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DOMESTIC VIOLENCE AND REPRODUCTIVE HEALTH TRAINING FOR ASSESSMENT AND INTERVENTION IN HEALTH CARE SETTINGS

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DOMESTIC VIOLENCE AND REPRODUCTIVE HEALTH TRAINING FOR ASSESSMENT AND INTERVENTION IN HEALTH CARE SETTINGS

Project Director Susan Pick, Ph D

Principal Researcher Gillian Fawcett

Research Assistants Teresa Venguer and Monica Gamboa

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SUMMARY

Between March and August, 1998, the Mexican Institute of Family and Population Research (IMIFAP) developed and evaluated a program to train health care professionals to detect, and respond appropriately to abused women in their care

During the first phase of the project, a bibliographic review of international research and program models was carried out Visits were also made to Mexico City based institutions working in the field of violence against women, in order to compile an up to date directory of services available Two health care institutions were identified to participate in the project the General Hospital of Ticoman, administered by the Public Health Ministry and the Federal District Branch of the Sistem for Integral family Development (Sistema para el Desarrollo Integral de la Familia- DIF D F) Both institutions have reproductive health care programs

Formative research was carried out in the form of a baseline survey and structured interviews with health care professionals from both institutions A total of 62 surveys in Ticoman and 51 in the DIF D F were completed and analyzed In addition, 6 interviews were carried out with different health professionals from Ticoman and 7 were carried out with physicians from the DIF D F Results from this research confirmed the need for training in the area of domestic violence, and were useful for the program development

In the second phase of this project, the training program was developed and subsequently piloted Two groups of health professionals (a total of 35) participated in the Ticoman General, and three groups of physicians and nurses (a total of 63) participated in the workshop from DIF D F

An instrument was developed to evaluate the knowledge of participating health care providers, and was applied to all participants at the beginning and end of each course A comparative analysis of the results of the completed pre and post test questionnaires showed significant improvement across all the groups in terms of

knowledge of types of violence, the cycle of violence, the psychological symptoms of abuse, indirect signs of abuse, and how to help the victim plan for an emergency Follow-up interviews were also carried out with those health care professionals who were interviewed at the beginning of the project These interviews confirmed and further explored the increase in knowledge reported in the pre and post test questionnaires, and demonstrated the impact of the course on health care practice

The dissemination phase of this project included the printing of 10,500 brochures for health care providers of national health institutions and faculties of medicine throughout the Mexican Republic, 500 informational packages for policy makers of these institutions, and the printing of 50 training manuals for program instructors A training workshop for instructors from different organizations in states surrounding the Federal District is in the process of being organized In addition to the dissemination activities contemplated in the original proposal, two working papers have also been published with some of the results of this project

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DOMESTIC VIOLENCE AND REPRODUCTIVE HEALTH TRAINING FOR ASSESSMENT AND INTERVENTION IN HEALTH CARE SETTINGS

1 INTRODUCTION

Despite over twenty years of activism against gender-based abuse, domestic violence continues to pose a significant threat to women's health and well being in Mexico [1] Although statistical data on rates of violence are not available nationally, regional data does show that intimate partner violence is a major problem for Mexican women Of all the victims of domestic violence who attended the Center for Attention to Family Violence, between 88 and 90 percent are women (Procuraduria General de Justicia del Distrito Federal-PGJDF, 1997) Results of regional studies in Mexico also suggest that between 30% and 60% of women in Mexico suffer some form of abuse at the hands of their partner (Shrader & Valdez, 1992, Ramirez & Uribe, 1993, Granados, 1995, Romero & Tolbert, 1995, Ramirez & Vargas, 1997)

In 1994, a World Bank report documented the wide range of physical and mental health consequences of violence against women by intimate partners in an effort to raise awareness of the extent and implications of this issue (Heise, Pitanguy & Germain, 1994) Two studies, one covering 390 randomly selected women in the United States and another with 2,000 randomly selected women in New Zealand, have found that abused women have significantly worse physical and mental health than women without a history of abuse (Koss, Koss, & Woodruff, 1991, Mullen et al , 1988, in Heise et al , 1994)

Abuse during pregnancy also represents a significant risk to the health of both the mother and the unborn fetus Low birth weight, low maternal weight gain, infections and anemia have been reported (Parker, McFarlene, & Soeken, 1994, Valdez & Sanin, 1996) Violence against women may also result in unwanted pregnancy, as well as sexually transmitted infections and HIV, either through rape or by affecting a woman's ability to negotiate contraceptive use (Heise, Moore, & Toubia, 1995, World

[1] We are aware that many children are also victims of domestic violence, however for the purpose of this project we shall use domestic violence to describe violence against women by an intimate partner

Health Organization- WHO, 1997) Data exists in Mexico to show that the number of HIV diagnoses among women of reproductive age has doubled in the last decade The proportion in 1985 was fourteen men to one woman, in 1995, the figure was six men to one woman (CONASIDA-Epidemiologia, 1996)

2 PROBLEM STATEMENT

The above data all point to health care services as potential "checkpoints" for the identification, and appropriate treatment of victims of violence As stated by the American Medical Association it its Diagnostic and Treatment Guidelines on Domestic Violence (1994) ***"A physician may be the first non-family member to whom an abused woman turns for help, he or she has a unique opportunity and responsibility to intervene Battered women often present repeated injuries, medical complaints and mental health problems, all of which result from living in an abusive relationship "*** Professionals working in health care will see abuse victims throughout different phases of the abusive relationship, unlike other professionals such as those within the justice system Despite routinely seeing the consequences of violence and abuse, physicians in all practice settings often fail to recognize their violent etiologies Indeed, as declared by the WHO director general in a recent statement (WHO, 1997) ***"Health care workers must be trained to recognize both the obvious and more subtle signs of violence, and to meet women's health needs in this regard "*** Domestic violence and its medical and psychological sequelae are sufficiently prevalent to justify routine screening, yet health care professionals lack the skills to assess, identify, treat and refer victims of abuse for further support

Failure to identify abuse may interfere with an accurate diagnosis and can be even more costly in terms of time and money spent on repeated visits, and treatment of sequelae (Titus, 1996) On the other hand, early identification and intervention may not only prevent or reduce further suffering and violence in victim's lives, but may also reduce the significant health care and productivity costs associated with domestic violence (Hadley, 1995) Nevertheless screening policies and protocols are

not effective on their own, since without institutionalized training programs, protocols will lay unused and domestic violence interventions will not take place consistently Powerful social myths surrounding domestic violence and a lack of knowledge about incidence, prevalence and the dynamics of abuse, prevent health care providers from assessing routinely for abuse (King & Ryan, 1996) In Mexico, violence against women is framed within a social and cultural context which considers it to be a private issue, and even when acknowledged, victim blaming is not uncommon (Fawcett, Isita-Espejel, Heise & Pick, 1997)

The physician's recognition and validation of an abused woman's situation is important, since silence or apparent disinterest convey a tacit acceptance of domestic violence In contrast, recognition, acknowledgement and concern confirm the seriousness of the problem and the need to solve it Moreover, research shows that battered women do expect health care providers to initiate discussion about abuse (Jackson, 1994, Rodriguez, Szkupinski & Bauer, 1996)

3 PROBLEM SOLUTION

Since 1995, IMIFAP has been training medical students, doctors and other health care providers to improve their knowledge of psychosocial factors of health, and to reflect on their attitudes to provider-patient relationships, especially communication about difficult topics such as sexuality The program also emphasizes the preventive role that the medical profession can play in society and reviews the ethical issues involved in this line of work Our observations during the training workshops have led us to conclude that health professionals do lack knowledge and skills that would allow them to detect and treat abused women appropriately Nor are they exempt from those cultural beliefs and attitudes held by the population at large which contribute to the widespread complicity toward violence against women

Studies show that with proper training and protocols, health care workers can become more sensitive to issues of violence against women One example is the emergency department of the Medical College of Pennsylvania, Philadelphia in the

United States After introducing training and protocols on violence, the proportion of female trauma patients found to be battered increased fivefold from 6% to 30% (Mcleer & Anwar, 1989) As part of the aforementioned IMIFAP program, we propose to develop and evaluate a training module to help the medical profession detect and respond adequately to women victims of abuse

Statistics from the Center for Attention to Family Violence in Mexico City (PGJDF, 1997) reveal that 76 3% of victims attending the center come from marginalized, low and low middle socioeconomic backgrounds, who are also more likely to attend the city's public health services This pilot project was therefore carried out in Mexico City, in conjunction with the General Hospital of Ticoman, administered by the Public Health Ministry, and the Federal District branch of the System for Integral family Development (Sistema para el Desarrollo Integral de la Familia- DIF D F) Both these institutions have reproductive health programs, such as family planning, pre-natal care, teenage mother clinics and breast feeding programs

4 OBJECTIVE

The general objective of this project was the development and evaluation of a program to train health professionals to detect and respond appropriately to abused women in their care

5 ACTIVITIES

5 1 Bibliographic review of research and program models

An extensive review of research and other training programs from both the United States and Latin America was carried out, in order to identify key issues to be addressed in the IMIFAP program Visits were also made to Mexico City based institutions, working to address violence against women, in order to create an up to date directory of services available to health care providers and their patients This

directory [2] also includes a description of the route that women will follow upon arriving at each of the institutions, so that health care providers can anticipate the questions women may have about being referred to one of these institutions

5 2 Selection of intervention sites and formative research

5 2 1 *Site selection*

Two institutions were initially approached in order to determine the project intervention sites The Public Health Ministry, and the Preventive Medicine Department at the Federal District Branch of the System for Integral Family Development (Sistema para el Desarrollo Integral de la Familia- DIF D F) It was considered that both these institutions have the potential for future training on a national level Since at this point, IMIFAP's interest was Mexico City, the Ministry of Public Health referred us to the Federal District Institute of Health Services (Instituto de Servicios de Salud del D F) The DIF D F was selected instead of larger health institutions, because it currently administers the only two shelters in Mexico City for abused women and their children

Originally, primary level health care settings had been selected in both institutions However, half way through the formative research, IMIFAP had to pull out of the first intervention site administered by the Federal District Institute of Health Services [3], due to changes in local management which obstructed our work The General Hospital of Ticoman, which is also administered by the Federal District Institute of Health Services , was then chosen to take the place of the former site Unfortunately, identifying a new intervention site and reinitiating the formative research, set the project back almost six weeks

The Department of Preventive Medicine at the DIF D F administers 51 doctors' offices in DIF community centers, and a number of mobile units throughout the city

[2] See Appendix 1 for this directory
[3] At this point, all the interviews had been completed at this intervention site and were being analyzed

Those physicians and nurses working in community centers were chosen to receive training, on the basis that there is a greater potential for follow up of patients than in the mobile units The DIF D F only offers primary level health care to the community, and patients requiring specialized treatment are referred to hospitals run by the Federal District Institute of Health Services The Ticoman General is one such hospital, offering a secondary level of specialization [4] through outpatient and hospitalization departments, it has also an emergency department It has 25 physicians, 57 nurses, and 12 social workers on permanent staff, covering three shifts- morning, afternoon and night time A group of physicians, nurses and social workers were selected by the hospital to participate in the training program

5 2 2 *Formative research*

In order to design a culturally appropriate training program, information was required about each intervention site, in terms of current screening for domestic violence, the number of cases detected in each setting, infrastructure, and organizational structure Information was also needed about health care providers' perception of their role, their knowledge and attitudes regarding domestic violence in Mexico, and their response to cases that they had experienced This information would also serve as a baseline for the post intervention evaluation [5]

Base line surveys

Base line surveys were distributed among health professionals at each of the intervention sites, totaling 62 in Ticoman [6] and 51 in the DIF D F [7] Although each survey had basically the same objectives, there were necessary differences due to the nature of each institution In each case, the surveys were completed by the health care providers themselves

Specifically the surveys were to explore the following points

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[4] Pediatrics gynecology/obstetrics internal medicine, opthalmology E N T general surgery and anesthesiology
[5] See section on evaluation, for further details
[6] See Appendix 2 for the Ticoman survey instrument
[7] See Appendix 3 for the DIF D F survey instrument

1 Existence of protocols or procedures for screening, registering and responding to abused women
2 Number of cases detected over the previous month
3 Knowledge of signs and symptoms related to domestic violence
4 Institutional information (organizational structure and infrastructure)

Results of the survey in Ticomán

While 88 1% of the 62 Ticoman survey participants affirmed that there was no screening protocol for domestic violence, 11 1% said that there was Only 25 4% of the respondents reported asking specific questions about abuse, the majority being direct questions Although 70 2% estimate having detected between 1 and 5 cases of domestic violence during the previous month, only 14 8% of the whole sample ever register domestic violence cases While 49 2% of the sample reported knowing institutions that help women who suffer violence, over half were unable to name these institutions Upon detecting a case of domestic violence, 43 9% of the respondents report referring the victim to the hospital psychologist, while 36 6% refer her to the social work department

After further investigation, we discovered that the hospital does have a program for detecting and managing cases of sexual and family violence, which may explain the confusion over the existence of a screening protocol However, this program is not widely known or followed by hospital staff, since only 7 3% of the respondents refer abused women to the Preventive Medicine Department in charge of this program The majority of those cases which are referred to this department are victims of child abuse and rape

Knowledge of symptoms that abused women may present was fairly poor within the hospital and in the responses we found a mixture of signs and symptoms As regards physical signs and symptoms, only 9 were correctly mentioned, the most common being hematomas (37 7%) followed by wounds (27 9%) Lesser mentioned signs were bruising, contusion, fractures, scars and pain With respect to the 12

psychological symptoms correctly mentioned, depression was the most frequent (24 7%) and other less frequently mentioned symptoms were fear, anguish, nervousness, and suicidal ideas

The majority of the respondents (63 5%) reported attending more than 10 patients during their shift, and 76 7% have only 15 minutes or less for each patient Only 38% of all patients are seen in a private space, while this is not so for 62% of the patients (those who attend the emergency department or are hospitalized) Just over half (53 2%) go into the doctor's office on their own, although 86 5% of the time, another health care worker- usually a nurse, is present This last figure points to the importance of integrating a range of health professionals into the training program

Results of the survey in DIF D F

The majority of the 51 survey respondents were physicians (45), and only 6 were nurses, which reflects the structure of the Department of Preventive Medicine at the DIF D F As regards routine screening, 77 6% of the respondents from this survey stated that there was no screening protocol to detect violence against women, while 22 4% affirmed that there was Interestingly however, 63 3% of the total sample reported asking specific questions to detect abuse, while only 36 7% did not This indicates that a large number reportedly screen on their own initiative When asked about the type of questions used, the majority were related to family relationships, as an indirect means of introducing the subject of abuse Although 64 7% detected between 1 and 5 cases during the previous month, only 9 8% report registering cases of violence

Unlike the health professionals at the Ticoman General who form part of a larger team of health care providers, the majority of DIF D F physicians work in isolation within their community centers Therefore when a victim of domestic violence is identified, a DIF physician generally does not have anyone else to turn to in the community center It is perhaps for this reason that 78 4% of the respondents reported referring abused women on to other institutions, while only 21 56% reported

giving guidance themselves Unfortunately, only 64% of the total sample knew of institutions where they could refer victims of domestic violence to, these included the DIF head offices, the local police headquarters and the Center for Attention to Family Violence

Knowledge of signs and symptoms was much more extensive among DIF respondents than in Ticoman A total of 23 different physical signs and symptoms were correctly reported, with the most common being Bruising (27 45%), hematomas (23 53%), pain (17 65%), wounds (25 69%), and headaches (13 73) The repertoire of psychological signs and symptoms was also greater than in Ticoman, with a total of 31 correctly mentioned The most commonly mentioned were Depression (64 7%), low self esteem (25 49%), fear (19 61%), anguish (17 65%), and anxiety (11 76%)

The majority of the respondents (80 4%)reported attending more than 10 patients during their shift, and the majority (90 2%) spend between 15 and 30 minutes on average with each patient Just over half of the patients (51%) are seen in a private space, and only 37 3% see the physician on their own

In terms of health care practice at the time of the survey, there was no formalized screening protocol in either intervention site, although DIF D F physicians were more likely to ask their patients about abuse Health professionals in Ticoman had less time for patients and were less likely to see them in a private space than physicians at the DIF D F Knowledge of physical and psychological signs and symptoms of abuse could be improved in both institutions Although a high percentage of health professionals from both institutions reported detecting between 1 and 5 domestic violence cases per month, very few actually registered these cases In the DIF D F , the majority of physicians reported referring on victims of abuse , but not all of them knew of institutions which can help these women In the Ticoman General, the majority of health professionals referred abused patients to the hospital psychologist

or social work, while very few actually referred them to the department in charge of the sexual and family violence program

Structured interviews (DIF D F and Ticomán)

In order to gain a deeper understanding of health care providers' knowledge, attitudes and perception of their role, we chose to carry out structured interviews with a small sample of professionals from each institution Six interviews were held with 2 physicians, 2 nurses and 2 social workers, randomly selected from 35 who would be attending the training program at Ticoman Seven interviews were held with physicians randomly selected from the 63 health professionals who would be attending the program at the DIF D F

Besides verifying some of the survey information, the structured interviews aimed to obtain the following information

1 Health professionals' knowledge of domestic violence
2 Their attitudes about this issue
3 The perception of their roles as health care providers in the context of domestic violence
4 The nature of their work and their experience of domestic violence cases

Information obtained from the structured interviews (DIF D F and Ticomán)

The structured interviews were audio-taped and transcribed, transcripts were then read carefully and information was coded and categorized For the purposes of this report, we shall describe the information obtained from the interviews that was relevant to program development

Knowledge about domestic violence

Health professionals from both the DIF D F and Ticoman considered that there is a high prevalence of family violence in Mexico, with women and children as the most common victims One interviewee also mentioned that elderly people and men are victims of family violence Adult men and women were considered to be the principle

perpetrators of family violence men toward women and children, and women toward children There was some resistance to conceiving that adult women could be primary victims of family violence in the discourse of some health professionals

> *"Generalmente son las mujeres ¿no?, esto es entre comillas, porque los mas afectados son los hijos " (Social worker, Ticoman)*

This can perhaps be explained by the following comment, which suggests that children of abused mothers are the most affected, because the women are generally the principle caregivers in the home

> *"Evidentemente pues, la mujer es la base de la familia, desde el punto de vista educativo, ella es la que se hace cargo de la educación de los niños y cualquier cosa que le afecte, tendra que afectar a los hijos " (Physician DIF)*

Indeed, when asked specifically about the social consequences of intimate partner violence, the interviewees also concentrated principally on the consequences suffered by children of abused women Children were emphasized as the principle victims, even when it was their mother who directly suffered abuse at the hands of her partner, which highlights the need for a revision of the idea that children are *indirect* victims of abuse

All the health professionals realized that violence has a social etiology education, economic problems, cultural factors, alcohol and drug abuse, and machismo were mentioned As regards types of intimate partner violence, sexual and economic violence were rarely mentioned by interviewees, and acts of economic and sexual violence were only described once This seems to indicate that economic control was perhaps not generally recognized as a form of violence before the course, since many of the health professionals mentioned economic hardship aa problem in the communities that they attend However, sexual forms of intimate partner violence are even more hidden than other forms of violence, and represent even more of a taboo

to health care providers None of the interviewees knew of the Cycle of Violence, nor did they know of the recent changes in legislation to support victims of violence

In general, what these health professionals hoped to learn from the course can be summarized as follows The etiology of violence, types of violence, how to identify a victims of abuse, how to ask the right questions, how to respond and give options, legal information, and information about specialized agencies that help abused women

Attitudes and role perception

The health professionals interviewed seemed to have an understanding of the reasons why women do not reveal the abuse or leave their abuser This could be divided into personal impediments such as fear of repercussions, emotional and economic dependency, insecurity, low self esteem, and social obstacles such as the cultural belief that violence is normal, ignorance, lack of support, criticism, and the lack of real alternatives Nevertheless, when talking about their experience of cases, interviewees tended to encourage victims to take action against or even leave their abusive partner, and expressed certain prejudices when women continued in abusive relationships

> *"Mi papel, pues, educar a la agregida, para que tenga un panorama más amplio y no permita que la agredan " (Physician, DIF)*

> *"Una vez tan feo la golpeo que empezo ella a clavarse el cuchillo así delante de sus hijos Entonces este, me enseñó las cicatrices y dices ¿como es posible que ni a ti misma te quieras?" (Social Worker, Ticomán)*

> *"Bueno, más que nada yo le digo, sabe que, eso hay que denunciarlo, no puede usted seguir viviendo asi en ese estado " (Physician, DIF)*

There was also some suggestion that abused women are weak and masochistic, that they are in some way *responsible* for allowing the abuse and that they establish a pathological relationship with their partner As a result of these attitudes, interviewees generally considered that the principle obstacle to intervention is the abused woman herself Although it should be emphasized that intervention is often synonymous to convincing the woman to take action against her partner

> *"A veces da un sentimiento de impotencia, el hecho de que quise ayudar pero esa gente está cerrada, no lo acepta " (Nurse, Ticomán)*

> *"Las mismas agredidas que no lo manifiestan, y que no lo permiten, bueno, no se dejan aconsejar " (Physician, DIF)*

> *"Si ella no quiere hacer la denuncia, aunque nosotras la detectemos que ha sido agredida, no la podemos obligar a que denuncie " (Social worker, Ticomán)*

In Ticoman, other obstacles that are particularly mentioned are more work related, such as too much work, lack of time, not having a specific program or protocol to address this issue, not knowing what to do

> *"Quizá alguna de las limitaciones importantes sería el exceso de trabajo, porque por la carga de trabajo a veces nos es imposible tratar de resolver un problema en una consulta de 10 minutos, y sobre todo no podemos establecer una adecuada empatía " (Physician, Ticomán)*

> *" Pues uno quisiera hacer algo ¿no? Cualquier información estaría buena para apoyarlos ( ) ahora, meterse mucho tiempo tampoco, porque si la institución no te respalda para nada ¿Por que lo vas a hacer?" (Social worker, Ticomán)*

Interestingly, the physicians from DIF D F also mentioned their profession as an obstacle, since they have been trained to isolate and cure the physical signs and symptoms of the patient, and do not generally consider the patient or the context of her relationships

> *"En las clínicas de atencion, estan, por decirlo asi, en su papel, de dar consulta, de detectar algun padecimiento y de tratar ( ) Lo que están viendo principalmente es la cuestión curativa nada más del cuadro, pero no se ahonda más en el aspecto psicológico o emocional " (Physican, DIF)*

Specifically the health professionals' perception of their role in the context of domestic violence, can be divided into two areas 1) Prevention work, such as giving talks, working with children, and generally disseminating information in the community 2) Attention to victims of abuse, such as detecting and referring these patients, and to a lesser extent listening to them and giving them guidance The perception of some health care workers was that their role in attending these cases was minimal or intermediary, and the importance of working as part of an integral team was also emphasized

As a result of the formative research, it was considered particularly important to include the following points in the program (in addition to the material from the bibliographic review)

- Symptomatology
- The importance of asking patients about abuse
- The importance of registering cases
- The (personal, family and social) consequences of intimate partner violence
- Why women find it difficult to leave an abusive partner
- Recent legislation in Mexico

It was considered that emphasizing the impact of abuse on women, would go some way toward dispelling myths and prejudices expressed about women who do not immediately leave or take action against their abuser In addition, while it is not possible to change some of the institutional obstacles that health professionals face, it is possible to for them to find ways in their individual practice to begin to address this issue

5 3 Development and implementation of training program [8]

Developing the training program was no easy task due to the large amount of material accumulated during the first stage of the project, which had to be adapted to the Latin American context in general, and Mexico in particular Using information from the research material and program models, together with the data from the surveys and interviews, the training program was divided into 3 units, each covering a specific topic 1) Information about domestic violence, 2) health care providers' roles, and 3) skills and strategies to manage domestic violence cases Those attitudes which perpetuate violence against women were to be challenged throughout the whole of the training program

It is considered that the issue of domestic violence is highly emotional, and participants should be encouraged to work on a personal level, before addressing this issue professionally Participatory methodology was therefore the basis for the program design, and exercises were developed in such a way that they would allow for reflection, analysis and discussion of each of the workshop themes

The training program was piloted with five groups of health care providers during the months of July and August, 1998 [9] The first version of the training program was conceived to be imparted during three 5 hour sessions However, due to observations of both the course instructor and the participants of the first course, the

[8] See Appendix 4 for the contents and bibliography of the training program
[9] See Appendix 5 for details of the 5 courses

program was revised and the final version is divided into three 6 hour sessions, covering a total of 18 hours

5 4 Evaluation

5 4 1 *Pre and post-workshop evaluation instrument (DIF D F and Ticomán)*

The impact of the training module was measured using a pre and post test instrument, designed to capture changes in knowledge of domestic violence, and of strategies for management of domestic violence cases in health care settings [10]
The instrument, in the form of a self applicable questionnaire, consists of a section of 5 closed multiple choice questions on prevalence of intimate partner violence against women and a section of 10 open ended questions regarding knowledge of the dynamics of abuse, and strategies for responding appropriately to these patients
The questionnaire was completed by participants immediately before and after the course

Results of multiple choice questions on prevalence

A comparative analysis of the results of the 5 multiple choice questions on prevalence only showed significant change in knowledge in the last group of course participants, this could be due to a combination of facts 1) the questions were not sensitive enough, and 2) the participants had a high level of correct answers in the pre test

Table 1 Results of multiple choice on prevalence

Median, t test and significance
(5 questions)

COURSE	N	MEDIAN BEFORE	MEDIAN AFTER	t	P
First Course DIF D F	17	3 588	4 000	-1 69	110
Second Course DIF D F	19	3 684	3 684	00	1 000
Third Course DIF D F	16	3 523	3 813	-1 17	261
First Course Ticoman	15	3 333	3 800	-1 33	204
Second course Ticoman	17	3 177	3 824	-2 52	023

p< 0 05

[10] See Appendix 6 for pre and post test instrument

Results of open ended questions

Each open ended question required between 2 and 5 answers, therefore the total number of correct answers per question was counted for each participant, and the average number of correct answers per question was determined for each group in the pre and post test A t-test was then carried out for each question, in order to establish the significance of reported changes

Table 2 First Course at DIF D F

Median, t test and significance for each question
(n=17)

QUESTION	MAX. NO. CORRECT ANSWERS	MEDIAN BEFORE	MEDIAN AFTER	t.	p.
Soc econ Consequences	2	588	941	-2 07	055
Abuser's Intention	2	1 059	1 765	-2 78	013
Types of violence	4	1 529	3 941	-6 44	000
Most common type	1	200	235	-1 00	332
Cycle of violence	3	000	824	-4 67	000
Physiological symptoms	5	1 765	3 118	-2 56	021
Psychological symptoms	4	1 000	2 059	-4 24	001
Indirect indicators of abuse	4	059	1 176	-5 90	000
Steps after detection	4	1 294	2 353	-2 66	017
Emergency planning	4	235	3 235	-13 22	000

P< 0 05

Table 3 Second course at DIF D F

Median, t test and significance for each question
(n=19)

QUESTION	MAX. NO. CORRECT ANSWERS	MEDIAN BEFORE	MEDIAN AFTER	t	P
Soc econ Consequences	2	526	1 316	-5 46	000
Abuser's Intention	2	1 000	1 895	5 93	000
Types of violence	4	1 737	3 579	-7 52	000
Most common type	1	214	444	-2 04	056
Cycle of violence	3	000	579	-4 16	001
Physiological symptoms	5	2 000	3 789	-4 92	000
Psychological symptoms	4	1 368	1 421	- 27	790
Indirect indicators of abuse	4	105	1 053	-2 61	018
Steps after detection	4	1 421	2 316	-3 54	002
Emergency planning	4	632	3 474	-8 26	000

p< 0 05

Table 4 Third course at DIF D F

Median, t test and significance for each question
(n=16)

QUESTION	MAX. NO. CORRECT ANSWERS	MEDIAN BEFORE	MEDIAN AFTER	t	P
Soc econ Consequences	2	563	750	- 82	423
Abuser's Intention	2	1 063	1 813	-5 20	000
Types of violence	4	2 188	4 000	-7 96	000
Most common type	1	071	267	- 81	432
Cycle of violence	3	000	813	-8 06	000
Physiological symptoms	5	2 688	3 875	-2 76	015
Psychological symptoms	4	1 563	2 688	-3 74	002
Indirect indicators of abuse	4	125	1 500	-4 20	001
Steps after detection	4	938	1 875	-2 80	014
Emergency planning	4	500	3 313	-11 47	000

p< 0 05

First course at Ticoman

Median, t test and significance for each question
(n=15)

QUESTION	MAX. NO. CORRECT ANSWERS	MEDIAN BEFORE	MEDIAN AFTER	t	P
Soc econ Consequences	2	467	667	-1 15	271
Abuser's Intention	2	800	1 467	-3 16	007
Types of violence	4	1 600	3 800	-6 20	000
Most common type	1	000	385	-2 65	019
Cycle of violence	3	000	800	-7 48	000
Physiological symptoms	5	1 000	1 267	- 84	413
Psychological symptoms	4	1 000	1 533	-2 26	041
Indirect indicators of abuse	4	200	733	-2 48	027
Steps after detection	4	667	1 933	-4 46	001
Emergency planning	4	267	3 800	-21 38	000

p< 0 05

Second course at Ticoman

Median, t test and significance for each question
(n=17)

QUESTION	MAX. NO. CORRECT ANSWERS	MEDIAN BEFORE	MEDIAN AFTER	t	P
Soc econ Consequences	2	118	353	-1 46	163
Abuser's Intention	2	647	1 235	-2 58	020
Types of violence	4	1 706	3 882	-8 84	000
Most common type	1	176	294	-1 00	332
Cycle of violence	3	118	824	-4 95	000
Physiological symptoms	5	412	2 412	-5 22	000
Psychological symptoms	4	353	1 235	-4 66	000
Indirect indicators of abuse	4	059	294	-1 46	163
Steps after detection	4	588	2 235	-6 82	000
Emergency planning	4	000	3 000	-9 35	000

p< 0 05

For all groups, the comparative analysis of completed pre and post test questionnaires showed an increase in knowledge, which was significant for those questions regarding the abuser's intention, types of violence, the cycle of violence, steps to take after detection, and how to help the victims plan for an emergency

5 4 2 *End line surveys*

The end-line surveys were to take place three months after the implementation of the training program, in conjunction with the review of structural changes adopted by each intervention site Due to the set backs previously mentioned regarding site selection, the project terminated just one month after completion of training Up to this point, the General Hospital of Ticoman had not reviewed its sexual and family violence program, nor had the Department of Preventive Medicine of the DIF D F committed to adopting a specific policy or program to detect and respond appropriately to abused women For this reason, it was considered that an end-line survey would not be capture a significant change in the management of domestic violence cases in the institutions in question

5 4 3 *Follow-up interviews (DIF D F)*

For the above mentioned reasons, follow-up interviews were held during September (one month after the course), with those health professionals who had been interviewed at the beginning of the project Up to the point of writing this report, 6 interviews had been carried out with physicians from the DIF D F and 5 with health care providers from Ticoman, of these, only the DIF interviews had been transcribed and analyzed

The interview guide for the follow-up interviews [11] was based on the original guide, although some questions were removed and others added, in order to explore in greater detail those changes in knowledge and practices after the course

Knowledge and attitudes about domestic violence

Although there was a certain amount of variation among the physicians with regard to what they had learnt from the course, particularly with regards to attitudes about domestic violence, the significant increase in knowledge found in the pre and post questionnaires was confirmed and further explored It is considered that attitude

[11] See Appendix 7 for the follow-up interview guide

change is an almost impossible objective to achieve in a three day course, but that dispelling myths and providing correct information sets the basis for this to occur

According to the interviewees, the workshop had given them information about intimate partner violence that they had been unaware of, despite their previous experience with abused patients In particular, the following points were mentioned as being new information Types of violence, the cycle of violence, elements that enable detection and management of abused women, places to refer these patients

> *"Ya con el curso que nos dieron, la capacitacion que nos dieron ya sabemos enfocarnos bien en el problema de nuestras pacientitas y sobre todo canalizarlas "*

> *"Eso por ejemplo lo del ciclo de violencia, nosotros no lo sabíamos, no lo manejábamos, este qué más, este bueno, los tipos de violencia si lo sabíamos pero como podríamos conocerlos mas o adentrarnos mas "*

When the physician who made the last statement was asked why she thought few health professionals had mentioned sexual violence in the previous interviews, she reported that it is because they may feel uncomfortable about what they consider an intrusion into their patients' private lives This idea was also confirmed by another physician

Some of the physicians showed an increased awareness of the origins of violence and that violence against women is a means of exercising power and control

> *"Uno es porque viene de una familia en la que ve que el padre es agresor, y luego, como mencionaban en el curso, sabe con quien ser agresivo ¿no?"*

"También a través de lo que es el control del presupuesto familiar puede haber un tipo de violencia ¿verdad? Porque si hay una cierta control a través de eso "

"Pues es como un impulso para para como te diré pues sacar su inferioridad ¿no? O sea, para no sentirse inferior, para sentirse que tiene el poder "

These physicians also showed a greater understanding of the wide range of consequences of intimate partner violence, and the impact that this has on the woman involved Before the course they could only mention the consequences for the children of abused women

"Son muchas ¿no? Va a haber un daño, lógicamente psicologico, va a haber ausentismo probablemente en el trabajo, enfermedades más frecuentes, este puede haber alcoholismo, drogradicción, tendencia a suicidio "

Some physicians were also able to demonstrate an understanding of the reasons why women do not leave their abuser when the violence starts, and that separation is a complex process Thus the idea that women are weak and are in some way responsible for *allowing* the violence to continue was no longer prevalent

"Algunas era pues el Síndrome de Estocolmo que nos comentaban, otras eran porque ellas quieren separarse pero piensan que va a cambiar el esposo ( ) otras de las causas es que aunque a lo mejor no se separan, ellas están buscando la manera de salirse pero no lo hacen inmediatemante ¿no?

"Lo que nos decían ¿no? no tiene los elementos suficientes, porque a veces se va y vuelve a regresar ¿no? Pero vuelve a regresar para unir mas cosas para poder prepararse y volverse a ir "

In particular, the physician who emitted the previous statement, also understood the risk involved for the patient if a health care provider or lawyer insists that she take action against her husband

"Es que una paciente cuando pone su demanda, es cuando más casos de homicidio se dan, digo ¿A cuántas ya las mandamos indirectamente al otro lado "

Role perception and experience of cases

Of the 6 physicians interviewed from the DIF, 4 had already detected women suffering abuse by the time of the follow-up interviews These physicians had assumed more actively their role of detecting and attending abused women, and report having begun to routinely ask their patients about family violence The other 2 physicians reported that they had only seen patients for complaints that they did not consider related to intimate partner violence At the time of this report, none of the physicians had started to carry out prevention work in the community, such as giving talks and disseminating information

Of those 4 physicians who had detected abused women, three were working in conjunction with their nurses, and report following the steps that they learnt in the course, including Asking about abuse, listening to their patient, evaluating the level of abuse, helping her plan for an emergency, referral to a specialized agency and follow-up [12]

"Bueno, primero le hice el interrogatorio, una vez que hice el interrogatorio, pues ya la evaluación de riesgo, que está en el primer

[12] See Appendix 8 for one physician's account of his experience of a case

grado de abuso, entonces lo primero que hice fue hacerle ver que ella está en una relación donde la violencia está empezando ( ) como este tipo de violencia puede seguir aumentando, yo lo que le hice saber es lo que tenemos nosotros para prevenir este tipo de violencia para si es posible mejorar la relacion "

"Le dijimos que estabamos para ayudarla, que cómo había sucedido esta situacion, que si quería contarnos, y ella empezó a decirnos todo Entonces le dijimos que si estaba dispuesta a ver que tipc de violencia y que riesgo tenía, y que esto iba a quedar en la consulta médica, entonces ella dijo que sí y aquí está La mandamos al CAVI y este le dijimos que regresara para ver com o le había ido "

Although as previously mentioned, the DIF D F had not taken up a policy to detect and respond to abused women, it did agree to distribute a format to register, on a monthly basis, those cases which physicians do detect This was implemented for the first time during September 1998 therefore results are not yet available, although IMIFAP will analyze this data and report to the DIF D F This may have influenced those physicians who are detecting abused women, who all report registering their cases on this format

5 5 Dissemination of project

This phase of the project includes the printing of 10,500 brochures for health care providers of different health service institutions and Faculties of Medicine throughout the Mexican Republic Over the period of the project, a data base was compiled in order to be able to distribute these brochures more effectively, and to record the scope of the distribution In addition, 500 informational packages were designed and are being printed for public health policy makers, and 50 training manuals are being printed for program instructors As soon as this material had been printed, a copies will be sent to INOPAL III/Population Council The training workshop for trainers from different organizations in Mexican states surrounding

the Federal District is in the process of being organized In addition to the dissemination activities contemplated in the original proposal, two working papers have also been published to advance some of the results of this project

6 CONCLUSIONS AND RECOMMENDATIONS

In conclusion, the formative research determined that there is both a great need and interest for information on intimate partner violence in health institutions in Mexico, since cases are being detected and managed although there are no formal protocols in place The training program had a significant quantitative impact on knowledge regarding domestic violence issues, and to a certain extent also had a qualitative impact on medical practice in at least one of the institutions involved However, it is of utmost importance that this issue be adopted as policy by national health institutions, in order for protocols to be put in place, and a significant change in practices to occur For this reason, widespread dissemination of information of this issue in national health institutions will be of great importance

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APPENDICES

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APPENDIX 2 9
Ticoman Survey

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DIF D F Survey

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Program Contents and Bibliography

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Details of Courses

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Pre and Post test Evaluation Instrument

APPENDIX 7 23
Follow up Interview Guide

APPENDIX 8 27
Case Experience

APPENDIX 1

DIRECTORY OF LOCAL SERVICES

CAVI
CENTRO DE ATENCION A LA VIOLENCIA INTRAFAMILIAR

Direccion Carmona y Valle # 54, 1er piso, Col Doctores
Telefonos 2-42-62-46, 2-42-62-48, y 2-42-60-25
Horario Lunes a Viernes 8 00 a 21 00 horas Existen guardias nocturnas todos los dias en Fray Servando # 32 1er Piso
Director Lic Samuel Rodriguez Serrano
Coordinadora de Trabajo Social Lic Angelica Mandujano Gonzalez
Coordinador de Asesoria Juridica Lic Domingo Viveros
Coordinadora de Seguimiento Juridico Ruth Martinez Morales
Representante de Apoyo Psicoterapeutico Ma Teresa Rangel Tapia

Servicios que presta

✓	Asesoria Juridica
✓	Intervencion en crisis
✓	Terapia psicologica individual
✓	Terapia psicologica grupal para mujeres y para niños
✓	Autorizacion para referir al albergue del D F

Cualquier persona que solicite la atencion pasa primero a Trabajo Social, en donde expone su problematica, posteriormente, dependiendo de cada caso, pasa a las siguientes areas, que son Servicio medico, Asesoria Juridica, Seguimiento Juridico, y Apoyo Psicoterapeutico

Cualquier persona que necesite el apoyo terapeutico, debera esperar su turno para ingresar, por un tiempo maximo de una semana

Se da atención a personas que viven en el D F

UAVI
UNIDAD DE ATENCION A LA VIOLENCIA INTRAFAMILIAR DE LA DELEGACIÓN VENUSTIANO CARRANZA

Direccion Lucas Alaman # 11, Col del Parque, Del Venustiano Carranza, (atras de la delegacion V C)
Telefono 5-52-73-16
Horario Lunes a Viernes 9 30 a 19 00 horas
Coordinadora general Lic Claudia Bernabe Gonzalez
Coordinador del area Psicosocial Dr Raul Corona Fuentes
Coordinadora del area Juridica Lic Ana Lilia Soria

Servicios que presta

✓	Asesoria Juridica
✓	Intervencion en crisis
X	Terapia psicologica individual
X	Terapia psicológica grupal
✓	Autorizacion para referir al albergue del D F

Cualquier persona que solicite la atencion pasa primero a Trabajo Social, en donde expone su problematica, si es necesario, posteriormente se da una intervencion en crisis, (si requieren de un tratamiento psicologico mas profundo, se les refiere al CAVI), despues pasan al area Juridica

Se da atencion a personas que viven en el D F

SUBDIRECCIÓN DE APOYO A LA MUJER Y LA FAMILIA
(DIF D F)

Tel 6-05-14-16

Responsables
Lic Esperanza Reyes Carrion
Lic Esther Madrid Buenrostro

Servicios que presta

[✓] Referencia al albergue del Distrito Federal

Si el medico considera que es un caso que debe referirse al albergue del D F , debera llamar por telefono personalmente para canalizar a la persona

COVAC
COLECTIVO DE LUCHA CONTRA LA VIOLENCIA HACIA LAS MUJERES A C

Direccion actual Mitla # 145, Col Narvarte
Direccion a partir de Agosto de 1998 Astronomos # 66, Col Escandon
Tel 5-19-31-45 y 5-38-98-01
Horario Lunes a Viernes 9 30 a 18 00
Directora Biologa, Patricia Duarte

Servicios que presta

[✓] Asesoría Juridica
[✓] Terapia psicológica individual
[✓] Terapia psicológica grupal

CORIAC
COLECTIVO DE HOMBRES POR RELACIONES IGUALITARIAS

Direccion Matías Romero n° 1353, int 2, Col Vertiz Narvarte
Tel 6-04-11-78
Horario 10 00 a m a 7 00 p m
Director Psic Francisco E Cervantes Islas
Antr Eduardo Liendro Zingoni

Servicios que presta

✓	Atención a hombres violentos
✓	Grupos de reflexión para hombres violentos
✓	Canalizacion a terapia individual (si es necesario)
✓	Capacitacion a personas interesadas en trabajar con hombres violentos

Es necesario hacer una cita previa por telefono

PROCEDIMIENTOS EN EL MINISTERIO PÚBLICO

La ruta que sigue al llegar a la delegacion una mujer que ha sido maltratada o violada, es la siguiente

1 Llega al ministerio publico dentro de la delegacion y se declara victima de maltrato o de violacion
2 Pasa con el medico legista siempre y cuando haya lesiones, quien determinara si son causadas por maltrato o violacion No se toman en cuenta los reportes de medicos realizados fuera del Ministerio Publico Aunque la mujer haya sido revisada previamente por su medico personal, tiene que pasar a revision con el medico legista
3 Si el medico legista no puede determinar la causa de la lesion, se canaliza a la mujer al hospital de Xoco, en donde vuelve a ser revisada
4 Puede levantar el acta dentro del hospital de Xoco, o bien, volver a la delegacion a levantarla
5 El acta pasa a la mesa de tramite hasta que se envía al juzgado (en la mesa de trámite puede estar más de un año)
6 Cuando el acta llega al juzgado, el juez tiene 2 dias para resolver el caso

El Ministerio Publico, canaliza a las mujeres que llegan maltratadas, o victimas de abuso sexual al CAVI o a las Agencias 46, 47, 48 o 49 que son las agencias investigadoras sobre delitos sexuales Estas se encuentran ubicadas en las siguientes direcciones

Agencia 46
Parque Lira No 94, Esq Sostenes Rocha, Col Tacubaya, Del Miguel Hidalgo
Telefonos 515-69-53 / 271-69-62 Ext 5218 / 5221

Agencia 47
Tecoalipan y Zompantitla, Col Romero de Terreros, Del Coyoacan
Telefono 554-29-43

Agencia 48
Fray Servando y Fco, del Paso y Troncoso, Col Jardin Balbuena, Del Venustiano Carranza, Telefono 625-87-48

Agencia 49
Vicente Villada y 5 de Febrero, Col Gustavo A Madero, Telefono 625-87-49

CENTROS DE ATENCION AL MALTRATO INTRAFAMILIAR Y SEXUAL (CAMIS)

CAMIS central
Tenayuca # 66 Tercer piso, edificio de la subprocuraduria
Tlanepantla, Estado de Mexico
Tel 3-90-74-00
Responsables
Mtra Patricia Valladares de la Cruz
Coordinadora General Lic Geldy Martinez Lara
Psic Miriam Nava Castillo

CAMIS Tlanepantla DIF
Toltecas # 15
Tel 5-65-22-66
Responsable
Lic Lilian Negrete Estrella

CAMIS San Juan Ixhuatepec
Av San Jose s/n, frente a la estacion de bomberos
Tel 7-15-50-58, 7-15-50-59, y 7-15-50-49
Responsable
Monica Figueroa

CAMIS Naucalpan
Via Adolfo Lopez Mateos y calle Corona
Tel 5-60-54-41, 3-58-31-32 y 5-76-36-12 (Ext 19)
Responsables
Psic Socorro Segura A
Psic Claudia Veronica Nájera

CAMIS Atizapan
Av Ruiz Cortines, esq Cambay s/n Col Lomas de Atizapan
Tel 8-22-02-54 y 8-22-16-75
Responsables
M P Olga L Monroy
Psic Rosa elena Alcantara

CAMIS Ecatepec
Via lopez Portillo, km 1 Col Ejidal E Zapata
Tel 8-82-16-71
Responsables
M P Gloria Carmona Martinez
Psic Maria Magdalena de Luna Farfan

CAMIS Cuautitlan Izcalli DIF
Av Constitucion 1000
Tel 8-73-21-10, ext 22
Responsables
M P Alma Delia Guzman Cano
Psic Ma de Jesus Luna Hernandez
Psic Claudia Guadarrama Q

CAMIS Texcoco
Calle Tenerías s/n, Barrio de la Conchita
Tel 4-48-46
Responsable
T S Ramon Ledezma Celis

CAMIS Nezahualcoyotl Centro de Justicia
Calle Ciclamores, esq Canelos Col La Perla
Tel 7-42-52-81 y 7-42-54-14
Responsables
Psic Blanca Lidia Roldan
T S Blanca Laura Rodríguez

CAMIS Nezahualcoyotl DIF
Aviacion Civil, esq Malinche Col Vicente Villada
Tel 7-32-97-58
Responsables
M P Martha Zapian Davila
Psic Ma del Pilar Cruz Pérez

CAMIS Nezahualcoyotl Palacio Municipal
Av Chimalhuacan, esq Caballo Bayo
Tel 7-36-43-31 y 7-36-58-83
Responsable T S Ana Lilia Cruz Rosado

CAMIS Chalco Centro de Justicia
Cerrada Tizapa Mina PB
Tel 5-15-81
Responsable
T S Ma de la luz Morales Cortez

CAMIS Toluca
Av Morelos, esq Jaime Nuno PB
Tel 1-48-344, 1499-11-15-03-88 ext 330
Responsables
Lic Gloria Muciño
Psic Ricardo Vivamco Moto

CAMIS Toluca DIF Central
Paseo Colon s/n, junto a DIForama
Tel 17-28-33
Responsables
M P Ma Teresa Blanquel Dominguez
Psic Xochilt Baltazar Medina

CAMIS Valle de Chalco
Calle 13 pte Lte 20, Mnz 140 Xico, cuarta seccion
Responsables
M P Racia Regina Neria Gonzalez
Psic Laura Olivia Hernandez Flores

CAMIS Chimalhuacan
Av Morelos #15, Barrio de San Pedro
Tel 8-52-32-80
Responsables
M P Rita Ma Bustillos del Moran
Psic Ma Enriqueta Davalos Duarte

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APPENDIX 2

ENCUESTA SOBRE VIOLENCIA CONTRA LA MUJER DIRIGIDA A PERSONAL DEL HOSPITAL TICOMAN

Por favor marque con una cruz el inciso de la respuesta que mas se acerca a lo que usted ha observado dentro del centro de salud Muchas gracias por su cooperacion

1) ¿Existe algun procedimiento de rutina para detectar casos de violencia contra la mujer?

   a) SI
   b) NO

2) ¿Hace usted preguntas especificas para detectar violencia contra la mujer?

   a) SI ¿cuales? _____
   b) NO

3) ¿Cuantos casos de violencia contra la mujer ha detectado usted en el ultimo mes?

   a) De 1 a 5
   b) De 6 a 10
   c) De 10 a 15
   d) 16 o mas

4) ¿Registra los casos de violencia contra la mujer que usted detecta?

   a) SI ¿donde? _____
   b) NO

5) En caso de detectar casos de violencia contra la mujer ¿con que profesional de la salud acude? _____

6) ¿Conoce usted alguna institucion a la que pueda referir los casos de violencia contra la mujer?

   a) SI ¿cual / es? _____
   b) NO

7) ¿Cuales son los sintomas fisicos de la mujer maltratada?

_____

_____

8) ¿Cuales son los sintomas psicologicos de la mujer maltratada?

_____

_____

9) ¿Cuanto tiempo dedica a cada consulta?

a) menos de 15 minutos
b) 15 minutos
c) 30 minutos
d) 45 minutos
e) 1 hora
f) mas de 1 hora

10) ¿En que turno trabaja usted?

_____

11) ¿Cuantos pacientes en promedio ve usted en un turno?

a) de 1 a 5
b) de 5 a 10
c) de 10 a 15
d) mas de 15

12) ¿En que departamento o area trabaja usted?

_____

13) ¿Cuenta usted con un cuarto privado para dar sus consultas?

a) SI
b) NO

14) ¿Las pacientes entran solas a consulta o con alguien?

a) solas
b) con alguien ¿quien?_____

15) ¿Quien mas, del personal del hospital esta presente en la consulta?

a) Enfermera
b) Trabajadora social
c) Otro, ¿quien?_____

ub

APPENDIX 3

ENCUESTA SOBRE VIOLENCIA CONTRA LA MUJER DIRIGIDA A PERSONAL DE SALUD DEL DIF D F

Por favor marque con una cruz el inciso de la respuesta que más se acerca a lo que usted ha observado Muchas gracias por su cooperacion

1) Si usted tuviera que clasificar la frecuencia de la violencia contra las mujeres en la familia en Mexico, ¿como la clasificaria?

   a) Muy frecuente
   b) Frecuente
   c) Poco frecuente
   d) No lo se

2) ¿Que tan frecuente es que en su trabajo vea a mujeres victimas de violencia intrafamiliar?

   a) Muy frecuente
   b) Frecuente
   c) Poco frecuente
   d) No lo se

3) ¿Cuantos casos de violencia de este tipo ha detectado usted en el ultimo mes?

   a) ninguno
   b) De 1 a 5
   c) De 6 a 10
   d) De 10 a 15
   e) 16 o mas

4) ¿Existe algun procedimiento de rutina para detectar estos casos?

   a) SI
   b) NO

5) ¿Hace usted preguntas especificas para detectar a mujeres maltratadas?

   a) SI ¿cuales? _____
   b) NO

6) ¿Registra los casos de mujeres maltratadas que usted detecta?

c) SI ¿donde? _____
d) NO

7) En caso de detectar estos casos de maltrato, ¿que hace?

_____

_____

8) ¿Conoce usted alguna institucion a la que pueda referir los casos de mujeres maltratadas?

c) SI ¿Cual / es? _____
d) NO

9) ¿Cuales son los sintomas fisicos de la mujer maltratada?

_____

_____

10) ¿Cuales son los sintomas psicologicos de la mujer maltratada?

_____

_____

11) ¿Cual es su profesion?

a) Medico/a
b) Enfermero/a

12) En promedio, ¿cuanto tiempo dedica a cada paciente?

g) menos de 15 minutos
h) 15 minutos
i) 30 minutos
j) 45 minutos
k) 1 hora
l) mas de 1 hora

13) ¿Cuantos pacientes en promedio ve usted en una jornada?

e) de 1 a 5
f) de 5 a 10
g) de 10 a 15
h) mas de 15

14) ¿Cuenta usted con un cuarto privado para trabajar?

c) SI
d) NO

15) ¿Las pacientes entran solas a consulta o con alguien?

c) solas
d) con alguien, ¿quien?_____

16) Desde su trabajo del DIF ¿Con que otros profesionales de la salud tiene coordinaciones?

_____

_____

17) ¿Ha recibido algun tipo de capacitacion en relacion a la violencia intrafamiliar?

Describe

_____

_____

18) ¿ Que considera que seria importante aprender para tratar el problema de la violencia intrafamiliar?

_____

_____

APPENDIX 4

THE ROLE OF HEALTH CARE PROVIDERS IN THE DETECTION AND MANAGEMENT OF DOMESTIC VIOLENCE CASES

CONTENTS OF EACH SESSION*

I) General information on violence against women by abusive partners

- Prevalence in Mexico, Latin America and other countries
- Analysis of the hidden burden of violence against women on the health care system
- Concepts and definitions of violence against women
- Identification of types of violence and behaviors accompanying them
- Analysis of the etiology of violence

II) The impact of violence against women in the couple's relationship and the role perception of health care providers with respect to this issue

- Analysis of the consequences of domestic violence on the social and economic growth of the country and on children's development
- Presentation of women's reasons for not leaving their abusers (Cycle of Violence, Learned Helplessness, Stockholm Syndrome)
- Discussion of the role of health care providers and services
- Analysis of the reactions of health care providers to patients who are abused by their partners
- Revision of the reasons that prevent health care providers from addressing domestic violence with their patients (barriers of providers and patients)
- Discussion of the ethical considerations related to dealing with domestic violence

* The workshop is divided into three 6-hour sessions for a total of 18 hours

III) Development of strategies and skills

- Analysis of the reasons why some women deny their victimization
- Discussion of the signs and symptoms of women who are victims of domestic violence
- Development of strategies for assertive communication (clarity of verbal and non-verbal language, empathy, feedback)
- Development of skills for appropriate questioning
- Presentation of steps to follow after the confirmation of violence (risk evaluation, identification of personal support networks, emergency plan, information on specialized centers, registration of the case)

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APPENDIX 5

DETAILS OF COURSES

Place	Date	Participants	Physicians	Nurses	Social Workers
DIF DF	6-8 / July/ 98	22	19	2	1
DIF DF	13-15/July/98	21	19	2	0
TICOMAN	20-22/July /98	18	3	13	2
DIF DF	27-30/July/98	21	21	0	0
TICOMAN	10-12/August/98	17	2	2	13

APPENDIX 6

CUESTIONARIO DE EVALUACIÓN PRE-POST

Nombre _____ Centro de Trabajo _____

Fecha _____ Instructor(a) _____

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1 Segun los datos que existen en Mexico, la prevalencia de la violencia contra la mujer es de
a) menos de 10%
b) 10 a 30%
c) 30 a 60%
d) mas de 60%

2 La violencia en la pareja es un mal de mujeres marginadas
a) cierto
b) falso

3 La violencia contra la mujer se da mas en medios rurales que en medios urbanos
a) cierto
b) falso

4 Las mujeres jovenes sufren mas violencia que las mujeres mayores
a) cierto
b) falso

5 Las mujeres corren mayor riesgo de ser victimas de violencia fuera de su hogar que dentro de su hogar
a) cierto
b) falso

6 Señala dos consecuencias socioeconomicas de la violencia contra la mujer

a) _____

b) _____

7 ¿Que busca la persona que ejerce la violencia contra la mujer?

a) _____ b) _____

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8 ¿Cuales son los cuatro tipos de violencia?

a) _____ b) _____

c) _____ d) _____

9 Segun los datos que existen en Mexico, ¿Cual de estos tipos de violencia es el mas comun?

_____

10 Nombra las tres etapas del "Ciclo de Violencia"

a) _____ b) _____

c) _____

11 Enumera cinco sintomas ***fisiológicos*** que puede presentar una mujer como resultado del estres de vivir en una situacion de violencia

a) _____ b) _____

c) _____ d) _____

e) _____

12 Enumera cuatro padecimientos ***psicológicos*** que puede presentar una mujer que sufre violencia

a) _____ b) _____

c) _____ d) _____

13 Señala cuatro indicadores ***indirectos*** de violencia (no incluir signos ni sintomas) que se presentan en la historia clinica de una paciente

a) _____ b) _____

c) _____ d) _____

14 Indica cuatro acciones a seguir para apoyar a una mujer que sufre violencia

a) _____

b) _____

c) _____

d) _____

15 Indica cuatro de los aspectos que debe tomar en cuenta la paciente para prepararse para una emergencia

a) _____

b) _____

c) _____

d) _____

APPENDIX 7

Guía de Entrevista de Seguimiento

Nota Iniciar averiguando si asistio al taller

I CONOCIMIENTOS Y ACTITUDES GENERALES

1 Indagar sobre su experiencia del taller

- Lo que no sabia y aprendio (que la practica medica no le dio)
- Lo que le gustaria profundizar
- Lo que no aprendio y quisiera aprender
- Lo que le ha servido

2 Indagar por que cree que el taller aborda especificamente el tema del maltrato a la mujer

3 Indagar por qué cree que se da la violencia en las relaciones de pareja

4 Indagar sobre la conducta del agresor- por que el actua asi

5 Indagar sobre las razones que tiene una paciente para callarse sobre el abuso

6 Indagar sobre las razones que tiene para permanecer con el agresor

7 Indagar sobre las diferentes consecuencias de los casos de violencia que han visto o escuchado personales, familiares, sociales

8 Indagar por que antes del curso la mayoria de los medicos plantean que las mujeres permiten el abuso, y si despues del taller estan de acuerdo con esto

9 Indagar por que antes del curso, los medicos casi no mencionaban la violencia sexual como un tipo de violencia

II DETECCIÓN DE CASOS DESPUÉS DEL TALLER
(Conocimientos, percepción de rol y actitudes)

10 Indagar que han hecho con respecto al tema dentro de la institucion (trabajo de prevencion, hablar con compañeros de trabajo)

11 Indagar si esta realizando preguntas de rutina para detectar casos

12 Averiguar si ha detectado algun caso

Sí

- Numero
- El tipo de violencia que ha detectado con mayor facilidad

No

- ¿Por que no ha detectado casos?

Nota Intentar indagar si se trata de limites personales o institucionales Indagar mas sobre los limites personales y percepcion de rol aqui, y dejar para el final de la entrevista los obstaculos institucionales

12a) Si ha detectado un caso

- La forma en que se detectaron- ¿Como pregunto?
- Describir a la persona y su situacion
- Indagar en que etapa del ciclo de violencia se encontraba esta persona cuando acudio
- Pasos que siguio el/la profesional de la salud
- Pasos mas faciles y mas dificiles
- Registro del caso ¿como?
- Posibilidad de seguimiento del caso
- Limites personales y percepcion de su papel como personal de la salud
- Hasta donde llegar como personal de salud en estos casos
- Sentimientos que provocan los casos

Nota Indagar por que se siguieron ciertos pasos y no otros

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12b) Si no ha detectado un caso

- Describir el siguiente caso de IMIFAP y que el/la profesional de salud imagine que le sucede

"Una mujer viene acompañada por su hermana, quien reporta que la encontro desmayada en el baño por la mañana La mujer se queja de fatiga severa y mareo y dice que se siente desganada La mujer entra sola a consulta, y al tomarle la presion, usted se da cuenta de varios moretones que tiene en el brazo "

- ¿Que hace? ¿Como preguntaria?

"Luego, ella empieza a llorar y le confiesa que en una discusion fuerte con su marido, el le habia agarrado del brazo para sacudirla y la habia empujado contra un librero Dice que despues el se fue de la casa, y no ha regresado Aunque siempre han discutido, es la primera vez que le ha lastimado asi Ella no sabe que hacer, pero tiene miedo de que el llegue borracho "

- ¿En que etapa del ciclo de violencia se encuentra la paciente?
- ¿Que pasos tomaria el personal de salud?
- Hasta donde llegar como personal de salud en estos casos
- ¿Que pasos le serian mas dificiles?
- ¿Lo registraria? ¿Como?
- ¿Le daria seguimiento? ¿Como?

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III FACILIDADES Y OBSTÁCULOS INSTITUCIONALES

13 Indagar sobre los obstaculos institucionales para

- Detectar
- Registrar
- Manejar
- Canalizar los casos de violencia

14 Indagar como se podrian superar estos obstaculos

15 Indagar sobre lo que piensan que se podria hacer cuando la instituciones de apoyo no funcionan adecuadamente

16 Indagar sobre la ruta ideal para el manejo de casos de violencia

17 Indagar quien dentro del centro serias el/la profesional mas adecuada para

- Detectar casos
- Atender casos
- Dar seguimiento a los casos

Nota Para Ticoman Indagar sobre canalizacion de casos al Programa de Violencia Intrafamiliar y Delitos Sexuales, si/no, ¿por que?

18 Indagar sobre las caracteristicas que deberia tener una persona para poder ayudar a una mujer maltratada?

APPENDIX 8

Case Experience

M a ver, podemos escoger uno de los casos, el que sea como más representativo, y que me platique cómo fue, desde que llegó la mujer y le empezó a preguntar

G bueno, precisamente vino por que se sentía mal, le dolía la cabeza, la parte posterior de la cabeza, el cuerpo, los hombros, las manos, los miembros inferiores, en fin, el cuerpo en general, haciendo mención de que se sentía muy cansada, fatigada, no tenía ganas de hacer nada, prácticamente no hacía ninguna actividad, y ya revisando este tipo de cuestiones, yo tomé los signos vitales, vi que no había problema de tipo orgánico, le hice saber, no hay nada, entonces este, le haces la pregunta dirigida de cuál es la relación con su familia, y empieza a manifestar que ha tenido problemas con el marido, que ha habido gritos, que ha habido golpes, manifestaciones de este de lo que son groserías, insultos y demás y de ahí empezó a salir todo el problema Tenemos una mujer casada de 29 años, que detecté el 7 de septiembre, tiene 2 hijos, 6 y 8, precisamente este, esta actitud de parte del marido existe desde el momento en que se casó, ha habido agresión física, ha habido agresión psicológica y sexual también y económica, manifestando prácticamente el poder completo ¿no?, manifiesta como signos principales los que ya mencioné además de ansiedad, cefalea, angustia y depresión, un cuadro depresivo total, entonces ya evaluando lo que es el riesgo, yo pienso que si existe un riesgo importante, se le mencionó lo del plan de seguridad que aprendimos ahí, que hay que preparar una maleta, que las llaves del coche, que alguna cosa ¿no?, y los datos sobre la canalización, las he estado canalizando a lo que es la Violencia Intrafamiliar y Protección a la Mujer que está en Lucas Alamán Número 11, y han ido, si han ido y me han dicho que las han atendido bien, que han manifestado su apoyo, y que sobre todo bueno, también a través de lo que es apoyo legal, han citado al esposo y que a manera de advertencia primero le han dicho que debe cambiar su actitud y que de no hacerlo se tomarían medidas ya más estrictas como es el de hacer una demanda en forma ya tipificada, y en

caso de no corregirse, sería cuestión de levantar una demanda y sería inclusive como causa de cárcel ¿no?

M ¿de qué manera siente usted que pregunta para que ellas, o sea, como qué características tiene el interrogatorio o su manera de dirigirse hacia ellas para que se abran y empiecen a platicar?

G pues las cuestiones de la relación entre lo que es ella y la familia tiene que ir posterior a lo que es la consulta ¿no?, por que ellas vienen precisamente con un objetivo que es el de que se sienten muy cansadas y la cuestión es de que andan buscando vitaminas o están buscando algún medicamento que las ayude, o evitar alguna enfermedad, ya solucionando el problema de la consulta, cuando no se detecta ningún problema orgánico, se hacen las preguntas dirigidas y este, manifestando que esto puede deberse a problemas de tipo emocional, entonces ya lo que hago yo principalmente es empezar con la familia, no con el esposo, por que cuando yo pregunto directamente al esposo, si se cierran un poquito, entonces ya, haciendo preguntas de la relación de ella con los hijos, ya se abre un poquito, que la escuela, que los niños, que mucho que hacer, que andan muy atareadas, y luego ya sobre los padres, que si la mamá, que si el papá, que si vive con ellos, que si los frecuenta, y luego ya va con los hermanos, y al final ya lo dejo al esposo, precisamente para que cuando ya está un poquito abierta la conversación, lo puedan manifestar, y este tipo de violencia, primero lo busco más que nada en la violencia de tipo psicológico, si existe control o de tipo psicológico, si existen palabrotas, si existe lo que son las agresiones verbales, después económico, después ya si ha habido golpes ¿verdad?, y al final dejo ya lo que es el tipo de violencia sexual por que es un poquito como tabú el hablar del sexo, pero cuando ya están abiertas a todo este tipo de violencia, ya lo pueden manifestar

M ahora, volviendo a este caso que había escogido, ¿en qué etapa del ciclo de violencia diría usted que se encuentra esta mujer?

G pues ya le dio la vuelta, ya le dio la vuelta varias veces ¿no?, no sé exactamente qué tantas, pero ya le dio el ciclo completo, ya ha llegado en que se han encontentado y otra vez ha empezado el ciclo, y otra vez se encontentan y luego el ciclo de violencia sigue

M ¿qué pasos siguió después de que ellas le comunican el problema?

G pues platicarles a cerca de que existen lugares, lugares en donde se les apoya, lugares en donde se les puede ayudar y sacarles de su problema ¿no?, muchas veces lo que preguntan en ese momento es si se les va a hacer algo al marido ¿no?, por que sea como sea se preocupan por ellos, de si les va a pasar algo, entonces les mencionamos que no, que solamente es para evaluar el problema en ese lugar y que se pueda dar un hasta aquí a la situación ¿no?, y no necesariamente se va a proceder contra el en forma legal, si no simplemente tratando de entender, de cambiar su actitud y bueno, ya si las cosas pasan a mayores, ya sería cuestión de evaluar ¿no?

M ¿y después de esto?

G después de esto se hace la canalización

M bueno, y con todos estos pasos que hay que seguir con estas mujeres, ¿qué pasos son los que se le hacen a usted más difíciles?, ¿hay algún caso en especial que le cueste trabajo?

G pues no precisamente ningún paso, antes si se me dificultaba la cuestión de las canalizaciones, por que no lo tenía yo inclusive ni lugares donde canalizarlas, ni sabía exactamente dónde estaban localizados, entonces bueno, ahora ya que lo sé a donde puedo mandarlas, es más fácil, vuelvo a repetir en el caso del interrogatorio no es difícil, en el caso de la educación o ¿cómo se podría decir?, orientación, pues se le da, no creo que sea difícil actualmente ya sabiendo todo lo que aprendimos en el curso, y ahora la canalización pues ya también tenemos lugares donde mandarlos, lo que sería más difícil es que ahí no las atendieran ¿verdad?, que no regresaran

( )

M ¿las mujeres que usted ve regresan generalmente con usted o vienen sólo una vez, o qué tan común es que usted las siga viendo?

G también esa es una de las cosas que cambia, por ejemplo, por que antes les da uno la orientación, si a caso uno les decía dónde podía asistir, y tampoco la dirección exacta, y ya no regresaban, en ocasiones regresan pero sólo por cuestiones de tipo de salud de los niños o de ellas o una persona que se siente mal desde el punto de vista orgánico, pero por su problema ya no regresaba,

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solamente tuve un caso de una persona que sı regresó, y regresaba constantemente, pero nada más un caso, y actualmente ya no, por que ahora ya se les hace precisamente la observación de que tienen que regresar a decir cómo se les atendió, qué fue lo que pasó

M ¿y de estos casos que ha detectado, sı han regresado?

G han regresado 3, 3 de los que yo mandé, precisamente para decirme que sı ha habido cambios, que sı han apoyado

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