

Review of PAHO's project

**Towards an Integrated Model of Care
for Family Violence in Central America. Final Report**

**Mary Ellsberg
Carme Clavel Arcas**

**Department for Democracy
and Social Development**

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Sida Evaluation 01/32

**Department for Democracy
and Social Development**

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Executive Summary

I Background

The Pan American Health Organization has implemented the project, “Towards an integrated model of care of family violence: Expansion and consolidation of interventions coordinated by the state and civil society,” since 1995. The Swedish and Norwegian governments have supported the project in the seven countries of Central America during two periods; the first from 1995–1997 and the second from 1998–2001.

The *overall objective* of the project is:

The existence of inter-sectoral responses at the community level in Central America to address the social problem of family violence against women.

The *purpose* of the project is:

Integrated Model Approach to Family Violence in the health sector consolidated and in operation in 30 communities in Central America.

The *expected outcomes* are:

- National norms and protocols for the detection, prevention and treatment of family violence and the promotion non-violent relationships, defined by consensus and institutionalized in the health sector.
- Policies and contents for training in comprehensive care for women defined and human resources trained in the 30 selected communities.
- Groups/mechanisms set up and strengthened in order to prevent and deal with family violence against women and promote healthy relationships in the 30 selected communities.
- Proposal for technical and financial mechanisms at the national level presented to health sector authorities to ensure the sustainability of integral care for family violence.

In 1996, a mid-term review of the project was conducted, coordinated by the team leader of the present evaluation team (Ellsberg and Claramunt, 1997). In 2001, the donors and PAHO decided to contract a team of two international experts to evaluate the program and document the lessons learned in the countries.

II. Objectives and Scope of the Study

The objectives of the review mission were defined as the following (see Appendix 2 for the complete Terms of Reference):

The study should primarily give the donors an overall picture of the advances of the project, impact, efficiency and sustainability of the project achievements, and secondarily to provide feedback to the participating groups and others interested in the subject matter.

The review shall focus on the efficiency (main accomplishments), effectiveness and lessons learned; assess the needs for a follow-up in each country and the level of sustainability of the project achievements in each country. It should be noted that it is not the task of the review team to

measure the short term or long term impact of the program. Should, however, such data be available from other sources it should be taken into account in the review.

Scope of work:

The review team shall analyze the progress of the project in all seven Central American countries with special emphasis on the following aspects:

- 1. Policy level – assess the implementation of policy and legislation on the national level.*
- 2. Health sector level – assess the institutionalization of the model and the application of norms and protocols for the detection and prevention of family violence at national, regional and local level.*
- 3. Community level – assess the model on local level including the development of local networks with the police, schools, churches, health personnel, NGO's, etc.*
- 4. Assess the policy and content of training in comprehensive care on national, regional and local level.*
- 5. Assess the extent of the incorporation of the model on local level in 15 selected communities.*

The period of time established for the mission was 8 weeks: one week for preparation, five weeks for field work and two for the drafting and presentation of both the preliminary and final reports.

III. Methodology used for the review

We used qualitative and participatory methods to achieve the aims of the review. A strategy was developed jointly with PAHO consisting of three main activities:

1. Document review

2. Interviews with key informants in each country: (Appendix 4 presents the complete list of individuals interviewed).

- PAHO consultants
- Ministry of Health staff
- Representatives of women's groups and institutions that collaborate on violence work

3. Focus group discussions with various stakeholders:

- Members of national level commissions to prevent violence
- Health providers from local health centers
- Community leaders
- Community violence prevention networks
- Clients of health services (women who had received individual services related to abuse, or who participated in support groups for victims.)

Field work was carried out between July 18 and August 25, 2001. Greater emphasis was placed on Nicaragua, Guatemala, Honduras and El Salvador, as agreed upon with the donor agencies and PAHO. In order to learn about some of the experiences of Panama, Costa Rica and Belize, a joint meeting with PAHO and country representatives was held in Costa Rica. The selection of key informants was made jointly with PAHO and the representatives of the ministries of health.

In total, more than 300 individuals were interviewed through the following activities:

- Visits to 5 countries
- 31 focus group discussions conducted
- Visits to 10 community project sites

In the group interviews we used the following participatory techniques to stimulate discussion (in Appendix 3 a complete description of the methods are presented).

- The road well-traveled (chronogram of collective histories)
- Who helps Rosita? (Venn Diagrams for institutional analysis)
- Achievements and barriers (free-listing)
- The story of Rosita (incomplete story for the analysis of quality of care).

As much as possible, the same techniques were used with the different groups, in order to permit comparisons between the views of clients, service providers and members of community networks.

In each of the sessions one of the consultants facilitated the session while the other took notes. The diagrams produced in the groups as well as the notes were transcribed afterwards for analysis.

IV. Conclusions and Recommendations

Project Strengths

The evaluation team found the following aspects to be the main strengths of the project:

- The project has increased the visibility of domestic violence as a public health concern and has promoted the development of public policies that address the problem in each of the countries of the sub-region.
- The project has provided technical and financial support for the development of technical proposals for policies and procedures to address domestic violence in all the countries. In four countries (Belize, Costa Rica, Panama and Nicaragua) they have been approved.
- The project has provided technical and financial support for the development of proposals for registration and monitoring systems for domestic violence in all of the countries. Registration formats exist and are functioning in all of the selected communities of the project. National monitoring systems have been approved and implemented in two countries (Belize and Panama). Costa Rica and Nicaragua have a monitoring proposal and a proposal for a unified violence registration system has been drafted in Guatemala, El Salvador and Honduras.
- The project carried out a study in four countries to show the feasibility of screening to detect victims and survivors of domestic violence.
- The project has encouraged the sharing of experiences for a health sector approach to family violence care, among the sub-regional and Andean countries.
- The project has developed an operations research methodology, The Critical Route, to achieve a rapid assessment at the local level based on the responses of the various stakeholders in the field.
- The project has succeeded in integrating gender and violence issues laterally into other PAHO programs in some countries. This contributed to leveraging additional resources to maximize impact. Among the countries visited by the review team this was particularly noticeable in Nicaragua and El Salvador.

- The project has promoted reflection on men's roles in violence prevention among male health personnel in all countries, particularly in Nicaragua, as a strategy to improve the health sector response to violence prevention.
- The project prompted discussions regarding the inclusion of a gender and violence module in the Schools of Public Health and Regional Master's of Sexual and Reproductive Health program of the sub-region. It also succeeded in having a gender and violence component incorporated into the curricula of primary schools and nursing schools in Belize and Panama.
- The project, together with other international agencies, contributed technical and financial support for the creation of multi-sectoral commissions that deal with domestic violence at the community, local and national levels in the respective countries.
- The project, in collaboration with other agencies and international NGOs, contributed to the analysis of and proposals for laws and public policies on domestic violence and promoted the follow-up for implementation at the sub-regional level.

In addition, at the country level:

- National programs have been implemented in all the countries to sensitize health personnel to issues of violence.
- In communities selected by the project, a large number of health personnel participating in the domestic violence program have been trained to detect and refer victims of violence.
- In most of the countries, increased access to the project has been achieved by integrating more health units and regions. In some cases this has been achieved with the support of PAHO's health sector reform projects (Nicaragua, El Salvador, Honduras, Costa Rica).
- Additional funds from PAHO and other agencies have been leveraged in the majority of countries to expand the project based on the same model of care.
- Services for domestic violence have successfully been integrated into country health sector reforms so that they are included as part of the basic health services package in Belize, Costa Rica, Nicaragua and Panama.
- Five training modules have been developed, with technical and financial support from PAHO: *Feeling, Thinking and Confronting Domestic Violence* on behalf of the PLANOVI commission, Costa Rica. These materials have been used for training in most of the other countries in the sub-region.
- Domestic violence has gained a place on the health agenda of Central America through the Ministers of Health Meeting (RESSCAD). Coordination with other policy programs (First Ladies Meeting etc.) of the sub-region was also promoted.
- Improved coordination between state institutions and civil society was achieved in programs where there had been little prior experience.

Challenges

The following issues were identified as the project's main challenges:

- The lack of political will in some countries, to implement and extend care for domestic violence throughout the health services.

- In those countries where the violence program is located in the mental health programs of the Ministries of Health, as is the case of Honduras and Guatemala, the team considered this approach to be a limitation for achieving greater impact and integration into the rest of health services.
- In several countries, policies and procedures for domestic violence have been proposed but never officially approved, or approved only recently. The lack of norms makes it difficult to assure uniformity in the type and quality of services, as well as to develop indicators for evaluating the quality of care.
- Internal coordination among the different areas of the health sector involved in the program (epidemiology, information and planning, reproductive health, mental health, etc.) is considered weak in Nicaragua, Guatemala, El Salvador, and Honduras; less so in Costa Rica, Belize and Panama.
- In terms of information systems, the lack of coordination and implementation of the systems among the different program areas is an obstacle for the institutionalization of the program and for highlighting the real magnitude of the problem. This is a constraint for decision-making and prioritizing activities.
- Among the countries, inequities in coverage, methodology, monitoring and evaluation, and replication plans were observed in terms of the quality and content of technical training.
- Continual personnel turnover in some cases the absence of national counterparts, over long periods, has hindered the national process of developing the model of care due to the lack of continuity and institutional memory.
- Technical and financial support offered by PAHO has had significant gaps in Honduras, in part due to the absence of a focal point of the Program for Women, Health and Development. This has hindered coordination with national counterparts.
- In all the countries visited the team considered that there was a lack of materials for creating awareness, training and social mobilization.
- In the PAHO offices located in El Salvador and Nicaragua, the team observed excellent coordination between the violence program and other technical support programs, for example the health reform projects. This has greatly facilitated the consolidation of the model and scaling up to other regions. In Honduras, Guatemala and Costa Rica, this kind of coordination appeared to be weaker.
- In the majority of the countries, community networks have been created or strengthened in the communities where the program is established. The strongest networks exist in Nicaragua, whereas, in Guatemala and Honduras, prevailing political and institutional conditions have made coordination more difficult.
- In all the countries visited the team considered that there was a lack of materials for creating awareness, training and social mobilization.

Sustainability of the Model

The sustainability of the model of care for domestic violence should be assessed from various viewpoints: institutional, financial and social. Our main conclusions regarding this concern are the following:

Institutional sustainability

One parameter for assessing institutional sustainability is the degree of acceptance of the model at the level of the Ministries of Health. Clearly, the issue of violence has achieved some level of promi-

nence at the regional level, as evidenced by events such as the *Gender Violence, Health and Human Rights of the Americas Symposium*, recently held in Cancún, Mexico. Nevertheless, we believe that the family violence program remains vulnerable to political changes in those countries that have not approved official policies and protocols.

Another way to assess institutional sustainability is the degree of acceptance by frontline health personnel. In the pilot communities we visited we found a very positive attitudes towards to program. The real challenge is to scale up the pilot programs into national policies.

In most countries we noted greater enthusiasm at the local level than at national level. This is very positive because this means that pressure to adopt official guidelines is more likely to come from civil society and from Ministry of Health personnel and not be perceived as an imposed from international agencies.

The countries that have been most successful in terms of expanding the model to other regions are Nicaragua, El Salvador, Costa Rica and Panama. In our opinion, Guatemala and Honduras are in relatively weaker situations in institutional terms.

Another aspect that should be assessed is to what degree the program is institutionalized within PAHO itself. In this respect, we observed some differences in the technical follow-up provided by the different PAHO field offices. Additionally, there was a difference in the degree of lateral integration of gender issued in general and violence specifically into other PAHO programs. An example of this is the situation of Honduras which remained without a focal point for almost a year. During this period project payments were not fulfilled; consequently, this resulted in program delays and disagreements among the national counterparts. The PAHO offices in Nicaragua and El Salvador have had the most success in this regard, particularly as it relates to linking the domestic violence program and health sector reforms.

Financial Sustainability

In terms of financing, the Ministries of Health in Costa Rica, Panama and Honduras have designated national resources for the establishment of the program. In Honduras it is important to note that 20 mental health staff have been allocated by the Ministry of Health for the Family Counseling Program. This ensures a good degree of sustainability for the family violence activities overall. Nevertheless, all of the countries lack funds for carrying out personnel training, and other activities such as case follow-up and supervision, as well as the necessary supplies for implementing the model.

Financial sustainability continues to depend on international support to a great extent. A successful result of the projects is the degree to which additional resources for family violence care have been leveraged from other donors. For example, in the case of Nicaragua, this is illustrated in the amount of resources of other agencies and projects (SAREM, GTZ, PROSILAIS) which have enabled the Ministry of Health to expand the model to other regions.

Social Sustainability

Social sustainability depends to a great extent on the level of organization and degree of awareness that exists among the population concerning violence. Of the countries we visited, Nicaragua is the country with the greatest degree of social sustainability. This is largely due to the history of Nicaragua where there is a strong tradition of social mobilization and where violence against women has been a high visibility issue for many years. Another important element is that, unlike many other countries in the sub-region, the Nicaraguan health sector has extensive experience in coordinating with community groups and other state institutions on issues of mutual concern (promoting breastfeeding, reducing maternal mortality, etc.) Furthermore, there are many other strong state programs related to domestic

violence, such as the Comisarias for Women and Children. An example of sustainability that we observed was that services continued to be provided for victims of violence through the volunteer work of many activists and local contributions from the Ministries, despite the discontinuation of international financing for over more than a year

In other countries that we visited we observed important improvement in terms of general awareness and commitment among civil servants concerning family violence. However, due to historical characteristics of each of the countries, the overall sustainability of the initiatives seems more precarious. For example, the situation of Guatemala is very unique, in that the enormous levels of social violence overall do not allow much room for discussion on domestic violence. Added to this is the lack of experience in coordination between the state and civil society. Accordingly it is not realistic to set similar goals for each of the countries, as each one has specific conditions that need to be considered.

Recommendations

In light of the previous discussion, our recommendations for the future of the project are the following:

International Cooperation

- The project has made important progress in its development; however, the model of care is still not completely consolidated at the country level. As a result, we feel that the project needs a new period of cooperation.
- In the case of Swedish cooperation, which is currently in the process of being reoriented to bilateral agreements with specific countries, we recommend the following:
 - A specific objective and budget should be included in the bilateral agreements to support follow-up activities to the domestic violence program.
 - In these countries the violence project should prioritize scaling up in the regions that are targeted by the bi-lateral programs.
 - Include the following issues in policy discussions with recipient governments: adoption of policies and protocols for the care of victims of violence, establishment of internal coordination within the Ministries of Health regarding violence related activities, implementation of information systems and monitoring of violence and training plans.
- In the case of the Norwegian cooperation, we recommend renewing the sub-regional support of the program, with an emphasis on the aspects that are pointed out in the following sections.

Technical Cooperation

- Despite the likely reduction in the total amount of funds available at the sub-regional level, we believe that it is a priority to maintain a level of minimal technical attention for all the countries, including countries that are not prioritized by the Nordic cooperation. We believe that it is essential to maintain the presence of the focal points in each of the countries to assure follow-up and technical support for activities.
- In order to ensure the overall coherence of the model at a sub-regional level, and to take advantage of the experiences of all the countries, we suggest that exchanges and technical training continue to be implemented at a sub-regional level with the participation of all of the countries.
- During the next period, we suggest that priority be given to consolidating the components of the Model of Care that were identified as weak or incomplete through exchanges, workshops and internships. We recommend accomplishing this by encouraging that the facilitation of activities be

led by one or more local organizations that have expertise on specific topics. This would contribute to strengthening national organizations, while supporting the establishment and theoretical and methodological coherence of the project at the sub-regional level. Examples of issues that would lend themselves to this approach could be working with men, social communication, monitoring and information systems, and facilitation of support groups.

- Expand the concept of family violence to a concept of gender-based violence in order to address other types of violence such as sexual assault, and child sexual abuse. This does not imply that other aspects of family violence (e.g., abuse of the elderly) can not be addressed as well.
- Promote increased lateral integration gender and violence issues into other PAHO programs at the country level.
- Promote a screening policy for violence in health services, based on an analysis of sub-regional experiences, and include identification of sexual violence.
- Maintain a dialogue with the countries to attain the adoption of policies and protocols, as well as the development of information and surveillance systems.
- Prioritize publishing and dissemination of training and awareness materials for health personnel, as well as behavior change and communication materials such as posters, brochures, etc.
- Increase emphasis on community promotion, including strengthening community networks and technical support in areas that have had the most difficulty.
- Create a training model, following the example in Nicaragua, using regional “teaching centers” to take advantage of the experiences of the most specialized centers, who can then provide training and technical assistance to newer centers
- Promote alliances between the different cooperating agencies and inter-agencies that are working on domestic violence in the sub-region to maximize resources and share successful experiences.
- Promote in each country the establishment of institutional and professional directories to facilitate referrals for women by health providers.
- Propose the use of common indicators for use by the information systems in each country in order to enable comparisons between the countries.
- Promote the use of the information that is collected in the information systems for local planning and dissemination.

I Background

The Pan American Health Organization has implemented the project, “Towards an integrated model of care of family violence: Expansion and consolidation of interventions coordinated by the state and civil society,” since 1995. The Swedish and Norwegian governments have supported the project in the seven countries of Central America during two periods; the first from 1995–1997 and the second from 1998–2001.

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In total, more than 300 individuals were interviewed through the following activities:

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As much as possible, the same techniques were used with the different groups, in order to permit comparisons between the views of clients, service providers and members of community networks.

In each of the sessions one of the consultants facilitated the session while the other took notes. The diagrams produced in the groups as well as the notes were transcribed afterwards for analysis.

Organization of the report

To facilitate reading we organized the results of the report by theme rather than by project aims. Each section of the report presents a general introduction to the issue, a brief summary of the results of group discussions and interviews, and the main lessons learned. The final section of the report presents the team's main conclusions and recommendations.

Limitations of the report

The main limitations of the report are in terms of time and space. The time that we were able to spend in each country was relatively short, with the exception of Nicaragua. In some cases it was not possible to interview all of the key people involved in the project. Therefore, we relied on the review of documents and the input of PAHO consultants to contextualize our findings and to determine how representative they were. We have attempted to minimize errors through the presentation and discussion of the preliminary results with national counterparts and PAHO consultants in Panama (October 2001). Corrections by each country team were incorporated into this final document.

A second constraint was the need to synthesize our conclusions in a relatively brief report. It would be nearly impossible to do justice to the wealth of information collected in such a short space. We also felt that it would be impractical to present the results of each country separately, particularly as much of the country-specific information is already available in reports drafted by the countries and PAHO. Therefore, we tried to synthesize as much as possible and to present a global vision of the accomplishments and barriers of the project. The report highlights those aspects of the project that are common to all countries as well as issues that are unique to a single setting. We have tried to rely as much as possible on the voices of the participants and to indicate where consensus and discrepancies were observed. We also tried to clearly indicate which statements are views of the interviewees and when they reflect the team's opinions.

We would like to acknowledge all of the individuals that supported throughout the completion of this document. In particular, we would like to thank Marijke Velzeboer-Salcedo, Cathy Cuellar, Janete da Silva, and the national PAHO consultants: Raquel Fernández, Sylvia Narvaez, Ruth Manzano, Rebeca Guizar, Florencia Castellanos, Sandra Jones, Dora Arozemena and Amalia Ayala for their unconditional support in all of the phases of developing this study. We are also grateful to Mette Kottman and Carola Espinoza from NORAD and Hans Åkesson of Sida who were very supportive and accommodating throughout. Finally, we would also like to thank the representatives of the Ministries of Health and national NGOs, and all of those individuals that shared their experiences and knowledge with us in a critical and constructive spirit.

IV The Central American Context

One of the greatest advances in recent years has been the recognition by all Central American governments that violence against women is a public health and a human rights concern, as well as an obstacle, with enormous economic and social costs, for the development of the countries in the sub-region. This recognition is largely the result of the arduous work of international and national women's groups that raised the topic of violence against women at the most important international conferences in the decade of the '90s. Among them were the Conference on Human Rights (Vienna, 1992), the International Conference on Population and Development (Cairo, 1994) and the Conference on Women (Beijing, 1995). In Latin America, the Inter-American Convention for the Prevention, Eradication and Sanction of Violence against Women (Belem do Pará), ratified by all of the region's governments, establishes the political framework for violence prevention. These international documents create an important political framework for the development of violence prevention activities. Moreover, all Central American countries have made important strides with regard to legislative and policy reforms to prevent and sanction violence against women.

A word about terminology

Family violence, violence against women, or gender-based violence?

There is currently no consensus regarding the most appropriate terminology to refer to the physical, emotional and sexual violence that women suffer from, generally by family members, but also by strangers. The majority of Central American policies, mandates and laws refer to the "struggle against family violence" or "domestic violence." In some cases sexual violence is also mentioned (Nicaragua, Belize and Panama). The PAHO project also refers to family violence, even though in practice the majority of their activities focus on intimate partner violence against women. For many, family violence is a politically more acceptable term because it includes all members of the family and does not explicitly mention gender inequalities. For this same reason, many women's rights activists consider the term to be a reversal of the language from the Inter-American Belém do Pará Convention, which refers explicitly to "violence against women" and recognizes it as a manifestation of historically unequal gender relations. Moreover, the term family violence does not address other common forms of violence against women, such as sexual assault by individuals outside the family. This topic was discussed at great length at the *Gender Violence, Health and Human Rights of the Americas Symposium, Cancún*. This conference was organized by various UN agencies including PAHO and was attended by representatives from health ministries and NGOs from throughout Latin America and the Caribbean.

At the Symposium participants agreed that, although use of the term "family violence" was, at one time, strategic for gaining acceptance among Ministries of Health, by now it is considered to be exclusionary, and either "gender-based violence" or "violence against women" are more appropriate terms.

Legal reforms: necessary but not sufficient

Another important achievement in the last six years has been the passage of legal reforms to address family violence in each of the Central American countries (Appendix 1).

Although the existence of an appropriate legal framework for sanctioning and preventing violence is clearly a necessary step, it is not sufficient to guarantee the protection of abused women and children. In the first place, there are many problems in the application of the laws, such as contradictions between recent penal code reforms and previous laws. For example, in El Salvador, the new Penal Code

reforms on domestic violence (1998) do not establish different sanctions according to the severity of the assault; punishments are minimal compared to other laws; and the laws only refer to crimes committed within the domestic sphere.

In other cases, the reforms do not address sex crimes (rape, incest), which are still considered private offenses. In Guatemala, for example, this means that only the victim can file charges against an offender:

We want sexual offenses to be officially prosecuted and incest to receive real sanctions. In Guatemala, incest carries a fine of 300–600 quetzales² and the aggressor can go free right away (CONAPREVI Network).

Mediation is neither forgiveness nor reconciliation

Another common problem is the use of mediation, or “out of court agreements”, for domestic and sexual violence. Mediation has become popular in many countries as a means to expedite solutions for misdemeanor offenses. However, when used in domestic violence or rape cases, it can be very counter-productive because there are few guiding rules or principles and therefore the agreements are subject to the individual interpretation of each judge or police officer. For example, in countries where Family Courts exist, the main interest of the court is not preventing violence but rather, preserving the family unit. In Guatemala, the indigenous women activists of Cobán explained,

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

Although in Nicaragua, mediation is not officially supposed to be used in cases of physical and sexual violence, we learned of various instances where it was used. One problem with mediation is that it assumes that both parties are negotiating under equal conditions; however, this is clearly not the case when a woman has been beaten or raped by her partner. The agreements that result from the mediation often disguise the aggression and disempower victims. They are usually registered as “marital disputes” rather than “assaults,” and in return for a husband promising not to hit his wife, she often has to promise not to provoke her husband or maintain order in the household; as if both parties were equally responsible: the husband for using violence and the wife for provoking him. A Nicaraguan lawyer commented,

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

In some countries, judges refuse to apply protection measures such as restraining orders for the aggressor, alleging that it violates his rights.

...If I apply the protection measures of Law 230 [by forcing the offender to leave the home], I am violating his constitutional right to own property ... (Judge from Nicaragua)

Finally, some of the family violence laws have created a new set of problems. For example, laws in Honduras and Panama oblige the health sector to offer treatment to aggressors as an alternative sentence. Additionally, the laws in Guatemala and Panama establish the obligation of public employees to notify the justice system if they become aware of cases of family violence. As a result health personnel are reluctant to ask clients about violence and to register identified cases for fear of becoming involved in criminal cases.

From words to action: National Plans for Violence Prevention

In all seven countries there are now national committees dedicated to preventing, sanctioning and eradicating family violence, within the framework of Belém do Pará and Beijing. Most committees are headed by the national institutions for the promotion of women and include representatives from the ministries of justice, education and child welfare, as well as women's NGOs that work on violence. Initially the health sector did not participate in these committees; however, now they are members in all countries with the exception of Guatemala. In Costa Rica, the health sector stands out as being the first state sector to establish a sector-wide plan for family violence in 1994; this was the precursor for the subsequent development of PLANOVI. The Ministries of Health in Panama and Belize have also played a prominent role in their national violence prevention programs.

One of the first tasks of the committees was been to achieve a basic agreement among the sectors to coordinate in a national violence prevention effort. In Costa Rica (PLANOVI 1994), and El Salvador national plans are already being implemented. In Belize, Guatemala and Nicaragua national plans have been drafted but not put into effect (see Appendix 1 for more details). In Panama and Honduras, national violence prevention plans are currently being developed.

The development of a national plan against family violence is an important achievement in itself, as it creates a political space for greater dialogue between civil society and the state, as well as committing the governments to a public discourse that sanctions violence. In many discussions with public employees and both men and women citizens in all of the countries we heard phrases such as “it is not like before, now there are laws to protect women”, and “now women have rights”. These perceptions represent a major shift in public awareness, and they indicate that violence against women is no longer viewed as a normal occurrence.

Nevertheless, we found that, in most countries, the transition from developing plans to putting them into practice seems to be problematic. This is partly due to budgetary constraints, but at the same time these difficulties have political undertones. In Nicaragua, the National Committee for the Fight against Violence carried out a very participatory planning process on family violence, resulting in an ambitious and comprehensive proposal; however, the proposal is now languishing for lack of resources to implement it. A member of the committee commented,

There is financing available from IDB, however, due to the lack of negotiations by the government the funds have not been disbursed. If this were really a priority of the government there would be 10 Ministers calling IDB daily to ask what's happening with the loan.

In other countries where there is little tradition of coordination between civil society and the state, and even among state institutions themselves, reconciling the priorities of different sectors is in itself a great challenge. Moreover, we got the impression that in general there is little coordination between the national committees and the local networks.

V The Health Sector: Building an Integrated Approach

What is an integrated model for addressing family violence?

One of the main challenges that PAHO and the countries have faced in this project has been to develop an integrated model of care for family violence from the health sector, with very few international experiences to guide them. The development of the model has involved two stages:

- A conceptual framework for addressing family violence in Central America based on existing social and epidemiological research, as well as new research carried out by the program itself (see the section on the Critical Pathways).
- A proposal for a strategic approach to family violence, which includes activities at the macro level (policy and legislation), the health sector, and the community level.

Some aspects of the violence prevention model are similar among the countries. For example, the basic principles for caring for victims of violence are nearly all derived from a human rights and gender framework (see example of Costa Rica in Boxes 2 and 3). Other issues, such as the organization of services for helping victims, and the development of norms and protocols and community level networks have been adapted to the historical conditions and needs of each country. In this sense, the model approach should be seen as a work in progress with different faces in each country. For example, in Honduras the model is based on Family Counseling Centers (*Consejerías de la Familia*) located in 13 health centers throughout the country. Each *Consejería* 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. In contrast, the organizational core of Nicaragua's model is the Woman and Children's Police Stations, run 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 non-governmental 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 sub-regional level. They include:

- The development of national policies recognizing violence as a public health problem;
- 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 self help groups for violence survivors;
- The promotion of male involvement in violence prevention activities;
- The development of an information system that permits tracking reports of family violence throughout the health system;
- The development of community level public awareness to promote non-violent lifestyles; and
- Setting up community networks to coordinate services and violence prevention activities.

In each country a few communities were selected for piloting the approach and in some countries there have been advances in terms of scaling up the program to include more regions. In the following sections we provide a brief discussion of the achievements and limitations encountered in the implementation of the model.

Policies on violence in the health sector: How important are they?

With the technical support of PAHO, policies and programs targeting family violence have been developed within the health sector of all the countries. In some countries the policies were achieved through specific Ministerial Decrees, as is the case of 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 is no specific health policy related to family violence, rather it is framed in the policy that relates to the integrated care for family. In Guatemala family violence is a sub-program nested within in the Mental Health Program.

In most of the countries, health policies related to violence are fairly recent, with the exception of Costa Rica. However, they are still not widely known by health personnel or even by the population that would benefit from them.

Lessons Learned:

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 their implementation.

Box 1

Central America is multi-colored, multi-ethnic, and multi-cultural

Proposals for policies, programs and models of care for family violence in the health sector should be careful to consider the diversity of languages, ethnicity and cultures existing in the region and in each of the countries, in order to ensure that their implementation is not discriminatory in practice.

Box 3

Some Key Aspects of the Family Violence Model Approach

Goals of Family Violence Intervention:

- 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
- To prevent future violence

Integrated care for family violence should include the following aspects:

- Accessible, continuous, effective, efficient, appropriate, trusting, confidential, secure, quality care, and guarantees the integrity of those affected.
- Considers care for different types of violence, both within and outside the family as well as witnesses of violence.
- Focus on changing the cycle of violence.

Develops mechanisms for systematic registration and situation analysis of individuals and families affected by family violence.

- All of this must be accomplished within a permanent monitoring system at a local, regional as well as national level.

Costa Rica Ministry of Health

Where are programs for the care of family violence located?

We discovered two organizational models of programs for addressing family violence within the Ministries of Health. In most countries the program is located in the department for women's health or reproductive health (Nicaragua, El Salvador, Belize, Panama). In Guatemala and Honduras the program was placed in the Mental Health Department. In general, we found that the women's health department appeared to be a more strategic placement for DV programs and facilitated the expansion of DV services throughout the primary health network. In contrast, mental health programs are generally scarce in the countries we visited, and are usually found only at the regional level or at specialized referral clinics.

Lessons Learned:

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

A few years ago the violence program in Guatemala was also situated in the women's health division of the Ministry of Health. The program disappeared for a few years, due to ministerial reorganization, and was only recently resurrected within the mental health program. Despite efforts made by the Mental Health division to rebuild the program, some ministry of health staff believe that the change has weakened the program. "Mental health is a virtual program", commented the director of a large health area that does not have a single psychologist. In Honduras where the model of care lies almost exclusively in the Family Counseling Centers (*Consejerías de la Familia*) it is particularly difficult to envision how the program could be scaled up without close coordination with the reproductive health program. Another problem in considering family violence as a mental health program is that it does not encourage linkages between the violence program and other health concerns, such as traumatic injury and reproductive health problems.

The women's health services program, on the other hand, is implemented in all of the health units, regardless of size, and supervision exists at the level of the different health areas and regions. In this manner, by integrating family violence laterally into reproductive health programs, it is possible to extend the scope of the program widely with relatively little additional investment.

Box 2

Principles that should guide care for Domestic family violence:

- Family violence is a serious problem that affects the physical, emotional and sexual health of the person that lives with it, 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 public health and human rights problem.
- Family violence is the responsibility of the perpetrator.
- 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 requested services for family violence.
- All individuals who suffer or have suffered family violence have the right to services and resources that guarantee his or her safety and confidentiality.
- All interventions should be carried out in a manner that respects individuals' rights and empowers them to make their own decisions.

Ministry of Health, Costa Rica

Table 1. Two organizational schemes for the placement of the family violence care program

	Mental Health	Reproductive Health
Advantages	Increased institutional response in units with specialized resources	Increased coordination w/other programs Model works without specialized resources More linkages with services for women at high risk
Disadvantages	Few mental health resources in most of the countries means more difficult to scale up activities More difficult to coordinate w/other programs	Level of response is more limited (crisis intervention in crisis, basic counseling and referrals)

Family Violence Program Committees in the Health Sector

Regardless of where the program is located, internal coordination between the key programs with 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. In Nicaragua, Belize and Guatemala we were told that there are efforts underway to increase coordination in such areas as family violence surveillance systems and gender related policies.

Lessons Learned:

Inter-programmatic coordination is essential for making sure that violence programs are integrated laterally into key health programs, and to ensure the sustainability of the violence program.

With norms or without them ...

Although all of the countries have developed proposals for norms and protocols, in some of them it has taken years to get them officially approved. To date, the norms have been approved in Costa Rica, Belize, Panama and recently in Nicaragua, whereas in Honduras and El Salvador approval is still pending.

In Guatemala, guidelines for addressing family violence were included in the norms for adolescent and mental health care. However, the scope of these norms is somewhat limited, since they have not been incorporated into the sexual and reproductive health programs.

The logic of the PAHO project strategy would be that the pilot project experiences in each country would serve as a laboratory for the development of national policies and norms; subsequently, they would be the foundation for scaling up the model to other regions. In the countries where norms for family violence care have not been institutionalized, the project has been obliged to continue training health personnel and expanding care and services for family violence to other regions in the absence of official guidelines. Health workers consider this to be a serious constraint, as it means that the care for victims or survivors of violence is left up to the criteria

Lessons Learned:

In general, having officially approved norms and protocols facilitates ensuring the quality of care, as well as scaling up of the pilot experiences.

Implemented norms and protocols guarantee the quality of care for family violence in health services. Furthermore, they enable the evaluation of services.

of an individual, without the benefit of a clear protocol. Furthermore, the lack of norms restricts screening, care, the information system and monitoring. Additionally, it is harder to achieve uniformity in the quality of care, or to assess the performance of professionals.

Another problem that we observed is high staff turnover in the health sector. There is no guarantee that the personnel providing care have experienced adequate awareness or training. As a result there is a risk that safety concerns and confidentiality in the provision of care for victims may be jeopardized. The existence of norms, protocols and ongoing supervision would help to offset these risks.

Nevertheless, in the daily routines of the sub-regional health centers and posts, with or without norms, health personnel have cared for and continue to care for victims and survivors of family violence. Moreover, in some places they have found creative solutions to overcome the constraints caused by the absence of norms.

Training Health Personnel

The PAHO project and the countries have carried out a tremendous awareness and training effort for health personnel at all levels.

We encountered various training strategies among the countries. Some countries have decided to train all personnel within certain health units. The advantage of this is that it creates a much more supportive environment within the center for the violence programs and motivates other staff, including administrative support personnel to help in identifying family violence cases. In other countries, training has been conducted through vertical programs, i.e., only mental health personnel or reproductive health program staff. Although this may result in greater coverage of the violence program in terms of the number of health centers involved, it is more difficult to have an effect on the quality of care for family violence if only one or two staff within each unit are trained. In Honduras, training has only been carried out among staff of health centers where the Family Counseling Centers are located. The main purpose of this training is to encourage staff to refer patients to the counselors.

In our discussions we found some confusion with respect to the use of the terms, *awareness*, *training* and *specialization*; thus, we think it is useful to clarify this point. As a doctor from Nicaragua commented,

**...Awareness activities are what 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.**

As a result of these efforts, personnel have observed considerable increases in the identification of cases as staff become more confident in their ability to offer women support.

Specialized training on certain topics was also carried out, for example, training on forensic medical procedures. Another example is a training conducted by PAHO with the SAREM project in Nicaragua to train psychologists and psychiatrists on how to treat childhood sexual abuse.

In order to be able to achieve mass training of personnel, national experts within the Ministries of Health have been trained as trainers as well as consultants from women's NGOs.

Lessons Learned:

It is important to train health personnel on the identification of and basic care for violence. This creates a favorable environment so that women can be identified and referred for care by any program of the unit.

Training should stem from a reflection of participant experiences and beliefs and not just from the technical aspects of care.

In Costa Rica, within the framework of PLANIVI, a module entitled *Feel, Think and Confront Family Violence* was developed to train staff in carrying out the violence protocols. This module was also used in the facilitator training of health personnel of the rest of the countries and multi-sectoral committees. In Guatemala a very innovative training package was developed utilizing participatory dynamics adapted to the reality of the country. In Nicaragua many health regions have used a training guide for health personnel that was developed by the National Network of Women Against Violence.

A significant accomplishment in all of the countries has been the expanded coverage of training to include other social actors in addition to health personnel: police officers, judges, women's groups, and teachers. This is especially helpful for stimulating multi-sectoral coordination for the project. For example, a Gender and Family Violence Module was developed to be implemented in the Schools of Public Health in Central America. In Guatemala, Belize and Nicaragua the nursing schools have developed a Gender and Family Violence Module.

Educational modules on violence have also been created within police academies and the armies in some of the countries with the support of ILANUD. In all of the countries contact with the Universities was made to introduce the theme to the schools of social sciences, education and law; however, in most cases, these have not yet been institutionalized.

Another experience that we found to be very innovative is the exchange program created in Nicaragua to promote in-service training in the regions where domestic violence work is being initiated. The Esteli health center has been converted into a kind of "Teaching Center", where personnel from other units can go for a few days to receive training and practice on family violence care. The most interesting aspect of this experience is that the visiting staff not only learn in the health centers but they also spend some days in the Women and Children's Police station and in local NGOs that address violence as well. As a result training on how to organize care networks and learn from the experiences of women's groups is provided. The support of PAHO's PROSILAIS project has enabled this activity to generate income for participating centers, thereby contributing to the financial sustainability of local networks. We believe that this experience could be replicated in the majority of countries that have any specialized care units. In Honduras, in particular, the role of the Family Counseling Centers could be enhanced strategically by converting them into teaching centers for the rest of the health personnel.

In terms of weaknesses, in some countries we observed an uneven level of quality in training. In most countries plans have not been developed for providing ongoing training follow-up. In some areas, training materials are either insufficient or of poor quality. We feel that this is an area that can be given more emphasis to in the future.

Lessons Learned:

Hands-on experiential teaching on family violence is key. Training should be targeted to various social actors and consist of various levels including awareness and basic and specialized training.

Internships and exchange programs are an excellent strategy to promote the exchange of experiences and training for personnel.

Box 4 Certificate of commitment with teachers in Bluefields, Nicaragua

In each school center trained by personnel in the health sector and the Multi-sectoral Commission on Violence Prevention, teachers sign a certificate of commitment to complete their training, where they draft their proposals for contributing to reducing child abuse and to eradicate family violence.

V The Model of Care for Women and Children Suffering from Violence

Following the Critical Pathways

At the beginning of the Family Violence project in Central America, PAHO carried out a multi-country study to provide base line information for planning the project's strategy. Qualitative research methods were used to study the process they referred to as "the critical route of women affected by family violence". This refers to the process that a woman goes through once she acknowledges her situation and decides to seek help (Shrader and Sagot, 1999). The objective of the study was to learn about the actions undertaken by women to seek care and solutions for their problems with violence, and to gain insights for designing programs and public policy on family violence. The study examined the perspectives of the responses found in the different state institutions or NGOs. At the same time, it explored the social representations of users and service providers with regard to violence.

The study was carried out in 10 countries: 7 in Central America and 3 Andean countries. The study results were presented in national reports and a summary of the countries. With few exceptions, the study results were conclusive: they revealed an inadequate response situation on behalf of the state institutions and victim-blaming attitudes on the part of providers.

The study results were very important, not only because of the information that they provided but also because they helped to mobilize local organizations in support of the program. Members of the National Commission for Violence Prevention in Guatemala commented, "The Critical Route study enabled us to publicly demonstrate that the system was not working; that there was no justice for abused women."

The findings confirmed that the weaknesses in terms of government responses to violence were similar among the countries. They also provided avenues to look for project strategies in each country. Recently the study methodology has been adapted to make it more operational. This protocol entitled, "Social Responses to Violence" provides an rapid assessment of the local situation with regard to violence prevention.

Why is family violence invisible in health services?

The critical pathways study confirmed that women who live with violence rarely reveal their situation spontaneously when attending a health center; even when they are there for violence related problems such as physical injuries. The women we interviewed offered a series of explanations for their silence:

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 from San Cristóbal, Guatemala)

Another common reason that women keep silent is they are ashamed to discuss personal issues or feel that health personnel do not care about their problems. Social discrimination is an additional barrier for indigenous women to talk about their personal problems in the health units:

People think that our [indigenous] clothes make us dumb...[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 *ladina* nurses are not interested in us... (woman from San Cristóbal)

Health workers that have not been trained generally avoid asking about violence, even when there are visible signs of violence, such as physical injuries. A Nicaraguan doctor quoted in the Critical Route study explained,

There isn't any type of screening carried out here. There's simply no time to talk or perform special exams for women reporting violence. The treatment for a victim of violence is not even close to that given to a woman with cancer (Critical Route report in Nicaragua).

It is even more difficult to tackle these problems when a woman is a health worker. A Nicaraguan nurse who was abused by her partner 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..."

The summary document of the 10 studies of the Critical Route concluded:

The health sector institutions have an uneven response with regard to this problem and the positive results obtained by some respondents depended more on the good will and actions of individuals providers than on institutional policy (Sagot, 2000).

Transforming the culture of silence surrounding the health sector is, therefore, the main challenge for any effort to address violence.

How are women living with violence identified?

There is no single strategy for identifying women living with violence. We have found four different approaches among the countries. In general, these resulted from the health team's experience more so than from a strategy developed nationally or through the PAHO sub-regional project. They include:

- *Not asking any routine screening questions*, but rather waiting for women to disclose violence spontaneously (passive identification), even when they arrive with clear signs of abuse. This was the practice used in some of the health units that we visited in Guatemala. Experience also indicates that it is the least effective way to identify cases of violence.
- *Universal screening* means asking all women about violence in every program and on every visit. The Ministry of Health and the Social Security Institute of Costa Rica have proposed implementing universal screening for its care for violence. This system is the most far reaching, however, it is costly and difficult to implement.
- *Asking about violence when staff suspect a case of violence*. This strategy was most commonly used in El Salvador and Honduras. It can be a cost-effective way to identify women, but only if staff are well trained and motivated.
- *Routine screening in certain "sentinel" programs*. This implies selecting some priority services in which there are more possibilities of identifying abused women or because they offer good opportunities to ask about violence (for example, pre-natal care, emergency services, mental health, etc.). This strategy was proposed in Nicaragua's violence prevention norms; however, it has not yet been implemented.

Lessons Learned

Waiting for women to disclose violence on their own is not an adequate strategy for reaching women living with violence. Experience has shown that women are willing to talk but it is necessary for health personnel to ask about violence.

It is possible to identify women affected by violence in any area of health services. The minimal requirements are privacy, trained personnel and the opportunity to listen and offer a minimal intervention.

Since violence is just beginning to be addressed within health services it is still too early to say what the most effective strategies for identifying women living with violence are. Nevertheless, we believe that the first two options are less feasible than the latter two. Experience has demonstrated that programs

Box 5
Questions used in the screening exercise

Did your partner ever throw objects, slam doors, destroyed furniture or run you out of the house after any conflicts or arguments?

In the last 3 months (if pregnant, ask during this pregnancy) have you ever been pushed or hit by your partner, boyfriend, or ex-boyfriend?

Are you currently afraid of being attacked, abused or hit by your partner, boyfriend?

without a screening policy identify only a fraction of those women requiring assistance. On the other hand, universal screening is not practical for the majority of health services, given the scarcity of qualified resources and time pressures experienced by health personnel.

The advantage of carrying out screening in sentinel services and in the case of suspicion is that it allows efforts to be focused on women most in need and in the most appropriate places to treat them. Furthermore, it establishes screening as an integral part of clinical history taking, especially for mental health, prenatal care, fertility and other reproductive health services, such as sexually transmitted infection programs, and finally for emergency hospital services where knowing the victim's history of violence is key for any intervention.

The screening study

PAHO conducted a study in four countries to assess the feasibility of performing regular screening in health services. In each site, personnel were trained on the basic concepts of family violence and on the use of a tool consisting of three questions on recent physical or emotional violence experiences by a partner. During a period that lasted one to three months the trained personnel asked the screening questions to 100% of women between the ages of 15–44 seeking health services, whether they be reproductive health services, general services, etc. In general, the use of the tool prolonged the exam an average of three minutes. Interviews with health workers as well as clients revealed that both groups felt comfortable with the questions.

Box 6
When should health personnel suspect violence?

- Anxiety
- Allergies
- Gastritis
- Colitis
- Migraines
- Bumps/bruises
- Malnutrition
- High blood pressure
- Learning problems in children
- Physical problems
- Sexually Transmitted Infections
- Termination of medical visits

Health personnel and clients in El Salvador

The study found that between 12–54% of women clients acknowledged being recent victims of marital abuse. The reproductive health programs generally registered a higher proportion of female victims of violence than the general morbidity programs. Considerable variation in the proportion of women identified as abused was observed among the different health units and even the same municipalities. This implies that identification depends on many factors in addition to the questions themselves. For example, the skill and interest of personnel asking the questions; the level of awareness among the general population; the existence of referral services; and the physical environment in which the exams are carried out (privacy, etc.).

Many providers found the screening exercise to be a very important experience. On one hand it underscored how many clients suffer from violence, even if they don't reveal it as the purpose of their visit. This understanding has motivated many health workers to view their work differently. For example, a psychologist explained,

The textbooks tell me how to treat depression, but now we have begun to change our diagnoses. We see that a patient may suffer from depression; however, it is secondary to the domestic violence problem. With this insight we can find a better approach.

A nurse from El Salvador explained how important it is to know whether a woman is suffering violence before advising her about family planning methods, as the options for an abused woman are more limited:

We try to help women plan, but our problem is that we can't provide monthly injections, which is the only method that can be concealed. If a woman uses an IUD her husband might feel it, and the pills are dangerous because he might find them. If she uses the 3-month injection method she won't get her period and her husband might become suspicious. Sometimes we tell them to have their friends keep their pills so that the husband won't notice.

Another valuable lesson illustrated by the screening exercise was that women are willing to talk about their experiences when personnel ask about them.

I challenged myself to find cases and I realized that it was possible.

Women are waiting for someone to knock on their door, some of them have been waiting for many years...They are grateful for the opportunity to unload their burden.

Sometimes we have to ask the question on a couple of visits. Maybe the first time it comes as a shock, but the second time she begins to trust us.

A woman's reaction depends on the level of trust that we provide. When you first start this process, it feels horrible, but not anymore. The most important thing is to listen to her, and not write at the same time, but rather give her full attention so that you don't lose her.

Lessons Learned

Carrying out an exercise of universal screening is an excellent tool for motivating health personnel to ask about violence and could be implemented in all sites that undertake work related to violence. The screening instrument should include questions on physical, emotional and sexual violence.

After completing the exercise it is important to implement a permanent screening strategy to maintain the accomplishments achieved in the initial exercise.

The screening experience gave staff confidence in their own abilities and motivated them to continue asking about violence, once they realized how common it was, and how grateful women were to be asked. In some centers, general awareness on violence is so high among staff that even the administrative support personnel, for example the cashiers, the cleaning staff and security guards have been trained to identify abused women and to point them in the right direction. Given the positive effects of routine screening, we were surprised to see that the questions were no longer being used routinely in any of the places that we visited. In most centers, after screening exercise was over, staff reverted to using their own methods for screening.

Box 7

When is a good time to ask about violence?

In family planning clinics

We ask if her husband agrees with family planning. If she says no then we know that there are problems.

In the exam I ask her how she feels about family planning and what would happen if he were aware. I let her know that her body belongs to her, even if her husband doesn't want to practice family planning.

You might become aware of [violence] because of a husband's jealousy and control. For example, sometimes they will say that they don't practice family planning "because he doesn't want anyone to see her".

In cancer prevention programs

Sometimes taking a pap smear, I'll see older women with injuries, dryness and bruises from forced sex.

When I see bruises I ask, "What happened here?" The women start to cry and say that they do not go for their routine exams because their husbands keep them locked in the house.

In Physical Therapy

I used to treat women with muscle spasms and I never asked questions. Then I started to realize that many of these cases were due to violence.

In General examinations

I treated a woman that came for a headache. When I asked her, it turned out that her husband had spent the last 3 days sharpening his machete saying that he was going to kill her. The whole time she wondered where he would hit her first. We had to develop a safety plan with her right then because she said she would not be able to return.

In well-child clinic

You shouldn't ask directly [about violence] because they might become afraid. I say, "Are there problems in the house?" "How does the father get along with the children? How do the children get along with each other?" Sometimes there is nothing wrong with the child but I use it as a ploy to talk with the mother.

In Dermatology

After several visits for chronic allergy problems in my hands, the doctor asked me if I was having problems at home and that's when I started to cry.

Health Workers in El Salvador

What if she says yes?

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?"

The prospect of having a woman break down in tears during a routine consultation, as described by a doctor from El Salvador, is what keeps many health professionals from asking about violence. Often they are afraid that they will not know what to do or will not have the time or resources to treat her if she reveals that she is a victim of violence; consequently, they prefer not to ask.

The health personnel that we interviewed found a series of creative responses for treating women with quality and kindness, without unduly disrupting the centers' regular activities.

In Honduras, in the 13 centers that have Family Counseling Centers, the response of personnel is limited to referring the client to the Center. This model, however, does not work for the majority of the health units in Central America, even in Honduras, which do not have mental health personnel.

A strategy that has worked well in sites that do not have specialized personnel is to designate a person responsible for violence in the health unit. For example, at the Chintúc health center in El Salvador, four nurses were trained to provide crisis intervention and basic counseling. On each shift the head nurse makes sure that there is at least one trained employee. As a result, when personnel identify a woman that requires immediate attention they can refer her to a trained staff member. The center prioritizes care for victims of violence so that they can be treated immediately without having to wait in line. To resolve the problem of privacy, some centers, like Chintúc in El Salvador and the health center in Estelí in Nicaragua, have set up special areas for violence counseling. In other cases, administrative offices are used to provide care.

This model is successful in the absence of specialized services; however, its scope is limited. Nurses provide a primary crisis intervention, giving advice and basic information on laws, existing services and how to develop a safety plan. When other services in the community are available, such as women's centers, they give referrals and often coordinate care with the centers. Women are invited to return, however, there is little capacity for providing case follow-ups.

I tell her, "What is happening to you has a name: it is called family violence." Then I give her a brochure and ask her to come back when she is convinced that she needs help.

Sometimes we visit her home but cover it up with other activities such as vaccination.

I can't let her leave while she is still crying, as this will scare off the other patients; I want her to leave smiling; I tell her how brave she is.

Now, I let her get out the last tear because I know this helps her. I refer her for help afterwards, but already she feels relieved.

I tell her, if she wants to cry, she should cry; if she wants to talk, she should talk... When she calms down, we help her to think about what she will do and what options she has.

Often times they feel guilty. I tell them that nothing justifies this treatment... I try to show them that violence is not normal, that they have rights...

Lessons Learned

It is not necessary to have specialized personnel in mental health to provide quality care for victims of violence.

What is essential is to motivate and train staff and to organize services so that women that need support with human quality and in a timely manner.

In our discussions with personnel we observed a very respectful attitude for the clients' decisions. We heard many phrases such as, "she is the owner of her life and she has to make her own decisions." This may be considered a reflection of the quality and impact of the awareness and training workshops.

The technique is similar in the polyclinic of Barrio Lourdes in El Salvador, which has many specialized personnel. The psychologist only intervenes in cases that require specialized care, however, there are various trained individuals to provide crisis counseling and care, including the physical therapist, a special educator and some nurses. They are also the ones that manage the support groups. This center is able to provide much for followup and support to women, however, including individual psychological care and support groups for survivors.

Listening doesn't cost a thing

In terms of what helps a woman most to resolve her violence problems, the Critical Route's informal summary points out,

The activities and interventions that helped affected women in all of the sectors the most included emotional support, precise information on their rights and on procedures, legal guidance and the support for their decision-making.

This is consistent with our interviews with clients and providers. The providers felt that what women most wanted was an opportunity to talk, without fear of being judged.

Just listening to them lifts a huge weight lifted off of their chests. That in itself is a lot.

I like to make women laugh, because sometimes it is important to see the positive side of things. I am not satisfied unless she leaves laughing.

Sometimes women come to us, not expecting us to solve their problems, but rather to be listened to...what they hope for is some advice.

The clients we spoke to expressed the same opinion. A client from El Salvador explained to us that she went to the health center seeking help after she saw a sign in the center that said, “We help victims of domestic violence here.” She told us, “women come here to find someone to listen to them.”

Support Groups

Support groups for survivors of violence have become very popular internationally. In Central America, there are several organizations for example, CEFEMINA in Costa Rica, with extensive experience in self-help or support groups for violence survivors.

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

The PAHO program has tried to promote support groups through staff training and distribution of educational materials. In each one of the countries there is at least one successful pilot experience with support groups. We found, however, a wide disparity in terms of how generalized the support groups are within each country. The success of support groups did not appear to depend on the level of specialized human resources; there were successful groups in one health post managed by an auxiliary nurse, while some centers equipped with specialized mental health teams assured us that it was impossible to establish such groups in their communities. The main reasons they mentioned were:

In rural communities everyone knows one another and they don't want to expose their personal lives to others, because of embarrassment or fear or retaliation by their husbands.

We have no specialized personnel to facilitate the groups.

We tried to create a group but the women did not want to attend; they are not interested.

In the end we got the impression that the success or failure of groups had much more to do with the motivation and skill of the individual health workers than with the community characteristics, or professional training of facilitators. In most countries one or two workshops were held to train facilitators, but they have received little additional training or follow-up support. We believe that the lack of experience of facilitators, coupled with the fear of failure, are significant barriers for the success of the support groups. Nevertheless, in the sites where support groups operate, the personnel as well as the participants assured us that it is a very helpful technique for survivors of violence.

The most comprehensive experience that we saw was at the polyclinic of Barrio Lourdes in El Salvador, where various support groups for survivors of violence are managed, including one for elderly women. What makes this experience noteworthy is that the groups are run by a physical therapist and special education specialist, although the center has several psychologists on staff. The facilitators were chosen not for their professional background but because of their interest in the topic and their ability to develop trust with people. An auxiliary nurse from Guazapa described her experience,

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

A Guatemalan psychologist remarked that group care gives better results than individual counseling because of the bonds that are created among the women.

The solidarity of the women is admirable. They give each other ideas for moving forward. Group sessions produce better results. After a few sessions they start telling each other, “have you tried such and such? Personally, the group helped me to understand them and to see how the others talk to them with great wisdom...

Box 9

What advice would you give abused women?

- Go to the health center to be listened to
- Love your children
- You need to want a change.
- That she matters and is important
- To be independent
- Know your rights

Support group women, El Salvador

The important thing is that the groups are anonymous; not everyone knows one another. You don't have to be Superman to facilitate a group, instead begin with patience and don't scold them...The main ground rule of the group is that “we are not here to gossip, but to work on our problems.

These considerations coincide with the opinions of the women that have participated in the groups:

I used to think that death was the only way out. I wanted to die but I couldn't kill myself because of my children... I thought it was my fault that he hit me. Here, I learned that it's no so... my self-esteem was very low, here they teach us to love ourselves... (Colonia Kennedy, Honduras)

I used to be very shy. I was enslaved in the house... Now, thanks to the group I feel liberated. (Comayagua, Honduras)

What helped me was to realize that I wasn't alone. There are many of us who feel trapped and silenced inside ourselves. Learning about laws and communicating among ourselves were very important. (Colonia Kennedy, Honduras)

Lessons Learned

Support groups can be an a useful technique for helping violence survivors. Nevertheless, health personnel need more training and support to become effective facilitators

Box 8

What we learned in support groups:

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

Support group, Barrio Lourdes, El Salvador

Sometimes I break down with them...

Reactions of health personnel towards violence

It is difficult to overestimate the impact on staff that care for victims of violence. “We’ve all had moments when the floor moves underneath us” acknowledged a Salvadoran psychologist. Many mentioned effects ranging from being worn out emotionally to fear of retaliation by aggressors, to frustration with women “who do not obey our orientations”. The stories of rapes, humiliation, injuries, and death threats leave physical and emotional scars on those that listen to them. As Claramunt pointed out, “trauma is contagious” and can manifest itself in emotional problems: depression, anxiety, fear or insensitivity to the pain of those suffering. It can also be exhibited in physical symptoms like chronic exhaustion, chronic pain, gastric problems or changes in sleeping patterns (Claramunt 1999). In Box 5 we present some of the reactions described by health personnel that have cared for victims of violence.

In some places, concern for physical safety must be added to the list of potential risks faced by providers. In Guatemala we heard dramatic evidence of the dangers that providers face. In one case, masked men attacked an NGO that managed a shelter for survivors of violence and raped several members of its team. The shelter eventually closed down. Naturally, these experiences create fear among personnel. A Guatemalan nurse told us, “Sometimes you feel afraid because a woman might reveal to her husband what you talked about during the exam.” Another nurse recalled treating a woman while her armed husband stalked outside the center looking for her:

I felt unsafe; I thought when is this man going to look for me?

A psychologist from Guatemala City told us,

Once you get involved in this, you know you are on your own, as there is no protection for us. I’ve learned that it’s better just to relax, because if you become afraid, you won’t be able to go on.

Although caring for violence cases is very draining, many providers also mentioned positive experiences in their personal and professional lives. More than one person noted that the awareness workshops helped them to overcome their own experiences of violence. In our discussions, personal achievements were talked about. For example,

This health unit works very well. It is like wiping away the dirt to see yourself in the mirror.

The awareness helped us get to know one another better and to have more consideration for each other.

Box 10

How do providers feel when they encounter violence?

In the beginning, I used to cry along with them...

I wanted to apply my own judgments.

I feel as though asking them questions is like revictimizing them.

Sometimes I feel angry with the both of them; I wish I could make her understand.

Sometimes I feel powerless and I don’t know how to help her.

Sometimes we are overwhelmed with our patients’ problems. We want to help them to wake up and react. We would like to see them move out of the situation because the way out is clear to us.

Sometime I wish I could make the decision for her, or tell her to leave him. But you can’t tell someone what to do.

The day before my vacation my last patient arrived with bruises and her daughter had strangulation marks on her neck. I got a lump in my throat and forgot everything I had been taught. I went home praying to God that he wouldn’t kill her while I was on vacation.

Three or four months after coming here and before I received training I had a case of a woman who had been beaten by her husband and raped by her older brother when she was 7 years-old. Her situation really got to me and I wasn’t able to sleep for several days.

Health workers, El Salvador

Self-help measures are considered by experts to be essential for providers that care for victims of violence. Self-help refers to any kind of activities meant to reduce stress and anxiety, including recreation or sessions for discussing the feelings and emotions that result from their work. Among the health centers that we visited we only found one center that mentioned holding occasional self-help activities. In other places, providers indicated that they feel that self-help activities are very important but that they have not been implemented. It is worth mentioning that PAHO has already developed a very complete guide for self-help training (Claramunt 1999); however, it is not widely known.

Lessons Learned

Self-care activities for health personnel are an essential part of the model of care for violence. They should be included in norms and implemented at the local level.

Box 11

You never expect your wife to do this to you... Honduran Men's Group

We interviewed 30 men in a group for offenders run by the Family Counseling Center of Colonia Kennedy, Tegucigalpa. These men attend a weekly 2-hour session for 8 weeks. All of them were ordered by the court to attend. They acknowledged that they would not have participated in the group if they had not been forced to. Most felt they had been victimized by the justice system. Only one man admitted to having ever hit his wife. Another man told us that he had reported his wife by employing the family violence law, "because she harassed me too much" and the judge required him to attend the groups.

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

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

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

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

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

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

I felt some hatred towards women before this (due to previous abuse by his mother). Then, thank God, my wife turned me in and now my life is different; I've left that burden behind.

What about the men?

Many of the people we interviewed mentioned a need to deal with male offenders, pointing out that it would be impossible to eliminate violence against women if the attitudes and behavior of violent men are not changed.

According to the providers, abused women often request help for their husbands – someone to give them advice and counseling, and to help them to change. These women do not want to end their relationships; what they want is for the violence to end. This is one of the reasons why out-of-court settlements are requested more frequently than criminal prosecution.

This desire, however, raises a series of dilemmas:

Is it really feasible to transform a lifetime of violent learning and behavior?

Is it sufficient to reduce physical violence if other forms of violence persist, for example emotional violence?

Who should be responsible for carrying out this work – the health sector or the justice system?

There aren't many successful experiences in the world that can provide guidelines for responding to these questions. In the United States, there are many batterers' treatment programs that include a variety of theoretical and programmatic

approaches. The majority of the programs last from 8–12 weeks. The participants are sent as an alternative sentence by the courts. Few evaluations have been conducted to measure the effectiveness of the programs. Results indicate that approximately half of the men drop out before finishing the course. Of those that complete the course, approximately half of them stop using physical violence, at least for some period of time. However, in many cases they continue to display other forms of violent and/or controlling practices. One key for success is the participant's motivation. Not surprisingly, men who participate voluntarily (for example, because they don't want to lose their relationship or because they feel bad about themselves) are more likely to change than those who attend as a form of punishment.

In Central America, there are few programs for batterers. In Honduras and Panama, family violence laws require the health sector to provide care for offenders and attending a batterers' treatment program may be used by the courts as an alternative sentence. In Honduras, we visited a program for male batterers, and we also interviewed the wives of some of the participants (See Box 11). Our brief impression was that some men were using the opportunity to reflect, while others were just "counting the hours" until their sentence was completed. The wives described positive changes in their husbands as a result of the program, although one woman confessed, "I still feel afraid of him".

The team has several concerns regarding the laws requiring the health system to treat offenders:

- No additional resources are allocated for these services; therefore, there is the risk of diverting funds that would otherwise be available for attending victims.
- The Honduran law establishes a kind of symmetry between male offenders and female survivors, since women are also obliged to attend counseling sessions, with the goal of "increasing their self-esteem". Just as the offenders, they can be sanctioned with community service if they fail to attend. Although, the intention of the measure is positive, we feel that the victim of a crime cannot not be obliged to receive treatment against her will; particularly as this goes against the main goal of care for survivors, that is, to strengthen her sense of personal autonomy. Moreover, it was evident in our discussions with offenders that they viewed this measure as an acknowledgment that both are equally responsible for the violence.
- The lack of norms and trained personnel for the treatment of offenders may result in jeopardizing women's safety
- There is no consensus among mental health professionals in the region (or elsewhere) regarding the theoretical and methodological guidelines for treating male offenders.
- There is little capacity for case follow-up to determine the effectiveness of the programs.

A Nicaraguan group, The Association of Men against Violence, which has received support from PAHO, has developed an innovative proposal to work with "men that have problems with power and control in their intimate relationships." This group explicitly addresses the problem of power and control because it considers male violence as merely one manifestation of relationships based on the subordination of one partner by another. By focusing on power and control, this approach attempts to avoid eliminating violent conduct of men, only to be replaced by other more subtle forms of domination. This program proposes working with male volunteers that have not already been prosecuted or sentenced for assault. In other words, they have selected as a target group, men that presumably are somewhat more likely to accept messages of equality than men who have entered into the justice system would.

This proposal establishes a clear difference between the male discussion groups and the offenders' groups; therefore, they feel that each should have a different methodology.

Instead of stimulating reflection among participants, as is the main purpose of the men's discussion groups, the priority for the groups for offenders is "the security of women and children. [The program's goal] is to treat men in order to first benefit women and children and then men."

Men as allies

Another important challenge is to ensure that care for family violence is regarded as an obligation for all health professionals and not as a activity that only involves female providers. We found some notable cases where male doctors had become strong allies of the violence program. For example in the health center of Estelí, one of the main counselors is a man. In El Salvador, a nurse acknowledged,

It does not matter whether it is a man or a woman who does the screening. In Guazapa, there is a male doctor who refers more cases than anyone else...It really depends on how sensitive you are ...

Nevertheless, these cases represent the exception rather than the norm. In all of the countries we visited, female providers spoke of difficulties in getting male professionals interested in the topic. In general, they feel that men are resistant toward the topic of violence. A study conducted by PAHO and Nicaragua's Ministry of Health noted that male professionals feel on the "defensive" and sometimes resist participating in violence training session for fear of being "singled out" or attacked.

This study, performed by the 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 (Montoya 2001).

In their discussions with health professionals, several male doctors acknowledged having been violent with their partners and several women disclosed having been victims of violence. The researchers concluded that,

These testimonies show the importance, not only of giving technical training to health providers on violence, but also of providing them with the opportunity to reflect on their own life experiences related to violence...

This study suggests the importance of creating opportunities for reflection among men to overcome some of the prevailing cultural barriers. Some awareness building activities specifically for male health workers have been initiated in several countries, with PAHO support. We feel that these activities contribute to the institutionalization of the violence program and should be encouraged.

Perceptions of providers of the quality of care offered to women affected by violence

The providers at the centers that have achieved a certain level of development in their violence prevention program expressed a great deal of pride and satisfaction in their program (see Box 12 for a list of topics most frequently mentioned). Above all, providers referred to improvements in the quality of care overall, and not only with regard to violence.

People tell us that this center is different, it is warmer... they come here because we listen to them...

Another achievement mentioned by several providers was a transformation in the role of health workers and particularly the empowerment of nurses:

Nurses have become aware of this issue. They understand that their job is more than taking someone's blood pressure or drawing blood. Breaking out of the traditional mold in every area was a big development.

We had to sensitize ourselves to avoid being aggressors ourselves in relation to the women. This was a major stumbling block to understand and overcome.

Additionally, providers mentioned changes in community relations and the sensitization of the population towards violence:

We are closer to the community now. People go to the health centers more often. Our users have become our best promoters.

People are familiar with the laws and know that they are protected. Nowadays women are no longer afraid to report violence.

In terms of the barriers faced by personnel with respect to violence-related care, the majority have to do with the work environment (lack of privacy, time pressures, productivity) or with administrative concerns, such as the lack of senior-level support.

The lack of accepted norms and information and epidemiological surveillance systems was a constraint mentioned by many of the providers. Better reporting of cases of violence registered within the health system would help justify the time that is devoted to caring for survivors, as well as demonstrating that violence is an important health problem.

Beyond the clinic: Community networks for violence prevention

Among the challenges revealed for consolidating the model of integral care is the consolidation of the *referral* and *counter-referral systems* between the different institutions and organizations involved in the care for intrafamily violence problems.

Some of these institutions are part of local networks, which facilitates communication and problem-solving between them. However, not all of the state institutions working with intrafamily violence issues actively participate in the networks or local committees.

The level of leadership of different types of organizations in the networks varies among locations. However, in all of the countries women's organizations and groups have played a key role in consolidating the networks. Aside from these groups, different sectors have played important roles in specific countries: for example, the National Police Force, through the Women and Children's Police Stations, have been the main force in Nicaragua, whereas in Costa Rica, Panama and Belize the health sectors have played a prominent role.

The absence of mechanisms for referrals and counter-referrals at a national level is seen as a major constraint to consolidation of the networks. Despite this we found that local initiatives have emerged in many communities to improve coordination.

To improve the referral and counter-referral system would help enormously to help women maneuver their way through the enormously complicated and duplicative procedures that exist in each institution.

With regard to the local networks, although efforts have been made in all the countries to improve coordination between different stakeholders, Nicaragua has the most consolidated networks. This is partly because local commissions have been functioning for several years, together with the Women and Children's Police Stations. In most regions of Nicaragua the participation of the Ministry of Health is fairly recent. In the other countries we visited the networks have had more difficulty maintaining regular meetings, and joint work plans.

Box 12
Care for victims of family violence
Strengths and constraints most often mentioned by health workers

Strengths	Constraints
Within the health services • Violence is recognized as a health problem that is related to other causes of disease • Greater credibility and respect among health personnel • Overall improvements in the quality of care • Changes in the providers' attitudes • Having physical spaces to care for victims in the health center • More integrated services for family violence • To have basic tools for addressing violence • Financial support from PAHO In relation to the community • We are closer to the community now • Better coordination with the police and district attorney's offices • Increased client demand for services • The population is more aware about violence At a personal level • Satisfaction for being able to help others • Staff have acquired new skills and knowledge	With the health services • Lack of approval and dissemination of norms and protocols • High staff turnover • Work overload • Not having enough time to attend to clients' needs adequately • Lack of paper supplies • Limitation in the registry/epidemiological surveillance systems • Not all staff are interested in the subject • Lack of a permanent plan for communication and information • Lack of self-care activities • Lack of adequate spaces for guaranteeing privacy • Lack of financial resources for training and follow-up of cases • Lack of support from some clinic directors • Staff don't train others after they have received training (this may be a problem in the selection of trainees) • Lack of trained mental health resources Lack of training materials. • Lack of informational/promotional materials (posters, pamphlets, etc.) At a community level • The attitudes of some clients (not accepting that they live with violence, unwilling to accept help) • Problems in coordination and referrals • Problems with the justice systems (laws are not enforced)

Another important initiative that has taken place in all of the countries has been training for community leaders (midwives, legal promoters, health leaders, etc.) to promote non-violent relationships and to refer victims of violence to the health services. The types of activities performed by the community leaders varies among the countries; in some communities they only refer cases to the police or health centers, whereas in other settings they have been trained to offer crisis intervention and legal counseling and even to accompany women through the legal process. In general these experiences have been very positive and have brought the clinics closer to the community. However, we also noted the importance of clear definitions of roles and responsibilities of all participants in order to avoid misunderstandings. In Guatemala we visited a community program initiated by the health center that was very successful at first, but later, difficulties between the health workers and the promoters led to a serious break-down in communication and the virtual disbanding of the group. One of the promoters lamented,

They brought us this program and we accepted it. Afterwards we had disagreements with the health center and we lost our locale and our furniture...Now we are full of fear and contradictions; the group is divided (violence promoter, Guatemala)

Lesson Learned

Community health leaders have a crucial role to play in violence prevention, both by promoting non-violent relationships, by informing the community and women in particular about their legal and social rights, and by providing information and appropriate referrals to abused women.

It is crucial to develop clear definitions of the roles and responsibilities of all actors, as well as regular meetings and feedback to ensure that community volunteers are receiving necessary support.

Some of the health workers familiar with the situation felt that part of the problem was that in the beginning, the health promoters received more training than the health providers themselves, and therefore, they took on a leadership role without the necessary support of the health personnel, and without having all the necessary skills to carry out their work. This experience, although painful, shows how important it is that community based programs be developed jointly between providers and the community, and based on local conditions, rather than being imposed from above.

VII Violence Information and Surveillance Systems

What doesn't get registered doesn't exist

Over the years, the PAHO project has paid a great deal of attention to the development of violence registration systems within the ministries of health, as a tool for evaluating programs and guiding future interventions.

In our field visits we found some kind of registration system in place in each of the pilot health centers. 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 patients living with violence are anxious to have an official registration system, so that violence becomes a more legitimate activity, and to justify the time that is spent on care for violence patients, since this activity is not included in their performance evaluations. Providers feel pressured by the desire to give quality care, and the need to fulfill productivity targets demanded by the health services.

In Nicaragua and El Salvador, health workers fill out registration forms, and send them to the regional offices, where they usually get 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 nor in the epidemiological surveillance system.

We did not see any instances where the service records were analyzed locally, or used for local planning. We also did not see feedback between national level and local.

We believe this is a generalized problem that affect not only violence work, but also other health programs such as malaria or dengue. Although there are general weaknesses in the flow of information, in the case of violence it is probably even worse,

There are violence surveillance systems set up in Belize and Panama. In Costa Rica, Nicaragua and El Salvador there are proposals for surveillance systems on violence, but they have not yet been implemented. The 10th International Classification of Disease, ICD 10 is being used in Costa Rica, Panama, Belize and Nicaragua.

One problem we noted is that the information resulting from the surveillance systems is not uniform among the countries. Some countries report only on the type of violence, for example, without including information on the age and sex of the victim, or relationship to the offender. In other cases, enormous amounts of information are collected on victims and offenders, but it is not consolidated or used. This makes it difficult to compare statistics throughout the region. We recommend that a set of key variables and indicators be developed and that all countries be encouraged to use them (Appendix 6 provides additional information about information systems on violence.)

Challenges of the violence information systems

Why do we need information?

Lesson Learned

The forms for a health surveillance system should be as simple as possible: they should be flexible, acceptable, timely and with enough sensitivity to detect the problem under study.

Collecting and synthesizing data on violence within the health services is crucial for demonstrating that gender based violence is a significant health problem and cause of morbidity. Moreover, it provides insights as to what groups and communities are at greatest risk, and to understand risk and protective factors, as well as evaluating the quality of interventions. A police captain in Nicaragua noted,

With our services and the reports of the Comisaria we can demonstrate that insecurity is greater at home than on the streets. (Police Chinandega, Nicaragua)

In all the countries where there are registration systems, the use of information appears to be limited. Although data are collected and sent on to regional and national authorities, but there is little analysis of the information or feedback to the health centers.

Implementing an information and surveillance system

The initial start of the registration systems in Panama, El Salvador and Belize demonstrated that it is impossible to consider the information system as a separate entity from the development of the care model. Information is an essential part of the model and requires norms and protocols for the care of family violence at the same time. In a few instances we found very elaborate systems for recording and analyzing violence statistics, but because providers were not trained to identify victims of violence, virtually no cases of violence were detected. Situations such as this are actually counter-productive, because they give a false impression that violence is not an important problem for the health system.

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

The Unified Form

In Panama, Belize, and Guatemala (under discussion) there is a single registration system that is meant to be used by all sectors that come into contact with victims, for example, the Ministries of Health, the policy, judges, forensic doctors, NGOs, etc. In Belize, the Ministry of Health is responsible for consolidating, processing and analyzing the information and afterwards reporting to the rest of the ministries. In Panama, the information is sent to the Legal Medicine Institute for analysis.

It is important to note that filling out the form itself is not the same as a filing a legal report. The purpose is to collect statistical information, not to set a criminal case into action. However, in Panama and in the proposal in Guatemala, filing out the registration form is equivalent to filing a criminal report.

Mandatory Reporting

Family Violence is considered “a health risk which must be reported” in the justice systems of Guatemala and Panama. In the cases of sexual violence against minors, there is also mandatory reporting in the majority of countries.

Mandatory reporting presents an ethical dilemma to providers, as it conflicts with a patient's right to confidentiality, as well as the right of clients to decide how to deal with the violence, which is one of the guiding principles of the model of care in family violence being implemented in the sub-region. In places where mandatory reporting is enforced, fines may be imposed on health personnel and other civil servants, although it is not clear how this will be enforced.

We believe that mandatory reporting will exacerbate the problem of under-reporting of family violence and will result in women being more reluctant to disclose violence, and for providers to ask about violence.

We heard many negative comments from providers about mandatory reporting of cases of violence. For example:

The fear of victims and survivors that providers will report the case to the authorities against their will.

Providers are reluctant to ask of document violence, for fear of the legal consequences of the report, such as becoming involved in court battles. or witness, or being placed at risk their lives by threat of the offender.

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.

Lesson learned:

The information and surveillance systems are an essential part of the model of care for family violence, and should not be developed in isolation from the development of services. For the system to work, it is important to develop norms and protocols for the care of victims, before implementing the reporting system.

The information systems are only valid if the data are used to improve services. There is an ethical contradiction in collecting information or active screening with the sole purpose of information, and not offering services in return.

VIII Conclusions and Recommendations

Project Strengths

The evaluation team found the following aspects to be the main strengths of the project:

- The project has increased the visibility of domestic violence as a public health concern and has promoted the development of public policies that address the problem in each of the countries of the sub-region.
- The project has provided technical and financial support for the development of technical proposals for policies and procedures to address domestic violence in all the countries. In four countries (Belize, Costa Rica, Panama and Nicaragua) they have been approved.
- The project has provided technical and financial support for the development of proposals for registration and monitoring systems for domestic violence in all of the countries. Registration formats exist and are functioning in all of the selected communities of the project. National monitoring systems have been approved and implemented in two countries (Belize and Panama). Costa Rica and Nicaragua have a monitoring proposal and a proposal for a unified violence registration system has been drafted in Guatemala, El Salvador and Honduras.
- The project carried out a study in four countries to show the feasibility of screening to detect victims and survivors of domestic violence.
- The project has encouraged the sharing of experiences for a health sector approach to family violence care, among the sub-regional and Andean countries.
- The project has developed an operations research methodology, The Critical Route, to achieve a rapid assessment at the local level based on the responses of the various stakeholders in the field.
- The project has succeeded in integrating gender and violence issues laterally into other PAHO programs in some countries. This contributed to leveraging additional resources to maximize impact. Among the countries visited by the review team this was particularly noticeable in Nicaragua and El Salvador.
- The project has promoted reflection on men's roles in violence prevention among male health personnel in all countries, particularly in Nicaragua, as a strategy to improve the health sector response to violence prevention.
- The project prompted discussions regarding the inclusion of a gender and violence module in the Schools of Public Health and Regional Master's of Sexual and Reproductive Health program of the sub-region. It also succeeded in having a gender and violence component incorporated into the curricula of primary schools and nursing schools in Belize and Panama.
- The project, together with other international agencies, contributed technical and financial support for the creation of multi-sectoral commissions that deal with domestic violence at the community, local and national levels in the respective countries.
- The project, in collaboration with other agencies and international NGOs, contributed to the analysis of and proposals for laws and public policies on domestic violence and promoted the follow-up for implementation at the sub-regional level.

In addition, at the country level:

- National programs have been implemented in all the countries to sensitize health personnel to issues of violence.
- In communities selected by the project, a large number of health personnel participating in the domestic violence program have been trained to detect and refer victims of violence.
- In most of the countries, increased access to the project has been achieved by integrating more health units and regions. In some cases this has been achieved with the support of PAHO's health sector reform projects (Nicaragua, El Salvador, Honduras, Costa Rica).
- Additional funds from PAHO and other agencies have been leveraged in the majority of countries to expand the project based on the same model of care.
- Services for domestic violence have successfully been integrated into country health sector reforms so that they are included as part of the basic health services package in Belize, Costa Rica, Nicaragua and Panama.
- Five training modules have been developed, with technical and financial support from PAHO: *Feeling, Thinking and Confronting Domestic Violence* on behalf of the PLANIVI commission, Costa Rica. These materials have been used for training in most of the other countries in the sub-region.
- Domestic violence has gained a place on the health agenda of Central America through the Ministers of Health Meeting (RESSCAD). Coordination with other policy programs (First Ladies Meeting etc.) of the sub-region was also promoted.
- Improved coordination between state institutions and civil society was achieved in programs where there had been little prior experience.

Challenges

The following issues were identified as the project's main challenges:

- The lack of political will in some countries, to implement and extend care for domestic violence throughout the health services.
- In those countries where the violence program is located in the mental health programs of the Ministries of Health, as is the case of Honduras and Guatemala, the team considered this approach to be a limitation for achieving greater impact and integration into the rest of health services.
- In several countries, policies and procedures for domestic violence have been proposed but never officially approved, or approved only recently. The lack of norms makes it difficult to assure uniformity in the type and quality of services, as well as to develop indicators for evaluating the quality of care.
- Internal coordination among the different areas of the health sector involved in the program (epidemiology, information and planning, reproductive health, mental health, etc.) is considered weak in Nicaragua, Guatemala, El Salvador, and Honduras; less so in Costa Rica, Belize and Panama.

In terms of information systems, the lack of coordination and implementation of the systems among the different program areas is an obstacle for the institutionalization of the program and for highlighting the real magnitude of the problem. This is a constraint for decision-making and prioritizing activities.

- Among the countries, inequities in coverage, methodology, monitoring and evaluation, and replication plans were observed in terms of the quality and content of technical training.
- Continual personnel turnover in some cases the absence of national counterparts, over long periods, has hindered the national process of developing the model of care due to the lack of continuity and institutional memory.

Technical and financial support offered by PAHO has had significant gaps in Honduras, in part due to the absence of a focal point of the Program for Women, Health and Development. This has hindered coordination with national counterparts.

- In all the countries visited the team considered that there was a lack of materials for creating awareness, training and social mobilization.

In the PAHO offices located in El Salvador and Nicaragua, the team observed excellent coordination between the violence program and other technical support programs, for example the health reform projects. This has greatly facilitated the consolidation of the model and scaling up to other regions. In Honduras, Guatemala and Costa Rica, this kind of coordination appeared to be weaker.

In the majority of the countries, community networks have been created or strengthened in the communities where the program is established. The strongest networks exist in Nicaragua, whereas, in Guatemala and Honduras, prevailing political and institutional conditions have made coordination more difficult.

In all the countries visited the team considered that there was a lack of materials for creating awareness, training and social mobilization.

Sustainability of the Model

The sustainability of the model of care for domestic violence should be assessed from various viewpoints: institutional, financial and social. Our main conclusions regarding this concern are the following:

Institutional sustainability

One parameter for assessing institutional sustainability is the degree of acceptance of the model at the level of the Ministries of Health. Clearly, the issue of violence has achieved some level of prominence at the regional level, as evidenced by events such as the *Gender Violence, Health and Human Rights of the Americas Symposium*, recently held in Cancún, Mexico. Nevertheless, we believe that the family violence program remains vulnerable to political changes in those countries that have not approved official policies and protocols.

Another way to assess institutional sustainability is the degree of acceptance by frontline health personnel. In the pilot communities we visited we found a very positive attitudes towards to program. The real challenge is to scale up the pilot programs into national policies.

In most countries we noted greater enthusiasm at the local level than at national level. This is very positive because this means that pressure to adopt official guidelines is more likely to come from civil society and from Ministry of Health personnel and not be perceived as an imposed from international agencies.

The countries that have been most successful in terms of expanding the model to other regions are Nicaragua, El Salvador, Costa Rica and Panama. In our opinion, Guatemala and Honduras are in relatively weaker situations in institutional terms.

Another aspect that should be assessed is to what degree the program is institutionalized within PAHO itself. In this respect, we observed some differences in the technical follow-up provided by the different PAHO field offices. Additionally, there was a difference in the degree of lateral integration of gender issued in general and violence specifically into other PAHO programs. An example of this is the situation of Honduras which remained without a focal point for almost a year. During this period project payments were not fulfilled; consequently, this resulted in program delays and disagreements among the national counterparts. The PAHO offices in Nicaragua and El Salvador have had the most success in this regard, particularly as it relates to linking the domestic violence program and health sector reforms.

Financial Sustainability

In terms of financing, the Ministries of Health in Costa Rica, Panama and Honduras have designated national resources for the establishment of the program. In Honduras it is important to note that 20 mental health staff have been allocated by the Ministry of Health for the Family Counseling Program. This ensures a good degree of sustainability for the family violence activities overall. Nevertheless, all of the countries lack funds for carrying out personnel training, and other activities such as case follow-up and supervision, as well as the necessary supplies for implementing the model.

Financial sustainability continues to depend on international support to a great extent. A successful result of the projects is the degree to which additional resources for family violence care have been leveraged from other donors. For example, in the case of Nicaragua, this is illustrated in the amount of resources of other agencies and projects (SAREM, GTZ, PROSILAIS) which have enabled the Ministry of Health to expand the model to other regions.

Social Sustainability

Social sustainability depends to a great extent on the level of organization and degree of awareness that exists among the population concerning violence. Of the countries we visited, Nicaragua is the country with the greatest degree of social sustainability. This is largely due to the history of Nicaragua where there is a strong tradition of social mobilization and where violence against women has been a high visibility issue for many years. Another important element is that, unlike many other countries in the sub-region, the Nicaraguan health sector has extensive experience in coordinating with community groups and other state institutions on issues of mutual concern (promoting breastfeeding, reducing maternal mortality, etc.) Furthermore, there are many other strong state programs related to domestic violence, such as the Comisarias for Women and Children. An example of sustainability that we observed was that services continued to be provided for victims of violence through the volunteer work of many activists and local contributions from the Ministries, despite the discontinuation of international financing for over more than a year.

In other countries that we visited we observed important improvement in terms of general awareness and commitment among civil servants concerning family violence. However, due to historical characteristics of each of the countries, the overall sustainability of the initiatives seems more precarious. For example, the situation of Guatemala is very unique, in that the enormous levels of social violence overall do not allow much room for discussion on domestic violence. Added to this is the lack of experience in coordination between the state and civil society. Accordingly it is not realistic to set similar goals for each of the countries, as each one has specific conditions that need to be considered.

Recommendations

In light of the previous discussion, our recommendations for the future of the project are the following:

International Cooperation

- The project has made important progress in its development; however, the model of care is still not completely consolidated at the country level. As a result, we feel that the project needs a new period of cooperation.
- In the case of Swedish cooperation, which is currently in the process of being reoriented to bilateral agreements with specific countries, we recommend the following:
 - A specific objective and budget should be included in the bilateral agreements to support follow-up activities to the domestic violence program.
 - In these countries the violence project should prioritize scaling up in the regions that are targeted by the bi-lateral programs.
 - Include the following issues in policy discussions with recipient governments: adoption of policies and protocols for the care of victims of violence, establishment of internal coordination within the Ministries of Health regarding violence related activities, implementation of information systems and monitoring of violence and training plans.
- In the case of the Norwegian cooperation, we recommend renewing the sub-regional support of the program, with an emphasis on the aspects that are pointed out in the following sections.

Technical Cooperation

- Despite the likely reduction in the total amount of funds available at the sub-regional level, we believe that it is a priority to maintain a level of minimal technical attention for all the countries, including countries that are not prioritized by the Nordic cooperation. We believe that it is essential to maintain the presence of the focal points in each of the countries to assure follow-up and technical support for activities.
- In order to ensure the overall coherence of the model at a sub-regional level, and to take advantage of the experiences of all the countries, we suggest that exchanges and technical training continue to be implemented at a sub-regional level with the participation of all of the countries.
- During the next period, we suggest that priority be given to consolidating the components of the Model of Care that were identified as weak or incomplete through exchanges, workshops and internships. We recommend accomplishing this by encouraging that the facilitation of activities be led by one or more local organizations that have expertise on specific topics. This would contribute to strengthening national organizations, while supporting the establishment and theoretical and methodological coherence of the project at the sub-regional level. Examples of issues that would lend themselves to this approach could be working with men, social communication, monitoring and information systems, and facilitation of support groups.
- Expand the concept of family violence to a concept of gender-based violence in order to address other types of violence such as sexual assault, and child sexual abuse. This does not imply that other aspects of family violence (e.g., abuse of the elderly) can not be addressed as well.

- Promote increased lateral integration gender and violence issues into other PAHO programs at the country level.
- Promote a screening policy for violence in health services, based on an analysis of sub-regional experiences, and include identification of sexual violence.
- Maintain a dialogue with the countries to attain the adoption of policies and protocols, as well as the development of information and surveillance systems.
- Prioritize publishing and dissemination of training and awareness materials for health personnel, as well as behavior change and communication materials such as posters, brochures, etc.
- Increase emphasis on community promotion, including strengthening community networks and technical support in areas that have had the most difficulty.
- Create a training model, following the example in Nicaragua, using regional “teaching centers” to take advantage of the experiences of the most specialized centers, who can then provide training and technical assistance to newer centers
- Promote alliances between the different cooperating agencies and inter-agencies that are working on domestic violence in the sub-region to maximize resources and share successful experiences.
- Promote in each country the establishment of institutional and professional directories to facilitate referrals for women by health providers.
- Propose the use of common indicators for use by the information systems in each country in order to enable comparisons between the countries.
- Promote the use of the information that is collected in the information systems for local planning and dissemination.

Appendix

Terms of Reference

External Review of the Project Towards an Integrated Model of Care of Intrafamily Violence in Central America Project PAHO/WHO

Background:

Since the beginning of the 1990s, PAHO/WHO's Women's Health and Development Program (HDW) has played a lead role in working with 42 municipalities in 10 Latin American countries to implement a participatory, intersectoral, community-based model for addressing domestic violence. This model was designed to function at three levels:

- the macro level – through the development of public policies and legislation;
- the sectoral level – through the establishment of norms and guidelines; and
- the micro level – working within the community to offer integrated actions aimed at women in need and their families, the offenders, and the community in general.

Initially developed in Central America with funding from the Swedish and Norwegian governments, the model has also been applied in three Andean nations (Peru, Bolivia and Ecuador) and by the IDB in six other countries in the region.

The network in each municipality plans, implements and monitors its own community based efforts and referral systems. In some countries the networks have been replicated at regional and national levels with members from local networks and national organisations, to influence policy and institutionalise efforts.

Project outcomes include: training modules for health care providers, police and judicial system; situation analysis tools, including an instrument for identifying the services and people that women access in “the Critical Route that Women take in Dealing with Family Violence”; referral and information systems; national media campaigns and materials; advocacy materials and meetings; national norms and procedures; support groups for battered women and for perpetrators. The project is currently in its second phase to expand the model to other regions of each country and to institutionalise its achievements at the national level. The purpose of the second stage is to make the process sustainable and incorporate it in the reform efforts in the seven Central American countries through application in 30 selected communities.

The intersectoral, community-based model has the following components:

1. Health services serve as initial detection point for women living in violent situations. Health care providers are trained to screen women during routine primary and reproductive health care visits and to apply protocol to assure quality service and data collection. In some cases providers are trained to collect judicial evidence.
2. A task force with representatives from PAHO/WHO, the Ministry of Health and NGOs apply a situation analysis in the community to assess the prevalence of domestic violence, using available data from the health and judicial system, police, existing surveys. They also apply “the Critical Route that Women take to Deal with Domestic Violence” instrument to identify organisations and people who help women address their situation.

3. Based on this information, health sector workers mobilise community organisations and leaders to form support and service networks. These networks may consist of the police, judicial systems, community leaders, NGOs, women's organisations, schools, churches hospitals, etc.; the mix varies according to community.
4. Each network meets regularly to plan, implement, monitor and co-ordinate activities that address the needs of abused women and their families. Intersectorial referral/information networks, training programs and support groups are set up to assure that women get quality care within their communities
5. Replication of networks at regional and national levels with representatives of local networks, national public (ministry of health, women's ministry and focal points, ministry of labour, education, welfare) and civil sector. These networks advocate for policies (training, norms, information systems), legislation and resources that address domestic violence at the national, regional and local levels.

The success of this model has been documented in various reports that have focused on the type and number of activities undertaken in the participant countries. However, there is little information regarding its effect on community users and providers, its integration into the health sector and its contribution to policies and legislation.

During the 2000 Annual Nordic Consultations, PAHO/WHO, NORAD and Sida agreed to the need of carrying out an external Review of the project.

Purpose:

The study should primarily give the donors an overall picture of the advances of the project, impact, efficiency and sustainability of the project achievements, and secondarily to provide feedback to the participating groups and other interested in the subject matter.

The review shall focus on the efficiency (main accomplishments), effectiveness and lessons learned; assess the needs for a follow-up in each country and the level of sustainability of the project achievements in each country. It should be noted that it is not the task of the review team to measure the short term or long term impact of the programme. Should, however, such data be available from other sources it should be taken into account in the review.

Scope of work:

The review team shall analyse the progress of the project in all seven Central American countries with special emphasis on the following aspects:

1. Policy level – assess the implementation of policy and legislation on the national level.
2. Health sector level – assess the institutionalisation of the model and the application of norms and protocol for the detection and prevention of intrafamily violence at national, regional and local level.
3. Community level- assess the model on local level including the development of local networks with the police, schools, churches, health personnel, NGO's, etc.
4. Assess the policy and content of training in comprehensive care on national, regional and local level.
5. Assess the extent of the incorporation of the model on local level in 15 selected communities.

In order to complement the broad picture on how the project has progressed the review shall give an in-depth view on how the projects has developed in six selected communities in three selected countries. PAHO/WHO will assist in selecting the three countries in Central America where the model has been implemented. The selection will be submitted to NORAD and Sida for their approval.

Implementation:

NORAD and Sida will contract independent consultants to carry out this review.

The consultant team to conduct the study should consist of two members, one consultant with a profound knowledge and experience of intrafamily violence projects, and one consultant with Latin American background also with knowledge and experience in this field. One of the consultants shall be appointed team leader. The team leader shall be responsible for the planning and co-ordination of the mission, the distribution of responsibilities among the consultants and finalization and presentation of the report. The consultants shall be fluent in English and Spanish.

The consultants shall be recruited for a period of eight weeks. Five weeks should be spent in the Region and the remaining time used for preparation and report writing.

PAHO will assist in setting up the agenda for each country and arranging site visits and interviews; providing all necessary documentation; accompanying the consultants to each visit and providing feedback to external consultants on their report in a timely fashion.

The review shall collect and analyse relevant information on the progress of all of the 6 selected communities. In addition the review shall in each one of the selected countries:

- conduct site visits to selected places of the project execution to include interviews with personnel in local health services participating in the project, women's groups and other entities, depending on the site;
- at the national level, conduct interviews with project counterparts at the Ministries of Health, the HDW national consultant and the PAHO/WHO representative, as well as other relevant persons at PAHO/WHO and/or other entities as deemed necessary. A check list would be designed for assessing institutionalisation of model within health sector, and for determining policy and legislation implementation.

In-depth interview instruments would be designed (jointly by the consultants and PAHO/WHO) to cover different sets of issues for different groups. Special emphasis should be given to lessons learned. User instruments will solicit information regarding use of IFV services, satisfaction, referral, participation in mutual support groups. For providers, training received, type of services delivered, referral and information systems. For network members, collaboration experiences, cross referrals, interchange of materials – procedures, information/surveillance, educational materials, training materials.

The consultants will be responsible for writing up the results, lessons learned and recommendations.

Reporting:

The team shall hold a debriefing meeting with representatives of NORAD, Sida and PAHO at the Norwegian Embassy in Managua at the end of the mission and at the same time deliver a preliminary draft report including major findings and conclusions from the mission.

A final draft shall be delivered to NORAD and Sida not later than three weeks after the mission has ended. After the comments of NORAD, Sida and PAHO the final report shall be typed on a word processor, using MSWord 6.0. The consultants shall also provide NORAD and Sida with a diskette to facilitate editing and printing.

The report shall be written in Spanish except for the executive summary which shall also be written in English.

The report should have an executive summary, scope and methodology of the review, major findings, conclusions and recommendations. The report shall not exceed 30 pages plus annexes.

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