento de Huércal-Overa
Centro de la Mujer Consell Insular de Menorca
CIM Coirós
CIM Concello de Xinzo de Limia
CIM de Palas de Rei

Concello de Bergondo

Concello de Brión

Concello de Burela

Concello de Coles

Concello de Fene

Concello de Guitiriz

Concello de Laxe

Concello de Maceda

Concello de Miño

Concello de Moaña

Concello de Mos

Concello de Tordoia

Concello de Tui

Concello de Vilalba

Concello de Xermade

Concello de Lalín

Consell Comarcal del Baix Penedès

Consell de Mallorca

Cuadrilla de Gorbeialdea

Diputación de Granada

Diputación de Palencia

Diputación de Sevilla

Diputación de Valladolid

Legazpiko Udala

Leitza, Goizueta, Areso Eta Aranoko Gizarte Zerbitzuen Mankomunitatea

Mancomunidad Bajo Segura de Servicios Sociales (Ayuntamiento de San Isidro, Ayuntamiento de San Fulgencio)

Mancomunidad de la Hoya de Buñol-Chiva

Mancomunidad de las Vegas (Ciempozuelos, Chinchón, Morata de Tajuña, Titulcia y Villaconejos)

Mancomunidad de Municipios de la Comarca de Ordes

Mancomunidad de Municipios Siberia

Mancomunidad de Servicios Sociales Auñamendi (Valle de Aezkoa, Valle de Erro, Auritz-Burguete, Orreaga-Roncesvalles, Luzaide-Valcarlos)

Mancomunidad de Servicios Sociales de Base de Zona Noáin (Beriáin, Biurrun - Olcoz, Cendea de Galar, Ibargoiti, Monreal, Noáin, Tiebas - Muruarte de Reta, Unzué)

Mancomunidad de Servicios Sociales THAM

Mancomunidad La Serranía

Mancomunidad La Vega (Algorfa, Jacarilla, Redován, San Miguel de Salinas)

Mancomunidad Montes de Cijara

Mancomunidad Santa Agueda

Mancomunidad Servicios Sociales de Base de Valdizarbe

Mancomunidad Terra de Celanova

Mancomunidad Valdizarbe

Mancomunitat de Carraixet

Mancomunitat de Municipis de la Vall d'Albaida

Mancomunitat Pla de Mallorca

Ordiziako Udala

Patronato Servicios Sociales de Arona

Servicios Sociales (PRAS) Fuente El Fresno

Servicios Sociales (PRAS) de Sta. Olalla, El Casar de Escalona y Otero

Servicios Sociales de Berriozar, Berrioplano, Ansoain, Juslapeña e Iza

Servicios Sociales de Daganzo de Arriba

Annex 2. Organisations and experts participating in the survey

In the fieldwork surveys, those organisations and experts identified in the specific questionnaires were the following (we thank them all for their valuable participation):

Acccem

Agrupación de Personas Sordas de Zaragoza y Aragón (ASZA)

Ángeles Blanco -Delegada de Derechos Humanos y Coordinadora de Incidencia de Confederación ASPACE.

Asociación AFEMAGRA Salud Mental Granada Nordeste

Asociación APSA

Asociación de Enfermedades Neuromusculares de Castilla La Mancha (ASEM CLM)

Asociación de Familiares y Personas con Enfermedad Mental de la Costa del Sol (AFESOL)

Asociación de Familiares y Personas con Enfermedad Mental de Moratalaz (AFAEMO)

Asociación de Mujeres con Discapacidad XARXA

Asociación de Mujeres Juristas THEMIS

Asociación de Mujeres Opañel

Asociación de personas con lesión medular y otras discapacidades físicas (ASPAYM Madrid)

Asociación Liber (antigua Asociación Española de Fundaciones Tutelares)

Centro de Atención Integral a Mujeres Víctimas de Violencia Sexual de la Comunidad de Madrid (CIMASCAM) (Fundación Aspacia)

Centro de salud de la Comarca de la Sierra de Albarracín

CERMI Andalucía

CER-Migracions, Universidad Autónoma de Barcelona

Comisión de Mujeres e Igualdad de CERMI Región de Murcia

Comisión Española de Ayuda al Refugiado (CEAR)

Confederación ASPACE

Confederación de Entidades de Personas con Discapacidad Física y Orgánica CODISA PREDIF Andalucía

Confederación Estatal de Personas Sordas (CNSE)

Confederación Plena inclusión España

Consell Comarcal del Vallès Oriental

Federación de Asociaciones de Mujeres con Discapacidad en Andalucía (FAMDISA)

Federación personas sordas de Valencia-Espai Dona (FESORD CV)

Federación Salud Mental Castilla-La Mancha

Fundación ASPACIA

Fundación Cermi Mujeres

Fundación de Solidaridad Amaranta

Fundación Márgenes y Vínculos

Fundación Save the Children

Fundación Secretariado Gitano

Hospital Clínico Universitario Lozano Blesa

Hospital Clínico Universitario Virgen de la Arrixaca

Hospital de Laredo

Instituto de la Mujer de Extremadura

Julia Mohino Andrés Plena Inclusión CyL

Laura Parra Sánchez (CERMI RM)

Lucía Ciudad Real Marlasca - AFAEMO

Maritxu Mayoral (Dir. del Centro de Acogida de Refugiados de Getafe)

Médicos del Mundo

Montserrat Vázquez Lolo - Federación Salud Mental Castilla-La Mancha

Núria González López (abogada experta en derechos humanos)

ONG Rescate

Plena Inclusión Castilla y León

Plena Inclusión Extremadura

Plena Inclusión La Rioja

Red Feminista de Derecho Constitucional

Salud Entre Culturas (SEC)

Servicio de Salud del Principado de Asturias (SESPA)

Stop Vientres de Alquiler

Unitat d'atenció a la salut sexual i reproductiva (ASSIR) del Institut Català de la Salut (ICS) Camp de Tarragona (Gerència Territorial)

Universidad Complutense de Madrid (investigadora anónima)

Universidad Pablo de Olavide (investigadora anónima)

Universitat de València (investigadora anónima)

Wassu Gambia Kafo (WGK)

Annex 3. Interviews: list of experiences and informants

We thank all the experts, local entities and organisations for their participation in this research.

The list of informants and experiences analysed is as follows:

NO.	**Experience/ entity**	**Informant**	**Ref.**
E1	SAVIEX: Support Service for Women and Girls with Disabilities Victims of Gender Violence in Extremadura (Cermi Extremadura)	Laura Ramos, Psychologist and head of service	E1P1
E2	Psychosocial Rehabilitation Centre of San Fernando de Henares (CRPS). Social Care Network for people with severe and long-lasting mental illness in the Community of Madrid.	Margarita Rullas Trincado, Director	E2P1
		Nadia Berodia Sánchez, Psychologist	E2P2
E3	Building Sexualities Project. Los Realejos Town Council (Santa Cruz de Tenerife) and the State Association Sexuality and Disability.	Natalia Rubio Arribas, Psychologist, sexologist and director - president	E3P1
E4	Alba service for the care and support of deaf women. Gender equality policy area of the State Confederation of Deaf People (CNSE).	Alba Prado Mendoza, Gender Equality Policy Coordinator and ALBA Service Manager.	E4P1
		Cristina López Arellano, Technician	E4P2
E5	Socio-legal support channel for women with cerebral paralysis who are victims of gender violence. ASPACE Confederation	Ángeles Blanco, Lawyer and Human Rights Delegate and Advocacy Coordinator	E5P1
E6	Women's Observatory of Plena Inclusion Madrid	Clara Moratalla, Sexologist and Psychologist Asociación AMI3 Madrid.	E6P1
		Psychologist (MDID care)	E6P2
E7	Specialised Assistance Units for women with disabilities who are victims of GBV. Confederation of Organisations of People with Physical and Organic Disabilities of Andalusia (CODISA PREDIF Andalusia)	Nieves Galán, Psychologist and Unit Coordinator	E7P1
E8	GS: Defending women's HRDs	Nuria González López, Lawyer expert in Human Rights	E8
E9	GS: Pregnancy, childbirth and postpartum care	Helena López Paredes, Midwife expert in SRH. UN Consultant	E9
E10	PakMir Pakistani Women's Association	Rubia Naz Ali Kousar. Spokesperson	E10

NO.	**Experience/ entity**	**Informant**	**Ref.**
E11	PAPATYA Crisis Centre (Germany) for crimes in the name of "honour".	Officer in charge of the service	E11
E12	Diasporas with significant "honour" practices in Spain	Sandra Santos Fraile, Anthropologist. Complutense University of Madrid. Institute for Feminist Research	E12
E13	Iranian and Kurdish Women's Rights Organisation (IKWRO) (UK). Counselling for victims of honour	Diana Nammi, Executive Director	E13
E14	Government Delegation on Gender Violence (DGVG)	Macarena Gámir Linares, Deputy Director General for Inter-institutional Coordination on gender-based violence	E14P1
		Belén Gallo, Forensic doctor and lawyer. Advisory member	E14P2
E15	United Nations High Commissioner for Refugees (UNHCR Spain)	Eva Menéndez Sebastián, Senior Protection Associate	E15
E16	Spanish Red Cross (SRC)	Head of ATENPRO Service	E16P1
		Head of the Women's Programme	E16P2
E17	Directorate General for Equality Policies and against Gender Violence of the Madrid City Council	Marta Oliva de la Torre, Head of the Unit for the Care of Intimate Partner/Ex-Partner Violence	E17P1
		Mª Carmen García, Director of Municipal Points I and II of the Regional Observatory on Gender Violence (PMORVG).	E17P2
		Yolanda Vega, Deputy Director of the Service for Women Victims of Gender Violence (SAVG 24 Horas)	E17P3
		Laura Membiela Ontoria, Coordinator of the Emergency Centre for women victims of gender-based violence	E17P4