Barbados Service Providers Knowledge, Attitudes and Practices (KAP) on Gender Based Violence and Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (HIV/AIDS)

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ACCRONYMS

CAFRA Caribbean Association for Feminist Research and Action
DAWN Development Alternatives for Women in the New Era (DAWN)
EPC Elroy Phillips Centre
FBO Faith Based Organization
GOB Government of Barbados
IPPF International Planned Parenthood Federation
LRU LadyMeade Reference Unit
MoH Ministry of Health
NHAC National HIV/AIDS Commission
NOW National Organization of Women
PLWHA People Living with HIV/AIDS
RBPF Royal Barbados Police Force
RPTC Royal Police Training Center
QEH Queen Elizabeth Hospital
UNIFEM United Nations Development Fund for Women
UWI University of the West Indies.
VCT Voluntary Testing and Counseling
CHAPTER ONE

BACKGROUND AND INTRODUCTION
INTRODUCTION

In 2005 the Inter-American Council for Women (CIM) Executive Committee included the issue of Gender and HIV in order to assume a more proactive role and leadership on the growing issue of the feminization of HIV from both a gender and human rights perspective.

Gender based violence (GBV) has become widely understood as a serious violation of women’s basic human rights as well as a ubiquitous and pervasive global public health issue that impacts women in virtually all societies. As the urgent need to address GBV has been emphasized in international agreements and declarations including the Inter-American Convention of the Prevention, Punishment and Eradication of Violence Against Women: Convention of Belem Do Para (OAS/CIM, 1994), the Fourth World Conference on Women (Beijing, 1995) and the World Health Assembly (Geneva, 1996), epidemiological research has documented the extent and magnitude of this crisis as well as its detrimental consequences to the health and well being of women\textsuperscript{1,2,3}. A growing body of research has also linked violence against women with HIV/AIDS risk\textsuperscript{4,5}. While GBV and HIV/AIDS constitute distinct but formidable epidemics, understanding their intersection as well as its implication for health services and programs is critical to effectively addressing these two public health crises. This paper will present a review of the complex linkages between gender based violence and HIV/AIDS with emphasis on the Caribbean region. The role of service providers in addressing these dual epidemics, as well as
their knowledge, attitudes and practices concerning gender based violence and HIV/AIDS will also be examined.

Gender Based Violence (GBV) is both a cause and a consequence of the unparallel spread of HIV among women in the Caribbean, the second most affected region in the world after Sub-Saharan Africa. Thus the integration of GBV and HIV/AIDS is inevitable for best practices and HIV reduction success.
CHAPTER TWO

LITERATURE REVIEW
Gender Based Violence: Definitions, Prevalence and Health Consequences

Violence against women is rooted in gender inequality. The phrase “gender based violence” which refers to physical, sexual and psychological abuse against women has been adopted to reflect the role that women’s unequal status in society plays in perpetuating this abuse. According to the Organization of American States, The Inter-American Commission of Women (CIM), Convention of Belem Do Para, “violence against women shall be understood as any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere.” Moreover, the United Nations Population Fund (UNFPA) definition of gender based violence is violence “involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual and psychological harm… It includes that violence which is perpetuated or condoned by the state.” In practice, gender based violence encompasses an array of abuses including physical, sexual, verbal and psychological abuse, childhood sexual abuse, rape and marital rape, dowry-related violence, sexual harassment, forced prostitution, and trafficking of girls and women. Potential perpetrators include spouses, partners, family members, acquaintances and strangers. Several common forms of GBV: intimate partner violence (IPV) including physical, sexual and
psychological abuse, as well as adult and childhood sexual abuse by any perpetrator and the intersection of these types of violence with HIV/AIDS will be considered.

Gender based violence exists in virtually all societies and transcends socioeconomic, religious and ethnic boundaries. As global research on GBV has increased over the years, the extent and magnitude of this crisis has become shockingly clear. It is estimated that one in every three women across the world has been physically or sexually abused\(^8\). Prevalence rates and patterns of GBV, however, vary by region and setting due to inconsistent research methods across studies and the lack of standardized definitions and measurement instruments for physical, sexual and psychological abuse. A review of over 50 population-based studies from 35 countries concluded that 10-52% of women had a history of lifetime physical abuse by an intimate partner and between 10% and 30% of women reported lifetime sexual abuse by an intimate partner\(^8\). The WHO multi-country study on women’s health and domestic violence estimated the extent of physical and sexual intimate partner violence in 10 countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania\(^9\). The study, which consisted of interviews with over 24,000 women, determined that lifetime prevalence rates of physical or sexual partner violence or both were between 15% and 71\(^9\). Between 4% and 54% of women reported physical or sexual violence or both by an intimate partner during the previous year\(^9\). These studies demonstrate that GBV is a widespread and serious problem that affects the lives of millions of women throughout the world.
Gender based violence has also been identified as an important issue within the Caribbean, yet little epidemiological data characterizing the extent of the problem exists for this region. The few studies that have been conducted demonstrate alarming rates of GBV. National data from Antigua and Barbuda estimated lifetime prevalence rates of physical abuse by an intimate partner at approximately 30%\(^8\). A study conducted in 1993 using an island-wide national probability sample of all women aged 20-45 in the Barbados reported that 30% of women had experienced physical violence\(^8\). In Dominica, a quantitative study of domestic violence found that 32% of respondents had experienced intimate partner abuse\(^10\). The 2002 Demographic and Health Survey (DHS) in the Dominican Republic found that one in four women had ever been physically abused, with 10% of women experiencing violence within the previous 12 months\(^11\). A recent study of intimate partner abuse in Haiti, found that 29% of women in the sample had experienced at least one act of violence in the previous 12 months\(^12\). In a separate study based in Jamaica, 26% of females aged 15 to 19 years of age reported ever having been forced to have sexual intercourse\(^13\). While further research is needed to better understand the magnitude and characteristics of violence in various settings within the Caribbean, it is clear that gender based violence impacts the lives of countless women in this region.

The myriad of detrimental and often enduring consequences of GBV to the health and well being of women has been increasingly documented and understood. These may include fatal outcomes such as homicide and suicide or nonfatal
outcomes including traumatic injuries, chronic pain syndrome, and gastrointestinal disorders\textsuperscript{14}. The mental health impact of GBV is often the most invasive and lasting consequence of the abuse and can involve anxiety, depression, posttraumatic stress disorder, low self-esteem and other psychological sequelae\textsuperscript{14}. Physical and sexual violence may also lead to a range of sexual and reproductive health problems including sexually transmitted infections, vaginal bleeding, fibroids, and urinary tract infections, sexual dysfunction, unwanted pregnancy, as well as complications during pregnancy\textsuperscript{14}.

A growing body of evidence has also linked violence against women with HIV/AIDS risk. HIV/AIDS is a major global health crisis that no longer affects primarily men; the face of HIV/AIDS is increasingly that of a woman. Since almost half of all adults currently living with HIV/AIDS in the world are now women, and the number of women and girls infected with HIV has increased in every region of the world over the last two years, HIV/AIDS represents one of the greatest public health problems confronting women today\textsuperscript{15}. The alarming feminization of the HIV/AIDS epidemic is particularly evident in regions suffering from generalized epidemics and those where transmission occurs primarily through heterosexual intercourse such as sub-Saharan Africa and the Caribbean.

The Caribbean region, for example, remains the second most affected region by HIV/AIDS in the world with an overall HIV prevalence rate of 1.6%\textsuperscript{15}. While national adult HIV prevalence rates vary from 3% in the Bahamas and Haiti, to 1.5% in
Barbados, to 0.2% in Cuba, inadequate HIV/AIDS surveillance in a number of countries limits full appreciation of the epidemic in the region\textsuperscript{15}. Dominica is one such country, with the most recent adult HIV prevalence rate reported as 0.2% in 2001\textsuperscript{16}. Despite these epidemiological limitations, AIDS is the leading cause of death among the 15-44 year old age group in the Caribbean and was responsible for 27,000 deaths in 2005\textsuperscript{15}. Currently, of the 330,000 people living with HIV/AIDS in the Caribbean, 51% are women\textsuperscript{15}. Furthermore, girls aged 15-19 are 6 times more likely to be infected with HIV than boys of the same age in Trinidad and Tobago and 2.5 times more likely in Jamaica\textsuperscript{15}. In Barbados, among the 15-24 year old age group the female to male ratio for HIV cases is currently 1.46:1\textsuperscript{17}. These statistics reflect the dramatic feminization of the epidemic that has occurred within the Caribbean region and underscore the significant threat posed by HIV/AIDS to the health status of women in the region.

There is no question that HIV/AIDS and gender-based violence constitute distinct but formidable crises endangering the health of women in the Caribbean and around the world. Analysis of the complex intersection of these two epidemics and its implication for health service delivery and programs is critical for the development of effective strategies to address these dual crises.
LINKAGES BETWEEN GBV AND HIV/AIDS

A number of investigations conducted primarily in the United States and sub-Saharan Africa have demonstrated associations between intimate partner violence and HIV/AIDS. Dunkle et al, cross-sectional study of South African women found that women who experienced physical IPV alone had a 56% excess risk of HIV infection (OR=1.56, 95% CI 1.21, 2.03), and those that experienced both physical and sexual IPV were at an even higher risk of HIV infection (OR=1.66, 95% CI) compared to women who had not experienced IPV. Another study reported that women who were HIV positive were almost twice as likely to have experienced physical abuse in their lifetime (OR=1.8, 95% CI 1.1, 2.8) than those who were HIV negative.

Research focused on the overlap between GBV and HIV/AIDS has identified a number of mechanisms through which these two epidemics are linked: 1) violence may increase a woman’s risk for HIV/AIDS through forced or coercive sexual intercourse with an infected partner, 2) violence may interfere with a woman’s ability to negotiate safer sex, 3) women who are HIV positive may be at a higher risk of violence particularly following disclosure of HIV serostatus to partners, 4) sexual abuse during childhood may be associated with high sexual risk taking behavior during adolescence or adulthood.
1) Forced or coercive sexual intercourse and women’s risk for HIV/AIDS

One of the direct mechanisms through which a woman can become infected with HIV through sexual violence is through forced or coercive sexual intercourse with an HIV infected partner. The use of force may result in trauma, vaginal lacerations and abrasions, which can increase the risk of HIV transmission\(^{14}\). A past history of forced or coercive sexual intercourse may also be indirectly associated with HIV risk by influencing sexual risk taking behavior and ability to negotiate condom use.

For example, a number of studies have demonstrated increased HIV risk in women who had experienced forced or coerced sexual intercourse\(^ {5,\ 18-26}\). A history of sexual violence was found to be significantly associated with inconsistent condom use\(^ {21,\ 23}\). Coerced women were also more likely to be afraid to ask a man to wear a condom because he might leave her or because he might strike her\(^ {24}\). Finally, a recent study showed that sexually assaulted women were more likely to have shared needles to inject drugs, exchanged sex for money, be diagnosed with an STI or have had genital ulcer disease\(^ {25}\).

2) Violence may interfere with a woman’s ability to negotiate safer sex

A growing body of research has provided evidence that violence may limit women’s ability to negotiate condom use\(^ {20-31}\). For example, Wingood and DiClemente reported that women who had abusive partners were more likely to report never using condoms or using condoms less frequently\(^ {30}\). Furthermore, these women
were at a higher risk of verbal abuse and threats of physical abuse or abandonment when asking to use condoms. Hamburger et al’s prospective trial of a safe sex counseling intervention demonstrated that HIV negative women with a history of physical abuse were 5 times less likely to report consistent condom use at the 1 year follow up than women who had no history of abuse (OR=0.2, 95% CI 0.09, 0.48). Other investigations provide evidence that abused women were more likely to report male partner control of sexual relationship and fear of partner response to condom negotiation than women who were never abused.

3) Women who are HIV positive may be at a higher risk of violence particularly following disclosure of HIV serostatus to partners

The role of HIV/AIDS as a risk factor for violence has also been assessed by a number of studies. Kiarie et al reported that 0.9% of women who had undergone antenatal HIV testing in Kenya experienced violence in the 2 weeks following testing. In the same study, after adjustment for history of domestic violence and partner notification, HIV positive women were 5 times more likely to experience violence than HIV negative women (OR=4.8, 95% CI 1.4, 1.6). Another research study conducted in Baltimore found that HIV positive women were significantly more likely to endure repeated abusive situations than HIV negative women.

The rates of violence specifically related to disclosure of HIV serostatus varied within the literature. One review of 15 journal articles (14 in Sub-Saharan Africa and 1 in Thailand) found that the rates of disclosure ranged from 16.7% to 86%, with
between 3.5% and 14.6% of women reporting violence as a reaction to disclosure\textsuperscript{34}. A recent prospective study from Barbados reported that only 28.8% of women had self-disclosed their HIV status to other people including their sex partner\textsuperscript{35}. Among the women who had not disclosed their HIV status, 23% gave fear of violence directed towards them as the primary reason for nondisclosure\textsuperscript{35}. Other barriers to non-disclosure identified in various studies include fear of abandonment, rejection, discrimination and accusations of infidelity. The lack of disclosure reported in much of the research may also limit the ability of the women to engage in preventative behaviors or to access treatment or support.

4) Sexual abuse during childhood may be associated with high sexual risk taking behavior during adolescence and adulthood

Childhood sexual abuse has been shown to be associated with high sexual risk taking behavior in a number of studies\textsuperscript{36-40}. For example, Cohen found that women who reported childhood sexual abuse were significantly more likely to report drug use (OR=4.25, 95% CI 2.68, 6.73), a male partner at risk for HIV (OR=2.07, 95% CI 1.59, 2.68), more than ten lifetime partners (OR=2.29, 95% CI 1.81, 2.89), and exchanging sex for money, drugs or shelter (OR=2.62, 95% CI 2.08, 3.33)\textsuperscript{37}. Voisen's study revealed that adolescents who had experienced childhood sexual abuse were 3.8 times more likely to engage in sex without condoms (OR=3.8, 95% CI 1.95, 4.48), 4.5 times more likely to engage in sex after drug use (OR=4.5, 95% CI 1.73, 7.06), and 3.5 times more likely to engage in sexual intercourse with
multiple partners (OR=3.5, 95% CI 1.29, 5.54) than those who had not experienced abuse\textsuperscript{39}.

**OTHER STUDIES FOCUSED ON GBV AND HIV/AIDS**

A number of research studies have also investigated other issues related to gender based violence and HIV/AIDS including interventions, access to medical care, and the role of men in these two intersecting epidemics. For example, in-depth interviews revealed that 64% of HIV positive women who had experienced GBV reported missing appointments for HIV care due to violence\textsuperscript{41}. Furthermore, 34% of the women had actually dropped out of HIV care for some time to avoid detection or because they felt too “worn down” by the abuse to continue with treatment\textsuperscript{41}. These findings suggest that gender based violence may be an under-recognized barrier to obtaining medical care for HIV/AIDS.

The contribution of men to the dual epidemics of HIV and GBV has been assessed by a number of studies\textsuperscript{42-49}. The majority have found that male perpetrators of physical or sexual violence engage in significantly higher levels of HIV risk behavior than non-perpetrators. In South Africa, men with a history of sexual assault were significantly more likely to have had a lifetime STI (OR=3.2, 95% CI 1.9, 5.4), a greater number of sexual partners (OR=1.5, 95% CI 1.2, 1.9), more unprotected intercourse (OR=2.6, 95% CI 1.8, 3.7) and increased use of alcohol in sexual contexts (OR=4.3, 95% CI 2.6, 6.9)\textsuperscript{45}. A study in Bangladesh found that men who reported physically abusing their wives were more likely to have engaged in
extramarital sex (OR=1.90, 95% CI 1.26, 2.88) and to have symptoms or diagnosis of an STI (OR=1.68, 95% CI 1.24, 2.26)\(^48\).

There is a dearth of research examining interventions to address GBV and HIV risks among women. Of the few investigations that had been conducted, one study found that women in abusive relationships were more interested in using female controlled methods of HIV prevention and less interested in using male controlled methods of HIV prevention than women in nonviolent relationships\(^50\). Two studies focused on HIV prevention interventions among abused women. Melendez et al found that an 8 session HIV prevention intervention that was specific to women’s issues and involved developing negotiation skills was effective in decreasing unprotected sex among abused women at one year post intervention\(^51\). Similarly, Wingood et al reported that women who had experienced GBV and who participated in an HIV prevention intervention were more likely to report consistent condom use over the 1 year follow up period, and were less likely to acquire an STI than the controls\(^52\). These two studies suggest that HIV prevention interventions can be effective among abused women and may not place them at further risk of abuse.

Finally, a cluster-randomized trial of a microfinance-based structural intervention in Southern Africa that targeted the underlying determinants of HIV and IPV reduced IPV by 55% among women in the intervention group relative to the control group (OR=0.45, 95% CI 0.23, 0.91)\(^53\). The intervention involved provision of loans for the development of income generating activities along with a 12-15 month training
curriculum which addressed topics including gender roles, HIV, violence and leadership\textsuperscript{53}. While the level of intimate partner violence was reduced, the rates of unprotected sexual intercourse among household co-residents of women receiving this intervention were unaffected by the intervention\textsuperscript{53}.

**Strategies to address the links between GBV and HIV/AIDS**

The existing literature provides strong evidence of the complex links between GBV and HIV/AIDS. However, the bulk of this literature is based on cross-sectional data and is limited to the United States or Sub-Saharan Africa. Further research, is needed to clarify the impact of both physical and sexual violence on HIV risk, as well as how being HIV positive influences the risk of violence in various settings and regions including the Caribbean. Research focusing on men and their perspectives is critical to better understand gender based violence and HIV/AIDS and is essential for the development of effective interventions especially since condom use, and physical and sexual violence against women are male behaviors. Strategies that target women only should not be expected to change the underlying determinants of these dual epidemics such as power disparities between men and women.

Reproductive health and HIV/AIDS programs and prevention efforts provide a unique opportunity to address GBV and HIV/AIDS as most women come into contact with the health system at some point in their lives. Health services including antenatal, family planning, STI and HIV/AIDS services thus represent an important entry point for the identification and care of women experiencing violence as well as
HIV infected women. Due to the severe negative consequences of violence on women’s health, routine screening for GBV is increasingly seen as the standard of care\textsuperscript{54}. Voluntary counseling and testing centers should integrate screening and referral for GBV, and HIV prevention efforts including condom promotion should take into account the impact of violence in the lives of women. In addition, domestic violence programs and services could be an important opportunity to identify and provide counseling for women at high risk for HIV.

**THE ROLE OF SERVICE PROVIDERS IN ADDRESSING GBV AND HIV/AIDS**

Service providers including clinicians and health care personnel are increasingly viewed as playing a key role in addressing GBV and HIV/AIDS\textsuperscript{55}. The recent WHO multi-country study on GBV and women’s health reported that while up to two-thirds of abused women never reported the abuse or sought formal help, the few that did generally requested the help of health workers and police\textsuperscript{9}. Since many of the women experiencing violence may not seek help, early detection of the problem by service providers could help diminish the consequences of the abuse and prevent further victimization\textsuperscript{9}. Moreover, if health providers do not ask about violence, they may actually misdiagnose victims and provide inappropriate care.

Most research indicates that women who are asked about abuse in a helpful, nonjudgmental way will respond truthfully, and that most clients of health services would welcome routine screening for violence\textsuperscript{56, 57}. Still many service providers are reluctant to ask such questions for fear of offending their clients, concerns that the
women would not respond truthfully, or that screening for abuse would place a great burden on the provider's time\textsuperscript{11, 55}. Other barriers to addressing GBV include lack of knowledge and technical competence as well as institutional constraints. In addition, service providers may hold misconceptions or biases regarding GBV including notions that violence is not a serious problem, or that victims may have done something to deserve the abuse\textsuperscript{11, 55}. In order to provide appropriate care and treatment for abused women while ensuring that they are not further victimized or blamed, these negative stereotypes and misconceptions must be addressed. However, changing these types of attitudes and beliefs may represent a significant challenge as they may be deeply embedded in some settings.

Despite recognition of HIV/AIDS and GBV as urgent problems within the Caribbean, there is little published material on the knowledge, attitudes and practices of service providers in the Caribbean with respect to these two issues. The International Planned Parenthood Federation, Western Hemisphere (IPPR/WHR) has focused on integrating GBV screening and services into sexual and reproductive health programs in Peru, Venezuela and the Dominican Republic\textsuperscript{11, 58}. In 2000, a baseline evaluation study was conducted to assess the knowledge, attitudes and practices of service providers in participating facilities in these countries. One of the surprising findings of this study was that 58\% of service providers surveyed had asked a patient a direct and specific question concerning GBV at least once in the past year\textsuperscript{58}. A number of self-reported perceived barriers to screening women for GBV were also identified. Fifty three percent of respondents reported fear of offending
the client, 51% reported lack of community resources, 34% described lack of private space to address GBV with women and 31% of service providers felt that they could do little to help women experiencing violence. The survey also identified gaps in knowledge among the service providers. One-third of providers could not name at least two referral agencies in their communities and 46% did not know that victims of GBV tend to use more health services than women who have never experienced abuse.

Profamilia, the IPPR/WHR affiliate in the Dominican Republic, found that physician’s attitudes towards GBV involved directing blame towards the victims rather than the aggressors. According to the Profamilia report, 57% of physicians felt that the majority of victims will deny abuse, 50% believed that adolescents’ inappropriate sexual behavior provokes sexual abuse, 14% stated that women stay with violent partners because to a certain extent they like being treated with violence, and 21% believed that men are unable to control their sexual behavior. These types of discriminatory attitudes may result in hostile and antagonistic interrogations and behavior towards victims seeking help which may further exacerbate the consequences of their abuse.

Data from these surveys was used by the IPPF/WHR initiative to guide integration of GBV screening and services into sexual and reproductive health service delivery programs. The health services response was strengthened by sensitizing and training all staff from the board of directors to the frontline service providers,
improving clinic infrastructure, policies and procedures regarding confidentiality, and the detection, referral and provision of GBV services\textsuperscript{59}. The final evaluation revealed that the program was successful not only in increasing detection of GBV, but also in significantly changing provider attitudes and behaviors\textsuperscript{59}.

Women who experience violence may come into contact with or require the services of various agencies in different sectors including the police, judiciary, education and social services. Thus, an effective response to GBV should involve not only health services but also other areas of service provision and support as well as coordination between these services. In the English-speaking Caribbean, efforts have been made to sensitize and train the police forces with respect to family violence, but these initiatives have not been rigorously evaluated\textsuperscript{60}. For example, in Barbados, while 250 of a total 450 police officers have participated in a 2-day training regarding GBV, and this topic has also been added to the core curriculum at the Police Training Facility, the impact of these initiatives has not been assessed\textsuperscript{10}. However, a 2001 survey by the Women’s Bureau of Dominica found that half of those who sought help from the police for issues related to domestic violence were unsatisfied with the police response, with improper evidence gathering and lack of follow-up being the most cited problems\textsuperscript{10}. Increased awareness of the high prevalence of GBV in Barbados has led to the initiation of a number of other strategies to improve the response to GBV. These include enactment of domestic violence legislation in 2001, opening of legal aid clinic as well as social service interventions regarding GBV such as public education and advocacy, counseling,
and to a limited extent crisis housing\textsuperscript{10}. While significant effort has been made to improve service provision related to GBV within various sectors, still further work is needed to implement an integrated approach to GBV and HIV/AIDS in Barbados.

\section*{Conclusions}

In the Caribbean, gender based violence including physical and sexual partner abuse is widespread and has serious negative consequences to the health and wellbeing of women. The health of Caribbean women is also dramatically threatened by the ongoing HIV/AIDS epidemic. Despite growing recognition of the intersection of these dual epidemics and its implications for health service programs, little research has focused on the Caribbean region. Furthermore, few initiatives to integrate GBV screening and services into reproductive and sexual health services are in place in this region. Further research is needed to better elucidate the complex links between GBV and HIV/AIDS as well as to identify effective interventions that can target these crises within the Caribbean. Service providers can and should play a key role in addressing GBV and HIV/AIDS. Evidence suggests that improving knowledge, attitudes and practices of service providers is not only possible, but is crucial for developing an effective response against these twin crises and ensuring that victims of violence receive appropriate care and services without further victimization. Further research concerning Caribbean service providers in the health, social and law enforcement systems and their knowledge, attitudes and practices specific to GBV and HIV/AIDS is needed to design and implement effective interventions. Although many challenges exist, it is
imperative that a swift and effective response to gender based violence and HIV/AIDS be implemented to improve the health and wellbeing of women and to ensure provision of their fundamental human rights.
CHAPTER THREE

METHODOLOGY
RESEARCH METHODOLOGY

A. Conceptual Framework

In the Caribbean, gender-based violence (GBV) including physical and sexual partner abuse is widespread and has serious negative consequences to the health and wellbeing of women. The health of Caribbean women is also dramatically threatened by the ongoing HIV/AIDS epidemic. Despite growing recognition of the intersection of these dual epidemics and its implications for health service programs, little research has focused on the Caribbean region. Furthermore, few initiatives to integrate GBV screening and services into reproductive and sexual health services are in place in this region.

Service providers including clinicians, health care personnel and police are increasingly viewed as playing a key role in addressing GBV and HIV/AIDS. Women who experience violence may also come into contact with or require the services of various agencies in different sectors including the police, judiciary, education and social services. Thus, an effective response to GBV should involve not only health services but also other areas of service provision and support as well as coordination between theses services. Many service providers, however, are reluctant to ask questions about violence for fear of offending their clients or because they have a lack of knowledge or technical competence regarding GBV. Others may hold misconceptions or negative attitudes towards GBV that can hinder the effective provision of services for victims of violence. Despite recognition of HIV/AIDS and GBV as urgent problems within the Caribbean, there is little published material on the knowledge, attitudes and practices of service providers in the Caribbean with respect to these two issues.

This pilot study will asess the knowledge, attitudes and practices (KAP) of service providers in Dominica and the Barbados regarding gender-based violence and HIV/AIDS. By employing both qualitative and quantitative methods to investigate
these issues, a comprehensive picture of the impact of and response to gender-based violence and HIV/AIDS will be obtained. The research will include a structured self-administered quantitative survey, as well as semi-structured in-depth interviews designed to provide rich qualitative data. Research participants will include service providers from various sectors including medical, legal and social, psychological services, educational and the police.

A. Research Question

“What are the knowledge, attitudes and practices (KAP) of service providers in various service settings within the Caribbean towards gender-based violence (GBV) and HIV/AIDS?”

C. Research Objectives

I. Map key service settings for providing prevention, care and treatment for HIV and violence against women.

II. Identify principal knowledge, attitudes, practices (KAP) of service providers.

III. regarding gender-based violence, HIV/AIDS and link between the two epidemics.

IV. And its integration of both issues in their work.

V. Assess Caribbean service providers’ personal experiences with GBV.

VI. Generate empirical evidence regarding the impact on women and institutions of the intersections of HIV and violence against women.

VII. Provide the facilities involved in the study with technical information to support the integration of both issues in their policies and programs.
D. Target Population

This research focuses on Caribbean service providers who may come into contact with the population that has experienced gender-based violence. This can include service providers from the health sector such as clinicians or health professionals working in reproductive health and HIV programs and services, as well as service providers working in the government, judicial system, law enforcement, social services, and the education system.

E. Data Collection
1. Geographic Areas

This research was conducted in the main urban areas of Barbados located in the Caribbean and has a population of 279,000 (2006 estimate). Bridgetown is the capital and main city in the Barbados. Within the city many sites were visited.

Barbados Site Visited (Surveys, Interviews and Observation)

1. National HIV/AIDS Commission
2. Royal Barbados Police Training Center
3. Royal Barbados Police Central Station
4. Royal Barbados Police – Blackrock Station
5. Royal Barbados Police Victim Support Group (Director)
6. Queen Elizabeth Hospital (Public Hospital)
7. Sandy Crest Emergency (Hospital Private)
8. Elroy Phillips Centre (PLWHA Hostel)
9. Ladymeade Reference Unit (LRU)
10. University of the West Indies (UWI, HARP) HIV/AIDS Response Program
11. University of West Indies Cave Hill, Student Health Service
12. Ministry of Health, HIV/AIDS Programme
13. Ministry of Health, Bureau of Gender Affairs
14. Ministry of Health, Food Bank for People Living with HIV/AIDS
15. Business and Professional Women’s Crisis Center and Shelter for Abused Women
16. Private Law Firm (anonymous)
2. Participants
The service providers in various settings were approached and asked to participate in the pilot study. Only service providers who are currently employed to provide services were surveyed. All service providers regardless of age, gender, religion were asked to participate. Once the answer is affirmative, a questionnaire was given to the service provider at the service point and asked to fill it out. They were given between 20 to 40-minutes before the researcher collected the questionnaire that will have only a number on it to provide a unique identification that is anonymous. Sixty-five service providers in various service points completed the survey and then were eligible to have their name put into a raffle for an electronic item.

H. Methods for Collecting Data
I. Quantitative Survey

A structured quantitative survey instrument was designed based on the International Planned Parenthood Federation/Western Hemisphere Region’s Provider Knowledge, Attitudes and Practices Survey Questionnaire (IPPF/WHR 2004).

The survey instrument for the current research study assesses the demographic characteristics of service providers, their knowledge, attitudes and practices regarding HIV and GBV, GBV training and sensitization, as well as barriers to GBV service provision. A range of questions exploring service provider knowledge and attitudes regarding the links between HIV/AIDS and GBV as well as provider’s personal experiences with GBV are also included in the survey. The survey was self-administered and required 30 to 40 minutes for completion.

Source: Improving the Health Sector Response to Gender Based Violence: A Resource Manual for Health Care Professional in Developing Countries, IPPF/WHR Tools /02 / September 2004.
Service providers including clinicians, health professionals, counselors, social workers, police, teachers and others working in the areas of GBV and/or HIV/AIDS were randomly selected and asked to anonymously complete the survey. The data will be compiled into a database for subsequent analysis. Confidentiality will be ensured during data collection.

II. Qualitative Survey for Semi-structured in-depth interviews

A qualitative survey instrument was designed to evaluate knowledge, attitude and practices of service providers regarding GBV and HIV/AIDS as well as the intersection between these two epidemics. The questionnaire is designed to be flexible and is composed of open-ended questions to promote exploration of new ideas and areas that may not have been anticipated at the start of the project. Ten extensive in-depth interviews per country will be conducted with service providers from a variety of sectors including health, legal, law enforcement, social services and the judicial system (see Addendum B). Interviews were confidential. Interviews will be recorded using a digital voice recorder and saved to digital media for subsequent analysis.

III. Validation Techniques

The main method of validation of research findings is the triangulation use of methods (survey) and source of information (interviews, observation, documents, etc). Triangulation “refers to the approach to data collection in which evidence is deliberately sought from a wide range of different, independent sources often by different means.
I. Ethical Issues

The various service settings will be contacted by letter and also by personal contact to get input into the process and content for the study. These setting included the Ministry of Health, Ministry of Gender, HIV AIDS Coordinators and the service facilities.

Each participant was asked to voluntarily participant in the study. All questionnaires were given, collected and scored anonymously.

The in-depth interviews will be held in a room with a closed door to assure privacy. To ensure confidentiality data protection questionnaires, surveys, diaries and other document are stored in a private non-accessible location. The Data Protection Act will be complied with rigorously. All interviews will be guaranteed anonymity and confidentiality. All interviews will be recorded and for each interview a separate data file to insures data protection and confidentiality.

Research on gender-based violence raises important ethical challenges. The issues of safety and confidentiality are of paramount concern, particularly since service providers will be asked about their own experiences with gender-based violence.

Issues of Concern:

- Safety of respondents and interviewers
- Protecting confidentiality
- Reducing potential distress to participants caused by the research
- Referrals for women requesting assistance to local services and community organization
J. Data Analysis

The Quantitative data from the survey was analyzed using Excel. The questionnaires will be analyzed with rank correlation coefficient using the simple and adjusted models and tables.

K. Final Report Presentation

A final report presenting the study results, interpretation and conclusions will be presented to key stakeholders in Barbados. A seminar/ workshop will be held to allow the service providers and other interested parties a forum to learn about and comment on the study findings. The feedback from these seminars will serve the dual purposes of dissemination of information and the opportunity to discuss the research findings.
CHAPTER FOUR

RESULTS
4.1 **Quantitative Survey**

The survey was given to 65 people of various sex, age, and professions. The areas of the survey are: A. General Information, B. Information about services and resources in the community, C. Attitudes, D. Knowledge; E. Training related to Gender-Based Violence; and, F. Personal Experiences with Violence.

4A. General Information
1. Sex
The sex of the 65 survey participants’ were 42 females, 64.6% and 23 males, 35.3% while the age of the participants ranged from thirty years to over sixty-five. The average age was about 51 years old while the majority of the participants were between 40 and 50 years old.

**Graph 4.1: Age Distribution**
2. Level of Education
The service provider respondents, the majority, almost 85% have an education level of University, Graduate School or Advanced professional degree of MD, JD or PhD. Just a little over 15% of the service providers completed high school or less and usually were in the oldest age categories. Overall the service providers surveyed were well educated.

Graph 4.2 Education Distribution

3. Professions
The survey participants were Doctors (6.15%), Nurses (13.86%), Counselor (6.15%), Social Worker (3.08%), Manager (3.08), Police (32.31%), Lawyer (6.15), and Other (29.2%). The other professions category includes support staff, nutritionists, clerical, housekeeping, Security, transport, all who potentially interact with a person who has experienced gender based violence and/or HIV/AIDS. The service providers were at their jobs from 1 year to over 35 years with the average at 9.4 years.
Graph 4.3 Occupation Distribution

Table 4.1 Service Providers Professions

<table>
<thead>
<tr>
<th>Profession</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>6.15%</td>
</tr>
<tr>
<td>Nurse</td>
<td>13.85%</td>
</tr>
<tr>
<td>Counselor</td>
<td>6.15%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3.08%</td>
</tr>
<tr>
<td>Teacher</td>
<td>0.00%</td>
</tr>
<tr>
<td>Manager</td>
<td>3.08%</td>
</tr>
<tr>
<td>Police</td>
<td>32.31%</td>
</tr>
<tr>
<td>Lawyer</td>
<td>6.15%</td>
</tr>
<tr>
<td>Other</td>
<td>29.23%</td>
</tr>
</tbody>
</table>

B. Information About Services and Resources in the Community (Q6-12)

During the past year 44.6% service providers have ask a women if she has been abused or mistreated with a direct and specific question at lease once, while 23.0% have asked indirectly when the woman had brought the subject up. In the past year service providers, more than 26% have not asked about violence directly or indirectly to clients in past year. In addition, in the past year between 41% and 80% of service providers were told that they had been abused or mistreatment: physical, sexual, emotional and / or sexual abuse during childhood.
Clients told 80% of the service providers that they experienced physical violence, 47.7% service providers were told about sexual violence, 70.7% service providers were told about emotional abuse, and 41.5% service providers were told about sexual abuse during childhood.

**Service Providers have been told about various types of violence (Q7)**

Service providers responded to violence and abuse in a number of ways and in the past year they responded by (Q7):
Of the service providers, 61% can list at least 1 organization and 44% were able to list a second organization in the community that provide specialized services for women who have experienced violence in their relationships. In the service providers’ organization, 50.7% have a written list of organizations or other community resources that a victim of violence can be referred to.

Table 4.2 Service Providers Responses to Violence and Abuse (Q8)

<table>
<thead>
<tr>
<th>Responses</th>
<th>Never</th>
<th>Many times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified and suspected</td>
<td>26.1</td>
<td>9.2</td>
</tr>
<tr>
<td>Listened and provided emotional support</td>
<td>21.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Documented information</td>
<td>43.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Informed client about counseling services</td>
<td>23.0</td>
<td>18.4</td>
</tr>
<tr>
<td>Informed client about medical services</td>
<td>23.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Informed client about legal services</td>
<td>35.3</td>
<td>7.6</td>
</tr>
<tr>
<td>Informed client about social services</td>
<td>26.1</td>
<td>10.7</td>
</tr>
<tr>
<td>Informed client about effects of violence on health</td>
<td>26.1</td>
<td>12.3</td>
</tr>
<tr>
<td>Helped client in danger establish safety plan</td>
<td>41.5</td>
<td>1.54</td>
</tr>
</tbody>
</table>

The barriers that prevent service providers from asking about violence and providing services to then are multifaceted. Asking women questions about violence can be offensive, 36.9% partially agree, 16.9% agree. When they do ask about violence, the
service providers, 47.6% state that there is not enough time, while 23.0% agree and 29.2% partially agree that the lack of private space is a barrier.

Service providers disagree 33.8% and 38.4% partially agree that they feel that there is little that they can do to help them. Referral to community resources is a key and 38.4% of the providers partially agree that the few resources in the community are sometimes a barrier. The other barriers cited by service providers include stigma and discrimination.

C. The Attitudes of Service Providers (Q13-15)

1. Overall Attitudes

Overall service providers that “… feel uncomfortable asking a woman about domestic violence (47.6 %) sexual violence (44.6 %) and sexual abuse (40.0%). Service providers agree, at 33.8% that women would feel offended if they asked them directly about domestic violence. Yes, 36.9% agree and 23.0% strongly agree that violence against women is a significant problem in their community. In addition they strongly disagree, 47.6% and disagree at 30.7% that domestic violence is a private affair and outsiders should not interfere. More than 60% in total disagree (36.9%) or strongly disagree (26.1%) that some women are to blame for domestic violence.

Clients told Service providers that they were victims of violence (physical, sexual, emotional, or sexual abuse during childhood). Eighty percent of the respondents cited physical abuse and seventy percent cited emotional abuse. Both sexual abuse in adulthood 49% and sexual abuse in childhood 49% were reported to respondents. Of the service providers about 45% agree, “Women don’t leave their violent partners because on some level they like to be mistreated, while about 55% disagree (strongly disagree, 32.3% and disagree is 23.0%).
1a. Physical Violence

For physical violence, the service providers disagree that a man has the right to hit if wife when she refuses sex at 89.2% or if she is thought to be unfaithful, 80.0% or disobeys him, 80.0%. Health providers agree, 44.6% have a responsibility to ask women about domestic violence.

Some women don't leave their violent partners because on some level they like to be mistreated is strongly disagreed by 32.3% and disagreed by 23.0% by service providers. Yet about half of the service providers agree that the above statement is true.

1b. Sexual Violence

Men cannot control their sexual behavior is strongly disagreed by 33.8% of the service providers and 29.2% disagree. In the same light, “forced sexual relations within a marriage is sexual assault” is strongly agreed by 38.4% and agreed by 36.9% of service providers.

“Women who experience violence are at a higher risk for HIV/AIDS than women who do not experience violence.” This statement overall was disagreed by service providers 46% (20.0 strongly disagreed, and 26.1% disagreed).

1c. HIV/AIDS

HIV/AIDS is a significant problem in my community, 40% strongly agreed while 13.8% agreed with this statement. About 78% of provider's disagree that HIV is punishment for bad behavior, while 70% also stated that they disagreed that they would be ashamed if someone in their family had HIV/AIDS, and 71% of service providers do not believe that HIV is a punishment from God and that people that
have it should not be ashamed of themselves (63.08%). Moreover, those who are HIV+ should be treated the same as people without HIV/AIDS (46%) according to service providers.

Service providers disagree 53.8% that “it is women prostitutes,” who spread HIV, but 33.8% believe that promiscuous men are spreading the HIV in (the) community.” They assert that 36.9% are comfortable providing services to clients. Yet, 46.1% neither agree or disagree and 29.2% “are not comfortable working with someone who is HIV infected.” The same service providers believe, 69.2% that the information that someone is HIV+ should be available to the community. More than 89.2% understand that “violence can seriously impact the health of women.

D. Knowledge (Q16-17)

The fact that Barbados has laws that “address domestic violence is known by 92.3% of the respondent service providers. “Domestic violence affects mostly poor women ” is a statement that more the 70% disagree.

Women are more likely to suffer violence from men they know stated 75.3% of respondents. “Most sexual assaults against women are committed by strangers” is a statement agreed by more then 30% of the respondents.

Forty percent do not know if victims of violence use more services than women who have not experienced violence. However 64% correctly identified the most dangerous time for a woman is when she decides to leave a violent partner. The family is exposed to the violence and boys, especially exposed to domestic violence are more likely to repeat this behavior as adults, asserts 854.6%.

Respondents identified depression and suicide ad the two topics related to gender-based violence, while “difficulty getting access to health services was cited only 29%
of the time. Unprotected sex, sexually transmitted diseases and reproductive health problems were cited only by the participants as being factors related to gender based violence, as with traumatic injuries.

Graph 4.5 Which factors are Related to Gender-Based Violence

Topics Related to Gender-Based Violence

Most of the service providers were able to link both depression (71%) and suicide (68%) to gender-based violence, but were not able to accurately link sexually transmitted infections, reproductive health problems and unprotected sex all at 54% with gender based violence. Only 29% accurately identified difficulty getting access to health services as being related to GBV.

Table 4.3 Topics Related to Gender Based Violence

<table>
<thead>
<tr>
<th>Topics Related to Gender Based Violence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unprotected Sex</td>
<td>54%</td>
</tr>
<tr>
<td>2. Depression</td>
<td>71%</td>
</tr>
<tr>
<td>3. Suicide</td>
<td>68%</td>
</tr>
<tr>
<td>4. Sexually Transmitted Infections</td>
<td>54%</td>
</tr>
<tr>
<td>5. Reproductive Health Problems</td>
<td>54%</td>
</tr>
<tr>
<td>6. Traumatic Injuries</td>
<td>55%</td>
</tr>
<tr>
<td>7. Difficulty Working</td>
<td>60%</td>
</tr>
<tr>
<td>8. Difficulty getting access to health services</td>
<td>29%</td>
</tr>
</tbody>
</table>
E. Training related to Gender-Based Violence (Q18-23)

In the last three years, 81% of the service providers surveyed, have had no training or sensitization related to domestic violence.

When asked which of the topics below related to GBV would they like to receive training, “how to provide services to the victims” was number one at 58.4%. The other areas of importance for service providers is “legal issues of violence” (49.2%), “indicators of violence” (44.6%), and referral options (40%).

<table>
<thead>
<tr>
<th>Training on Topics Related Gender-Based Violence</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicators of violence</td>
<td>52.3</td>
</tr>
<tr>
<td>2. How to ask about violence</td>
<td>16.9</td>
</tr>
<tr>
<td>3. Legal issues related to violence</td>
<td>49.2</td>
</tr>
<tr>
<td>4. How to provide services to victims of violence</td>
<td>41.2</td>
</tr>
<tr>
<td>5. Referral Options</td>
<td>58.4</td>
</tr>
<tr>
<td>6. Other</td>
<td>40.0</td>
</tr>
</tbody>
</table>

The Service providers surveyed, 61.5% thing that HIV/AIDS programs and services including Volunteer Counseling and Testing Centers (VCTs) should incorporate screening and referral for gender-based violence.
F. Personal Experiences with Violence (Q24-31)

Service providers, as a part of the general community have experienced violence, and 44.6% said that they have witnessed gender-based violence in their community. In the past year they personally experienced physical violence by a partner 7.6%, sexual violence at 3.0%, and emotional violence, 15.3%. When asked about these experiences in a life-time the percentages are either double or triple the abuse in the last year with 20.0% for physical violence, 9.2% for sexual violence and 30.7% for emotional violence. Six percent of service providers report experiencing childhood sexual abuse. Of the service providers who have experiences physical, sexual or emotional abuse by a partner in their lifetime, 4.6% sought help with respect to the violence.

Table 4.5 Personal Experiences with Violence (Q26)

<table>
<thead>
<tr>
<th>Type of Violence /Abuse</th>
<th>% Last Year</th>
<th>%Life-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Violence by partner</td>
<td>7.6</td>
<td>20.0</td>
</tr>
<tr>
<td>Sexual Violence</td>
<td>3.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Emotional Abuse by a partner</td>
<td>15.3</td>
<td>30.7</td>
</tr>
<tr>
<td>Childhood Sexual Abuse</td>
<td>-</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Service Providers Positive Response to Specific Partner Violence (Q27)

Service providers themselves have been the target of violence in their personal relationships. The percent of those who have experienced specific physical violence in their lifetime range from a low of 4.6% for being kicked, dragged or beat up to a high of 23% experiencing being slapped or having something thrown at them and almost 14% experienced being pushed or shoved. Perhaps the most startling is the percent of those threatened with a weapon in the past year, 4.6% and in a lifetime 6.5%.
Table 4.6 Service Provider Positive Response to Specific Partner

<table>
<thead>
<tr>
<th>Service Providers Positive Response to Specific Partner Physical Violence (Q27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Abuse Experienced</td>
</tr>
<tr>
<td>a. Slapped or thrown something at you</td>
</tr>
<tr>
<td>b. Pushed or shoved you</td>
</tr>
<tr>
<td>c. Hit you with hand or object</td>
</tr>
<tr>
<td>d. Kicked, dragged or beat you up</td>
</tr>
<tr>
<td>e. Chocked or burnt you</td>
</tr>
<tr>
<td>f. Threatened with weapon (gun, knife)</td>
</tr>
</tbody>
</table>

Service Providers Positive Response to Specific Partner Sexual Violence

Significant for service providers is that forced sexual intercourse during a life time is 16.9% and in the past year 4.6%. Seventy-five percent of the service providers have a higher education, income, and information, yet, they experience forced intercourse at a high percentage rate and 6.15% of them had intercourse in the past year and during their life time out of fear of violence. The experience of sexual humiliating or degrading behavior is 3.0%.

Table 4.7 Service Provider Positive Response to Specific Sexual Violence

<table>
<thead>
<tr>
<th>Service Providers Positive Response to Specific Partner Sexual Violence (Q28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Abuse Experienced</td>
</tr>
<tr>
<td>a. Forced sexual intercourse</td>
</tr>
<tr>
<td>b. Had intercourse out of fear</td>
</tr>
<tr>
<td>c. Sexual Humiliating or degrading</td>
</tr>
</tbody>
</table>
Service Providers Positive Response to Specific Partner Emotional Abuse

Service providers experienced emotional abuse at a higher rate, than physical and sexual abuse. The emotional abuse of being “insulted or made you feel bad about yourself” is 18.4% in the past year and 23.8% in their life-time. The service providers being belittled or humiliated in front of others is 12.3% in the past year and 16.9% during their life-time. Partners have scared and intimidated the service providers in 9.2% in the past year and 15.3% during their life-time and in addition threatened to hurt you or someone you care about was 7.6% during the last year and 10.7% in a life-time.

Table 4.7 Service Providers Response to Specific Partner Emotional Abuse

<table>
<thead>
<tr>
<th>Type of Abuse Experienced</th>
<th>% Past Year</th>
<th>% Life Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Insulted or made you feel bad about yourself</td>
<td>18.4</td>
<td>23.8</td>
</tr>
<tr>
<td>b. Belittled or humiliated you in front of others</td>
<td>12.3</td>
<td>16.9</td>
</tr>
<tr>
<td>c. Scare or Intimidate you</td>
<td>9.2</td>
<td>15.3</td>
</tr>
<tr>
<td>d. Threatened to hurt you or someone you care about</td>
<td>7.6</td>
<td>10.7</td>
</tr>
</tbody>
</table>
CHAPTER FIVE

DISCUSSION
Discussion

I. Service Providers Knowledge, Attitudes, and Practices

A. Gender-Based Violence

The service providers surveyed are educated with more the 80% of them with some form of college or technical education after high school. The average age is about 45 years old and a female to male ratio of 2/1 and most have been in their profession for more than 10 years.

Over 90% of service providers know that there are laws in Barbados that address domestic violence. Also they were able to correctly identify violence as being a problem without regard to socio-economic class. The barriers that prevent service providers from asking direct questions about violence is that they feel uncomfortable asking and also believe that asking about violence would be offensive. In addition, providers cite both lack of time and space to allow for privacy.

Service Providers more than 80% are receiving information about violence and abuse (physical, sexual and emotional) and a majority, over 60% could name at least one place to refer clients and 40% could name two referral places. In their professional capacities, more than 50% at their professional location have a written list of organizations to refer those who have experienced violence. Yet, service providers have “never” successfully documented the information (43%), help the client in danger establish a safety plan (41%) and also inform the client about legal service (35%). The service providers were able to “many times” inform clients about counseling service (18%) and the listened and “listened to and provided emotional support (15%). Providers believe that there are few referral resources in the community, thus they feel that there is little that they can do to help the person who
has experienced violence. Almost 50% believe that at some level women like to be mistreated or have behaved in a manner to justify the abuse.

**B. HIV/AIDS**

Service providers cite stigma, discrimination as being the most significant barriers to disclosure and getting support for those who are HIV positive. Yet, in the survey more than 70% answered that HIV is not a punishment form God, and those who have it should not be ashamed and that they would not have shame for an HIV+ person in their family. More than 70% do not feel comfortable providing services to those who are HIV positive. Yet, less than 30% believe that getting access to health services is related to gender-based violence. Also because stigma and discrimination more than 70% believe that the HIV status of a client should be kept secret and not known to the public.

**C. Personal Experiences with Violence and HIV**

Service providers themselves have witnessed gender-based violence in their community. Also they have experienced violence first hand in their lifetime. Although 30% experience emotional abuse, 20% physical abuse and 9% sexual abuse, very few of them sought out service, only 4.6%. Service providers themselves, even with adequate knowledge about HIV/AIDS are not adapting to being comfortable to provide services to someone who is HIV+ because of the stigma and discrimination. Thus, one need to wonder if service providers themselves are able to comfortably seek and access services for both violence and HIV. From the survey, it could be concluded that a barrier to giving services to others has a foundation in not being able to comfortably seek the same services for ones self.
D. Settings for Providing Prevention, Care and Treatment for HIV and Violence against women

During the field study several settings were identified that have various care, treatment and support mechanisms, workshops and classes with attention to HIV and GBV.

**Gender-Based Violence (Domestic and Sexual)**
- Royal Barbados Police Central Station, Victim Support Services
- Ministry of Health, Bureau of Gender Affairs
- Business and Professional Women’s Crisis Center and Shelter for Abused Women

**HIV/AIDS**
The following programs deliver services and education about HIV/AIDS
- Elroy Phillips PLWHA Hostel
- Ladymeade Reference Unit (LRU) and Laboratory
- University of the West Indies (UWI, HARP) HIV/AIDS Response Program
- University of West Indies Cave Hill, Student Health Service
- Ministry of Health, HIV/AIDS Programme
- Ministry of Health, Food Bank for People Living with HIV/AIDS

**The integration of GBV and HIV/AIDS**

**Training in Gender Based Violence and HIV/AIDS**
Few service providers have had training or sensitization in gender-based violence. The exception is the Royal Barbados Police Force. New police recruits receive two days of “domestic violence” training and ten days of “sexual offences” training. A manual, for the Domestic Violence course, *Domestic Violence and the Law: the Truth About Domestic Violence and How to Deal with Domestic Disputes*, was written by the instructor, Sergeant Lieutenant Christine Holder.
E. Legislature and Law on Sexual Assault in Marriage

Domestic Violence and the Law

The Government of Barbados recognizes that violence against women remains very prevalent in our society. When a woman says no to sexual relations in marriage and it occurs anyway, this is considered a sexual assault, only if the woman is separated for one year and has filed for divorce. If not, then any forces sexual assault can not be considered against the law. Specifically stated: “Under the Sexual Offences Act, a husband commits the offence of rape where he has sexual intercourse with his wife without her consent by force or fear where there is in existence in relations to them:

- A decree nisi of divorce
- A separation Order within the meaning of Section (2) of the Family Law Act
- A Separation Agreement
- An order for the husband not to molest his wife or have sexual intercourse with her
CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS
Conclusion and Recommendations

Service providers are informed about gender-based violence and are looked to for advice, recommendations and acceptance. The most unexpected providers (food bank, transport, house cleaning, pharmacy) are the first line of information for the client giving information about the exposure to violence and thus a higher probability for HIV infection.

Although the Government of Barbados, Non-Governmental Organizations and Faith Based Groups have addressed both the issues of Gender-Based Violence and HIV/AIDS, up to this point it has not been carried out in a coordinated and integrated manner to give benefit to the maximum number of service providers, who in turn can train their colleagues.

The integration and coordination of services for Gender-Based Violence and HIV/AIDS has not occurred in the various sectors that attempt to meet client needs. Integration of programs within various settings is the key to an effective address to the feminization of HIV/AIDS and the undisputable connection to Gender-Based Violence and Gender-Based Violence to the increase of incidence of HIV in the Caribbean.

Once again training on the issues of integration and coordination of gender-based violence and HIV/AIDS for service providers of the complex intersection of GBV and HIV/IDS and it implication for health service delivery and programs is critical for the development of effective strategies to address these dual crisis.

Thus the coordination of various stakeholder to deliver services to clients is accomplished through education of the service providers. Education of Trainers who can train others in Gender-Based violence and HIV/AIDS in various service settings is the way forward.
Recommendations

1. The final report will be presented in-country to the various GBV/HIV integration of services stakeholders through the format of a seminar/workshop. The study results, interpretation and conclusions will be presented. A seminar / workshop allow the service providers and other interested parties a forum to learn about and comment on the study findings. The feedback from these seminars will serve the dual purposes of dissemination of information and the opportunity to discuss the research findings.

2. The continued integration of services for GBV and HIV/AIDS through the close coordination between the Ministry of Health, Bureau of Gender Affairs, National AIDS Commission, National Organization of Women, The Business and Professional Women, and Faith Based organizations, and other Non Governmental Organizations.

3. The coordination of Non-governmental, government and other agencies
   - Ministry of Health, LadyMeade Reference Unit, Food Bank, HIV/AIDS Hostel
   - National AIDS Commission
   - Bureau of Gender Affairs
   - Business and Professional Women’s Organization
   - National Organization of Women
   - Professional and Business Women’s Club (Crisis Center and Shelter)
   - Faith Based Groups
4. Implementation of a Information Technology Regional Network and online resource center on the “Integration and Intersection of Gender Based Violence and HIV/AIDS.

5. Training of Service Providers on Gender-Based Violence and HIV/AIDS

   Implementation of OAS Program for Training the Trainer on “Empowerment, HIV/SIDS and Violence against Women in the Caribbean”

   Integration of Gender Based Violence and HIV/AIDS component in Royal Police Training Courses / Workshops on “Domestic Violence” and “Sexual Offences”

   Integration of Peer Education Workshop of the topic: Intersection of Gender Based Violence and HIV/AIDS” into the Peer Education Workshop at the University of West Indies, Chapel Hill, HIV/AIDS Rapid Response Program (HARP)
REFERENCES


64. Holder, Christine, Domestic Violence and the Law: The Truth about Domestic Violence and How to Deal with Domestic Disputes, Prepared by C.Holder, S/SGT, Instructor, Royal Police Training Center (RPTC),
ADDENDUM A
A Qualitative In-Depth Interviews
For
Service Provider
Knowledge, Attitudes and Practices
Regarding Gender-Based Violence and HIV/AIDS

1. When you hear the words gender-based violence, what do they mean to you?

2. a. How common is gender-based violence in your community?
   b. What are the factors that contribute to gender-based violence in your community?

3. a. What are the negative consequences of gender-based violence for victims? For the community?
   b. How does violence impact the health and wellbeing of women?
   c. Do you think that HIV/AIDS and violence are linked? How?

4. a. Do most victims of gender-based violence seek help? Why or why not?
   Where would victims of gender-based violence turn to for help?
   b. Do you know of any organizations in this community that offer specialized services for women who are in violent relationships or who have experienced violence in the past? Who are they? What is your relationship with them?
   c. Are there any laws in your country regarding domestic violence?

5. What would local service providers do to help victims of gender-based violence?

6. In your experience, what are the barriers for identifying and providing services for victims of gender-based violence?

7. a. How often do you come in contact with clients who are victims of abuse?
b. Can you tell me how these experiences originated, what you did and what the client did?
c. Do you routinely ask clients about violence? Why or why not?

8. What is currently being done at your facility/organization for gender-based violence?
   a. Have any of the staff received sensitization or training on gender-based violence?
   b. If yes, what type of training, what was the duration and what topics were covered?
   c. Are clients routinely asked about gender-based violence in this facility?
   d. Does your facility/organization have a written list of organizations or other community resources that a woman who is a victim of violence can be referred to?

9. Do you think that health providers should routinely ask women about violence? Why or why not?

10. Do you think that HIV/AIDS programs and services should include screening and referral for gender-based violence? Why or why not?

11. a. What could be done to improve services for gender-based violence in your organization?
    b. What could be done to improve services for gender-based violence in your community?

12. Is HIV/AIDS a significant problem in your community?
    a. What factors contribute to the spread of HIV/AIDS in your community?
    a. How are HIV positive people treated by your community?
ADDENDUM B

A Quantitative Survey on Service Provider Knowledge, Attitudes and Practices Regarding Gender-Based Violence and HIV/AIDS

General Information
City:____________________________________________
Country:__________________________________________
Name of Clinic/Centre/Organization: __________________

1. What is your sex? □ Female □ Male
2. What is your age? ____________
3. What is the highest level of education that you have completed? ____________
4. What is your job within the organization?
   □ Medical Doctor □ Manager
   □ Nurse □ Police
   □ Counselor □ Lawyer
   □ Social Worker □ Other (Please Specify) ________________
   □ Teacher

5. How long have you been working in this organization? ____________

In this survey, gender-based violence can include:
• Domestic Violence (Physical, Sexual or Emotional Abuse)
• Sexual Violence or Assault
• Sexual Abuse during childhood

B. Information about services/resources in the community
6. In the past year, have you ever asked a woman if she has been abused or mistreated?
   □ Yes I have asked a direct and specific question at least once.
   □ No, I have not asked a direct question but I have asked indirectly when a woman has brought it up
   □ No, I have not asked any questions about violence in the past year.

7. Has a client ever told you that she was the victim of:
   a. Physical violence by her partner? □ Yes □ No
   b. Sexual violence? □ Yes □ No
   c. Emotional abuse by her partner? □ Yes □ No
   d. Sexual abuse during childhood? □ Yes □ No
8. Service providers can respond to violence in a number of ways. In the past year, how often did you do each of the following? (Please circle only one number for each question)

<table>
<thead>
<tr>
<th></th>
<th>Neve r</th>
<th>Once</th>
<th>Several times</th>
<th>Many times</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I identified or suspected that a client had been harmed or abused.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. I listened to and provided emotional support to a victim of violence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. I documented information about a case of violence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. I informed a client about referral services for counseling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. I informed a client about referral medical services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. I informed a client about referral services for legal services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g. I informed a client about referral services for social services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h. I informed a client about the effects of violence on health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. I helped a client in a dangerous situation establish a safety plan.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j. Other. (Please Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

9. Can you name at least 2 organizations in your community that offer specialized services for women who are in violent relationships or have experienced violence in the past?
   ☐ Yes (Please list 2 organizations) 1.__________________ 2.__________________
   ☐ No

10. In your organization, is there a written list of organizations or other community resources that a woman who is a victim of violence can be referred to?
    ☐ Yes
    ☐ No
11. **In your experience**, what barriers prevent you from asking women questions about violence and providing services to victims of violence?

Please circle one number which best represents whether you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Disagree (This is not a barrier)</th>
<th>Partially Agree (Sometimes this is a barrier)</th>
<th>Agree (This is a barrier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I do not have enough time.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. There is a lack of private space.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. I feel there is little I can do to help them.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. There are few resources in the community where I could refer victims of violence.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. I could offend a woman if I ask questions about violence.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. I have not received enough training to address violence.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g. I could provoke retaliation from the abuser.</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

12. What other barriers prevent you from asking women questions about violence and providing services to victims of violence?

a. ____________________________________________________________

b. ____________________________________________________________

c. ____________________________________________________________

C. **Attitudes**

13. Please circle one number which best represents whether you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Women would feel offended if I asked them directly about domestic violence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Violence against women is a significant problem in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Domestic violence is a private matter and outsiders should not interfere.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. A man has the right to hit his wife if she refuses to have sex with him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. A man has the right to hit his wife if she is unfaithful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. A man has the right to hit his wife if she disobeys him.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
g. Health providers have a responsibility to ask women about domestic violence.  

h. Some women are to blame for domestic violence because their inappropriate behavior provokes their partner’s aggression.  
i. Women don’t leave their violent partners because on some level they like to be mistreated.  
j. Men cannot control their sexual behavior.  
k. Forced sexual relations within a marriage is sexual assault.  
l. Women who experience violence are at a higher risk for HIV/AIDS than women who do not experience violence.  
m. I feel uncomfortable asking a woman about domestic violence.  
n. I feel uncomfortable asking a woman about sexual violence.  
o. I feel uncomfortable asking a woman about childhood sexual abuse.  

14. Please circle one number which best represents whether you agree or disagree with the following statements.  

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. HIV/AIDS is a significant problem in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I would be ashamed if someone in my family had HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. HIV/AIDS is punishment for bad behavior.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. People with HIV/AIDS should be treated the same as people without HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. It is women prostitutes who spread HIV/AIDS.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. People with HIV should be ashamed of themselves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. HIV is a punishment from God.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Promiscuous men are the ones that spread HIV in our community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. I am not comfortable working with someone who is HIV infected.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j. I am comfortable providing services to clients who are HIV infected.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
15. If a person learns that he/she is infected with the virus that causes AIDS, this information should
   □ a. Be kept a secret
   □ b. Be available to the community

Why? (Please Explain)
___________________________________________________________________
___________________________________________________________________

D. Knowledge
16. Please circle the letter which indicates whether you believe the following statements are true or false. If you do not know the answer, please circle “Don’t Know”.

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There are laws in my country that address domestic violence.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>b. Victims of violence tend to use health services more than women who have not experienced violence.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>c. The most dangerous time for a woman is when she decides to leave a violent partner.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>d. Women are more likely to suffer violence from men they know.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>e. Boys who are exposed to domestic violence are more likely to repeat this behavior as adults.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>f. Domestic violence mostly affects poor women.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>g. Most sexual assaults against women are committed by strangers.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>h. Violence can seriously impact the health of women.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>i. Violence is a risk factor for HIV/AIDS.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>j. Violence may interfere with a woman’s ability to negotiate safer sex.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>k. Childhood sexual abuse is associated with risky sexual behavior during adolescence and adulthood.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>l. Violence may be a consequence of disclosure of HIV status.</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
</tbody>
</table>

17. Which of the following are related to gender-based violence?

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Unprotected sex</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>b. Depression</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>c. Suicide</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>d. Sexually transmitted infections</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>e. Reproductive health problems</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>f. Traumatic injuries</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>g. Difficulty working</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
<tr>
<td>h. Difficulty getting access to health services</td>
<td>T</td>
<td>F</td>
<td>DK</td>
</tr>
</tbody>
</table>
E. Training related to Gender-Based Violence

18. In the past 3 years how many times have you received training or sensitization related to domestic violence? ____________________________

19. If you have received training or sensitization related to domestic violence please list:

<table>
<thead>
<tr>
<th>Name of organization providing training</th>
<th>Year</th>
<th>Duration of training</th>
<th>Topics Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>_____</td>
<td>_________</td>
<td>____________</td>
</tr>
<tr>
<td>b.</td>
<td>_____</td>
<td>_________</td>
<td>____________</td>
</tr>
</tbody>
</table>

20. On which of these topics related to gender-based violence would you like to receive training?

- □ Indicators of violence
- □ How to ask about violence
- □ Health effects of violence
- □ Legal issues related to violence
- □ How to provide services to victims of violence
- □ Referral options
- □ Other (Please Specify) ____________________________
- □ None

21. Do you think that health professionals should routinely ask women about violence?

- □ Yes □ No

Why? (Please Explain)

_________________________________________________________________________
_________________________________________________________________________

22. Do you think that HIV/AIDS programs and services including Volunteer Counseling and Testing Centers (VCTs) should incorporate screening and referral for gender-based violence?

- □ Yes □ No

Why? (Please Explain)

_________________________________________________________________________
_________________________________________________________________________

23. What suggestions do you have for improving services for gender-based violence in your organization?

_________________________________________________________________________
_________________________________________________________________________
F. Personal Experiences with Violence

24. Have you ever witnessed gender-based violence in your community?
   □ Yes  □ No

25. In the past year, have you experienced any of the following?
   a. Physical violence by a partner □ Yes □ No
   b. Sexual violence □ Yes □ No
   c. Emotional abuse by a partner □ Yes □ No

26. In your lifetime, have you ever experienced any of the following?
   a. Physical violence by a partner □ Yes □ No
   b. Sexual violence □ Yes □ No
   c. Emotional abuse by a partner □ Yes □ No
   d. Childhood sexual abuse □ Yes □ No

27. Has a partner ever... (Please select Yes or No)

   A) In the past year  B) In your lifetime
   a. slapped you or thrown something at you that could hurt you?
      □ Yes □ No  □ Yes □ No
   b. pushed you or shoved you or pulled your hair?
      □ Yes □ No  □ Yes □ No
   c. hit you with his fist or with something else that could hurt you?
      □ Yes □ No  □ Yes □ No
   d. kicked you, dragged you or beat you up?
      □ Yes □ No  □ Yes □ No
   e. choked or burnt you on purpose?
      □ Yes □ No  □ Yes □ No
   f. threatened to use or actually used a gun, knife or other weapon against you?
      □ Yes □ No  □ Yes □ No

28. Please answer the following questions. (Please select Yes or No)

   A) In the past year  B) In your lifetime
   a. Has a partner ever physically forced you to have sexual intercourse when you did not want to?
      □ Yes □ No  □ Yes □ No
   b. Have you ever had sexual intercourse when you did not want to because you were afraid of what your partner might do?
      □ Yes □ No  □ Yes □ No
   c. Has a partner ever forced you to do something sexual that you found humiliating or degrading?
      □ Yes □ No  □ Yes □ No
29. Has a partner ever... (Please select Yes or No)

<table>
<thead>
<tr>
<th>A) In the past year</th>
<th>B) In your lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

a. insulted you or made you feel bad about yourself?  
   □ Yes □ No □ Yes □ No

b. belittled or humiliated you in front of other people?  
   □ Yes □ No □ Yes □ No

c. done things to scare or intimidate you on purpose (eg. By the way he looked at you, by yelling and smashing things?)  
   □ Yes □ No □ Yes □ No

d. threatened to hurt you or someone you care about?  
   □ Yes □ No □ Yes □ No

30. If you have experienced physical, sexual, or emotional abuse by a partner in your lifetime, did you ever seek help with respect to the violence?
   □ Yes (Please specify where you sought help)  
   1.________________________
   2.________________________
   □ No

31. If you answered yes to the previous question (question 30), were you satisfied with the help that you received?
   □ Yes  
   □ No

Why? (Please Explain)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for completing this survey.