



“Listen to the voices of these women and girls telling their stories. They are asking us to hear them and do something about gender-based violence, the most pervasive form of abuse in the world.

This is an important book, and I hope it will make a difference.”

—Isabel Allende



Pan American Health Organization
Pan American Sanitary Bureau, Regional Office of the
World Health Organization
525 Twenty-third Street, N.W.
Washington, D.C. 20037
www.paho.org

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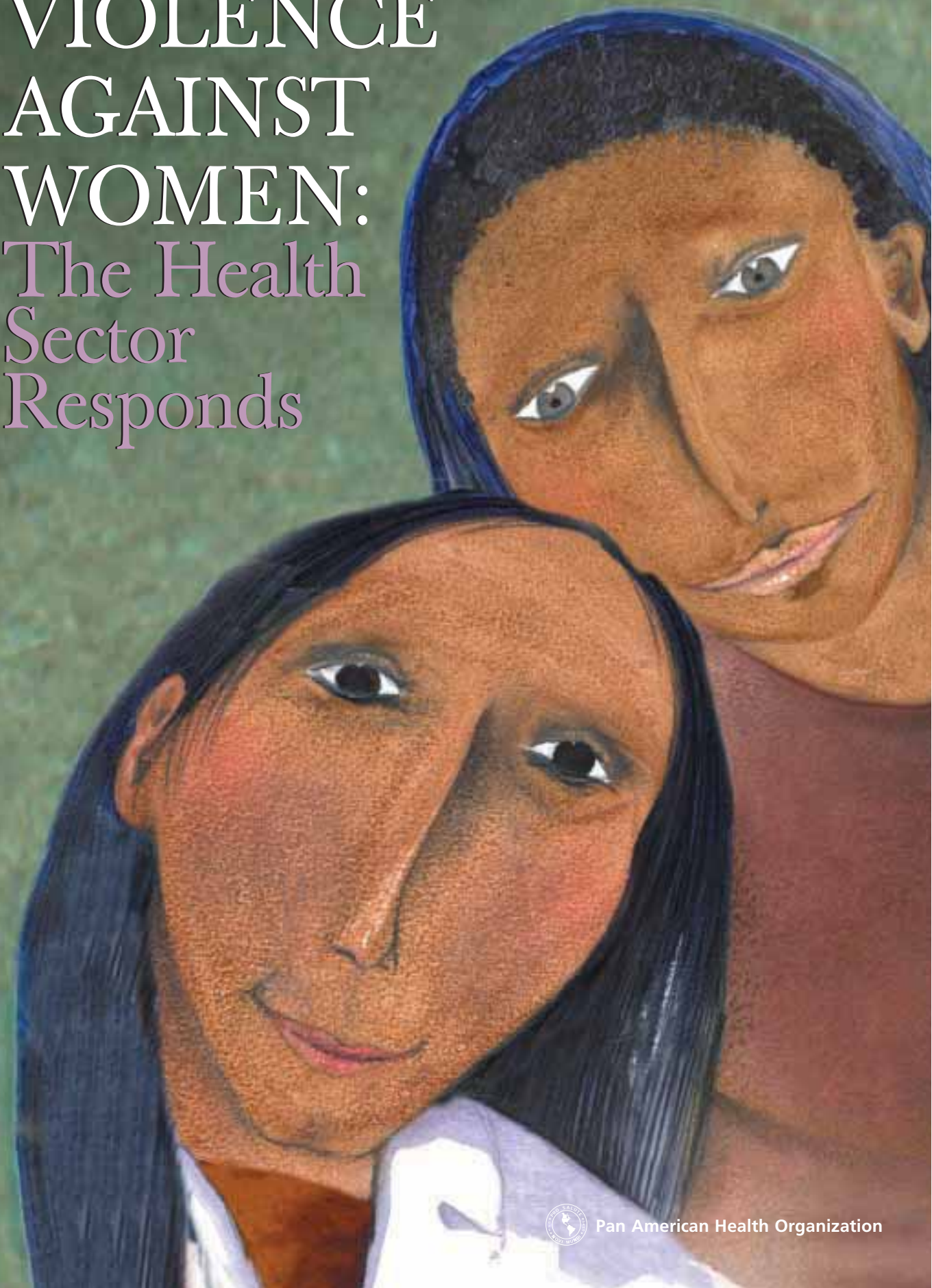
Program for Appropriate Technology in Health

PAHO

VIOLENCE AGAINST WOMEN: The Health Sector Responds

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VIOLENCE AGAINST WOMEN: The Health Sector Responds



Pan American Health Organization



VIOLENCE AGAINST WOMEN:

The Health Sector Responds

VIOLENCE AGAINST WOMEN: The Health Sector Responds

Marijke Velzeboer
Mary Ellsberg
Carmen Clavel Arcas
Claudia García-Moreno

Produced in collaboration with



PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH



NORWEGIAN AGENCY FOR INTERNATIONAL DEVELOPMENT



SWEDISH INTERNATIONAL DEVELOPMENT AGENCY



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION
525 Twenty-third Street, N.W. Washington, D.C. 20037 U.S.A.

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Lápiz y Papel
Quito, Ecuador

DESIGN BY ULTRADESIGNS
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THE AUTHORS

Marijke Velzeboer, Coordinator for the Women, Health, and Development Program of the Pan American Health Organization (PAHO), prepared Section I (Chapters One through Three). *Mary Ellsberg*, Senior Program Officer, Program for Appropriate Technology in Health (PATH), and *Carmen Clavel Arcas*, International Fellow, National Center for Injury Prevention and Control, U.S. Centers for Disease Control and Prevention (CDC), prepared Section II (Chapters Four through Seven). *Claudia García-Moreno*, Coordinator, Department of Gender and Women's Health of the World Health Organization (WHO) provided the global insights presented in Chapter Eight. *Roberta Okey*, of PAHO Publications, served as the book's editor.

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Clearly, the long-term support of the Governments of Norway and Sweden has not only enabled the development of the integrated approach, the Central American project, and its subsequent evaluation, but the production of this book, as well. Special thanks are due to Carola Espinoza and Mette Kottman and of the Norwegian Agency for International Development (NORAD) and Hans Åkesson of the Swedish International Development Agency (Sida), in particular, for their assistance throughout the project's assessment phase. Likewise, the authors owe a debt of gratitude to the Government of the Netherlands for supporting the contributions of our Bolivian, Ecuadorian, and Peruvian colleagues to this book.

The authors wish to dedicate this book to all the survivors of violence who so courageously have shared their stories with the desire that others might benefit from their experiences and live safer and happier lives. Their situations are both unique and universal, contributing to our knowledge and understanding of gender-based violence and informing our resolve and actions to overcome it. We hope that the lessons learned in Central America will transcend national and cultural boundaries to find resonance everywhere in the world where dedicated and concerned individuals are looking for guidance in making their communities healthier and violence-free.

PREFACE

I am pleased that the publication of this book takes place at the beginning of the Pan American Health Organization's first administration to be headed by a woman, and that in this, my first book preface, I have the opportunity to place on record my commitment to turning the tide against gender-based violence in the Region of the Americas.

The voices of the women you will hear throughout this book's narrative are rooted in the reality of their everyday lives and call for a compassionate response in the form of recognition and an end to their suffering. The first call for action, to be sure, focuses on the health sector. But implicit in the ultimate, all-encompassing response is action by a diverse partnership involving governments and communities of doctors, nurses, and other health professionals working alongside their counterparts: political leaders, the police and court systems, NGOs, schools, and churches.

PAHO's work in Central America to end violence and to utilize health as a bridge to create long-lasting peace began in 1985, and improving the health situation of women was, and continues to be, a cornerstone of the efforts of PAHO and the international community to consolidate democracy and subregional integration. For more than a decade, the Governments of Norway and Sweden have recognized the pivotal role of women in families and communities in the construction of peace at its most basic and elemental level, and the Nordic cooperation's steadfast belief in this principle is largely responsible for the groundwork that has made this book possible.

Finally, I would like this book full of voices to serve as our social conscience as we embark on an international, interagency campaign during 2003 and beyond to lead and support community initiatives to prevent gender-based violence and to empower women and girls everywhere to realize their full potential and offer our societies the rewards of their wisdom and experience.

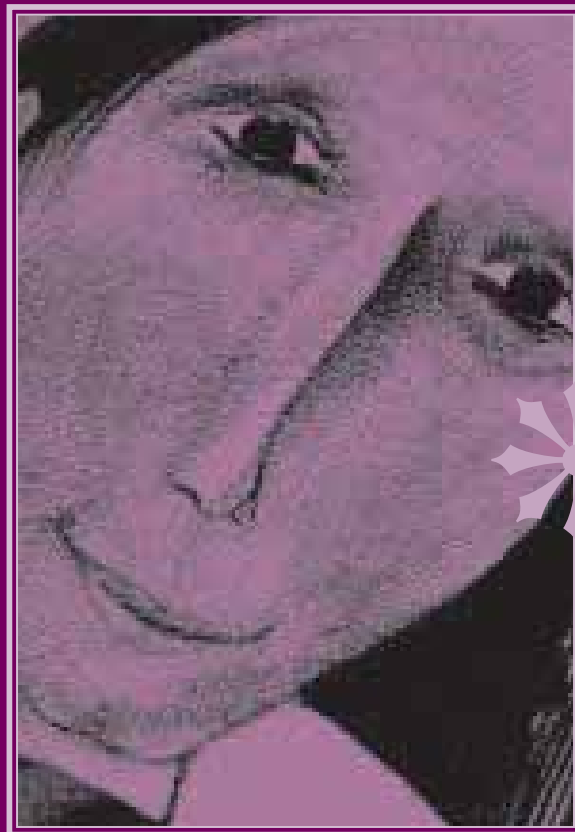
MIRTA ROSES PERIAGO
Director

INTRODUCTION

Gender-based violence (GBV) is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women. It is also an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in society. The consequences of GBV are often devastating and long-term, affecting women's and girls' physical health and mental well-being. At the same time, its ripple effects compromise the social development of other children in the household, the family as a unit, the communities where the individuals live, and society as a whole.

Violence against Women: The Health Sector Responds provides a strategy for addressing this complex problem and concrete approaches for carrying it out, not only for those on the front lines attending to the women who live with violence, but also for decision-makers who may incorporate the lessons in the development of policies and resources. For those communities where support for women does not yet exist, the authors hope that this book will motivate health providers and leaders to more directly confront the issue of gender-related violence and ensure support to affected women in resolving their situation.

This book is a collaborative effort between the Pan American Health Organization (PAHO) and the Program for Appropriate Technology in Health (PATH), with technical assistance provided by the U.S. Centers for Disease Control and Prevention (CDC). PAHO produced the first three chapters of Section I: Chapter One gives an overview of why gender-based violence is a public health problem. Chapters Two and Three discuss the development, implementation, and achievements of PAHO's integrated strategy for addressing GBV, starting with how the "Critical Path" study helped define the strategy. In the next four chapters of Section II, PATH presents the strategy's application and its "Lessons Learned" at the macro, or political, level (Chapter Four), within the health sector (Chapter Five), in the clinic (Chapter Six), and beyond the clinic to the community at large (Chapter Seven). The World Health Organization contributed the final chapter (Chapter Eight), which offers a more global perspective on how the lessons learned and the integrated strategy may be applied in other communities around the world.



The obstacles to overcoming family violence are 500 years of culture ingrained through socialization in our children.

—Montserrat Sagot, 2001

SECTION I

The Health Sector Responds to Gender-Based Violence

INTRODUCTION

One important achievement of the last decade is that violence against women is increasingly recognized as a major public health problem. Due in large part to the tireless advocacy of women's organizations, the issue has been placed on the agenda of a number of international conferences: the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (Cairo, 1994), and the Fourth World Conference on Women (Beijing, 1995). The commitments made during these conferences by participating governments, international agencies, and donors directed growing attention to this globally alarming problem.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Belém do Pará, 1994), provide a concrete political framework for action, by calling on governments to develop and monitor legislation and other related actions. Almost all countries in the Region of the Americas have since ratified these conventions and passed legislation penalizing violence against women.

Yet even prior to the existence of international sanctions against GBV, women's organizations in many parts of the Americas had proposed and lobbied for legislation, formed national coalitions, obtained funding to train police and judges, and provided counseling and services for affected women. The health sector, however, had been conspicuously absent in most of these efforts.

Section I of this book describes PAHO's efforts to mobilize the health sector in joining these forces. Recognizing the pivotal role this sector could play in GBV prevention, in 1993 the Organization passed a resolution calling on its member countries to develop policies and plans for the prevention and management of violence against women.

PAHO's Women, Health, and Development Program was entrusted with developing a health strategy in accordance with the resolution. The following year, the Program and its health sector and other counterparts launched an integrated approach that built upon existing efforts, while strengthening the health sector's participation and contribution in addressing GBV at the policy, service delivery, and community levels. By the end of 2002, a total of 16 countries had implemented this approach; 10 countries with the support of PAHO, and six with the support of the Inter-American Development Bank. The Governments of Sweden and Norway funded PAHO's work in the Central American countries, while the Government of the Netherlands supported work in Bolivia, Ecuador, and Peru.

“... so I felt that my life had changed, that I was another person, that I was not the same, that I would not suffer anymore. . . .”


—Guatemalan woman

Achievements related to the approach are numerous, but the most significant was the new role of the health sector in joining forces for advocacy, in organizing community networks, and in preventing, detecting, and caring for women and families living

with violence. The intersectoral community networks piloted by the new project were subsequently replicated far beyond the initial two networks programmed for each country. Countries shared materials and experiences for training health workers, on developing protocols and information systems, and on starting self-help groups. These experiences leveraged additional support from governments, civil society, and other sources, that in turn resulted in the training of thousands of providers from the health and other sectors, in improved health policies, and in the strengthening of coalitions that advocate for new or better national legislation.

During the implementation period, PAHO's network of focal points for the 10 project countries and their health sector counterparts met yearly to evaluate the project's activities and agree on annual operational plans. While these evaluations revealed a great number of operational achievements, PAHO wanted to know if the project had in reality made a difference in the practices and attitudes of decision-makers, service providers, and the women themselves. Thus, the Women, Health, and Development Program approached its Nordic donors to carry out a participative assessment in the Central America countries.

The donors agreed, and contacted the Program for Appropriate Technology in Health (PATH) and the U.S. Centers for Disease Control and Prevention (CDC) to work with PAHO to carry out the assessment. Both organizations have extensive experience working in Central America on GBV issues and with PAHO, and were thus familiar with the project. The assessment was carried out during October and November, 2001, and included an extensive review of project documents and visits to two selected project sites each in El Salvador, Guatemala, Honduras, and Nicaragua. In Belize, Costa Rica, and Panama, the assessment team interviewed decision-makers and project coordinators from PAHO and the health sector.

The resulting "Lessons Learned" (Ellsberg and Clavel Arcas 2001), attest to the achievements of the project and accredit these to the integrated approach that was applied at all levels, through coalitions, capacity-building of the health and other sectors, and community networks. They also point out the challenges that remain for the health sector in addressing the complex problem of GBV and in its collaboration with other sectors. These "Lessons" provide the basis for this book. 

Chapter One

Gender-Based Violence: A Public Health and Human Rights Problem

Gender-based violence, or “violence against women,” includes many kinds of harmful physical, emotional, and sexual behaviors against women and girls that are most often carried out by family members, but also at times by strangers. The United Nations Declaration on the Elimination of Violence against Women includes a widely accepted definition of violence against women as:

... any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life.

—United Nations General Assembly, 1993

This definition places violence against women within the context of gender inequity as acts that women suffer because of their subordinate social status with regard to men.

There is much debate about a universally agreed-upon GBV terminology. In Latin American countries most laws and policies use the term “family violence” when referring mostly to violence against women by an intimate partner. PAHO initially used the term “family violence” in the early days of its work in this area, but has since shifted to the use of “gender-based violence” or “violence against women” to refer to the broader range of acts that women and girls commonly suffer from intimate partners and family members, as well as individuals outside the family. Thus, both these terms will be used interchangeably throughout the book. The term “family violence” will only be used when referring to the titles of formal laws or programs.

GENDER-BASED VIOLENCE: HOW PREVALENT? HOW COMPLEX?

According to a recent review of 50 studies from around the world, between 10% to 50% of women have experienced some act of physical violence by an intimate partner at some point in their lives (Heise, Ellsberg, and Gottemoeller 1999). This and an earlier World Bank review (Heise, Pitanguy, and Germain 1994) highlight some of the characteristics that often accompany violence in intimate relationships:

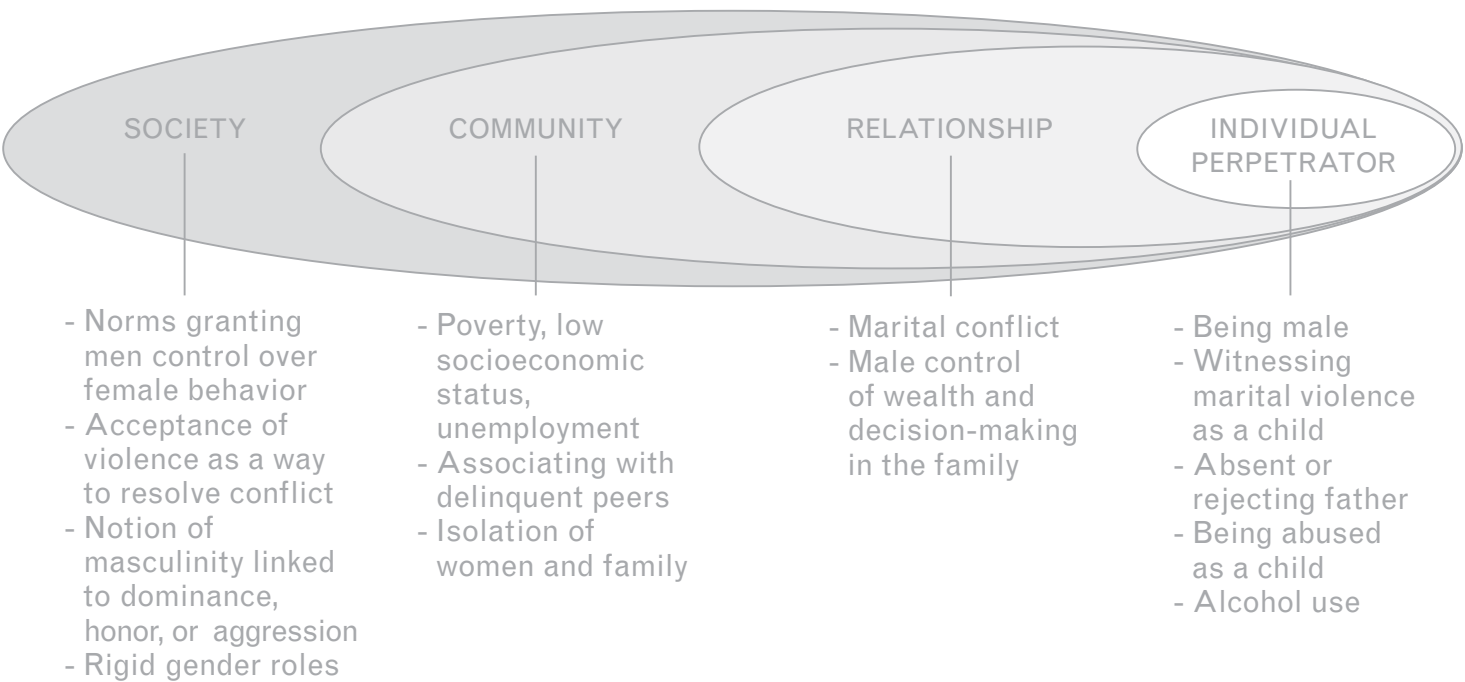
- The great majority of perpetrators of violence are men; women are at the greatest risk from men they know.
- Physical violence is almost always accompanied by psychological abuse and in many cases by sexual abuse.
- Most women who suffer any physical aggression by a partner generally experience multiple acts over time.
- Violence against women cuts across socioeconomic class and religious and ethnic lines.
- Men who batter their partners exhibit profound controlling behavior.

In León, Nicaragua, among 188 women who were physically abused by their partners, only five were not abused sexually, psychologically, or both.

—Ellsberg et al. 2000

These studies show that gender-based violence is a complex problem that can not be attributed to a single cause. There are risk factors, such as alcohol and drug abuse, poverty, and childhood witnessing of or experiencing violence, that contribute to the incidence and severity of violence against women. Overall, however, it is a multicausal problem, influenced by social, economic, psychological, legal, cultural, and biological factors, as illustrated in the figure below.

FIGURE 1-1. ECOLOGICAL MODEL OF FACTORS ASSOCIATED WITH INTIMATE PARTNER VIOLENCE

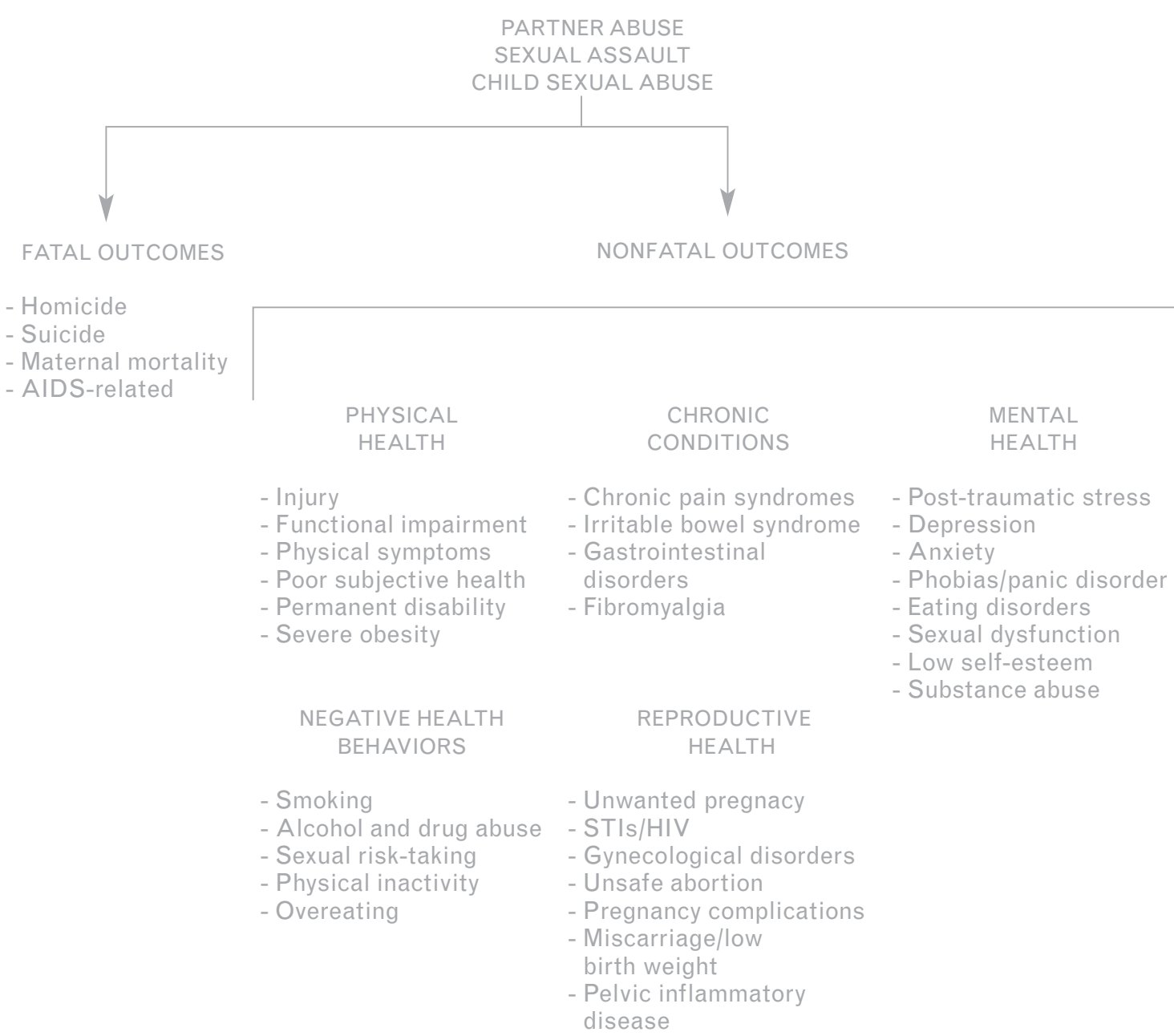


From: Heise, Ellsberg, and Gottemoeller 1999

WHY IS GENDER-BASED VIOLENCE A HEALTH PROBLEM?

As time goes on, there is increasing evidence and awareness among health providers and policymakers of the negative health outcomes of gender-based violence. It has been associated with reproductive health risks and problems, chronic ailments, psychological consequences, injury, and death (Figure 1-2.).

FIGURE 1-2. HEALTH OUTCOMES OF VIOLENCE AGAINST WOMEN



From: Heise, Ellsberg, and Gottemoeller 1999

Physical and sexual abuse affect women’s reproductive health, either directly through the risks incurred by forced sex or fear, or indirectly through the psychological effects that lead to risk-taking behaviors. Children may also suffer the consequences, either during the mother’s pregnancy, or during their own childhood due to neglect or the psychological and developmental effects of living with or experiencing abuse (Heise, Ellsberg, and Gottemoeller 1999). The following table summarizes how violence undermines women’s control over their own reproductive health, as well as the health of their children.

TABLE 1-1. REPRODUCTIVE HEALTH RISKS AND CONSEQUENCES OF VIOLENCE AGAINST WOMEN

- Men who are physically abusive are also more likely to have multiple sexual partners, and to coerce their partners into sex, thereby exposing them to sexually transmitted infections (STI), including HIV.
- Women in abusive relationships are less able to refuse forced sex, use contraception, or negotiate condom use, thereby increasing their risk of unwanted pregnancies and STI/HIV.
- Sexual and physical violence increase women's risk for many reproductive health problems, such as chronic pelvic pain, vaginal discharge, sexual dysfunction, and premenstrual problems, as well as pregnancy loss from abortion or miscarriage, and low birthweight in infants.
- Fear, geographical isolation, and lack of economic resources may prevent women from seeking reproductive health services—prenatal care, gynecological and contraceptive services, STI/HIV screening and care—and to adequately care for their children.
- Witnessing or experiencing violence against women during childhood has been associated with risk-taking behavior during adolescence and adulthood: early sexual initiation, adolescent pregnancy, multiple partners, substance abuse, trading sex, and not using condoms or other forms of contraception.

Based on information from Population Reports (Heise, Ellsberg, and Gottemoeller 1999)

However severe the physical consequences of violence, most women find the psychological consequences to be even more long-term and devastating (Sagot 2000). A recent World Health Report titled *Mental Health: New Understanding, New Hope* points to the disproportionate rates of depression among women and recognizes that GBV may contribute to these high rates (WHO 2001). Recurrent abuse can erode women’s resilience and places them at risk of other psychological problems as well, such as post-traumatic stress disorder, suicide, and alcohol and drug use.

Health care providers can play a crucial role in detecting, referring, and caring for women living with violence. Abused women often seek health care, even when

they do not disclose the violent event. While women tend to seek health services more than men throughout their lifespan, studies show that abused women seek services even more for ailments related to their abuse (García-Moreno 2002). Thus, interventions by health providers can potentially mitigate both the short- and long-term health effects of gender-based violence on women and their families. In Section II of this book, we will see the effects of these life-transforming and, at times, even life-saving interventions on the lives of women and their families affected by violence. 🌸

Chapter Two

The “Critical Path” Studies: From Research to Action

“It is said that we were all born under a star; when I watch the stars at night I ask which of them is mine, so that I can change it for another one.”

—Quechuan woman, Peru

When PAHO’s Women, Health, and Development Program developed its integrated strategy for addressing gender-based violence, it started out with an analysis of the problem. The “Critical Path that Women Follow to Solve Their Problem of Domestic Violence”¹ series of country studies and their results were instrumental in the strategy’s development in many ways. The studies’ action-oriented methodology provided vital information on women living in violent situations at the same time that it shed light on the types of local services (health, law enforcement, legal/judicial, educational, religious, nongovernmental, etc.) they most typically sought help from and in which sequence. It also revealed the most common obstacles they encountered from these institutions. Perhaps most importantly, the results of the studies served as a catalyst for raising awareness and mobilizing communities and policymakers to address the needs of women living in violent situations.

The need for such a study first arose from a series of women’s health assessments that were carried out in the early 1990s by PAHO and its ministry of health partners in seven Central American countries.² The results identified GBV as a health priority within the study communities and highlighted the shortcomings and lack of coordination between existing services.

In response to this situation, PAHO and its multiple counterparts developed and applied the “Critical Path” qualitative research protocol. It was designed to catalyze the construction of an integrated strategy for addressing GBV that targeted women living in violent situations and incorporated local community resources and the social sectors—particularly the health sector—in a coordinated response to the problem. Its results provided community and national stakeholders with a much deeper understanding of the barriers that women faced in breaking their silence and in overcoming the obstacles, humiliation, and inadequate responses they encountered along their critical path.

The “Critical Path” results piloted 16 networks in 10 countries and stimulated national attention in each case. The health and other sectors responded by developing and implementing care procedures and protocols, training services providers, and setting up information systems to better detect and respond to GBV within the respective service centers. Moreover, in each country results were published and presented in national fora with policymakers, reinforcing the commitment to improve national policies and legislation that could address the alarming problem.

These first “Critical Path” studies entailed a lengthy research process that delayed the immediate use of the data by the communities. As a result, the protocol was simplified for its easier and more flexible application. The more streamlined “rapid assessment protocol” (RAP) has since been applied in many more communities, where its more readily available results inform their plans for addressing GBV issues (PAHO 2002). The Spanish and English versions of the original protocol and the RAP, the publications of

country results, as well as of case studies of the 10 countries in Spanish,³ are available through the PAHO Women, Health, and Development Program’s Web site at www.paho.org/genderandhealth. The information provided in this chapter is largely based on the study results compiled in the 10 country case studies (Sagot 2000).

WHY THE “CRITICAL PATH”?

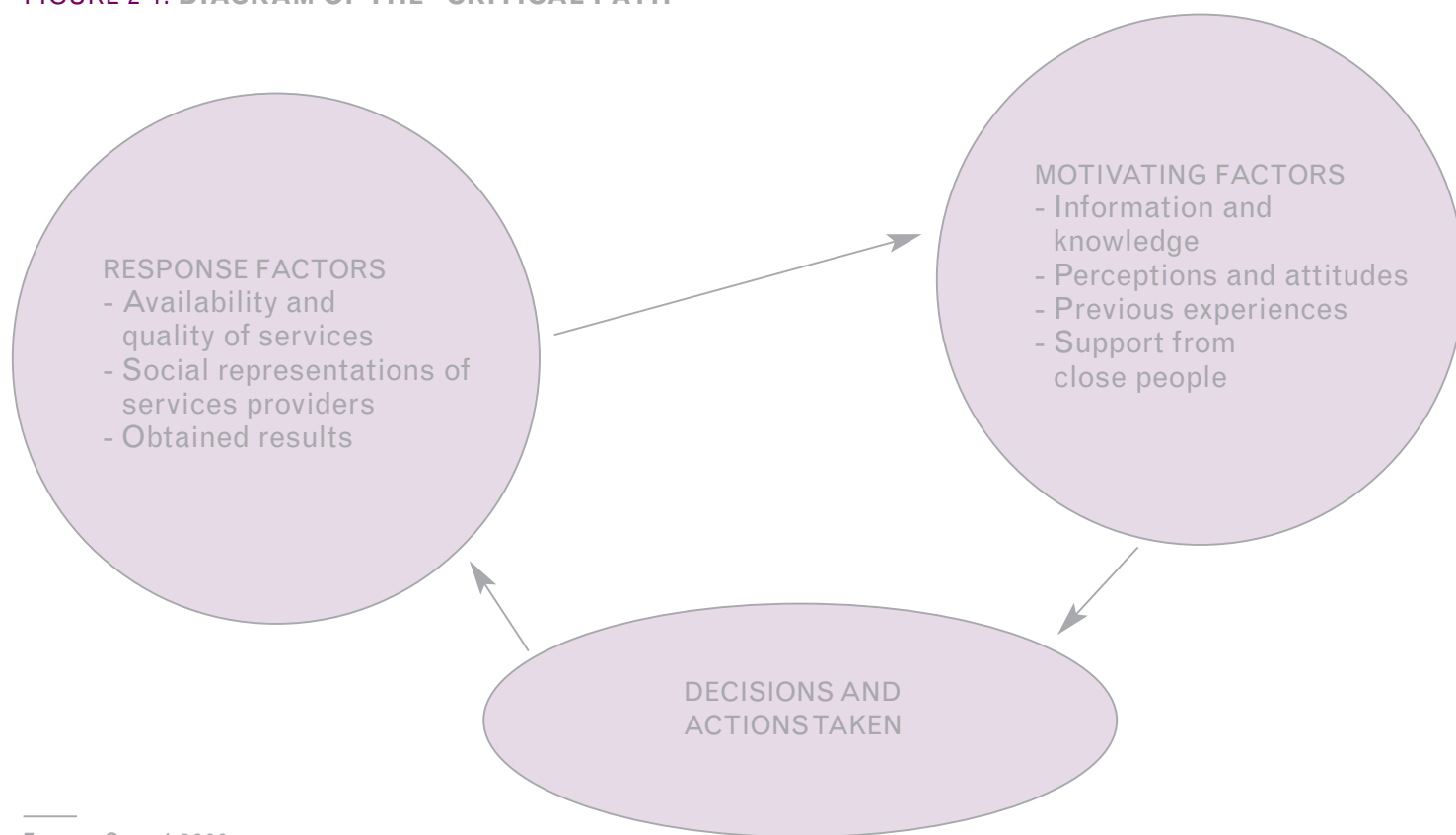
Information is key for identifying and addressing GBV, yet widespread under- and non-reporting continue to contribute to the problem’s invisibility. The 2000 United Nations report *World’s Women* estimates that only 2% of sexual abuse among children and between 20% and 30% among women are reported (United Nations 2000). The “Critical Path” starts to bridge this gap by providing baseline information on the characteristics of women living with violence and the factors that motivate them to search for solutions. At the same time, it identifies the kind of responses by institutions that influence women to take or avoid taking the first steps on their path (Figure 2-1.).

1 “The Critical Path” research protocol was initially published in Spanish and then translated into English with the title *Women’s Way Out*. For the sake of maintaining the concept of the critical path that women follow to escape their violent situations, the shorter title “Critical Path” will be used to refer to the research protocol and the study. Also, the term “gender-based violence” will be used instead of “family” or “domestic violence,” unless the latter forms part of a formal title or quoted definition.

2 The “Situation Analysis of Life Conditions with a Gender Perspective” (ASIS) and the “Diagnosis of Social Actors Working to Prevent Intrafamily Violence” were carried out in all seven Central American countries with support from the Governments of Norway and Sweden.

3 The original “Critical Path” protocol was developed by Monserrat Sagot and Elizabeth Shrader, who also coordinated the research process in the 10 countries. Sagot compared the results of the countries in *La ruta crítica de las mujeres afectadas por la violencia intrafamiliar en América Latina: estudios de caso en diez países (2000)*.

FIGURE 2-1. DIAGRAM OF THE “CRITICAL PATH”



From: Sagot 2000

In addition to helping women and communities break the silence, the “Critical Path” also facilitates the coordination of responses that is essential for effectively addressing this complex problem. First, it helps women analyze and reconstruct their own experiences and empowers them to seek solutions within their own communities. At the same time, the research process helps community members and institutions to become more aware of their own shortcomings in responding to the needs of abused women, while motivating them to work together to achieve this common goal.

THE “CRITICAL PATH” METHODOLOGY

The “Critical Path” study was carried out in 16 communities of the 10 countries that were included in the two PAHO projects to address gender-based violence.⁴ The study communities reflected the diversity of rural and urban settings in Latin America, as well

as that of its ethnic groups. Data were gathered between 1997 and 1999, and results were published in most countries by 2000.

The “Critical Path” uses an interactive, qualitative methodology with a standard protocol that was translated and adapted for the various ethnic groups. The process was guided by a set of pre-established ethical principles based on respect for the women’s experiences as recounted, assurance of confidentiality and personal security, and a commitment by all participating institutions to the prevention and eradication of gender-based violence.

Information was collected through in-depth interviews with the women and semi-structured interviews with service providers in the health, law enforcement, legal/judicial, education, religious, and NGO sectors, as well as through focus groups with community

⁴ “The study was initially carried out in one community of each of the Central American countries and in three communities in each of the Andean countries as part of the PAHO gender violence projects. These will be reviewed in Chapter Three and were carried out in Central America with support from the Governments of Norway and Sweden, and in Bolivia, Ecuador, and Peru with support from the Government of the Netherlands.

members. PAHO and its ministry of health counterparts selected the study communities based on size, the availability of basic services, and the existence of NGOs and/or women’s organizations. From each community, participants included 15 to 27 women, aged 15 years or older, who were presently experiencing gender-based violence and who had contacted a service provider within the previous 24 months. A minimum of 17 providers from among the various types of service centers were interviewed in each community.

Data analysis was based on the interpretation of structured questionnaires. Interviews were recorded and transcribed for detailed analysis. The researchers worked closely with community teams to develop their skills and knowledge for collecting, analyzing, and utilizing the results.

FINDINGS OF THE “CRITICAL PATH” STUDIES IN THE 10 COUNTRIES

Even though the study included women from different countries and socioeconomic and ethnic groups, their experiences were tragically similar. Common characteristics included a general unawareness of their rights and the fact that most had taken at least some initial steps toward resolving their situation and had met with frustrating results. All experienced violence as a control measure being wielded by their intimate partners to reinforce the unequal power relationships within the family and the aggressor’s own position of impunity.

“One of the issues is the machismo in our culture that says that a man is the strongest and has to be, in whatever manner, over a women, and when something does not suit him, he just beats her.”
—Justice of the peace, El Salvador

In the comparison of the “Critical Path” studies of the 10 countries, Sagot provides

a comprehensive and touching review regarding the common experiences of many different types of women (Sagot 2000). She quotes at-length from heart-wrenching accounts of women living lives enclosed in violence, and of their resourcefulness, courage, and strength in dealing with their situation, both within their families and when seeking help in their communities. Significantly, the majority of these women did not consider private or public services as part of their path, either because they were unaware of the support these institutions could provide, or because they had received inefficient or humiliating treatment by these groups in the past.

“The bureaucracy! Can you imagine? A person abused by her husband goes to the police station, then has to go to a forensic doctor, then back to the police, then to the district attorney’s office; everything is such a mess. . . .”
—“Critical Path” report, Peru

“I report this case to the authorities, who then do nothing with him. They’re not going to lock him up for the rest of his life. They’re not going to heal my leg. . . . And if they would only lock him up for a day or two to teach him a lesson! I know they won’t punish him.”
—“Critical Path” report, Costa Rica

**HIGHLIGHTS OF THE “CRITICAL PATH”:
THE WOMEN’S FIRST STEPS**

All women interviewed identified GBV as a serious problem affecting their lives. They all reported being subjected on a regular basis to physical violence that included slaps, punches, and beatings, but some were also threatened with knives and guns, thereby placing their health and lives at great risk.

“He punched me again. He struck me on the temple, was on the verge of strangling me. It took me two months to recover, to be able to swallow again, and once again I ended up with a swollen and black eye.”

—“Critical Path” report, Honduras

“He tried to kill me twice. The third time I think he will succeed.”

—“Critical Path” report, Belize

Physical violence was almost always accompanied by psychological abuse. Yet, for however damaging and humiliating women described their physical and sexual abuse to be, they deemed the psychological violence to be even more painful, since it targeted their sexuality, self-worth, and parenting ability. Violence that included threats to their children was especially traumatic:

“He tells her: ‘you are stupid [crying]], you are worthless and useless,’ and she was only a year old. Then he tells me: ‘look at your baby. She is worthless and stupid; you do not respect her.’ . . . She was only a year old; she couldn’t even talk yet; so she just stared at him, taking it all in.”

—“Critical Path” report, Guatemala

“Because of the abuse my uterus was removed. . . . He continues to hit me, now always on the face, but what hurts most are the insults. I’m telling you, they are worse than if he had put a dagger in my back.”

—“Critical Path” report, Peru

Most women also suffered sexual violence, but many were not aware of this abuse during most of their relationships, since they considered forced sex to be part of their domestic obligations.

“First he beats me, and afterwards he has sexual relations with me.”

—“Critical Path” report, Guatemala

“When I was his girlfriend, he would tell me to go to his room. . . and I would be afraid. Then, one time, he pulled my panties down and got on top of me. I just thought this was the way things were. After that, whenever I would go there, he always did the same thing. It has always been like this.

Talking with other people, I have been told that men caress you, but I don’t know anything about that.”

—“Critical Path” report, Guatemala

Intimate partners often subjected women to economic violence by limiting, withholding, or withdrawing financial support from them and their children, by threatening or actually by throwing them out of the house, by controlling any income the women brought home, and by breaking objects of value to the family.

Aggressors were men from all generations and all types of relationships, though the majority were intimate partners.

“The type of violence I see the most is that between husband and wife, because husbands don’t really feel part of the marriage. They are good-timers, they are *machista*, they go out with women they find on the street, they don’t take care of the home. When they do come home, there are problems. . . .”

—Health worker, “Critical Path” report, Panama

For a few women the abuse began immediately after establishing a relationship with their partners. For the majority, however, the violence started following cohabitation or marriage, a point at which their partners’ behavior became markedly more aggressive. From that point these men were able to establish complete dominance over their partners and their sexuality.

“The problem started when we got married.”

—“Critical Path” report, El Salvador



courtesy PAHO/WHO-Honduras

Honduran women attend a community meeting to learn more about GBV.

“Before he was different; he didn’t so much as break a plate. But once he felt that he had his little chickie in his hand, he said: ‘now the claws come out,’ and he became a different person.”

—“Critical Path” report, El Salvador

In many cases, the aggression had been long term, often starting or escalating during the first and subsequent pregnancies. Abuse during pregnancy not only resulted in abortions and sterility for the women, but also placed the lives of their unborn children at extreme risk.

“His intentions were to pull my baby out of my belly, because he put his knees on my belly and mistreated me.”

—“Critical Path” report, Nicaragua

“I am eight months pregnant and when he comes home, he starts to rail and break up things. He kicked me in my belly, and the water bag burst.”

—“Critical Path” report, Belize

Some women also reported having been abused by other members of their families, or by priests or teachers, even during childhood. Some young women reported entering into relationships, often with older men, to escape the abuse they experienced from their families.

“Well, if you can imagine, at the age of 8, to be exact, I was raped by my older brother.”

—“Critical Path” report, Nicaragua

“I have been abused by my father and brothers many times. Once, when I was 10 years old, my dad hung me from a tree because I ate a piece of cheese.”

—“Critical Path” report, Peru

In isolated rural areas, aggressors could more easily control their women’s freedom. These women were least likely to interact with neighbors and to have access to social services, and were, therefore, at a higher risk of harm from violence.



Over the past decade, awareness by women of their civil rights has spread from large urban centers to smaller towns and villages around the Americas. This anti-violence demonstration by women indigenous leaders in Sucre, Bolivia, has helped to promote violence prevention messages throughout the country and is spurring communities to view violence in a different way than in the past.

“For three years he kept me locked in a room. He opened the door at six in the morning to leave, and he wouldn’t return until six in the evening. Not until that moment would I see the light of day.”
—“Critical Path” report, Guatemala

Women often reported tolerating abuse because they feared that resistance might only intensify the situation. Staying in the relationship was also often encouraged by social pressures from their own mothers, children, and other community members in order to keep the family together. Lack of independent financial resources and family and institutional support also inhibited their actions.

“My face was bruised for a long time, perhaps a month. I didn’t pursue the case because he told me that he could always get out of prison, but I would never get out of the cemetery. And I didn’t want to die.”
—“Critical Path” report, Honduras

“I’ve been patient because I feel sorry for my children. To leave them or take them with me would be worse, wandering about, because I don’t have a place to go with them. That’s why I’ve put up with so much from him.”
—“Critical Path” report, El Salvador

“My parents told me: ‘If he is your husband, you just have to put up with the situation; that is the way it is.’ Then my mother said: ‘This is how I have suffered with my husband, too.’ ”
—“Critical Path” report, Peru

The women tended to tolerate their violent situations until they came to the realization that their coping strategies were not working and that their partners would not change. They were especially motivated to take the first steps when they perceived changes in the pattern of abuse, such as when the violence escalated; there was infidelity; their aggressors squandered their support, income, or possessions; and especially when the aggression was aimed at their children.

“He had a gun, and he threatened me with it . . . all the time it was: ‘I am going to kill you, you common whore! I am going to kill you!’ So when he fired that gun, then I really became afraid. That is how I finally got the courage to go to the police.”
—“Critical Path” report, Bolivia

“I left because he hit my boy. He threw a big piece of sugarcane at him. I got very angry because he threw that stick at my boy as if he were an animal, and he knocked him down.”
—“Critical Path” report, El Salvador

Reliable support from family members and friends and gaining access to information about gender violence helped motivate women to take the first steps towards resolving their situations.

“When the neighbors saw how my husband beat me up, they told me that it just wasn’t worth it for me to stay. They encouraged me to leave him.”
—“Critical Path” report, Ecuador

“Thank God for those advertisements! When I saw them, I said: ‘I have to find out more; I have to leave; I have to find out what can be done about this.’ ”
—“Critical Path” report, Honduras

Once women reached the point of being able to analyze their futile and dangerous situations, and to acknowledge that they were tired of living in fear for their safety and that of their children, they accepted that they could not tolerate any more abuse and were ready to take action. For most women, the way out—their critical path—was painful and extended, often with relapses back into the relationship, while a few were successful in their initial attempt and were able to follow a straightforward course out of their situation.

“. . . I felt like I had to fight to defend my right to live in peace, to find calmness, and to raise my children without violence, so that they could grow up normally and have normal marriages.”
—“Critical Path” report, Costa Rica

“. . . I took the decision because I felt like I was drowning.”
—“Critical Path” report, Honduras

“Because I don’t love him any more, I want to leave him. . . . I got desperate because I used to love him even though he hit me. But now I don’t feel anything for him, and I don’t want to be with him anymore.”
—“Critical Path” report, Guatemala

While the majority of the women’s paths taken out were convoluted and at times contradictory, analysis of the study data showed that their decisions to start the path

and the directions they chose to take were constantly guided by careful consideration of the possible risks and outcomes.

ARE SERVICE PROVIDERS PART OF THE PROBLEM?

When asked why they did not include public or private services in their “critical path,” most women identified as primary obstacles the negative attitude of these providers and their inability or unwillingness to meet their urgent needs. These attitudes caused women to feel frustrated and uncertain; they feared that they would again be victimized and that there would be impunity for their aggressors.

“Often women do not show any [physical] evidence of abuse, so their claims are not believed and they are treated poorly. Many times they are blamed before anyone hears their side of the story. That’s why most women don’t go to the police.”

—Police officer, Peru

“Opening up discussions regarding violence only seems to weaken the women’s position. They feel coerced to accept the impunity of their aggressors and to forgive and forget, and even to respect these men.”

—“Critical Path” report, Ecuador

During their interviews, almost all providers of health, legal, and police services confirmed that women often feared that seeking their services would somehow worsen, instead of improve their situation. At the same time, this group acknowledged adhering to traditional, patriarchal views that gender-based violence is a private matter, one that in most cases was warranted, and for which women were often to blame.

Generally speaking, the providers accepted that they did not understand all the complexities of GBV. Few professed to be fully conscious of the extreme danger that

women in their own communities faced daily in their abusive situations or about the dire conditions that eventually drove them to seek help. Furthermore, the providers were rarely aware of the risk involved in initiating and adhering to a “critical path” out of violence, while at the same time, they expressed frustration that women rarely followed the straightforward paths that providers were likely to prescribe.

According to the women, the generalized lack of understanding on the part of service providers resulted in such antagonistic behaviors as indifference, questioning, mocking, and attempts to instill guilt; in extreme cases, even sexual harassment and collusion with the aggressors were noted. When they did respond to the women, the providers would rarely follow up their cases or refer these clients to appropriate services. As a result, the women would often give up in frustration in dealing with the labyrinths of “proof” they were required to provide in order to initiate criminal or judicial proceedings. Especially in dealing with the police and judicial systems, women in all the countries studied noted an overwhelming feeling of futility in ever seeing their civil rights protected and receiving justice for the wrongs committed against them.

STEPS ALONG THE “CRITICAL PATH”: HOW WELL DID THE SECTORS RESPOND?

➤ **The health sector:** Women’s reactions to the care they received from this sector were mixed. While almost all of the women interviewed said that they had visited their community health center on a number of occasions for various conditions—some of them related to their abuse—they concurred that health providers rarely asked them questions about violence or screened them for it.

“Women see these [health] institutions as places where they can heal their wounds or illnesses, but not as the right place to talk about their violent experiences.”

—Montserrat Sagot, 2001

“The staff here do not ask and do not have the proper training for detection; nor do they consider it to be part of their job.”

—Health provider, Honduras

During the time of this study, only a very few health providers had received any specialized training in dealing with women living in violent situations, and none had protocols or standards for care. Perhaps for this reason, the women perceived a generalized reluctance by health workers to deal directly or in a sustained fashion with their problem. Most health personnel elected instead to refer the women to the police or local court system, fearing perhaps that treating and following up on these cases would ensnare them in extended legal processes for which they had no time and wished to avoid at all cost.

“We verify a rape with a relative. We are not interested in who did it, or how or where it happened because that is none of our business . . . it's a legal problem.”

—Doctor, Ecuador

Furthermore, the study showed, most providers had no further contact with these women and were thus unaware of any subsequent treatment or assistance they received elsewhere.

➤ **Law enforcement and legal/ juridical systems:** The police and legal services were, in many instances, the first places women went, whether on their own or upon referral by health workers or other service providers. Police stations were present in almost all the communities studied. They

were also the least supportive, in terms of the providers' attitudes and willingness to help and the availability of gender-sensitive services and information. This, combined with the fact that the police and juridical officials generally were not aware of laws to protect the women—nor did they apply them—caused great frustration and humiliation among the women in all the countries studied. This overall deficiency was further exacerbated by the lack of coordination between the various sectors when women sought help, causing additional delays and/or interruptions in the “critical paths” women attempted to take out of their situations.

“When women come and ask to reprimand their husbands, we don't even keep a record of the complaint.”

—Policeman, El Salvador

“All in all, it's a very painful experience. Many times the women go to the police in tears, and the police tell them not to be irresponsible and waste their time, as if they didn't have anything else to do. Then they tell them: ‘So be it missus, tonight your man will be between your legs again.’ In other words, besides not helping them, they disrespect them.”

—Legal services provider, Nicaragua

“In the long run, the person just gets tired of going from one place to the next. A woman is raped, and first she goes to the police, where they tell her this is a family issue. They arrest the character and make him pay a fine because they don't want to send the case to the court. So next she goes to a lawyer; then to the district attorney's office and the judge, and many times she's told there's not enough information to prosecute . . . so eventually she says: ‘Okay, fine’ . . . and just gives up and leaves.”

—“Critical Path” report, Bolivia

➤ **Education sector:** Because gender and family violence are issues normally falling outside the domain of educational policies and curricula, schoolteachers understandably feel ill-equipped to respond to the needs of affected students and their families. Therefore, most teachers maintained a cautionary attitude that wavered between awareness of the problem and avoidance of becoming involved in legal issues regarding minors.

“Some of the other teachers told me: ‘don’t interfere, don’t let yourself get too close, because sometimes when you try to do a favor, it can really complicate your own life.’”

—Teacher, Peru

“... It is not the responsibility of our staff to become too deeply involved in the family problems of our students.”

—Teacher, Ecuador

Some teachers, however, said they had provided support to students despite the

lack institutional guidelines, and they expressed a desire to see violence-related issues better addressed in their schools in the future.

“In the absence of specific policies regarding violence, teachers have relied upon their own instincts and used their best judgment.”

—“Critical Path” reports, Peru

➤ **Community organizations:** These groups would appear to be in the best position to detect and address GBV, principally because they are made up of townspeople who are involved in all aspects of local life. The analysis showed, however, that most conventional community organizations, such as labor unions and cooperatives, held traditional beliefs and provided no support at all to women affected by violence. Even in local businesses where women held leadership roles, these managers usually lacked the information, skills, and policies to detect and respond to the problem. On occasion, women did seek



courtesy PAHO/WHO-El Salvador

While still far from being the norm, some young schoolchildren, such as this group in El Salvador, have received information and discussed gender-based violence in the classroom with their teachers and other community members.

spiritual support to help them gauge their situation and justify their actions. Some religious organizations acknowledged an awareness that gender-based violence existed, but in their practices and counseling, they usually provided no specific support to affected women.

“A woman must count to three and swallow, so that the anger goes away and to avoid more aggressions.”

—Priest, Ecuador

“I asked [the nun] if that was normal or what. . . . She told me that it was not normal, that it was a rape and that I did not have to say otherwise.”

—Costa Rica

According to the interviews, women’s organizations provided the best support, especially those which provided services related to women’s health, legal rights, self-esteem, and other related issues. Groups of this type were often able to effectively meet women’s needs, because their mission was to serve disadvantaged and abused women. Unfortunately, their support was limited mostly to larger urban areas and did not extend to rural communities.


“. . . We listen to the woman and then put the ball back in her court: how would she like us to help her, we ask. . . . We treat those who seek our services with respect; we explain possible alternatives, but the decisions are theirs.”

—Women’s NGO, Honduras

LEARNING FROM THE “CRITICAL PATH”

In all 10 countries studied, the “Critical Path” results conclusively confirmed that GBV is a serious public health and human rights problem. They also indicated that as long as the problem remains largely invisible to and disregarded by society as

a whole, the social development of women, girls, their families, and communities everywhere will be compromised and diminished. The research process included a component in which the results were presented to the various sectors that had been interviewed. The women’s stories, in particular, helped to “break the silence” regarding this complex problem and changed the attitudes of the study communities towards GBV by making their residents, and especially service providers, more aware of the tremendous burden placed on the numerous women affected due to the woeful inadequacies of services and national policies. This, in turn, spurred the communities to create concrete, intersectoral actions to address gender-based violence.

The analysis of the results of the “Critical Path” showed that the success of interventions depended on the availability, quality, and coordination of services, and, most of all, on the commitment of the providers. Women provided the most positive responses when they felt that the institutions, whether public or private, were genuinely concerned about their welfare, provided emotional support and information, respected and supported them, and showed a willingness to defend their rights and safety. They particularly appreciated the efforts of providers to help strengthen their self-determination and facilitate their ability to make their own decisions about when and how to free themselves from their violent situations. The services deemed most effective were those which remained unencumbered by rigid, institutionalized mandates and whose flexibility enabled individual situations and needs to be taken into account. To the extent to which the institutions exhibited these qualities, they were able to serve as valued stepping stones along the women’s “critical paths.” 

Chapter Three

Joining Forces to Address Gender-Based Violence in the Americas

“... Intimate partner abuse against women is a complex problem, from its causes to its consequences to its effective prevention. Only when we are convinced that our societies must be free from violence, can we embark on the path toward its abolition.”

—Cecilia Claramunt, 1999

In the early 1990s, as women’s rights and the interrelationship between health and socioeconomic development gained new importance on international agendas, PAHO and its ministries of health counterparts in Central America carried out the first gender and health situation assessment, with support from the Governments of Norway and Sweden. The timing was especially relevant, since most countries were undergoing health sector reform processes to increase efficiency and decentralize services, without necessarily taking into consideration how these processes could affect men and women differently. Many women’s organizations, therefore, feared that women might be further marginalized as a result of these reforms.

The assessment focused on the health situation of women, as well as the existing sources of care and information that could bridge the gender equity gap; it was carried out with health personnel and leaders in study communities in the seven Central American countries. Among the multiple inequities identified, the prevalence of and lack of response to gender-based violence emerged as the most urgent health need. The results also provided important clues as to the issue’s complexity and suggested that an effective response could not be mounted by the health sector acting alone. These findings led to the “Critical Path” study reviewed in Chapter Two, which provided an in-depth view of the reality of countless women living with violence and of the institutions that could join forces to address the situation.

In response to these results and the 1993 PAHO resolution, PAHO presented its first proposal to address violence against women to the Nordic donors in 1994. The 1995–1997 project focused on women and girls in the 12–49 age group and on possible collaborations between the health sector and civil society. Soon afterwards, the Government of the Netherlands provided funds to implement this strategy in Bolivia, Ecuador, and Peru, as well.

The way the strategy was implemented varied according to the specific needs and situations of each locale, but all the countries addressed GBV at three levels—national policy, sector, and community—and in collaboration with partners. Allies were identified through a “Diagnosis of Social Actors Working to Prevent Intrafamily Violence” (1995) and through the research of the “Critical Path that Women Follow to Solve Their Problem of Domestic Violence” (1996).

The next phase of the Central America project (1998–2002) sought to consolidate this strategy and its prior achievements by institutionalizing the norms and protocols for the detection and care of victims, training community leaders and providers from the health and other sectors, and expanding networks and support groups for women and men to 30 communities. Due to internal policy changes, the Government of the Netherlands ceased its multilateral support for the Andean project when it ended in 2000, opting instead to continue with bilateral support for Bolivia (2001–2002) and Ecuador (2000–2002).

PUTTING THE PIECES TOGETHER

The “Lessons Learned” assessment and the yearly project evaluations credited the project’s impressive achievements in large part to the strategy’s targeting of outcomes from its conception and to the integrated partnership approach that had been applied at all three levels.

FIGURE 3-1. THE INTEGRATED STRATEGY FOR ADDRESSING GENDER-BASED VIOLENCE

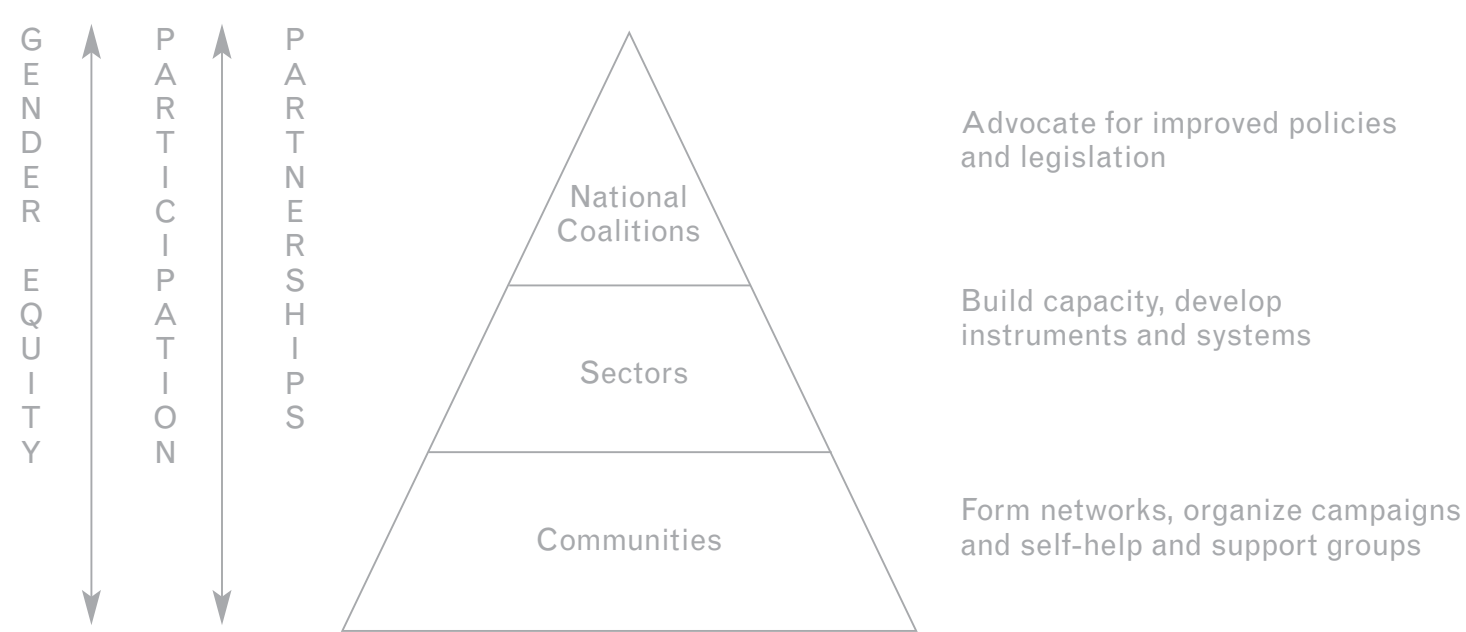


Figure 3-1. illustrates the three operational levels of this approach and the crosscutting values of gender equity, participation, and partnerships. The primary goal of this strategy is to put in place policies, capacities, systems, and networks to better detect and care for women who live with violence and to prevent gender-based violence by promoting a culture of peace, respect, and equity within families and communities. Each of this strategy's components has been carefully selected, based on research results, experience, and the process of negotiation. The values, interventions, and operational levels are briefly described below, and their applications will be more thoroughly discussed in the second half of this book.

CROSSCUTTING VALUES

- **Gender equity:** Gender-based violence places women at risk of health problems and even death and is related to their inequitable socioeconomic status within their families and society in general. The resulting subordination and sense of powerlessness often thwarts women's ability to seek help and protection for themselves and their children. It is, therefore, important that policymakers, service providers, and community leaders be aware of these underlying inequities that affect women's human rights and health.
- **Partnerships:** GBV is a complex problem that cannot be solved by the health sector alone. Its causes are multiple and interrelated, and therefore addressing them calls for a multisectoral approach. It is therefore imperative to create alliances at all levels with partners best suited to address these causes, such as the juridical, law enforcement, health, education, and social welfare sectors, as well as local political and community leaders and NGOs. Other key allies are the women's organizations that provide expertise,

accountability, and advocacy, and the national offices of women's affairs that formulate and monitor government policies.

- **Active participation** by community stakeholders and beneficiaries provides the creative approaches and sense of ownership essential for formulating policies, developing networks, and changing the culture of violence.



courtesy PAHO/WHO-Ecuador

Training material prepared by Ecuadorian community network highlights the crosscutting values of partnerships and active participation that are key elements in the integrated approach promoted by PAHO.

INTERVENTIONS OF THE INTEGRATED STRATEGY

- **Detection** of abused women is the first step towards breaking the vicious circle of violence and preventing future and additional harm to the affected individuals. Since health providers are in regular contact with women, it is important that they learn how to screen for GBV on a regular basis (Chapter Six).
- **Attention and care.** The solution to violence against women is neither straightforward nor exclusively medical. The number and variety of challenges women and

their children face, presented in Chapters Five and Six of this book, make it imperative that providers be able to rely on effective policies, training materials, care protocols and procedures, efficient registration and referral systems, and the institutional support necessary to ensure the quality and specialized care that these clients need.

- **Promotion and prevention.** Raising awareness about gender-based violence, and the laws and services that address it, are key for preventing violence against women. Campaigns promoting gender equity, women's legal rights, and conflict resolution are the first steps toward creating a lasting culture of mutual acceptance and self-esteem for women and men. Incorporating gender issues, particularly those related to GBV, in school and university curricula raises collective awareness and helps prepare communities and professionals to more effectively address violence and its sequelae.

OPERATIONAL LEVELS OF THE INTEGRATED STRATEGY

- **Community level.** As described in Chapter Seven, the foundation of this strategy lies at the community level, where networks may be formed and encouraged to prevent, detect, and respond to violence against women. Health centers can play a catalytic role in mobilizing the community to develop these networks, in the sense that they can provide the training and set up the necessary surveillance and referral systems among the network's members. In many communities a simplified "Critical Path" survey has been conducted to identify stakeholders and the common obstacles women face when attempting to leave their violent situations. Network composition varies by community, but typically consists of the local health center, police station, court system, school-

teachers, community leaders, and women's organizations; in some communities church representatives and others participate, as well.

The networks usually develop work plans and meet regularly to coordinate activities. Bolivia (OPS 2000) and Peru (OPS 2001) have developed simple training manuals for use by networks, and members of the Central American project have also developed a strategic planning manual to guide this process (PAHO-Costa Rica 2001). Within their respective communities, networks organize and carry out campaigns against violence, provide information and support to families living with GBV, facilitate referrals, and coordinate training sessions.

"Now there is a lot more information on the radio and on TV; you know there are places to go, and if you get out before it's too late, they can save your life, and you can live in peace."

—*"Critical Path" report, Honduras*

As we will see in Chapter Seven, in an increasing number of communities, these networks have organized support groups for women and men that are commonly led by health center staff. Some members of these support groups have, in turn, taken the leadership to form other self-help groups within their communities.

- **Sector level.** In order to build capacity and set up the necessary systems to detect and care for abused women, public and

NGO sectors need to have access to specific policies and tools. In most of the project countries the health sector has taken a leadership role in making these available, while in some countries, this sector has coordinated with the local police department, women's NGOs, and/or universities for their development and implementation.

These sectors have worked together to publish modules and train health directors and providers—doctors, nurses, promoters, social workers, and others—as well as service providers from other sectors. The health sector has developed protocols and procedures for care that have been validated in the communities and provide an effective basis for training programs. As we will see in Chapter Five, currently the health sector is working with other sectors to refine registration and epidemiological data collection processes and thus facilitate better identification and tracking of cases of violence.


- **National policy level.** Stakeholders need to form cohesive alliances to advocate for policies and legislation aimed at preventing, treating, and penalizing violence, as well as for securing the resources for their implementation and continuous monitoring. In most countries, the health sector has allied with stakeholders from other sectors to form national and/or regional coalitions. These are described in Chapter Four.

During regular meetings, the coalitions share experiences; collaborate in developing policies, training materials, information systems, and other tools; and carry out national campaigns. They also assure that their respective achievements are sustained and institutionalized, which is

key for expanding the strategy to new areas throughout the country.

WHAT HAS THE PROJECT ACHIEVED?

By the end of the project's second phase (2002), the model strategy has resulted in the creation of more than 150 intersectoral community networks in 10 countries. In Central America, counterparts are using modules to train additional providers, have approved protocols and procedures, and are developing surveillance systems in all seven countries. These partnerships have strengthened national coalitions and enabled them to sustain advocacy efforts despite various changes of governments and health ministers. At the regional level, PAHO has joined forces with other United Nations agencies, regional women's organizations, and other partners to implement the international and regional conventions described in the introduction to Section I, and in 2001 it hosted a regionwide inter-agency symposium to identify priorities and formulate strategies for strengthening the health sector's response to GBV.

Constructing this integrated strategy has been the work of many groups and individuals. The process has been creative and innovative in the sense that it has brought together entities—the health sector, law enforcement agencies, the court system, educators—who in the past approached the issue of gender violence in different ways and did not always share the same perspectives and goals. The results, as shown in Table 3-1., could not have been achieved without the collective efforts of all these and other groups, working together at various levels and sharing a common commitment to break the silence surrounding an important public health and human rights issue. As a result, public interest and awareness have reached new heights. Now there is no turning back. 

**TABLE 3-1. ACHIEVEMENTS IN ADDRESSING GENDER-BASED VIOLENCE
IN 10 COUNTRIES, 1995-2002**

1.REGIONAL LEVEL

- *Symposium 2001: Gender-Based Violence, Health, and Rights in the Americas:* 300 representatives of agencies, governments, and NGOs of 27 countries agree to a plan of action to mobilize the health sector to address GBV.
- *Technical exchanges* facilitated between Central American and Caribbean countries to expand GBV strategy to five Caribbean countries, as well as exchanges among 10 project countries on policy promotion, training of health personnel, and development of networks and support groups and of surveillance and information systems.
- *Political commitment:* GBV prevention placed on the agenda of regional and subregional policy fora and summits.

2.NATIONAL POLICY LEVEL

- *Advocacy:* Intersectoral coalitions formed in 10 countries to advocate for GBV policies and legislation.
- *Legislation:* GBV laws passed in 10 countries; monitoring bodies established in six Central American countries.
- *Research:* “Critical Path” results published in 10 countries; prevalence study on GBV and men’s roles conducted in Bolivia; knowledge, attitudes, and practices study carried out in Peru.
- *GBV prevention campaigns* carried out in 10 countries.
- *Health sector reform:* GBV detection, care, and prevention policies incorporated in health sector reform processes of five countries.

- *Education:* Study of violence in primary school curricula in Belize and Peru, and in university-level curricula in Belize, Costa Rica, El Salvador, Nicaragua, Panama, and Peru.

3.SECTOR LEVEL

- *Strengthening capacity:* Instruments and systems developed and implemented (norms and protocols in 10 countries, surveillance systems in five countries, and training modules in 10 countries); more than 15,000 representatives from health and other sectors have received training each year of project period.

4.COMMUNITY LEVEL

- *Community networks:* Formation of more than 150 community networks comprised of health, education, and judicial sectors; police; churches; community leaders; and women’s organizations.
- *Support groups* for men and women formed in five countries, community self-help groups in eight countries.
- *Zero tolerance campaigns* and other nonviolence activities promoted in numerous communities.