Women are waiting for someone to knock on their door; some of them have been waiting for many years. . . .

—Health provider, El Salvador
SECTION II

Lessons Learned from Central America

INTRODUCTION

In 2001, as the second period of Nordic funding for PAHO’s Central American GBV project was coming to a close, there was consensus among PAHO, the donors, and national partners that the time had come to assess the actual achievements of the project before moving forward.

It was already obvious from yearly meetings with national project partners and project reports that a great deal had been accomplished in the last seven years: laws had been reformed; policies on violence had been implemented in many countries; countless providers had been sensitized to the issues of violence; registration forms for tracking violence had been developed; and community networks had been established. However, it was not possible to determine from these meetings and reports what difference these activities had actually made in the lives of women and their families who had been affected by violence.
The Norwegian and Swedish international cooperation agencies NORAD and Sida were particularly interested in carrying out an overall assessment of the project’s achievements, as well as of its impact, efficiency, and sustainability. In addition, PAHO was anxious to use the opportunity to provide a more in-depth view of what the impact of the project had been to date, in order to strengthen, and if necessary, reorient, future cooperation.

Specifically, the partners were interested in finding out whether the policy reforms and training efforts had changed the way health providers thought about violence and addressed it in their practice. Were they more likely to ask women about violence, and if so, did they feel more confident in their ability to respond appropriately? Did the project affect the overall quality of health services in any way? Had coordination between institutions dealing with violence been strengthened? Had the “critical path” that women followed to overcome violence become any less burdensome? Most importantly, how did women feel about the new role that the project encouraged health providers to take on? Did it help them feel safer or more empowered to deal with the violence in their lives?

Therefore, an important aim of the review was to identify the important lessons and advice that providers, activists, and policymakers, as well as survivors, could offer to others embarking on similar projects.

The Program for Appropriate Technology in Health (PATH) was asked to carry out the review, and the U.S. Centers for Disease Control and Prevention (CDC) provided technical assistance. Because the International Planned Parenthood Federation, Western Hemisphere Region (IPPF&WHR), was also initiating an evaluation of its own GBV project in the Dominican Republic, Peru, and Venezuela, the review team collaborated with consultants and representatives of IPPF as well as PAHO in the development of the methodology. Both in-depth qualitative and participatory methods were used, including:

1. a review of project documents, as well as documents produced within the project countries

2. interviews with key informants in each country, including:
   + PAHO consultants
   + ministry of health staff
   + representatives of women’s groups and institutions that work together in the area of violence
3. focus group discussions with various stakeholders, including:

- members of national level commissions to prevent violence
- health providers from local health centers
- community leaders
- members of community violence prevention networks
- clients of health services (women who had received individual services for violence-related problems or who had participated in support groups for victims)
- members of an offenders’ treatment program (Honduras).

The selection of key informants was made jointly by PAHO and representatives of the ministries of health, and the focus groups were set up by the local health centers and community networks. In total, more than 300 individuals were interviewed through the following activities:

- visits to five countries
- 31 focus group discussions
- visits to 10 community project sites.

During the group interviews the review team used the following participatory techniques to stimulate discussion (Chapters Six and Seven present a more complete description of the methods used):

- “The Road Traveled” (a chronogram of collective histories)
- “Who Helps Rosita?” (Venn diagrams for institutional analysis)
- achievements and barriers (free-listing and ranking)
- “Rosita’s Story” (story completion for the analysis of quality of care).

As much as possible, the same techniques were used with the different groups, in order to permit comparisons between the views of clients, service providers, and members of community networks. In each of the sessions, one member of the review team facilitated the session while another took notes. The diagrams produced in the groups as well as the notes were transcribed afterwards for analysis.

The fieldwork for the study was carried out during July and August 2001. Given the limited time available for the study, the team decided to focus on achieving a greater depth of analysis in a few countries rather than visiting all of the countries, but obtaining a more superficial view. Therefore, field visits were performed only in El Salvador, Guatemala, Honduras, and Nicaragua. In order to learn about some of the experiences of Belize, Costa Rica, and Panama, a joint meeting with PAHO and its country representatives was
held in Costa Rica. The preliminary results of the review were presented in a seminar in Panama for representatives from PAHO, the partner countries, and donors in October 2001. Comments from all the participants were incorporated into the final report (Ellsberg and Clavel Arcas 2001), available on PAHO and Sida’s Web sites (www.paho.org and www.sida.se, respectively).

The second section of this book presents the highlights of the evaluation, with an emphasis on the lessons learned by the project participants. It also includes some examples of project achievements from Bolivia, Costa Rica, Ecuador, and Peru, even though these countries were not included in the initial study.

The main constraints of this report are the relatively limited amount of time and space available to provide an in-depth view of such a broad topic. With the exception of Nicaragua, the time spent by the review team in each country was relatively short, and in some cases it was not possible to interview all of the key people involved in the project. Therefore, a debriefing seminar was held in Panama with PAHO and national counterparts in order to ensure that the study’s findings would be placed within their proper context and to address any issues of concern or perceived shortcomings of the study.

Because it would be impossible to do justice to the wealth of information collected during the research for this book, the review team has tried to synthesize the findings as much as possible in order to present a global vision of the project’s principle accomplishments and barriers. Section II will therefore highlight those aspects of the project that are common to all countries, as well as issues that are unique to a single setting. Whenever relevant, international experiences are also referred to. The team has relied as much as possible on the actual voices of the participants and indicates areas where consensus and discrepancies were observed. At the same time, the evaluators have attempted to clearly indicate which statements are views of the interviewees and when they reflect the team’s own opinions.

The review team would like to acknowledge all of the individuals who provided support throughout the completion of this lessons-learned review. These include the PAHO individuals listed in this book’s acknowledgments section and those from the ministries of health, national NGOs, and the Governments of Norway and Sweden. Their steadfast commitment and support have enabled the PAHO project evaluation to come to fruition.
Chapter Four

Policy and Legal Reforms on Gender-Based Violence

As pointed out at the beginning of this book, in the last decade there has been a dramatic surge in international recognition of violence against women as a human rights and public health problem. The Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, signed in Belem do Pará, Brazil, in 1994, marks a particular watershed for the Americas, as all countries in this Region committed themselves to making broad policy and legal reforms to address violence against women.

By the time of the PAHO project review in 2001, national committees had been established in all seven countries of Central America for the purpose of improving coordination and monitoring progress on the development of national plans and policies on violence. Most committees are headed by the national institutions for the promotion of women’s rights and include representatives from the ministries of justice, education, and child welfare, as well as women’s NGOs that work on violence. Initially, the health sector did not participate in these committees; however, now it has members in all countries with the exception of Guatemala. In Costa Rica, the health sector stands out as being the first state sector to establish a sector-wide plan for family violence; this step in 1994 served as the precursor for the subsequent development of PLANOV (see Box 4-1.). The Ministries of Health in Belize and Panama have also played a prominent role in the development of national violence prevention programs.
One of the first goals of each of the committees was to achieve a basic agreement among the sectors to coordinate in a national violence prevention effort. In Costa Rica (PLANOVI 1994) and El Salvador national plans are already being implemented. In Belize, Guatemala, and Nicaragua national plans have been drafted but not put into effect. In Honduras and Panama, national violence prevention plans are currently being developed.

The creation of a national plan on violence against women is an important achievement in itself, as it creates a political space for greater dialogue between civil society and the state, at the same time that it commits governments to a public discourse that encourages sanctions against violence (see Box 4-2. on Peru’s experience). Nevertheless, in most countries the transition from developing plans to putting them into practice seems to be problematic. This is partly due to budgetary constraints, but at the same time these difficulties have political undertones. In Nicaragua, the National Commission on Violence against Women carried out a highly participatory planning process on violence against women that resulted in an ambitious and comprehensive proposal. However, shortly after its approval, the proposal languished for lack of resources to implement it. A member of the committee commented:

“The Inter-American Development Bank has offered to finance the plan, but due to the lack of pressure by the government, the funds have not been disbursed. If this were really a priority for the government there would be 10 ministers calling the IDB every day to ask what’s happening with the loan.”

In other countries where there is little tradition of coordination between civil society
For the first time in Peru, national ministries, civil society, and international agencies have achieved a coordinated, sustainable approach to the issue of family and gender-based violence vis-à-vis the formation of the Mesa Nacional Multisectorial para la Atención Integral de la Violencia Familiar (National Task Force for the Comprehensive Care of Family Violence). Current members include the Ministries of Health, Education, Justice, Interior, and PROMUDEH (Program for Women and Human Development); and the Flora Tristán Center, a nongovernmental organization. Other participating (but nonvoting) agencies are the Pan American Health Organization (PAHO), the United Nations Population Fund (UNFPA), and the United Nations Children’s Fund (UNICEF). Coordination of the Mesa rotates every six months, giving all sectors the opportunity to manage the coalition’s agenda.

In 1999, as the result of the Critical Path process, the official members and Peru’s Attorney General signed a national agreement that mobilized political will at all levels. The decree also facilitated a consensus-building process that resulted in the formation of networks at different levels and in the coordination of services that respond to the needs of Peruvian women living with violence.

The coordination of the members’ contributions and expertise has resulted in greater quality and efficiency of the programs and policies that address gender-based violence.

Accordingly, the Mesa has coordinated training programs for health and other sector providers and has established a national database of information, research, and surveillance results.

The model of the Mesa Nacional has been replicated in 18 departments (states) and in many of their respective communities. During this process, the various sectors have been able to overcome many long-standing obstacles and work together to support and care for those affected by violence. The decentralized Mesas have raised their communities’ awareness about the existence of violence and have provided incentives to overcome this problem. Their efforts have been strengthened by the regular sharing of lessons learned and best practices among communities and departments.

Beginning in 1997, a number of communities started self-help groups of women affected by violence. Through the coordinated efforts of their Mesas, member institutions facilitated the training of these groups’ coordinators from Lima, Cuzco, and Piura, which resulted in the formation of more than 40 women’s, men’s, and mixed groups that involve approximately 500 participants per year, the majority of whom are women.

Throughout this process, PAHO has played a leadership role in consensus-building, the formation of Mesa working groups, and the creation of community self-help groups.

Maria Edith Baca, PAHO/WHO-Peru
and the state, and even among state institutions themselves, reconciling the priorities of different sectors is, in and of itself, a considerable challenge. A further obstacle is the oftentimes poor coordination between the national committees and local networks.

**RECENT LEGISLATIVE REFORMS IN CENTRAL AMERICA**

In the last 10 years, there has been an important movement to reform the laws concerning gender-based violence. This has largely been a result of the efforts of national as well as international women’s organizations, such as the Latin American Committee for the Defense of Women’s Rights (CLADEM). The critical legal analysis and lobbying efforts of women activists have been crucial in raising awareness of the weaknesses of current legislation and the need for reforms.

Another contributing factor has been the growth of women’s commissions in the national legislative bodies who have contributed, often through bipartisan efforts, to reforms in critical areas. PAHO has been a principal agent in facilitating this process by targeting women parliamentarians, political leaders, cabinet advisors, and even wider political spaces such as RESSCAD (meetings of Ministers of Health of Central America and the Dominican Republic) in order to exchange experiences and define priority issues for joint action. Its presence in national reform processes within and outside the health sector is part of its wider advocacy role to defend the right of women to be free of violence.

Although the initiation of the reform process has had similar roots in the different countries, the actual content of the laws is largely determined by the specific political circumstances in each nation. The capacity of social movements and even women’s commissions to influence the final content of legal reforms is often limited. In some cases, new elements were added to laws making them more discriminatory to women, such as a reference to “virtuous women” in the definition of sexual crimes in Panama’s Domestic Violence Law, or the addition of a clause criminalizing the “promotion” of homosexuality in the Nicaraguan Reform of the Penal Code on Sex Crimes. Although the content of the domestic violence laws varies by country, there are some common features. The most important achievements of the legal reforms have been the following:

- the establishment of protective measures (Belize, Costa Rica, El Salvador, Guatemala, and Nicaragua);
- expanding the concept of injury, so that severe psychological damage, such as major depression or post-traumatic stress disorder resulting from abuse, may be considered a criminal offense (Nicaragua);
- establishing family ties as an aggravating circumstance in the case of injury, which warrants the use of more severe, rather than weaker, penalties (Nicaragua); and
- changing the status of sex crimes and spousal violence to public offenses, and broadening the definitions, as well as the sanctions, for rape and incest (Belize, Costa Rica, Honduras, Nicaragua, and Panama).

**GAPS AND PROBLEMS IN THE NEW LEGISLATION**

In most countries, even where reforms have been passed, there are still important gaps. For example, although the Panamanian legislation contains a number of important and innovative measures regarding violence prevention, the treatment of victims of
abuse, and sanctions to offenders, it is still generally very weak in terms of offering protection for abused women and children. In other countries, the legal reforms have been primarily geared towards protection and prevention, as in Costa Rica, and few changes have been made in the area of sanctions. Belize and Nicaragua have possibly the most progressive and complete legislation overall, in terms of addressing issues related to prevention, protection, and sanction. Following are some examples of gaps and contradictions in terms of legal protection and sanctions for offenders that are still present in many Central American countries:

+ **Many legislative reforms do not address sex crimes (rape and incest), which are still considered private offenses.** In Guatemala, for example, this means that only the victim can file charges against an offender. Many women, and particularly children, are reluctant to file charges, and given the lack of protective measures, it may be quite dangerous for them to do so. Moreover, in many countries rape in marriage is not recognized as a crime. In the case of incest and spousal abuse, fear or family pressure often prevent women from reporting these crimes, or once reported, the charges are often subsequently dropped. This is considered by Guatemalan women’s rights activists to be a serious constraint:

> “. . . We want sexual offenses to be officially prosecuted and incest to receive real sanctions. In Guatemala, incest carries a fine of 300-600 quetzales [US$ 40-90], and the aggressor can go free right away. . . .”
> —Member of the Guatemalan Violence Prevention Commission, CONAPREVI

+ **Penalties for injuries and sex crimes are often very low,** and quite often can be exchanged for a court pardon or for minimal fines.

+ **In some countries, such as Honduras, arrests can be made only after a criminal investigation has been concluded,** which means that the woman who reports spousal abuse must wait up to two days before the police can make an arrest, during which time the abusive husband may still be living in the house with her.

+ **Legislation which restricts women’s access to family property or which does not guarantee men’s obligation to provide child support keeps women in abusive relationships for reasons of economic dependency.** An example of progressive legislation in this respect is that of Honduras, where in the case of separation of common property, the house may belong to the husband, but everything inside it by law belongs to the wife.

**PUTTING THE LAWS INTO EFFECT**

Legislative reform is only the first step in developing effective strategies against gender-based violence. It is equally important to ensure that the justice system applies the laws correctly, and that women and children have a sufficiently adequate understanding of the legal system to be able to demand that their rights be safeguarded.

This is a weak area in all of the countries studied, where in many cases judges and police have little or incomplete knowledge of laws, and for various reasons do not apply them appropriately. In many countries the specific criminal procedures to be followed in applying the new laws are not yet clear. Furthermore, there appear to be many difficulties in establishing effective coordination between the law enforcement
Teachers and students attend public forum on violence prevention in Guatemala.
and judicial sectors, both at the local and national levels. Following are examples of some of the weaknesses found:

* Interpreting the law are often based on cultural norms that are tolerant of violence against women and children. For example, in Costa Rica, being under the influence of “a violent emotional state” is considered to be an extenuating circumstance for the crimes of homicide and injury, and legal experience in gender-based violence has shown that many judges interpret “jealousy,” “heated discussions,” anger, and infidelity as legitimate causes for such a state.

This means that even when new laws are passed sanctioning GBV, it is much harder to change the logic under which the laws are applied. In Nicaragua, Justices of the Supreme Court have displayed biases in favor of offenders with such public statements as “If a man hits a woman, she must have done something to deserve it,” and “A man who beats his wife must have a good reason for it; surely she did something to provoke it” (Ellsberg, Liljestrand, and Winkvist 1997).

This belief is not exclusive to judges, but rather permeates the attitudes and practices of other public officials, such as police officials, human rights ombudsmen, and public prosecutors in charge of investigating and processing charges of violence. This mindset often affects judgments on the criminality of a given act, especially when the only evidence is the victim’s testimony. This is especially critical in the case of sexual abuse of children, where the main evidence is usually testimonial in nature.

* There is little coordination between family courts and criminal justice courts. Where they exist, family courts are usually in charge of issuing protective orders, whereas criminal courts are mandated to handle criminal proceedings against offenders. This means that, in practice, women are required to follow separate procedures for what, nonetheless, constitutes a criminal act, which in turn often produces contradictory and inequitable results. At the same time, women typically receive very little guidance to help them comprehend and successfully navigate the bureaucratic processes required for their complaint to be addressed.
There is a risk of contradiction in the application of family law and domestic violence legislation. Many Central American countries have recently passed family codes, which generally establish the preservation of the family as a primary goal. The spirit of this legislation can be contradictory to that of domestic violence legislation, which has the goal of protecting the physical and moral integrity of individuals within the family. In practice, what this means is that whenever judges rule according to the principal of family unity, women will be obliged to remain with their abusive husbands, particularly in countries where effective protective measures are not in place.

In Honduras and Panama, the new laws establish the possibility of allowing offenders to receive “curative treatment” in lieu of prison sentences. There is a great deal of controversy regarding the effectiveness of short-term psychological treatment in “curing” violent behavior (this issue will be addressed more thoroughly in Chapter Seven). However, a further constraint is that neither the Honduran nor the Panamanian public health system currently has established norms for the treatment of offenders, nor the capacity to carry out large-scale treatment programs.

Mediation is neither forgiveness nor reconciliation. Another common problem is the use of mediation or out-of-court arrangements (fianzas de paz or arreglos extrajudiciales) for domestic and sexual violence situations. Mediation has become popular in many countries as a means to expedite solutions for misdemeanor offenses. However, when used in domestic violence or rape cases, it can be counter-productive because there are few guiding rules or principles for performing mediation, and therefore the agreements are subject to the individual interpretation of each police officer or judge. In Guatemala, as the indigenous women activists of Cobán explained,

“...The deputy mayors in the indigenous communities often use mediation as a way to make couples reconcile, because the focus is on sustaining the family at all cost...”

—Cobán promoter

Although in Nicaragua, mediation is not officially allowed to be used in cases of violence and sexual offenses, several judges acknowledged that it frequently is applied. One difficulty with mediation is that it assumes that both parties are negotiating under equal conditions; however, this is clearly not the case when a woman has been beaten or raped by her intimate partner. As a consequence, the agreements that result from mediation often disguise the aggression. They are usually registered as “marital disputes” rather than “assaults,” and in return for a husband promising not to hit his wife, she is often asked to promise not to provoke her husband and maintain order in the household. The faulty premise behind this solution is clear: it implies that both parties are equally responsible; the husband for using violence and the wife for provoking him. As one Nicaraguan lawyer commented,

“It was such a struggle to get the police to stop using out-of-court agreements... Now with judicial mediation the whole package has been transferred over to the courts, but the problem is the same.”

In some countries, judges refuse to apply protection measures such as restraining orders for the aggressor, alleging that it violates his rights.
Mandatory reporting discourages health providers from asking questions related to violence, for fear of getting involved in court cases. The laws in Costa Rica, El Salvador, Guatemala, and Panama establish the obligation of public employees to notify the justice system if they become aware of cases of family violence. As a result, health personnel are reluctant to ask clients about violence and to register identified cases for fear of becoming involved in criminal cases.

In many cases, legal proof of abuse is required by specially trained forensic physicians, of which there are very few in Central America. PAHO advocates that the laws be modified to allow any trained doctor to perform this examination. Bolivia recently passed a law permitting this, and the Organization is working with the Universidad Mayor de San Andrés, the national university, in the development of a training manual for medical students in legal medicine.

The problems mentioned above have many serious consequences, but the most important of these is that:

- women may be more reluctant to report violence, either because they believe that nothing can be done, or because of fear of reprisals;

- women and children may be exposed to greater risks by reporting acts of violence when there are not effective measures to protect them; and

- the impunity resulting from the lack of institutional response reinforces the belief among abusive men that they are allowed to beat their intimate partners and children.

As we have seen in this chapter, the increased international and regional attention that has been focused on gender-based violence as a social justice issue and human rights violation, combined with the advocacy and commitment of principally women’s groups to this topic, have raised public and political awareness of the need for national policy and legal reforms to protect women and children from violence and to provide them with legal instruments to redress wrongs committed against them, whether by their intimate partners or through incest or rape. However, the changes that will be required are not always clear, since they often conflict with issues of privacy, socialization practices, and long-ingrained cultural patterns. At the heart of this change will be innovative actions at the community level—the construction of viable intersectoral networks and sustained cooperation—supported by national political commitment to remove as many barriers as possible to the development of a new culture of mutual respect among men and women. The examples of Costa Rica, Peru, and Ecuador (Boxes 4-1., 4-2., and 4-3.) illustrate the various aspects and possibilities of this approach.

In the next two chapters, we will see how the health sector, through its human face—the actual health workers—can play a key role in caring for women affected by violence and in increasing the visibility of GBV through better awareness, training, and reporting of cases.
In Ecuador gender-based violence is officially recognized as a public health and a social justice problem, and the right to a life free from violence is established in the nation’s Constitution. The comisarías itinerantes, or mobile support units, offer an innovative response to women affected by violence in rural and/or remote areas where access to health education and legal services is limited and/or inadequate. The principal function of these comisarías “on loan” from other jurisdictions is to increase awareness about Law #103, (titled Violence against Women and Families, approved by the Government in 1995), reduce the risk of gender-based violence, and protect affected community members by enabling women to receive social, psychological, and legal advice. Furthermore, the coordination between local officials and visiting comisarías, while lacking formal legal authority, facilitates the training and conscience-raising of local authorities, service providers, and the community. The comisarías’ activities are carried out within health and legal service centers and include:

- carrying out campaigns and informing affected women, providers, and the community about all national laws and legal instruments, especially Law #103, and increasing access by the affected women to legal services;
- disseminating information and options for those women and families affected by violence;
- increasing access by the affected women to health care and improving the quality and sensitivity of health services that respond to intrafamily and gender violence problems;
- introducing intrafamily and gender violence issues into basic educational curricula at the community level; and
- facilitating the dissemination of emergency contraception as an alternative to unwanted pregnancies resulting from sexual violence.

This initiative applies the constitutional rights guaranteed to all Ecuadorians, especially women, to have access to:

- information on their human rights, and, in particular, about their sexual and reproductive rights, and to a life free of violence, as stated in Law #103;
- quality health services which address intrafamily and gender violence;
- comisarías in all communities; and
- participation in community activities related to the prevention and control of violence.

As a result of this strategy, the comisaría have contributed to greater visibility of gender violence in communities throughout Ecuador. Health services have stimulated the replication of this strategy, with increasing focus on the importance of strengthening mobile legal and psychological services as well.

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Chapter Five

The Health Sector: Building an Integrated Approach

This chapter highlights the most significant experiences and lessons learned from PAHO and its Central American partners after nearly a decade of work in developing an integrated public health approach for addressing gender-based violence. This approach, as discussed in Chapter Three, includes interventions at the macro level (policy and legislation), the health sector (both policy and services), as well as at the community level.
WHY IS GENDER-BASED VIOLENCE INVISIBLE IN THE HEALTH SECTOR?

International research has consistently shown that women living with violence suffer a wide range of serious physical and mental health problems and visit health services more frequently than non-abused women. Despite this, medical records rarely identify violence as a reason for medical consultations, and, as the “Critical Path” study confirmed, most health care providers do not consider violence to be an important issue in their work (Heise, Ellsberg, and Gottemoeller 1999).

Many studies indicate that women living in violent situations rarely reveal their situation spontaneously to medical personnel, even when seeking help for violence-related problems, such as physical injuries. Providers, on the other hand, rarely ask women whether they have suffered violence, even when there are obvious signs of abuse. The situation described by a Nicaraguan doctor in the “Critical Path” study is representative of most health services in Central America:

“There’s simply no time to talk or perform special exams for women reporting violence. The quality of care given to a victim of violence is not even close to that given to a woman with other chronic conditions.”

As in the “Critical Path” studies, women interviewed by the review team offered similar explanations for their reluctance to talk about abuse: they feel ashamed of the violence and that health personnel will not be interested in or concerned about their problems.

“I thought that there were just a few people living like this and that it was something shameful. . . . I thought it would be embarrassing for someone to find out that a man was hurting me this way.”

—Ellsberg et al. 2000

Another barrier for disclosure is the fear of reprisals and economic hardship:

“Women do not speak for fear that [the husband] will be put in jail and then no money will come into the household. Also because they are afraid of him. They think, ‘if I talk he will kill me, he will choke me. . . .’”

—Woman activist from San Cristóbal, Guatemala

In Guatemala, indigenous women expressed their mistrust of the health system in general, due to experiences of discrimination in their dealings with health personnel:

“People think that our [indigenous] costumes make us stupid. . . . [In the health center] we have to wait longer. They call the ladinas first and tell us to please step aside. We do it because of the language and our fear of not being able to express ourselves well in front of the health personnel. The ladinas nurses are not interested in us. . . .”

—Woman activist from San Cristóbal, Guatemala

Providers also described many barriers that kept them from asking their clients about violence. Some felt that women would be offended by the question or that they would not know how to respond or that the providers would not have the time or resources to treat her if she revealed that she had been abused. A Salvadoran doctor described his early experiences in screening for violence this way:

“Sometimes I ask a woman about violence, and right there she begins to cry; she becomes a sea of tears. She closes up, and I have to wait. When someone isn’t sensitized he can get annoyed and think, ‘Why did I even ask?’ and, ‘Now how am I going to get rid of her?’”

Providers worry that screening for abuse will add yet another burden to their already overstretched capacity. In the majority of
health centers, caring for women suffering violence is not yet part of the professional profile, and there are no information systems in place that would allow them to justify the time spent on violence cases.

Providers’ attitudes about violence are also shaped by prevailing cultural norms. A study carried out among reproductive health providers by the International Federation of Planned Parenthood in three Latin American affiliates found that many of these providers expressed attitudes that place blame for violence on women rather than on their aggressors. Over half felt that some women’s inappropriate behavior provokes their partner’s aggression. Nearly one-fourth felt that women do not leave violent situations because on some level they like to be treated with violence (Guedes et al. 2002).

During the project evaluation interviews, many health providers noted having experienced violence themselves. In most of the group discussions with these personnel, at least one disclosed having been beaten by a partner. A Nicaraguan nurse who had been abused described her experience this way:

“I wanted to get things off my chest but I felt rejected by the other health workers . . . they thought less of me and made me feel guilty. . . . I would have liked for them to have explained that there are laws and support centers for women; to make me feel safe, to tell me that I wasn’t alone. . . . I wish they had said to me, ‘How do you feel? This is not your fault. . . . I care about what happens to you. . . .’”

Although in the discussion groups participants did not mention having been violent toward a partner, a study conducted by PAHO and Nicaragua’s Ministry of Health found that, in individual interviews with health professionals, several male doctors acknowledged having been violent with their partners, and several women disclosed having been victims of violence. This study, performed by the Nicaraguan Association of Men against Violence, noted:

“Health workers—doctors, nurses, health inspectors—are men first before they are health workers. As a result, they cannot escape from the machista socialization that all men receive from their environment.”

—Ministry of Health, Nicaragua, 2001

Transforming the culture of silence and complicity around gender-based violence is consequently the overriding challenge for any effort to influence health policy and programs.

**PAHO’S INTEGRATED APPROACH TO ADDRESSING VIOLENCE FROM A PUBLIC HEALTH PERSPECTIVE**

Given the lack of relevant international experiences to guide the integration of GBV into health policy and programs, PAHO and its partner organizations have developed an integrated approach in Central America, as was described in Chapter Three. Using the findings of the “Critical Path” research as a point of departure, this approach is being adapted and implemented in each country, integrated into the work of local stakeholders, and grounded in a thorough assessment of national and local realities.

In this sense, instead of promoting a “one-size-fits-all” model for addressing gender and family violence, the hallmarks of PAHO’s approach have been flexibility and respect for local experiences. The project has sought to strengthen ongoing processes in each country, while encouraging the adoption of a basic set of guiding principles through technical collaboration, international meetings, and exchanges between countries. For example, the Honduran violence prevention model is based on the establishment of 13
Family Counseling Centers (Consejerías de la Familia), or FCC, located in regional health centers throughout the country. Each FCC has at least one social worker and psychologist and provides individual and group counseling for victims of violence, as well as training and prevention activities for health workers and community promoters. The Mental Health Department of the Honduran Ministry of Health manages the FCCs. In contrast, the cornerstone of Nicaragua’s violence prevention model is the Women and Children’s Police Stations (Comisarías de la Mujer y la Niñez), led by the National Police Force. In every city where a Comisaría exists, the local health services participate in a broad-based support network of governmental and nongovernmental organizations.

Despite national differences, the PAHO project has supported a series of common activities in each country, as well as international conferences and exchanges between countries, in order to encourage coherence at a subregional level. These include:

+ the development of national policies recognizing violence as a public health problem and outlining basic principles for caring for victims of violence from a human rights and gender framework (see example of Costa Rica’s approach in Boxes 5-1. and 5-2.);

+ the drafting of norms and protocols that define the kind of care that should be offered, by whom and how; as well as defining mechanisms for monitoring activities;

+ the development of a training plan for personnel on the use of the norms;

+ the creation of support groups for violence survivors;

+ the promotion of male involvement in violence prevention activities;

+ the development of an information system that permits tracking reports of GBV throughout the health system;

+ the development of community-level public awareness to promote nonviolent lifestyles; and

Clinics that offer care for women living with abuse, such as this one in Ecuador, can play a pivotal role in reinforcing their clients’ self-esteem and courage to continue on their “critical path” by simply providing a secure setting where the women may be heard, receive assurance they are not alone and are not to blame, and be provided with advice on how best to protect themselves.
the establishment and/or strengthening of community networks to coordinate services and violence prevention activities.

In each project country at least one community was initially selected for piloting the integrated approach. During the second stage of the project over 150 communities throughout the subregion implemented the approach. In some countries it has been possible to leverage other national and international resources in order to scale up the project to include even more geographical areas. The following sections describe some of the main achievements and challenges encountered by the project assessment team with regard to GBV policies and norms.

HEALTH SECTOR GBV POLICIES: HOW IMPORTANT ARE THEY?

One of the early aims of the PAHO project was to encourage the ministries of health in partner countries to adopt explicit policies addressing GBV. To date, all of the countries now have some kind of national policy statement regarding family violence and/or violence against women. In some cases the policies were achieved through specific Ministerial Decrees (Nicaragua), and in other countries the legislative reforms on family and sexual violence stipulate the role of the health sector in violence prevention. In El Salvador, there was no specific health policy related to gender-based violence at the time of the review; instead, it was included in the specific policy guiding the integrated care for families. In Guatemala, family violence is a subprogram nested within the Mental Health Program.

The policies are usually fairly general and simply state that:

- sexual and physical violence against women and children is a serious public health problem;
- health services should provide basic care for victims of violence; and
- providers should coordinate with other state institutions and nongovernmental organizations to ensure an integrated approach for the care of victims and in violence prevention activities.

The national policies on violence are potentially strategic tools for stimulating greater sensitivity among health providers and program managers about the issue and for forging a collective awareness among personnel that violence is an important public health issue that all providers need to address. However, in many countries where GBV health policies exist, they have not been widely disseminated, and there is still a large contingent of health workers who do not know about them.

LESSONS LEARNED

The establishment of a specific health sector policy outlining the role of health providers in addressing violence is a key step towards institutionalizing violence programs and raising awareness among personnel.

However, it is not enough to develop appropriate health sector policies on violence: it is equally important to disseminate them as widely as possible among health workers, as well as the population at large, so that the health sector can be held accountable for policy implementation.

WHAT IS THE MOST STRATEGIC PLACEMENT FOR GBV PROGRAMS WITHIN THE HEALTH SECTOR?

The experience of Central American programs indicates that where the program is
placed within the health sector can have a profound impact on program implementation. From a policy perspective it is strategic to have the GBV program placed at a sufficiently high level organizationally so that it may influence overall planning and health sector reforms. In Costa Rica, and initially in Nicaragua, the GBV programs have been managed from the Planning Division of the Ministry of Health. This placement may be strategic for raising the profile of GBV at the national level and promoting inter-programmatic coordination. However, because the planning departments are generally not closely linked to hospital and primary care services, it may be more difficult to integrate GBV services into programs that are based in other ministerial divisions, such as those for mental health and reproductive health programs.

In most of the project countries, GBV and family violence programs are located either in the national departments for women’s, maternal child, or reproductive health (Belize, El Salvador, Nicaragua, and Panama) or in the mental health programs (Guatemala and Honduras). Because gender-based violence affects many different aspects of women’s lives, ideally, interventions to prevent violence and mitigate harm should be as broad as possible in their scope. For example, PAHO’s experience indicates that including GBV programs in national reproductive health programs can facilitate the integration of GBV services into core reproductive health services such as prenatal care and family planning, as well as enabling their expansion throughout the primary health network.

LESSONS LEARNED

The placement of program coordination for care for gender-based or family violence in the areas of women’s health and reproductive health services facilitates lateral integration into other programs and services.

The experience of Guatemala, on the other hand, exemplifies the challenges of addressing GBV when it is placed organizationally within mental health services. At one time the family violence program in Guatemala was situated in the maternal and child health division of the Ministry of Health. Due to ministerial reorgan-
Family violence is a serious problem that affects the physical, emotional, and sexual health of the person that lives with it and her/his family and can even lead to death. Family violence is a criminal offense with legal repercussions; therefore, it should be addressed in a timely and effective manner. Family violence is the responsibility of all society, as well as a public health and human rights problem. Violence is caused by the perpetrator, not the victim. Violence is a learned behavior, and, therefore, it can be unlearned. Nothing justifies family violence.

- People have the right to live under conditions that allow their integrated development and respect for their rights.
- All individuals, regardless of sex, age, religion, economic level, sexual orientation, nationality, and political beliefs, should be cared for when requesting services for family violence.
- All individuals who suffer or have suffered family violence have the right to services and resources that guarantee personal safety and confidentiality.
- All interventions should be carried out in a manner that respects individuals’ rights and empowers them to make their own decisions.

**BOX 5-1. PRINCIPLES TO GUIDE CARE FOR SURVIVORS OF FAMILY VIOLENCE**

**TABLE 5-1. TWO ORGANIZATIONAL STRUCTURES FOR THE PLACEMENT OF GBV/FAMILY VIOLENCE CARE PROGRAMS**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Mental Health</th>
<th>Reproductive Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increased institutional response in units with specialized resources</td>
<td>- Increased coordination with other programs</td>
<td>- More limited level of response (crisis intervention, basic counseling, and referrals)</td>
</tr>
<tr>
<td>- Few mental health resources in most of the countries means more difficult to scale up activities</td>
<td>- Possibility of providing basic care without mental health specialists</td>
<td></td>
</tr>
<tr>
<td>- More difficult to coordinate with other programs</td>
<td>- More linkages with services for women at high risk</td>
<td></td>
</tr>
</tbody>
</table>
LESSONS LEARNED
Inter-programmatic coordination is essential for enabling violence programs to become integrated laterally into key health programs and for ensuring the sustainability of the violence program.

INTER-PROGRAMMATIC COORDINATION IS CRITICAL
Regardless of where the GBV program is located, internal coordination between key programs within the ministries of health that are involved in violence prevention (i.e., mental health, reproductive health, planning, epidemiological surveillance, etc.) is essential.

In most countries, however, with the exception of Costa Rica and Panama, inter-programmatic coordination is weak. This leads to difficulties in implementing norms on violence and inconsistencies in the approach used by different programs within the same ministry. For example, in some ministries each division has a different system for registering information on violence, with the result that the data collected throughout the ministry are not comparable.

WITH NORMS OR WITHOUT THEM . . .
Norms and protocols that outline specific responsibilities and tasks that health personnel should carry out with regard to violence is another instrumental step toward securing the uniformity and sustainability of these programs. It is important that all stakeholders, including providers, program managers from other key ministerial divisions, other institutions that coordinate with the health services (forensic medicine institutes, police, etc.), and representatives of nongovernmental organizations, all participate in the development, validation, approval, and implementation of these service polices to ensure that they are both appropriate and feasible to implement.

PAHO’s Women, Health, and Development Program provided technical assistance to each of the project countries in the development of national norms and protocols for addressing violence. However, in some countries it has taken years for the norms to be officially approved. To date, norms have been approved in Belize, Costa Rica, Panama, and recently in Nicaragua, whereas in El Salvador and Honduras approval is still pending.

In Guatemala, guidelines for addressing family violence were included in the norms for adolescents and mental health care. However, the scope of these norms is somewhat limited, since they are not included in other key programs, such as reproductive health.

In countries where norms and protocols have not yet been approved, this presents a serious obstacle for the expansion and sustainability of GBV programs. The PAHO program envisioned that the piloted experiences in each country would serve as a laboratory for the development of national policies and norms and would facilitate scaling up the approach in other geographical areas. In the countries

LESSONS LEARNED
In general, having officially approved norms and protocols helps to ensure the quality of care and also facilitates the scaling up of pilot experiences.

Implemented norms and protocols guarantee the quality of care for GBV and family violence in health services. Furthermore, they enable an evaluation of the services.
where GBV norms have been approved, but not been institutionalized, the project has been compelled to continue training health personnel and expanding care and services to new regions in the absence of official guidelines. Health workers consider this to be a significant constraint, as it means that the care for survivors of violence is left up to the discretion of individual staff, without the benefit of a clear protocol detailing how screening, care, and referrals should be performed. Additionally, without protocols in place, it is harder to achieve uniformity in the quality of care or to assess the performance of professionals.

Another challenge that health providers face is high staff turnover in the health sector. This means that even when GBV training has been carried out, new personnel may still lack the necessary experience and skills for providing services to victims of violence. Without this training, safety concerns and confidentiality in the provision of care may be jeopardized. The existence of norms, protocols, and ongoing supervision would help to minimize these risks.

Nevertheless, in the daily routines of health centers and posts, with or without norms and protocols, health staffs have cared for and continue to care for victims and survivors of family violence. In many places they have found creative solutions to overcome the constraints caused by the absence of norms, in many instances motivated by their own personal commitment and simple desire to help others.

**TRAINING HEALTH PERSONNEL**

One of the key strategies for raising awareness within the health sector about GBV is to conduct sensitization and technical training for health personnel at all levels.

The review team encountered a great deal of variation in the different countries in terms of the strategies used for training
personnel. Some trained all personnel within certain health units. The advantage of this method is that it creates a more supportive environment for GBV issues within the center and motivates all staff, including administrative personnel, to assist in identifying people suffering violence. In other countries, training has been more restricted, such as only to mental health personnel or women’s health program staff. Although this approach may result in greater GBV coverage by health centers in general, it is more difficult to achieve impact on the quality of care of people living with violence if only a relatively few staff members within each center are trained. In Honduras, for example, training has been carried out only among the staff of health centers where Family Counseling Centers are located. The main purpose of this training is to encourage staff to refer patients to the counselors.

Given the complexity of GBV and providing care for its victims, there are different levels of training that need to be developed and applied in a strategic manner. In this regard, there is some confusion with respect to the terms awareness building, training, and specialization. As a doctor from Nicaragua commented, “...Awareness activities lead our staff to the point at which they ask, ‘what can we do?’ Once we reach this point we can begin training to learn how to actually care for women suffering from family violence.”

There is no doubt that the extensive training of health personnel supported by the PAHO project has resulted in considerable increases in the identification of cases, as staff become more confident in their ability to detect violence and offer women support. In addition to general training of providers, it is also important to include specialized training, such as on forensic medical procedures. Another example is a training conducted by PAHO with the Government of Finland-supported SAREM project in Nicaragua to train psychologists and psychiatrists on how to treat childhood sexual abuse.

Training of trainers is important to ensure sustainability, especially within areas of the ministries of health where staff turnover is constant. In addition to health personnel, consultants from women’s NGOs have also been trained as trainers in some instances.

Using effective and tested training materials is important; many are available throughout Latin America and are listed at the end of this book in the GBV Resources Section. In Costa Rica, within the framework of PLANOFVI (see Box 4-1.), a set of modules entitled *Feel, Think, and Confront Family Violence* was developed to train staff in identifying and supporting women living with violence. These modules have been used and/or adapted by other Central American countries for training health and other sector personnel. In Guatemala and Peru innovative training packages have been developed that incorporate participatory dynamics adapted to the reality of each country. In Nicaragua many regional health centers have used a training guide for health personnel that was developed by the National Network of Women against Violence.

A significant contribution in all of the countries studied has been the expanded coverage of training to include other social actors: police officers, judges, representatives of women’s groups, and schoolteachers. This has been a significant factor in stimulating multisectoral coordination for the project. One example of this work is
an integrated “Gender and Family Violence Module” that has been implemented in several schools of public health and nursing schools throughout Central America.

Educational modules on violence have also been created within police academies and the armed forces in some of the countries with the support of the United Nations Latin American Institute for the Prevention of Crime and Treatment of the Delinquent (ILANUD).

Another innovative method for exchanging experiences and promoting “best practices” has been carried out in Estelí, Nicaragua. The health center and anti-violence commission here have created a regional training center where health personnel and community activists from other parts of the country can participate in short internships and receive practical training in GBV care. Perhaps the most valuable aspect of this experience is that the visiting staff spend time not only in the health center, but also in the Women and Children’s Police Station and with local NGOs that address violence. As a result, interns learn not only the clinical aspects of care for victims of violence, but also how to organize community prevention networks. The project has leveraged support from other sources, such as the Swedish Government-supported PROSILAIS project, thereby contributing to the financial sustainability of local networks. This experience could easily be replicated in other health facilities that have specialized care units, such as the Family Counseling Centers in Honduras, or the polyclinic in Barrio Lourdes, El Salvador.

Although a great deal of emphasis has been placed on sensitization and training in the PAHO project, interviews with many health staff indicated that the quality of training was still uneven between countries and between different areas within the same country. There was general agreement that more efforts were needed to develop standardized training curricula that could be adapted for use throughout the Central American subregion.

**VIOLENCE INFORMATION AND SURVEILLANCE SYSTEMS: WHAT ISN’T REGISTERED DOESN’T EXIST**

Compiling data on violence within the health sector is crucial for demonstrating that gender-based violence is a significant cause of morbidity and mortality. Moreover, data collection provides much-needed insight into potential risk and protective factors, which in turn enable program managers to improve the quality of interventions and policies. As a police captain in Chinandega, Nicaragua, noted,

> “With our services and the reports of the Comisaria we were able to demonstrate that the lack of personal safety is greater in the home than on the streets.”

**LESSONS LEARNED**

It is important to train all health personnel on the identification of and basic care for women suffering violence. This creates a favorable environment so that individuals may be identified and referred for care by any program within the health center.

Training should include discussions of gender equity and should provide participants not only with technical information, but also with an opportunity to examine their own experiences and beliefs.
Community development workers discuss family violence issues with schoolchildren in a village in Belize.
Over the years, the PAHO project has placed special emphasis on the need to develop violence registration systems within the ministries of health and other sectors for monitoring and guiding interventions.

In all of the project countries there is a commitment to documenting cases of violence even though many challenges in implementation remain. Each of the pilot health centers has set up some kind of registration system for tracking violence, but there is little consistency. The forms used for reporting cases of violence are different among the countries, and even between different regions within some countries (particularly in El Salvador and Nicaragua.)

Providers who attend women and families living with violence are anxious to have an official registration system, in part to increase the legitimacy of addressing the issue, and also so that these activities may be included in personnel performance evaluations. Providers feel pressured by the desire to provide quality care, on the one hand, and the need to fulfill productivity targets demanded by the health services, on the other. Another concern voiced was the need to ensure that once these data are collected, there are also systems in place for their analysis and use.

In El Salvador and Nicaragua, health workers fill out registration forms and send them to the larger regional offices, where they usually become “stuck”, and are not sent on to the national information offices. In Honduras, the forms filled out by the Family Counseling Centers are sent directly to the national mental health department. Because this system bypasses the national statistics office of the Ministry of Health, the data are not included in the national health services statistics or in the epidemiological surveillance system.

This is a generalized problem that affects not only violence programs, but also other health programs such as malaria or dengue. Although there are overall weaknesses in the flow of health information, in the case of violence, the problem appears to be particularly challenging.

National violence surveillance systems have been set up in Belize and Panama, where uniform information is collected in several institutions (i.e., police stations, forensic medicine institutes, health centers, and hospitals, etc.) and analyzed centrally. At the time of the PAHO project review, proposals had been developed for tracking violence in Costa Rica, El Salvador, and Nicaragua, but they had not yet been implemented. One encouraging sign for improved surveillance of violence is the increasing acceptance by statisticians of the 10th International Classification of Diseases, (ICD-10). The ICD-10, currently in use in Belize, Costa Rica, Nicaragua, and Panama, allows for additional codes to be added to the tracking system for injury and disease indicating that violence was a contributing cause. However, in El Salvador and other countries, only primary causes of disease and injury are registered in national statistics, so that even if the ICD-10 codes for

**LESSONS LEARNED**

Surveillance systems for violence should consider collecting as a minimum, information identifying the type of violence (i.e., physical, sexual, or emotional), the sex and age of the victim of violence, as well as the age and relationship of the perpetrator to the victim.
violence are used, they may not always appear in national reports.

One problem is that the information resulting from the surveillance systems is not uniform among the countries. Some countries report only on the type of violence without including information on the age and sex of the victim, or the victim’s relationship to the offender. In other cases, enormous amounts of information are collected on the characteristics of violent events, as well as on the victims and offenders, but the information is not consolidated or subsequently utilized. In the cases where data are processed, they are often presented in a way that is difficult to interpret (e.g., presenting data on either sex or age of victims but not both, or not distinguishing between characteristics of victims of child sexual abuse and violence by an intimate partner).

As a result, despite the many achievements of PAHO’s gender violence project, today it still is not possible to compare statistics among countries in the Central American subregion. A seminar held in 2001 with representatives of the Ministries of Health of the seven nations concluded that the development of a set of key variables and indicators for all countries was an urgent priority. Information identifying the type of violence (i.e., physical, sexual, or emotional), the sex and age of the victim of violence, as well as the age and relationship of the perpetrator to the victim, were considered to constitute basic information that should be included in any registration system.

A final concern by the review team was that in all the countries where there are registration systems, the use of information appears nonetheless to be limited. Although data are collected and sent on to regional and national authorities, there is little analysis of the information or feedback to the health centers for the purpose of local planning.

**WITHOUT APPROPRIATE INTERVENTIONS, THERE IS NOTHING TO REGISTER**

A major weakness found in several countries included in the review was that the information systems for tracking violence were often developed independently of the norms and protocols for its treatment, resulting in little coordination between the two processes. In some cases, elaborate systems for recording and analyzing violence statistics were put into place even before providers had been trained to identify or treat victims of abuse. Not surprisingly, virtually no cases of violence were detected. The development of information systems in these circumstances can actually be counterproductive, because it gives a false impression that violence is not an important problem. Furthermore, experts have warned that untrained personnel can actually cause additional harm to women by asking about violence in insensitive or victim-blaming ways.

“In order to put the surveillance system into practice, we realized we needed to have specific protocols for caring for violence. Otherwise, there would be no information to register.” —Ministry of Health representative, Belize

**UNIFIED INFORMATION SYSTEMS AND MANDATORY REPORTING**

In Belize, Guatemala, and Panama, a single registration system is being developed that is intended to be used by professionals from all sectors that come into contact with violence victims, such as the Ministries of Health, law enforcement, the court system, and NGOs. The system also applies to reports by forensic doctors. In Belize, the Ministry of Health is responsible for consoli-
dating, processing, and analyzing the information from these sectors and then afterwards reporting it to the other pertinent ministries. In Panama, the information is sent to the Legal Medicine Institute for analysis.

The review team discovered that the difference between filling out a registration form and filing a legal report remains a grey area in many cases. Ideally, the purpose is to collect statistical information, not to set a criminal case into action. However, in Panama and in the proposed system for Guatemala, the information is geared to go automatically to the criminal justice system, equating the completion of the registration form with filling a criminal report. In both these countries, health providers are required by law to report cases of violence to the legal authorities. In most other Central American countries, health providers are required only to report cases of sexual violence against minors, but not cases of violence against adults.

**DOES MANDATORY REPORTING OF VIOLENCE HELP PROTECT WOMEN?**

Mandatory reporting presents an ethical dilemma to providers, as it conflicts with a patient’s right to confidentiality, as well as with her right to decide how best to deal
with her situation, which is one of the guiding principles of the integrated approach. In places where mandatory reporting is required, fines may be imposed on health personnel and other civil servants who do not comply; other ways in which this mandate will be enforced and monitored, however, remain unclear.

Studies in some states in the United States that have mandatory reporting requirements indicate that women are more reluctant to disclose acts of violence if they know this information will be passed on to the police. Providers, likewise, are also less likely to ask about violence if they fear they will be caught up in legal disputes. These concerns were echoed by providers in countries with mandatory reporting laws:

“Victims and survivors are afraid that providers will report the case to the authorities against their will.”
—Health provider, Guatemala

“Providers are reluctant to ask about or document violence for fear of the legal consequences of the report, such as becoming involved in court battles, or being a witness, or having their lives placed at risk by threats from the offender.”
—Ministry of Health official, Panama

“Even though we have received training in how to fill out the form in the emergency room, health workers do not want to fill it out for fear of the legal repercussions.”
—Health provider, Panama

Many ministry of health officials, as well as women’s rights activists, expressed the belief that in order to strengthen the health sector’s ability to identify and care for victims of violence, it will be necessary to reform the laws regarding mandatory reporting, wherever these exist. As this chapter has shown, the development and placement of GBV policies within the health sector, the training and sensitization of health personnel, as well as the creation of cohesive and uniform information-gathering and reporting systems capable of being shared by other sectors involved in violence-related issues, are all areas where significant improvements have been marked in the last few years. Despite these achievements, however, significant technical and human challenges remain to be overcome.

In Chapter Six we will take a closer look at what happens behind the doors of the neighborhood health clinic between women and health providers and how their expectations about one another can influence the effectiveness of the care these women receive.

LESSONS LEARNED

Information and surveillance systems are an essential part of the integrated approach to gender-based violence and should not function independently from the development of services. For the reporting system to work, and before it is implemented, it is important to develop norms and protocols for the detection and care of the affected women and to train providers in their appropriate use. Untrained personnel can actually cause harm to women by asking about violence in insensitive or victim-blaming ways.

Information systems are only valid if the data are used to improve services. Not only is it a waste of resources, but also it is unethical to collect information or carry out active screening for violence with the sole purpose of information-gathering, if no services are offered in return.