

GENDER-BASED VIOLENCE, HUMAN RIGHTS, AND THE HEALTH SECTOR: LESSONS FROM LATIN AMERICA

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In 1993, the United Nations (UN) General Assembly defined gender-based violence as “any act of . . . violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life.”¹ A recent analysis of more than 50 population-based surveys found that between 10% and 50% (or more) of adult-women respondents around the world reported having been physically assaulted by an intimate male partner at some point in their lives. Psychological abuse almost always accompanied physical abuse, and sexual abuse was present in a third to more than half of the cases.²

By labeling such violence as gender-based, the UN highlighted the need to understand this violence within the con-

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text of women's and girls' subordinate status in society. As Heise et al. have argued: "Many cultures have beliefs, norms and social institutions that legitimize and therefore perpetuate violence against women."³ As a result, in many settings, family members, religious leaders, health workers, social- service agencies, police, the judiciary, the media, and other institutions minimize or even justify the suffering caused by physical, sexual, and emotional abuse of women. In other cases, the problem is recognized but no one will take responsibility for providing services or prosecuting offenders. Even when legislation exists, judges may refuse to sentence perpetrators, police may not investigate, social services may be underfunded and therefore inadequate, and health providers may not recognize sequelae of violence or may treat women with disrespect.

In recent years, advocacy groups have raised awareness of gender-based violence (GBV) as a human rights violation, and a growing number of international agreements have addressed violence against women. These include the 1981 Convention on the Elimination of all Forms of Discrimination Against Women, the 1993 Declaration on the Elimination of Violence Against Women, and the 1994 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women.⁴⁻⁶ The 1994 International Conference on Population and Development (Cairo), and others like it, have also reaffirmed the right of women and men to be free of discrimination, coercion, and violence.⁷ The World Conference on Human Rights (Vienna 1993) and the Fourth World Conference on Women (Beijing 1995) both addressed violence against women as a violation of human rights.⁸

Some countries have responded to these international agreements by strengthening legislation against GBV. However, GBV poses a challenge to classic human rights work because it occurs in what have traditionally been considered "private spheres" (e.g., the family and the home) rather than involving direct abuse by the state.^{9,10} Consequently, freedom from GBV cannot be ensured through government action alone but requires convincing the broader society that violence against women is a

violation of human rights.

Because GBV is both a public health problem and a human rights violation occurring in the “private” domain, international documents have increasingly called on governments to collaborate with health services.¹¹ For example, the Beijing Platform for Action (1995) called for governments and nongovernmental organizations (NGOs) to “develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict.”¹²

In recent years, several affiliates of the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) have tried to overcome the ambivalence traditionally expressed by the health sector by addressing gender-based violence in the context of providing sexual and reproductive health services. This article describes efforts to improve the health system response to survivors of violence and to raise awareness of GBV as a violation of human rights among health professionals, clients, and the broader society.

Background and Project Description

The 1994 Cairo Conference called for a comprehensive approach to sexual and reproductive health based on a foundation of respect for human rights.¹³ Following the Cairo and Beijing conferences, IPPF began work to incorporate those principles and recommendations into its policies and programs. In 1995, the IPPF Members Assembly approved the IPPF Charter on Sexual and Reproductive Rights, based on 12 rights grounded in international instruments, including the right to privacy, the right to information and education, the right to the benefits of scientific progress, and the right to be free from torture and ill treatment. The Charter interprets those rights in the context of sexual and reproductive health.^{14,15}

IPPF/WHR used a number of strategies to ensure that its affiliates’ policies reflected the principles of Cairo and Beijing. At the regional level, IPPF hired self-identified feminists as staff members and worked for changes within its Board of

Directors. At the country level, affiliates forged links with women's groups and implemented pilot programs to enhance their awareness of and approach to gender. During this period, the IPPF/WHR Regional Office heard increasingly from both providers and clients in Latin America and the Caribbean about the need to address violence against women.

To meet this need, three IPPF/WHR affiliates, including PROFAMILIA (the Dominican Republic), INPPARES (Peru), and PLAFAM (Venezuela), joined with the Regional Office to develop a project that would integrate the issue of GBV into existing services of 11 clinics that specialize in sexual and reproductive health. The project, which began in early 1999 and is expected to end in December 2002, had several objectives, including (1) to improve the institutional response to women who experience violence through adjustments to infrastructure, client flow, and clinic resources, as well as training health providers to detect, treat, and refer GBV survivors; (2) to conduct information, education, and communication activities to raise awareness of GBV in the broader community; and (3) to collaborate with other organizations to improve laws and their application.

In contrast to initiatives that have focused exclusively on intimate-partner violence, IPPF/WHR and its affiliates chose to address a broader definition of GBV that encompasses all kinds of sexual violence, including a history of childhood sexual abuse, as well as physical, sexual, and emotional abuse by an intimate partner.

Project Evaluation

To ensure comparable data, the project team developed standardized indicators and instruments for use by all three affiliates. In early 2000, external consultants carried out a baseline survey of knowledge, attitudes, and practices of 79 providers, including physicians, midwives, nurses, counselors, and other health workers. External consultants assessed the infrastructure and resources at the 11 participating clinics using an observation guide, and made an institutional-needs diagnosis at each affiliate. (Details of baseline methods and findings have been published elsewhere.)¹⁶ Throughout the project, the affiliates gathered statistics on

screening levels, detection rates, referrals made, and services provided. Each affiliate conducted case studies on pilot programs, and Regional Office staff made site visits and held informal interviews with providers, managers, and clients to monitor the project.

In late 2001, the affiliates participated in a midterm evaluation. This evaluation included a quantitative client-satisfaction survey of 691 female clients, but it was primarily designed to collect qualitative data using group discussions with providers (6 groups), external informants (2 groups), and women who had experienced violence (8 groups); 14 individual, in-depth interviews with women who had experienced violence; 14 interviews with key informants from the affiliates and other organizations in each country; and a systematic documentation of pilot strategies used to meet certain project objectives. The same consultant collected and analyzed the qualitative data in all three countries to maximize comparable results. Every effort was made to follow the ethical guidelines for conducting research on gender-based violence published by the World Health Organization (WHO).¹⁷

Increasing Awareness of the Health Consequences of Human Rights Violations

The affiliates' experience underscores the need to raise both providers' and clients' awareness of the health consequences of GBV. A growing body of epidemiological evidence documents the effects of GBV on women's health, suggesting that if providers are unable or unwilling to recognize the sequelae of violence, they may not be adequately diagnosing, treating, or advising their clients.¹⁸

Health consequences of GBV range from physical injury and chronic pain to mental and emotional disorders—such as anxiety and depression—to fatal outcomes such as suicide or homicide.¹⁹ Effects of violence on women's sexual and reproductive health are particularly relevant for IPPF affiliates. Fear of violence prevents many women from using contraception or proposing condom use, thereby increasing their risk of unwanted pregnancies and sexually transmitted infections, including HIV.²⁰ Childhood sexual abuse often leads to risky behaviors in adolescence and adulthood, such as mul-

multiple sexual partners and unprotected sex.²¹⁻²³ Research suggests that violence may be more prevalent during pregnancy (an estimated 4% to 8% of pregnancies) than conditions such as pre-eclampsia (an estimated 6% to 8% of pregnancies) or gestational diabetes (an estimated 2% to 7% of pregnancies.)²⁴⁻²⁶ Evidence also suggests that sexual violence may increase the risk of gynecological disorders that are otherwise difficult to diagnose or treat, such as chronic pelvic pain and recurrent vaginal infections.²⁷

Many health professionals are unaware of these health consequences simply because GBV has never been part of their professional training. In the baseline survey, 72% of providers reported never receiving training related to violence. The midterm evaluation suggested that teaching providers to recognize the clinical signs of GBV can make a difference. As one male gynecologist from the Dominican Republic explained: "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."²⁸

In addition, health professionals are often unaware of the extent to which women living in violent situations are at risk for future injury or even death. Intimate-partner violence often escalates over time, both in frequency and severity.²⁹ Women in violent situations may also be more likely to commit suicide or homicide.³⁰ Some providers who were unaware of these risks at the outset of the project said in their baseline interviews that they considered GBV to be outside the bounds of their practice. One male gynecologist explained that he had not discussed the issue of violence with his clients because "people do not come for those things [violence]. We have to address only those things [physical concerns] they require or request."³¹

In some cases, raising awareness about the health consequences of violence can change a provider's approach to care. As Lynn Freedman argued, epidemiology can be a "powerful tool" for demonstrating that "even an individual's physical health—not to mention her mental and emotional health—is inextricably tied to the wider conditions of her life. Thus physical health cannot be detached from political and social concerns."³²

Because a woman's ability to recover from or escape violence may require social, economic, emotional, and legal resources, providers who address GBV with clients may find themselves offering emotional support, helping with safety planning, or making referrals to social or legal services. The midterm evaluation found that by addressing GBV, providers had to consider broad dimensions of health and well-being. Such an approach conforms to WHO's definition of health as "a state of complete physical, mental and social well being," but it remains a paradigm shift for professionals whose training focused solely on biomedical concerns.^{33,34} One physician from the Dominican Republic explained: "Before, I thought this was not part of my job. I limited myself to medical treatment [for the abuse], but ignored the psychological and legal aspects and simply didn't ask questions about them."³⁵

The project's experience supported the idea that epidemiological data on GBV can have the power to persuade health professionals that wider social inequities and attacks on human dignity are not just abstract social or political phenomena but directly concern their daily work. When providers see a link between GBV and injury, disease, and death, they may be more open to new explanatory frameworks, including gender and human rights.

Meanwhile, raising women's awareness of their own health risks as well as of the risks to their children can motivate them to seek help. During midterm interviews, women subjected to GBV often described going through several emotional stages that evolved from denial to understanding, which began with hoping the partner would change, to attempting to manage the problem by doing only what the partner wanted, to finally deciding to seek outside help. Several women said that recognizing the impact such violence had on their health was a powerful catalyst for change. A woman from the Dominican Republic explained that: "I was dying without realizing it. When the [female] physician told me that my health problems were related to what was happening in my house, I then 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."³⁶

A Greater Responsibility to Respect Human Rights Within Medical Practices

The midterm evaluation also revealed that efforts to address GBV within the affiliates brought about changes that would protect clients' rights within the clinics. For example, the project emphasized protecting clients' privacy during consultations, confidentiality of medical records, and safety. As a result, clinics improved their physical infrastructure, adjusted their client flow, and revised their policies to protect client records. At baseline, interruptions were common during consultations in four clinics, and at least four clinics lacked space where they could counsel clients without being overheard. All 11 clinics now have clear and stringent policies about confidentiality, and all have adequate areas for private consultations. At midterm, clinic managers told interviewers that the effort to improve respect for privacy and confidentiality had raised their appreciation of these elements as components of quality of care more generally.

Additionally, the midterm evaluation showed that the affiliates had reviewed and—when necessary—revised their sexual harassment policies. Subsequently, two affiliates confronted cases of sexual harassment, which led to the dismissal of the providers. One manager said that if staff members had not been actively addressing GBV, they might not have believed the woman or acted decisively against the aggressor. These examples suggest that with respect to both privacy and sexual harassment, the project prompted the affiliates to improve respect for the rights laid out in the IPPF Charter on Sexual and Reproductive Rights.^{37,38}

Finally, one essential way that health programs can respect human rights and promote human dignity is to ensure sensitive and appropriate care for women who experience violence. How providers react can have an enormous emotional impact on women who disclose violence. Providers who blame survivors, minimize violence, or act as if women are lying can cause tremendous harm.³⁹ For instance, one Peruvian gynecologist told a baseline interviewer: "For anatomical reasons, it is impossible for a man

to rape a woman if she wants to avoid it."⁴⁰ It is difficult to imagine how a rape survivor could receive humane or appropriate care during a consultation with that doctor.

Provider attitudes are relevant even when a clinic has no GBV-screening policy. Women may disclose experiences of violence even when health-care providers do not ask; and providers may ask about GBV, whether or not their clinic has a formal policy. Before routine screening policies were implemented, baseline interviews were conducted with the 36 physicians who participated in the project. Those interviews revealed that two out of three had asked a client a direct, specific question about GBV during the past year, and nearly 90% reported that at some point during their practice a client had disclosed an experience with GBV.

Without training, however, many otherwise excellent professionals may react to clients in less than ideal ways. During the midterm interviews, a gynecologist from the Dominican Republic reported that before the project began: "Doctors preferred not to bring up the topic because they did not have the tools to respond to women." Nevertheless, he admitted: "When doctors did talk, we often defended the man."⁴¹ During baseline interviews, attitudes of many of the 79 providers reflected a tendency to blame victims rather than aggressors. More than half (53%) said that some women's "inappropriate" behavior provoked their husbands' aggression. Respondents' examples of such behavior included infidelity and poor housekeeping. Of all respondents, 41% believed that some adolescents' "inappropriate" sexual conduct provoked sexual abuse. Nearly a fourth (23%) said that women do not leave violent partners because on some level they like being treated that way. Overall, one in five agreed that men have no control over their sexual behavior.

After the project began, some managers realized that some of their staff's extreme negative views posed a risk to women who might disclose abuse. Those managers then had to consider whether such staff members should continue practicing in their clinics. All three affiliates now question job applicants about GBV during the interview process.

Sensitization and Training: Key to Incorporating a Rights-Based Perspective

All three affiliates held workshops to raise awareness about gender issues long before the project began. These efforts, however, had not always translated into health providers' taking a human rights perspective with clients. Some staff had believed that gender sensitivity meant treating men and women the same, regardless of context or needs. In settings where human dignity is often disrespected, treating women and men equally may mean treating them with equal disrespect, particularly when hierarchies created by profession, social status, class, gender, or ethnicity generally encourage disrespect of subordinates.

To address that issue, it was important to emphasize the impact of unequal power relationships between men and women on sexuality and health.^{42,43} Exploring cultural and social norms that justify, excuse, or ignore men's use of violence against women was also helpful.⁴⁴ Ultimately what brought participants together was to emphasize that human dignity and human rights are inalienable and indivisible and that women have a right to live free of violence under all circumstances; they should not have to relinquish their rights to live with a husband or to ensure economic support for their children.

The complexity of issues surrounding rights, gender, and violence made it clear that much of the project's hope for success lay in the quality of the training health workers would receive and therefore in the effectiveness of the trainer. With that realization in mind, project organizers looked for a trainer who had a human rights perspective, had worked with survivors of violence, knew the epidemiological evidence, and understood the sociological dynamics of violence. That person needed to have substantial experience dealing with GBV in the region and with the medical, legal, social, and psychological dimensions of GBV. In addition, the trainer needed professional credibility (particularly with physicians) and the ability to communicate, in a nonthreatening way, concepts that might challenge trainees' belief systems. The project was fortunate to find Maria Cecilia Claramunt, a trainer from Costa Rica, who embodied all those skills. Regional training was followed up by a series of

two or more training sessions in each country, which provided a uniform approach at all sites.

Trainers may have difficulty convincing health professionals that awareness of GBV is relevant in their practice (much less that they need to embrace a human rights perspective). For that reason, the project emphasized that training should start with participants' own beliefs and concerns, be sustained over time, and incorporate ongoing support and monitoring. Ideally, training should coincide with a broader effort to review an institution's policies and resources, including service protocols, screening tools, and referral directories. In other words, training should be part of what Heise et al. called a "systems approach"—one that involves the whole organization and does not expect individual providers to act alone.⁴⁵

Although final results of the training will not be rigorously analyzed until the evaluation is complete, anecdotal evidence suggests that deeply entrenched provider attitudes can be difficult to change. On the other hand, training can sometimes change attitudes in dramatic ways, and some professionals have reported noticing a broad transformation in their views. As one male gynecologist from the Dominican Republic stated: "I arrived at the training to learn technical issues. But afterwards, my life, my relationship with my wife and my two children cannot ever be the same."⁴⁶

Links between the Health Sector and the Legal Sector

From the project's outset, the affiliates grappled with a number of concerns related to legal services and rights. First, many providers were unaware of laws related to GBV or were hesitant to discuss GBV with their clients, fearing that they would be required to report a case to authorities or to testify in court proceedings. The baseline interviews revealed a low level of knowledge about health workers' legal responsibilities. In the Dominican Republic, for instance, many providers knew of specific legislation (which had been widely publicized by the affiliate), but few knew what their actual obligation was. Thus, educating providers about their rights and responsibilities was an important element of the project.

Second, the affiliates struggled with the question of where to refer women who needed affordable legal advice. In some cases, they forged links with existing legal services; in others, they hired lawyers to work in-house, advising clients and educating staff, as well as to carry out external advocacy. Such services are expensive, however, and whether the affiliates can sustain this approach over time remains to be seen. Even when health programs provide legal services, however, GBV survivors often need external services, such as forensic examinations and interventions from police and the courts. Fearing that in such settings women may be treated poorly, some clinics have had staff accompany women to services when possible. During the midterm evaluation, women said that having a staff member with them when they sought external services was helpful. Again, this service may be difficult to sustain because it is staff-intensive.

Planners were initially concerned about the cost and time involved in criminal proceedings. Although that is still a concern, service records as well as the midterm evaluation indicate that most of the demand for legal services regards divorce proceedings, property disputes, child-custody arrangements, and spousal support payments—the legal tools that allow women to leave a violent relationship and still support themselves and their children.

Promoting Human Rights in the Broader Society: Improving Legal Protection for Women

Advocating for legislative change and for better enforcement of existing laws are other ways to protect women who experience GBV. From the beginning, the affiliates realized that they were most likely to achieve success by collaborating with a network of organizations. All three have joined networks at the local and national levels to advocate for legal and judicial reform.

Among the three affiliates, PROFAMILIA has been the most active in legal advocacy. Even before the multicountry project began, PROFAMILIA had successfully campaigned to reform laws regarding violence. Once that legislation passed into law, PROFAMILIA produced booklets and a video that explained the new laws clearly and in plain lan-

guage. PROFAMILIA's experience is evidence of how a health organization can work to improve protection for women's rights.

According to midterm interviews, applying the new legislation has been problematic. Judges sometimes reduce sentences, even when the law does not allow for judicial discretion. Judges and other government agents frequently fail to recognize their obligation to protect the woman or to prosecute the offender, but instead recommend that the couple reconcile. To address this problem, PROFAMILIA collaborated with the Women's Support Nucleus and the Department for the Protection of the Rights of Children, Adolescents, and Families to carry out a series of seminars for employees who work at the Justice Department of the Dominican Republic.⁴⁷ These seminars aimed to raise awareness of gender-based and family violence and to teach employees about their role in enforcing the laws. Participants have included investigators, inspectors, public prosecutors, officers of the court, administrators, and police officers.

Justice Department representatives reported that PROFAMILIA helped them to identify strengths and weaknesses in their systems, to improve the way they manage cases, and to recognize the need for systematic registers of offenders, specialized forms, continued capacity-building efforts, and multidisciplinary teams of investigators, lawyers, health workers, social workers, and psychologists to evaluate and pursue cases. In the past year, the Attorney General of the Dominican Republic enacted four resolutions that call for continued partnerships with NGOs such as PROFAMILIA. This experience illustrates the kind of partnership that is possible between the health sector and the legal system to promote human rights.

Conclusion

In many ways, the IPPF/WHR project has illustrated what Jonathan Mann and his colleagues believed would be the results of the health sector's paying more attention to human rights: an increased awareness of the health consequences of human rights violations—in this case GBV; a

greater responsibility to respect human rights within their practices; and more efforts to promote respect for human rights within the broader society from their position as health workers.⁴⁸ As this article has described, the midterm evaluation found that as a result of the project, providers and clients reported greater awareness of the health consequences of gender-based violence as a human rights violation, clinics strengthened measures to protect clients' rights, and all three affiliates contributed to wider efforts to advocate for legal protections of women's rights within the broader society.

This project produced other lessons as well. First, addressing GBV revealed key areas in which the affiliates' effort to incorporate a human rights perspective into health services was incomplete in terms of ensuring clients' privacy and safety, and preparing health workers' to provide humane and appropriate care to GBV survivors. Second, a human rights approach proved essential for integrating GBV into health services because it gave providers a clear set of principles for understanding the wider context of GBV and the need to protect GBV survivors' dignity and rights. Third, addressing GBV within the health sector motivated providers to recognize the broader social, economic, and political factors that influence women's health and even to change the way that providers viewed health and well-being. Finally, by emphasizing the importance of confidentiality, privacy, women's autonomy, human rights, and a more holistic approach to health, the midterm evaluation found that affiliates improved their overall quality of care.

GBV presents the health sector with an important opportunity to explore linkages between health, gender, and rights in both theoretical and practical ways. Ensuring that clinics have the basic resources and personnel to ethically and adequately address GBV is important for improving quality of care and promoting respect for human rights. The health sector cannot win this battle alone, but health programs can contribute to increasing respect for human rights within their services and in society in general.

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