Chapter Seven

Beyond the Clinic: Violence Prevention with Other Community Partners

One of the most important lessons that health providers have learned, as they take on gender-based violence in their daily practice, is that no one profession or group can eliminate violence working on its own. Although national policies, laws, and programs are necessary to create a supportive environment for change, the real work of violence prevention takes place in the communities themselves. In many different geographical settings visited by the review team, the health care providers who reported having the most positive experiences in addressing GBV attributed much of their success to close coordination with other local leaders, government institutions, and NGOs based in their own communities.
The principal community-based activities carried out as part of the PAHO project were the following:
+ training health leaders and promoters;
+ strengthening local networks for coordinating violence prevention efforts;
+ public education, within and outside the clinical setting;
+ reflection groups with men; and
+ support groups for women survivors of violence.

This chapter presents the achievements and constraints of the various PAHO GBV programs and initiatives from the perspective of community participants and clients. In order to gain the perspective of stakeholders outside the health sector, the assessment team met with community health leaders and midwives, women’s groups, and other organizations participating in both local and national commissions for violence prevention. Participatory techniques such as the use of timelines and Venn diagrams were used to encourage participants to talk candidly about the community forces that have helped or hindered violence prevention efforts. These techniques and the information they yielded will be described in this chapter.

COMMUNITY HEALTH PROMOTERS
Sensitizing community leaders (traditional birth attendants, legal advocates, health promoters, etc.) about GBV was considered an important strategy for engaging community members in violence prevention in all countries. The intensity of training and awareness-building initiatives varied among the countries, as well as the specific activities performed by community promoters. In some communities the promoters only referred cases to the police or health centers, whereas in other settings they had been trained to offer crisis intervention and legal counseling and even to accompany women through the legal process. The community volunteers provide an important link between health services and the communities. In most cases health promoters also carry out educational activities on violence prevention and provide women with information about their legal rights and other available community services.

In the Justo Rufino Barrios Clinic in Guatemala City, health promoters perform short theatrical skits in the waiting rooms as a way of introducing the topic of violence and encouraging patients to talk to their providers if they need help. Because health leaders, and particularly traditional birth attendants, are well-respected in their communities, they are particularly well-positioned to be able to influence views and behavior.

LESSONS LEARNED
Community health leaders have a crucial role to play in violence prevention, through the promotion of nonviolent relationships, and by informing the community and women in particular about their legal and social rights and providing information and appropriate referrals to abused women. In addition to providing appropriate training, health providers should work together with community health leaders to agree upon the roles and responsibilities of all actors. Providers should also meet regularly with community volunteers to ensure that they are receiving sufficient support in their work.
“I helped a woman who felt smaller than a cockroach because her husband wanted to take away her house and the children. I took her to the health center, and after she talked to them her burden was lighter.” —Community health worker, El Salvador

The training sessions for community promoters commonly address a broad range of issues, such as different types of violence and their impact on the health of women and children, and include a discussion of gender roles and how gender-based discrimination encourages violence. The participants also gain a greater understanding of how the legal system works and what options are available to victims of violence in their own communities.

In many health centers that have programs for community health promotion, the GBV training is carried out as part of a larger, more comprehensive training that includes aspects of reproductive and child health, environmental sanitation, and other basic health topics. In some settings, however, community women were invited to workshops on violence prevention and became so motivated by the training sessions that they started their own violence programs. For example, a group of traditional birth attendants in the town of Santa Lucia, Guatemala, created their own violence prevention organization and obtained support from the local mayor’s office as well as the health center to provide counseling for abused women. After the creation of the Luciana Women’s Group, many women felt for the first time that there was someone they could turn to with their problems. After the group members had received additional training through the PAHO project, health personnel would refer women to them, and the group even set up an office within the health center itself and the members took turns staffing the service. One of the strengths of this approach was that women felt more comfortable talking to someone with a background similar to their own:

“... Women felt supported by the women’s office that was in the mayor’s office, and they used to say to their husband, ‘if you hit me I’ll take you to the office....’” —Traditional birth attendant, Santa Lucia, Guatemala

“... Women, when they begin to talk about their situation of violence, want someone to tell them what to do, because they feel disoriented, with very low self-esteem, and they need economic help.” —Traditional birth attendant, Santa Lucia, Guatemala

Another group of Mayan women from the town of Totonicapán in Guatemala, feeling that the government offices would be unable to respond adequately to the needs of indigenous women, created their own center for abused women with international support.

“... In the indigenous communities of Guatemala, even though women are informed about the laws, it is not enough, because the community leaders, mostly men, have a lot of influence on women’s decisions, and their view is that violence is ‘normal’ among couples. ...” —Educator from Cobán, Guatemala

“Women feel much better when they are accompanied to the courts and the police station by the project’s legal promoters because they feel that they are not alone and that they are being listened to. ...” —Mayan midwife from Totonicapán, Guatemala

In other communities, particularly in El Salvador and Nicaragua, services for abused women offered by local women’s groups already existed when the PAHO
project started, although in most cases there was previously little coordination between these groups and local health services. In these cases, the goal of the PAHO project was to encourage health providers to reach out to the groups already working on violence, to learn from them, and to begin to coordinate with them in prevention activities and care for the survivors. Health providers in communities where work on violence was already ongoing found that the existence of these resources made it much easier for their own programs to take hold.

COMMUNITY-BASED NETWORKS
PAHO’s integrated approach for addressing GBV has placed great emphasis on the development of community-based networks for violence prevention. The Critical Path study found that improving coordination between institutions that deal with GBV was an essential step to improving care for survivors, who, in most cases, were forced to maneuver their way through enormously complicated and duplicative procedures in each institution, which, as this book has shown, caused many women to become discouraged and eventually abandon their search for help.
Community-based networks have two major goals—to provide a comprehensive range of services that effectively meets the needs of survivors of violence, which can be achieved by improving communication and coordination between groups working on GBV; and secondly, to raise public awareness and transform community attitudes that encourage and/or tolerate violence.

When the PAHO GBV project first began, there was a wide disparity between the countries with regard to the levels of GBV interest and awareness among local institutions. In some countries, such as Nicaragua, violence prevention networks had already been operating for many years, and the main challenge was motivating health personnel to participate in them. In other cases, health workers, with the help of the PAHO project, took the initiative to bring community groups and institutions together for the first time. To date, there is still a great deal of dissimilarity among the countries with regard to how highly developed the networks are. In Guatemala, for example, where there is very little tradition of coordination between state institutions and civil society, community leaders noted that it has been a struggle to maintain ongoing coordination among the different governmental actors, such as the police, judges, and the health sector, and even more difficult to coordinate actions with women’s groups. Providers and women’s activists reported that periodical efforts were made to increase coordination, but that these tended to dissipate fairly quickly. In the town of Comayagua, Honduras, coordination between the Family Counseling Center and other institutions dealing with violence (the Human Rights Commission, police, child welfare bureau, etc.) was very strong. However, network members reported that they did not meet regularly as a group, or plan activities jointly, but rather settled specific issues on an ad hoc basis as the need arose.

In order to understand how community members—both clients and the service providers themselves—view the different types of support available to survivors of violence, a participatory technique called “Who Helps Rosita,” based on the use of Venn diagrams, was carried out in the various project communities visited (see Figures 7-1., 7-2., and 7-3.). This exercise compares the relative support provided by state institutions, community services, and individuals. Different sized and colored circles were used to represent these and other groups who could potentially help Rosita, who, as we saw in Chapter Six’s introductory section, is a mother of two children and lives with her abusive husband. The darker colored circles indicated government institutions, and the lighter ones represented nongovernmental groups, such as women’s organizations, church groups, friends, relatives, and neighbors. The participants were asked to assess each of the groups according to how helpful they found them to be (represented by the size of the circle—the larger the circle, the more helpful), and how responsive they were (the closer the circles’ proximity to Rosita, the more responsive they were considered to be to her needs).

There was a clear relationship between the strength of local networks and the women’s perceptions of the number and types of institutions that they could turn to for help. In two sessions with Guatemalan activists—one with community health leaders in a peri-urban neighborhood of Guatemala City and another with indigenous women activists from the rural town of Totonicapán—the participants’ views of state institutions were quite similar, despite the differences between the two settings (Figures 7-1. and 7-2.). In
both cases, participants considered church groups and family networks to be the most important sources of support for abused women. At the same time, the health center—and specifically the GBV personnel—were considered to be the only government-run services that were responsive to women. In general, all other institutions that might be expected to help abused women, such as the police, the courts, forensic doctors, etc., were categorized as either unavailable or not helpful.

Not surprisingly, in both settings, health providers acknowledged that it had been very difficult to build institutional networks for the coordination of GBV work, since the other institutions seemed unwilling to commit the time and effort needed to create and sustain them.

A very different situation was found in the rural town of Apopa, in El Salvador, where the director of the health center brought together more than 20 members of the local violence prevention commission, including the town’s mayor, police chief, NGO representatives, and district health officials, to discuss its work with the review team. Although participants acknowledged that the commission had, at best, functioned only on an intermittent basis, its formation had clearly generated a higher level of enthusiasm and concern around the issue. Interestingly, this was reflected in the results of a focus group discussion with women clients of the Chintic Health Center in Apopa. These women were able to name several government institutions, as well as NGOs and women’s groups, who could assist abused women [Figure 7-3]. Many of them had personally been helped or else knew someone who had been helped by the police or the local courts. They told many stories in which the police had been sup-

portive of women living in violent situations even when family members and neighbors had not offered them help.

“When the family took his side, the police told them to stay out of it, and they didn’t let his mother go to the station with him.”
—Health promoter, Apopa, El Salvador

WHAT MAKES A COMMUNITY NETWORK SUCCESSFUL?
Of the four countries visited during the review, Nicaragua has the longest and richest experience with community networks for violence prevention. Even in the towns where efforts to address GBV in the health center were just getting underway, they benefited enormously from the already-established tradition of strong community participation and coordination.

Nicaragua’s experience is unique in several respects. To begin with, there has been an

LESSONS LEARNED
The establishment of community networks can greatly help in coordinating services for victims of violence and in developing joint programs for violence prevention. In all of the countries reviewed, women’s organizations and related groups have played a pivotal role in consolidating the networks. In addition, different sectors have played key roles in specific countries: for example, the National Police Force, through the Women and Children’s Police Stations, have been the driving force for coordination in Nicaragua, whereas in Belize, Costa Rica, and Panama, the health sector has played a prominent role.
FIGURE 7.1. WHO HELPS ROSITA?
Opinions of Mayan women from Totonicapán towards institutions and groups working with gender-based violence in Guatemala, using Venn diagrams. Darker circles indicate government institutions, and the lighter ones represent nongovernmental groups, such as women’s organizations, church groups, friends, neighbors, and relatives. The more helpful the group the larger the circle and the closer its proximity to Rosita. Positive and negative signs (+/-) placed together indicate that the experience with this group could be either positive or negative, depending on the particular situation.
FIGURE 7-2. WHO HELPS ROSITA?
Opinions of health volunteers from Justo Rufino Barrios Clinic, Guatemala, towards various types of support networks for abused women

- **Neighbors (+/-)**: They don’t like to get involved, since he is the man of the house.
- **Psychologist in the health center**: She listens to the women and teaches them to love themselves.
- **Social worker at the health center**: Women pretend to be sick so that they can get permission to go to the health center.
- **Police**: They say he is her husband and she should put up with him.
- **Rosita’s family (+/-)**: They don’t like to get involved, since he is the man of the house.
- **Churches, spiritual retreats +/-**: They tell her “it’s your fault; you should take better care of your husband.”
- **Health volunteers**: We are members of the community, and we understand what is going on.
- **Rosita’s family (+/-)**: They can help her to escape.
- **Public Ministry Office**: They can help her to escape.
FIGURE 7-3. WHO HELPS ROSITA?
Opinions of community women from Apopa and Guazapa, El Salvador, regarding community resources for gender-based violence

You can call 911, and the police will come with a counselor.

The doctors here are like psychologists.

You can call 911, and the police will come with a counselor.

They call the husband in, and if he doesn’t come they go pick him up.

The neighbors told the police I had bloodied myself just to make him look bad.

The neighbors told the police I had bloodied myself just to make him look bad.

They are close and can tell you where to go.

The neighbors told the police I had bloodied myself just to make him look bad.

The neighbors told the police I had bloodied myself just to make him look bad.

You can call 911, and the police will come with a counselor.

They call the husband in, and if he doesn’t come they go pick him up.

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extensive organized movement of women’s organizations working with GBV for more than 10 years. Over 100 organizations throughout the country participate in the National Network of Women against Violence, which also has regional networks in most of the major cities and towns. The Network carries out yearly national awareness campaigns; it drafted and successfully lobbied for the passage in 1997 of the Family Violence Law; and network members play an active ongoing role in the development and monitoring of the Women and Children’s Police Stations. It also has a research and health commission, which, in 1995, together with the Medical School of UNAN-León, performed the first population-based study on the prevalence of domestic violence in Central America (Ellsberg et al. 2000). The group also has produced educational materials on GBV, including a training manual for health workers used widely throughout the country (Red de Mujeres contra la Violencia 1999). In several districts, members of the local violence networks have helped to train health workers in GBV.

Without a doubt, a major force that has shaped work on GBV in Nicaragua is the creation of the 17 Women and Children’s Police Stations (Comisarias) that currently function in all the major cities throughout the country. The stations are staffed by trained women police officers and social workers and have been financed primarily through international support. In addition to receiving and investigating complaints of violence, the police stations work together with local NGOs to provide rehabilitation services and public education on violence. Whenever a Comisaria is set up, local networks are established to provide technical support and oversight for its work. Network members also receive training and other resources for prevention activities and services that have contributed greatly to the strength of the Comisarias as well as to the community networks.

In Nicaragua, the review team met with the local violence prevention networks in Chinandega, in the country’s northwestern corner; Bluefields, on the Atlantic Coast; and Esteli, a town in the country’s northern area.

In addition to being the first pilot site for the PAHO project, Esteli was one of the first cities to establish a Women and Children’s Police Station. There are five different non-governmental centers in the town that provide psychological, legal, and/or medical services for survivors of violence, including Acción Ya, Nicaragua’s first shelter for abused women. In addition to these centers, a Commission for Violence Prevention has been created that includes the local and district judges, the district attorney, and representatives of the Ministries of Health, Education, and the Family. Using an exercise called “The Road Traveled,” members of the network described the most important moments in their history and placed these in chronological order along a timeline, with positive events on the top half of the line and factors that negatively influenced the process on the bottom (Figure 7-4.).

In Esteli the process began in 1995 with the establishment of the Women and Children’s Police Station. According to the group, the achievements that most contributed to the consolidation of its work were:

* carrying out joint training workshops for all members of the network (police, judges, and youth groups);

* travel exchanges with other countries to learn from their experiences (for example,
FIGURE 7-4. THE ROAD TRAVELED
A timeline of significant events developed by the Commission for Violence Prevention in Estelí, Nicaragua

- 1995 Opening of the first Women and Children’s Police Station
- 1996 The network expands coverage and carries out extensive training, dissemination, and coordination activities
- 1997 First municipal network created in Condega municipality
- 1998 Children’s rights network created
- 1999 PROSILAIS–PAHO workshops on masculinity for police, youth, rural communities
- 2000 Travel exchange between networks Nicaragua/Bolivia
- 2001 New Police Station project launched

“At first it was hard to join forces.”

The funding of the Police Stations project was discontinued for 18 months. During this period there were fewer meetings and project activities. The social worker was laid off.

By developing joint plans for training and public awareness activities, the Estelí network was able to optimize scarce funding and to leverage funding from other sources, such as the PROSILAIS health reform project funded by the Swedish Government, which financed the study tours of health professionals from other regions in the country to Estelí.

Another example of effective leveraging of resources is the newly formed violence prevention commission in Bluefields. The Ministry of Health representatives have

- a PAHO-supported exchange between the Estelí network and a town in Bolivia);
- the creation of municipal networks in the smaller towns surrounding Estelí, such as Condega, which increased the scope of the GBV work considerably;
- setting up a national training program in Estelí, where professionals from other regions can learn from the experiences of all of the centers participating in the program; and
- establishing a local initiative in which area groups contributed time and resources to keep the Women and Children’s Police Station running during a period when international funding had been discontinued.
played a key role in strengthening the commission’s work by sharing resources with other members to carry out sensitivity training on GBV to professionals working in other sectors that have a strong influence on community attitudes, such as teachers, judges, and religious leaders. After participating in sensitivity workshops, teachers are asked to sign a pledge listing the outreach activities they plan to carry out together with their students and colleagues.

While not visited by the review team, the indigenous town of El Alto in Bolivia also offers another interesting example of the potential of well-integrated community violence prevention networks to score impressive gains in mobilizing resources and raising public awareness around the issue of violence (Box 7-1.).

**INCORPORATING MEN IN CHANGING THE CULTURE OF VIOLENCE**

In most countries that the review team visited, both providers and clients underscored the importance of encouraging the participation of men in all violence prevention activities, pointing out that it is not possible to eliminate violence against women if the attitudes and behavior of violent men are not changed as a central part of this process.

Providers noted that abused women often request help for their husbands—someone to provide the men with guidance and counseling to help motivate them to change. These women do not necessarily want to end their relationships; what they want is for the violence to end. This is one of the reasons why out-of-court arrangements incorporating these types of services are requested more frequently than criminal prosecution.
BOX 7.1. THE EXPERIENCE OF BOLIVIA:
THE NETWORK FOR THE PREVENTION AND CARE OF FAMILY VIOLENCE

In September 1998, in the city of El Alto, Bolivia, a group of governmental, nongovernmental, and community organizations formed the Network for the Prevention and Care of Family Violence. Together they developed a work plan and set up committees for implementing the plan and for mobilizing technical and financial resources among the member organizations.

Since its beginning, the Network has been successful in coordinating the work of a wide variety of city government entities, such as the Office of Gender Affairs, the Office of Social Administration, the health center, the public defender’s office, the police unit responding to family-related and emergency situations, the local team of Doctors without Borders, and a confederation of more than 100 grassroots organizations.

With their shared agenda these members worked together to achieve the following:
- In 2001, members registered 15,371 cases of violence out of a total population of 98,670 women.
- The health center recorded 297 cases of family violence, of which 36% were referred to the police and/or other legal authorities. Before there was no reporting of this type.

The lessons learned are:
- Effective systems for collecting and analyzing information on gender-based violence are critical for determining the problem’s scope; for raising awareness among service providers, particularly from the health sector; and for influencing political decision-making at the local level.
- Partnerships among governmental, nongovernmental, and local organizations that are built on sustained commitment and incorporate each member’s expertise are essential for the delivery of well-integrated and high-quality services.
- The community’s ethnic identity, of predominately Aymara origins, must be recognized and incorporated in the targeting of interventions and in the promotion of rights and equity.

Dora Caballero, PAHO/WHO-Bolivia

courtesy Gregoria Apaza Center for the Promotion of Women
In Canada, Europe, and the United States, there are many treatment programs for abusers that include a variety of theoretical and programmatic approaches. Most programs have a duration of 8–12 weeks. The participants are sent to the programs as an alternative sentence by the courts. Few evaluations have been conducted to measure the effectiveness of this strategy. Attendance data, however, indicate that approximately half of the men drop out before completing the program. Of those that do finish, approximately half of them stop using physical violence, at least for some period of time. However, in many cases they continue to display other forms of violent and/or controlling behavior. One key for success is the participant’s motivation. Not surprisingly, men who participate voluntarily (for example, because they don’t want to lose their family and/or end their relationship or because they feel true remorse about their actions) are more likely to change than those who participate in a program they basically feel is punitive in its intent (Edleson 1995).

In Honduras and Panama, family violence laws require the health sector to provide treatment for offenders, and the courts may use attendance to an abusers’ treatment program as an alternative sentence. In Honduras, the review team visited a program for male abusers and interviewed the wives of some of the participants who attended therapy sessions at the Family Counseling Center (see Box 7-2.). It appeared that some men did use the opportunity to reflect on their behavior, while many others were merely “counting down the hours” until their sentence was completed, without ever assuming any real responsibility for their actions. Some of the wives described positive changes in their husbands’ behavior and actions as a result of the program, although one woman who had lost consciousness more than once due to the brutality of her husband’s assaults confessed: “I still feel afraid of him.”

During its assessment, the review team found several areas of potential concern regarding the laws requiring the health system to treat offenders:

- No additional resources are allocated for these services; therefore, there is the risk of diverting funds that would otherwise be available for treating violence victims.

- The Honduran law establishes a kind of symmetry between male offenders and female survivors. Women are also obliged to attend counseling sessions, with the goal of “increasing their self-esteem.” Just as the offenders, they can be punished with mandatory community service if they fail to attend. A psychologist at the Colonia Kennedy Family Counseling Center noted that one woman who had been assaulted by her husband was now in danger of losing her job because of the mandatory therapy sessions and that she had been unable to obtain a deferral from the judge. Although the intention of the measure is positive, obligating the victim of a crime to receive treatment against her will violates the most important principle of care for survivors; that is, to strengthen a sense of personal autonomy. Moreover, it was evident in discussions with offenders that they viewed this measure as an “official” acknowledgment that men and women are equally responsible for the violence.

- There is no consensus among mental health professionals in these two countries (or elsewhere in the project countries studied) regarding the theoretical and methodological guidelines for treating male offenders. Therefore, the lack of norms
BOX 7.2. “YOU NEVER EXPECT YOUR WIFE TO DO THIS TO YOU. . . .”
EXPERIENCES FROM A MEN’S GROUP IN HONDURAS

The review team interviewed 30 men in an offenders’ group run by the Family Counseling Center of Colonia Kennedy, Tegucigalpa. All of these men attend a weekly two-hour session for eight weeks by order by the courts. They acknowledged that they would not have participated if they had not been required to do so. Most felt themselves to be victims of the criminal justice system. Only one man admitted to ever having hit his wife. Another man explained that he had filed charges against his wife under the family violence law, “because she nagged me too much,” and the judge required him to attend the groups instead.

“The judge here is biased against us. Even if the wife wants to find a solution the judge does not help settle things. She treats men badly; then if the wife is listening, it gives her ideas.”

“When I was in front of the judge, my wife became bold and tough.”

In terms of the negative attention by the judge toward male aggressors, the men suggested that having a male judge for the men would be a fairer approach, “as they understand one another better,” and having a female judge for the women.

A few men acknowledged some benefits from attending the groups, despite the unpleasantness of being obligated to attend.

“You never expect your wife to do this to you; even so, I have learned something here, and my behavior will be different in the future. You realize that not everything you do is right; for example, thinking that a wife is her husband’s property.”

“The first time you attend, it’s hard to talk. Here, everyone can tell their own version of things. You feel relieved when you tell the truth. That helps; it’s one less burden, and you stop believing that you know everything and you’re a good person.”

“I felt some hatred towards women before this [due to previous abuse by his mother]. Then, thank God, my wife turned me in [to the police], and now my life is different; I’ve left that burden behind.”
and trained personnel for the treatment of offenders in these cases may only further jeopardize the women’s safety.

There is little capacity for case follow-up to determine the effectiveness of the programs.

A Nicaraguan group, the Association of Men against Violence, has developed an innovative proposal to work with “men who have problems with power and control in their intimate relationships.” This group explicitly addresses the problem of power and control because it considers male violence to be merely one characteristic of relationships based on the subordination of one partner by another. With this approach the group aims to avoid the “trap” that some programs fall into by focusing exclusively on eliminating physical violence, while ignoring other more subtle forms of domination. This program targets male volunteers who have not already been prosecuted or sentenced for assault; i.e., those men who presumably are somewhat more likely to accept messages of reciprocity than men who have already entered into the justice system.

The Nicaraguan proposal establishes a clear difference between men’s reflection groups and abusers’ groups; they feel that different methods are warranted in each case. In some of the other Central American experiences, the distinctions between the two types of groups appear to be more blurred.

The main purpose of the Nicaraguan abusers’ groups is to enhance “the security of women and children. [The program’s goal] is to treat men in order to first benefit women and children, and then men.” As one member of the Association noted, “In the abusers’ groups there is no agreement to keep the discussions confidential. This means we are able to verify whether men have changed their attitudes and behavior by checking with their partners. Men who participate in the group have to agree to this rule.”

**LESSONS LEARNED**

Abusers’ treatment groups should not be confused with men’s reflection groups. The purpose of the reflection groups is to encourage men (either community members or health workers) to challenge prevailing cultural views on masculinity and to become more sensitive to gender-equitable norms. Men’s groups can be an effective way to involve both adults and young men in violence prevention activities.

In contrast, most health services are not equipped to manage abusers’ treatment groups, particularly when the courts mandate attendance as an alternative sentence. These programs require a different methodology and trained personnel, and if poorly managed, can put women at even greater risk. Ideally, the criminal justice system or professionals outside the public health system should manage these groups.

**CHANGING COMMUNITY NORMS ON VIOLENCE**

As discussed in Chapter One of this book, one of the major findings of international research on the causes of GBV is that, although individual risk factors, such as witnessing violence as a child, poverty, or use of alcohol, may increase a specific individual’s likelihood to use violence, cultural norms play a large role in overall levels of violence in a community. In many parts of the world, it is considered both a right and even an obligation for men to physically
chastise their wives in the face of perceived transgressions. A man’s honor often depends on his ability to control his wife’s behavior. In a study performed by the Nicaraguan Network of Women against Violence, a rural man explained how to beat his wife without leaving visible scars that might get him in trouble with the police:

“You have to know just how to give it to a woman. Women should be hit where it doesn’t show, and preferably on the bottom with a belt or using the flat end of a machete. . . . This isn’t serious because it can’t be seen; but if I hit her in the eye, that’s a problem. . . .” —Ellsberg, Liljestrand, and Winkvist 1997

Community-based educational activities can increase women’s knowledge of legal and social rights and empower them to seek help for abuse. They can also challenge the underlying beliefs that justify women’s subordination and the use of violence for settling conflicts. Promoting nonviolent and equitable relationships between men and women is the key to preventing future violence.

Over the last 10 years, numerous groups in Nicaragua have carried out national campaigns against violence. The Nicaraguan Network of Women against Violence carries out a yearly campaign that combines mass media messages on popular television and radio shows with local activities, petitions, and buttons with popular slogans (Box 7-3.).

A Nicaraguan NGO, the Puntos de Encuentro Foundation, has also carried out national media campaigns targeting different groups, such as one encouraging men to be more equitable in their relationships and to find new ways to resolve conflicts (Figure 7-6.).

A Demographic and Health survey performed in 1998 found that nearly half of all Nicaraguan women had seen or heard at least one of the messages, and that of these, almost half of the women could repeat at least one of them (Rosales et al. 1999).

Puntos de Encuentro also produces a television program called Sexto sentido (Sixth Sense) targeting adolescents of both sexes. The show, which has received top ratings among its youthful viewers, addresses a variety of issues, such as sexuality, generational conflicts, gender equity, and violence against women and children. In an evaluation of the program, a young woman said:

“. . . After watching Sexto sentido I knew what to do when a friend told me that she had been sexually abused by someone in her family. I followed the same steps as the girl in the show, and I gave her the telephone numbers they show so that she could talk to someone who was better informed.”

—Puntos de Encuentro 2002
Health centers can also provide an ideal setting for spreading messages about violence. In the United States, many health professionals prominently display posters or wear buttons that tell clients “You can talk to me about violence” (Heise, Ellsberg, and Gottemoeller 1999). In Peru, the Ministry of Health, in conjunction with the Flora Tristán Center and PAHO, developed small tents to be placed on providers’ desks (Figure 7-7). The side facing clients notes: “No one has the right to mistreat you. If you suffer violence in your home, your health is being seriously affected. Talk to us about it.” The reverse side reminds providers to take the opportunity to talk about violence with their clients. The Nicaraguan Network of Women against Violence produced small cards for providers to give their clients with the title, “If you are living with violence, there are ways out.” The cards are small enough to be easily hidden and provide basic information about the domestic violence law, how to prepare a safety plan, and where to go for help.

Many of the centers visited by the review team had posters displayed about violence and/or distributed brochures to their clients about violence, but few of these had been developed specifically for health care settings. Instead, most had been produced by local women’s groups or international human rights organizations. Several health workers suggested that ministries of health and PAHO should develop a regionwide public awareness campaign specifically addressing GBV as a health problem and encouraging women to talk to their providers about violence. “We need to create a comfortable environment in the health center, with messages saying that we care about violence,” observed a nurse in Bluefields, Nicaragua. One of the women interviewed in El Salvador explained that the main reason she went to the health center

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**BOX 7-3. SLOGANS FROM NICARAGUAN CAMPAIGNS AGAINST VIOLENCE**

- I Want to Live without Violence (Nicaraguan Network of Women against Violence)
- There is No Excuse for Violence (Nicaraguan Network of Women against Violence, based on a U.S. campaign by the Family Violence Prevention Fund)
- The Next Time Someone Raises a Hand, Let It Be to Greet You (Puntos de Encuentro NGO)
- Family Violence is One Disaster that Men can Prevent (Puntos de Encuentro)
- Violence Affects One Out of Every Three Women in Nicaragua . . . And What Are We Doing about It? (National commission for violence prevention)
- Neither Blows that Hurt, Nor Words that Wound (Children’s rights coordinating committee)

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**FIGURE 7-6. “SEVEN THINGS EVERY MAN SHOULD KNOW TO AVOID A DISASTER IN HIS RELATIONSHIPS WITH WOMEN,” an anti-violence campaign targeting men carried out by the Puntos de Encuentro Foundation, Nicaragua**
with her problems was that she had seen a handwritten sign on the wall that said “We help victims of domestic violence here.”

SUPPORT GROUPS FOR SURVIVORS
Support groups are effective and low-cost techniques for helping survivors overcome their experiences of violence. In the Americas, there are several organizations, for example, CEFEMINA (Centro Feminista de Información y Acción) in Costa Rica and the Flora Tristán Center in Peru, with extensive experience in organizing self-help or support groups for violence survivors.

One of the main advantages of support groups is that they enable centers to respond to many more individuals than would be possible with individual psychological care. Additionally, the group facilitator does not have to be a mental health professional, although special training is necessary. Another advantage is that women are given the opportunity to help each other; to realize that they are not the only ones that suffer from violence; to develop common ties; and in some cases, to even take collective action. These are all important factors in helping women sustain their resolve to overcome violence.

PAHO has promoted the development of support groups through staff training and distribution of educational materials. In each project country, there has been at least one attempt to create an ongoing program of support groups. One important aspect of this process observed by the review team was that the success of support groups did not appear to depend on the level of specialized personnel; there were successful groups in one health post managed by an auxiliary nurse, while some centers equipped with specialized mental health teams assured the team that it would be impossible to establish groups of this type in their communities. The main difficulties cited by health providers included:

“‘In rural communities everyone knows one another, and they don’t want to expose their personal lives to others because of embarrassment or fear of retaliation by their husbands.’” —Comayagua, Honduras

“‘We have no specialized personnel to facilitate the groups.’” —Chinandega, Nicaragua

“‘We tried to create a group but the women did not want to attend; they are not interested.’” —Santa Lucía, Guatemala

In general, it appears that the success or failure of support groups has much more to do with the motivation and skill of the individual health workers than with the characteristics of a particular community or the professional training of facilitators. In most project countries one or two workshops had been held to train facilitators, but these professionals have received little additional training or follow-up support. The lack of experience of facilitators, coupled with the fear of failure, are a significant barrier for the success of the support groups. As one psychologist from Guatemala observed:

FIGURE 7.7. TABLE TENT USED IN PERU to encourage women to discuss violence with health providers. The text says: “No one has the right to mistreat you. If you suffer violence in your home, your health is being seriously affected. Talk to us about it.”
“. . . It is important not to scold the women . . . . In order to facilitate a support group you need to be trained and learn to deal with your own experiences of violence. . . .”

Nevertheless, in the sites where support groups continue to operate, the health personnel as well as the participants are convinced that they are an excellent technique for helping survivors of violence.

The polyclinic of Barrio Lourdes in El Salvador operates a comprehensive program with several support groups for survivors of violence, including one for elderly women. What is noteworthy about this experience is that a physical therapist and special education therapist facilitate the groups, although the center has several psychologists on staff. The facilitators were chosen not for their professional background but because of their interest in and commitment to the topic and their ability to develop trust with their clients.

A Guatemalan psychologist found group support to be more beneficial to women than individual counseling because of the bonds that are created among the participants:

“The solidarity of the women is admirable. They give each other ideas to move forward. Group sessions produce better results. After a few sessions they start asking each other, ‘Have you tried such-and-such?’ Personally, seeing how the women talk to each other with such wisdom has helped me to understand the problem better. . . .”

“The important thing is that the groups are anonymous; not everyone knows everyone else. You don’t have to be Superman to facilitate a group; instead [just] begin with patience, and don’t scold them. . . . The main ground rule of the group is that ‘We are not here to gossip, but to work on our problems.’”

**BOX 7-4. IMPORTANT QUALITIES FOR FACILITATORS OF SUPPORT GROUPS**

- Training in gender and violence
- Training in the dynamics of abuse, different types of abuse, and their consequences
- Familiarity with strategies for empowerment and recuperation
- Training in ethical norms for working with violence against women and knowledge of existing laws

*From: Claramunt 1999*

**BOX 7-5. WHAT WE HAVE LEARNED IN SUPPORT GROUPS**

- To be independent
- To value ourselves
- To be more responsible with our children
- To make responsible decisions for ourselves
- To recognize our qualities
- Not to be violent
- To develop self-esteem
- To put our abilities into practice
- To say, “I am competent, I can do it”
- To empower ourselves
- To have our rights respected and not be abused
- To love ourselves
- To forgive
- To liberate ourselves
- To respect
- To love
- To have solidarity within the group

*Statements from support group, Barrio Lourdes, El Salvador*
An auxiliary nurse from Guazapa, El Salvador, described her experience this way:

“It took a lot of work to create this group. After receiving individual care, each woman is invited to join. We started with 12 women, then the number decreased. We now have 6 women that meet every 15 days. I have had to fight with my boss to have the time to care for them. I have also taught them handicrafts, which they have enjoyed.”

The indigenous promoters from Totonicapán, Guatemala, also noted that offering to teach the women practical skills provided additional incentive for their participation:

“. . . The groups are working well, but our strategy is to include classes on cooking and traditional medicine so that more women will come and their husbands won’t be suspicious about their participation. . . .”

The following comments of women who have participated in support groups provide a moving testimony to the importance of the groups. The main comment heard over and over from survivors who had come into contact with caring health providers, either in groups or in individual sessions, was how important it was for them to feel that someone cared and was willing to listen, and then could give them information and encouragement that bolstered their sense of self-worth and knowledge about their rights.

“... The groups are working well, but our strategy is to include classes on cooking and traditional medicine so that more women will come and their husbands won’t be suspicious about their participation. . . .”

“What helped me was to realize that I wasn’t alone. There are many of us who feel trapped and silenced inside ourselves. Learning about laws and communicating among ourselves were also very important to help us break our silence.”

—Colonia Kennedy, Honduras

“... Now, thanks to the group, I feel liberated.”

—Comayagua, Honduras

EXPANDING THE CIRCLE

The narratives presented in Section II of this book have been selected to help the reader come away with a greater appreciation for and understanding of what the review team considers to be the single most all-encompassing lesson learned from the PAHO project evaluation: that individuals and institutions, working together in an integrated approach, can harness enormous power to transform not only their own

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**LESIONS LEARNED**

Support groups can be a very effective technique for helping violence survivors.

Nevertheless, health personnel do need training and ongoing support to be effective facilitators.

“I used to think that death was the only way out. I wanted to die but I couldn’t kill myself because of my children. . . . I thought it was my fault that he hit me. Here, I’ve learned that it’s not so . . . my self-esteem was very low, [but] here they teach us to love ourselves. . . .”

—Colonia Kennedy, Honduras

“I used to be very shy. I was enslaved in the house. . . . Now, thanks to the group, I feel liberated.”

—Comayagua, Honduras

“What helped me was to realize that I wasn’t alone. There are many of us who feel trapped and silenced inside ourselves. Learning about laws and communicating among ourselves were also very important to help us break our silence.”

—Colonia Kennedy, Honduras

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**BOX 7-5. WHAT ADVICE WOULD YOU GIVE WOMEN WHO ARE LIVING WITH VIOLENCE?**

- Love your children
- Go to the health center to be listened to
- You need to want a change
- You matter and are important
- Be independent
- Know your rights

_Statements by women from Barrios Lourdes support group in El Salvador_
In Chapter Eight, these stories and lessons will be placed and explored within a larger context: that of other communities around the world. The collective experiences can provide both a theoretical and practical blueprint for dedicated individuals and groups, wherever they may be, who wish to embark on a similar journey and who seek solidarity, inspiration, and guidance in their own efforts to rid our societies of violence and create a new international culture of true equality between women and men.

Incorporating men in open discussions on GBV, such as this one in Honduras, are an effective strategy that can be used by community groups to promote the idea that violence prevention and mutual respect are everyone’s responsibility.

thoughts, feelings, and actions, but also those of the communities where they live. While a central theme of this book has been the importance of the health sector taking a lead role in galvanizing this process, the review team also found abundant evidence of the need for true cooperation and binding partnerships with other key sectors to consolidate and institutionalize the initiatives currently underway. If this goal is achieved, the circle can be widened within communities and the dynamic extended to new ones.
Chapter Eight

Global Implications: The PAHO Approach to Gender-Based Violence

WOMEN ARE WAITING FOR THE WORLD TO RESPOND

The women in the pages of this book who described lives filled with physical and emotional abuse are not unique. In fact, their suffering is mirrored back to us in every language and from every corner of the world. In the words of Kofi Annan, Secretary General of the United Nations, violence against women is “the most pervasive human rights violation, respecting no distinction of geography, culture, or wealth” (U.N. Secretary General SG/SM/6334). What has changed is that in the last few years there has been a growing awareness and acceptance that the problem exists, and with it, a more palpable commitment to identifying and addressing its roots.
GBV has long been of concern to both the World Health Organization (WHO) and PAHO. Both have given the issue high priority in their work with national governments and grassroots advocacy at the community level. Both are aware of the opportunities available for public health to play a central role in turning the tide against violence and of the responsibilities the health sector can and must assume in this pivotal role.

In 1995, WHO, in its position paper presented at the Fourth World Conference on Women in Beijing, identified violence against women as a priority issue for women’s health (WHO 1995). Meanwhile, PAHO’s Women, Health, and Development Program had already started work in this area, following the passage in 1993 of a resolution urging PAHO member countries to develop policies and plans for the prevention and control of violence against women and the launching of the integrated approach the following year. From the beginning, PAHO and WHO have been at the forefront of building up the evidence base on the magnitude and nature of intimate partner violence and sexual violence, through studies such as the Critical Path (Sagot 2000) and the WHO Multi-Country Study on Women’s Health and Domestic Violence (WHO 2002). This proactive resolve is well captured in WHO’s recently launched World Report on Health and Violence. In the report’s preface, the Organization’s Director-General, Gro Harlem Brundtland, notes: “The report also challenges us in many respects. It forces us beyond our notions of what is acceptable and comfortable—to challenge notions that acts of violence are simply matters of family privacy, individual choice, or inevitable facets of life” (WHO 2002).

The search for effective and long-lasting solutions, from interventions for primary prevention to caring for the victims and survivors of violence, is ongoing. However, in terms of “what works,” the experiences are still limited and scattered and often not well documented and disseminated. The efforts by the Pan American Health Organization to document its experience in Central America in this book is therefore an important contribution to this field.

It seems obvious to point out that when developing responses to gender-based violence, it is necessary to take into account the particular locale and the resources available, the prevailing social norms and laws, and the characteristics of the health, legal, and other sectors. No one model “fits all,” and each intervention will need to be adapted to the specific context (social, cultural, political) in which it is being applied. However, many of the lessons learned from experiences like the ones described in this book may have wider applicability, in spite of coming from one region of the world, and could serve in many respects to guide responses in other settings. This chapter discusses the wider applicability of the approach used by PAHO and its partners in Latin America to other settings.

THE PAHO APPROACH: NEW LOCALES, NEW POSSIBILITIES

PAHO’s work on gender-based violence started with the Critical Path Study described in Chapter Two. The importance of this study was that it documented and provided the first in-depth understanding of what happened to women once they broke their silence and actively sought help: from state services, church and schools in their community, and even neighbors and family members. Acquiring this type of information and understanding, which could be obtained in different ways and at times by adapting and even simplifying the methodology, is an important basis upon which to develop
interventions. As we have seen, the results provide critical insight into the nature and variety of roadblocks and other obstacles women commonly face in their search for care and support. In addition, the study suggested that for every woman who does seek help, there are many, many more whose suffering remains invisible. How do we reach this group, and how do we encourage these women so that they can transform their lives and end the violence they face daily? Improving the response of the existing services—formal and informal—is the most obvious and logical starting point for this change to take place.

The review of the PAHO approach to violence against women; specifically, its work in diverse communities across Central America, as described in Section II of this book, revealed key characteristics that succeeded in finding roots despite the peculiarities of geography, social and cultural beliefs, and political structures. On the contrary, these qualities suggest the approach’s relevance and potential adaptability to other corners of the world where women do not yet have access to services and systems that might provide recognition, care, and support. As other communities contemplate taking the first step toward responding to these women, they might wish to keep in mind the approach’s overarching commonalities, presented below, and find them of use in localizing the strategy in new settings:

(1) **The approach is flexible and non-prescriptive.** In each PAHO project community, the principal stakeholders mutually identified the specific approach to be taken, which were the best institutions and/or departments to guide the process, and who were the most relevant partners. While there was one common overriding goal and similar accompanying objectives, there was no drive to impose a single generic model on all settings in the seven project countries.

(2) **The approach calls for action at several levels.** Project participants soon recognized that simultaneous action at multiple levels offers the best possibility for a “successful” response to violence. Specifically, these levels are: (a) the macro level of national policies; (b) in programs of different public sectors, with a focus on the health sector; and (c) at the level of the community. Concrete actions must be developed at all three of these levels, and action at each level serves to synergistically support and reinforce the response in the other levels.

(3) **A multisectoral approach achieves the best results.** The need for a plurality of disciplines and fields of expertise—health, education, law enforcement, the courts system—coming to bear on the issue of violence is now well recognized and documented. Yet the forging of this primordial dynamic has been—so far, at least—perhaps the most elusive of all goals to achieve and maintain. This might be because, in responding to violence, there is no one obvious sector to take the lead. Which force becomes the standard-bearer, so to speak, will vary in different settings and is often related to a key personality who is willing to move the issue forward. In some Latin American countries, it has been the legal and judicial sector which has come to the forefront, while in others it has been the health sector, and in still others, it has been the office of women’s affairs.

In the PAHO Central America project, priority was given to the health sector, as the natural counterpart of PAHO. Regardless of which sector takes the lead, a public health approach nonetheless seeks to ensure that all sectors are engaged, work collaboratively, and that their roles are well specified and
mutually reinforcing. A plan of action delineating the specific role and functions of each sector can help to clarify and minimize “territorial disputes.” Resource allocation at the national and/or local levels will also need to reflect adequately the role of each sector.

(4) Partnerships and networks provide the necessary underpinning. In all the PAHO project settings, women’s organizations dedicated to ending gender-based violence were involved and played a key role in the development of the response. This point cannot be emphasized enough. It is thanks to the persistent and highly energized efforts of women’s organizations and the women’s rights movement that the issue of gender-based violence is on the global political agenda today. At a time when neither the world’s interest in, nor the strategic resources for, advocacy work against violence were available, these organizations struggled unrelentingly, often despite meager funding sources, to provide a response to and support for women living in violent situations. It is critical that they do not become marginalized at this juncture, but rather that their expertise and commitment be permanently harnessed in the creation of new and broader responses by governments and other actors to a problem that persists in nearly every society around the world.

Partnerships and multisectoral action at the community level require time, energy, commitment, and resources. The development of networks, as has been achieved by PAHO and its collaborators, is only the first step in the process. One of the important lessons learned is that once a network is established, additional input and support are needed to ensure that the network remains active. Developing clear objectives and monitoring the impact of the network’s activities are equally important. Globally, there is a need to evaluate more systematically the impact and benefits of both formal and informal networks to address gender-based violence, such as was done with those created by the Central American project.

GALVANIZING THE HEALTH SECTOR RESPONSE

A particular objective of the initiative to stop GBV, and of the work of PAHO and WHO specifically, is to strengthen the health sector’s response, keeping in mind the need for collaboration within this sector and with other sectors. The Critical Path study provided countless descriptions of inconsequential, non-supportive, and even damaging encounters between women and health personnel. Thus, a focus on improving the health sector response was well justified, not only because this government entity is the natural counterpart to PAHO and WHO, but because it is the one sector which women are most likely to come into contact with at some point in their lives.

As has been discussed elsewhere (García-Moreno 2002), the health sector has a fundamental role to play in violence prevention and in caring for women affected by this problem. A key function lies in the identification of women seeking health services for whom violence may be an underlying risk factor. A supportive encounter with the health sector, it is argued, may enable a woman to recognize the problem if she has not yet done so, may encourage her to seek help, and may help her to access care, treatment, and support from other community sources. Asking a woman about violence can shed light on the underlying causes for the clinical problems she identifies as the formal reason for her consultation, and, to the degree to which she is ready to talk, lead to a more accurate diagnosis, better targeted treatment, and the identification of
other appropriate community resources and services as needed. Knowledge that a woman is suffering from violence can also contribute to the prevention of further episodes and to potential morbidity and mortality from this cause.

For all this to happen, however, the health encounter needs to take place in a confidential and caring setting, with a provider who is sensitive, nonjudgmental, and willing to spend sufficient time to provide the support and care needed. In turn, health providers must be equipped with the knowledge and skills that will allow them not only to identify women in violent situations, but to provide them with the subsequent treatment, care, and referrals needed.

As the experience of PAHO and others (Guedes 2002 et al.) has shown, enabling the health sector to respond appropriately to GBV, and sustaining this response, is not an easy task. This is because concerted, interconnected action at different levels of the public health hierarchy are key to this sustainability. Health policies, norms, and protocols at the national, local, and facility level provide the necessary blueprint for the development and implementation of training and intervention programs. As we have seen in the various countries, no one approach or entry point exists; rather, there are different options, and in each case the best choice depends on the availability of a range of resources, including funds, staff, and commitment. Some of the key elements of the health sector’s work, as well as the areas that were identified as needing strengthening in the PAHO experience, are discussed below. These observations and experiences may be useful to others in addressing GBV issues in their own communities.

**TRAINING OF HEALTH PERSONNEL**

Training is critical to developing and sustaining a high-quality, long-term health sector response to gender-based violence. Reviews of training programs on violence against women for health providers show that in many cases these are not satisfactory and the content and quality are variable and inconsistent (Davidson et al. 2001). Many of the programs tend to be of limited duration, and while they may raise awareness of the problem, they may not always provide sufficient skills or address providers’ values and attitudes that impact on their ability to respond to the problem. Also, they tend to focus on the individual provider and rarely address the structural or institutional context within which the provider’s work takes place (García-Moreno 2002).

One of the limitations of many training programs has been that they become an end in themselves, with little attention to the structural and other transformations that need to accompany training. The PAHO approach included an emphasis on training, involving the technical input, support, and participation of ministries of health and other local entities. Numerous health providers (and other community service providers) have been trained throughout the life of the project. There has been, however, little systematic evaluation of this training and its impact.

The PAHO experience also has led to the development of a broad range of training tools and materials, many of which are targeted to specific groups, including indigenous cultures, schoolteachers, children, and men, and which take into account local customs and values. But might not this body of local inspiration find a larger audience? Perhaps at this stage it would be helpful to review the wealth of what is available, cull the best examples, and determine the keys
to their impact. While there may be a need for local specificity in the development of these materials, it is also important to avoid reinventing the wheel and duplicating efforts. A comprehensive review of which training tools and approaches have worked best in the different Central American settings would be of great value to the participating countries and stimulate new interest in larger circles beyond.

While the PAHO review did not include a quantitative assessment of the outcomes and impact of the various health sector training programs that have been developed as part of the project, it nonetheless provides indications for further work by highlighting the numerous lessons learned and key ingredients which could lead to a more lasting impact of training activities in the future. These are briefly outlined below:

(1) **A systems approach may increase impact.** An approach that takes into account the overall system rather than focusing only on the health provider has the potential to have more impact. Otherwise, providers may find themselves unable to implement changes, even with the sufficient knowledge and motivation to do so. In this project, training of providers was supported by variable degrees of institutional change and the development of norms and protocols to guide providers, and in some cases, administrators as well.

(2) **Universal screening is not always the golden standard.** “Universal screening,” i.e., asking all women coming through a health service about exposure to violence, is usually taken as the golden standard. Yet there may be situations in which asking women may not be feasible or cannot be done in a way that ensures confidentiality. In this situation, providing the woman with basic information in portable form, such as a leaflet or brochure, regarding services at the provider’s facility or elsewhere in the community, may be more useful and less likely to cause harm. To be effective and to “do no harm,” universal screening needs to be supported by intensive provider training, system changes, and the availability of care protocols and norms, with ongoing monitoring of their implementation and of the screening process’s impact on the lives of the women themselves. The guiding principle of any health service response must be to “do no harm,” and this should orient and inform the introduction of changes in the health sector, so that while universal screening may remain the long-term objective, there may be other steps that are necessary before a health service can introduce this in a systematic manner.

(3) **Mere identification is not enough.** Identifying women who are living with violence is really only the first step. An adequate response is necessary, and it is suggested that as a minimum this should include: appropriate care and treatment, assessment of immediate danger, the provision of information on or referral to existing services, counseling and developing a safety plan with the woman, and providing follow-up and support. However, special challenges arise when there are few or no other services to which women may be referred and providers have limited resources for follow-up and support. This is particularly true in small towns or remote rural areas, as we have seen in the case of Central America. There is a much higher risk that these women will fall through the cracks and never be heard from again, as we have also seen. In this situation, other strategies need to be identified, during the initial consultation, always keeping the women’s safety and well-being as the paramount consideration.
(4) Horizontal versus vertical integration of violence programs: which works best? Integrating violence concerns across different health programs appears to be more useful than addressing violence as a separate vertical program. Several entry points exist in the organization of health services, as was shown in the Central American project. In some countries, violence work took place from within reproductive health services, while in others, violence activities formed part of mental health services. In still other countries, accident and emergency departments have served as the starting points, as have primary outpatient services (García-Moreno 2002). Generally, however, reproductive health services are more widely available—even in low resource settings—and those most likely to be used by women—ill and healthy—at some point in their lives, thereby providing a natural entry point for addressing GBV. However, the best location will depend on the specific circumstances of each locale and its available resources, which would include the existence of a supportive administrative environment and policies. In the Central American review, overall it appeared that reproductive health services were most likely to have the basic resources and support mechanisms necessary to address violence, particularly compared to mental health services. In an ideal context, all health services for women should incorporate GBV considerations into their work, so that these considerations are integrated horizontally across the spectrum of health services offerings. Inter-programmatic coordination is a vital element to ensure that the women receive continuity in care and consistent messages about their problems, no matter which type of health service they seek.

(5) Caregivers need emotional support. For those on the front lines of response, caring for women suffering from violence can be a very draining experience. While there is general agreement that caregivers should be provided with emotional support systems, as we have seen, this rarely occurs in reality. The valuable service provided by health professionals to their clients—at times even life-saving—as well as the mental and physical toll it claims on these providers, requires more recognition and compensation. Resources need to be allocated to offset the potentially harmful effects to providers’ health and well-being by creating structured time and space mechanisms in which caregivers can share their experiences, emotions, and needs.

(6) The approach to GBV should be holistic. At times, there is a tendency towards a fragmentation in response to different forms of violence, meaning that the treatment for the physical, sexual, and psychological/emotional sequelae are sometimes separated (or some are not addressed at all). A holistic approach would integrate the health response to these different manifestations regardless of the victim’s relationship to the perpetrator (intimate partner, other family member or relative, acquaintance, or stranger). In practice, programs have tended to focus on only two types of violence—that by intimate partners living in the same household (sometimes also called “domestic” or “intrafamily” violence) and sexual violence, usually perpetrated by strangers. Response to the latter has tended to emphasize the importance of the victim submitting to a forensic medical examination, sometimes to the detriment of (and separately from) the health care response.

It is important to be aware of the various types of health and other needs arising from these different situations of violence. For example, a single event of rape by a
stranger or a gang rape gives rise to particular health care needs, including that of a forensic medical examination. These needs are likely to be different to those of a woman suffering from ongoing abuse by an intimate partner occurring over many years. Intimate partner abuse oftentimes escalates in frequency and/or intensity, so the risks may vary as well at different times. Yet it is not realistic, particularly in resource-poor settings, to have separate services for different types of violence. In many places, care and support, regardless of the type of abuse, are likely to be provided by the same practitioner. The nature of professional training and of the specific norms and protocols, therefore, needs to address the local range of needs and situations as much as possible. In some settings, for example, specific forms of violence such as dowry-related or female genital cutting may need to be included in training on gender-based violence. One of the lessons learned was that when setting up GBV services, the most effective strategy is to integrate rather than fragment the response to violence’s many forms. Based on this, PAHO project participants in the future plan to expand work beyond the current focus of intimate partner abuse to such areas as sexual abuse, including child sexual abuse.

(7) Documentation and follow-up are central elements to the health sector response. It is important for health services personnel to record accurately and completely the information on abuse they gather from their clients. It is equally important to ensure the confidentiality of this data and that there are mechanisms to protect against its misuse. The availability of accurate and complete documentation could help ensure better response, care, and follow-up. However, the “rules of the game” in information-sharing across sectors (for example, between doctors and police officials) remain largely a grey area, and other sectors sometimes secure access to sensitive information without the consent of the affected woman. Also, if the same woman requests services in different areas within the health sector, problems often result that could perhaps be improved with better record-keeping. Inconsistencies in health information intake and management were identified as one of the weakest components in the PAHO study, despite the importance of this information when developing new interventions. There needs to be greater clarity about what data need to be collected, by whom, and for what purpose. Record-keeping and data-gathering are most likely to be done correctly when those doing this understand and see the value of the process—particularly its usefulness in monitoring performance and impact (both their own and the health service’s in general).

THE HEALTH SECTOR AND THE COMMUNITY

The following sections address the health sector’s interaction with other sectors and entities in the community and present observations based on the Central American experience with potential wider applicability to other GBV programs:

(1) The health sector should be proactive in raising community awareness about women and violence issues and GBV prevention. The work inside the health sector can be greatly enhanced by an advocacy and communication strategy that raises local awareness of the problem and informs the general public about the availability of services. During the Central American review, health professionals noted that many of the posters and brochures currently used in their clinics had not been specifically developed for health care settings. Furthermore, workers at various
points suggested that ministries of health and PAHO develop a regionwide health promotion campaign targeting GBV and encouraging women to talk to their providers about violence. Clearly, such a campaign—in the Americas and other WHO regions—could gain resonance from the participation of other sector partners, if the messages crafted present a unified voice against violence. Therefore, each partner’s contribution must be a clear and accurate reflection of this sector’s field of expertise, and at the same time buttress messages by others. This same dynamic applies at the local level, where it is even more critical for the sector services to create and sustain linkages and present coherent messages that address the gamut of GBV issues—personal health and well-being, the family, available support systems, and legal rights and protections.

(2) The legal and health interface requires clearer definition. Mandatory reporting, i.e., the requirement that health workers provide information to law enforcement officials regarding all patients they suspect to be victims of domestic violence, deserves special mention in this chapter, as it remains a controversial issue. The requirement originated with the need to report child abuse, given the status of children as minors in need of state protection. In the case of adult women, however, many women’s group advocates—and sometimes the women themselves—consider that they should be able to decide freely whether to seek protection or not, rather than having this imposed upon them by the judgement of others. Further, some studies indicate that mandatory reporting may pose a threat to the safety of women in abusive relationships and may create barriers to their seeking help or talking with health providers about their problem (Rodríguez 1998).

In at least three of the Central American countries participating in the PAHO project, mandatory reporting for intimate partner violence against women has been instituted. PAHO and health policymakers in the Americas will need to close ranks and present a clearer position on this in the future, in keeping with the guiding principles of “doing no harm” and respect for women’s autonomy and decision-making capacity. As new programs emerge in other parts of the world, these players, as well, will need to carefully examine the pros and cons of different government policies, such as mandatory reporting, and, in particular, determine their impact on women’s lives and safety.

(3) GBV monitoring and surveillance are particularly weak when compared to other health issues. Central to violence prevention is the ongoing availability to gather and disseminate accurate information about the types and amount of violence in a particular location, factors that are associated with it, and the consequences of that violence. This information is essential for heightening the problem’s visibility—particularly the significance of its contribution to morbidity and mortality statistics—but also for informed policy formation, strategic decision-making, and the appropriate allocation of health resources. Surveillance on violence against women poses particular challenges, as noted by Campbell (Campbell 2000) and discussed in Chapter Five.

One serious weakness identified in the PAHO project was the fact that information systems for tracking violence were often developed independently of the norms and protocols for its treatment. Despite having received training on information-gathering and recording, if professionals do not possess the proper skills and techniques for asking about violence or the institutional environ-
ment is not conducive to this process, the necessary data may not be collected or might not be reliable. This may not only be harmful for the affected women, but also creates the false impression that violence is not an issue of social and political concern in the community. Furthermore, as Chapter Five pointedly notes, information-gathering by health professionals and others presents the ethical imperative to provide care and services in return.

When introducing a system to record GBV-related information cases, its effectiveness is directly proportional to its compatibility and uniformity with systems in other areas within the same country, at the very least. Ideally, however, global standards, such as the WHO Injury Surveillance system (WHO 2001) and the International Classification of Diseases (ICD-10) categories should be followed whenever possible.

A minimum standard set of information—the type of violence (physical, sexual, emotional, etc.), and the age and sex of the victim, as well as the age and relationship of the perpetrator to the victim—should be universally uniform to enable comparisons between systems. Additionally, data on violence presented centrally should always be disaggregated by sex and age.

(4) Community networks and support groups for violence survivors provide a springboard for solidarity and action.

A key element of the PAHO approach is its emphasis on the creation of dynamic community networks for the prevention of violence. The positive work and achievements of these networks in all the PAHO project settings attest to the almost limitless opportunities for sustainable and locally developed responses with which the larger community can develop a sense of identity and ownership. The impact of women’s groups and well-known, committed local leaders and decision-makers has already been noted. The combined synergy of these and other high-profile grassroots players has contributed perhaps more than any other factor to the transformation of social norms that once unquestionably viewed gender-based violence as a private family matter off-limits to public scrutiny and preventive action.

In many of the PAHO project communities, support groups for violence survivors offered positive reinforcement and practical strategies to women in abusive relationships. In other settings, however, the results of similar endeavors were mixed and inconclusive. There appears to be no “magic formula” beyond the personal skills and deftness of the group facilitator in engaging the participants in finding workable solutions to their situations, regardless of that leader’s specific background or training. These groups are attractive in this sense, because they can provide a vibrant, ongoing source of support for women in resource-poor settings, with a minimum of investment from the “formal” sector. At the same time, they create the potential for collective action and the challenging of public perceptions about the inescapability of violence. It is important to explore these type of initiatives further and evaluate more systematically the structure and components of the most successful among them, how they have ensured continuity and sustainability over time, and what types of support (institutional, financial, training, etc.) they feel have most contributed to their effectiveness.

FINAL WORDS

This chapter seeks to highlight how the groundbreaking work of PAHO and its many collaborators in Central America can find new roots in other communities throughout the Americas and the world. The authors of this book have followed the
development of the Critical Path study and subsequent project review closely and have shared their insights so that others might see what has worked and what has not worked in the various settings. The lessons learned presented herein, while perhaps bearing the sociocultural and political idiosyncrasies of their geographical birthplace, nonetheless afford glimpses of local adaptability in communities everywhere in the world where women remain the invisible and choiceless victims of violence.

World human rights activist and Nobel laureate Nelson Mandela recently referred to the “legacy of day-to-day, individual suffering”, observing that:

This suffering . . . is a legacy that reproduces itself, as new generations learn from the violence of generations past, as victims learn from victimizers, and as the social conditions that nurture violence are allowed to continue. No country, no city, no community is immune. But neither are we powerless against it.

Instead, he notes with firm conviction,

Violence can be prevented. . . . In my own country and around the world, we have shining examples of how violence has been countered. Governments, communities, and individuals can make a difference. 

Mandela’s final statement is perhaps the most important lesson learned by PAHO and its partners in Central America (and the Andean countries, as well). Governments, communities, and the courageous victims of violence themselves have taken the first steps that in the future will enable these women to live lives free from violence and fear. Their collective achievements are a call to action to others. For if the roots of violence remain hidden behind closed doors, the family—the nucleus for the cross-generational imprinting of human values and ideals—is irrevocably damaged, and society’s Wellspring of aspirations for future transformation and cleansing is rendered barren. This specter should compel even the most sceptical and resistant to urgent action.

\[1\] Excerpts from Foreword of the World Report on Violence and Health (WHO 2002)
CHAPTER EIGHT: Global Implications: The PAHO Approach to Gender-Based Violence
The following resource materials have been compiled as a service to our readers. Resources are organized reverse-chronologically and alphabetically. Those resources only available in Spanish or not available online are so indicated. The section groupings are:

I. PAHO (Women, Health, and Development Program/HDW) and WHO Materials
II. Program for Appropriate Technology in Health (PATH) Materials
III. Centers for Disease Control and Prevention (CDC) Materials
IV. Other Background Materials
V. Training Manuals and Guides
VI. Conventions and Declarations
VII. Internet/Web Resources
I. PAHO AND WHO MATERIALS

+ **HDW Gender and Health Fact Sheets**
  HDW/PAHO publishes a monthly fact sheet in English and Spanish on a current theme in gender equity and health. Topics related to GBV include:
  - Men’s Role in Gender-Based Violence, 2002
  - Social Responses to Gender-Based Violence, 2002
  - Trafficking of Women and Children for Sexual Exploitation in the Americas, 2001
  - Domestic Violence during Pregnancy, 2000
  - Health Workers and Gender-Based Violence, 2000
  http://www.paho.org/english/hdp/hdw/factsheets.htm

+ **WHO Multi-Country Study on Women’s Health and Domestic Violence**
  *World Health Organization, 2002.*

  An introductory brochure to the study, which is policy- and action-oriented and is being carried out in partnership with research institutions and/or national ministries and women’s organizations working on issues related to violence in eight countries.
  http://whqlibdoc.who.int/hq/2002/WHO_FCH_GWH_02.2.pdf


  Chapter 4 of the report discusses intimate partner violence, and Chapter 6 discusses sexual violence.
  http://www5.who.int/violence_injury_prevention/main.cfm?p=0000000682


  Chapter 4 focuses on sexual violence against women. Most reported cases of sexual violence among refugees involve female victims and male perpetrators. It is acknowledged that men and young boys may also be vulnerable to sexual violence.


  In the last few years in Central America, a series of efforts have contributed to ensure that all seven countries recognize intra-family violence as a public health concern deserving immediate attention. As a result, countries have put into place legislation and committed human and financial resources designed to facilitate the operation and consolidation of a model of integral care to respond to intra-family violence.
  http://www.paho.org/English/HDP/HDW/integratedmodel.pdf


  From 4–7 June 2001, the Symposium brought together representatives from the ministries of health, women’s NGOs, civil society, and U.N. agencies from 30 countries as well as international donor agencies to identify priorities and formulate strategies for strengthening the response of the health sector to GBV.
La ruta crítica que siguen las mujeres afectadas por la violencia intrafamiliar.  
Translated into English as: Domestic Violence: Women’s Way Out.  
This publication demonstrates that intra-family violence is a complex problem which requires coordinated and intersectoral solutions involving the participation of both the State and civil society.  
English: http://www.paho.org/English/HDP/HDW/womenswayout.htm

Violence against Women: WHO Fact Sheet No. 239.  
Violence against women and girls is a major health and human rights concern. While violence has severe health consequences for the affected, it is a social problem that warrants an immediate coordinated response from multiple sectors.  
http://www.who.int/inf-fs/en/fact239.html

This meeting report is divided into three main sections. The first section contains a summary of each presentation. The second section summarizes the discussion, and the third details the recommendations and conclusions from the meeting (held 23–25 October 2000).  
http://www5.who.int/violence_injury_prevention/download.cfm?id=0000000151

Commissioned by the Global Commission on Women’s Health. Prepared by Rights and Humanity in collaboration with the WHO Women’s Health and Development Unit and the Global Commission on Women’s Health.  

Gender and Public Health Series  
This series published by PAHO contains the following GBV-related topics:  
Nº1 Battered Women: A Working Guide for Crisis Intervention, 1999  

Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women.  
Research on violence against women raises important ethical and methodological challenges. Researching abuse is not like other areas of investigation—the nature of the topic means that issues of safety, confidentiality, and interviewer skills and training are even more important than in other forms of research.  
http://www5.who.int/violence_injury_prevention/download.cfm?id=0000000130
GBV Resources Section

* Violence against Women: A Priority Health Issue Information Pack.  
  The package focuses on violence in families, rape, and sexual assault, violence against women in situations of conflict and displacement, as well as violence against the girl child. The consequences of violence on women’s health and the role that public health workers can play in multisectoral efforts to end the violence are explored.  
  http://www5.who.int/violence_injury_prevention/download.cfm?id=0000000154

II. PATH MATERIALS

  This publication is a compendium of articles that highlight the negative impact that marginal status has on the health and well-being of various vulnerable groups. Various aspects of gender-based violence are presented and included in several articles. 

* Violence against Women: Effects on Reproductive Health.  
  * Outlook, Volume 20, #1, 2002. 
  This report presents an overview of violence from a public health perspective. It describes the effects of violence on women’s reproductive health. The report provides examples from research and successful programs and explores how the health sector can take an active role in the prevention and treatment of violence against women. 
  http://www.path.org/resources/pub_outlook.htm

  This publication is a collection of articles by public health and human rights experts who examine both the common interests and significant differences that the two perspectives bring to reproductive health issues.  

III. CDC MATERIALS

  This National Institute of Justice research report presents findings from a survey of 8,000 U.S. women and 8,000 U.S. men about their experiences as victims of intimate partner violence (rape, physical assault, and stalking). 
  http://www.ojp.usdoj.gov/nij/pubs-sum/181867.htm

* The Screen Show on Intimate Partner Violence during Pregnancy.  
  A training tool to help increase clinicians’ understanding of the important role they can play to identify, prevent, and reduce intimate partner violence. The content of the screen show is supplemented by a bibliography, references to several protocols for screening, and organization resource lists.  
  http://www.cdc.gov/nccdphp/drh/violence/ipvdp.htm
+ **Violence and Reproductive Health.**
  This special issue looks at such topics as screening practices for abuse during prenatal visits; the role of reproductive health care services; the relationship between sexual abuse and sexual risk; and women, violence, and HIV.
  http://www.cdc.gov/nccdphp/drh/wh_viol_mchjv4n2.htm

+ **Building Data Systems for Monitoring and Responding to Violence against Women. 1998.**
  This report provides recommendations regarding public health surveillance and research on violence against women developed during a workshop held 29–30 October 1998.
  http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4911a1.htm

+ **Intimate Partner Violence and Sexual Assault:**
  A guide to help individuals and organizations find appropriate materials for group or self-training.
  http://www.cdc.gov/ncipc/pub-res/ipvasa.htm

**IV. OTHER BACKGROUND MATERIALS**

+ **Supplemental Issue on The Role of Health Professionals in Addressing Violence against Women. International Journal of Gynecology and Obstetrics, 78 (Supplement 1), 2002.**
  This issue includes articles on violence against women and Brazilian health care policies; American College of Obstetricians and Gynecologists: responding to violence against women; and a global overview of gender-based violence, among others. Full text available via ScienceDirect: http://www.sciencedirect.com

+ **Gender Dimensions of Alcohol and Alcohol-Related Problems in Latin America and the Caribbean. World Bank, 2001.**
  This report examines the gender dimensions of alcohol consumption and alcohol-related problems in Latin America and the Caribbean. Its principal findings are: (1) men bear most of the burden of alcohol-related diseases; (2) alcohol plays an important role in instigating unsafe sex practices and violent behaviors, including domestic violence; and (3) men are more likely than women to drink alcohol heavily and excessively, and drinking norms influence these gender differences in alcohol consumption.

  This report showcases a variety of media and communications strategies to be used to end violence against women. The report is a collaboration between UNIFEM and the Media Materials Clearinghouse of the Johns Hopkins University Center for Communications Programs.
  http://www.unifem.undp.org/resources/freeofviolence/index.html
This report compares the findings of three population-based studies on violence against women in Nicaragua. The report examines the differences among the results and the possible effects of methodological factors on underreporting and validity. (Not available online.)

This publication presents research on the prevalence and incidence of violence against women in Indonesia. It presents the methodology used and the research results and concludes with recommendations. (Available through PATH.)

This study on domestic violence describes the powerlessness of women in situations of violence and notes that up to half of the world’s female population may be victimized by those closest to them at some time in their lives. Within this context, issues related to intimate partner violence take on added urgency because of the rapid spread of the AIDS virus in many parts of the world. http://www.unicef-icdc.org/publications/pdf/digest6e.pdf

This preliminary overview of available literature suggests that, within the context of gender and the HIV epidemic, sexual violence is a complex phenomenon with multiple determinants, consequences, and manifestations.

This paper employs both a human rights and a development framework to identify the limitations and strengths of each approach for understanding and responding to domestic violence, as well as to clarify the links that need to be made between the frameworks.

A publication that documents seven important programs dedicated to ending violence against women in Bosnia and Herzegovina, Cambodia, Honduras, India, Kenya, Nigeria, and the West Bank and Gaza. http://www.unifem.undp.org/resources/tfbook/index.html
Ending Violence against Women.
In-depth study by the Johns Hopkins School of Public Health and the Center for Health and Gender Equity. Based on over 50 population-based surveys and more than 500 studies of domestic violence, the report finds that by far the greatest risk of violence comes not from strangers, but from male family members, including husbands.
In English: http://www.jhuccp.org/pr/l11edsum.stm
In Spanish: http://www.jhuccp.org/prs/sl11edsum.stm

Violence against Women, Gender, and Health Equity.
This paper starts with a broad definition of violence against women and then focuses on domestic and sexual violence in particular. It provides an overview of the magnitude of domestic and sexual violence against women and of its various consequences including those involving health for women and their children.
http://www.hsph.harvard.edu/Organizations/healthnet/HUpapers/gender/garcia.html

The Facts about Gender-Based Violence.
This report provides a definition of gender-based violence and includes statistics on its worldwide magnitude. It also details the different forms of violence that women face every day ranging from sexual harassment to female genital mutilation and rape.
http://www.ippf.org/resource/gbv/ma98/1.htm

The Intimate Enemy: Gender Violence and Reproductive Health.
The Panos Institute, 1998.
The report shows how local communities around the world are providing medical, legal, and counseling services for victims and lobbying for changes in laws and customs to address the problem head-on. http://www.panos.org.uk/briefing/genviol.htm

The Nicaraguan Network of Women against Violence:
Using Research and Action for Change.
This report examines the anti-violence movement in Nicaragua, which began in the 1980s and has been led by the Nicaraguan Network of Women against Violence. It outlines the various strategies used to advocate for the inclusion of domestic violence on the country’s national political agenda. (Not available online.)

The study explores the various forms of GBV and how growing awareness of the phenomenon in recent years has led to the establishment of new institutions and the adoption of legislative amendments, which in turn have served as a focal point for collective action by women.
http://www.eclac.cl/publicaciones/UnidadMujer/7/lcl957/lcl957i.pdf
V. TRAINING MANUALS AND GUIDES

+ *Violencia domestica: Modelo de intervención en unidades de salud*  
This manual is a guide for the development of multidisciplinary networks for the detection and care of intra-family violence against women from the perspective of the health sector. Available only in Spanish. (Not available online.)

+ *A Practical Approach to Gender-Based Violence: A Program Guide for Health Care Providers and Managers.*  
This publication contains practical steps needed to integrate gender-based violence into reproductive health facilities. It is also meant to help a wider range of readers understand the interrelationships between reproductive and sexual health and violence.  

+ *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence.* *U.S. Institute of Medicine, 2001.*  
The book identifies the gaps which exist in current training and the challenges identified by health professionals in their attempts to address violence. It also sets out priority areas for future training efforts and presents a number of recommendations to guide those efforts.  
http://www.nap.edu/books/0309074312/html/

+ *Manual para el abordaje de la violencia contra la mujer*  
The primary objective of this manual is to make women themselves aware of their rights, specifically their right to live free from violence. The publication is divided into the following sections: a review of international human rights declarations and instruments; the Guatemalan legal/constitutional context; what is violence against women?; where does violence happen and who perpetrates it?; what forms does violence take?; why should you denounce violence?; who can denounce violence?; how can you denounce violence?; what is the role of the police sector?; what is the role of the judiciary?; how is violence registered?; and what happens after you denounce violence. Available only in Spanish. (Not available online.)

+ *Tools for Providers Working with Victims of Gender-Based Violence.*  
*International Planned Parenthood Federation, 2001.*  
The tools in this publication were developed for facilitating an approach to gender-based violence within the context of sexual and reproductive health care. The kit includes the following sections: Definitions; Screening Tool; Sample Stamp for Client Intake Form to Record Information on GBV; Management Checklist; Legal Framework for Service Providers Addressing GBV; Knowledge, Attitudes, and Practices Questionnaire for Health Care Providers; and Observation Guide.  
http://www.ippfwhr.org/whatwedo/bastatools.html
The document highlights components of promising programs being implemented in the United States, contains an example of the process one state chose to design and implement sexual assault prevention education programs for this age group, and includes a list of resources.

The publication presents separate modules establishing guidelines on the following seven aspects of violence: child physical abuse and neglect and child sexual abuse; domestic violence; elder abuse and neglect; strategies for the treatment and prevention of sexual assault; mental health effects of family violence; physician guide to media violence; and a physician firearms safety guide.
http://www.ama-assn.org/ama/pub/category/3548.html

A multi-specialty, comprehensive routine screening document on domestic violence. In addition to specific guidelines for primary care, obstetrical and gynecological, family planning, urgent care, mental health, and in-patient settings, it includes an extensive bibliography, documentation forms, and other useful materials.

This kit contains a series of information packets for health care providers interested in developing a comprehensive health care response to domestic violence. Packets include: General Information on the Health Care Response to Domestic Violence; The Emergency Department Response to Domestic Violence; Screening Patients for Domestic Violence; Mandatory Reporting of Domestic Violence by Health Care Providers; and Violence against People with Disabilities.

A series of protocols to help reproductive health care workers address gender-based violence in their practices, with a specific emphasis on screening women during routine reproductive health care visits. Includes a section on working with women’s groups and other NGO partners who provide social and legal support services for victims of violence.
http://www.familycareintl.org/pubs/index.html
Say No to Violence:
Women’s Department and National Women’s Commission, 1999.
This handbook produced in Belize provides a collection of strategies to aid both the woman who finds herself in an unacceptable relationship and those who endeavor to offer her assistance in solving her problems. The interventions that a helper can initiate are wide-reaching but nonintrusive and are based on the belief that abused women must be supported in finding the means of resolution that are most appropriate for each woman’s particular situations. (Not available online.)

Violencia familiar: Enfoque desde la salud pública
[Intra-family Violence: From a Public Health Perspective].

¿Cómo atender a las mujeres que viven situaciones de violencia doméstica?
Orientaciones básicas para el personal de salud
[How to Care for Women Living in Situations of Violence: Basic Orientations for Health Personnel].
Red de Mujeres contra la Violencia (Network of Women against Violence), 1998.
The publication begins with an introduction describing what gender-based violence is, what its different forms are and how to recognize them, GBV as a public health problem, and its physical and psychological effects. It then presents an overview of GBV in Nicaragua, its prevalence, and the country’s response, and then concludes with a comprehensive series of possible interventions that will help health personnel to recognize GBV and develop effective responses. Available only in Spanish. (Not available online.)

Designed as a training tool for clinicians to increase understanding of the role they can play in identifying, preventing, and reducing intimate partner violence. The slide set is designed as an introductory or supplementary learning tool to be used in conjunction with other reinforcing and enabling strategies, including role-playing, periodic discussions at staff meetings, staffing changes, and institutional support. Includes a situation report and potential areas of action for clinical staff. http://www.cdc.gov/nccdphp/drh/violence/ipvdp.htm

Prevención de la violencia por medio de la educación en la familia y la escuela
[Preventing Violence through Education in the Family and at School].
This document presents a training course aimed at school-aged children who demonstrate violent tendencies and/or behavior. It proposes working with children to teach them nonviolent conflict resolution and other coping skills. Available only in Spanish. (Not available online.)

The manual includes information to educate practitioners on screening, identification, assessment, and interventions with victims of domestic violence and their batterers; practical tools including a model hospital intervention packet outlining effective protocols and sample forms for screening, domestic violence/abuse assessment, documentation, safety planning, and discharge; and ideas to help develop and implement response strategies and programs within a variety of health care practices and settings.


**VI. CONVENTIONS AND DECLARATIONS**


1974 Declaration on the Protection of Women and Children in Emergency and Armed Conflict http://heiwww.unige.ch/humanrts/instree/e3dpwcea.htm


1995 Fourth World Conference on Women (Beijing) http://www.un.org/womenwatch/daw/beijing/platform/


**VII. INTERNET/WEB RESOURCES**

* Centre for Research on Violence Against Women and Children*

The Centre is one of an alliance of five research centers in Canada whose purpose is to promote the development of community-centered action research on violence against women and children and to facilitate individuals, groups, and institutions representing the diversity of the community to pursue research issues and training opportunities related to the understanding and prevention of abuse. http://www.uwo.ca/violence/index.html
* **Coalition against Trafficking in Women**  
  The Coalition is composed of regional networks and affiliated individuals and groups and serves as an umbrella that coordinates and takes direction from its regional organizations and networks in its work against sexual exploitation and in support of women’s human rights.  
  http://www.catwinternational.org/

* **End Violence against Women, Johns Hopkins University, Center for Communications Programs**  
  This site features an online collection of materials and resources on preventing violence against women. It is part of an ongoing effort to share information with health professionals who seek information and resources on this subject.  
  http://www.endvaw.org/

* **End-Violence Working Group**  
  Sponsored by UNIFEM, this listserv unites people from over 120 countries in a virtual community that works to end violence against women. It provides information and recommendations to U.N. agencies and publications; promotes the visibility of developing country organizations working against gender-based violence; expands networking among NGO, government, international, educational, religious, and other groups; and shares information about policies, strategies, cases, and best practices. To subscribe, send an e-mail to majordomo@mail.edc.org, leave the subject line blank, and write “subscribe end-violence” in the message area.  
  http://www.edc.org/GLG/end-violence/hypermail/

* **Family Violence Prevention Fund**  
  The Family Violence Prevention Fund, through the National Health Initiative on Domestic Violence (NHIDV), addresses the health care response to domestic violence through public policy reform and health education and prevention efforts. The NHIDV develops educational resources, training materials, and model protocols on domestic violence and screening to help health care providers better serve abused women.  
  http://endabuse.org/

* **Flora Tristán Center**  
  Since its founding in 1979, this nongovernmental organization has worked in a number of areas to improve the living conditions of women in Peru. The Web site provides background on national and international projects and training, and contains articles and publications. (Information in Spanish only.)  
  http://www.flora.org.pe/

* **Regional Training Program against Domestic Violence**  
  ILANUD focuses its efforts on the sensitization and training of members of the judiciary, the penal system, ministries of health and education, and the staff of police academies and universities. (Information in Spanish only.)  
  http://www.ilanud.or.cr/vioenciadamestica

* **International Planned Parenthood Federation (IPPF), Western Hemisphere Region (WHR)**  
  The IPPF/WHR Web site contains information on its GBV projects in Latin America and the Caribbean. IPPF/WHR publishes a quarterly newsletter called *IBASTA!*, which can be
accessed and downloaded from its Web site. *BASTA!* reports on the efforts of IPPF affiliates in Latin America and the Caribbean to address GBV within the framework of sexual and reproductive health and offers practical information and tools to service providers who wish to work in this area. http://www.ippfwhr.org/

* Isis Internacional
Together with the Isis affiliate offices in Manila and Kampala, Isis in Chile oversees the Program on Violence against Women, an information and communications initiative that provides informational materials and resources to organizations worldwide. (Information in Spanish only.) http://www.isis.cl/

* A Life Free of Violence: It’s Our Right (United Nations Inter-Agency Campaign on Women’s Human Rights in Latin America and the Caribbean)
This site is part of the UNDP’s contribution to the U.N. Inter-Agency Campaign on Women’s Human Rights and provides a compilation of materials provided by all partner agencies. http://www.undp.org/rblac/gender/

* Minnesota Center against Violence and Abuse (MINCAVA)
The MINCAVA Electronic Clearinghouse strives to provide a quick and easy access point to the ever-growing number of resources available online on the topic of violence and abuse. One focus of the Clearinghouse is to assist faculty and staff in developing higher education curricula on violence and abuse. The Clearinghouse shares in electronic form curricula and syllabi used in violence education programs at institutions of higher education across the United States. http://www.mincava.umn.edu

* National Sexual Violence Resource Center
A clearinghouse of information, resources, and research related to all aspects of sexual violence. Activities include collecting, reviewing, cataloguing, and disseminating information related to sexual violence; coordinating efforts with other organizations and projects; providing technical assistance and customized information packets on specific topics; and maintaining a Web site with up-to-date information. http://www.nsvrc.org

* National Violence against Women Prevention Research Center (NVAWPRC)
The Center serves as a clearinghouse for prevention strategies by keeping researchers and practitioners aware of training opportunities, policy decisions, and recent research findings. http://www.vawprevention.org

* Nursing Network on Violence against Women (NNVAW)
The NNVAW was formed to encourage the development of a nursing practice that focuses on health issues related to the effects of violence on women’s lives. http://www.nnvaw.org

* Program for Appropriate Technology in Health (PATH)
PATH is a nongovernmental organization whose mission is to improve the health of women and children. Its Web site features access to resources related to women’s health and gender issues. www.path.org
+ **Puntos de Encuentro**

Puntos de Encuentro is a nongovernmental organization in Nicaragua dedicated to communication, research, and education on issues affecting the health and development of women and adolescents. The group’s Web site contains information on its programs, including Sexto sentido, a popular television series targeted toward adolescents which uses a gender perspective to address issues adolescents might experience in their daily lives, such as gender-based violence. (Information in Spanish only.) http://www.puntos.org.ni/

+ **Queen Sofia Centre for the Study of Violence**

This site is a bibliographic database of Spanish and English language resources on gender-based violence/violence against women. http://www.gva.es/violencia/

+ **Reproductive Health Outlook**

Provides links to numerous sites of organizations addressing violence against women and includes sections on gender and men and reproductive health. http://www.rho.org

+ **Reproductive Health for Refugees Consortium (RHRC)**

This Consortium is a partnership of seven organizations dedicated to increasing access to a range of quality, voluntary reproductive health services for refugees and displaced persons around the world. Gender-based violence is one of the four essential and complementary technical areas of reproductive health on which RHRC focuses its work. The Web site also features several links to reports and guides on addressing gender-based violence in refugee settings. http://www.rhrc.org/resources/gbv/index.html

+ **SIVIC**

This site specializes in the treatment of domestic violence and is targeted particularly toward health sector professionals. In addition to providing background information on the problem of domestic violence, the site also offers practical advice on how health care providers can identify, evaluate, and help women who are the victims of domestic violence during the course of health consultations. An initiative of the European Commission, the site contents are available in English, French, Italian, Portuguese, and Spanish. http://www.sivic.org

+ **United Nations Development Fund for Women (UNIFEM)**

UNIFEM provides financial and technical assistance to innovative programs and strategies that promote women’s human rights, political participation, and economic security. The Web site features information about international resolutions concerning violence against women, UNIFEM’s work, available resources, and the application process. http://www.unifem.undp.org/trustfund/

+ **Violence Against Women Electronic Network (VAWnet)**

Provides support for the development, implementation, and maintenance of effective violence against women intervention and prevention efforts at the national, state, and local levels through electronic communication and information dissemination. VAWnet participants, including state domestic violence and sexual assault coalitions, allied organizations, and individuals, have access to online database resources. http://www.vawnet.org
BIBLIOGRAPHY AND REFERENCES


- Ellsberg M, Claramunt C. Mid-term review of PAHO’s project: Organizing and strengthening women and promoting coordinated actions between government and civil society at the local level to prevent and treat intrafamily violence against women. Managua: Pan American Health Organization; 1996.


- Ramellini T, Mesa S. Estrategias de intervención especializada con personas afectadas por la violencia intrafamiliar: emprendiendo un camino. San José, Costa Rica: Centro Nacional para el Desarrollo de la Mujer y la Familia; 1997. (Colección Metodologías. Sentir, pensar y enfrentar la violencia intrafamiliar).


