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Gender-based violence is endemic in Venezuela, as it is in many other countries. Despite this fact, few organizations within the country address the problem. Family planning organizations have largely ignored it, because they see it as outside the purview of their mission. In the capital city of Caracas, only one organization, a feminist nongovernmental organization (NGO) called AVESA (for Asociación Venezolana para una Educación Sexual Alternativa, or Venezuelan Association for Alternative Sexual Education) had a well-established program to combat gender-based violence and assist victims. In concert with a broad Latin American feminist movement, AVESA has argued that violence is a sexual and reproductive health issue—and that bodily integrity is a human right. This is the story of how the staff at the Asociación Civil de Planificación Familiar (PLAFAM)—the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) affiliate in Venezuela—came to share that vision, to recognize the effect that women's social context has on its clients' sexual and reproductive health, and to meet the needs of victims of violence. Although PLAFAM has already learned many lessons about integrating work on gender-based violence into its sexual and reproductive health programs, the ongoing project described in this chapter has little precedent. As such, it proceeds, in part, by trial and error.

GENDER-BASED VIOLENCE IN VENEZUELA

In Venezuela, as elsewhere, there are few reliable data on the overall prevalence of gender-based violence. Available data come mostly from the small number of cases reported to the authorities or, occasionally, to NGOs. Because such data are not al-

ways reliably gathered and because gender-based violence tends to be greatly underreported, these statistics are not likely to present an accurate picture of the true scope of the problem. Nonetheless, they suggest that gender-based violence is commonplace. In Caracas, 40 percent of women who seek hospital emergency services report having been beaten by their partners; 89 percent of violence victims had been treated previously for problems related to violence (Davies 1998). The Justice of Peace,[1] which handles cases involving disputes between families or neighbors, receives ten complaints of violence every day in Caracas; 97 percent of its caseload involves domestic violence perpetrated against women and children (Calzadilla 1998). The abuse is not limited to battering. In Venezuela an average of 12 women report being raped every day; 72 percent of these women are under the age of 19, and most are raped by someone they know (AVESA 1998a). Because the majority of victims do not dare report the abuse to authorities, these figures represent only a fraction of the true prevalence of violence against women.

The existence of such violence is minimized, rationalized, and denied by individuals from every social class. Yelling, slapping, and hitting a partner with an object are often called "lovers' troubles" (AVESA 1998b). Aggressors who are detained by police are generally released without any sanctions, allowing the pattern of violence to continue unchecked.

WHERE PLAFAM BEGAN

Throughout the 1970s and 1980s, PLAFAM offered medical services, including family planning, gynecological services, antenatal care, testing for sexually transmitted infections (STIs), basic infertility services, and ambulatory surgery such as tubal ligation. By the mid-1990s, it was operating three clinics (one expressly for adolescents, and two outside of Caracas). By 1995 PLAFAM was conducting about 1,000 family planning visits each month, primarily from its central clinic in Caracas. Counseling activities were introduced in 1986, but addressed only family planning.

Staff realized that they were seeing women who were the victims of violence, usually at the hands of their partners. For many years, most staff did not see a connection between violence and sexual and reproductive health. Some wanted to help but lacked the skills to do so. Fearful of what could emerge if they initiated a discussion of violence, they likened the experience to opening Pandora's box. As one staff member put it: "The organization had no mechanism that helped me to help a woman who had been abused. I did not know what to do." When a client was bold or desperate enough to initiate a discussion of the topic, she was referred to AVESA for psychological and legal counseling. This precarious arrangement, by which a staff member at

PLAFAM would telephone AVESA to alert staff there that a client was being referred, did not allow for continuity of care or appropriate follow-up by PLAFAM. The staff member would provide the client with AVESA's address, telephone number, and the name of a contact. Clients who decided to use AVESA's services negotiated fees on a sliding scale, with a maximum fee of approximately US$7. Because of time constraints and safety concerns associated with contacting victims of violence, staff were not always able to follow up to determine whether the woman had reached AVESA or whether the services she received had been helpful.

In July 1997 PLAFAM'S executive director and its information, education, and communication (IEC) director attended a two-day IPPF/WHR workshop in New York designed to sensitize affiliate leaders to the prevalence of violence and to delineate its connection to sexual and reproductive health. The workshop included exercises, role-plays, and didactic material that examined how such violence affects victims, why it is not discussed, how to introduce the topic to staff, and possible programmatic responses.

CONFRONTING "LOVERS' QUARRELS": SENSITIZING STAFF

Upon returning to Venezuela, PLAFAM's leaders decided to find a way to address violence in their services. They showed PLAFAM staff *The Tribunal of Vienna,* a documentary film of the testimony of victims of violence who spoke at the International Conference on Human Rights in 1993. The documentary, along with the ensuing discussion, illustrated the overwhelming frequency and devastating impact of violence against women. It also helped staff realize that this issue hit close to home and involved not only the clients they treated professionally but also many individuals they knew socially, including members of their own families. They talked about the use of the "lovers' quarrel" euphemism as a way to ignore and excuse a serious problem. They also explored the ways that the fear of violence affects a woman's health and impedes her ability to use contraception or protect herself from STIs. Staff, who had sent a representative to the 1994 International Conference on Population and Development in Cairo and discussed its outcomes and their relevance to PLAFAM's mission, agreed that they needed to help clients who were experiencing violence.

PLAFAM adopted three key strategies: (1) increasing staff awareness of violence and developing their skills to identify, assess, counsel, and appropriately refer violence victims; (2) developing and procuring materials for clients on violence and sources of support; and (3) collaborating with existing community alliances that engage in advocacy against violence. Each of these activities is described below.

The initiative began in September 1997 with a two-day awareness workshop for every employee, including clerical and technical staff, janitors, and receptionists in

addition to administrators, clinicians, and counselors. The rationale for involving all employees was twofold. First, PLAFAM recognized that if the project was to succeed, all staff would need to be aware and convinced of the relevance of violence to sexual and reproductive health, the organization's main mission. Second, many types of staff would need to be involved in identifying and assisting victims for maximum project effectiveness. The workshop was led by the IEC director, a consultant on gender, and a Venezuelan feminist with expertise in group dynamics and violence issues. The objectives were to enable staff to (1) gain a conceptual understanding of gender violence; (2) understand the personal and interpersonal effects of gender violence; and (3) design a plan of action compatible with PLAFAM's mission and resources.

Participants began to understand the effect of violence on women's reproductive and sexual health. They also learned that when clinic staff pose questions about violence in a sensitive and nonjudgmental manner, many clients will talk about their experiences. Moreover, they realized that as the only health care agency many women visit, PLAFAM was in a unique position to assist women who were experiencing violence. As they began to rethink the ways they could help these women, the participants' apprehensions diminished. As one counselor explained: "I knew something about gender-based violence, but before the workshop I felt anxiety whenever the topic arose."

HELPING WITHOUT FIXING: REORIENTING STAFF

The next stage of staff development emphasized allowing staff to determine how they would use this new knowledge in their work. It moved beyond sensitization to assisting providers in defining their roles, teaching them how to identify victims' symptoms, and finding ways to lift the barriers to clients' disclosure. Staff worked on techniques to initiate discussion with clients, and also began to explore how working with victims of violence might affect them personally.

A three-day skills training workshop for all clinicians, counselors, administrators, and receptionists was held in June 1998. Staff responded positively to the initial exercises, which focused on internal and external barriers to integrating violence into their work. However, by the second day of training, the providers began to realize that they were being asked to make radical changes to the way they worked, from actively doing or giving something concrete to clients (e.g., a physical exam or a contraceptive) to what they perceived as more passive engagement of clients (e.g., offering support, listening nonjudgmentally, and providing referrals to qualified professionals). Participants became anxious and overwhelmed. They expressed concern that if they raised the topic of violence they would upset the client without being able to provide her with tangible ways to handle her psychological pain and "fix" the trauma. Participants

also expressed anxiety that clients would require more than they would be able to provide. Furthermore, participants worried that they were being required to add an additional assignment to their already busy schedule and that they would fail.

On the third day, the participants engaged in role-plays. As "clients," they were better able to appreciate both the hesitation about and the relief of disclosing violence, and saw how helpful it was to have someone listen carefully and communicate a sense of caring and concern. As "staff," they could feel the client's palpable relief at disclosure and her appreciation for being listened to and cared for. Staff, initially concerned that they could not fix clients' dilemmas, found that disclosure and emotional support were useful and helpful in and of themselves.

Even with training, staff capacity would be inadequate to deal with the many requirements of clients who revealed violence. As a result, PLAFAM recruited a project coordinator (a psychologist), who was to oversee the project in all clinic sites, and two part-time psychologists, who were responsible for conducting in-depth follow-up assessments of clients who disclosed violence, providing counseling in individual and group settings, and convening support groups to help staff deal with difficult cases and respond to the feelings that emerged as they listened to women's painful stories. Because none of the psychologists had prior direct experience with gender-based violence counseling, PLAFAM arranged training in collaboration with AVESA that included three-month part-time internships at AVESA.

REORIENTING SERVICES TO ADDRESS VIOLENCE IN CLIENTS' INTIMATE RELATIONSHIPS

In addition to helping clients who were experiencing gender-based violence, PLAFAM staff wanted to educate all of its clients about violence. To alert clients that PLAFAM was a safe place to talk about a previously taboo topic, staff used a range of print materials, including:

- Posters on the clinic walls telling clients that violence is common but unacceptable and informing them that help is available at PLAFAM.
- A booklet of examples of acts that constitute physical, psychological, and sexual violence and information on where clients can go for legal, medical, and psychological help.
- Two-sided bookmarks, with information on violence on one side and referral numbers on the other.

These materials were placed in the waiting room, consulting rooms, and bathroom. Staff felt that the materials would help some clients feel more comfortable discussing violence with their counselor. If some women were not ready to explore the

issue during the clinic visit, they could keep the bookmark until they felt ready to make a call or visit one of the referral facilities. Clients could also take the literature with them and pass it on to a friend or relative.

SCREENING FOR VIOLENCE

Attention to the topic of violence begins as soon as a new client checks in for her appointment.[2] To help prepare her for the sensitive questions that will follow, the receptionist describes PLAFAM's services, including those related to violence.[3] A counselor (most likely a social worker or educator) then takes the client to a private office and follows a general protocol that was developed during the three-day skills training workshop to introduce the topic of violence and screen the client. Although a special form was developed for this purpose, it was found to be too time-consuming and repetitive, and was never used. In the early stages of the project, counselors thus used their own discretion in introducing the topic of gender violence and asking related questions. Later in the project a more systematic and specific protocol was adopted, which requires:

- Investing extra effort in establishing rapport while asking preliminary general questions.
- Explaining that PLAFAM is concerned about the high incidence of abuse and the lack of safe, supportive places where women can discuss this problem—and that, for this reason, counselors ask all new clients the same set of questions. The client may decline to be screened.
- Asking the client four direct questions to assess whether she has experienced emotional, physical, and sexual violence, including sexual violence in childhood (the process used to develop this tool is described later in this chapter). The counselor asks about specific behaviors because many women do not view such behaviors as abusive or label themselves as victims of abuse.
- Observing other clues (e.g., affective change, nonverbal communication) that suggest the client is extremely anxious about the topic.
- Documenting the client's answers and other observations in her chart.
- Asking two questions to assess a victim's current safety and, if needed, taking appropriate steps, such as assisting with the development of a safety plan.

If a woman answers "yes" to any of the questions about exposure to violence, the counselor's job is to listen, provide emotional support, and inform the woman about the availability of a voluntary in-depth consultation with the staff psychologist, who can better identify her needs and help her determine the best course of action. A client who chooses to have an in-depth consultation is sent directly to the psychologist be-

fore undergoing her clinical exam. If a woman is distressed and a psychologist is not available, the counselor provides the client with emotional support before she continues on to her clinical exam. (PLAFAM recently hired two additional psychologists to ensure that women who wish to see a psychologist will, in most instances, be able to do so immediately.)

The psychologist conducts an in-depth evaluation and a more thorough risk assessment[4] to document the client's history of violence and to assess the seriousness of her symptoms, her current vulnerability, and whether and how the violence is affecting her children. On the basis of this information, the psychologist identifies the types of services the client may need. If the psychologist determines that a client is in imminent danger, she will try to help her formulate a safety plan, if that is the client's choice. Safety strategies can include memorizing important phone numbers, opening a bank account in the woman's own name, rehearsing an escape plan, and/or leaving extra money, copies of important documents, and a change of clothes with a trusted friend or relative.

Onsite referrals may include: (1) follow-up individual counseling; (2) further assessment by the psychologist, if necessary; or (3) if the client has been recently battered, a consultation and exam with the PLAFAM physician, who will document her physical injuries, sometimes using a "body map."[5] The psychologist may also make outside referrals to social, psychological, and legal agencies listed in the resource directory (see below) and call agency staff to inform them of the referral. After the psychological assessment, the client may choose to complete her visit and obtain the services for which she originally came, generally on the same day. If the woman has run out of time or is too distraught to undergo her medical consultation, her visit may be rescheduled.

Clinicians, too, have been trained to recognize symptoms of violence by observing marks on the body, to be responsive if a client chooses to disclose that she is being abused, and to provide related counseling. If a client has already discussed the issue of violence with a counselor and/or psychologist, her chart provides the clinician with this information. A client who states during the initial interview that she has not experienced violence may choose subsequently to disclose its occurrence to the clinician. This may happen because the clinician has asked the client about it in response to psychological or physical symptoms, or it may occur in response to the concerns noted on the chart by the counselor. Alternatively, the client may feel able to disclose it spontaneously with this particular person at this point in her visit. Then, if the client chooses, she is referred to the psychologist for the in-depth assessment and appropriate referrals. Depending on the client's emotional state, the clinical exam is completed, interrupted and continued later, or rescheduled for another day.

OFF-SITE REFERRALS

To provide clients with safe and useful referrals, PLAFAM set out to learn about other agencies involved in work related to violence. The agency hired a consulting psychologist to develop a directory of psychological, social, and legal organizations in or near Caracas for women exposed to violence. The psychologist created a questionnaire to evaluate the type and quality of assistance each organization offered. Eight key organizations were asked 17 questions about the populations they served, the services they provided, and whether and how they handled the referrals they received. She also identified other organizations that provide services to victims of violence. The results were compiled into the *Institutional Directory of Gender-based Violence Service Providers*. The directory has three sections: The first defines violence, violence prevention, and gender; the second describes in detail 25 institutions to which referrals can be made for various legal, social, and other services; and the last is an index that can be used to cross-reference referrals. PLAFAM gives each of its counselors a copy of the directory and instructions on how to use it.

JOINING THE ANTI-VIOLENCE ADVOCACY COMMUNITY

Venezuela had never had a law regarding gender-based violence. PLAFAM joined an alliance of feminist NGOs working to sensitize Venezuelan parliamentarians about gender-based violence and the need for a law that addressed it. PLAFAM had some experience with advocacy, particularly in the area of adolescent sexual health. While the feminist groups thought it was unusual for a reproductive health NGO to become involved in the topic of violence, PLAFAM was welcomed, in part because of its efforts to sensitize the feminist community to the connection between gender violence and sexual and reproductive health. To promote the law on violence, which had been stalled in the National Congress for years, PLAFAM, in collaboration with other NGOs, engaged in advocacy activities such as developing mass-media campaigns (using television, radio, and print media); distributing flyers in public places, including subway stations; and co-organizing demonstrations outside and inside the National Congress. All of these activities were focused on increasing public awareness about gender violence with messages about its pervasiveness and unacceptability and promoting rapid passage of the anti-violence bill.

In 1999, a law was passed outlawing both violence against women and violence within families. This was a major victory for PLAFAM and the advocacy alliance the agency had joined. To publicize the law, PLAFAM is distributing flyers in its waiting room that describe women's rights under the law, and potential avenues of action and redress.

PLAFAM'S NEW PROGRAM IN PRACTICE

When PLAFAM staff began screening women for violence, they had many questions. Would clients readily disclose their experiences with violence? Would they resent the invasion of their privacy? Would the counselors feel overwhelmed? Would the service make a difference in women's lives?

It did not take long for the staff to feel the effects of the new initiative. The very first client interviewed disclosed a history of incest, was given the opportunity to explore its impact with the counselor, and expressed appreciation for being asked about abuse. Efforts to measure progress more systematically were initially hampered by the evolving nature of the assessment tools. As noted earlier, the screening form initially developed was never integrated into the screening protocol. Whether and how the counselors introduced the topic of gender violence and asked related questions was left to their discretion. Without a concise and standardized set of questions, the process of screening was challenging and difficult to document.

In an effort to standardize the screening process and to reduce the time required for this task, four IPPF/WHR affiliates and the IPPF/WHR regional office jointly created an abridged screening form that contained four questions addressing psychological/emotional violence, physical violence, sexual violence, and sexual violence in childhood (see Box 1). If a woman responds affirmatively to these questions, two additional questions are asked to assess her current safety: "Are you afraid of your partner or another person close to you?" and "Will you be safe when you return home from PLAFAM?" Based largely on previously validated screening tools, this abridged form has been adapted to the Venezuelan context and is currently being tested.[6] The form requires between four and ten minutes to administer, depending on the client's responses.

The prevalence of gender violence detected among women with this form is striking: Over one-third (38 percent) of new clients were identified as victims of violence, compared to only 7 percent when the counselors relied on unsystematic screening. At the central clinic, where the most complete data are available, 161 clients were determined to be victims of gender violence between September and November 1999 (see Table 1).[7] The majority of cases involved psychological violence (61 percent), followed by childhood sexual abuse (44 percent), physical violence (42 percent), and sexual violence (34 percent).

There are several likely reasons for the increase in the prevalence of violence detected with the new screening form. First and foremost, all new clients are screened using the form. In addition, the more systematic approach, coupled with counselors' greater reported comfort with the process, may contribute to a higher response rate among those screened. Another contributing factor may be the approval and increased public awareness

Box 1. Abridged screening form for victims of gender violence

Case number: **Date:** **Name of counselor:**

Introduction. You know, at PLAFAM we offer education and services about domestic violence, violence in the workplace, and violence in childhood. There are many types of violence that affect a great number of women, and many women living in violent situations have found it helpful to receive assistance for themselves and their children. We at PLAFAM are concerned about the well-being of our clients and we always ask these questions in a confidential manner.

1. Psychological/emotional violence in the family. Have you ever felt hurt emotionally or psychologically by your partner or another person important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, and so forth.)

❑ Yes ❑ No Who ____________________

When ____________________ How ____________________

2. Physical violence. Has your partner or another person important to you ever caused you physical harm? (For example, hitting, cutting, or burning you?)

❑ Yes ❑ No Who ____________________

When ____________________ How ____________________

3. Sexual violence. Were you ever forced to have sexual contact or intercourse?

❑ Yes ❑ No Who ____________________

When ____________________ How ____________________

4. Sexual violence in childhood. When you were a child, were you ever touched in a way that made you feel uncomfortable?

❑ Yes ❑ No Who ____________________

When ____________________ How ____________________

of the new law against domestic violence, which was passed shortly before the new screening form was instituted. The increased public discussion that resulted from the advocacy campaign undertaken by PLAFAM and feminist NGOs and the passage of the law may have made the topic more "discussable."

While clients' responses to PLAFAM's new services have not been systematically assessed, several smaller-scale efforts to document women's views have yielded preliminary feedback. When women have voiced complaints, they have stemmed primarily from their frustration with the legal system, which tends not to respond as quickly as they expect. The vast majority of reactions, however, have been positive:

> *I had never had the help of a psychologist. If I had not come here, I don't know what I would have done, where I would have gone. I could have even taken my life; it was a matter of disappearing.*

Table 1. Number and percentage[a] of clients identified as victims of gender-based violence in PLAFAM's central clinic, Caracas, Venezuela, September–November 1999

Total no. of new clients (%)	No. of clients identified as victims of gender-based violence (%)	Cases of psychological violence (%)	Cases of physical violence (%)	Cases of sexual violence (%)	Cases with a a history of childhood sexual abuse (%)
429 (100)	161 (38)	99 (61)	68 (42)	55 (34)	71 (44)

[a] Percentages of types of violence total more than 100 percent because some women experience multiple types of violence.

I feel much better now [that] I confront things [including my abuser]. . . . I invite my friends to come to PLAFAM, too. If I had known about this before, imagine how many problems I could have avoided. The thing is that we are not going to talk about our problems to anyone because we think that there's nobody to help but we can always find a friendly hand.

Before coming to this clinic, I felt like anyone could step over me. Now I feel safe. . . . Staff provided me with a lot of support. [Now] nobody can do to me what they did when I was a little girl. I don't feel bad saying that I went through . . . this bad experience.

In addition, many clients have taken the educational materials to use or pass on to others. As word of the services spreads, some women have started to come to PLAFAM specifically for services related to violence.

Staff at the clinics have been sensitized so effectively to this issue that the cleaning woman, the watchman, and the receptionist have all referred women themselves. Counselors derive a great sense of satisfaction:

In the beginning, it was very complicated for me to ask people [about violence] because I thought, "What are they going to say?"; maybe they don't want someone meddling in their lives. Well, to my surprise, it's been the opposite. It turns out that women are waiting for someone to ask them about this topic. It's incredible but I believe that when we ask, women think: "Finally someone is giving me the chance to talk about this suffering." I think this is an accomplishment.

It's really incredible to be able to help somebody who arrives for a cytology appointment and leaves here thanking us because in addition to that, we've been able to help her with her relationships.

To me, this has been one of PLAFAM's initiatives that has more closely met the real needs of clients. . . . [Violence] affects most of the population that attends the clinic.

The issue of violence is something that is very close to women's hearts and the fact that we talk about it here is wonderful.

As staff became aware of the prevalence and consequences of violence, they also began to understand its link with sexual and reproductive health. The voluntary or coercive nature of sex may surface in a discussion with a woman choosing a contraceptive method, a teenager with an unplanned pregnancy, or a client with multiple episodes of STIs. A doctor who sees marks on a woman's body no longer ignores what such bruises imply. Now, PLAFAM staff "see" the problem and know what to do next: ask, assess, counsel, and refer.

In spite of the dedication of some physicians, most remain reluctant to screen women themselves because they believe that gender-based violence is in the domain of psychologists. PLAFAM has continued to sensitize physicians to the importance of their role, but their full engagement remains a challenge.

Following up on outside referrals to determine whether or not they have taken place, as well as whether or not they were helpful, has also proven difficult. Telephoning clients is not feasible, because receiving a follow-up phone call would endanger some women, and many do not have a phone. Staff had requested that the referral organizations keep track of women referred by PLAFAM so they could determine, at a minimum, whether women had proceeded with the referral. Unfortunately, this has not worked as smoothly as hoped, as outside referral organizations are not always willing or able to comply. As a result, the staff are devising new monitoring procedures, which may include the use of referral coupons—slips of paper that are given to clients to hand to the referral site during check-in and later collected by PLAFAM staff.

Keeping the information in the referral directory current and accessible also requires ongoing attention. PLAFAM is presently updating the directory and creating a condensed version that will be a more user-friendly "rapid resource" for counselors. The original directory, although useful, was too lengthy, making it difficult for providers to quickly find the appropriate referral for each client. Finally, PLAFAM continues to struggle with the scarcity of referral organizations—particularly shelters and safe houses—that provide services to victims of gender violence in Venezuela.

EXPANDING SERVICES

Given the demonstrated need for and acceptability of PLAFAM's violence intervention, the agency is exploring various ways to expand its services, including:

- Providing violence-related screening and counseling for returning clients as well as new ones. PLAFAM plans to implement this gradually and with care-

ful monitoring so as not to overload existing staff or decrease the quality of services provided.

- Implementing onsite follow-up support and self-help groups for victims at all three clinic sites.
- Providing assistance and referrals for perpetrators of gender-based violence who seek help.

Two additional psychologists and two part-time lawyers have been hired to make this expanded mission possible. This staff recruitment was made possible by the generous financial support PLAFAM now receives for its gender-based violence work. The association is also seeking ways to enhance the long-term financial viability of the project, as well as evaluating the effects of the first phase of its gender violence work before it expands into a wider range of services. In the interest of sustainability, PLAFAM has developed consultancy agreements with municipalities and NGOs that may play greater roles in providing violence services in the future. PLAFAM has also been asked to conduct information, education, and communication activities with the Caracas public defender's office, and is encouraging other public-sector organizations to assume greater responsibility in this area.

The volume of clients at PLAFAM clinics may also require attention as this project evolves. A woman who comes for a Pap smear and discloses violence may end up in a lengthy counseling session and decide to postpone her clinical exam to another day. Conversely, a client who comes expecting to speak only with a counselor or nurse (e.g., for a condom refill) may unexpectedly be referred to the physician for an examination of physical injuries. So far, the clinic has remained flexible. However, it may become increasingly difficult to maintain this flexibility as the demand for services grows and staff time is stretched to capacity. In addition, providing counseling services on an individual level may not be the most effective or cost-effective method to assist victims of violence. PLAFAM is therefore exploring the potential contributions of community volunteers, self-help groups, group counseling sessions, and other strategies.

DOCUMENTATION AND DATA COLLECTION

As discussed previously, PLAFAM is still refining its data collection procedures in order to facilitate follow-up on referrals and to track service needs and performance.

Efforts are being made to incorporate information about violence into the institution's management information system. There is a plan to incorporate violence-related data into an existing software system (called CMX). Currently, the system is being tested in a few Latin American countries. During this process, CMX's ability to protect client confidentiality and to manage violence-related data will be assessed.[8]

Given the pilot nature of this project, it is critical to monitor and evaluate the effectiveness of the interventions in a way that is both methodologically satisfactory and substantively thoughtful. Toward this end, PLAFAM, in concert with IPPF/WHR affiliates in the Dominican Republic and Peru, has developed tools to evaluate certain aspects of its gender violence work. These tools include an institutional assessment questionnaire to measure the degree to which gender violence has been integrated into existing services; a knowledge, attitudes, and practices questionnaire to assess providers; and an observation and interview guide for assessing physical characteristics of the clinics, including whether private space is available for counseling. These IPPF/WHR affiliates also hope to create tools, such as exit and in-depth interviews, to evaluate client perspectives on violence services, and to develop case studies of women referred to other organizations to evaluate the nature and quality of their services.

Over the next year, PLAFAM and IPPF/WHR will use these tools to assess the longer-term effects of the project on both the agency and its beneficiaries.

CONCLUSION

As governments in many countries gradually assume responsibility for providing contraceptive services, NGOs continue to play a role in advocating for the support of sexual and reproductive rights, creating new service options, and broadening attention to the context of women's lives. While the gender violence project described in this chapter is at an early stage, several important lessons are already clear.

Many women want to talk about the violence they have experienced, even when they have never done so before. While many providers were initially skeptical about routine screening for gender-based violence, and particularly about asking women direct questions on the subject, PLAFAM's experience confirms the experience reported elsewhere: Women will take advantage of the opportunity to discuss their experiences with violence if invited to in a caring and confidential manner. Even the question concerning childhood sexual abuse, which was heatedly debated during the development of the screening form, has not been perceived by women as too invasive.

Routine gender violence screening in the context of sexual and reproductive health programs raises a number of ethical questions. Is it advisable to screen when the full range of services victims might need is not readily available? Does the screening ultimately have a positive effect on these women's lives? Does it put women in danger? Readers are advised to consult Heise, Ellsberg, and Gottemoeller (1999), relevant chapters in Burns et al. (1997), Shrader and Sagot (2000), and IPPF/WHR (2000, 2001) for detailed information on the critical elements that should be in place before violence screening programs are initiated.

Having a chance to talk and feel supported is itself a valuable experience for most victims of violence. One of the providers' main concerns was that there was little that they could offer to victims. They had been trained to fix problems and did not perceive acknowledging violence and validating a woman's experience with violence as interventions. Helping providers to see such services in this light requires a major change in perspective. This is particularly true among physicians, who often consider gender-based violence concerns to be outside their purview.

Staff can overcome their own anxieties about responding to victims of violence. They can be trained to provide screening, counseling, and referrals, as long as they are supported in doing so through training, proper protocols and tools, and supervisory support. The collaborative development of these tools has been invaluable in supporting staff and clarifying their roles. Sensitive, caring providers can be trained to screen and counsel women even if they hold no formal training in psychology or social services.

Finding support for women who have experienced violence is a challenge. Referral systems for gender-based violence are extremely limited in many settings. This work thus requires an understanding of the capacity of other organizations and the creation of strong alliances in order to meet client needs for legal assistance and other services. PLAFAM is working with a range of other private and public organizations to expand the range of available services, thus helping to ensure the future viability of the project and enabling the association to focus on the areas in which it has greatest expertise.

Addressing gender-based violence within the context of sexual and reproductive health is complex but possible. A violence project may require conventional family planning programs to revise client-flow patterns, introduce new tools and data systems and adapt existing ones, provide emotional support mechanisms for staff, interact with an array of community and governmental agencies, and become familiar with the legal framework affecting both victims and providers. Although these can be time-consuming and complex tasks, family planning programs must recognize that unless a woman's experience with gender-based violence is taken into consideration, even conventional family planning services may not be successful. How, for example, can a provider counsel a client on the best contraceptive method or on HIV prevention strategies if he or she is not aware of the level of negotiating power the client holds? Given the fact that sexual and reproductive health workers are often the only health care providers to whom women have access, it would be ideal if they could systematically screen all clients and provide them with the appropriate psychological, medical, social, and legal services either in-house or through nearby organizations. If this is not feasible, there are a number of steps that both providers and organizations can take. They can ensure a client's privacy and respect her confidentiality, validate her experience with violence,

facilitate links to other services that are not available in-house, inform a client of her legal rights, respect her choices and autonomy, inform her of the existence of emergency contraception, and further educate themselves about gender-based violence and its relationship to sexual and reproductive health. Most importantly, providers and organizations can consider a client's experience with violence when providing family planning counseling and STI/HIV prevention and testing.

Ultimately, screening for violence allows for thorough and context-sensitive counseling for other reproductive health matters such as contraception, STI prevention, and unwanted pregnancy. Indeed, by recognizing and responding to the violence that is a part of many women's lives, PLAFAM has taken steps toward transforming family planning clinics into programs for sexual and reproductive health. Its experience will undoubtedly prove useful for other family planning programs seeking to help victims of violence around the globe.

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Notes

1 The Justice of Peace is a legal organization run by communities in conjunction with the municipal civil courts.

2 Because PLAFAM had no way of knowing what sort of response to expect from clients, it had no way of anticipating the demands clients might place on staff and the disruption such demands might cause to client flow. It was therefore decided that counselors would begin by screening only new clients for violence.

3 The initial counseling service is free. Thereafter, counseling fees are negotiated on a sliding scale, with a maximum fee of approximately US$5.

4 To assist with and standardize the consultation, an in-depth assessment form was developed to help the psychologist secure a thorough documentation of the client's experience. In addition, a danger assessment form, developed in the United States by Jacquelyn Campbell at Johns Hopkins University, was adapted to help counselors evaluate women's current risk.

5 A body map is a diagram of a woman's body, both front and back, on which the health care provider can document injuries. It permits visual confirmation by women with limited literacy, who can point to body parts that have been injured without using embarrassing or unknown terms, and is also helpful in legal proceedings. Not all providers recognized the value of this tool, so it was not used in all cases.

6 It is expected that after validation, other family planning associations might choose to incorporate these questions into their clinical history forms—a step toward institutionalizing attention to gender violence.

7 The data for January–August 1999 were collected using the original protocol (which was applied inconsistently, asked different questions, and detected a prevalence of only 7 percent), and were recorded in a manner that did not reflect multiple types of violence. The data are thus not comparable and are not included in Table 1.

8 IPPF/WHR anticipates that as CMX becomes fully available, it will enable all the region's affiliates to collect and manage data related to gender-based violence.

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