



INTEGRATING SCREENING AND REFERRALS FOR GENDER-BASED VIOLENCE INTO HIV/STI SERVICES: LESSONS FROM A PILOT PROJECT IN JAMAICA

Brief

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Gender-based violence (GBV) increases people’s vulnerability to HIV and other sexually transmitted infections (STIs). It also adversely affects the ability of people living with HIV to access and adhere to care, treatment, and support (Gardsbane, 2010). Groups especially vulnerable to GBV include women, men who have sex with men, sex workers, and transgender individuals. In Jamaica and globally, relatively few individuals belonging to these groups seek services to address GBV. However, incorporating these services into HIV/STI clinical care could help overcome this challenge and improve health outcomes.

In 2012, the USAID- and PEPFAR-funded Health Policy Project (HPP) supported a leading Jamaican nongovernmental organisation, Woman Inc., to assess strategies for integrating GBV screenings and referrals into clinical HIV/STI care. This pilot project aimed to help health providers identify patients who have experienced GBV, better understand those patients’ needs, and connect them to other sources of support as appropriate. The pilot was conducted at Kingston’s Comprehensive Health Centre, a site highly regarded for its HIV/STI care. Since 1984, Woman Inc., the implementer of the pilot, has helped women throughout Jamaica who have experienced violence.

Planning for GBV Screenings and Referrals

Initial planning for the pilot began in October 2011 and ended in November 2013 with stakeholder meetings to assess lessons learned and next steps. HPP and Woman Inc. worked closely with the Kingston and St. Andrew (KSA) Health Department to develop the pilot. The pilot site, the Comprehensive Health Centre (CHC), has a dedicated section (Section III) for HIV/STI services and a high volume of patients, including people believed to be especially vulnerable to GBV.

Early on, through review of existing directories and organisational mandates, the pilot team identified and engaged organisations in Kingston and St. Andrew that could help patients who have experienced GBV, including agencies offering psychological counselling, specialised medical care, legal support, shelter, or other services. Some organisations worked with gender and sexual minorities, while others focused on GBV or on people living with HIV. The identified organisations then became the referral list for the pilot.



What is Gender-Based Violence?

Gender-based violence is violence directed at an individual based on his or her biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity (Khan, 2011).

Prior to implementation, the team also conducted a brief assessment to gauge the attitudes of the “front-line” healthcare providers at the CHC most likely to implement GBV screenings. This assessment entailed interviews with doctors, nurses, social workers, contact investigators, and adherence counsellors. The team found that many providers felt a need to address the experiences of GBV among women and key populations with high burdens of HIV. Prior to the pilot project, the CHC did not formally screen patients for GBV.

Training for Providers and Referral Agency Personnel

Woman Inc. adapted its existing GBV training curriculum for the pilot and trained 22 health providers. Part one of the adapted curriculum aimed to strengthen knowledge of GBV, sexuality and sexual orientation, and the link between GBV and HIV/STI transmission. Part two familiarised providers with the screening tool and referral process. Providers engaged in role-playing exercises to gain experience asking the questions from the screening tool and making referrals. The trainers also addressed provider concerns related to screening, such as fear of offending patients or not knowing how to respond to patient disclosure of violence, as well as frustration over a patient’s decision not to report violence to the authorities or leave a violent partner. Finally, the training encouraged personal reflection on norms that can drive negative treatment of key populations.

Due mostly to staff rotation among facilities, the team learned that some originally trained personnel would not be working in CHC Section III during the pilot period. Thus, a special day-long training was held for staff currently posted in Section III, shortly after the commencement of screening.

Woman Inc. trained 31 staff members from community agencies to strengthen their capacity to serve clients referred to them from the pilot. This training, which used a curriculum that Woman Inc. modified from the provider training, was delivered in two separate three-hour evening sessions. The training covered the links among GBV, HIV, and STIs; counselling in response to GBV and HIV; and the GBV screening tool and referral process.

GBV Screening Tool and Referral Process

Woman Inc. developed a GBV screening tool and referral kit based on existing tools, as well as inputs from community stakeholders and potential referral agencies. The kit consisted of the following elements:

- A small client card, the size of a business card, which outlined the basic elements of a safety plan on one side and a list of primary referral agencies on the other. The card was kept small to allow clients to safely keep it on their person and to facilitate easy distribution to all clients screened by healthcare workers.
- A letter-size laminated sheet, which listed primary referral agencies on one side and a “how to” guide for developing a safety plan on the other. This sheet provided healthcare workers with a quick reference for offering patients safety information or referrals.
- A full list of referral agencies, including several island-wide agencies.
- A referral card to be completed by the healthcare provider if a referral was made to an agency not listed on the client card.

The screening and referral process began when a provider sought verbal consent from a patient. This request for consent included a description of the GBV screening tool, as well as the planned uses for and confidentiality of the information collected through the screening questions. The provider also informed patients that they did not need to answer the questions and that electing not to participate would not affect the quality of care they received. If verbal consent was given, the provider proceeded with screening questions about the patient’s experiences with violence or mistreatment. The provider may also have discussed steps to reduce the risk of harm. As needed, the provider could refer a patient to organisations offering additional services or support.

Providers also filled out a summary sheet based on the screening results, which covered client background and

consent, clinical history, experience of violence, estimated time spent with the screening tool, and the type of provider using the screening tool. The sheets, which were used by the research team for analysis, did not contain personal identifiers such as the patient's name.

Assessment Methodology

To assess the pilot, the research team analysed data from the patient screening summary sheets and conducted interviews with CHC Section III providers. The responses from the screening questions were synthesised and, with no identifying information disclosed, shared with the KSA Health Department, community referral agencies, and other stakeholders, who were also asked to provide their feedback on the pilot. A patient's responses to the screening questions will remain in her or his medical chart, subject to the same confidentiality as the rest of the chart. The study design received Institutional Review Board (IRB) approval and was reviewed and approved by the Ethics Review Board of the Jamaican Ministry of Health.

Screening Results

From July to October 2013, providers discussed GBV screening with a total of 105 patients. This figure includes patients who did not give consent to be screened and those whose screenings were incomplete. In total, 87 patients answered screening questions about their experiences with any of four forms of violence: sexual, physical, and psychological violence, and threats of danger. Most of these respondents ($n = 54$, or 62%) reported experiencing at least one form of violence in the past 12 months.

The method for selecting patients to be screened varied by provider. Doctors and nurses reported screening patients only as time permitted. Other providers incorporated screenings into patient counselling sessions before HIV/STI blood testing. Contact investigators—whose job is to track the source of HIV/STIs, provide counselling, and support confidential partner notification—reported identifying candidates based on the questions they typically asked of clients.

Since the screening tool was not administered systematically or with a scientific sampling strategy, no conclusions may be drawn about the extent of GBV among the clinic's patient population. An important finding, however, was that a number of patients, including those from sexual or gender minority groups, were willing to speak with providers about violence. Healthcare personnel made 42 referrals for 38 patients (four patients received referrals to two types of agencies). Most referrals were for

psychological assistance, including counselling for GBV or suicidal thoughts, as well as for spiritual needs. Five referrals were to a legal or human rights organisation, and a few were for specialised medical services.

Challenges and Lessons

Identifying and training the providers who implement GBV screenings. An early challenge involved identification and training of personnel who would be working in CHC Section III during the pilot period. In Jamaica, providers are not necessarily attached to just one clinic. In planning training, it is important to factor in potential personnel rotation across several clinics or other system issues that affect staffing.

Implementing the screening tool in a short timeframe.

A number of providers found the screening tool too long to implement in a high-volume clinic. The tool had three sections, with each section ranging from four to 16 questions that could be asked of patients. During the pilot, it took an average of nine minutes to implement the tool ($n = 67$ screenings with times noted), with individual times ranging from one to 18 minutes. Providers voiced a preference for a simpler tool with only three or four questions.

Integrating screening and referrals into clinical processes.

Providers made their own determinations about whether (and how) to incorporate screening into their interactions with patients. For more systematic screening, it is important to concretely define with whom, where, and when screening best fits into the standard clinical processes for different types of providers and services. Effective integration likely requires not only the active engagement of providers but also the agreement of clinic managers.

Primary Benefits

Healthcare personnel deemed the referral component a major strength of the project, noting that they were previously unaware of GBV resources available in Kingston. Providers reported using all of the referral materials they were given and requested more so they could continue making referrals. Personnel from referral agencies also valued the referral kit highly, reporting that these items helped them work with patients more efficiently and effectively.

Numerous providers noted that administering the screening questions helped them improve communication with their patients. They believed that the training and screenings gave them a stronger overall understanding

of their patients and helped them to see some patients, especially those from marginalised groups, in a more positive light. Many mentioned feeling more informed about GBV and HIV. After the pilot ended, some CHC providers reported that they continued to make referrals if they knew or suspected a patient had experienced GBV.

Community stakeholders also valued the project, which they believed helped local agencies deliver more sensitive care in response to GBV among women and key populations. They noted that the pilot helped foster “cross-fertilisation” of knowledge and skills among different community groups. For example, the training helped key population groups better understand GBV and increased understanding of key populations among groups focusing on violence against women. For Woman Inc., a pioneer in programming to reduce violence against women, the project provided valuable education about GBV among key populations.

Recommendations

- **Develop a shorter tool for GBV screenings in high-volume facilities.** Busy healthcare personnel were interested in screening but wanted a tool with only three or four questions.
- **Determine where a GBV screening tool fits into established, routine processes within the clinic.** Doing so requires a detailed understanding of each provider’s work, as well as how GBV screening could be incorporated into the provider’s work and patient conversations.
- **Engage with both providers and clinic leadership** on how best to integrate GBV screenings and referrals into established or routine clinical processes.
- **Consider staff rotation and other health system issues in project planning.** Plan for multiple trainings to address rotation, attrition, and transfers. If possible, develop a training plan that capitalises on pre-scheduled “non-clinic” days for doctors and other personnel.
- **Package referral information in different ways to serve different audience needs.** For example, the wallet card provided an easy, discreet resource for

patients, while the full referral list enabled providers and community agencies to better serve clients.

- **Compile a referral list of agencies “friendly” to women and key populations.** Before the pilot, providers reported they did not know where to refer patients for GBV support and services.

Next Steps and More Information

Ministry of Health and community stakeholders in Jamaica expressed support for a second phase of the pilot, with screenings carried out at additional health centres in Kingston. Phase 2 would enable the project team to alter its approach based on lessons from the first phase.

More information on the GBV screening project may be obtained from Woman Inc. via their Facebook page: www.facebook.com/pages/Woman-Incorporated-Kingston-Jamaica/110786635602236



More information on the Health Policy Project’s work in Jamaica is available via the HPP website: www.healthpolicyproject.com/index.cfm?id=country-jamaica

References

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