



**HEALTHCARE RESPONDING
TO VIOLENCE AND ABUSE**



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**Understanding the dynamic
influence of context: adaptive
work in the health care response
to domestic violence in occupied
Palestinian Territory**

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Complexity and context

- *Complexity* – more than surfacing active ingredients and chains of mechanisms underpinning interventions.
- Important aspect of complexity is the *context* into which interventions are introduced and the *adaptations* that emerge from this.
- Context as “*an unstable and unfolding process*” rather than a place or organisational structure.
- HERA interacted with the socio-cultural, political and economic aspects of context in Palestine.
- How did providers/women overcome the uncertainties created by this interaction?

Socio-cultural, economic & political aspects

Occupation restricts access to health, education, other services

Importance of family (father/brother rule)

Family as a place to build coherence & identity

Absence of specific laws sanctioning VAW

Occupation related violence

Lack of protection for providers

Physical and mental states of insecurity

Normalisation of domestic violence

Women's economic dependence

Tribal resolution systems

Legal systems that reinforce patriarchal ideology

Separation of communities from land, places of work, social networks

Sumud (steadfastness, perseverance)

Adaptive work that women and providers engage in to make HERA workable as it interacts with the dynamic context

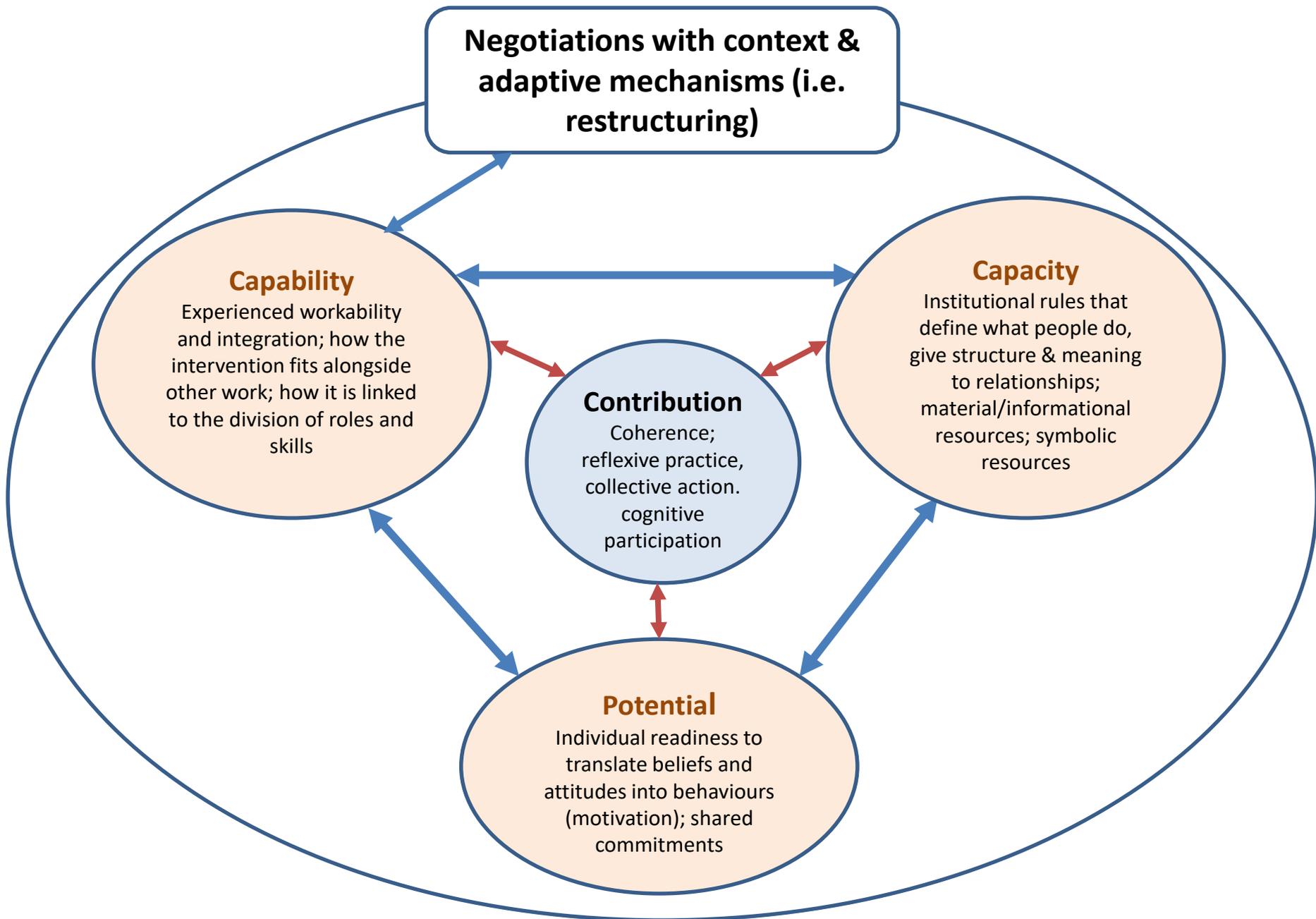
HERA

Normative restructuring

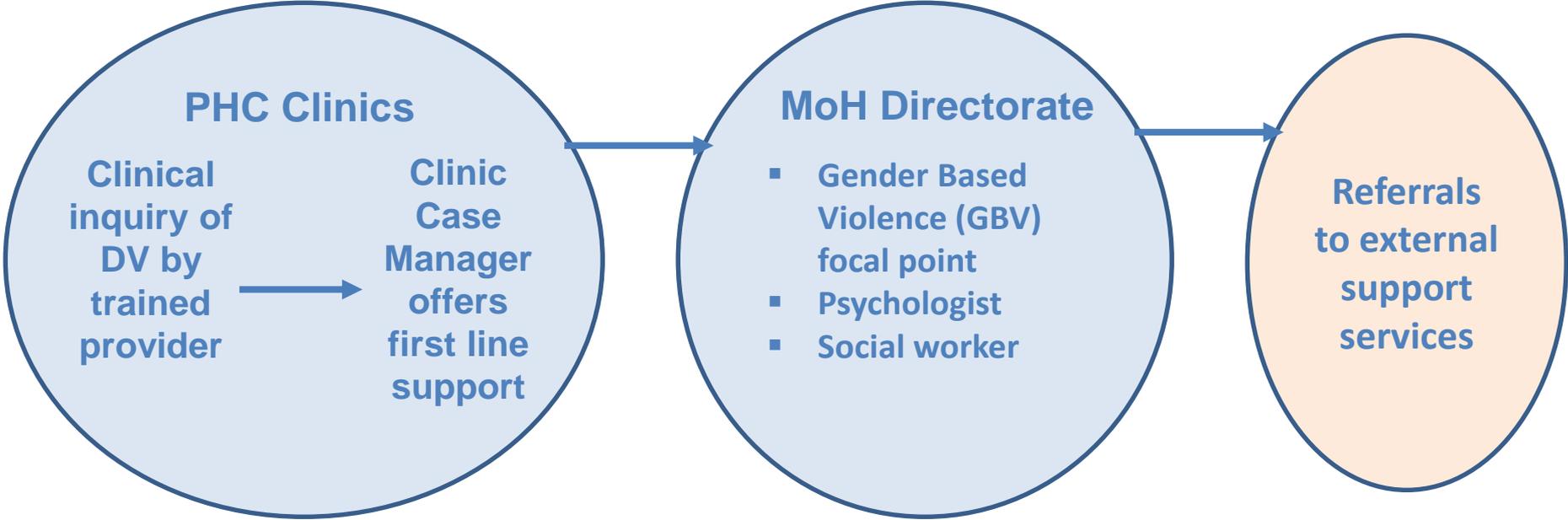
Relational restructuring

Extended Normalisation Process Theory: sensitising concepts

- **Complex adaptive systems (CAS)** – they can transform & self-organize when they encounter turbulence or ‘shocks’ in the environment
- Implementation processes are **emergent** – they unfold over time and shaped by different factors
- **Adaptive mechanisms in a CAS**
 - **Relational restructuring:** changes to the way people interact, group processes, accountabilities to each other as they implement the intervention
 - **Normative restructuring:** modification to rules, conventions, resources that provide the scaffolding for everyday work



Referral pathway Palestine



Key Findings

(Capabilities/adaptive work)

Improvisation of practice and transformation of roles (relational restructuring)

- Clarity of roles and responsibilities within the care pathway created greater accountability in the health system.
- Clinic Case Managers modified their role in response to women choosing not to be referred externally. Encounters with Clinic Case Manager became the focus for a therapeutic intervention.
- Clinic was a safe place for respite. Women could diffuse feelings of emotional pain and have someone bare witness to the violence.

*Before I talked to [Clinic Case Manager] I felt strangled, like something was holding me around my neck...I wanted to cry and scream and scream. It's not that I wanted to talk, I wanted to scream...I feel like I've released a bit. My mental state is relieved.
[Woman, 30 yrs]*

*Why should I scatter myself, get a divorce and all that? I don't want any of that to happen. All I want is to live.
[Woman, 27 yrs]*

Subterfuge and controls over knowledge (normative restructuring)

- Things that threaten the intervention may also support it:
 - Porous boundaries between clinic and community facilitated trust and disclosure, but carried a risk of exposure and adverse outcomes
 - Providers exercised discretion with documentation of violence (despite MoH requirements)
- Women and providers used deception (“*cover stories*”) to ensure women accessed support at the clinic
- Coordination of support in severe DV cases by MoH– not all providers were informed in order to protect them

They know me, they've gotten used to me because we're all from the same town. I know and was reassured that she wasn't going to talk about it to anyone. That she wouldn't spread talk around.

[Woman, 27 yrs]

Governing behaviours of self and others (normative restructuring)

- Volatile environment – exposure can bring risk to all involved
- Providers' curtail their actions due to fear of retaliation from family and fear for the woman
- Interactions bound up with cultural values about preservation of marriage/family
- Transgression of boundaries in patient/provider relationship (e.g. provider as peacekeeper/mediator)
- Families also complicit in policing behaviours and silencing of abuse (e.g. monitoring women at the clinic, restricting freedom, covering up the abuse)
- Providers and women negotiate over whether or not to document violence

Back when we were dealing with the [high risk] case [she] told me that she wouldn't notify me about any more risky situations which could potentially endanger our lives.

[GBV Focal Point,
Female]

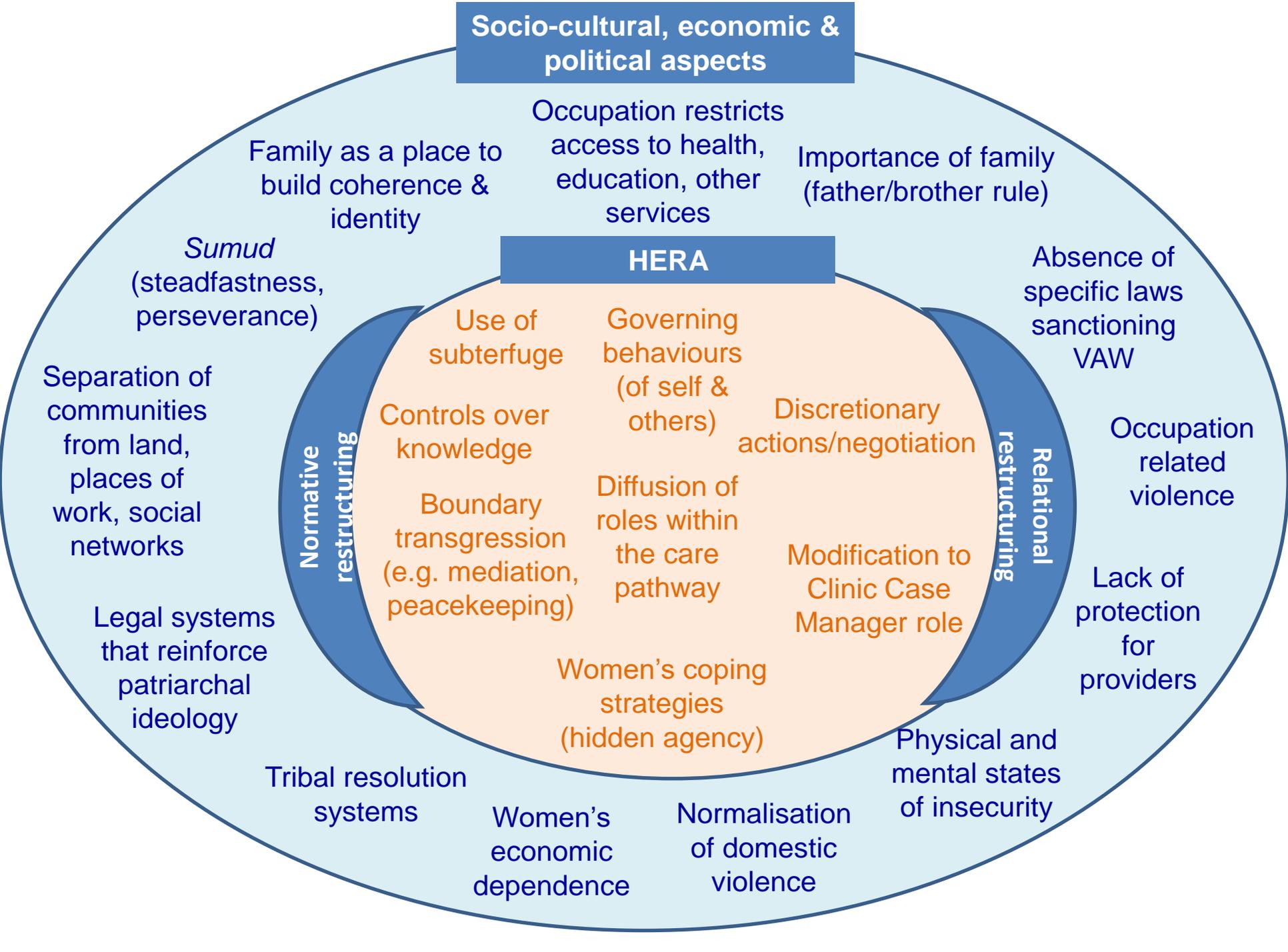
Synergies with capacity and potential

- Clinic Case Managers did not feel adequately prepared for their modified role (unanticipated outcome).
- Limited role legitimacy as DV only part of their work - not formalised or resourced.
- Further de-prioritization of DV under burgeoning workloads/lack of staff
- Lack of congruence in positive values re: DV between clinical teams and Directorate level managers.
- Challenge to keep providers in the training (location, lack of cover)
- Implications for sustainability of HERA (role of case manager/training)

...we were even more enthusiastic than the health directorate, than the supervisor, the minister, the manager, and so it would give some motivation. But they tell you “do as you please, if you want to deal with them, welcome”
[Doctor, Male]

Socio-cultural, economic & political aspects

HERA



Take home messages

- Despite the inelastic context, providers and women found ways of working with constraints.
- Importance of considering context when implementing and evaluating interventions.
- ENPT enhanced the analytical process by encouraging new ways of thinking about the data.
- Things that threaten an intervention may also support it.
- Surfaced nuances about intervention/context interactions that affected fidelity to HERA.

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