Chapter Six

What Happens at the Clinic?

During its evaluation of the PAHO project, the review team found major differences in the quality and types of health services available in different countries, and even in different health facilities within the same pilot communities. However, most providers noted that some combination of the following activities was performed at their centers:

- SCREENING FOR ABUSE, either through routine questions or upon suspicion that the woman might be a victim of violence;
- RISK ASSESSMENT, to determine the woman's immediate risk of future violence;
- APPROPRIATE CARE, including treatment for injuries, addressing reproductive health needs, and crisis intervention;
- DOCUMENTATION of the violent event and health consequences in the medical charts or on special registration forms;
- COUNSELING, to provide women with basic information about legal rights and other options and to assist in developing a safety plan, etc.;
- REFERRALS, either for specialized services within the health system (psychological, forensic medicine, etc.) or to outside institutions (police, child welfare, courts, etc.); and
- SCHEDULING OF FOLLOW-UP VISITS, to provide continuing support.

This chapter describes the strengths and challenges that providers described in their efforts to integrate care for survivors of violence (i.e., those who had already initiated their "critical path") in ongoing programs.

MEXFAM illustration

THE STORY OF ROSITA

In order to facilitate discussions with providers and clients about how women living with violence are treated in the health center, the review team adapted an incomplete story technique first developed by the Mexican Family Planning Foundation (MEXFAM) (Fawcett et al. 1999). In this story, Rosita is the mother of two children who is abused by her husband and feels hopeless about her situation. The story ends when Rosita goes to the health center for a routine visit and the nurse asks her whether she has ever been mistreated by her husband. The exercise is carried out in a group setting, and the participants are asked to imagine how the story ends through a discussion of the following questions:

- What will Rosita tell the nurse when she asks her questions about violence?
- How will Rosita feel when she is asked about violence?
- How does the nurse feel about asking Rosita about her family life?
- What will happen to Rosita if she admits what is happening to her at home?
- What type of help would be most useful to her?
- Do you think she will receive this help at the health center?
- Do you think Rosita's situation is common among women in this community?

These questions were used to introduce a more focussed discussion on the type and quality of services offered to women in Rosita's situation at the participants' health center.

IDENTIFYING WOMEN LIVING WITH VIOLENCE

The approaches that providers use to identify women living with violence vary greatly among the Central American countries studied and even among clinics within the same country. The various approaches may be categorized in the following way:

- **not asking any direct screening questions.** Most providers in Guatemala did not ask women directly about violence, even when there were signs of abuse, but if women disclosed violence on their own the providers would try to offer support. In Guatemala the GBV norms are part of the national mental health program, and there is no official policy on screening, so identification of violence is largely left to the discretion of the individual provider. International experience has shown that this is generally not an effective strategy for identifying survivors of violence.

- **universal screening** refers to a policy of 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 in their GBV norms. This system is the most far-reaching; however, it is also the most costly and difficult to implement, particularly in low resource settings.

- **asking whenever violence is suspected.** This approach was commonly used in

El Salvador and Honduras. It can be a cost-effective way to identify women, but only if the staff are well-trained and motivated.

- **integrating GBV screening and services into selected "sentinel" programs**. This means carrying out routine screening in certain priority areas where abused women are more likely to be identified (for example, in emergency services or mental health programs) or in areas where identifying a history of violence is most likely to improve the overall quality of services (i.e., prenatal care, STIs, family planning, etc.). This approach was adopted in Nicaragua's GBV norms; however, it has not yet been fully implemented.

Since these GBV programs are still relatively new, it is perhaps still too early to assess the most successful approaches for identifying women living with violence. Nevertheless, it seems evident that the first two options are less likely to be as effective as the latter two. Experience has demonstrated that programs without a screening policy identify only a fraction of those women requiring assistance. On the other hand, it is not feasible to implement universal screening in the majority of Central American health services, given the scarcity of qualified resources and time pressures experienced by health personnel.

However, a mixed strategy consisting of screening all women with signs of abuse in all programs and performing routine screening of all women in certain "sentinel" programs might be an effective compromise. This approach would allow providers to optimize resources by targeting women who are at greatest risk for abuse. Moreover, integrating screening and care for survivors of violence into reproductive and mental health programs could contribute to enhancing the quality of care in these programs, as well.

LESSONS LEARNED

It is not enough to simply wait for women to disclose violence on their own. Experience has shown that many women are willing to talk about violence, but it is usually necessary for health personnel to take the initiative and open the discussion.

Screening for violence may be performed in any area of health services. The most important requisites for an effective screening program are privacy, trained and empathetic staff, and the ability to listen and offer some basic counseling.

"WOMEN ARE WAITING FOR SOMEONE TO KNOCK ON THEIR DOOR..."

Results of a Screening Exercise for Violence

To date, most experiences with screening have taken place in Canada, Europe, and the United States, where conditions are generally quite different from those of health services in low resource settings. In order to assess the feasibility of introducing a policy of screening for violence, PAHO conducted a study in four Central American countries between 1999 and 2000. The purpose of the study was to determine the acceptability of routine screening among health workers and clients and whether the use of a screening instrument would enhance identification of violence in the clinical setting. At each site, all personnel, including administrative staff, were sensitized about GBV. Providers were trained in the use of a screening instrument that consisted of three questions about recent experiences with physical or emotional violence involving a partner. During a one-to-three-month period, staff used the instrument to screen all women between the ages of 15–44 who came to the health center for any reason. On average, the questions took about three minutes to ask. Subsequent interviews with the health workers, as well

BOX 6-1. TYPES OF COMPLAINTS LEADING PROVIDERS TO SUSPECT VIOLENCE

- Anxiety
- Allergies
- Gastritis
- Colitis
- Migraines
- Bumps/bruises or unexplained injuries
- High blood pressure
- Learning problems in children
- Sexually transmitted infections
- Termination of medical visits

Statements by health personnel and clients in El Salvador

as their clients, revealed that both groups felt comfortable with the questions.

The study revealed that between 12% and 54% of all clients disclosed experiences of recent physical or emotional partner violence. Reproductive health services generally identified the highest proportion of cases of violence. Surprisingly, the number of abused women identified varied greatly among the different health centers, sometimes even among those within the same communities.

The variation in disclosure rates is likely due to a number of factors. International research has shown that women's willingness to disclose violence depends on many factors beyond the specific wording of questions. 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 whether the screening is performed in privacy are all factors that may influence disclosure. Some studies have found that it may be necessary to ask women about violence on more than one occasion before they feel comfortable discussing the issue. Discussions with providers in Barrio Lourdes, El Salvador, about the screening experience confirmed this view:

"Sometimes we have to ask the question on a couple of visits. Maybe the first time it comes as a shock, but by 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 your full attention so that you don't lose her."

BOX 6-2. IPPF'S SCREENING TOOL FOR GBV

- Have you ever felt hurt emotionally or psychologically by your partner or another person important to you?
- Has your partner or another person important to you ever caused you physical harm?
- Were you ever forced to have sexual contact or intercourse?
- When you were a child, were you ever touched in a way that made you feel uncomfortable?
- Do you feel safe returning to your home tonight?

(The full instrument is available at the IPPF Web site at www.ippfwhr.org.)

Most of the providers who participated in the screening exercise found it to be an eye-opening experience. It revealed to them the extent to which violence can contribute to a woman's complaint, even though she may not mention it as the purpose of her visit. This understanding has changed the way many health workers view their work. For example, as one physical therapist from the Barrio Lourdes clinic in San Salvador explained,

"I used to treat women with muscle spasms all the time, and I never asked them any questions. Then I started to realize that many of these cases were due to violence."

A psychologist from the same clinic added,

"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 to help her."

A second valuable insight from the screening exercise was that, contrary to initial expectations, women were not only willing to talk about their experiences of violence, but often deeply grateful for the opportunity to tell their stories.

"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."
—Nurse, El Salvador

Finally, the experience demonstrated the importance of involving all staff in the training on GBV. In one health center in El Salvador, the medical director noted that he had initially been skeptical about the screening exercise, as he had never had a woman disclose instances of violence in a medical visit before. After participating in the exercise, he became an enthusiastic convert: "I challenged myself to become more alert about possible cases [of violence], and I realized that it was not as difficult as I had thought." Not only does this physician now routinely ask his patients about violence, but he also obtained funds from the Ministry of Health to build an additional space in the health center so that women could talk to counselors in privacy. Box 6-3. illustrates several informal screening techniques used by health workers in a variety of health programs.

Many other programs have also found that the routine use of a short screening tool can greatly increase identification rates for violence (McFarlane et al. 1991; Feldhaus et al. 1997). IPPF has carried out a program in three Latin American affiliates (the Dominican Republic, Peru, and Venezuela) to integrate services for GBV into existing reproductive health programs. The providers found that by introducing a five-question screening tool into the client history-taking for all new clients, identification of women who had suffered GBV increased to 38% of all new clients, compared with only 7% when providers asked questions at their own discretion (Guedes et al. 2002).

Among the PAHO project communities, the screening experience gave staff confidence in their own abilities and motivated them to

LESSONS LEARNED

Encouraging health personnel to screen women for violence in their regular practice can be an excellent exercise for raising general awareness and helping personnel to become more confident in treating cases of violence. Ideally, the screening instrument should include questions on physical, emotional, and sexual violence, and should include experiences that have occurred at any point in the client's lifetime, as well as the most recent experiences. In prenatal clinics, the screening instrument should also ask about violence during the current pregnancy.

After completing the exercise, it is important to implement and monitor a permanent policy for screening and care of the survivors in order to maintain the achievements of the initial exercise.

BOX 6-3. INDIRECT WAYS TO START A CONVERSATION 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 me."*

In cancer prevention programs

- *Sometimes while 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 child wellness programs

- *I don't ask directly [about violence] because women 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.*

During dermatology consultations

- *After several visits for a chronic allergy on her hands, I asked her if she was having problems at home, and that is when she started to cry.*

Statements from health workers in El Salvador

continue asking about violence. However, the exercise alone was not sufficient to change providers' behavior. In the centers where new policies on screening and care for survivors of violence were not implemented and monitored with strong, sustained leadership and support from management, some momentum was eventually lost over time. In these centers staff admitted that they no longer asked women about violence on a routine basis. Similar results were found in a study of a U.S. emergency room, where screening protocols had been instituted with great success. However, a few years later, it was found that levels of detection had fallen back to the initial levels, due to the lack of monitoring and follow-up support to staff (McLeer et al. 1989). These experiences underscore the importance of using a "systems" approach to integrating violence into health programs, including institutional policies and protocols for identifying and treating victims of abuse.

IF SHE SAYS YES, THEN WHAT?

A concern that has frequently been voiced with regard to GBV screening programs is that too much emphasis is placed on screening as an end in itself, without

enough consideration of what happens next. Some critics question whether it is even ethical to screen for violence if there is not a program in place and services to refer women to once they disclose violence (García-Moreno 2002). This concern is echoed by health workers who fear that if a patient discloses violence, it will open up a "Pandora's Box" of problems that they will not know how to respond to (Sugg and Inui 1992). This is a particular concern in low resource settings, where there may be few or no places to which to refer women suffering abuse. Others argue that asking about violence is, in itself, an intervention, by signaling to women that violence is unacceptable and that it can affect their health. One of the primary aims of this review was to hear what providers and women clients felt were the most important strengths of the GBV programs, in addition to their more visible weaknesses.

In each country there was at least one pilot health center that had one or more specialists (either social workers, psychologists, and/or psychiatrists) who had been trained to work with survivors of abuse. In Honduras, women who are identified as abuse survivors by health providers are referred directly to the Family Counseling Centers (FCC), which have been established in each of the country's 13 health districts. Women receive individual or group counseling at the FCC, and if necessary, may be referred to the police, child welfare department, or the human rights commission for additional help. Some of the FCC clients who were interviewed had been in individual therapy for more than one year and expressed great satisfaction with the support they had received. However, this model of care is neither feasible nor cost-effective in many low resource settings where counseling services of this type are either scarce or nonexistent.

An alternative strategy that has worked well in these settings is to designate one or more staff as GBV counselors. 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 supervising nurse makes sure that there is at least one trained counselor available. This strategy ensures that providers have backup resources whenever they identify a woman that needs help. Furthermore, the center has established prioritized care for survivors of violence so that they may be treated immediately without having to wait in line. To ensure privacy, some centers, such as Chintúc in El Salvador and the Estelí health center in Nicaragua, have designated special rooms that can be used for counseling. In other cases, administrative offices are used to ensure privacy.

This approach provides effective basic support for women in the absence of specialized services. Providers are more likely to screen for violence when they know that backup support is available to them. Counselors are able to provide primary crisis intervention and counseling, as well as basic information on existing laws and services and how to develop a safety plan. When other services in the community are available, such as women's centers, the counselors give referrals and often coordinate care with these centers.

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 receive treatment with a human quality and in a timely manner.

courtesy PAHO/WHO-El Salvador

Women's support and self-help groups, such as this one in El Salvador, give women the opportunity to help each other and to realize that others care and they are not the only ones that suffer from violence. The bonds of solidarity that are formed can empower women to transform their situations and end the violence through mutual support.

One limitation of this approach that was noted is the lack of capacity for providing follow-up to women. As one nurse at the Chintúc health center explained, at times, if the health personnel are particularly concerned about a woman, they will develop creative mechanisms that will enable them to check on clients:

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

Unfortunately, however, most providers reported having little time or resources for follow-up activities and acknowledged that it is not uncommon for them to lose track of clients who stop coming to the clinic or simply never return after the initial visit. At the Barrio Lourdes Polyclinic in El Salvador, which specializes in community mental health care, a similar basic approach to care is used. All personnel were sensitized in GBV and trained to screen women whenever they suspect abuse. In addition, several staff members were given additional training to provide emotional support and to facilitate support groups for survivors. Because of the center's close ties to the community in general, it has been successful in providing long-term follow-up and support to women, including individual psychological care and the development of support groups for survivors. The GBV counselors come from a variety of disciplines, including physical therapy, special education, and nursing. The center's psychologist provides supervision, guidance, and emotional support to the violence counselors and receives referrals from them in cases that require specialized care.

When asked what kind of professional profile they thought was most suitable for a GBV counselor, the staff at Barrio Lourdes noted almost unanimously that a person's profession or gender was less important than personal motivation, and this explained why their own counselors had such diverse backgrounds.

LISTENING IS KEY

"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."
—Nurse, El Salvador

When a woman decides to talk to her provider about violence it may be the first time that she has ever disclosed her situation to anyone, including her own family. Therefore, providers have an enormous responsibility to ensure that, at the very least, women are treated with respect and compassion and that they do not contribute to "revictimizing" patients through indifference or by making women feel that they are to blame for their situations. (More information about how providers can help women living with violence is provided in Box 6-4.) Health workers stressed the importance of listening and allowing women to tell their stories without rushing them. A Salvadoran doctor, who acknowledged that he used to get impatient if a patient started to cry in his office, confessed that, after the training, his attitude changed:

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

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 off of their shoulders. That in itself is a lot."
—Nurse, El Salvador

"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 smiling."
—Doctor, El Salvador

"Sometimes women come to us, not expecting us to solve their problems, but rather just to be listened to . . . what they hope for is some advice."
—Doctor, El Salvador

In addition to listening to women, providers can help women assess whether they or their children are in immediate danger. There are several instruments that have been used internationally for this purpose, such as the Danger Assessment Screen (Campbell 1995). The IPPF program asks all women: "Do you feel safe returning home tonight?" (Guedes et al. 2002). Depending on her response, providers can help her to review options and to develop a safety plan to protect her and her family in the future (Box 6-6. gives an example of how to develop a safety plan).

As the following account from a Guatemalan nurse suggests, providers may have only one opportunity to intervene:

"Once I treated a woman who came for a headache. When I asked her, it turned out that her husband had been sharpening his machete for the last three days, saying that he was going to kill her. She had spent the whole time wondering where he would cut her first and that was how she got the headache. We had to develop a safety plan with her right then because she said she would not be able to return."

Another lesson that many providers expressed is that it is impossible to provide quality care, particularly in the case of reproductive health services, unless they take into account the specific needs of women living with violence. For example, 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 many abused women are not able to use contraceptives to avoid unwanted pregnancies without their husbands' permission:

"We try to help abused women who want to use family planning, 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 three-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."

Both providers and women agreed that the most helpful messages that providers can give to survivors of violence is that violence is wrong and that it is not her fault.

"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."
—Nurse, El Salvador

"Oftentimes 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." —Nurse, El Salvador

"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."
—Doctor, El Salvador

For a woman who has been living with overwhelming shame and guilt for many years, this message can be nothing short of life-transforming. As one Honduran woman who had even contemplated suicide as her "only way out" noted, the care and support of health workers had, in fact, saved her life and taught her how to accept and respect herself.

BOX 6-4. HOW CAN HEALTH WORKERS BEST SUPPORT WOMEN LIVING WITH ABUSE?

Health workers often feel that there is little they can do when a woman discloses abuse. But what providers say and do can have an important influence on a woman's course of action (McCauley et al. 1998; Gerbert et al. 1999). The act of asking questions about violence can let women know that providers consider violence to be an important medical problem and not the client's fault. As one Latin American woman said: "The doctor helped me feel better by saying that I didn't deserve this treatment, and he helped me make a plan to leave the house the next time my husband came home drunk," (Sagot 2000).

Women in the United States also emphasize the power of validation, noting that it provided "relief," and "comfort," and "planted a seed," and "started the wheels turning" toward changing their perception of their own situation (Gerbert et al. 1999). Some of the ways in which health workers can promote healing for women living with violence are described in the "Empowerment Wheel" used in violence prevention training (see Box 6-5.).

Even if an abused woman does not disclose the violence on a first visit, asking about it shows that the clinician cares and may encourage her to talk about it on a later visit. While health workers ideally should coordinate their actions with other community-based services, such as local women's groups, providers can take several useful steps during the initial clinic visit (Parker and Campbell 1991; Warshaw and Ganley 1998).

1. Assess for immediate danger. Find out whether the woman feels that she or her children are in immediate danger. If so, help her consider various courses of action. Is there a friend or relative who can help her? If there is a women's shelter or crisis center in the area, offer to make the contact for her. Some hospitals and clinics have adopted explicit policies allowing abused women to be admitted overnight if it is unsafe for them to return home (Josiah 1998; Leye et al. 1999). Leaving a violent partner temporarily does not necessarily end the violence, however. The most dangerous moment for a woman with an abusive partner is often immediately after she leaves or announces her decision to leave a relationship (Campbell 1995).

2. Provide appropriate care. For women who have suffered sexual assault, appropriate care may include providing emergency contraception and presumptive treatment for gonorrhea, syphilis, or other locally prevalent STIs. Unless clearly necessary, clinicians should avoid prescribing tranquilizers and mood-altering drugs to women who are living with an abusive partner since these may impair their ability to predict and react to their partners' attacks.

3. Document the woman's condition. Few providers adequately document cases of abuse against women. In Johannesburg, South Africa, a review found that in 78% of cases of abuse providers had not recorded the identity of the perpetrator. Clinical records included such graphic but general descriptions as "chopped with an axe" or "stabbed with a knife" (Motsei and the Centre for Health Policy 1993). Careful documentation of a woman's symptoms or injuries, as well as of her history of abuse, are helpful for future medical follow-up. Documentation is also important in the event that she decides to press charges against the abuser or to seek custody of the children. Documentation should be as thorough as possible and clearly state the identity of the offender and his or her relationship to the victim.

4. Develop a safety plan. Although women cannot prevent violence from recurring and they may not be ready to report their partner to the police, there are ways that they can protect themselves and their children. These include keeping a bag packed with important documents, keys, and a change of clothes, or developing a signal to let children know when they need to seek help from neighbors. Health care providers should review a sample safety plan with the woman and decide together which actions may help in her situation (see Box 6-6.). Sample safety plans can also be taped to the walls of the clinic's restroom and examining room, where women may read them in privacy and without embarrassment.

5. Inform the woman of her rights. When a woman takes the step of disclosing her situation, it is crucial that medical practitioners reaffirm that the violence is not her fault and that no one deserves to be beaten or raped. The penal codes of most countries criminalize rape and physical assault, even if specific laws against domestic violence do not exist. Medical staff should find out what legal protections exist for victims of abuse and where women and children can turn for genuine help in enforcing their rights.

6. Refer the woman to other community resources. Health care providers can help victims of abuse through early detection and by referring them to available local resources. The needs of victims generally extend beyond what the health sector alone is able to provide. Therefore it is essential that health care providers know in advance what other resources are available to help victims of abuse. It is especially useful for health workers to meet personally with others who provide services for victims of violence because providers will be more likely to refer a woman to someone whom they know when there is a face behind the name.

From: Heise, Ellsberg, and Goettemoeller 1999)

BOX 6-5. **GENDER-BASED VIOLENCE: ARE HEALTH WORKERS PART OF THE PROBLEM?**

...OR ARE HEALTH WORKERS PART OF THE SOLUTION?

The Medical and Power Wheel, developed by the Domestic Violence Project, Inc. Kenosha, Wisconsin, U.S.A.

BOX 6-6. DEVELOPING A SAFETY PLAN

Health care providers can help women protect themselves from intimate partner violence, even if the women may not be ready to leave home or report abusive partners to authorities. When clients have a personal safety plan, they are better able to deal with violent situations. Providers can review these points below to help each woman develop her own personal safety plan:

- Identify one or more neighbors you can tell about the violence, and ask them to seek help if they hear a disturbance in your home.
- If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- Stay away from any room where weapons might be available.
- Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best.
- Have a packed bag ready, containing spare keys, money, important documents, and clothes. Keep it at the home of a relative or friend, in case you need to leave your own home in a hurry.
- Devise a code word to use with your children, family, friends, and neighbors when you need emergency help or want them to call the police.
- Decide where you will go if you have to leave home, and have a plan to get there.
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he is demanding to calm him down. You have the right to protect yourself and your children.
- Remember: you do not deserve to be hit or threatened.

Adapted from Buel 1995 in Heise et al. 1999
MEXFAM illustration

"IN THE BEGINNING I USED TO CRY ALONG WITH THEM. . . ."

Health Providers Also Need Emotional Support

One of the themes that emerged in the assessment was how deeply providers were affected by caring for survivors of violence. "We've all had moments when the floor moves beneath us," acknowledged a Salvadoran psychologist. Many mentioned effects ranging from being exhausted emotionally to fear of retaliation by aggressors to frustration with women "who do not follow our advice." The stories of rape, humiliation, injuries, and death threats leave physical and emotional scars on those who listen to them. As one study 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 such as chronic exhaustion, chronic pain, gastric problems, or changes in sleeping patterns (Claramunt 1999). Some of the reactions of providers are described in Box 6-7.

BOX 6-7. PROVIDERS' RESPONSES TO VIOLENCE

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

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

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

"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 away."

"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."

Statements by health workers from Barrio Lourdes, El Salvador

One issue that is often hard for providers to accept is that they may not be able to "fix" a woman's problem. What is even more challenging is that, as the Critical Path study showed, the woman may decide not to follow the provider's advice or to take actions that providers don't understand. This can be frustrating, particularly for doctors, who are trained to measure success by patient compliance and whether or not an illness is cured. In a discussion group with providers in Barrio Lourdes in El Salvador, several nurses acknowledged that this was often a challenge:

"Sometimes I feel angry with her; I wish I could make her understand."

"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."

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

In some places, threats to their own physical safety must be added to the list of challenges that providers face. In one case described by Guatemalan providers, masked men

LESSONS LEARNED

Emotional support is essential for health providers who care for survivors of violence.

Activities to ensure support for personnel should be included in norms and implemented at the local level.

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. As one Guatemalan nurse admitted:

"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 come looking for me?"

A psychologist from Guatemala City also noted:

"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 women suffering from violence is very draining, many providers also mentioned positive experiences in their personal and professional lives. Many observed that the awareness workshops had helped them to overcome their own experiences of violence and fears and to strengthen bonds with their other colleagues. As two providers in El Salvador observed:

"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."

Emotional support for providers should be considered as an essential component of any program to address GBV. Emotional support refers to any kind of activity that

BOX 6-8. TAKING CARE OF OURSELVES: SUGGESTIONS FOR PRACTICING SELF-HELP FOR PROVIDERS WORKING WITH GBV

- **Getting to know our own history:** When we work in the field of family violence, the process of self-help begins by healing the wounds of personal abuse, when these exist.
- **Taking care of our bodies:**
  - Deep breathing exercises
  - Physical exercise
  - Eating well
  - Getting enough sleep and resting
  - Practices that aid relaxation and healing and provide energy, such as aromatherapy, bioenergetics, and music therapy
- **Transforming our thoughts:**
  - Flexibility
  - Optimism
  - Understanding and empathy
  - Relativism in evaluating problems, viewing them as an opportunity to learn and to change old habits
  - Taking responsibility for our decisions and actions
  - Thinking in the present tense
- **Staying in touch with our feelings**
- **Reviewing what we have accomplished every day**

From: Claramunt 1999

helps to reduce stress and anxiety, including recreation or sessions for discussing the feelings and emotions that result from their professional responsibilities. PAHO has developed a guide for the emotional support for providers (Claramunt 1999). Nevertheless, only one of the centers visited by the review team mentioned holding occasional support activities for providers. On the other hand, all of the providers agreed that more attention should be given to this issue in the future.

"THIS CENTER IS DIFFERENT; IT IS WARMER"

Reflections on 10 Years of Experience

Despite the many difficulties that they have faced, health providers who work with GBV expressed a great deal of pride and satisfaction in their accomplishments (see Box 6-10. for a list of topics most frequently mentioned). Most importantly, providers felt that dealing with violence had improved the quality of care in the center.

BOX 6-9. FUTURE STEPS FOR STRENGTHENING GBV WORK

- Develop a protocol for screening and care for victims
- Create indicators for evaluating the program
- Design a better registration system
- Prepare budget for evaluation
- Incorporate more follow-up training
- Spread the program to other centers: "others should be following our example–it's not rocket science"
- Assign special rooms for talking to women
- Receive more training in legal issues
- Ensure more emotional support for staff: "we need a space to talk about what has happened"
- Include a psychologist or psychiatrist for referrals

Statements by health workers at Chintúc Health Center, Apopa, El Salvador

courtesy PAHO/WHO-Ecuador

Women respond most positively to community staff who have effective personal skills and show true interest in the women and their situations.

BOX 6-10. **CARE FOR VICTIMS OF FAMILY VIOLENCE: STRENGTHS AND CONSTRAINTS**

Within the health services
- Recognition of violence as a health problem with many different possible physical and mental manifestations
- 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
- Having more integrated services for family violence
- Having basic tools for addressing violence
- Having financial support from PAHO

In relation to the community
- Feeling a greater closeness to the community now
- Better coordination with the police and district attorney's offices
- Increased client demand for services
- Increased community awareness about violence

At a personal level
- Satisfaction from being able to help others
- Acquiring new skills and knowledge

Within 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
- Limitations in the registry/ epidemiological surveillance systems
- Lack of interest by some staff 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
- Incomplete transfer of knowledge at times to others following training by some staff
- 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 system (laws are not enforced)

Statements by health workers in Estelí, Nicaragua

"People tell us that this center is different; it is warmer. . . .They come here because we listen to them. . . ."
—Nurse, El Salvador

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."
—Nurse, El Salvador

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 demonstrate more definitively that violence is an important health problem.

Both providers at the clinic level and national program coordinators agreed that the major challenge facing them is to use the wealth of lessons gained from the pilot experiences in order to scale up to national programs while ensuring the sustainability of the existing programs. In some countries, particuarly in Costa Rica and Panama, considerable progress has been made in institutionalizing the GBV program through national policies and budgetary allocations. In El Salvador and Nicaragua, PAHO and the Ministries of Health have been able to extend the coverage of the program by leveraging resources from other international projects, such as the Swedish Government-supported health reform programs in both countries.

Perhaps the greatest source of pride mentioned by health providers was the improvement in their relationship with the community. Providers felt great satisfaction in the belief that they were contributing, not only to improving the lives of individual women and families, but also to transforming the way community members view violence in general:

"We are closer to the community now. People go to the health centers more often. Our clients have become our best promoters."
—Nurse, El Salvador

"People are familiar with the laws and know that they are protected. Nowadays women are no longer afraid to report violence."
—Nurse, El Salvador

In Chapter Seven, we will go beyond the clinical setting to the community at large, where we will see how local resources can complement the work of health providers in responding to gender-based violence and how these groups can work together most effectively to transform community norms and attitudes.