

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 (*Comisariías 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

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.

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.

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.

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-

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.

ization the program was discontinued and has only recently been resurrected within the mental health division. Despite efforts by the mental health division to rebuild the program, some authorities acknowledge that the change has weakened the program. "Mental health is a virtual program," commented the director of a large health district in Guatemala that does not have a single psychologist. In Honduras, as well, where dealing with GBV is the exclusive domain of the Family Counseling Centers, its integration into maternal and child health and other health programs has faced similar challenges due to restraints imposed by organizational structure.

In contrast, reproductive health services, such as family planning and prenatal care, are available throughout the health system, even in the smallest health posts. There is generally technical support and supervision for the program at the district level, as well. Therefore, by integrating GBV laterally into reproductive health programs, it is possible to extend the scope of the program widely with relatively little additional investment.

Moreover, because reproductive health services are available in virtually every health care setting everywhere, no matter how modest or sophisticated, integrating care for GBV in these basic services increases the quality of care in the programs, as well. In contrast, mental health services are generally scarce, are usually found only at the regional level or at specialized referral clinics, and are therefore able to reach only a small proportion of women living with violence.

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

- 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.

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Ministry of Health, Costa Rica

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

	Mental Health	Reproductive Health
Advantages	<ul style="list-style-type: none"> - Increased institutional response in units with specialized resources 	<ul style="list-style-type: none"> - Increased coordination with other programs - Possibility of providing basic care without mental health specialists - More linkages with services for women at high risk
Disadvantages	<ul style="list-style-type: none"> - Few mental health resources in most of the countries means more difficult to scale up activities - More difficult to coordinate with other programs 	<ul style="list-style-type: none"> - More limited level of response (crisis intervention, basic counseling, and referrals)

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 policies 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.

BOX 5-2. COSTA RICA'S FAMILY VIOLENCE MODEL APPROACH: KEY ASPECTS**The goals of family violence intervention are:**

- to protect victims of family violence;
- to strengthen the capacity of personnel for decision-making and problem-solving;
- to contribute to healing the effects of violence; and
- to prevent future violence.

Integrated care for family violence should have the following characteristics:

- accessible, continuous, effective, efficient, appropriate, trusting, confidential, secure, quality care that guar-

- antees the individual integrity of all those affected;
- care for different types of violence, both within and outside the family, as well as for witnesses of violence;
- a focus on changing the cycle of violence;
- mechanisms for the systematic registration and situation analysis of individuals and families affected by family violence; and
- the ability to accomplish the above components within a permanent monitoring system at a local, regional, and national level.

Ministry of Health, Costa Rica

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 PLANNOVI (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 *Comisaría* 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.



courtesy PAHO/WHO-Belize

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-



courtesy PAHO/WHO-Honduras

Children are society's least protected members, particularly in matters of family violence. This group of Honduran children participate in a march to raise awareness about the issue.

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 fil-

ing 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.