

Review of Public
Health-Care Protocols,
Guidelines & Procedures on
Gender-Based Violence
in Barbados



ACKNOWLEDGEMENTS

This report is a product of the United Nations Population Fund (UNFPA)/ Sub-Regional Office for the Caribbean and was prepared by Isiuwa Iyahun, UNFPA Assistant Representative – Barbados. UNFPA wishes to acknowledge the assistance of Kim Clarke, Consultant, in the collection of data and undertaking of background research in preparation of this report.

UNFPA acknowledges the assistance of all respondents and staff of the following agencies and organizations:

- ❖ *Anglican Diocese of Barbados*
- ❖ *Barbados Family Planning Association*
- ❖ *Bureau of Gender Affairs*
- ❖ *Business and Professional Women's Association*
- ❖ *Child Care Board*
- ❖ *Community Legal Services*
- ❖ *Men's Education Support Association*
- ❖ *Ministry of Health*
- ❖ *Probation Department*
- ❖ *Royal Barbados Police Force*
- ❖ *Welfare Department*

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Editor: Christina Johnson
Design/Layout: Solo Studio



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A ACRONYM ABBREVIATION



MS & ATIONS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
MESA	Men's Educational and Support Association
NGO	Non-governmental organization
PHC	Primary Health Care
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization



INTRODUCTION

Gender-based violence is an umbrella term for any harmful act perpetrated on the basis of socially constructed gender roles. Such acts include physical violence, sexual abuse/ rape, emotional/ psychological abuse, verbal abuse, sexual harassment and property violence. By far the most common form is domestic violence by an intimate partner or other family member, with women and girls comprising the majority of victims.

Violence against women is defined in Article 1 of the United Nations Declaration on the Elimination of Violence against Women as: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.”

The root causes of gender-based violence are socio-cultural and driven by value systems that place women in socially vulnerable spaces with limits on the extent to which they can negotiate for power and autonomy within relationships and with society in general. This often has economic implications as women in abusive relationships are financially dependent and unable to leave violent partners.

The right of women to freedom from violence is clearly articulated in several international treaties that Barbados has signed and/or ratified, including:

- ❖ UDHR: Universal Declaration of Human Rights, 1948
- ❖ ICESCR: International Covenant on Economic, Social and Cultural Rights, 1966
- ❖ ICCPR: International Covenant on Civil and Political Rights, 1966
- ❖ CEDAW: Convention on the Elimination of All Forms of Discrimination against Women, 1979





❖ CRC: Convention on the Rights of the Child, 1989

Barbados is also a signatory to the Programme of Action from the International Conference on Population and Development (ICPD) and the Beijing Platform for Action from the United Nations Fourth World Conference on Women, both of which commit governments to take measures to eliminate violence against women. For example, the Programme of Action states that “Special emphasis should be placed on the prevention of violence against women and children” (Paragraph 4.27), while governments agree in the Platform for Action to “Adopt and/or implement and periodically review and analyse legislation to ensure its effectiveness in eliminating violence against women, emphasizing the prevention of violence and the prosecution of offenders” (Paragraph 124(d)).

Governments have three levels of obligations concerning rights: to respect, protect and fulfil:

- ❖ To *respect* a right means refraining from interfering with the enjoyment of the right.
- ❖ To *protect* a right means enacting laws that create mechanisms to prevent violation of the right by state authorities or by non-state actors. This protection is to be granted equally to all.
- ❖ To *fulfil* a right means to take active steps to put in place institutions and procedures, including the allocation of resources, to enable people to enjoy the right.

Operating within a rights-based framework requires the recognition that every person is a rights-holder and is entitled to freedom, well-being and dignity. A rights-based approach develops the capacity of duty-bearers to meet their obligations and encourages rights-holders to claim their rights. It also focuses on those who are the most vulnerable, excluded or discriminated against.

Within the context of a health-care system, survivors of gender-based violence, who are in this case the rights-holders, are entitled to the highest standard of care from health-care providers (the duty-bearers). Recognizing that health status and health outcomes are socially determined is also critical to understanding the obligations of health-care systems to survivors, who are included among vulnerable populations in the rights-based approach. Gender-based violence can have profound short- and long-term effects on health, as outlined on the following page:



HEALTH EFFECTS OF GENDER-BASED VIOLENCE

TYPES OF VIOLENCE

Childhood sexual abuse (for adolescent and adult victims)

Rape

Gender-based violence in general (including childhood sexual abuse and rape)

REPRODUCTIVE, BEHAVIOURAL AND SOCIAL HEALTH EFFECTS

Gynaecological problems, STIs including HIV and AIDS, early sexual experiences, early pregnancy, infertility, unprotected sex, unwanted pregnancy, abortion, re-victimization, high-risk behaviours, substance abuse, suicide, death

Unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STIs including HIV and AIDS, suicide, death

Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, STIs including HIV and AIDS, pelvic inflammatory disease, gynaecological problems, low birth weight, miscarriage, adverse pregnancy outcomes, suicide, death

The obligations of service providers (including health-care providers) to ensure full and comprehensive access to services is clearly articulated in the treaties and global agreements previously outlined. Health-care administrators, managers and providers are important to the prevention, diagnosis and treatment of gender-based violence in order to meet professional obligations to ensure the best health outcomes for clients, a fundamental objective of a properly functioning health-care system. Furthermore, linking these health outcomes, within a rights-based framework, as part of an appropriate strategy for prevention and treatment of gender-based violence, will require a concerted effort to view survivors as having the right to responsive and comprehensive health-care services.

It is clear that for health-care services to respect, protect and fulfil the rights of victims of gender-based violence, systems have to be put in place to detect and respond to their needs in a holistic and comprehensive manner. This would imply strong institutional relationships between the health-care system and other agencies tasked with the responsibility to respond to survivors of gender-based violence. Moreover, for health-care professionals to see themselves as duty-bearers in preventing violence against women will require a paradigm shift.

Removing the burden of responsibility for violence from survivors is an implicit recognition of their right to freedom from violence and, importantly, the obligation



of the state to ensure this freedom. This is a necessary first step that must be taken by the state organs responsible for ensuring individual freedom from violence. Agencies responsible for intervention have been called upon to be part of an integrated community-based response to these crimes and violations. Common features shared by “best practice” models for an integrated response to gender-based violence often include the following:

- ❖ Holding communities responsible for perpetrators of violence and not placing this burden on the victim;
- ❖ Implicitly recognizing that gender-based violence evolves out of a systemic use of coercion, intimidation and other related forms of abuse that may or may not be readily apparent;
- ❖ Ensuring that interventions are sensitive to the individuals experiencing violence and incorporate their economic, cultural and personal needs;
- ❖ Developing interventions that focus on reducing perpetrator violence as part of a preventative approach.

While there has been an acceptance in the Caribbean among victim advocates of the need for an integrated community-based response to violence, the involvement of the health-care system has been minimal. The criminal justice and social welfare agencies are regarded, by and large, as the government agencies with the primary responsibility to respond to the needs of survivors. Most initiatives have included legal/ constitutional reforms, batterer intervention programmes, advocacy and communications initiatives and interventions addressing masculinity and behaviour change. There is a perception that the involvement of the health-care system is tangential, except as part of a response to a case often initiated within spheres that have very little to do with a person’s existing health status. To illustrate, the victim in a rape case might encounter the health-care system to obtain emergency contraception or post-exposure prophylaxis to prevent HIV infection. The interaction is

reactive and automatically places health-care professionals as incidental actors in addressing rape and/or gender-based violence. The perceived responsibility of the health-care professional at that point is to administer clinical treatment and make an exit from the case.

However, it is clear that violence against women is inextricably linked to gender-based inequalities including inequalities in access to and the responsiveness of health-care systems. Health-care providers have a stake in preventing these offences, which manifest themselves as reproductive, sexual and mental health problems. If undetected, gender-based violence can reduce the effectiveness of reproductive and sexual health programmes and other interventions aimed at optimizing health outcomes. The social and behavioural effects of undetected and untreated gender-based violence are also evident in vulnerabilities – to, for example, the adoption of high-risk behaviours, negligence, substance abuse and suicide --- that undermine national efforts aimed at achieving the best health outcomes for every woman, man, girl and boy.

The tenuous linkages that currently exist between the criminal justice, social welfare and health-care systems in addressing gender-based violence in the Caribbean region raises questions related to the obligations of duty-bearers in the health-care system and whether protocols/ procedures/ guidelines, where they exist, allow or prevent health-care providers from adequately identifying and addressing the needs of survivors. How these providers view gender-based violence is critical for adequate service delivery and for the full exercise of the rights of survivors. There is therefore a need to discern how gender-based violence is handled in the health-care system in order to strengthen the national response to these violations and to further complement other initiatives currently taking place to prevent violence.





REVIEW OF POLICY & LEGAL FRAMEWORKS

In order to ascertain how governments have sought to address gender-based violence, it is important to look at the relevant legal and policy frameworks in Barbados and the Caribbean. While gender-based violence is a human rights violation and embodies practices, behaviours and attitudes that are harmful, it is unfortunately part of the cultural, socioeconomic and political fabric of Caribbean societies. Gender stereotypes and underlying power imbalances that characterize gender-based violence are often manifested in the private sphere, within families and intimate relationships. However, the perception of these violations as solely “private” family problems stands in the way of governments developing measures to eliminate this violence in both the public and private spheres, as they are obligated to do under the various international conventions to which they are signatories.

Despite the above, progress has been made in raising public awareness of the need to eliminate gender-based violence in the region, with women’s organizations taking the lead. Caribbean governments have sought to address gender-based violence mostly through legal reform and have signed on to international and regional instruments committing the state to proactively tackle the issue. These instruments include the United Nations Declaration on the Elimination of Violence against Women and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (“Convention of Belém do Pará”). The constitutions of most Caribbean countries prohibit gender-based discrimination. Although none specifically addresses gender-based violence, most prohibit inhumane and degrading treatment and provide the rights to freedom from torture, to security of the person and to due process of law, all of which could be interpreted





as guaranteeing the right to freedom from gender-based violence (Clarke 1998). In all Commonwealth Caribbean countries there are criminal sanctions for sexual offences and rape, indecent assault, defilement, and procuring and abduction of women. Legal responses in these countries provide civil and criminal remedies for cases of assault, which would cover gender-based violence, including speedy actions to put in place injunctions and protection orders. Some countries have introduced specific legislation on gender-based violence.

It is evident that adequate legal and policy frameworks on gender-based violence are fundamental to victim protection and can in some circumstances, depending on the extent of enforcement, be deterrents. Prevention and response is heavily reliant on intervention by the state into personal relationships to protect victims from abusive partners. The police and the courts therefore play an obvious and central role, and advocates for victims of gender-based violence have focused intensely on these critical justice administration institutions.

In Barbados there are several Acts that can be used to cover gender-based violence, although they do not speak to it specifically (nor do they refer specifically to the role of the health-care system in the prevention, management and care of cases). These are:

- ❖ The Domestic Violence Act (Protection Orders) 1992
- ❖ The Sexual Offences Act 1993
- ❖ The Offences against Another Person Act 1994
- ❖ The Child Care Board Act 1969
- ❖ The Prevention of Cruelty to Children Act 1904 (amended 1981)
- ❖ Young Persons Protection Act 1918
- ❖ Minor Offences Act 1998

The existing Domestic Violence Act provides for Protection Orders, though these can be violated at any time and as such may not

always afford survivors with effective safety and legal redress from violent perpetrators, most of whom are/were intimate partners. Within the legislation it is stated that these Orders should be granted within two days or as short a period as possible. However, there have been reports of cases where Orders have taken as long as two months to be granted, possibly placing the safety and protection of survivors in jeopardy. Additionally, gender-based violence can be classified as a criminal offence under the Domestic Violence Act only if the Protection Order is breached, thereby triggering a response from the police. In the event that a victim of domestic violence wishes to bring a case against the perpetrator, the alleged offence is treated as any other act of violence such as physical assault, which limits the ability of practitioners to accurately assess the level of domestic violence and the particular vulnerabilities and experiences of survivors.

The Sexual Offences Act addresses the issue of rape and other sexual offences on a broad scale. Part one (1) of the Act states that: “Any person who has sexual intercourse with another person without the consent of the other person and who knows that the other person does not consent to the intercourse or is reckless as to whether the other person consents to the intercourse is guilty of the offence of rape and is liable on conviction on indictment to imprisonment for life.”

However, it does not adequately address the issue of marital rape, which is covered by the following:

“(4) 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 relation to them:

- (a) a decree nisi of divorce;
- (b) a separation order within the meaning of section 2 of the Family Law Act;
- (c) a separation agreement; or
- (d) an order for the husband not to molest his wife or have sexual intercourse with her.





(5) A husband who commits the offence of rape is liable on conviction on indictment to imprisonment for life.

(2) Where a marriage is void under Part II of the Marriage Act, the husband of the marriage is not guilty of an offence under this section because he has sexual intercourse with the wife, if at the time of the commission of the alleged offence, he believed her to be his wife and had reasonable cause for the belief.”

In 2002 the CEDAW Committee noted with concern that, under the Act, marital rape is recognized as a crime only in very limited circumstances. This places an undue burden on married victims of sexual violence and limits their access to justice. The Committee also expressed concern with the difficulty in the granting and enforcing of Protection Orders.

Notwithstanding the limitations in these legal and policy frameworks, any effort to address gender-based violence by the public health-care system requires linkages to the justice system and police.





SUMMARY OF RESEARCH PROCESS

UNFPA's "Strategy and Framework for Action to Addressing Gender-Based Violence for 2008-2011" states that strengthening the capacity of health systems "within a multi-sectoral framework of mutually reinforcing interventions for prevention and management of violence against women and girls" needs to be developed at all levels. Included in the key areas it identifies as required to strengthen the health sector's role in this area is "Establishing or improving health sector policy, legal and normative frameworks and protocols for screening, managing and referring cases of gender-based violence in its various forms (e.g. domestic, sexual, harmful practices) and throughout service-delivery policies and protocols (e.g. family planning; prenatal, maternal and post-natal care; psychosocial and legal advice; HIV counselling and testing)."

In 2008, guided by the Strategy and Framework, UNFPA embarked on a research initiative with the objective of clarifying exactly how gender-based violence is handled in the primary health-care system in Barbados. The focus of the research was on primary health-care services because most persons accessing health care in the country go to polyclinics. The research design included the following:

- ❖ The administration of a questionnaire to health-care providers in polyclinics;
- ❖ The administration of a questionnaire to social service agencies, civil society and faith-based organizations;
- ❖ Document review of policies, protocols, guidelines and clinical and administrative procedures employed by health-care professionals in the primary health-care/ polyclinic sector. This





included a review of formal and informal procedures/ protocols/practices.

RESEARCH OBJECTIVES

The overall objective of this research initiative is to provide data and information to support policy reform aimed at strengthening the prevention, treatment and response to gender-based violence in the primary health-care system of Barbados. While the health-care system is essential to prevention and response, it has been only tangentially involved in interventions in this area. This research aims to:

- ❖ Clarify the existing approach to prevention, care and response to gender-based violence in the primary health-care system, with a view to providing practical recommendations for institutional strengthening, where necessary, and systematizing and sharing best practices currently employed.

- ❖ Obtain information on institutional linkages to other agencies tasked with responding as gender-based violence is multi-dimensional and requires a multi-sectoral response. The research also complements ongoing national initiatives aimed at responding to and preventing gender-based violence. Until women are free from violence in all spheres and until national prevention and response mechanisms are strengthened, the Millennium Development Goals (MDGs) and goals set out in the ICPD will not be achieved. Therefore, the ultimate objective of this review is to contribute to the national achievement of the MDGs by 2015 and the ICPD Programme of Action.

RESEARCH STRATEGIES AND APPROACHES

The research design took into account the following strategies and approaches, which emphasize a rights-based approach to addressing primary health care and gender-based violence.

PAHO/WHO Primary Health-Care Strategy

Since 1978 the World Health Organization (WHO) has been promoting Primary Health Care (PHC), which was adopted during the Alma-Ata Conference and is intended to strengthen countries' capacity to implement a coordinated, effective and sustainable strategy to tackle existing health problems, meet new health challenges and improve health equity. Existing gender-based inequities in the health-care system can be dealt with using the PHC strategy, which aims to address the root causes of poor health. The PHC strategy recognizes that health is socially determined as these root causes result from unequal power relations between those who are privileged and those who are marginalized. As mentioned earlier, gender-based violence is rooted in gender inequity, particularly within intimate relationships, and can lead to a myriad of health problems. The PHC strategy provides an opportunity to promote equitable and sustainable improvements in health systems to meet the needs of those who are marginalized, including victims of gender-based violence.

People have the right to quality, responsive and comprehensive health care. Resilient legal, institutional and organizational frameworks accompanied by adequate and sustainable human, financial and technological resources are required for the PHC-based health system. Furthermore, optimal organizational and management practices at all levels to achieve quality, efficiency and effectiveness aimed at maximizing individual and collective participation in health are also required. All these elements are critical to meeting the needs of survivors of gender-based violence, the majority of whom may not report their experiences through the health-care system, but who do in fact frequent health centres to request treatment for illnesses that continue to recur if they remain in abusive relationships. A PHC-based health-care system would be able to diagnose and respond effectively to the





needs of vulnerable populations, including survivors of violence, as is their right. What is also critical to understand is that the PHC system promotes inter-sectoral action in order to address determinants of health and equity. As mentioned previously, the interconnectedness of institutions tasked with responding to the needs of gender-based violence is essential and is a fundamental recognition of its multi-dimensional nature. The research design therefore focuses on the primary health-care system's management of gender-based violence while assessing the institutional linkages to other agencies that work closely with victims of such violence. As the recommendations from this research initiative are intended to include recommendations for reform, the PHC-based system is presented as a viable, practical and sustainable equity-based model to aspire to.

Duluth Model on Public Intervention¹

The Duluth Model encompasses protecting victims from ongoing abuse, holding perpetrators and intervening practitioners accountable for victim safety and offering offenders an opportunity to change. The intervention focuses on stopping the violence, not on fixing or ending the interpersonal relationships within which it is taking place. This model is viewed as holistic as centres for responsibility for prevention and responding to gender-based violence lie within the community. The model recognizes that survivors have a right to a life free from violence and asserts that:

- ❖ The primary responsibility of placing controls on abusers belongs to the community and the individual abuser, not the survivors of abuse.
- ❖ Battering is a form of domestic violence that entails a patterned use of coercion and intimidation, including violence and other related forms of abuse, whether legal or illegal. To be successful, initiatives must distinguish between and respond differently to domestic violence that constitutes battering and cases that do not and adjust those

interventions to the severity of the violence.

- ❖ Interventions must account for the economic, cultural and personal histories of the individuals who become abuse cases in the system.
- ❖ Both survivors and offenders are members of the community; while they must each act to change the conditions of their lives, the community must treat both with respect and dignity, recognizing the social causes of their personal circumstances.

The model shares several principles in common with the PHC strategy, including a reliance on interagency intervention as follows:

- ❖ Change is required at the basic infrastructure levels of the multiple agencies involved in case processing.
- ❖ The strategy for change must be centred on victim safety.
- ❖ Agencies must participate as collaborating partners.
- ❖ Abusers/ perpetrators must be consistently held accountable for their use of violence. Based on the above, the research design took into account the shared responsibility for gender-based violence among various agencies within and outside the health-care system. Additionally, a specific focus on assessment of available infrastructure and tools available was incorporated into the research design in order to ascertain the capacity of institutions to respond to gender-based violence in Barbados.

RESEARCH METHODOLOGY

A purposive sample of agencies was identified, and between September and December 2008 a questionnaire was administered “face-to-face” to each respondent to determine the extent to which protocols and guidelines have been established for the management of gender-based violence.² Respondents were asked to respond to several questions relating to

¹ See Shepard and Pence 1999.

² See Annex 1 for a list of persons interviewed.





aspects of gender-based violence management based on their knowledge of what is currently practiced in the institution in which they work or operate.

In conducting the review, Section B of the questionnaire, which relates to Client and Perpetrator Profiles, was forwarded to interviewees prior to the face-to-face interview. This was done in an effort to allow persons time to gain a better understanding of the information being sought as well as speeding up the data collection process. However, this process was somewhat futile as only one agency, namely the Child Care Board, completed this section of the questionnaire ahead of the interview session. Other questionnaires were completed at the time of the face-to-face interview.

Constraints

❖ Data gathered by the Police Department are not disaggregated by sex. To achieve this disaggregation for the purpose of the research would have required more human resources and time than could be provided during the review period.

❖ Data gathered by the Police Department do not record gender-based violence in particular but violence in general. Therefore, statistics may not reveal the actual level of gender-based violence in Barbados.

❖ Data gathered by the Child Care Board do not always identify the appropriate sex and may be misleading if a comparison is to be made between sex and the incidence of gender-based violence.

❖ Persons identified within the primary health-care system as key personnel for the interviews, as requested by the Ministry of Health, were the Senior Health Sisters and Medical Officers of Health. Although knowledgeable, these may not have been the most appropriate respondents since general practitioners and staff nurses have more contact with patients.

❖ Key personnel interviewed were not familiar with the term gender-based violence and could not clearly define or identify with it. There was a persistent misunderstanding that gender-based violence referred to only domestic violence and did not include other violent acts. In order to ensure that each respondent understood the type of information that was being requested, a definition of gender-based violence was provided during the administration of the questionnaire. Additionally, respondents were constantly reminded of this definition throughout this process.

❖ The survey instrument used for the review did not adequately cover information on the perpetrators of gender-based violence.





ANALYSIS OF RESEARCH RESULTS

A. THE PRIMARY HEALTH-CARE SYSTEM

The adequacy of the primary health-care system's response to the needs of the victims of gender-based violence (which includes physical battery, sexual assault/ violence, child sexual assault/ violence and mental/ emotional violence) relies on available infrastructure as well as the capacity of staff to handle this human rights violation. The interpretation and understanding of the mission of the primary health-care system by staff and service providers also clarifies the manner in which gender-based violence is viewed.

Analysis of the research findings reveals that that there are no formal or clearly defined protocols on the management of gender-based violence cases within the primary health-care sector in Barbados. Health-care personnel are not mandated to prevent, treat or manage cases of gender-based violence with any urgency, and no special conditions apply to these cases. It is left up the discretion of the attending physician to treat such cases either with urgency or as regular clinic visits.

A) THE POLYCLINICS

Five out of eight polyclinics, which represent 63 per cent of the polyclinics in the country, were included in the review. Therefore the sample size is representative of the sector. The majority of services provided are in the areas of general medicine/ practice, maternal and child health and family planning.

The research revealed that no members of staff at the polyclinics are specifically assigned to gender-based violence cases. This should not be misunderstood to indicate that gender-based violence cases are not handled at all. In fact, medical/ health professionals frequently treat illnesses that might be related to gender-based violence. However, these illnesses may not be reported as gender-





based violence and may not be diagnosed as such.

Perceptions and attitudes of health-care providers regarding gender-based violence

Respondents possessed less than adequate knowledge of gender-based violence: its existence, consequences, management and prevention. Notwithstanding this, they all had their own perceptions about it. Regarding practices, health workers did not seem to readily know what was expected of them.

One respondent thought that gender-based violence was a matter for police intervention and not health-care professionals. Some health-care workers seemed unsure as to how they could intervene. Some did not think it was feasible for them to tackle the issue since they feared retaliation by the perpetrator against them and their staff members. They also felt that at times it was futile to assist female victims of domestic violence since in their view these women always seemed to end up returning to the relationships that were causing them harm. There was also the perception that reporting the case might eventually result in worse consequences for the victim as the abuser might seek redress, taking out his anger on the victim in a manner that might be much more detrimental to her health and well-being. Additionally some respondents at the polyclinics thought that such cases would be better managed at the general hospital (the Queen Elizabeth Hospital) and not by them.

One respondent in particular stated that there was a probability of misreading the situation that was presented and that some cases were best reported or referred to social workers and not the police. She was of the opinion that it was best to treat the injuries as just injuries and not to make assumptions about gender-based violence. She also thought that given the very private nature of the Barbadian society, it was best not to ask patients about

abuse but rather to wait for them to broach the topic.

It was reported by the respondent at one polyclinic that due to the volatility of the area in which the clinic is located, staff were abused on a regular basis although there are guards posted at the institution. She saw the need for more police protection/ patrols and even more so if gender-based violence cases were involved.

One health-care professional was adamant that the polyclinic in question did not handle cases of gender-based violence and therefore did not have the need to manage them. This is an interesting response because, as mentioned earlier, gender-based violence might be the root cause of many illnesses. A provider who was not able to discern this linkage would not be able to even conceptualize how to address such a case appropriately. This was in comparison to the attitude of another health-care professional who saw addressing gender-based violence as very important. This differing attitude may stem from the fact that the latter provider and her staff have a close relationship with the patients, do many house visits and foster favourable relations with the members of the surrounding communities.

What is notable is that there was a general acceptance by the respondents that the state is responsible for child protection, which could explain why cases of child abuse, when identified, were treated with relatively more urgency when compared to adults.

Physical infrastructure and observation of frontline staff and client interaction

Although not part of the research design, observations were made while waiting to administer the questionnaire of the manner in which frontline staff interacted with clients. The physical infrastructure and set-up was also noted. Patients visiting the polyclinics are asked to wait in a general waiting area at the





front of the building while their files are being retrieved by the Admissions Clerk. After that point they are ushered into another waiting area before being seen by the nurse. The door to the room in which they see the nurse is not generally closed and at times there is another nurse in the room, sometimes giving attention to another patient. After this process, the patient is asked to sit and wait once more to be seen by the doctor. The waiting area is lined with chairs accommodating up to 40 patients at any one time, so that there is very little privacy. Privacy and confidentiality is only guaranteed as the patient enters the

doctor's office.

Protocols, guidelines and procedures

Respondents from the five polyclinics interviewed revealed that there are no formal policies or guidelines for the management of cases of gender-based violence. There are, however, instances where a step-by-step procedure is utilized. The specific responses to questions on step-step-procedures in cases of sexual violence or assault and non-sexual physical assault of adults (18 plus) are outlined below.

STEP-BY-STEP PROCEDURE FOR MANAGING ADULT CASES OF SEXUAL VIOLENCE OR ASSAULT

NAME OF CLINIC	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Polyclinic	Client's records taken from registry, nurse records initial information, patient examined by doctor (nurses try to "fast track" patients, but no formal process or procedure in place)	Senior Health Sister
Glebe Polyclinic	Not applicable*	Medical Officer of Health and Senior Health Sister
St. Philip Polyclinic	Not applicable*	Senior Health Sister and Nurse
Sir Winston Scott Polyclinic	Client examined by a doctor after being screened by nurses, information recorded on their police report form (which they come with)	Medical Officer of Health and Senior Health Sister
Warrens Polyclinic	Client's records retrieved from the registry by the registry clerk, client's vitals and information recorded in the patient's file by the nurse, client examined by the doctor.	Medical Officer of Health

* Note: Not applicable means respondents said they did not handle cases of gender-based violence.



HIV AND STI PREVENTION AND TREATMENT AND EMERGENCY CONTRACEPTION PROCEDURES IN CASES OF SEXUAL VIOLENCE OR ASSAULT FOR ADULTS

NAME OF CLINIC	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Polyclinic	Tested for STIs, HIV, AIDS and pregnancy	Senior Health Sister
Glebe Polyclinic	Not applicable*	Medical Officer of Health and Senior Health Sister
St. Philip Polyclinic	Not applicable*	Senior Health Sister and Nurse
Sir Winston Scott Polyclinic	Tested for STIs, HIV, AIDS and pregnancy	Medical Officer of Health and Senior Health Sister
Warrens Polyclinic	Tested for STIs, HIV, AIDS and pregnancy, and counselling services provided	Medical Officer of Health

* Note: Not applicable means respondents said they did not handle cases of gender-based violence.

Based on an analysis of the responses above, it seems that reliance on the victim to identify sexual and physical abuse is paramount.

The responsibility for the reporting (and consequently the identification) of sexual violence in two out of the five clinics included in the analysis lies with the victim, as there is no specific procedure for identifying these cases. It may be that respondents stated that cases of gender-based violence are not treated within the health-care system because many patients who visit the clinic with ailments or injuries choose not to report the cause to the doctor or nurse who attends to them. Through probing and observations these cases could be identified as gender-based violence, but this was left up to the discretion of the attending doctor or nurse.

In one clinic, the respondent indicated

that a female constable is requested to take a statement from the victim, which could be interpreted as an attempt at sensitivity towards the needs of the victim.

Two out of the five clinics indicate that this question is “not applicable”, a response that may require further probing as it could be interpreted in a number of ways. On the one hand, it might indicate that these polyclinics have never treated victims of gender-based violence. On the other hand, it might indicate that symptoms/ illnesses that could be associated with gender-based violence, including sexual violence (for example, STIs, unintended pregnancies, gynaecological problems, pelvic inflammatory diseases) are either not treated at all in these polyclinics or are not perceived as linked in any way to sexual violence. As these illnesses are treated at these polyclinics, it can be assumed

STEP-BY-STEP PROCEDURE/ PROTOCOL FOR MANAGING CASES OF NON-SEXUAL PHYSICAL ASSAULT TO ADULTS

NAME OF CLINIC	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Polyclinic	Evidence statement taken, assessment of injuries, information recorded on their police report form (which they come with)	Senior Health Sister
Glebe Polyclinic	Not applicable*	Medical Officer of Health and Senior Health Sister
St. Philip Polyclinic	Not applicable*	Senior Health Sister and Nurse
Sir Winston Scott Polyclinic	Client examined by the doctor after screening by nurses, information recorded on their police report form (which they come with), referred for counselling.	Medical Officer of Health and Senior Health Sister
Warrens Polyclinic	Clients' records retrieved from the registry by the registry clerk, client's vitals and information recorded in the patient's file by the nurse, client examined by the doctor	Medical Officer of Health

* Note: Not applicable means respondents said they did not handle cases of gender-based violence.

that they are not regarded by these medical professionals as having any relationship to gender-based violence.

It should be noted that although personnel at the polyclinics treat reported sexual assault cases with urgency, these cases are generally handled within the accident and emergency section of the Queen Elizabeth Hospital. The response there is essentially entirely reactive in order to prevent further deterioration of the victim's condition. There is no mechanism in place for detecting gender-based violence at the hospital. Consequently, health-care

professionals encounter these cases mostly within the context of an emergency. This does not address detection and prevention of gender-based violence and is not based on an assessment of the individual's existing health status, which would require interaction on a sustained basis.

If cases of sexual assault are reported to the police department, victims are usually treated by a police doctor. Notwithstanding this, one respondent within the primary health-care sector suggested that there was a general procedure of dealing with sexual



assault victims, whether adult or child, in a “fast track” manner. These patients’ files are retrieved from the clinic registry without the usual waiting period, both nurse and doctor see the patient ahead of others within a very private setting, and the patient spends more time with a counsellor. In cases of child sexual assault, the incident is reported or referred to the Child Care Board to be managed.

Records

Medical records provide an insight into the health challenges experienced by individuals, and also provide information on the approach to detection, diagnosis and treatment taken by health-care professionals. If they are well kept, it could also be envisaged that these records might serve as factual evidence establishing or corroborating the occurrence of abuse. Most records in polyclinics are kept indefinitely. In some jurisdictions outside of Barbados, medical records can be used for obtaining a range of relief services for victims such as protection/ restraining orders and as evidence in court cases. These records could also prove useful to victims in less formal legal contexts to support their allegations of abuse. In some jurisdictions in the United States, medical records can aid victims in obtaining access to services such as public housing, welfare, victim compensation and immigration relief. For such institutional linkages to exist between the primary health-care system and other service providers in Barbados, appropriate and targeted protocols would need to be developed and implemented. For this reason, many health-care protocols and training programmes stress the importance of documenting abuse.

For the purposes of this research, it was important to obtain information on whether health-care professionals were collecting data on gender-based violence and if so, the kinds of data. Furthermore, the objective was to analyse, through the type of data collected, the manner in which cases of physical,

sexual and mental/ emotional abuse were handled. Basic but critical demographic data – including name, age and injuries sustained – are collected when a client is identified as having experienced physical, sexual and/or mental/ emotional abuse. The respondent at one clinic said that information was also collected on clients who presented with recurrent injuries to assess the level of fear they manifested. Data collection on recurrent injuries and fear levels could be interpreted as increased sensitivity on the part of the health-care professional to the needs of victims experiencing gender-based violence.

What is important to note here, as with the previous section on protocols, is that health-care providers rely on their own discretion when addressing gender-based violence.

Screening

A respondent at one polyclinic said that screening took place for adult clients and minors for gender-based violence, but only when the patients/ victims reported that they had been assaulted. This highlights what appears to be a misunderstanding of the rationale for screening, which is to detect violence, and it should therefore take place prior to victims reporting an assault. This “screening” for physical battery and mental/ emotional abuse would take place during a regular check up, when the victim presented with physical injuries and/or when referred by doctors.

Counselling services

Providers at two polyclinics referred gender-based violence clients for trauma/ psychological counselling “most of the time”. Respondents at two other polyclinics referred such clients “sometimes”. For providers at one polyclinic these services were viewed as not applicable to their context as they were of the view that they did not treat victims of gender-based violence.

Counselling services were provided at two of the polyclinics “most of the time”





and provided at one polyclinic “all of the time”. At one polyclinic counselling was rarely provided. It is again apparent that the provision of these counselling services to victims is done arbitrarily and at the discretion of the health-care provider.

Referrals

The respondent at one polyclinic said clients were referred to other agencies providing support to cases of gender-based violence, such as non-governmental organizations (NGOs), social services, legal aid, shelters and the Child Care Board. Another polyclinic referred clients “most of the time”. Three polyclinics “rarely” referred clients.

With respect to children, respondents at the polyclinics were asked to identify agencies with which they currently liaised to manage cases of gender-based violence. Respondents at four polyclinics identified the Child Care Board while one polyclinic identified social services. Agencies that provide shelter for victims of gender-based violence and other support were not cited, which might signal weak institutional linkages with such agencies.

The research revealed that health-care providers at one clinic referred gender-based violence clients for legal aid “most of the time”, which is a positive sign as such actions point to sensitivity to the victims’ need for protection. Providers at the other polyclinics said that victims were referred to legal aid “sometimes”, “rarely” or “never”. However, these referrals appear to be at the discretion of the health-care provider and there is no guarantee that they will continue if there are staff movements, changes or transfers, as there are no official protocols.

Confidentiality

Respondents at four out of five polyclinics stated that there was a general confidentiality policy for all clients. All respondents at all polyclinics stated that there was no specific

confidentiality policy for gender-based violence cases.

Inter-sectoral collaboration

The Duluth Model, described earlier, requires infrastructural change that includes victim safety as central to any intervention aiming to address gender-based violence. Interagency collaboration is encouraged as part of this since service provision must address the multiplicity of needs from shelter and financial security to health and childcare.

In an effort to discern the extent to which interagency collaboration exists, health-care providers were asked to provide information on their relationship with various institutions, organizations and service providers outside of the health-care sector. Respondents representing service-providers and agencies outside of the health-care system were also asked to provide information on the relationship with the polyclinics.

Based on an analysis of the responses, it is clear that institutional collaboration with other agencies that bear responsibility for or are directly involved with managing gender-based violence cases is weak. These agencies and organizations include women’s organizations, Crisis Centre personnel, the national gender machinery and the police. This finding further highlights the need for all institutions tasked with addressing the needs of victims of gender-based violence to “talk” to one another, if the goals of integrated service provision are to be achieved.

B) COMMUNITY MENTAL HEALTH SERVICES

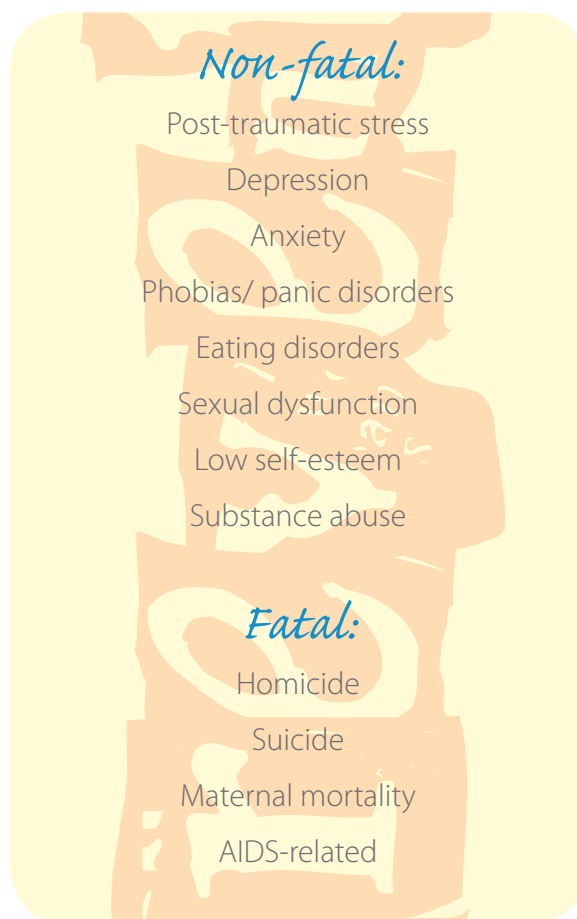
Community Mental Health Services is the agency that provides psychiatric and counselling care within the primary health-care system. As mentioned earlier, the PHC strategy calls for a holistic multi-sectoral approach to addressing health problems. Collaboration with mental health services at the community level would thus be required





in any intervention aimed at providing assistance to survivors of gender-based violence. With this in mind, the Community Mental Health Services in Barbados was included in this research initiative in order to gain further insight into the approach taken by mental health professionals in addressing gender-based violence.

Epidemiological evidence shows that gender-based violence (particularly partner abuse, sexual abuse and child sexual abuse) negatively and profoundly affects victims' emotional health and can lead to both fatal and non-fatal outcomes as outlined below (IPPF 2004):



It is therefore critical that capacity should exist at the primary health-care level to identify and respond adequately to victims who may be experiencing the abovementioned illnesses. However, the responses to the questionnaire mirror, in many respects, the information provided by the polyclinics. No staff are specifically assigned within the

Community Mental Health Services to handle cases of gender-based violence. However, while it does not have any formal protocols in place for gender-based violence, the agency does provide counselling services to victims who are referred. Counselling takes place at the community psychiatric clinics. Some cases are referred to the Department of Psychology or the Psychiatric Hospital for more in-depth counselling.

C) THE BARBADOS FAMILY PLANNING ASSOCIATION

The Barbados Family Planning Association, an affiliate of the International Planned Parenthood Association, is a major provider of sexual and reproductive health services to the Barbadian population. The organization has a close relationship with the Government, which provides an annual subvention to assist with service delivery in reproductive health. Furthermore, the majority of women, at some point in their lives, will seek reproductive health care, making it necessary to include this organization in the research scope.

Overview of services and institutional approach to gender-based violence

Services provided through the organization include:

- ❖ Sexual and reproductive health-care services;
- ❖ Community-based programmes;
- ❖ Sexual and reproductive health education;
- ❖ Total quality care clinic for men.

Women are not only the majority of victims of gender-based violence but also the majority of clients seeking sexual and reproductive health care. These services thus provide a key entry-point for detection of gender-based violence. The Barbados Family Planning Association, as a major provider of reproductive health-care services outside of the public health-care system, is strategically placed to address the issue.

While there is no institutional protocol





on gender-based violence, there are other procedures in place to counsel clients on:

- ❖ Reporting crimes of gender-based violence to the police;
- ❖ Pressing charges against perpetrators;
- ❖ Taking a medical exam;
- ❖ HIV testing;
- ❖ Contraceptive use and pregnancy testing;
- ❖ Emergency contraception;
- ❖ Pregnancy risk from gender-based violence;
- ❖ STI treatment.

Staff have been provided with training on management of gender-based violence cases, but not since 2003. Survivors are seen in a private consultation room, where they are examined by a doctor or nurse. There is a confidentiality policy that covers all clients (though not one specifically related to gender-based violence). If confidential information is divulged by staff members, their services will be terminated. The Staff Committee, which sits on the General Board of the Association, determines the consequences for breaches in confidentiality.

Records

A social worker is responsible for the collection of data related to gender-based violence, according to the respondent, and has received training in data collection methods (though not in gender-sensitive data collection). The respondent interviewed said that records are sometimes shared with the police, legal aid and social service agencies. These records are kept manually and for a period of two or more years.

Screening

The Association does not screen clients for gender-based violence.

Support services

The Association provides information on gender-based violence to clients and survivors via posters and magazines. Some workshops and meetings also address gender-based

violence.

Referrals

Survivors are referred to the organization for trauma and psychological counselling “most of the time”, according to the respondent. When asked how often the organization provides gender-based violence counselling to clients, the respondent said “all of the time”. Survivors are “sometimes” referred to social service agencies, the Crisis Centre and other support services.

Links to the justice system and police

Clients experiencing gender-based violence, except minors, are often referred to a particular lawyer for legal assistance. Support is also provided to the client in preparation for court proceedings. If the client is a minor, the case is referred to the Child Care Board.

B. SOCIAL SERVICES

As stated previously, the majority of cases of gender-based violence are unreported. While there are a variety of reasons for this, it is thought that the absence of comprehensive gender-based violence response mechanisms is a key factor. While the primary health-care system remains the central focus of this research, examining the linkages to social services is a major objective. As previously stated, the institutional linkages between the primary health-care system and social service agencies in Barbados are not strong. However, the inclusion of social service agencies in the research design is essential given their mandate to provide support to vulnerable populations, including survivors of gender-based violence. The rationale for inclusion of these agencies in the study is twofold:

- ❖ To examine the institutional linkages/relationship to the primary health-care system, with regards to gender-based violence specifically;
- ❖ To examine the internal institutional approach taken by social service agencies to addressing gender-based violence.





The following agencies were included in the study in this regard:

- a) Barbados Welfare Department;
- b) Child Care Board;
- c) Business and Professional Women Association.

A) BARBADOS WELFARE DEPARTMENT

The Barbados Welfare Department is mandated to “provide professional social work services for the resolution of individual and family problems, the enhancement of personal and social development and the alleviation of poverty”. It is the social service agency of the Government and provides assistance through two main programmes: the Family Services Division and the National Assistance Unit.

Family Service Division

The Family Service Division is the arm of the Department tasked with providing social work services. The problems it addresses include:

- ❖ Family maintenance;
- ❖ Marital dysfunction;
- ❖ Domestic violence;
- ❖ Conciliation matters;
- ❖ Custody/ access disputes;
- ❖ Multi-problem families;
- ❖ Limited legal aid for domestic disputes.

It is also responsible for the “Fatherhood Initiative”, which provides counselling for fathers on parenting and care-giving.

National Assistance Unit

The National Assistance programme provides monetary and in-kind assistance, the latter of which includes food vouchers, clothing and miscellaneous supplies. It also provides educational assistance, grants for school uniforms, assistance with rent and utilities and necessary items such as hearing aids, spectacles and dentures. Rental assistance support is only provided for ongoing rent obligations. The programme operates through each parish with geographical divisions in St. Michael, Rural North and Rural South.

Monetary grant assistance is provided for a 26-week period and is terminated unless a review is conducted with a recommendation for renewal of support.

Overview of services and institutional approach to gender-based violence

As stated previously, the Family Services Division does provide services specifically addressing gender-based violence. A questionnaire was administered to the Welfare Department to ascertain the nature of these services. Based on the responses, it would seem that the Department’s assistance is mostly in the area of counselling. The responsibility for reporting, similar to the primary health-care system, is on the victim.

Staff members have received training on gender-based violence, specifically on domestic violence laws, community sensitization strategies and child counselling. The Government provides resources for this training. However, more training and sensitization at all levels is recommended as the Welfare Department is expected to comprehensively deliver services that meet the needs of victims in a holistic manner. It collects evidence on incidents/ assaults related to survivors of gender-based violence that is subsequently included in a written statement. Such clients are examined in a private consultation room and are assessed during initial and subsequent interviews with social welfare workers. The Welfare Department typically refers cases involving children to the Child Care Board. With regards to confidentiality, the institutional policy covers all clients, and staff have signed an official “Secrecy Act”.

Many clients of the Welfare Department have experienced or currently experience violence. A study on child support in Barbados funded by the United Nations Development Fund for Women (UNIFEM) revealed that domestic violence was a common feature





among a sample of women receiving National Assistance (UNIFEM 2006). What is notable is that the services offered by both the Family Services and National Assistance programmes are not gender-specific in their design, according to the study.

Records

A manual system is used for records in the Welfare Department. Information in the records of victims is used as testimony in court cases and to track the progress of clients. This shows a level of institutional linkages with the justice system, but not with the health-care system, which was not mentioned or referred to in the responses.

Screening

The Department screens clients for gender-based violence, specifically physical battery, sexual assault and mental/ emotional abuse. This screening process occurs at initial visits.

Counselling services

The Department refers clients experiencing gender-based violence for trauma/ psychological counselling “all of the time” and provides this services directly to clients “most of the time”. However, no staff member has been trained specifically to offer counselling related to gender-based violence.

Referrals

The Department relies heavily on referrals. Clients identified as victims of gender-based violence and who are minors are usually referred to the Child Care Board and other social service agencies. Adult clients who report gender-based violence are referred to the police.

Links to the justice system and police

Clients are regularly referred for legal aid, specifically to Community Legal Services and two lawyers. The agency provides “moral and spiritual support” and “financial assistance” to clients as they seek redress through the court system. Capability assessments are

also undertaken and provided to the judicial system for cases related to gender-based violence. However, even though clients are referred to the police, most never actually report.

Inter-sectoral collaboration

Although the respondent stated that the relationship with the primary health-care system is “good”, it is evident that there is little collaboration between the institutions. The manner in which gender-based violence is addressed by the Welfare Department indicates that related health concerns (including sexual and reproductive health and mental/ emotional issues related to violence) are not integrated into the management of and response to victims’ needs. Institutional relationships with the Bureau of Gender Affairs (the national gender machinery) and NGOs that directly serve victims of gender-based violence also appear to be limited.

B) THE CHILD CARE BOARD

Violence against children is unfortunately part of the cultural fabric in the Caribbean. Consequently, this research would be incomplete without addressing institutional approaches to addressing this issue.

The Child Care Board is the governmental agency mandated to perform the child protection functions of the state. The Board’s mandate includes a child protection function that covers situations related to gender-based violence.

Overview of services and institutional approach to gender-based violence

Five Child Care Officers, four of whom are women, comprise a Child Abuse Team that is specifically assigned to manage gender-based violence cases. Eighteen other Child Care Officers can also be called upon to address child abuse cases. No formal training in the area of gender-based violence has been provided, according to the respondent.





The Child Care Board has specific protocols/guidelines on gender-based violence that were developed in 1982 and revised in 1997. The protocols are available in manual form and are generally accessible to staff. They are not, however, accessible to the public. There is no national protocol on child abuse that would provide guidance to service providers on detecting and responding to violence against children. However, such a protocol is currently being developed.

Procedure for managing child cases of sexual violence or assault

The step-by-step procedure taken by the Child Care Board when handling cases of sexual violence is as follows:

“For referrals, the Queen Elizabeth Hospital alerts the Child Care Board. The child is admitted to the hospital ward where a Child Care Board Officer and Social Workers visit and meet with the child and parents. A “care plan” is developed depending on the age of the child. If the perpetrator lives in the home and cannot be removed, arrangements are made with the mother to move from the home.”

Implicit in the above statement by the respondent is the assumption that the mother is rarely the perpetrator or not sanctioning the abuse.

In “walk-in” cases, that is, cases where a child reports directly to the Child Care Board that he or she has been abused, the child is referred to the hospital for a medical examination where a doctor will administer post-exposure prophylaxis (PEP) if sexual assault is known to have occurred 24–48 hours prior to admission. PEP is not guaranteed if the medical examination takes place in a private clinic or hospital. After the medical examination, the matter is referred to the police and a risk assessment is carried out to evaluate the safety of the home environment. If the home is deemed unsafe for the child, the homes of other family members,

guardians and community members are assessed to see if they are suitable. Foster care is also explored if the family or community environment is unsafe. If foster care is not available, the child is placed in a residential care centre (children’s home).

The protocols do not appear to include HIV/STI prevention and treatment or emergency contraception.

Procedure for managing child cases of non-sexual abuse (i.e. physical battery):

The respondent said that:

“If severe, the child is removed. A “time out” period may be required in order to give other agencies time to work on the case. The child may be placed in a home [if severe].”

The “time-out” period refers to a short period of time provided to all parties involved to “calm down” and allow for counselling and assessment while the child is removed from the home. Information on injuries is recorded on an Injuries Assessment form specifically designed for this purpose. Completion of this form is required if the child reports with visible injuries.

In cases of mental/ emotional abuse, the Child Care Board refers the child for counselling (see below).

Records

Clients’ records are kept in computerized files and also manually. There is a computerized intake system. These records are kept indefinitely. Child Care Officers and senior personnel within various departments have access to the records/ confidential information related to cases of gender-based violence.

Records related to gender-based violence are sometimes shared with other agencies that provide services to victims including the police and Community Legal Service (which provides legal aid).





Counselling services

The Child Care Board offers counselling to clients on gender-based violence and sometimes, depending on the severity of the case, refers clients for trauma/ psychological counselling to the Child Guidance Clinic at the Psychiatric Hospital.

Referrals

The Board refers clients mostly to other social service agencies, the Church and the police. The respondent said that follow up is done with clients.

Links to the justice system and police

The Board refers clients (minors) for legal advice/ support, although there are no formal arrangements in place with law firms or Community Legal Services. The agency continues to provide support to clients and to the court system through the provision of testimonies and case reports/ statements.

Inter-sectoral collaboration

The respondents said that meetings take place between the Board and the police at least twice a year and monthly with health-care and social services agencies to discuss child abuse cases. The respondents also said that institutional collaboration with the court system and the Bureau of Gender Affairs was good. However, interaction with both appears to be limited as the respondent could not indicate how frequently they met to discuss issues specifically related to gender-based violence. Institutional collaboration with civil society, including women's or men's groups, is infrequent. The relationship with churches was reported as "good".

C) BUSINESS AND PROFESSIONAL WOMEN'S ASSOCIATION

Shelters and crisis centres have been the cornerstones of programmes for survivors of gender-based violence, particularly in developed countries. Shelters typically provide support groups, counselling, job training, childcare, coordination assistance

with social/ welfare services, legal issues and referrals for treatment. In Europe and the United States, women activists took a lead role in setting up these shelters, many of which are now staffed with trained professionals and receive government assistance (Krug et al. 2002).

Operating shelters has generally been a major challenge in developing countries. The expense of maintaining them has been used as a reason for avoiding them, with many countries setting up telephone hotlines or non-residential crisis centres instead. Another approach has been to set up informal networks of "safe homes" where neighbours or communities can volunteer their homes or community centres or places of worship as temporary shelters and sanctuaries from violent partners.

The Business and Professional Women's Association, a women's NGO, operates a Crisis Centre and the only shelter for survivors of gender-based violence in Barbados (set up and funded by the Government). Institutional linkages and relationships with other key stakeholders are therefore critical.

Overview of services

The Crisis Centre and domestic violence shelter have a staff of 35, most of whom are women. The shelter also receives assistance from a small number of volunteers. The Crisis Centre provides counselling and public sensitization on issues related to violence against women and also helps survivors with accessing social services and legal assistance. As the sole provider of shelter assistance for survivors of gender-based violence, the Crisis Centre plays a vital role.

Given the mandate of the organization, it comes as no surprise that the staff have received training in gender-based violence, which was provided from 2006–2008. Only trained staff are assigned to manage cases involving gender-based violence. While there





is no specific budgetary allocation for training, donor agencies and the private sector have provided support.

Sensitivity to the needs of survivors is reflected in the manner in which cases are handled. Case management is reliant on taking written statements and using case forms that capture the necessary data. Importantly, there appears to be institutional collaboration with key agencies such as the police and Community Legal Aid.

Existence of protocols/ procedures/ guidelines

The Crisis Centre has a protocol for victims of gender-based violence that was developed and implemented in 1999. It is accessible only by staff and not the public because of confidentiality and protection of staff and clients from perpetrators who may be “seeking revenge”, according to the respondent.

The protocol, based on the response to the administered questionnaire, appears to be response-driven and covers the following areas:

- ❖ Reporting gender-based violence crimes to the police;
- ❖ Pressing charges against perpetrators (if known);
- ❖ Taking a medical exam;
- ❖ HIV testing;
- ❖ Contraceptive use and pregnancy testing;
- ❖ Emergency contraception;
- ❖ Pregnancy risk from gender-based violence;
- ❖ STI treatment.

Records

Staff of the Crisis Centre and counsellors are responsible for collecting data on gender-based violence. These persons have received training in gender-sensitive data collection. The data are mostly used to compile reports for the Government at the end of the year, to share information with the media and by researchers.

The President of the Business and Professional Women’s Association and shelter staff have access to case records, which are sometimes shared with other agencies including the police or Community Legal Services. Records are kept for nine years.

Screening

Clients are screened at the Crisis Centre for physical battery, sexual assault and mental/emotional abuse. Screening takes place at initial visits, annual non-gynaecological visits, regular check-ups, when victims present with physical injuries and “shelter” house meetings. Only adult clients are screened.

Counselling services

Counselling is routinely provided in the Crisis Centre due to the trauma experienced as a result of the abuse/violence. As noted above, staff and volunteers have been trained in counselling.

Referrals

Referrals are often made to other agencies including other NGOs, social services, legal aid and the Child Care Board. According to the respondent, follow up is usually done. Links to the justice system and police The respondent said that 50–79 per cent of clients of the Crisis Centre report to the police. The relationship with the police was described by the respondent as “good”.

Inter-sectoral collaboration

With regards to other agencies and sectors, questions were asked about the nature of these institutional relationships and the frequency of meetings to discuss gender-based violence. The respondent said that the relationship with most organizations that provide services to survivors is good. According to the respondent, the Crisis Centre has a working relationship with the Gender Bureau.

Confidentiality

There is a confidentiality policy in place at the Crisis Centre that covers all clients. There





is also a specific confidentiality policy for gender-based violence. Staff are barred from disclosing any information about clients, and there are penalties in place for both clients and staff in cases of confidentiality breaches.

C. THE POLICE AND THE JUSTICE SYSTEM

a) The Police Department

The critical role of the police cannot be emphasized enough when addressing the needs of survivors of gender-based violence. Ensuring women’s safety is essential to enable them to exercise their rights to freedom from violence, and “duty-bearers” – which include service providers such as the police – must hold victim safety and protection as paramount. Perpetrator accountability is also just as important, and the police bear responsibility for this as well.

Three police stations and the Criminal Investigation Department were included in

the scope of the research.

Overview of services and institutional approach to gender-based violence

The police have been the beneficiaries of several training and capacity-building initiatives on gender-based violence provided by women’s NGOs and inter-governmental organizations. The findings of this research show some increased awareness by the police of women’s vulnerability to violence, especially to sexual violence. However, there is a need to strengthen awareness and response mechanisms related to gender-based violence in order to reduce the significant burden on survivors to address these violations. Outlined below are the step-by-step procedures taken by the police in relation to adult cases of gender-based violence.

STEP-BY-STEP PROCEDURE FOR MANAGING ADULT CASES OF SEXUAL VIOLENCE OR ASSAULT

NAME OF STATION	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Police Station	Statement taken by a female constable, victim examined by police doctor, referred for counselling (case dealt with by female constable)	Station Sergeant
Criminal Investigation Department	Statement taken, examined by police doctor, referred for counselling, perpetrator arrested if identified	Superintendent
District A Police Station	Full statement on the incident taken, client examined by police doctor	Station Sergeant
District C Police Station	Patrol sent to get person to station, female officer interviews client; if perpetrator identified, male inspector arrests him	Station Sergeant



STEP-BY-STEP PROCEDURES FOR HIV AND STI PREVENTION AND TREATMENT AND EMERGENCY CONTRACEPTION IN SEXUAL VIOLENCE OR ASSAULT FOR ADULTS

NAME OF STATION	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Police Station	Tests carried out for STIs, HIV, AIDS and pregnancy	Station Sergeant
Criminal Investigation Department	Tested for STIs, HIV and pregnancy	Superintendent
District A Police Station	Tests carried out for STIs, HIV, AIDS and pregnancy	Station Sergeant
District C Police Station	Client tested for STIs and pregnancy	Station Sergeant

STEP-BY-STEP PROCEDURE FOR MANAGING ADULT CASES OF NON-SEXUAL PHYSICAL VIOLENCE OR ASSAULT

NAME OF STATION	STEP-BY-STEP PROCEDURE	RESPONDENT(S)
Black Rock Police Station	Evidence/ statement is taken, assessment of injuries made, given police report to take to the doctor	Station Sergeant
Criminal Investigation Department	Statement taken, examined by police doctor, referred for counselling, perpetrator arrested if identified	Superintendent
District A Police Station	Statement on incident taken, client questioned as to the course of action they want the police to take	Station Sergeant
District C Police Station	Report completed, victim referred to relevant agencies, perpetrator charged if identified	Station Sergeant



With regard to sexual violence, there is an assumption, as seen in the responses of some of the respondents above, that the victims are women, hence the emphasis on case management by female constables. There is also a more pronounced level of consistency in the approach taken by police stations to obtaining a written statement and examination by the police doctor and the tests carried out for STIs, HIV, AIDS and pregnancy. This may or may not be due to required procedures that must be followed in responding to alleged criminal offences. These procedures play a part in removing individual discretion and allow for the consistency that is necessary for the collection of evidence, investigation and, if the perpetrator is identified, arrest.

Non-sexual cases do not appear to be addressed with the same consistency when compared to the sexual violence cases. Apart from obtaining statements, there is variance in the approach to addressing these cases across the police stations. In Black Rock, once the statement and evidence is taken, the client is referred to the health-care system. In District A, the client is required to advise the police on the next course of action to take. In District C, once the report/ statement is completed, there might be referrals to other agencies and charges brought against the perpetrator. The variance in the approaches might therefore allow more discretion by the parties involved as there are no official protocols for addressing these crimes.

Cases involving minors are referred to the Child Care Board. Mental/ emotional abuse cases are referred to the Psychiatric hospital.

Records

Records on gender-based violence are kept manually and also electronically, and the Station Sergeants and the Superintendent have access to them. These records, including the police reports, are relied on for evidence if the cases reach the court system.

Counselling services

The police perform a counselling role to survivors of gender-based violence and also refer clients to other agencies for these services. Training has been provided on counselling related to gender-based violence.

Referrals

In addition to the referrals for counselling, the police refer survivors to Community Legal Services and social service agencies including the Child Care Board.

Inter-sectoral collaboration

Institutional linkages are necessary for any monitoring or surveillance system for gender-based violence that might be developed. As such, it was important to ascertain from the police what institutional relationships exist with the other governmental and non-governmental agencies tasked with responding to survivors of gender-based violence.

As expected there is a strong institutional relationship with the following agencies based on the responses from the respondents interviewed:

- ❖ Child Care Board;
- ❖ Community Legal Services;
- ❖ Mental Health;
- ❖ Probation;
- ❖ Social Services.

The relationship with the primary health-care system does not appear to be as strong as with the abovementioned. It should be noted that referrals to the health-care system may be as a result of an emergency related to cases such as rape or physical battery. The majority of these referrals would go to the Queen Elizabeth Hospital, which provides emergency care, and not the polyclinics, which provide primary health care.

While there are no official guidelines for gender-based violence specifically, there are established procedures for the following;





- ❖ Pressing charges against perpetrators;
- ❖ Taking a medical exam;
- ❖ HIV testing;
- ❖ Contraceptive use and pregnancy testing;
- ❖ Emergency contraception;
- ❖ Pregnancy risk from gender-based violence;
- ❖ STI treatment.

B) COMMUNITY LEGAL SERVICES

Community Legal Services is entrusted with the critical mandate of providing legal assistance to those citizens who would otherwise not be able to afford this. The staff of the agency is small and comprises five administrative staff, two lawyers and two means officers/ paralegals. All the staff are female except for one male lawyer and the Deputy Director, who is specifically assigned to handle gender-based violence cases.

Overview of services and institutional approach to gender-based violence

Approximately 50 per cent of cases handled by Community Legal Services relate to persons seeking protection orders in cases of domestic violence. This indicates a high demand for legal assistance from survivors in seeking redress through the justice system.

Community Legal Services therefore interacts frequently with survivors, the police and the court system in assisting clients with court matters related to gender-based violence. However, none of the staff has received training on gender-based violence specifically and there are no discrete funds allocated to address these types of cases.

Existence of protocols/ procedures/ guidelines

Community Legal Services does not have any protocols, guidelines or procedures specifically addressing gender-based violence.

Records

Data are regularly shared with other agencies including the police, according to the

respondent. Case records are kept for as long as the matter remains active.

Referrals

Referrals are made when necessary to lawyers outside of Community Legal Services. Clients are also referred to social services agencies, NGOs, the Child Care Board and the Crisis Centre.

Links to the justice system and police

Understandably, Community Legal Services has a strong institutional relationship with the police and the courts, given the agency's mandate. When asked to describe the relationship with both sectors, the respondent said the relationship with the police was "excellent". With regard to the court system, the relationship with the Magistrates Court was said to be "fair" and with the High Court "excellent".

Inter-sectoral collaboration

Collaboration with social service agencies, civil society (including women's organizations) and faith-based organizations was said to be "fair". Collaboration with the health-care sector also does not appear to be strong as there is infrequent interaction with the sector.

C) PROBATION DEPARTMENT

The Probation Department plays a critical role in justice administration and reducing criminality. The programmes of the Department are designed to encourage the prevention and reduction of juvenile delinquency and criminal behaviour. It therefore interfaces regularly with clients who have come into conflict with the law. While perpetrators of gender-based violence are not referred to the Department, its role in the justice system with regard to perpetrators and approach to criminality and rehabilitation warranted its inclusion in the research design.





Overview of services and institutional approach to gender-based violence

The Probation Department plays a major role in offering counselling to clients and provides a support function to the court system through the preparation of probation reports. There are two programmes that are designed specifically to address the needs of young girls and men: the “Girls’ Circle” and “As Man”. The Girls’ Circle brings together young girls in conflict with the law and/or with behavioural problems. The programme provides an opportunity for them to receive counselling within a group setting. The “As Man” programme addresses anger issues related to masculinity. While these two programmes do not specifically deal with gender-based violence, they are gender-specific and are tailored to respond to the needs of the target groups.

Referrals

The Probation Department sometimes refers clients to other social service agencies and NGOs, but not on a routine basis.

Inter-sectoral collaboration

Given the agency’s mandate, there is a strong institutional relationship with the police and court system. Institutional linkages with civil society and the health-care system are not strong, which again is to be expected given the specific focus of the agency on preventing and reducing criminal behaviour.

D. OTHER KEY STAKEHOLDERS

a) Men’s Educational Support Association

Women’s organizations have taken the lead role in advocating for accountability and justice for survivors of gender-based violence. Increasingly, the role of men in preventing gender-based violence has been viewed as important. The Men’s Educational and Support Association (MESA) provides counselling and advice mainly to men. It

offers a forum for men to share experiences and ideas. MESA’s members are all volunteers and are all male.

MESA’s role in addressing gender-based violence is to provide counselling and referral support for its members. The respondent interviewed said that MESA’s relationships with the justice system, the Gender Bureau and women’s organization were poor. There was a non-existent relationship with the Crisis Centre that provides shelter support to victims, the majority of whom are women.

b) Anglican Diocese

People’s spiritual and/or religious beliefs can often determine the choices and decisions they make. This is no different for survivors of gender-based violence. Furthermore, the majority of Barbadians are Christians and most of them are Anglican. With this in mind, it was important to ascertain the role of the Anglican Church in addressing gender-based violence in the country.

In addition to general church services, the Anglican Diocese provides the following services:

- ❖ Counselling;
- ❖ Education -- specializing in HIV and AIDS;
- ❖ Outreach programmes – breakfast programme, homework programme;
- ❖ Advocacy;
- ❖ Referrals to other organizations;
- ❖ Support, spiritual guidance.

The respondent interviewed said that staff of the Diocese who address gender-based violence do so on a voluntary basis. They have received formal training in gender-based violence in the following areas:

- ❖ Domestic violence laws;
- ❖ Children’s rights;
- ❖ Community sensitization strategies;
- ❖ Gender-based violence/ gender issues;
- ❖ Male gender-based violence issues;
- ❖ Female gender-based violence issues;





- ❖ Child counselling;
- ❖ Identification of gender-based violence.

The last training was provided in 2006/2007. There is a confidentiality policy although not one specifically for gender-based violence. Clergy or staff of the Diocese who violate this confidentiality can lose the license to serve; the consequences for breaches in privacy and confidentiality are determined by the Bishop.

The Diocese refers survivors to legal services and to a particular law firm. The Synod has two officers who are legally trained and who are also able to offer support in this regard. Moral and spiritual support is provided to survivors along with financial assistance and counselling. With regards to survivors who are minors, these cases are referred to the Child Care Board and also the police and some magistrates.



RECOMMENDATIONS

Governments, as agents of accountability, have an obligation to ensure that human rights are protected and promoted. This obligation extends to all spheres, public and private, within and outside the home. Consequently, intervention in personal relationships to prevent and/or respond to violence is a state obligation. Within the context of this research, it is clear that service providers (duty-bearers) are in need of support to develop or strengthen the skills necessary to identify and respond to gender-based violence. Institutional strategies within and between agencies need to be developed to assist with this process and to progress towards a comprehensive multi-sectoral response.

This recommended process of institutional transformation will require changing the mindsets of service-providers in terms of their perception of and how they handle cases of gender-based violence. It requires changing whom they view as responsible for addressing this violence and what roles the victim, the service provider, the perpetrator and the community have to play in ending it. This process will therefore require addressing social and cultural norms and practices that inform the behaviours and thought processes of service providers. It will require removing the cultural, social and economic barriers that prevent the victims of gender-based violence (the majority of whom are women) from enjoying their rights to a life without violence. It is understandable that, as members of the community themselves, service providers' perceptions of gender-based violence are informed by cultural norms. However, if these cultural norms and practices are harmful and prevent victims of gender-based violence from receiving assistance, cultural change will be necessary. As seen in the diagram below, cultures, values and traditions directly affect community institutions and agencies (governmental and non-governmental) that provide critical services to the population and who are also duty-bearers. These include the social services, the police, the health-care system, the courts, the media and religious institutions, among others. The manner in which these institutions address the needs of victims can have



a positive or negative impact on women's ability or inability to exercise their right to freedom from violence.

A. General recommendations

During the research process respondents were asked to provide recommendations regarding what resources were needed, in their view, to assist them in addressing gender-based violence. The responses mostly reflect a need for training on the issue, for gender-sensitive data collection and for improved victim support services (see Annex 2).

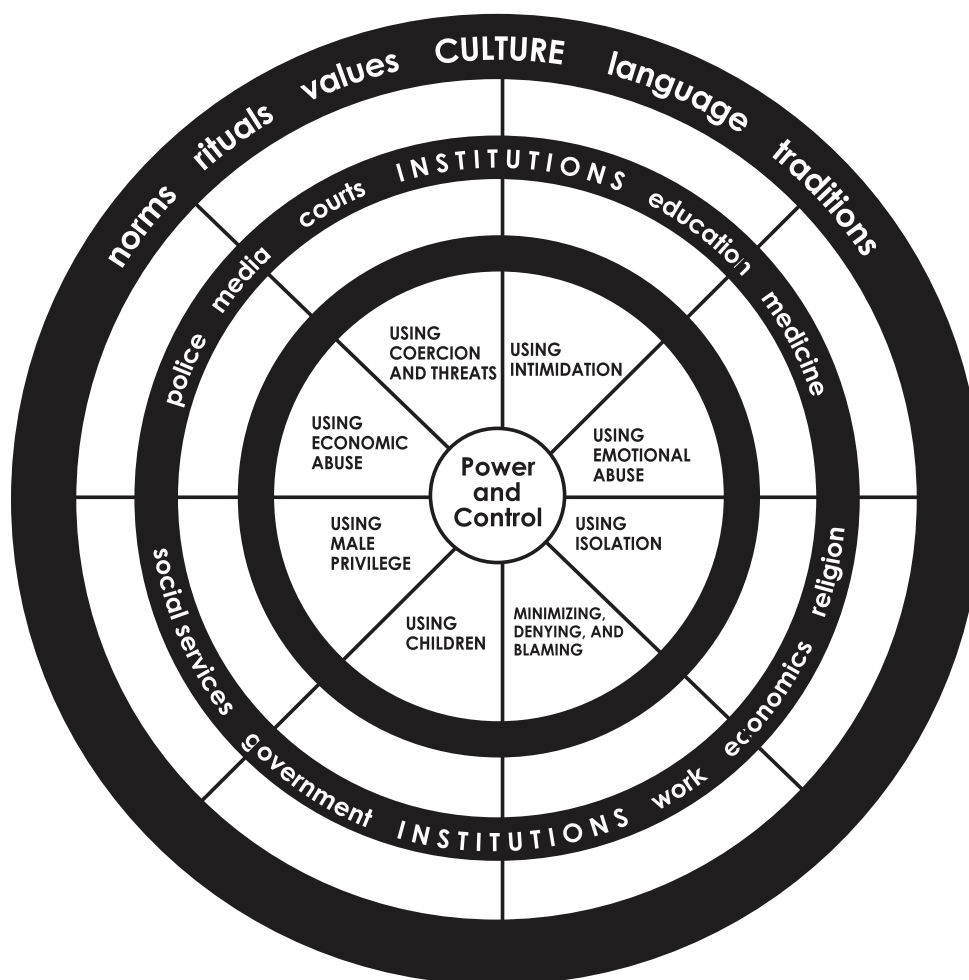
The following recommendations, in addition to those proposed above, are suggested for an

integrated and comprehensive multi-sectoral approach to preventing and responding to gender-based violence in Barbados.

A) CENTRALIZE HUMAN RIGHTS AND VICTIM SAFETY IN INSTITUTIONAL APPROACHES

The research revealed that the burden of reporting gender-based violence in Barbados lies with the victim. There is a need to shift this responsibility to community and government institutions. As noted previously, this would require changes in the mindsets of service-providers, which would be reflected in the way they manage gender-based violence. These changes have to take place

POWER & CONTROL WHEEL



Source: Domestic Abuse Intervention Programs 2008.





with all service providers in order to ensure coherence and a move towards comprehensive and integrated responses that involves law enforcement, the justice system, education, social welfare, health and civil society and guarantee the full exercise of the right of all persons to freedom from violence and to gender equality.

B) DEVELOP PROTOCOLS AS PART OF AN INTEGRATED AND MULTI-SECTORAL APPROACH

The reliance on individual discretion to guide the response to gender-based violence does a disservice to survivors and creates barriers to the enjoyment of their right to a life without violence. This is because the power to decide what kind of assistance (if any) survivors receive lies with the service provider. Furthermore, the institution can avoid the obligation to provide adequate services to victims in the absence of protocols that necessitate a response. Reliance on individual discretion leaves the survivor powerless in this context.

Unsurprisingly, the agencies/ institutions that have received training on gender-based violence demonstrate a higher level of sensitivity to the needs of survivors than those that have not. Due to the absence of protocols, however, there is no guarantee that this sensitivity will remain if there are changes in personnel. What the research has also shown is that training alone, while necessary, is not sufficient. In order to ensure that comprehensive access to assistance is provided to survivors of violence, protocols and guidelines must be developed to guide service providers. Importantly, these protocols become part of the modus operandi of the institution, thereby minimizing individual discretion, obligating an adequate response from the service provider and empowering the survivor.

C) DEVELOP AND STRENGTHEN NETWORKING AMONG SERVICE PROVIDERS

This research has shown that institutional collaboration and communication between service providers is needed. Interagency agreements to strengthen coordination between law enforcement, social service providers, the health-care system and other governmental and non-governmental agencies responsible for victim support are recommended. These agreements would facilitate dialogue and cooperation between agencies, thereby leading to a comprehensive response to the needs of survivors of gender-based violence, as is their right.

D) STRENGTHEN MONITORING AND TRACKING SYSTEMS WITHIN AND BETWEEN SERVICE PROVIDERS

As duty-bearers, service providers should be provided with the tools necessary to monitor and assess cases of gender-based violence.

Monitoring systems allow for an assessment of how cases are managed and the nature of the response, which is necessary for ensuring accountability.

Monitoring systems can be utilized at both macro (policy) and micro (individual) levels (Shepard and Pence 1999). Macro-level monitoring and tracking systems can be used to assess the status of cases and their movement through, for example, the health-care, criminal justice and social services systems. This can provide critical information on the nature and status of the response to cases of gender-based violence and identify strengths and weaknesses. It can be utilized by community-based service-providers to track cases and to guide their response to victims. When social workers, police officers or health-care providers can access information that provides complete and updated information about a case, their response is enhanced at the community level.



E) ENHANCE SUPPORTIVE COMMUNITY INFRASTRUCTURE FOR SURVIVORS OF GENDER-BASED VIOLENCE

Survivors of gender-based violence need access to community resources such as shelters, long-term housing, financial assistance, legal aid and counselling as well as childcare services for those who are mothers or guardians. This research revealed that while some of these services exist in Barbados, most are not gender-sensitive or tailored to respond to the needs of victims. To illustrate, the requirement that welfare assistance for rent is only offered in cases of “ongoing rental obligations” could prove problematic for a victim of gender-based violence who resides with an abusive partner and who may have to sacrifice rental assistance if she leaves to seek shelter elsewhere. As most clients of the National Assistance programme of the Welfare Department are poor, this could leave the victim without access to alternative shelter assistance. The abuser could be removed from the residence only if it can be proved that he is a danger to the other inhabitants in the residence and a Protection Order is granted, which may take considerable time. It is possible for a “special case” to be made for such a victim, but this leaves the welfare officer/ social worker with considerable discretion unless protocols are developed to specifically ensure emergency shelter assistance for victims.

The research also revealed that interagency communication and collaboration is weak. Many social service agencies are short-staffed and have heavy caseloads, which pose significant barriers to adequate service delivery. These resource challenges need to be addressed and steps taken towards making the services gender-sensitive as most do not take into account the differential needs of women and men.

F) ENHANCE INTERVENTIONS WITH PERPETRATORS OF GENDER-BASED VIOLENCE AND ON MASCULINITY

Gender inequality and existing cultural norms that encourage “hyper-masculinity” and objectify women need to be addressed in interventions aimed at eliminating gender-based violence. Batterer intervention programmes are one way to ensure that perpetrators of violence are held accountable and are also given an opportunity to change their behaviour. Educational programmes and advocacy initiatives aimed at working with young men and boys on gender equality and violence prevention can also result in socio-cultural change towards an acceptance of peace and rejection of violent masculinity. Ultimately, addressing gender-based violence requires change at individual, institutional and societal levels. As part of a comprehensive approach to addressing gender-based violence, working with perpetrators and with men will be necessary.

G) ENHANCE COORDINATION WITH THE BUREAU OF GENDER AFFAIRS

As the national gender machinery, the Bureau of Gender Affairs can play a vital role in advancing gender equality and in developing policies related to gender issues. The research revealed a need for training and sensitization on gender equality and gender-based violence, which the Bureau is well placed to provide. Furthermore, the development of national policies and protocols on gender-based violence will require technical assistance and support from the Bureau.

B. Recommendations for the primary health-care sector

a) Provide training on human rights and gender-based violence for health-care professionals

One clear barrier to the provision of adequate care to victims of gender-based violence is that health workers themselves lack the knowledge and skills necessary to





identify and possibly treat these cases, as was evidenced by the research findings. Health-care providers must be trained to respond to disclosures of violence in an appropriate manner while ensuring privacy, confidentiality and support for survivors. They must have the knowledge to respond and should be provided with the tools to strengthen their capacity in this regard. In order to create an enabling environment that is responsive to the needs of survivors, health-care professionals must be fully aware of the dynamics of violence as a violation of human rights that undermines the attainment of positive health outcomes. The research showed that there is a need for training on gender-based violence and a need for health-care professionals to view all clients as rights-holders. The Bureau of Gender Affairs is well placed to provide this training.

Facilitating institutional change towards a rights-based service-delivery framework requires sensitization and training. This would require that health-care professionals – the duty-bearers responsible for ensuring the best health outcomes for clients – are sensitized to the specific needs of the most vulnerable, including women. As most victims of gender-based violence do not report these violations, the burden should not be on them to reveal abuse. Processes requiring attitudinal and behaviour change hinge on socio-cultural transformation. Training and sensitization in human rights, in order to promote the highest standard of health as a right to be enjoyed by all, would be essential.

As noted previously, the PHC strategy recognizes that health is socially determined and that poor health outcomes (including those resulting from gender-based violence) are more often than not caused by unequal power relations between those who are privileged and those who are marginalized. This recommended training in human rights and gender-based violence would enable health-care professionals to detect

violations and respond adequately to victims. Furthermore, increased sensitivity and awareness of these issues would lead to responsive service delivery to which victims are entitled and that is necessary for their attaining the highest standard of health.

b) Develop protocols on gender-based violence and primary health-care as part of an integrated and multi-sectoral approach

As already discussed, the research revealed that there are no clearly defined protocols (formal or informal) on the management of cases of gender-based violence within the health-care sector. Health-care personnel are not mandated to prevent, treat and manage such cases with any urgency, and no special conditions apply to these cases. It is left up to the discretion of the attending physician to treat cases of gender-based violence either with urgency or as regular clinic visits. There is a need for guidelines to be developed to assist health-care professionals to adequately diagnose and respond to gender-based violence.

The development of protocols must be a multi-sectoral process as referral systems and inter-agency data and knowledge exchange are critical to ensuring optimal case management. Heise et al. suggest reforms throughout the agency or organization (in this case the primary health-care system), including changes in procedures and systems, norms, policies and protocols, infrastructure upgrades to ensure private consultations, creation of referral networks, and strengthening the ability of staff to provide emergency assistance such as danger assessment, safety planning, emotional support, STI prophylaxis and emergency contraception (Heise, Ellsberg and Gottemoeller 1999). This is in response to the observation that stand-alone policies rarely produce long-term changes in quality of care for survivors of violence unless there is system-wide reform. The following are therefore recommended as critical components of a protocol:



(i) Provide routine enquiry/ screening of clients for violence

Professional health-care workers must be trained to screen individuals for gender-based violence on a routine basis while conducting intake interviews. This should be considered part of standard care. It is now generally accepted that screening is necessary in order to respond adequately to the needs of victims in health-care centres. Current intake forms can be revised to incorporate questions on abuse and can be used to alert nurses and doctors as to the cases in need of special intervention.

Routine enquiry requires asking all clients direct questions about their experiences whether or not there are signs of abuse. As noted earlier, most victims of gender-based violence will not disclose their experiences of abuse without being asked directly. It is also important to note that victims may not bear physical symptoms/ signs of abuse. Routine enquiry also has several other advantages:

- ❖ It contributes to changing social attitudes to gender-based violence.
- ❖ It is less likely to make women experiencing violence feel stigmatized as all women are targeted, not just those who are suspected victims.
- ❖ It is less likely to compromise the safety of gender-based violence victims as all clients are targeted.
- ❖ Health-care professionals report that their perceptions of which women were victims and which were not were often incorrect. (*Home Office 2004*)

The primary health-care setting (particularly general practice) is also the best setting for ensuring that all victims are likely to be reached and provides an appropriate entry point for screening.

(ii) Ensure inter-agency collaboration

Formulating and implementing health-care protocols must incorporate inter-agency collaboration with involvement from

community-based organizations and other governmental and non-governmental institutions, such as legal aid, criminal justice institutions, the police, women's groups, social welfare and social services. This collaboration of networks can improve the range and quality of services available to and accessible by victims of gender-based violence in a comprehensive manner.

The Duluth Model, recognized internationally as a leading tool to assist communities in eliminating gender-based violence, emphasizes a victim-centred approach that prioritizes the needs of the persons experiencing abuse. As these needs are multi-dimensional and involve assisting the client with accessing legal, social welfare, counselling and financial assistance, among others, inter-agency collaboration is essential.

(iii) Establish a rights-based framework

Importantly, if policies and procedures are to be implemented, reference must constantly be made to the internationally recognized laws and standards that have been set out to govern the management of such issues, namely:

- ❖ Convention for the Suppression of the Traffic in Persons and Exploitation of the Prostitution of Others (1951)
- ❖ Convention on the Political Rights of Women (1954)
- ❖ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)
- ❖ Convention on the Rights of the Child (CRC) (1989)
- ❖ United Nations Declaration on the Elimination of Violence Against Women (adopted by the UN General Assembly in 1993)
- ❖ International Conference on Population and Development (ICPD) Programme of Action (1994)
- ❖ Beijing Platform for Action (agreed to at the United Nations Fourth World Conference on Women in 1995)
- ❖ Protocol to Prevent, Suppress and Punish





Trafficking in Persons, especially Women and Children (2003) [supplementing the United Nations Convention against Transnational Organized Crime]

There are several model protocols available. The UNFPA Sub-Regional Office for the Caribbean has developed a Medical Protocol specific to victims of sexual and child abuse that could complement a protocol to address all other forms of gender-based violence. It provides a step-by-step procedure for conducting an examination of a sexual abuse victim and provides critical information on STIs and pregnancy prophylaxis as well as helpful information on the dynamics of Rape Trauma Syndrome and the psychological impact of sexual abuse on children and adults.

The Ohio Domestic Violence Protocol for Health Care Providers could also be considered for replication as it addresses all forms of gender-based violence (Ohio Domestic Violence Network 2003). It was developed under the guidance of an inter-agency team comprising health-care professionals, advocates of survivors of domestic violence, social workers and women's organizations, which importantly reflects a multi-sectoral perspective. The protocol is rights-based and was developed with this approach as a fundamental principle.





C ONCLUSION

This research achieved its overall objective of providing key data and information to support policy reform aimed at strengthening the prevention, treatment and response to gender-based violence in the primary health-care system of Barbados. The findings reveal the need for the development of a rights-based service-delivery framework to comprehensively detect and respond to the needs of survivors of gender-based violence. The findings also reveal the need for a paradigm shift towards rights-based approaches within the health-care system and other agencies tasked with the responsibility to assist survivors. Promoting the understanding and acceptance of gender-equality is critical to this rights-based approach.

In conclusion, duty bearers, including health-care providers, have an ethical responsibility to adequately address gender-based violence. While the health-care system's responsibility, in this regard, must be shared with other sectors, a woman's visit to a health-care provider may be her only chance to receive support, care, and assistance with escaping an abusive relationship. Interventions aimed at strengthening the capacity of the primary health-care system in Barbados to address gender-based violence will require multi-sectoral efforts based on respecting, protecting and fulfilling the rights of women and all individuals to lives free from violence.





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Offences against the Person Act 1994, 1st September 1994

Prevention of Cruelty to Children Act 1904 (amended 1981)

Sexual Offences Act 1993

Young Persons Protection Act 1918



ANNEXES

ANNEX 1: List of persons interviewed

INSTITUTION	INTERVIEWEES	TITLE
Anglican Diocese of Barbados	Owen Estwick Eric Lynch	Diocesan Secretary Arch Deacon
Barbados Family Planning Association	Elrene Sealy	Assistant Executive Director
Black Rock Police Station	David Lewis	Station Sergeant
Black Rock Polyclinic	Phyllis Murrell	Senior Health Sister
Bureau of Gender Affairs	Patricia Boyce	Research Officer
Business and Professional Women's Association	Mary Thompson	President
Child Care Board	Desiree Jemmott Colin St Hill	Private Day Care Coordinator Child Abuse Coordinator
Community Legal Services	Jennifer Small	Deputy Director
Community Mental Health Services	Dr. Gajapathy Asokan	Consultant Psychiatrist
Criminal Investigation Department	Erwin Boyce	Superintendent
District A Police Station	Steven Griffith	Station Sergeant
District C Police Station	Elson Straughn	Station Sergeant
Glebe Polyclinic	Dr. Elliott Douglin Elma Payne	Medical Officer of Health Senior Health Sister
Men's Education and Support Association (MESA)	Ralph Boyce	Chairman
Probation Department	Donta Lovell	Chief Probation Officer
St. Philip Polyclinic	Judith Greaves Cassandra Grimes	Senior Health Sister Nurse
Sir Winston Scott Polyclinic	Dr. Ingrid Cumberbatch Mary Brathwaite	Medical Officer of Health Senior Health Sister
Warrens Polyclinic	Dr. Heather Harewood	Medical Officer of Health
Welfare Department	Cheryl Holder	Senior Welfare Officer for Family Services



ANNEXES

ANNEX 2: Comments from interviewees on equipment/ tools/ resources needed to better manage cases of gender-based violence

NAME	COMMENT 1
Anglican Diocese of Barbados	Education and training on gender-based violence
Black Rock Police Station	Statistical programming to disaggregate data into male/ female and to also profile cases
Black Rock Polyclinic	A template to include in the health information system, specific to gender-based violence, so information can be collected
Business and Professional Women's Association	A good tracking system
Child Care Board	Handouts on gender-based violence for dissemination
Community Mental Health Services	Training for assessment and counselling in gender-based violence cases or case management
Criminal Investigation Department	Database to disaggregate data
District A Police Station	Training for police officers to bring most of them in line with counselling services and certain aspects of social work and human behaviour
District C Police Station	Literature
Men's Education and Support Association (MESA)	Training
St. Philip Polyclinic	Counselling training
Sir Winston Scott Polyclinic	Training of personnel
Warrens Polyclinic	Protocols, training on protocols
Welfare Department	Computers



ANNEXES

ANNEX 2 CONTINUED: Comments from interviewees on equipment/ tools/ resources needed to better manage cases of gender-based violence

NAME	COMMENT 2	COMMENT 3
Anglican Diocese of Barbados		
Black Rock Police Station	Training in the area of gender-based violence	Improved resources for victims
Black Rock Polyclinic		
Business and Professional Women's Association	Computer program to track cases	Male personnel to assist with threatening cases
Child Care Board	Relevant audio/ DVD on child abuse with a Caribbean flavour	
Community Mental Health Services		
Criminal Investigation Department	Training on gender-based violence cases	
District A Police Station	24-hour availability of social services sector	
District C Police Station	Training	
Men's Education and Support Association (MESA)	Larger facilities	
St. Philip Polyclinic	Dedicated timeframes to deal with cases	Gender-based violence team
Sir Winston Scott Polyclinic	Database to accurately and efficiently capture and store information	
Warrens Polyclinic	Database system to capture information on gender-based violence	
Welfare Department	More in-depth training on gender-based violence issues	



NOTES







UNFPA Sub-Regional Office for the Caribbean/Barbados
UN House
Marine Gardens
Hastings
Christ Church

Tel: 246 467 6000 / 6135
Fax: 246 435 3243

