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# Towards an Integrated Model of Care of Intrafamily Violence: Broadening and Consolidating Interventions Coordinated by the State and Civil Society

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## I. BACKGROUND

In the last few years in Central America, a series of efforts have contributed to ensure that all seven countries recognize intrafamily violence as a public health concern deserving immediate attention. As a result, countries have put into place legislation and committed human and financial resources designed to facilitate the operation and consolidation of a model of integral care to respond to intrafamily violence.

Included among these efforts are:

1. The implementation of public policies in the majority of the countries that contribute to eliminate all forms of gender discrimination. For example, in Costa Rica the law guaranteeing equal opportunities for men and women was enacted in 1990; in Panama, Belize and El Salvador, similar policies have been implemented, and in Guatemala the current government made a commitment, within the peace accords, to confront gender inequity.

2. The creation and ratification of legislation that protects women against different forms of violence, including intrafamily violence. Belize, Guatemala, El Salvador, Nicaragua, Costa Rica and Panama all have enacted such laws. Only Honduras has yet to implement similar legislation.

3. The creation and strengthening in all seven countries of efforts of the organized community to confront intrafamily violence. Among these forms of organization are included neighborhood groups, groups of midwives, local communities, to name a few.

4. The formation of working groups comprised of women and some men in governmental and non-governmental organizations that are working together to construct an integrated, multifaceted theoretical model that frames violence against women within the sociocultural reality of Central America. These groups have produced important literature, theoretical as well as practical, as a result of their deliberations.

5. The creation and operationalization in the seven countries of the subregion of an integral model of care of survivors of intrafamily violence which has necessitated:

⇒ The recognition in all seven countries of intrafamily violence as a public health issue.

⇒ The construction of a theoretical framework that responds to the Central American situation but that facilitates a degree of conceptual uniformity and consensus on intervention criteria.

⇒ The identification of social responses through the "Diagnosis of Social Actors by Country", 1995, and the "Critical Path Women Follow to Resolve a Problem of Domestic Violence" research carried out in 1996.

⇒ Design of mechanisms to document and record incidents of intrafamily violence. Tegucigalpa, December 1996; Dominican Republic 1997.

⇒ Systematized local country protocols.

⇒ Health personnel sensitized with regard to the problem of family violence against women.

⇒ The definition of characteristics that guide the integral model of care.

⇒ The definition of the main areas of focus.

## II. JUSTIFICATION

Violence against women has increasingly been recognized in the international arena as a major issue for women's human rights, most recently at the Fourth World Conference on Women held in Beijing in 1995. More recently, there has been a growing awareness of the impact of violence on women's mental and physical health and most of the contributions that public health can make to addressing violence. Among the most prevalent forms of violence against women are those perpetrated by intimate partners including the physical, mental and sexual abuse of women and the sexual abuse of children and adolescents.

Although reliable population-based data on violence against women by their partners are scant, particularly for developing countries, a growing body of research confirms its pervasiveness. Approximately nine valid population-based quantitative studies in Latin America and the Caribbean indicate that approximately 20 to 60% of women are victims of physical violence by their partners/ex-partners. On average, 50-60% of women who experience physical violence from their partners are sexually abused by them as well (Heise et al 1994). The table below summarizes some of this data.

From population based studies plus other research based on convenience samples we know that:

- The perpetrators of violence are almost exclusively men.
- Women are at the greatest risk of violence from men they know.
- Women and girls are the most frequent victims of violence within the family and between intimate partners.
- Physical violence in intimate relationships is almost always accompanied by severe psychological violence and verbal abuse.
- Violence against women by their partners cuts across socio-economic class, religious and ethnic lines.
- Men who batter also exhibit profound controlling behavior, sexual jealousy and possessiveness.
- Almost universally, the response of professional and social institutions has been to blame the victim.

- Violence against women can result in long-term mental, physical and sexual health problems (Heise et all, 1995).

PERCENTAGE OF WOMEN WHO REPORT BEING HIT BY AN INTIMATE PARTNER

| Country | % | Country | % |
|---|---|---|---|
| ANTIGUA | 30 | BARBADOS | 30 |
| CHILE (Santiago) | 26 | COSTA RICA | 54* |
| COLOMBIA | 20 | GUATEMALA | 36* |
| ECUADOR | 60* | MEXICO | 34* |
| NICARAGUA | 50 | | |

*Study was based on a non-representative sample and cannot be generalized to the country as a whole.

Source: Study data compiled by the United Nations Statistical Office, as cited by L. Heise, 1996.

Violence against women in families dramatically increases their risk of poor health. Studies exploring violence and health consistently report negative and far-reaching effects, the true extent of which is difficult to ascertain because of the largely invisible nature of the crimes. An analysis in the World Bank's Development Report (1993), estimating the health years of life lost due to different causes, concludes that between 5% and 16% (depending on the region) of the healthy years of life lost to women of reproductive age can be linked to gender-based victimization, rape and domestic violence.

Below are outlined some of the health consequences of violence against women in families.

Health Consequences of Violence Against Women

Nonfatal outcomes

Physical health outcomes:

- Injury (from lacerations to fractures)
- Unwanted pregnancy
- Gynecological problems
- STDs including HIV
- Miscarriage
- Pelvic inflammatory disease
- Chronic pelvic pain
- Headaches
- Permanent disabilities
- Asthma
- Self-injurious behaviors (smoking, unprotected sex)

Fatal outcomes

- Suicide
- Homicide
- Maternal mortality
- HIV/AIDS
-

Mental health outcomes:

- Depression
- Fear
- Anxiety
- Low self-esteem
- Eating problems
- Sexual disfunction
- Obsessive-compulsive disorder
- Post traumatic stress disorder

Studies consistently report that intrafamily violence against women is a substantial burden on health care systems globally. One major U.S. study (Buel, 1995) found that:

⇒ A history of rape and or domestic violence was a stronger predictor of physician visits and outpatient cost that was any other variable, including age and cigarette smoking.

⇒ Victimized women sought medical attention twice as often as non-victimized women in the study year.

⇒ Medical care costs of women who were raped or assaulted were 2.5 times higher than the costs of non-victims.

Violence against women contributed to an escalating drain of health system resources that might otherwise be used for the community as a whole. Often victims present with vague somatic complaints that are difficult to diagnose and treat. Unidentified victims may become over-medicated and repeat users of health services. Furthermore, some research suggests that violence against women by their partners tends to escalate in frequency and severity over time and may lead to homicide. These increased levels of violence will further burden the health care sector which, in Central America, is increasingly limited by funding constraints.

In the Central American sub-region, the governments and civil society in the seven countries are taking on the issue of violence against women in the family as a public responsibility of considerable magnitude. As a result of the local experiences supported by the Nordics in each country during the period 1994-1997, countries have learned from a process of continuous engagement with local communities in selected sites, how to implement initiatives of intervention and prevention of violence against women, piloting models on a small scale that can be scaled up to achieve broader coverage.

This project seeks to contribute to the strengthening, consolidation and replication of the experiences developed in the last three years in Central America to prevent intrafamily violence and offer safe solutions to battered women. It will use a two pronged approach: at the local level, it will continue to create coordinated community networks where all of the actors, among them the health sector, the legal system including police and judges, churches. Other NGOs and community based groups, devise and implement a collective response to violence. At the national level, it will contribute to the implementation of diverse mechanisms that protect women from violent partners and will ensure that women know that there is a law which can be applied to safeguard them and their families.

## III. HOW CAN THE HEALTH SECTOR ADDRESS THE PROBLEM OF INTRAFAMILY VIOLENCE AGAINST WOMEN?

This question has to do with the means by which the various disciplines, institutions, and nongovernmental organizations can work together to detect, prevent, and deal with intrafamily violence and how to promote nonviolent and healthy relationships among people.

Research generates information on policies, strategies and effective methods to prevent intrafamily violence. The participation of women's movements and other social actors can also suggest means for controlling intrafamily violence, some in the short and medium term, although others will require long-term efforts. The Model for Integrated Care of Intrafamily Violence is viewed as a participatory process translated into policies applied at the local level that define **health as a social product** and consider **intrafamily violence to be preventable, since it is a social construct.**[1] The essence of the Model is the promotion of healthy relationships among people.

### DEFINITION OF INTEGRATED CARE OF INTRAFAMILY VIOLENCE

Integrated care is viewed as a system that operates at various levels: at the macro level in public policies and legal precepts; at the intermediate level at the sectoral institutional level, through the various governmental sectors that establish norms and guidelines; and at the micro level, where the system operates in communities. These three levels interact and support one another to carry out integrated actions aimed at the victims of intrafamily violence, offenders, families, communities, and society in general.

The actions include the following aspects: detection, prevention, treatment, and the promotion of nonviolent and harmonious relationships among people, carried out through the application of integrated social, psychological, legal, and biomedical measures.[2]

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[1] Further details on the Model's referential framework are provided in L. Guido's document "Proposal for a Framework for the Construction of a Model for Care of Intrafamily Violence."

[2] Some of the elements of this definition are taken from PLANOVI, Costa Rica.

The development of the model at all three levels may be taken as an indicator of equity in a given country. For this purpose a legal framework conducive to gender equity that promotes harmonious relationships and punishes violence is required. It also requires the participation of various institutions, particularly those pertaining to health, education, and justice, in addition to the participation of civil society in its varied expressions.

In some countries actions will be more limited, focusing solely on areas in which they are able to influence certain organizations. The diagram presented in Figure 1 may also be viewed as the planning of a process that can continue to develop actions to eliminate intrafamily violence in the short, medium and long term.

The model involves the key actors in eliminating violence and assigns priority to providing responses to the victims. Nevertheless, such responses will be incomplete if the offender population is not dealt with and the actions involved are not directed toward the community and the society as a whole.

**The Model Considered from the Standpoint of the Health Sector**

Figure 2 shows how the Model may be considered **from the standpoint of health sector, which is the area that will be influenced by the Project**.

At the present time the APAXVIF Project particularly affects seven communities at the micro level in Central America. The project proposed for 1998-2001 aims to extend the model to 23 new communities.

In structuring a model to provide comprehensive care for victims of intrafamily violence, consideration must by given to the three levels of intervention:, primary prevention, general and specialized care. At each level of intervention, it is important to incorporate the four axes in which the intervention takes place: detection, treatment, prevention, and promotion.

The Model for Integrated Care of Intrafamily Violence Against Women is based on the **promotion** of nonviolent ways of living and the organization of networks and mechanisms for the detection of intrafamily violence at the community level with the participation of a variety of social actors.

Depending on the level of intervention, the care provided in the health sector will be general, or specialized. The victims may enter the comprehensive health care system through health centers, clinics, or hospitals, but will not necessarily require care at all levels.[3]

At the primary prevention level the interventions will be directed to develop multifaceted strategies and actions at community level (formation of networks, design of prevention strategies including work in schools, churches, etc.)

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[3] Guido, Lea. Marco de referencia para la construcción de un Modelo de Atención Integral a la Violencia Intrafamiliar con énfasis en las mujeres. PAHO/WHO. San José, Costa Rica. March 1997.

At the general care level the victims will receive general biomedical care, individual and group psychological care (crisis intervention, individual therapy, participation in support groups), and follow-up.

At the specialized care level the victims will receive specialized medical, psychological, social, and legal care, and will be returned to the general or basic level (as appropriate) for follow-up and integration in support or self-help groups in their respective communities.

## IV. SUPPORTING POINTS FOR THE DEVELOPMENT OF THE MODEL

To date, the APAXVIF Project has catalized the following:

1. Proposals for the documentation and organization of registries by type of intrafamily violence, sex, and age. Initiation of implementation of the proposal at seven local levels.

2. Development of actions between private and public entities involved with the intrafamily violence problem in the seven selected localities.

3. Operation of seven local networks against violence in Saint Lucia, Guzapa, Guadalupe, Tegucigalpa, Orange Walk, Juan Díaz, and Estelí.

4. Sensitization and training at the community and health level on the topic of violence in the seven selected communities.

5. Initiation of training for service providers for intervention in the intrafamily violence problem.

6. Development of a conceptual framework and formulation of the Model of Institutional Care. March 1997.

7. Development of model protocols by type of violence and affected population, to be implemented in accordance with the level of complexity of the services. March 1997.

8. Activities in progress at the local level that ensure comprehensive and effective treatment of victims and that can be systematized.

9. Local plans of action in Guazapa, Juan Díaz, Estelí, Goicoechea, Guadalupe, and Saint Lucia.

10. Initiation of care for women victims of intrafamily violence; information; formation of self-help groups in three communities; and care and crisis intervention in one community. It is expected that this process will be completed and systematized in the seven communities by the end of 1997.

Moreover, during the period 1995-1997, the APAXVIF Project initiated actions which need to be consolidated in order to institutionalize the Model and ensure its sustainability in a new period of cooperation with the Central America countries. (1998-2001) They include:

1. Early and effective intervention for women who are victims of intrafamily violence by applying detection criteria by the personnel of the health services.

2. Identification of factors that stimulate the development of juvenile sex offenders through community and interinstitutional efforts at the local level.

3. Development of campaigns to promote harmonious, nonviolent, and nondiscriminatory attitudes in 30 communities so as to bring about changes in the social representation of intrafamily violence.

4. Development of standardized regulations and procedures for the detection, registry, and treatment of intrafamily violence to be made official and disseminated by the national health authorities.

5. Carrying our of specialized actions to control the reincidence of violent behavior through the development of councils and groups to study masculinity and develop strategies targetted at modifying the association between male dominance and self-worth.

6. Development of indicators to evaluate interventions in detecting, preventing, and dealing with intrafamily violence, and promoting nonviolent interactions.

7. Institutionalization of the process in sectoral policies and the setting up of organizations in the seven Central American countries.

## V. PRINCIPAL PROBLEMS IDENTIFIED IF THE PROCESS IS CURTAILED IN 1997

Because they have been successful, the seven local experiences of the Central American countries with regard to the Model for Integrated Care of Intrafamily Violence require institutional actions that will ensure their consolidation and sustainability through the inclusion of intrafamily violence care in health sector policies, plans, and programs.

The interruption of the process generated by APAXVIF would cause the following problems:

1. The Integrated Model of Care of Intrafamily Violence norms and protocols would remain as an isolated experience. Although intrafamily violence has been recognized as a public health problem, it has not yet been supported by the policies and models of care defined by the health sector in four of the seven Central American countries.

2. The human resources of the health sector will not be notably affected by the learning experience. The availability of human resources trained in intrafamily violence in the seven countries would remain limited.

3. The intrafamily violence issue would continue to be absent in the services provided by the health sector. There have been successful experiences in dealing with intrafamily violence; however, they have been focused on one geographical area in each country.

4. Local networks and groups have been constituted to disseminate experiences in the area of intrafamily violence; however, sectoral and national mechanisms do not exist in all the countries to guarantee and promote social participation.

5. The consequences of intrafamily violence will continue to affect the health of women.

**These problems would hamper the sustainability and institutionalization of the Integrated Model of Care of Intrafamily Violence**

## VI. PROPOSAL TO CONTINUE WITH A SECOND PHASE IN 1998-2001

In view of the progress achieved and the problems detected through the Project **Strengthening and Organization of Women: Coordinated Actions between the State and the Civil Society at the Local Level for the Prevention, Treatment, and Detection of Family Violence 1995-1997"** and the availability of financial resources for the four-year period 1998-2001, it was decided to direct activities toward the consolidation and sustainability of the Integrated Model of Care of Intrafamily Violence in the understanding that this second phase would constitute a major step forward in leading the Project toward institutionalization.

## VII. OBJECTIVES AND EXPECTED RESULTS

| **OVERALL OBJECTIVE (Goal)** |
|---|
| Existence of intersectoral responses to the social problem of intrafamily violence against women at the community level in Central America. |
| **OBJECTIVE OF THE PROJECT (Purpose)** |
| Integrated Model of Care of Intrafamily Violence in the health sector consolidated and in operation in 30 communities in Central America. |
| **RESULT 1** |
| Norms and protocols for the detection, prevention, and treatment of intrafamily violence and the promotion of nonviolent relationships defined by consensus and institutionalized in the health sector. |
| **RESULT 2** |
| Policy and contents for training in comprehensive care for women defined and human resources trained in the 30 selected communities |
| **RESULT 3** |
| Groups/mechanisms set up and strengthened in order to prevent and deal with intrafamily violence against women and promote healthy relationships in the 30 selected communities. |
| **RESULT 4** |
| Proposal for technical and financial mechanisms at the national level presented to health sector authorities to ensure the sustainability of integrated care of intrafamily violence. |

**Strategies for Attaining the Expected Results:**

1. The core strategy of the Project will be the **mobilization of political resources** for the consolidation of national organizations and the formulation of policies, plans, and norms for dealing with intrafamily violence.

   This strategy will involve advocacy at the political-regulatory level of the countries to contribute to the development of sectoral policy with regard to intrafamily violence and to the establishment of treatment norms and protocols.

2. **Strengthening of the local experiences of the seven countries through their dissemination** in 30 communities.

   The experiences in each country need to be disseminated and strengthened in order to ensure their impact on the political and decision-making levels in the Central American region.

3. **Training of human resources in the health sector and in nongovernmental organizations** participating in the Project in order to improve their skills in dealing with intrafamily violence and thus strengthen institutional and social participation.

4. **Direct technical assistance** for the development of conceptual and methodological frameworks, plans, and sectoral policies in addressing the problem of intrafamily violence in each country.

5. Mobilization of national organizations, institutes, and/or regional women's offices, cooperation agencies, multilateral organizations, and nongovernmental organizations to support national initiatives to deal with intrafamily violence and the use of an **intersectoral approach** in order to institutionalize the process.

6. **Participation of various social actors in implementing** the Project: health sector, local women's organizations, organization of the civil society concerned with the problem at the local level, state institutions involved in municipal development, women's police stations (where they exist), medical examiners, and local legal systems. Each country will form a network with the various social actors both at the regulatory-political level and in the communities in which the Project is being carried out.

7. From the beginning, the Project will carry out a strategy[4] to ensure its **sustainability**: political ratification of the process by the national authorities of the seven countries; request for national counterparts that will make it possible for the country to be strengthened institutionally, both at the regulatory level and local levels; decrees and ministerial regulations that will make it possible to bring the process under public control and stabilize national sectoral and local technical organizations.

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[4] In 1997 visits will be made to national authorities to ensure this process. Visits will likewise be made in early 1998 to countries evidencing political changes.

## VIII. PLANNING MATRIX FOR THE PROJECT FOR THE ENTIRE PERIOD 1998-2001

The network includes the elements the Project is expected to impact upon and the measurement indicators to be employed.

| PURPOSE | INDICATORS | MEANS OF VERIFICATION | ASSUMPTIONS |
|---|---|---|---|
| Integrated Model of Care of Intrafamily Violence in the health sector consolidated and in operation in 30 communities in Central America. | 1. Intrafamily violence recording mechanisms set up in the health sector. (1998)<br><br>2. Number of women who request services in the health units of the 30 selected localities. (1999)<br><br>3. Type and percentage of actions carried out by the local health services and percentage of referrals made during 1998-2001 | 1. Publication of health sector statistics on morbidity and mortality attributable to intrafamily violence<br><br>2. Case records<br><br>3. Referral system form | 1. Political will of national authorities<br><br>2. Financial resources enabling implementation of the Project |

| EXPECTED RESULTS | INDICATORS | MEANS OF VERIFICATION | ASSUMPTIONS |
|---|---|---|---|
| **RESULT 1**:<br>Norms and protocols for the detection, prevention, and treatment of intrafamily violence and the promotion of nonviolent relationships defined by consensus and institutionalized in the health sector. | 1. Documents on norms and protocols prepared in 1998 in the seven countries of Central America<br><br>2. Norms and protocols approved by national authorities in 1999 | 1. Data on intrafamily violence available in the health sector<br><br>2. Case records and registries | 1. Political decision |
| **RESULT 2**:<br>Policy and contents for training in comprehensive care for women defined and human resources trained in the 30 selected communities. | 1. Proposal of policies and contents prepared and approved by authorities of the seven countries<br><br>2. Thirty communities in Central America providing training of personnel in integrated treatment of family violence in 1998 | 1. Document on execution and monitoring of the Plan | 1. Support of the health sector authorities.<br><br>2. Availability of financial resources for its execution. |
| **RESULT 3:**<br>Groups/mechanisms set up and strengthened in order to prevent and deal with intrafamily violence against women and promote healthy relationships in the 30 selected communities. | 1. Seven local networks and core groups carrying out the process in the 30 communities selected starting in 1998<br><br>2. Number of self-help groups functioning and women participating. 1998-2001<br><br>3. Number and kinds of promotion activities carried out in each community. 1998-2001 | 1. Minutes of meetings and agreements concluded<br><br>2. Registry of groups by community<br><br>3. Local plans of action | 1. Support of the process by local authorities and participation by local leaders<br><br>3. Community participation in activities to combat violence |
| **RESULT 4**:<br>Proposal for technical and financial mechanisms at the national level presented to health sector authorities to ensure the sustainability of integrated care of intrafamily violence. | 1. Technical proposals prepared in the seven countries starting in 1999 to deal with intrafamily violence.<br><br>2. Decrees and resolutions approved and intrainstitutional | 1. Proposal document<br><br>2. National and sectoral commissions, local groups, and | 1. Political decision to expand coverage to other localities<br><br>- Allocation of human and financial resources<br><br>2. Willingness of the ministries of health to work with other |

| EXPECTED RESULTS | INDICATORS | MEANS OF VERIFICATION | ASSUMPTIONS |
| --- | --- | --- | --- |
| | and intersectoral coordination mechanisms (commissions, networks) defined<br><br>3. Plan for the mobilization of resources presented to the authorities. | networks<br><br>3. Document | institutions and nongovernmental organizations |

Implementation of the matrix of the Project is detailed in the activities of the seven countries and in subregional activities through annual planning exercises in which each country and the subregion as a whole formulate expected results and measurement indicators for each period, subject to annual evaluation.

## IX. EXPECTED RESULTS, ACTIVITIES, AND PERIOD OF EXECUTION

**RESULT 01:** Norms and protocols for the detection, prevention, and treatment of intrafamily violence and the promotion of nonviolent relationships defined by consensus and institutionalized in the health sector.

| ACTIVITIES | PERIOD |
|---|---|
| 1. Advocacy at the political and decision-making levels of the health sector of recognition of intrafamily violence as a health priority. | 1998 |
| 2. Proposal to the countries of comprehensive models to combat intrafamily violence originating in the health sector based on systematization of the seven local experiences accumulated during 1995-1997. | 1998 |
| 3. Proposal for recording mechanisms discussed and adapted in the seven countries at the regulatory level. | 1998 |
| 4. Adjustments and validation for recording incidents of intrafamily violence in the 30 communities. | 1998-1999 |
| 5. Training of personnel in registry of incidents of intrafamily violence in the 30 localities. | 1998/1999 |
| 6. Adjustment and validation of norms and protocols in the 30 communities and approval by the national authorities. | 1998/1999 |
| 7. Publication of, and training in, norms and protocols for chiefs of priority programs at the regulatory level, and for health personnel in 30 communities. | 1998/2000 |
| 8. Proposal for formation of groups to discuss masculinity and of councils for offenders with nongovernmental organizations. | 1998/2000 |
| 9. Evaluation and monitoring of the operation of norms and protocols in the 30 communities at the country and subregional levels. | 1998/2000 |

**RESULT 2:** Policy and contents for training in comprehensive care for women defined and human resources trained in the 30 selected communities.

| ACTIVITIES | PERIOD |
|---|---|
| 1. Identification of training needs at each level of care by country. | 1998 |
| 2. Preparation of a training plan for each country. | 1998 |
| 3. Approval of the plan by the respective authorities. | 1998 |
| 4. Preparation of mechanisms for the selection of personnel to be trained at each level: local, general, and specialized. | 1998-1999 |
| 5. System of continuous evaluation of contents, modalities, receptivity, duration, and utilization of the training plan in the 30 communities. | 1998-2001 |
| 6. Preparation and reproduction of teaching material for the training of personnel at the community, general, and specialized levels. | 1998-2001 |
| 7. Development of internships in services at the subregional level. | 1998-2001 |
| 8. Monitoring and evaluation of the Plan for Training Human Resources in each country at the locality, country, and subregional levels. | 1998-2001 |

**RESULT 3**: Groups/mechanisms set up and strengthened in order to prevent and deal with intrafamily violence against women and promote healthy relationships in the 30 selected communities.

| ACTIVITIES | PERIOD |
|---|---|
| 1. Rapid evaluation of the local Critical Path followed by women affected by intrafamily violence and identification of local actors capable of participating in social responses to intrafamily violence in the 23 new communities. | 1998 |
| 2. Formation of groups to implement the process in the 30 communities. | 1998-1999 |
| 3. Subregional technical support for implementation of the Integrated Model of Care of Family Violence in the selected areas. | 1998-2000 |
| 4. Preparation of local plans of action and training in that regard for local social actors. | 1998-2000 |
| 5. Exchange of experiences between country and subregional localities. | 1999-2000 |
| 6. Monitoring and evaluation of local plans of action according to criteria established by the Project, by country and subregion. | 1998-2000 |

**RESULT 4**: Proposal for technical and financial mechanisms at the national level presented to health sector authorities to ensure the sustainability of integrated care of intrafamily violence.

| ACTIVITIES | PERIOD |
|---|---|
| 1. Training, regulation, and technical strengthening of human resources in the national commissions and local networks for dealing with intrafamily violence. | 1998-2001 |
| 2. Methodological and technical support for preparation of sectoral plans for dealing with intrafamily violence. | 1998-2001 |
| 3. Preparation of coordination mechanisms between local networks and sectoral health commissions. | 1998-1999 |
| 4. Plan for the mobilization of political and technical resources to ensure sustainability of the Project upon conclusion of its execution. | 1999-2001 |
| 5. Evaluation of the Project | 1999-2001 |

## X. COVERAGE OF THE PROJECT

The Project will have a duration of four years and cover 30 communities in the Central American subregion.

**1.** The selection of of communities will be based on several criteria including: i) prevalence and incidence of violence or those at greatest risk of violence, as demonstrated by judicial of health records or prevalence studies; ii) those sites undertaking health reform that canb e permeable to including prevention and treatment of intrafamily violence in restructuring efforts. Communities with population of 20,000 - 50,000 are suggested.

**2**. The **target population** of the Project will be women victims of intrafamily violence and the **population beneffiting from the project** will consist of boys, girls, adults, and elderly adults affected by intrafamily violence, in addition to offenders and the general population of the selected communities.

**3.** **Types of intrafamily violence**: physical, sexual, emotional violence, and violence by virtue of negligence.

**4**. The **participating actors** will be: the State through the health sector, women's movements, nongovernmental organizations, municipalities, and other forms of organization of the civil society and the State in accordance with the social and political characteristics of each country. During its execution the Project will encourage the active participation of various actors at the macro, intermediate, and micro levels.

**SOCIAL ACTORS**

| LEVEL | WOMEN'S MOVEMENTS | OTHER ORGS. CIVIL SOCIETY | STATE | UN AGENCIES | PAHO |
|---|---|---|---|---|---|
| MACRO | - National networks to combat intrafamily violence* | | - National government commissions to combat family violence<br><br>- Executive branch<br><br>- Parliamentary women's commissions | - UNICEF<br><br>- UNDP<br><br>- UNFPA<br><br>- UNIFEM | - Regional WHD Program<br><br>- WHD subregional advisor<br><br>- Subregional interprogram coordination |
| INTER-MEDIATE | | | - Health sector<br><br>- Women's offices<br><br>- Other governmental agencies, by country | | Other PAHO country programs:<br><br>- Health Promotion<br><br>- Health Policies<br><br>- HIV |
| MICRO | - Local networks to combat intrafamily violence<br><br>- NGOs that deal with intrafamily violence | - Local and children's organizations, men’s groups that work in masculinity. | - Municipalities<br><br>- Health sector<br><br>- Education | | - Interprogram work |

* In countries in which they exist or may arise as the result of the Project, if necessary.

## XI. MONITORING OF THE PROJECT

The Project will be monitored on the basis of **expected results**, their **indicators**, and the **local plans of action** drawn up in the 30 communities.

1. **The levels** to be monitored are:

   Subregional
   National
   Local

2. **Monitoring instruments**:

   **Diagnosis** of the initial situation in which the Project is carried out. January 1998/April 1998 (rapid evaluation, Critical Path, and Diagnosis of Actors in accordance with subregional methodology) in the 30 communities.

   **Annual plans of action and annual evaluations**: for the subregion, country, and localities selected in accordance with criteria.

   **PAHO control and planning instruments**:

   BPB of Subregion and country, and semiannual evaluation by PAHO.

   An impact evaluation will be made upon conclusion of the Project.

3. **PAHO resources for monitoring the Project**:

   Regional Program on Women, Health, and Development

   Subregional Advisor on Women, Health, and Development

   National Advisor on Women, Health, and Development

4. Country level resources for monitoring the Project:

   National and local counterparts of the Program on Women, Health, and Development

## XII. TOTAL BUDGET AND CONTRIBUTION OF THE COUNTRIES

### 1. Request presented to donors for the period 1998-2001

| DONOR | TOTAL AMOUNT OF THE PROJECT | PLUS 13% OVERHEAD | TOTAL |
|---|---|---|---|
| SWEDISH CONTRIBUTION | US$ 1,910,326.00 | US$ 248,344.00 | US$ 2,158,670.00 |
| NORWEGIAN CONTRIBUTION | US$ 900.000.00 | US$ 117.000.00 | US$ 1,017,000.00 |
| TOTALS | US$ 2,810,326.00 | US$ 365,344.00 | US$ 3,175,670.00 |

The amount of the Swedish contribution is programmed for four years (1998-2001).

The Norwegian contribution is programmed for three years (1998-2000)

### 2. Distribution of the Project budget in accordance with results and donor for the entire period without PSC.

| RESULTS | SWEDISH CONTRIBUTION | NORWEGIAN CONTRIBUTION | TOTAL |
|---|---|---|---|
| RESULT 1 | -- | US$ 291,981.00 | US$ 291,981.00 |
| RESULT 2 | US$ 601,260.00 | -- | US$ 601,260.00 |
| RESULT 3 | -- | US$ 608,019.00 | US$ 608,019,00 |
| RESULT 4 | US$ 1,309,066.00 | -- | US$ 1,309.066.00 |
| TOTAL | US$ 1,910,326.00 | US$ 900,000.00 | US$ 2,810,326.00 |

## 3. Overall budget per country by year and results (without PSC).

| COUNTRIES AND RESULTS | YEAR I | YEAR II | YEAR III | YEAR IV | REAL TOTAL |
|---|---|---|---|---|---|
| **BELIZE** | | | | | |
| Result 1 | 5,562 | 5,871 | 6,311 | -- | 17,744 |
| Result 2 | 11,536 | 11,845 | 11,845 | 12,409 | 47,635 |
| Result 3 | 11,845 | 11,948 | 14,232 | -- | 38,025 |
| Result 4 | 14,060 | 14,214 | 14,317 | 18,490 | 61,081 |
| Subtotal | **43,003** | **43,878** | **46,705** | **30,899** | **164,485** |
| **GUATEMALA** | | | | | |
| Result 1 | 7,128 | 7,524 | 8,087 | -- | 22,739 |
| Result 2 | 14,784 | 15,180 | 15,180 | 15,903 | 61,047 |
| Result 3 | 15,180 | 15,312 | 17,676 | -- | 48,168 |
| Result 4 | 18,018 | 18,216 | 18,348 | 22,570 | 77,152 |
| Subtotal | **55,110** | **56,232** | **59,291** | **38,473** | **209,106** |
| **HONDURAS** | | | | | |
| Result 1 | 7,938 | 8,379 | 9,007 | -- | 25,324 |
| Result 2 | 16,464 | 16,905 | 16,905 | 17,710 | 67,984 |
| Result 3 | 16,905 | 17,052 | 20,457 | -- | 53,414 |
| Result 4 | 20,065 | 20,286 | 20,433 | 24,680 | 85,464 |
| Subtotal | **61,372** | **62,622** | **65,802** | **42,390** | **232,186** |
| **EL SALVADOR** | | | | | |
| Result 1 | 8,262 | 8,721 | 9,374 | -- | 26,357 |
| Result 2 | 17,136 | 17,595 | 17,595 | 18,434 | 70,760 |
| Result 3 | 17,595 | 17,748 | 20,170 | -- | 55,513 |
| Result 4 | 20,885 | 21,114 | 21,267 | 25,525 | 88,791 |
| Subtotal | **63,878** | **65,178** | **68,406** | **43,959** | **241,421** |
| **NICARAGUA** | | | | | |
| Result 1 | 8,424 | 8,892 | 9,558 | -- | 26,874 |
| Result 2 | 17,472 | 17,940 | 17,940 | 18,795 | 72,147 |
| Result 3 | 17,940 | 18,096 | 20,526 | -- | 56,562 |
| Result 4 | 21,294 | 21,528 | 21,684 | 25,947 | 90,453 |
| Subtotal | **65,130** | **66,456** | **69,708** | **44,742** | **246,036** |
| **COSTA RICA** | | | | | |
| Result 1 | 8,046 | 8,493 | 9,129 | -- | 25,668 |
| Result 2 | 16,688 | 17,135 | 17,135 | 17,951 | 68,909 |
| Result 3 | 17,135 | 17,284 | 19,695 | -- | 54,114 |
| Result 4 | 20,338 | 20,562 | 20,711 | 24,962 | 86,573 |
| Subtotal | **62,207** | **63,474** | **66,670** | **42,913** | **235,264** |
| **PANAMA** | | | | | |
| Result 1 | 8,640 | 9,120 | 9,803 | -- | 27,563 |
| Result 2 | 17,920 | 18,400 | 18,400 | 19,276 | 73,996 |
| Result 3 | 18,400 | 18,560 | 21,001 | -- | 57,961 |
| Result 4 | 21,840 | 22,080 | 22,240 | 26,509 | 92,669 |
| Subtotal | **66,800** | **68,160** | **71,444** | **45,785** | 252,189 |
| **SUBREGION** | | | | | |
| Result 1 | 36,000 | 39,000 | 44,712 | -- | 119,712 |
| Result 2 | 20,000 | 20,000 | 20,000 | 23,382 | 83,382 |
| Result 3 | 80,000 | 81,000 | 83,262 | -- | 244,262 |
| Result 4 | 148,000 | 151,000 | 152,000 | 154,293 | 605,293 |
| Subtotal | **284,000** | **291,000** | **299,974** | **177,675** | **1,052,649** |
| **REGION** | | | | | |
| Result 2 | 11,500 | 13,500 | 14,000 | 16,400 | 55,400 |
| Result 4 | 30,000 | 29,500 | 31,500 | 30,590 | 121,590 |
| SUBTOTAL | **41,500** | **43,000** | **45,500** | **46,990** | **176,990** |
| **TOTAL** | **743,000** | **760,000** | **793,500** | **513,826** | **2,810,326** |

## OVERALL BUDGET PER COUNTRY BY YEAR AND RESULTS WITHOUT PSC

**SWEDISH CONTRIBUTION**
**in US$**
**(Annual overall requests and by country)**

| COUNTRIES AND RESULTS | YEAR I | YEAR II | YEAR III | YEAR IV | REAL TOTAL |
|---|---|---|---|---|---|
| **BELIZE** | | | | | |
| Result 2 | 11,536 | 11,845 | 11,845 | 12,409 | 47,635 |
| Result 4 | 14,060 | 14,214 | 14,317 | 18,490 | 61,081 |
| Subtotal | **25,596** | **26,059** | **13,262** | **30,899** | **108,716** |
| **GUATEMALA** | | | | | |
| Result 2 | 14,784 | 15,180 | 15,180 | 15,903 | 61,047 |
| Result 4 | 18,018 | 18,216 | 18,348 | 22,570 | 77,152 |
| Subtotal | **32,802** | **37,191** | **33,528** | **38,473** | **138,199** |
| **HONDURAS** | | | | | |
| Result 2 | 16,464 | 16,905 | 16,905 | 17,710 | 67,984 |
| Result 4 | 20,065 | 20,286 | 20,433 | 24,680 | 85,464 |
| Subtotal | **36,529** | **37,191** | **37,338** | **42,390** | **153,448** |
| **EL SALVADOR** | | | | | |
| Result 2 | 17,136 | 17,595 | 17,595 | 18,434 | 70,760 |
| Result 4 | 20,885 | 21,114 | 21,267 | 25,525 | 88,791 |
| Subtotal | **30,021** | **38,709** | **38,862** | **43,959** | **159,551** |
| **NICARAGUA** | | | | | |
| Result 2 | 17,472 | 17,940 | 17,940 | 18,795 | 72,147 |
| Result 3 | 21,294 | 21,528 | 21,684 | 25,947 | 90,453 |
| Result 4 | **38,766** | **39,468** | **39,624** | **44,742** | **162,600** |
| Subtotal | | | | | |
| **COSTA RICA** | | | | | |
| Result 2 | 16,688 | 17,135 | 17,135 | 17,951 | 68,909 |
| Result 4 | 20,338 | 20,562 | 20,711 | 24,962 | 86,573 |
| Subtotal | **37,026** | **40,480** | **37,846** | **42,913** | **155,482** |
| **PANAMA** | | | | | |
| Result 2 | 17,920 | 18,400 | 18,400 | 19,276 | 73,996 |
| Result 4 | 21,840 | 22,080 | 22,240 | 26,509 | 92,669 |
| Subtotal | **39,760** | **40,480** | **40,640** | **45,785** | **166,665** |
| **REGION** | | | | | |
| Result 2 | 11,500 | 13,500 | 14,000 | 16,400 | 55,400 |
| Result 4 | 30,000 | 29,500 | 31,500 | 30,590 | 121,590 |
| Subtotal | **41,500** | **43,000** | **45,500** | **46,990** | **176,990** |
| **SUBREGION** | | | | | |
| Result 2 | 20,000 | 20,000 | 20,000 | 23,382 | 83,382 |
| Result 4 | 148,000 | 151,000 | 152,000 | 154,293 | 605,293 |
| Subtotal | **168,000** | **171,000** | **172,000** | **177,675** | **1,052,649** |
| **TOTAL** | **450,000** | **473,578** | **458,600** | **337,444** | **1,910,326** |

**OVERALL BUDGET BY COUNTRY, YEAR, AND RESULTS WITHOUT PSC**
**NORWEGIAN CONTRIBUTION**
**in US$**

**(Annual overall requests and by country)**

| COUNTRIES AND RESULTS | YEAR I | YEAR II | YEAR III | YEAR IV | TOTAL PERIOD |
|---|---|---|---|---|---|
| **BELIZE** | | | | | |
| Result 1 | 5,562 | 5,871 | 6,311 | -- | 17,744 |
| Result 3 | 11,845 | 11,948 | 14,232 | -- | 38,025 |
| Subtotal | **17,407** | **17,819** | **20,543** | | **55,769** |
| **GUATEMALA** | | | | | |
| Result 1 | 7,128 | 7,524 | 8,087 | -- | 22,739 |
| Result 3 | 15,180 | 15,312 | 17,676 | -- | 48,168 |
| Subtotal | **22,308** | **22,836** | **25,763** | | **70,907** |
| **HONDURAS** | | | | | |
| Result 1 | 7,938 | 8,379 | 9,007 | -- | 25,324 |
| Result 3 | 16,905 | 17,052 | 19,457 | -- | 53,414 |
| Subtotal | **24,843** | **25,431** | **28,464** | | **78,738** |
| **EL SALVADOR** | | | | | |
| Result 1 | 8,262 | 8,721 | 9,374 | -- | 26,357 |
| Result 3 | 17,595 | 17,748 | 20,170 | -- | 55,513 |
| Subtotal | **25,857** | **26,469** | **29,544** | | **81,870** |
| **NICARAGUA** | | | | | |
| Result 1 | 8,424 | 8,892 | 9,558 | -- | 26,874 |
| Result 3 | 17,940 | 18,096 | 20,526 | -- | 56,562 |
| Subtotal | **26,364** | **26,988** | **30,084** | | **83,436** |
| **COSTA RICA** | | | | | |
| Result 1 | 8,046 | 8,493 | 9,129 | -- | 25.,68 |
| Result 3 | 17,135 | 17,284 | 19,695 | -- | 54,114 |
| Subtotal | **25,181** | **25,777** | **28,824** | | **79,782** |
| **PANAMA** | | | | | |
| Result 1 | 8,640 | 9,120 | 9,803 | -- | 27,563 |
| Result 3 | 18,400 | 18,560 | 21,001 | -- | 57,961 |
| Subtotal | **27,040** | **27,680** | **30,804** | | **85,524** |
| **SUBREGION** | | | | | |
| Result 1 | 36,000 | 39,000 | 44,712 | -- | 119,712 |
| Result 3 | 80,000 | 81,000 | 83,262 | -- | 245,262 |
| Subtotal | **116,000** | **120,000** | **127,974** | | **363,974** |
| **TOTAL** | **285,000** | **293,000** | **322,000** | | **900,000** |

**COUNTRY AND PAHO CONTRIBUTIONS DURING THE ENTIRE PERIOD**

| | |
|---|---|
| **COUNTRY CONTRIBUTIONS** | **US$ 1,800,000 *** |
| **PAHO CONTRIBUTION** | **US$ 600,000 **** |
| **TOTAL CONTRIBUTION OF COUNTRIES AND PAHO FOR THE PERIOD** | **US$ 2,400,000** |

* Local personnel, stationery, per diem

** Regional program, infrastructure, stationery, and national consultants.

# ANNEXES