



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



19th SESSION OF THE SUBCOMMITTEE OF THE EXECUTIVE COMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

Washington, D.C., USA, 12-14 March 2001

Provisional Agenda Item 7

MSD19/8 (Eng.)

7 February 2001

ORIGINAL: ENGLISH

DOMESTIC VIOLENCE SURVEILLANCE SYSTEMS IN CENTRAL AMERICA

This document presents the information and surveillance systems for domestic violence that have been implemented in seven Central American countries. These systems are part of the comprehensive model for addressing intrafamily violence developed by PAHO and its national and intersectoral counterparts to confront this prevalent problem in Central America. The model is applied at the community level through intersectoral networks that detect, support, and look after the women who live in violent situations; at the level of the health and other sectors through instruments, surveillance and referral systems, norms and protocols, and training for their application; and at the national level through intersectoral coalitions that advocate for the institutionalization of the model's achievements, and for favorable policies and legislation.

The information systems are an important part of the model in defining the prevalence and the characteristics of the problem, providing information for programming care and interventions, for the formulation of policies, and their surveillance.

The 19th Subcommittee can strengthen the PAHO's Women, Health, and Development Program and its national counterparts in applying the model and its information and surveillance systems in the Central American countries, and in its replication in the other countries of the Region in order to address the violence that affects between 40% and 60% of the women of the Americas.

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1. Introduction

“Will this nightmare ever end? Will I ever be able to hold my head up and not feel the shame and the pain in my soul?”

In June 2000 member countries of the United Nations gathered alongside nongovernmental representatives in an evolving spirit of shared vision and goals to present and evaluate the progress of country actions based on the commitments derived from the Fourth World Conference on Women, held in Beijing in 1995. It is not uncommon today to see more highways and superhighways created to define and monitor global, regional and national targets for equitable human development. However, the picture often shows painful detail. Whereas the decade closed with heightened awareness of the overarching need for stronger efforts to reduce poverty, health, ethnic, gender, and other inequities; the Region of the Americas depicts an ambiguity of an almost trademark nature.

In Central America particularly, the winds of reform changes, unprecedented civil stability and overall economic growth have not obscured or overshadowed the stark reality of significantly differing access to health care; the nightmare of pediatric AIDS and increasing mortality due to road traffic accidents; in addition to the disease burden and loss of life years due to family violence.

The Governments of the seven countries of Central America all subscribe to the “Convention for the Elimination of all Forms of Discrimination Against Women” (CEDAW); the ratification of the Convention of Belem Do Para; and the accord of the Ministers of Health of Central America and the Dominican Republic (RESSCAD), to make violence a health priority, as well as other human rights initiatives and commitments. It is within this climate that the Directing Council of the Pan American Health Organization (PAHO) resolved in 1993 that violence, particularly intrafamily violence, would be given priority as a public health issue of regional relevance and importance.

PAHO presently executes a specific project in 10 countries of the Americas to institutionalize an integrated model for addressing intrafamily violence. The Central American experience in this approach can serve as a comprehensive attempt aimed at fostering social and emotional health for women, families, and communities. The model is built on the axes of prevention, care, detection, and promotion. The basic premise for understanding the magnitude of the problem in relation to the hierarchy of unequal relations between men and women has created a wealth of information, including the surveillance of family violence.

Intrafamily violence is juxtapositioned as gender violence with the corresponding health implications and responsibilities. The surveillance response to intrafamily violence is one experience that Central America can share through this paper.

2. Intrafamily Violence, Health Information and Surveillance Systems

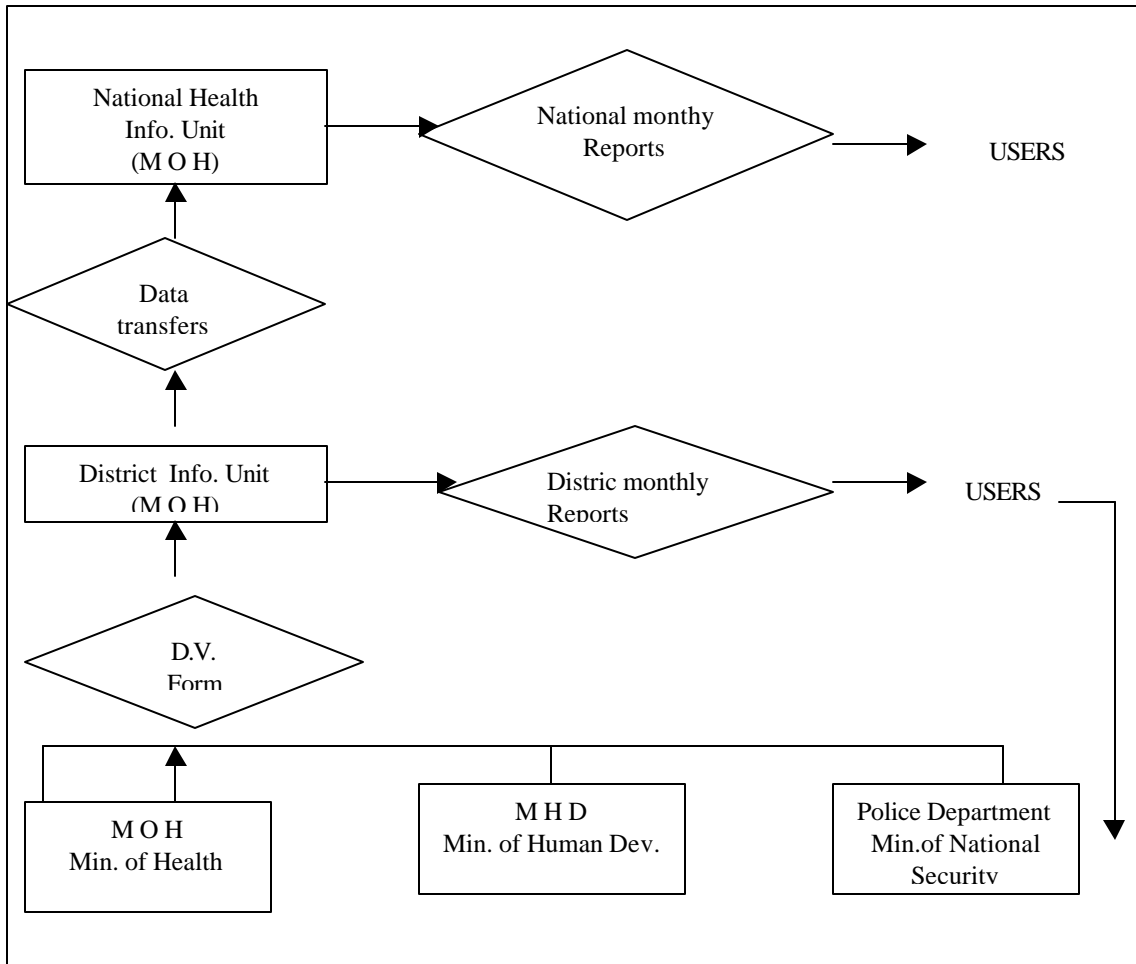
A fundamental difference between previous years and the decade of the nineties is the growing value of information (evidence) as a central element in the formulation of policies and projects, based on a social organization that guarantees the participation of various stakeholders in the process of decision-making. This quantum leap utilizes indicators to establish starting points, reflect outcomes, and accompany the level of attainment of the outcomes, and it provides opportunities to attain, modify, and maintain outcomes.

Health information and surveillance systems possess a status quo which is vehemently defended, while at the same time persistently debated and challenged within changing paradigms in health and human development. Because health information is collected systematically, continually, and opportunely, is reliable and relevant, and is necessary to determine the health condition and situation of a given population, true surveillance and monitoring of gender violence surpasses the traditional scope of the health sector. This has been clearly corroborated by participants in the first subregional meeting on registering family violence held in late 1996. Consequently, the monitoring of intrafamily violence proposes new situations in the collection, production, analysis, and use of public health information. This presents significant implications for the development of intersectoral organizational mechanisms and is a premise not to be overlooked, especially at the attitudinal level.

The best public health surveillance of today collects pertinent information, classifies and interprets it, and uses the process to define methods of intervention. The process is then continued as new information is collected and analyzed to measure the impact of the problem. Surveillance is inherently outcome-oriented and focused on various outcomes associated with health-related events or their immediate antecedents. Where risk factors or specific procedures are linked to health outcomes, it is often useful to measure them, because they may be more frequent than the health outcomes themselves.

In the surveillance of intrafamily violence this principle becomes suddenly “mysterious” in health settings. An ecological model offers more precise understanding of the individual factors, the conjugal relation, the family model, the community, the culture, the laws, and public policies surrounding intrafamily violence and gender violence in general. Whereas risk factors include residence, poverty, education, and number of children, two convincing higher risk factors are gender and a history of violence in the family. The “mystery” can be better understood by recognizing the dynamics, which transcend the factors surrounding the particular event. In Central America, the process has begun to respond to gender violence as a phenomenon of multiple manifestations, within the framework that women are at higher risk of being abused and that social barriers exist that hinder its detection.

Figure 1. Domestic Violence Surveillance Structure in Belize



Source: National Health Information Surveillance Unit, Ministry of Health, Belize

Health information and surveillance systems in the Americas are also responding to and incorporating indicators which allow for closer monitoring of the attainment of health conditions among and between groups of populations. This challenge is shared among governments seeking equitable development within their internal reform processes. Monitoring gender violence then sets the framework to address a serious public health issue and the prevention of a severe human rights violation, which impacts negatively on social and economic development. Figure 1 presents an example of the effort of Belize to integrate intrafamily violence surveillance into the national health information and surveillance system.

3. Gender Violence Surveillance in Central America

At the same time that PAHO's Directing Council adopted its resolution to make violence a priority public health problem, the national and international demands for achieving equality for women were being expressed with increasing vigor. The Fourth World Conference on Women held in Beijing in 1995 endorsed domestic violence as one of 12 priorities for action to reduce the most egregious manifestations of gender inequality. Already in existence were the conventions to eliminate the discrimination against women, but now other dimensions were being introduced to ensure integrated attention to women's health.

New attention was given to gender violence to replace the "cases" of injury appearing at health points of entry. Even though the complex nature of violence against women complicates consensus on its registration and monitoring, increased attention demanded availability of information. Studies began to show the prevalence of violence and the emerging long-term effects on mental and emotional well-being of women and their families. Even the loss of productivity and life years was brought to the forefront. The reform processes in health also questioned, and in a few cases uncovered, the costs for addressing versus not addressing family violence.

For Central America the challenges were daunting. The problem was still considered invisible or alien to national health responses. In 1996 PAHO accompanied the seven Central American countries to conduct a research entitled "Critical Path Followed by Women Victims of Intrafamily Violence." The results of these studies in several communities in Central America (Estelí, Guazapa, Goicoechea, Juan Díaz, Orange Walk, Santa Lucía-Cotzumalguapa and Villa Adela) played a critical role in creating new national agendas to address family violence. The findings confirmed suspected gender inequities and cultural perceptions, but they also drove home a staggering reality: the responses to family violence in Central America were more "available" from the nongovernment community; the victims of violence perceived the responses to be scattered; and many institutional service providers did not have any special training or orientation on their role to prevent and attend intrafamily violence and sometimes did not feel it was their responsibility. The silver lining was that women saw the institutions as credible sources and that there were numerous responses throughout the subregion, though nonorganized.

In 1996 a subregional pooling of the minds began to review and develop the registration component of the response to family violence. At this point, it is necessary to clarify that for the purposes of this paper and within the framework of a model of attention, intrafamily violence is: Any action or omission that results in injury to the physical, sexual, emotional, social, and economic integrity of a human being where there is a family or intimate

relation between the aggressor and the victim. It may be in the form of direct abuse, neglect, or any other conduct destined to threaten, degrade, control, coerce, or deprive freedom.

Conclusions of the 1996 Central American meeting to review intrafamily violence registration showed little consensus and much resistance, and unfamiliarity with the intersectoral process, while there was agreement that surveillance is a priority. Participants agreed that the way forward was to increase documentation on intrafamily violence; to mobilize specific technical support to and within the countries; to designate national responsible bodies for the prevention of violence; to continue to explore the viability of a uniform subsystem for the surveillance of violence; to coordinate technical exchange between the countries, and to conduct a posterior evaluation of forward actions on intrafamily violence surveillance. Mini-plans were drafted by all seven countries.

Obviously public health and other social issues hardly ever await planning processes. Many defined and specific responses to intrafamily violence surveillance continued within the countries. Nonetheless, the demand for country-specific reliable data outgrew existing national responses. Country human development reports, national health plans, CEDAW updates, State of the Nation reports, and others served to highlight the gaps of reliable data. This phenomenon in some cases also paralleled flaws in existing health information systems (verticality, limited processing and analysis, under-utilization-duplication, and the lack of availability to local planners).

In 1999, PAHO coordinated the III Taller Centroamericano de Registro, Vigilancia y Prevención de la Violencia Intrafamiliar y Sexual in El Salvador. The conclusions were that the advancement in intrafamily violence surveillance mirrors the progress in reducing gender inequities in general. This came as a “surprise” to some, as an “embarrassment” to others, and as a real catalyst to many. Be reminded of the context of these developments, where softwares, databases, and competing information systems were mushrooming within the health sector, often with considerable financial resources and political priority. The 1999 meeting then revealed important strides alongside major obstacles. At a glance, not one country boasted an integrated surveillance response; nonetheless, each and every one was registering data and on the way to national or local surveillance, including the generation of improved gender indicators.

The following comparative table explains each country’s responses in integrating family violence surveillance (Table 1). Specific data analysis is not the focus of this paper; nonetheless, sample tables with information from four countries with different surveillance systems are included in the Annex.

**Table 1. Intrafamily Violence Surveillance in Central America:
Indicators in Health Information and Surveillance Systems
Perspectives of Seven Countries**

Country	Level of Surveillance	Year started	Data Collection Instrument	Sectors; Participating, Collection/Production of Information	Variables and Indicators	Information Users	Major Responsible Sector
BELIZE	National and local multi-sectorial system	1999	Standardized computerized form compatible with ICD-10 and national health information surveillance system	Health, police, department of women, NGOs, family court	Basic variables and more. Indicators: No. of women, pregnant women, repeated cases and deaths	health , police, women's commission, NGOs, media networks	Health
COSTA RICA	Various national and local efforts, but no centralized system	1991-1994	No standardized instrument but health is finalizing one which is compatible to the ICD-10	Health, social security, Judicial system, INAMU, delegación de la mujer	Basic variables and more. Indicators: No. of women, % of women, No. of deaths	Health social security, INAMU, researchers, NGOs, media, judicial, and women's dept. networks	No one sector is responsible
EL SALVADOR	Local, but national efforts are underway	1997	No standardized instrument	Health, police, fiscalía general de la república. medicina forense	Basic variables	Health, police, fiscalía general de la república, medicina forense	Health is the proposed sector (epidemiology unit)
GUATEMA-LA	National and local in health and others	2000	Standardized form at national and local level compatible with ICD-10	Health, police, national statistics office (INE)	Basic variables and more. Indicators: No. of women, pregnant women, and deaths	Health, IGSS, networks	Health, oficina de derechos humanos
HONDURAS	Local, but the non-health national departments o register data	1998	No standardized instrument, but proposal presented for approval	NGOs, police, health, ministry of education	Basic variables	NGOs, police, ministry of education	Health
NICARAGUA	Local, there are national efforts underway to make one national system	1998	No standardized form	Health, forensic medicine, and the commissaries (police)	Basic variables are included. Indicators: No. of women, reported cases, and deaths	Comisariás de la mujer (policía, salud)	Police, health
PANAMA	National and local in the health sector	1997	Standardized health reporting form compatible with ICD-10	Health and local networks, as well as new partners, "Comisión de análisis y tendencias"	Basic variables and other (sex, age, type of violence). Indicators: No. of women, and deaths, % of pregnant women	Health, local networks	Health

Source: 1996. Health Sector Intrafamily Violence Registration, Central America Meeting.
1999 Registration Surveillance of Intrafamily Violence in Central America.
2000 Evaluation of Central America. Intrafamily Violence Plans of Action.

To describe the process in Central America of family violence surveillance, it is important to place it within a broader framework of institutionalizing a model of care for intrafamily violence. No single effort describes the combination of experiences being led in each country. Nonetheless, within the subregional advancement, concrete steps have led to the present surveillance actions in the seven countries. Perhaps increasing awareness on the issue of intrafamily violence as a public health and human rights problem has had immeasurable results. The role of the media in utilizing other wider health promotion strategies with communities and municipalities has also magnified the public dialogue, even if with sensationalism in many instances. The building of traditional and nontraditional alliances was also an opportune strategy in light of the priority shifts occurring due to health reform processes. But without a doubt, the most uniform experience of achieving intrafamily violence surveillance has been the dogged persistence of multiplying stakeholders, alongside sustained technical support. To quote one national epidemiologist, “I never imagined this thing could really happen.”

But the experts continue to remind policymakers that surveillance really has no purpose if the information does not contribute to improved attention or interventions regarding the given problem. Methodologically, four challenges are identified: determining the magnitude of the problem in order to develop policies; monitoring the quality of care for persons affected; developing methods for comparing sectoral responses and improvements; and guaranteeing the safety of researchers, service providers, and informants. If results do improve care and increase prevention efforts with new partners, increased emphasis on intrafamily violence surveillance could justify the use of painfully limited national resources.

From the Central American experience, it is important to add the following steps to those already presented for intrafamily surveillance:

- The existence of a plan or protocol for the treatment of victims.
- Training and retraining of service providers.
- Availability of validated intrafamily violence registration forms.
- Commitment of the institutional sectors.
- Defined coordinating mechanisms across sectors, which allows true social participation.

To assume that the process underway is stable would be a grave mistake, but to underestimate its advancement would be impardonable.

4. Preliminary Successes

Whereas there are existing efforts to analyze and monitor inequities between men and women, the real toll of family violence and the profound harm on the lives of women and families are not so readily addressed. In the area of intrafamily violence surveillance cautious, but significant, successes are occurring. Perhaps the single most important achievement is that today all seven countries register and consider family violence registration to be a national priority. This success can be attributed to sustained advocacy at local and national levels, with the involvement of old, new, and emerging grassroots stakeholders. Of note is that this experience epitomizes the spirit of self-determination in matters related to health, and encourages respect of human rights and social participation in health and well-being.

As recently as 1995 no health sector in Central America had formally recorded and reported cases of intrafamily violence. Presently, the panorama is varied among the seven countries from an integrated national health sector response in Panama, to a local multisectoral experience in El Salvador, and a national integrated and multisectoral system in Belize (Table 1). In response to Hurricane Mitch, four of the affected countries initiated the specific screening and registration of partner violence in targeted outpatient clinics and emergency centers. The results of that experience will be available this year and the preliminary data corroborates the need for increased attention to the active surveillance of intrafamily violence in health facilities.

The Central American experience is framed within the conception of intrafamily violence as gender violence, and places its surveillance within existing information and service structures, while building new local and national responses. Some qualities of intrafamily violence surveillance systems in each Central America country are outlined in Table 1. Common successes are:

- The approach maintains the philosophy of an integrated model.
- The community, through local networks and sector representatives, participates in the design and implementation of the surveillance system.
- Basic variables for registering intrafamily violence are developed and validated in national and subregional discussions.
- Increased transparency and accountability are being broadened into other aspects of the health sector.
- Local users and producers of intrafamily violence data have increased access to the processed information.
- Data collection instruments are ICD-10 compatible.
- Guidelines and protocols exist for improved surveillance and attention to victims of intrafamily violence.

- Indicators are being generated to monitor national, international, and United Nations commitments of the countries.

5. Challenges and Gender Perspectives

To debate on the complex challenges still facing the seven countries of Central America to validate the intrafamily violence surveillance efforts, could frustrate this subregional effort. Yet it is fair for social planners and national decision-makers to ask: what is the aggregated value to human development that could be obtained through intrafamily violence surveillance?

The dollar value of health surveillance experiences in Latin America is still being quantified, but there is insufficient data on the sensitization for analyzing these or for reducing the social and professional barriers that still persists. Obstacles encountered in the Central America process include:

- Attitudinal change is a slow process.
- Organizational changes are often whimsical.
- Intersectorial efforts can easily diffuse expressed ownership of processes.
- Political commitment can shift overnight.
- Technical shortcomings (quality assurance, confidentiality, lack of expertise).
- Lack of experience and commitment to conduct evidence-based planning or monitoring.

6. Recommendations in Gender Mainstreaming

The Central American experience in intrafamily violence surveillance, while still not fully completed, can challenge basic principles of other public health issues. Isn't it paradoxical that the principles of self-determination, equal opportunities, respect for human rights, recognition of differing needs, and social participation are the same ones that are reaffirmed in the Central American intrafamily violence surveillance experience?

These principles are included in the following recommendations for surveillance systems that make visible those flagrant gender inequities which hinder development, are shared across sectors, and are totally preventable. Specific surveillance systems are included in Table 1, as well as their characteristics: collection instruments, training, integrated approaches, quality controls, relation to existing health information and surveillance systems, and the inclusion of gender violence indicators in regular health and human development profiles, or health situation analysis and trends publications.

Surveillance systems should:

- Consolidate existing efforts, emphasize timely production of reports, and make information widely available to all the relevant sectors, reinforcing the importance of decentralized processes.
- Strengthen alliances between surveillance systems of different sectors to facilitate referrals, follow-up, and sharing of results.
- Conduct research on surveillance data to formulate and monitor policies that reduce inequities in public health.
- Close the gap between researchers, policymakers, providers, and the users of intrafamily violence interventions.
- Contribute to the protection and improve care of victims of violence.

Without this framework, it is not possible to determine if the process really represents a true value to confront and overcome the violation of a basic human right: "Sin los derechos de la mujer, no hay derechos humanos."

7. Subcommittee Support

If we were to bear in mind the painful plea of one faceless woman in any home in the Region, our specific interventions perhaps could be more readily defined. The Women, Health, and Development Program submits the following concrete actions for the consideration of the Subcommittee:

- Ensure and advocate for intrafamily violence data to be reflected in all major national development reports.
- Utilize gender violence indicators in State of the Nation addresses and other relevant public health speeches.
- Promote and support the intersectoral bodies that monitor and validate intrafamily violence surveillance systems.
- Visit gender violence and health information systems centers, to support and better understand the dynamics of data generation and analysis.
- Foster the utilization of gender violence indicators in local municipalities.
- Establish national spaces to introduce accountability in the achievement of intrafamily violence prevention policies. One example is the design of yearly reports on the progress of institutional and sectoral responses to family violence.
- And last, but not least, at the risk of sounding deceptively simple, test the system with a real case scenario.

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Sample Country Reports on Intrafamily Violence

Belize

September 1999–December 2000

Total cumulative cases	511*
Females	85%
Males	15%
Age group most affected (20-29 years)	43%
Cases referred	20%
Type of violence (physical)	43%
Urban cases	70%
Deaths	Not registered
*In mid-1999 the draft report showed 126 cases	

Source: National Health Information/Surveillance Unit, Ministry of Health, Belize

Costa Rica

1998-1999*

Total cases	976
Females	87%
Males	13%
Age group most affected (20-39 years)	57%
Type of violence:	
Physical	57%
Sexual	16%
Psychological	4%
Economic and others	23%
*Datos hasta junio de 1999	

Source: Informe del Poder Judicial, Costa Rica

La tabla anterior registra un caso de homicidio. De acuerdo con el estudio de Carcedo y Sagot *Femicidio en Costa Rica: 1990-1999*, San José, 2000, en 1998 se produjeron 20 casos de femicidios y en 1999 llegaron a 26 casos.

El Salvador

2000

Total cases	3,037
Females	100%
Males	Not registered
Age group most affected	31-40 years
Type of violence:	
Physical	43%
Psychological	57%
Deaths	Not registered
Month of most cases	May

Panamá

1997-1999 (September)

Total cumulative cases	1,507
Females	91%
Males	9%
Age group most affected (20-40 years)	66%
Type of violence:	
Physical	58%
Sexual abuse	24%
Urban cases	> 50%
Deaths	Not registered

Source: Centro de Recepción de Denuncias, Policía Técnica Judicial, Panamá