IPPF

Western Hemisphere Region

From choice, a world of possibilities

The health service response to VAW:

lessons from IPPF/WHR associations in Latin America

Alessandra Guedes – independent consultant

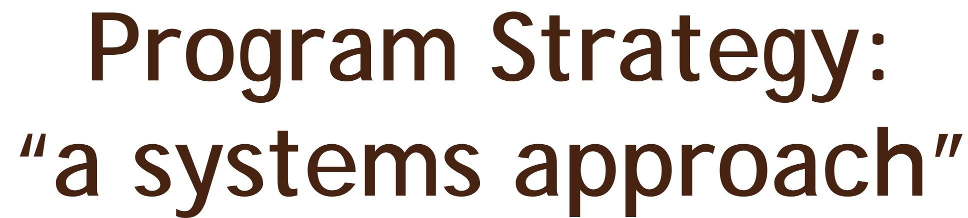
Alejandra Meglioli – IPPF/WHR

Sarah Bott – independent consultant

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



- 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)

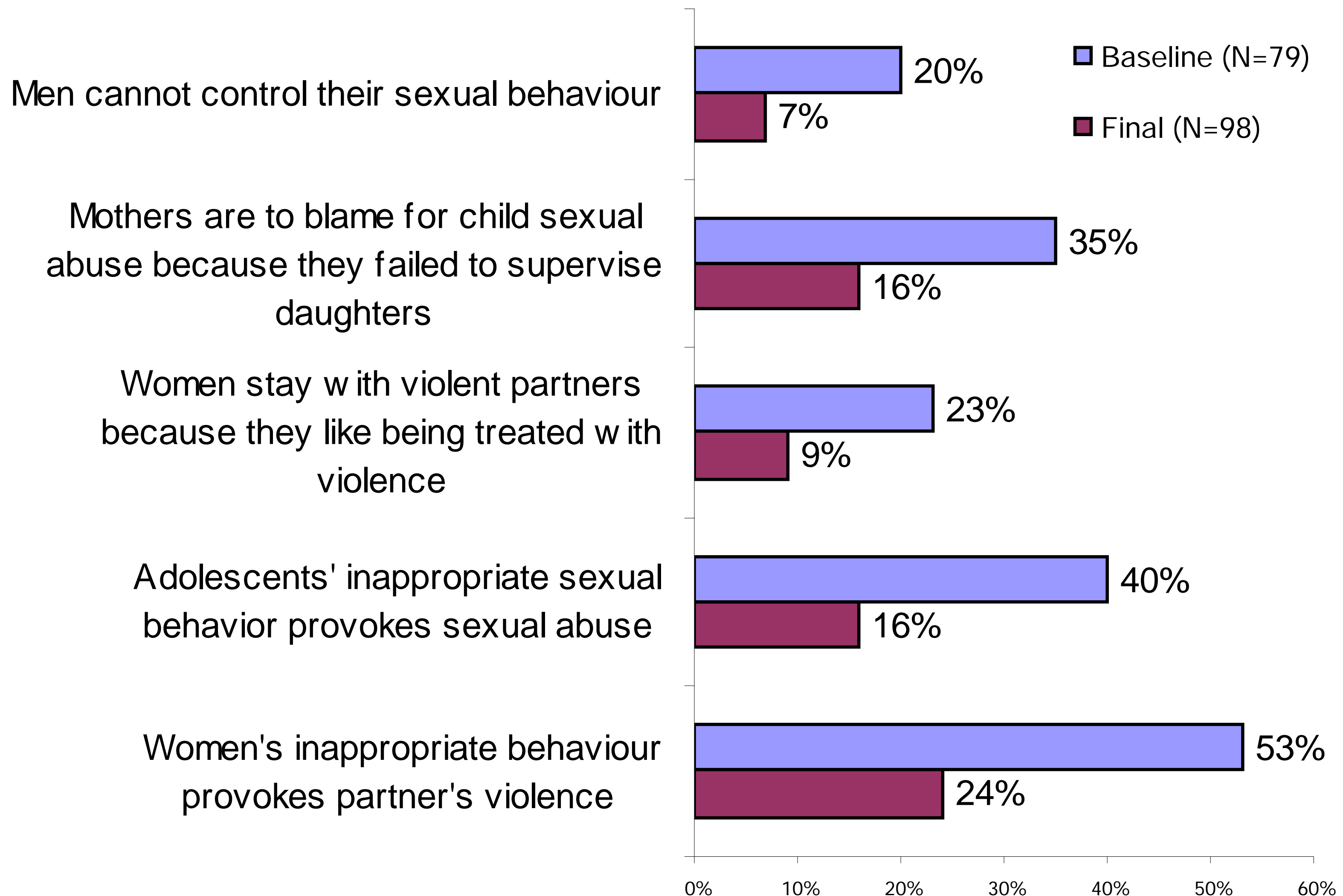
KAP survey (98 interviews with providers); Clinic observations/interviews (12 clinics); Random record reviews

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



Findings: the systems approach improved the clinic infrastructure

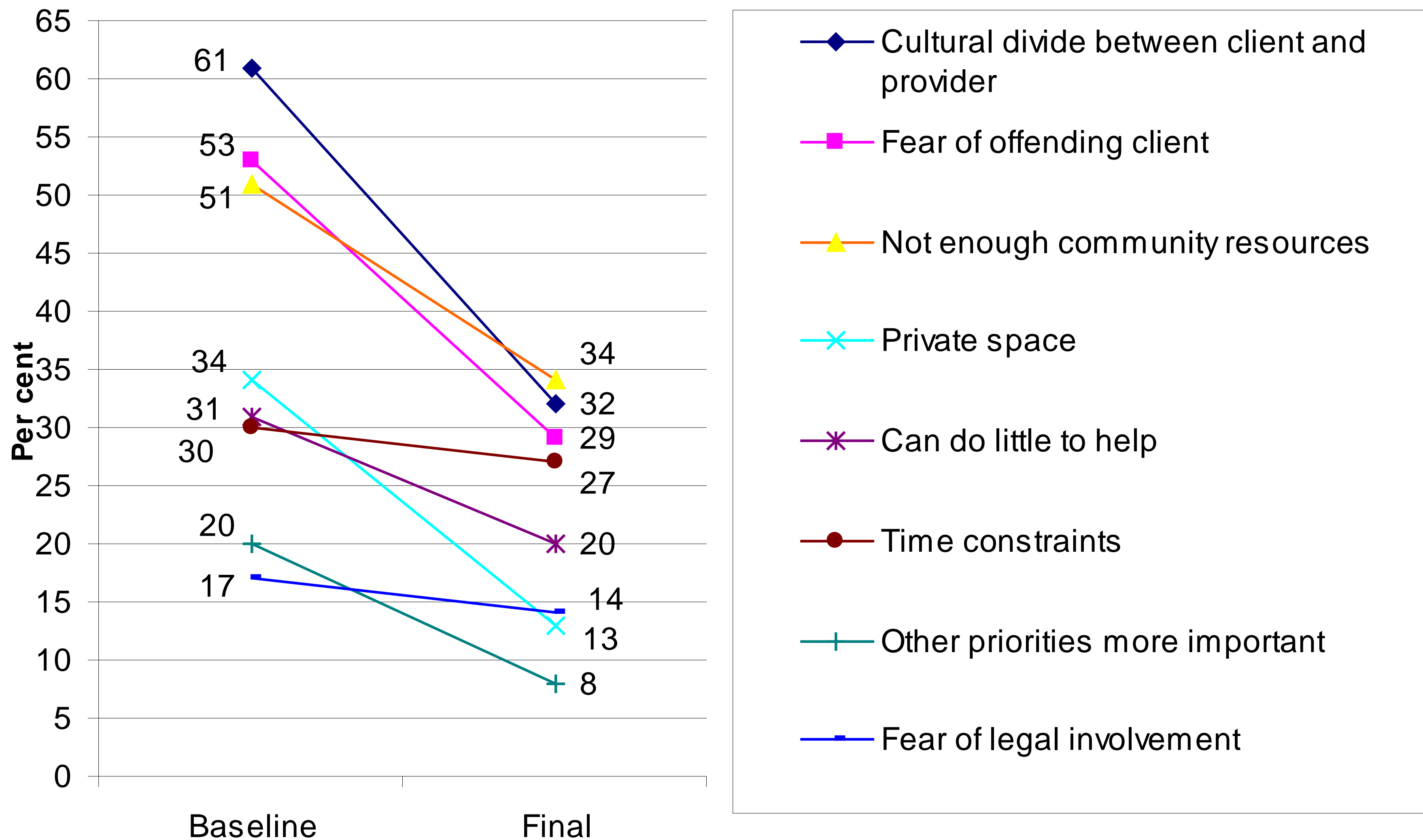
<u>At baseline, of eleven participating clinics:</u>

- 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

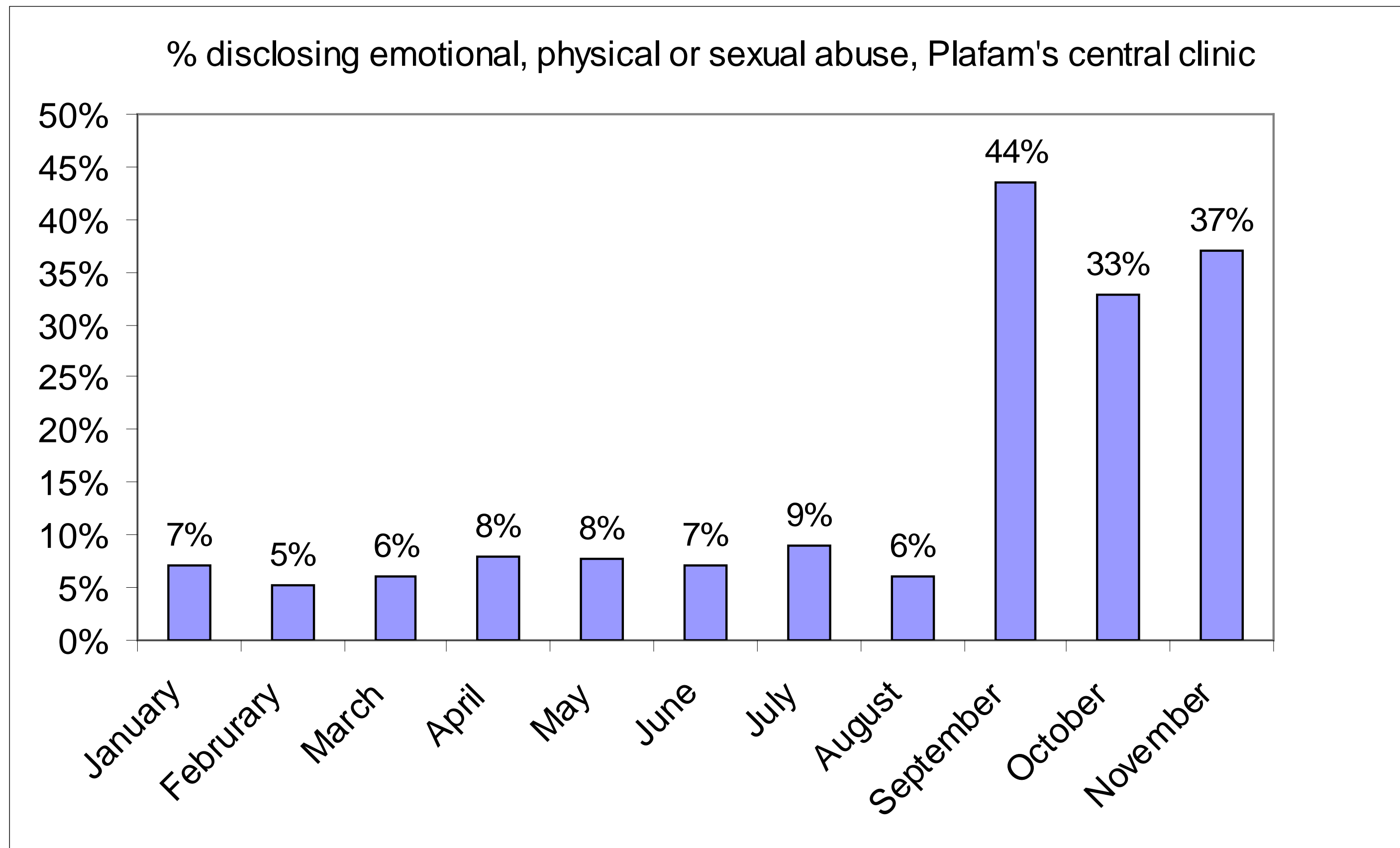
<u>By follow-up:</u>

- 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

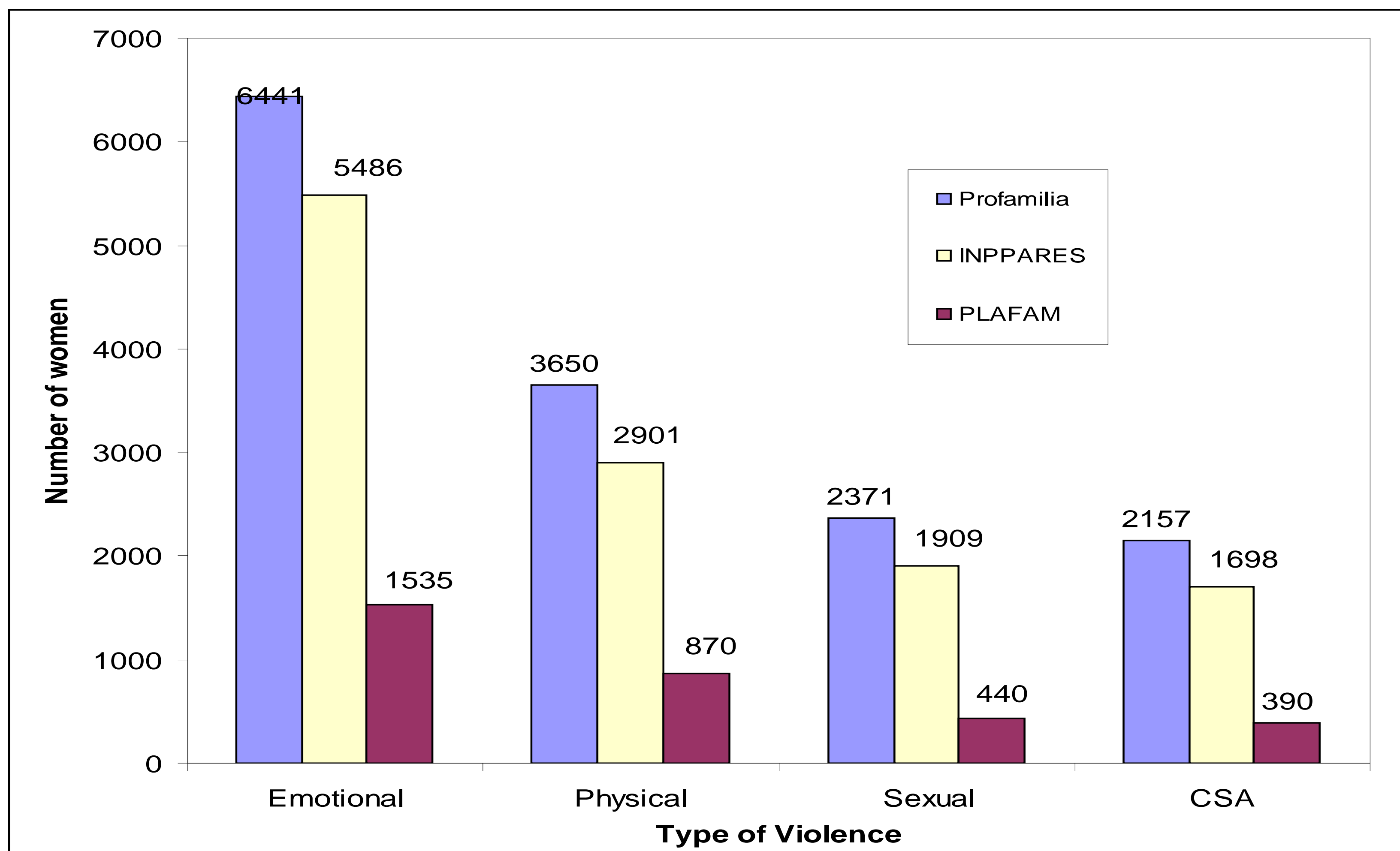
Findings: the systems approach reduced barriers to asking women about violence



Findings: Detection rose w/ introduction of written tool, January – December 1999



Numbers of women who reported emotional, physical or sexual violence in response to routine enquiry



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 a 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:

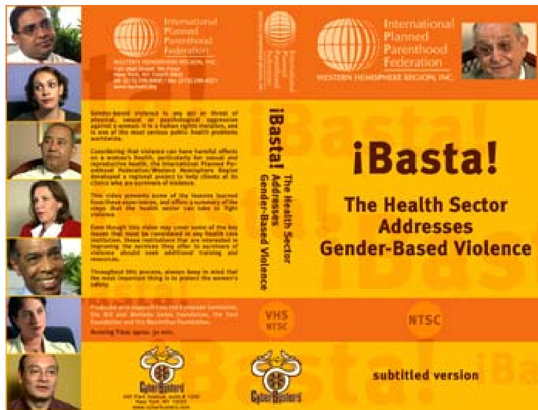
1. Working within resource-poor settings in challenging, but simple, low-cost interventions, such as support groups, can be very powerful.
2. Preparing a health care organization to respond adequately to violence against women requires a package of reforms throughout the health care organization.
3. 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.

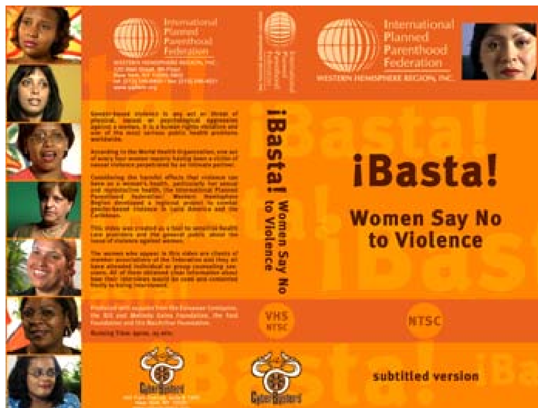
Thank you…Gracias…Merci…Obrigada!

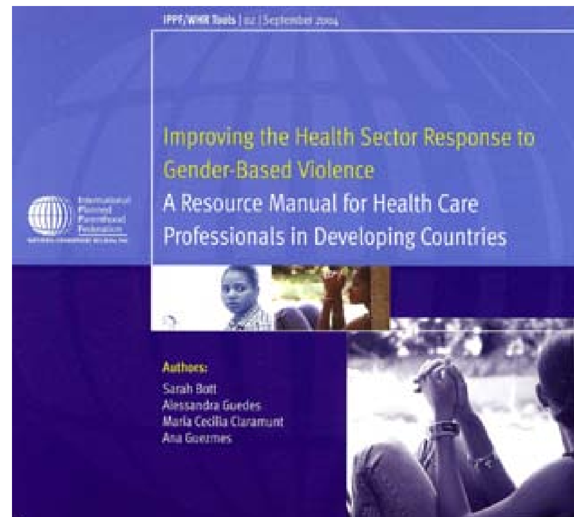
For further information and resources:

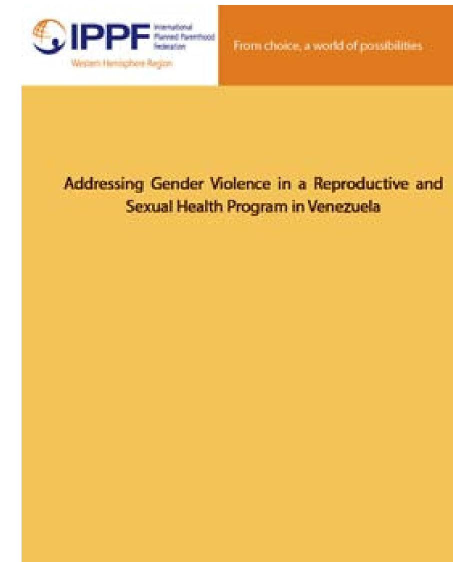
www.ippfwhr.org

or alessandra.guedes@uol.com.br









Publications related to the initiative

Bott S., Guedes A., Guezmes A. 2005 “The health service response to sexual coercion / violence: Lessons from IPPF/WHR Member Associations in Latin America.” in: Jejeebhoy S, Iqbal S, Shyam T (Eds). Sex Without Consent: Young People in Developing Countries. London, Zed Books.

Majdalani M, Alemán M, Fayanas R.,Guedes A., Mejía R. 2005 “Validation of a short questionnaire to use in clinical consultations to detect gender violence.” Pan American Journal of Public Health. 5:79-83.

Bott S., Guedes A., Guezmes A., Claramunt C. 2004. Improving the health sector response to gender-based violence: A resource manual for health care managers in developing countries. International Planned Parenthood Federation, Western Hemisphere Region: New York.

Guedes A., Helzner J., Tabac L., 2002 “Innovative approaches to gender and sexual and reproductive health: Linking gender-based violence, HIV prevention and quality of care.” *The Journal of Health Management*. Volume 4, Number 2, pages 283-300.

Guedes A., Bott S., Guezmes A., Helzner J. 2002 “Gender-based violence, human rights, and the health sector: lessons from Latin America.” *Health and Human Rights.* Volume 6, Number 1, pages 177-193.

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.

Guedes A., Stevens L., Helzner J., Medina S. 2002 "Addressing gender violence in a reproductive and sexual health program in Venezuela," in Haberland, N and Measham D (eds.), *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning.* New York: Population Council. Pages 257 – 273.