The health service response to VAW: lessons from IPPF/WHR associations in Latin America

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Summary of the presentation

1. Findings from IPPF’s regional initiative in Latin America/ Caribbean (1999 to 2004)

2. Brief description of strategies used to expand the initiative to other countries (2004 to present)

3. Policy implications - take away messages
Objectives of IPPF/WHR initiative

1. Strengthen the institutional capacity of SRH services to address VAW

2. Raise awareness of VAW as a public health problem and a human rights violation

3. Contribute to improved legislation and application of laws

4. Increase knowledge about the health sector response to VAW
Program Strategy: “a systems approach”

- Sensitize all staff; train frontline providers
- Build internal / external referral networks
- Strengthen privacy and confidentiality
- Revise policies and protocols
- Rework staffing / patient flow
- Implement routine enquiry
- Equip clinics with emergency supplies
- Provide in-house legal aid and counseling
- Establish women’s support groups
- Improve service information systems
Key evaluation questions
Could a systems approach improve the health service response to VAW as measured by:

Changes in provider KAP
Changes in clinic resources
Provider perspectives
Perspectives of female clients generally
Perspectives of survivors specifically

What strategies are feasible and sustainable for IPPF associations in Latin American?
Controversy over asking women about violence

**Routine enquiry:** routinely asking women whether they have experienced violence

**Potential risks:** emotional harm from provider’s poor reaction, retaliation from perpetrator

**Potential benefits:** More appropriate health care, referral to services that might reduce risk of additional violence, mitigating consequences of past abuse
Evaluation design

Baseline (2000):
KAP survey (79 providers baseline);
Clinic observation/interview guide (11 clinics)

Service statistics (continuous):
Detection numbers and rates, number of services provided, etc.

Midterm evaluation (2001):
16 group discussions w/ providers, survivors & external stakeholders;
14 in-depth interviews with survivors; 14 key informant interviews;
Client satisfaction survey (691 female clients); Case studies of pilot strategies

Follow-up evaluation study (2002)
KAP survey (98 interviews with providers); Clinic observations/interviews (12 clinics); Random record reviews
Baseline finding: some survivors disclosed violence w/out routine enquiry

At baseline – even before routine enquiry:

- Majority (58%) of providers had asked women about violence in past year
- Most (85%) said a client had disclosed violence to them (in some cases w/out being asked)
- Most (85%) had never received training on violence
- Some consultation rooms could be overheard from outside and some histories taken in reception areas
- Most clinics lacked referral information, screening questions, IEC materials and key policies/protocols
Findings: the systems approach improved provider attitudes

- Men cannot control their sexual behaviour
  - Baseline (N=79): 20%
  - Final (N=98): 7%

- Mothers are to blame for child sexual abuse because they failed to supervise daughters
  - Baseline (N=79): 35%
  - Final (N=98): 16%

- Women stay with violent partners because they like being treated with violence
  - Baseline (N=79): 23%
  - Final (N=98): 9%

- Adolescents’ inappropriate sexual behavior provokes sexual abuse
  - Baseline (N=79): 40%
  - Final (N=98): 16%

- Women’s inappropriate behaviour provokes partner’s violence
  - Baseline (N=79): 53%
  - Final (N=98): 24%

Women’s inappropriate behaviour provokes partner’s violence
Findings: the systems approach improved the clinic infrastructure

At baseline, of eleven participating clinics:
  - About half (5/11) had a referral directory
  - 10 had EC, but didn’t all know how to prescribe
  - Most 8/11 lacked written protocols
  - Most 8/11 lacked a way to document cases
  - Lack of private space was common at baseline:
    - Could hear consultations in the next room
    - Consultations were frequently interrupted

By follow-up:
  - Infrastructure and resources improved in all clinics
  - Greater commitment to privacy and confidentiality
  - But, interruptions were still a problem
  - Sometimes difficult to meet with clients alone
Findings: the systems approach reduced barriers to asking women about violence.
Findings: Detection rose w/ introduction of written tool, January – December 1999

% disclosing emotional, physical or sexual abuse, Plafam's central clinic
Numbers of women who reported emotional, physical or sexual violence in response to routine enquiry

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Profamilia</th>
<th>INPPARES</th>
<th>PLAFAM</th>
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<tbody>
<tr>
<td>Emotional</td>
<td>6441</td>
<td>5486</td>
<td>1535</td>
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<tr>
<td>Physical</td>
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<td>2901</td>
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<tr>
<td>Sexual</td>
<td>2371</td>
<td>1909</td>
<td>440</td>
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<tr>
<td>CSA</td>
<td>2157</td>
<td>1698</td>
<td>390</td>
</tr>
</tbody>
</table>
Lessons learned: Routine enquiry

Value of written tool
Need support for staff
Providers from all levels can be trained to ask
Be flexible when defining which services are better positioned to ask women
Ensure privacy and confidentiality
Be prepared to offer basic intervention: detection, documentation, support, risk assessment/ safety planning, referral, follow-up
Stratify women according to levels of risk and prioritize service on this basis
Repeat process periodically
Respect women’s autonomy
Do NOT have providers who are not sensitive to violence implement routine enquiry women
Lessons learned: Training

Trainer is key
Training of trainers not recommended
Ensure follow up trainings.
Start with epidemiological data (particularly for MDs.)
Address providers’ beliefs, attitudes and concerns
Discuss GBV as a violation of human rights and public health problem; address gender and power
Provide ongoing support to providers
Field-testing tools can be a powerful catalyst for change
Changing attitudes is difficult and requires long-time commitment, but change can be dramatic:
“I arrived at the training looking to learn technical issues, afterwards my life, my relationship with my wife and two children can never be the same”
Findings: Positive consequences from women’s perspectives

- **Realization that violence is a problem:** “I was dying without realizing it. When the physician told me that my health problems were related to what was happening in my house, I started to understand what was going on with me. It was as if a screen was lifted from my eyes and I started to think that I didn’t deserve this. Although it is difficult, there are ways out.”

- **Not feeling judged:** “The good thing is that they don’t judge you and this enables you to talk”

- **Feeling safe / assurance of confidentiality:** “We feel comfortable because we know that others will not find out.”

- **Being believed / feeling less isolated:** “This was the first time that I felt taken seriously and that they believed my story.”

- **Obtaining emotional support:** “When I told my story to the provider, she gave me security, she gave me courage, she gave me strength.”
Findings: Positive consequences from providers’ perspectives

Improved quality of care
“The GBV project is really what brought quality of care to the organization.” - Clinic Director

Integrated approach to a woman’s health
“In addition to being more humane, now I see the patient as a whole.” - Gynecologist

Greater efficiency
“Now I am also more efficient. With this new approach, I see that many pathologies that could not be explained before are related to violence.” – Gynecologist

Implementation of sexual harassment policies
What did IPPF do with knowledge acquired?

Strategies used to expand the experience

Evaluated model with accumulated experience and tools ready to be used/adapted

South-south collaboration within IPPF:
- Staff involved in the initiative traveling to other countries to provide technical assistance
- Exchange visits between IPPF associations
- Provision of capacity building grants to support the work of interested associations

South-south collaboration with public sector:
- MoH staff from Honduras travelled to Profamilia (DR)
- In Paraguay, adapting IPPF’s model to the public sector
- In the DR, provision of technical assistance to public sector maternity hospital
What are the next challenges?

Explore the links between:

- VAW and HIV
- VAW / sexual violence and unplanned pregnancies & abortion

Explore how best to link to efforts addressing child maltreatment (a particular concern when addressing VAW within maternity hospitals)

How best to promote the primary prevention of VAW
What does it mean to achieve success?
A gradual process

- Quality of care improves
- Better health diagnoses
- Increase in women who know their rights
- Increase in women who know where to seek help
- Changes in access to legal protections
- Ending isolation
- Improved self-esteem, self-image
- Improved relations with friends, family, children
- Received benefits from legal system (restraining order, custody/property, sanctions against aggressor)
- Feel that their lives have improved
- Improved sexual and reproductive health
- No longer live in violent households or are at risk
Take away messages:

1. Working within resource-poor settings in challenging, but simple, low-cost interventions, such as support groups, can be very powerful.

2. Preparing a health care organization to respond adequately to violence against women requires a package of reforms throughout the health care organization.

3. Providers need to be adequately prepared ➔ potential to do harm needs to be taken seriously.

4. But, providers from all levels can be trained to ask women about violence and to respond adequately.

5. ALL health care services for women need to consider the implications of violence and be prepared to respond adequately to disclosures ➔ even in the absence of a routine enquiry policy.

6. Ignoring violence may lead to incorrect diagnoses and interventions.

7. Addressing violence and implementing a routine enquiry policy has the potential to lead to improved quality of care and better SRH outcomes.
Thank you...Gracias...Merci...Obrigada!

For further information and resources:
www.ippfwhr.org
or alessandra.guedes@uol.com.br
Publications related to the initiative


Guedes A., Bott S., Cuca Y. 2002 “Integrating systematic screening for gender-based violence into sexual and reproductive health services: Results of a baseline study by the International Planned Parenthood Federation / Western Hemisphere Region.” International Journal of Gynecology & Obstetrics, Volume 78, Supplement 1, Pages S57-S63.