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# Assessing COVID-19 and Intimate Partner Violence Care in Jamaica: A Syndemic Approach

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2021

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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# Abstract

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**Background:** Since its emergence in late 2019, the novel coronavirus (SARS-CoV-2) has spread COVID-19 globally. Simultaneously, global health institutions have indicated that global rates of IPV are rising. There have been few studies on IPV in Jamaica in recent years, especially regarding IPV services and care at SRH clinics. Thus, there is a need to assess the impact of COVID-19 on critical IPV services and care, as told by healthcare providers in Jamaica.

**Methods:** This facilities-based study utilized a retrospective cross-sectional concurrent mixed method (qualitative and quantitative) to assess IPV services and care in the context of COVID-19 in Jamaica. In the summer of 2022, 29 in-depth interviews and 51 surveys with SRH providers were conducted in partnership with the AIDS Healthcare Foundation. The survey included demographics and the prevalence and availability of IPV screenings both before and during the COVID-19 pandemic. In-depth interviews asked participants to share their experience with service delivery prior to and during the pandemic as it related to IPV care. Descriptive and bivariate analyses were calculated from quantitative data using SAS software v.9.4. Qualitative interview data were fidelity checked, de-identified, and coded using a deductive codebook, thematic analysis, and a consistent comparative method via MAXQDA v.22.

**Results:** The data revealed three key themes: 1) IPV is a significant issue in Jamaica and providers believed it increased nationally during the pandemic, 2) infrastructural and social challenges led to inconsistent IPV screening, inadequate provider training, and insufficient privacy and confidentiality within clinics, and 3) a subsequent conflation existed between inconsistent screenings for IPV and perceived prevalence of it. Contrary to existing literature, participants identified challenges with IPV screening due to a lack of training, protocol, and space to do so privately rather than as a result of personal biases.

**Conclusion:** It is imperative to standardize comprehensive and validating care across the Jamaican health clinics to increase IPV case identification and ensure patients feel safe to disclose. Further, the MoH should focus on improving capacity, establishing IPV training programs, investing in onboarding psychosocial teams, and developing the infrastructure for private, confidential, and safe IPV care across health clinics.

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# TABLE OF CONTENTS

# FIGURES

# ACRONYMS/DEFINITION OF TERMS

**AHF** – AIDS Healthcare Foundation

**CDC** – Centers for Disease Control and Prevention

**CI** – Contact Investigator

**COVID-19** – COVID-19 is the disease caused by SARS-CoV-2, a coronavirus that emerged in December of 2019 and caused a pandemic of respiratory illness and millions of deaths around the world (Johns Hopkins Medicine, 2022). This project often denotes the "beginning of the pandemic," as March 2020, when physical distancing and lockdown mandates were implemented globally.

**DV** – Domestic Violence is defined by the United Nations as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner; it can be physical, sexual, emotional, economic, or psychological, and includes behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, or injure someone (United Nations, n.d.a). Respondents in the interviews used the terms DV and IPV interchangeably.

**GBV** – Gender-Based Violence refers to harmful acts directed at an individual that are rooted in gender inequality, abuse of power, and harmful norms – it includes sexual, physical, mental, and economic harm inflicted in public or in private (United Nations High Commissioner for Refugees, n.d.). GBV is an umbrella term that includes many forms of violence, but in the context of the Jamaican health care system, domestic violence is the primary form that is screened for and managed.

**HARK** – Humiliation, Afraid, Rape, Kick screening tool

**HITS** – Hurt, Insult, Threaten, Scream screening tool

**HIV/AIDS** – HIV (Human Immunodeficiency Virus) is the virus that weakens the immune system, ultimately leading to AIDS (Acquired Immune Deficiency Disease).

**IDI** – In-Depth Interview

**IPV** – Intimate Partner Violence is defined as abuse or aggression that occurs in a romantic relationship and can refer to both current and former spouses or dating partners (Centers for Disease Control and Prevention, n.d.). This is the term that will be used throughout this thesis.

**IRB** – Institutional Review Board

**MCH** – Maternal and Child Health

**MoH** – Ministry of Health, Jamaica

**NERHA** – The Northeast Regional Health Authority, one of four health authorities in the de-centralized Jamaican health system.

**NSAP-GBV** – The National Strategic Action Plan to Eliminate Gender-Based Violence

**PLWHA** – People/Patients Living with HIV/AIDS

**PVS** – Partner Violence Screen

**SERHA** – The Southeast Regional Health Authority, one of four health authorities in the de-centralized Jamaican health system.

**SRH** – Sexual and reproductive health

**SRHA** – The Southern Regional Health Authority, one of four health authorities in the de-centralized Jamaican health system.

**STI** – Sexually Transmitted Infection

**UN** – United Nations

**UNFPA** – United Nations Population Fund

**UNHCR** – United Nations High Commissioner for Refugees

**UNICEF** – United Nations Children’s Fund

**U.S.** – United States

**USPSTF** – United States Preventive Services Task Force

**UTECH** – University of Technology, Jamaica

**WAST** – Woman Abuse Screening Tool

**WHO** – World Health Organization

# I. INTRODUCTION

## A. Introduction and Rationale

Intimate partner violence (IPV) is a widespread public health problem, and initial reports from United Nations Women indicate that since the beginning of the SARS-CoV-2 pandemic, global rates of IPV continue to steadily rise (United Nations Women, 2021). IPV, defined as abuse or aggression that occurs in a romantic relationship, refers to both current and former spouses or dating partners (Centers for Disease Control and Prevention (CDC), n.d.). More broadly, the United Nations (UN) defines domestic violence (DV) as physical, sexual, emotional, economic, or psychological acts of abuse that occur in any relationship, characterized by behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound an individual (UN, n.d.a). The key distinction between the two definitions is within what type of relationship the violence takes place. This thesis will use the term IPV, however both terms were used interchangeably by the study's participants. Ultimately, both IPV and DV function to gain or maintain power and control over another that often reifies gender inequality.

Violence against women and girls is a pervasive and common issue that many face in their lifetime and drastically increases their likelihood for long-term health impacts. The World Health Organization (WHO) estimates that globally, one in three women experience physical and/or sexual IPV or non-partner sexual violence in their lifetime (WHO, 2021). Additionally, IPV has measurable effects on quality of life and health outcomes for women. For instance, more than 40% of women who experience IPV report injury which simultaneously threatens their general welfare and increases chances of short- and long-term disabilities from violence (WHO, 2021). In fact, intimate partners commit 38% of all murders of women, demonstrating a significant reduction in life expectancy (WHO, 2021). Furthermore, IPV increases women's risk for sexually transmitted infections (STIs), as women who have been sexually abused are 1.5 times more likely to have an STI (WHO, 2021). Lastly, women experiencing IPV are 16% more likely to suffer a miscarriage and 41% more likely to have a pre-term birth (WHO, 2021). With increased risk of injury, STI transmission, and pregnancy complications, IPV poses a significant threat to women's right to life, health, and autonomy.

While regional studies are crucial to understanding trends in IPV prevalence, organizations often conduct them in regions that receive significant funding and aid. Notably, global IPV research often neglects the Caribbean region, including the island nation of Jamaica. The 2016 Women’s Health Survey is the most recent evaluation of physical and/or sexual partner violence in Jamaica, and it found an IPV lifetime prevalence of 28% (Williams, 2016). While comparable to global statistics, underreporting is a key issue with IPV. As a result, the true prevalence of IPV remains unknown, since the data only represents the incidents of violence willingly reported by women.

Furthermore, a variety of influential factors, such as social norms, structural barriers, and overall resource availability play a role in the persistence of IPV. As a result, violence against women and girls is the subject of many countries’ health improvement goals and policies (Garcia-Moreno et al., 2005). Likewise, Jamaica put forth policies and evaluations to address IPV, such as the National Strategic Action Plan to Eliminate Gender-Based Violence of 2017, the Women’s Health Survey of 2016, and the National Policy for Gender Equality of 2011. These policies aim to redress systemic discrimination and to empower men and women through gender equality and equity (The Bureau of Women’s Affairs & The Gender Advisory Committee, 2010). Despite these policies, Jamaica still experiences epidemic rates of gender-based violence (GBV), the second highest femicide rate in the world (United Nations Population Fund (UNFPA), 2022), and nearly a third of women experience IPV in their lifetime (UN Women, 2018). In fact, other studies indicated even higher rates of IPV, with

45-83% of women who have been in at least one sexual partnership in their lifetime experiencing at least one act of IPV in the past year (Anderson, 2012; Priestley, 2014).

On a global scale, policy alone is not enough to decrease rates of IPV. In the context of Jamaica, societal perceptions of IPV, reporting, and healthcare screening and protocols all play a role in the life cycle of violence against women. The general stigma of experiencing IPV prevents many women from coming forward, thus signifying lower rates of reporting. The very nature of violence related to gender is disempowering, which in turn creates a pernicious social structure of silence and shame (Wall, 2012). Combined with the fact that the last major monitoring and evaluation of violence in Jamaica occurred in 2016, it is hard to measure the effects of the aforementioned policies on empowering women and decreasing rates of overall GBV, including IPV.

After the novel coronavirus (SARS-CoV-2) pandemic began in 2020, the existing infrastructure of health clinics across the globe was tested. In March of 2020, the global community rapidly adopted measures to curb viral transmission. Such measures had a negative effect on many nations' healthcare systems, which led to supply chain issues, workforce shortages, and reprioritization of services (UN Department of Economic and Social Affairs, n.d.). Sexual and reproductive health (SRH) services, a critical IPV resource for women and girls, were left in the dust in the wake of pandemic. Individual-level barriers to care worked in congruence with public fear, economic strain and uncertainty, and vast lockdown measures to create an ideal environment for IPV to increase. Further, studies show global increases in rates of IPV of 25-30% since the start of the pandemic (Boserup et al., 2020).

The effects of COVID-19 have been minimally studied in Jamaica. Since March of 2020, over 150,000 confirmed cases of COVID-19 have been documented in Jamaica, with a mortality rate of just over 2% (WHO, 2022a). And with the most recent studies on IPV in

Jamaica concentrated in 2016 or earlier, there is a gap in the evidence examining the pandemic context of IPV and, in the scope of this thesis, how the pandemic impacted screening, protocols, and care for IPV within the Jamaican health system. Further, as demonstrated by many broad-overview studies, IPV generally increased during the pandemic worldwide (Boserup et al., 2020; Harvey, 2021). Additionally, some research theorizes that challenges with privacy, confidentiality, and limitations in screening within health clinics and social norms with reporting possibly contributed to this increase (Wall, 2012). Thus, there is a need to understand this claim within the context of Jamaica, and the relationship IPV rates have with screening protocols in place and COVID-19. By understanding how providers practice IPV screenings and care in SRH clinics in Jamaica, there is an opportunity to analyze and improve upon the ways in which the healthcare system, particularly integrated community health centers, can better facilitate standardized, private, and non-judgmental IPV screening, and how it can provide and maintain confidential and equitable care during times of emergency.

## B. Research Questions and Framework

This research is a sub-study of a broader facilities-based study, titled "Assessing Changes in Sexual and Reproductive Health and HIV/AIDS Services During the COVID-19 Pandemic in Jamaica." The objective of the broad project assessed the impact of the COVID-19 pandemic on SRH and HIV/AIDS service delivery in Jamaica health centers, specifically exploring influences on commodities, concerns and strategies during the onset and continuation of the pandemic, provider strategies to address the changes in guidelines and screening protocols, and how community integrated health centers across the country adapted to meet patient needs during the pandemic (EGHI Field Scholars Proposal, 2022). Listed below are the research question and sub-question for this thesis. These questions were developed as a subset to the broader facilities-based study and sought to understand the impact of COVID-19 on IPV screening protocols, care, and perspectives as told by health personnel.

*Research Question*

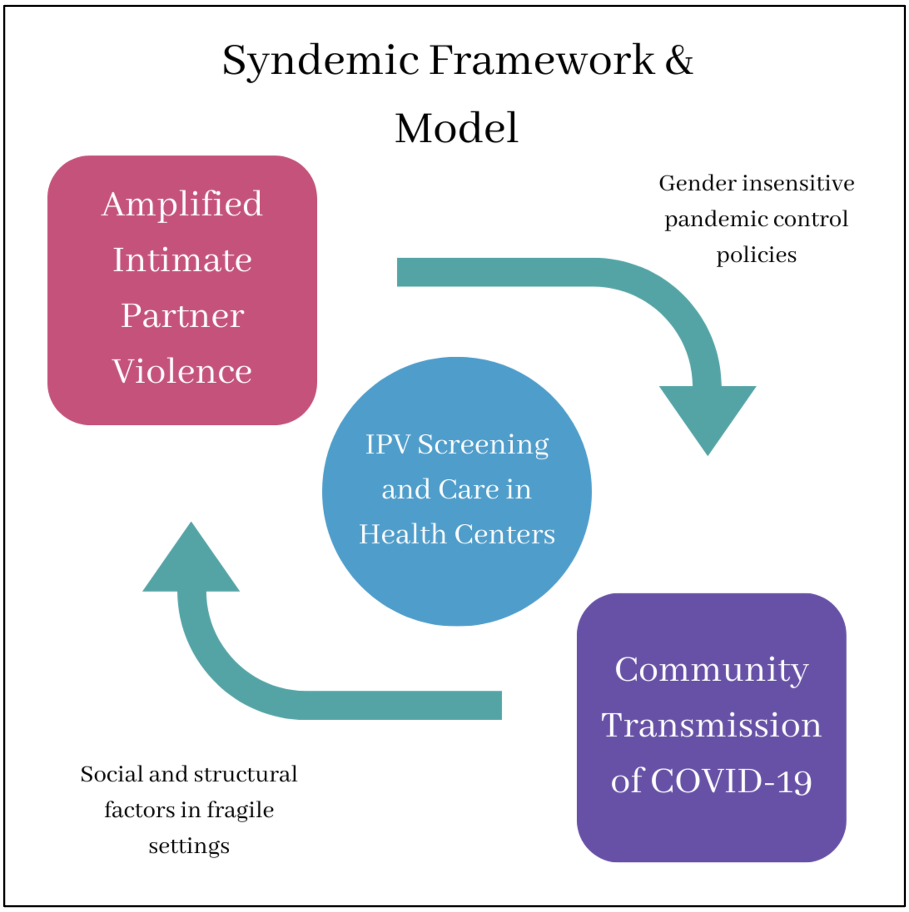
What do healthcare service providers and administrators view as the main barriers and facilitators to accessing SRH services and HIV/AIDS care during the pandemic?

*Sub-Question:*

How were integral screening procedures and referrals for HIV/AIDS and violence administered or changed during this time?

This thesis will be evaluated through an adapted syndemic framework to understand the connections between IPV and COVID-19, as outlined by Stark et al., (2020) and Vahedi et al., (2021) (See Figure 1).

*Figure 1: Syndemic Framework & Model (Adapted from Vahedi et al., 2021)*



Vahedi et al., (2021) defines a syndemic as the “co-occurrence of two or more epidemics or pandemics that interact in a population to compound the severity of each through social, psychological, biological, or behavioral pathways.” For Jamaica, the country-specific epidemic of IPV and the COVID-19 pandemic compounds upon each other to form a syndemic. The response to COVID-19 makes vulnerable groups like women and girls more at risk for IPV, thereby exacerbating community transmission of the virus (Vahedi et al., 2021). Thus, the instability and fragility imposed by the system of gender inequality proves detrimental for rates of both IPV and COVID-19 transmission.

The syndemic framework identifies gendered dimensions of COVID-19: the virus itself does not increase rates of IPV, rather, the gendered social system and insensitive policies magnify the risk of transmission (Stark et al., 2020). Furthermore, this thesis posits that the health system sits at the center of this framework; health centers act as a primary intervention point for both the COVID-19 virus and IPV. This thesis will assess the methodology of screening protocols and the efficacy of points of care as it relates to IPV and COVID-19, with the aim to provide insight on how these two issues compound on one another.

Additionally, the syndemic framework operates under the assumption that to combat the impacts of one pandemic, both pandemics must be addressed together to be effectively managed. Stark et al., (2020) identifies two examples of how COVID-19 and IPV compound upon each other:

1. Shelter-in-place policies may exacerbate IPV if women and girls live with an abuser.
2. The simultaneous reduction of economic opportunities from COVID-19 may drive women and girls to engage in survival sex, potentially increasing transmission of the virus.

Thus, this research utilizes the syndemic framework in the context of Jamaica’s healthcare system. Assessing the IPV screening protocols, perceptions, and procedures within the clinics will provide insight on how both IPV and COVID-19 continue to persist in this environment.

## C. Significance Statement

Through the process of in-depth interviews and surveys with SRH/HIV/AIDS care health providers, this project produced data with the potential to inform policy change and medical practice in Jamaica. The United Nations Sustainable Development Goals provide a blueprint for such change and seek to promote good health and well-being of all persons; however, studies indicate that the pandemic could stall and potentially reverse over a decade of progress in women’s health (UN, n.d.b). With studies already showing drastic increases in IPV since the start of the pandemic (Boserup et al., 2020; Bourne et al, 2021; Krubiner et al., 2021; Crawford et al, 2021), COVID-19 poses a significant threat to women’s health outcomes. Beyond the cultural, socioeconomic, and systemic barriers already preventing people from accessing IPV services, new global shortages, uncertainties, and reprioritization of health services burgeoned in the wake of the pandemic, only adding to the challenges of help-seeking and accessing IPV care.

While Jamaica’s public health care system is free and allows for readily available SRH services, various barriers to accessing care for IPV persist. Thus, this project seeks to examine the factors that influence IPV services in Jamaica, including access to health services, barriers to IPV care in the context of organizational and national COVID-19 policies, current screening protocols, and cultural and social nuances. As a result, this thesis utilized a multidisciplinary approach to inform future pandemic policy, communications, and practice. By quantitatively analyzing perceived screening frequency and IPV case load and qualitatively assessing provider perceptions of the barriers to accessing IPV services, this thesis aims to provide a framework for improved IPV and COVID-19 planning. Within the syndemic framework, the assessment of how IPV at a health facilities level interacts with COVID-19 presents an opportunity for more accessible IPV screening and services and better health outcomes for vulnerable people in Jamaica and beyond if provided the opportunity to replicate this study and its evaluations in other countries.

# II. LITERATURE REVIEW

## A. Background

This literature review provides an overview on IPV in Jamaica and the healthcare system, assesses research gaps, and analyzes current policy measures and social influences on IPV. The existing national data on IPV prevalence and other measures ends in 2016, before the emergence of COVID-19, indicating a need for ongoing pandemic data. Following the pandemic, global health institutions, like the UN, estimated that lockdowns, isolation, heightened financial and health stressors, and movement restrictions intensified rates of sexual and physical violence against women (UN Women, n.d.). While there are a growing number of studies focused on COVID-19 and IPV and the impact of the pandemic on help-seeking for IPV at health centers, only one evaluation of current violence rates in Jamaica was found. With limited data on Jamaica's pre- and post-pandemic IPV rates, elucidating the impact of the pandemic on IPV service delivery and accessibility remains challenging.

The relevant literature review was assessed through the syndemic framework, as mentioned in the Introduction. Thus, this thesis analyzed IPV as an epidemic in both the Jamaica and global context and investigated the contextual influences of the COVID-19 pandemic in relation to impacts on IPV experiences, screening, and care within the health sector. The searches conducted on PubMed, JSTOR, and Elsevier included the following search terms: "(Jamaica + "Intimate Partner Violence" or "Domestic Violence") and (Jamaica + "Intimate Partner Violence" or "Domestic Violence" + COVID-19) and (Jamaica + "Intimate Partner Violence" or "Domestic Violence" + policy)." Additionally, the search criteria had no date limitations because the recent COVID-19, IPV prevalence, and IPV policy publications specific to Jamaica are severely limited.

Initially, the search resulted in 17 articles from PubMed, 71 from JSTOR, and 52 from Elsevier. After reviewing abstracts and the full text of each article, 21 were selected.

Studies were excluded if they did not assess IPV services and care within the health system before and during the pandemic. This review includes grey literature, such as survey publications from UN Women, the Inter-American Development Bank, and the United Nations Population Fund (UNFPA), as they report the most recent prevalence data on IPV. The information from these articles and publications is categorized by six topics in the Jamaican context:

1. IPV prevalence data
2. IPV risk factors and consequences
3. Social influences on IPV
4. Existing IPV policy measures
5. IPV screening and care delivery
6. COVID-19 influence on IPV service availability and accessibility.

While some of the literature speaks about gender-based violence more broadly, this review is primarily assessing IPV.

### *i. IPV Prevalence among Jamaican Population*

There have been no national surveys or studies in recent years on IPV prevalence in Jamaica. While Jamaica and global IPV rates are comparable (Williams, 2016; WHO, 2021), the most recent nationally conducted survey of IPV in Jamaica, the 2016 Women's Health Survey, was conducted seven years ago. This survey is still the most cited source for IPV prevalence among organizations like WHO and UN Women, despite it being outdated. Several other studies were conducted before that reported even higher rates of both lifetime and previous year experience of IPV. In 2014, a study with 9,641 Jamaican women of "reproductive age" who had been in at least one sexual partnership in their lifetime found that about 83% of respondents had experienced at least one act of IPV (physical, sexual, or emotional) in the previous year (Priestley, 2014). A 2012 study among men and women aged 15 to 30 years found that 45% of women and 40% of men had experienced IPV (Anderson, 2012). Further, the study found that 72% of women and 57% of men reported experiencing sexual coercion, or unwanted sexual activity that happens when you are pressured, tricked, threatened, or forced in a nonphysical way (Anderson, 2012; Office of the Assistant Secretary for Health, 2021). While these studies provide insight on the context of violence in Jamaica, they are nearly or more than a decade old and represent a gap in current IPV rates.

While the five studies had different prevalence rates of IPV, a common theme in the literature was the likelihood and limitations of the data due to underreporting. Asking people to self-report experiences of violence ultimately reflects in underreporting, as social factors, cultural norms, and stigma often deter women from coming forward (Wall, 2012; Priestley, 2014). Ultimately, the literature demonstrates that IPV occurs in Jamaica comparably to global averages, although underreporting may impact the true prevalence.

### *ii. IPV Risk Factors and Consequences*

The literature highlighted a variety of risk factors for IPV and the subsequent consequences it has on survivors in Jamaica. The Priestley (2014) study identified indicators for increased IPV experiences, such as childhood/teen violence, wealth status, and age. Individuals who witnessed violence between parents as a child were twice as likely to experience IPV; women aged 15-24 were three times more likely to experience violence from a partner than women 35 and older; and women in the three lowest quintiles of wealth were two times more likely to experience IPV than wealthy women (Priestley, 2014).

Further, a study by the Caribbean Policy Research Institute (CAPRI) found that in communities with higher rates of violence, IPV took place in roughly 60% of households (Jones et al., 2021). Another cross-sectional survey, conducted in 2020 with 340 cis- and transgender sex workers in Jamaica, found 49% of respondents experienced IPV, nearly double the prevalence of the Women's Health Survey of 2016 (Logie et al., 2020). Researchers found that while transgender women reported significantly higher police and client violence, cisgender women reported significantly higher IPV than transgender women or cisgender men (Logie et al., 2020). Taken together, these studies support the need for attention in communities that may be more vulnerable to IPV.

### *iii. Social Influences and IPV*

While the literature review yielded little on social influences and the healthcare system as a point of care for IPV, it did provide insight into the social factors that influence IPV more broadly. Four cross-sectional studies in the Caribbean looked at what factors influence IPV and ultimately identified what norms in the are associated with violence. Two of the studies focused on male gender norms and the role of masculinity in the perpetration of violence. A study conducted in 2012 examined masculinity and gender attitudes among 1,141 fathers in four Jamaican communities (Anderson, 2012). They found that most young males felt pressure to "perform heteronormativity" and confirm their heterosexuality with behaviors like initiating sex at a young age, having multiple sexual partners, and displaying aggressive sexual attitudes (Anderson, 2012). The study also found that men had a complicated relationship with IPV and GBV. While they disavowed violence against women, citing it as wrong, they believed that women should be subject to violence if they were unfaithful, disobedient, or not upholding their gender roles (Anderson, 2012). This literature suggests that perceptions surrounding violence against women are seen as conditional and acceptable in certain settings. There is an implication that men hold the power to decide when violence against women is permissible or condemnable.

Another study in 2021 in Jamaica analyzed survey data from the 2008 Reproductive Health Survey and further corroborated the results of Anderson (2012). It found that men living in urban areas were twice as likely to commit a violent act against female partners than those in rural areas (Priestley & Lee, 2021). This study hypothesized that some social and cultural norms in Jamaica are rooted in deep-seated patriarchal views – views that propagate the idea that violence is the masculine way to resolve relationship conflict (Priestley & Lee, 2021). Both the Priestley and Lee study (2021) and the literature overall revealed another key indicator for IPV victimization and perpetration: witnessing and experiencing violence in early childhood (Priestley, 2014; Priestley & Lee, 2021). Experiencing violence in early childhood is common in Jamaica; the United Nations Children's Fund (UNICEF) found that 85% of children under age 15 experienced violent discipline at home (UNICEF, 2019). Additionally, witnessing violence – especially between parents or guardians – can model violence as an acceptable relationship norm and conflict resolution strategy, and thus put children at greater risk for IPV (Roberts et al., 2010; Pingley, 2017).

Studies also found that social factors, such as economic status and lack of educational opportunity, may be related to the experience of violence in adulthood. The Priestley (2014) study found that women with no primary school education were twice as likely to experience a sexually violent act. Lower educational attainment is also linked with income inequality because this phenomena is concentrated in communities with inadequate education infrastructure. The difficulties that come with finding jobs or opportunities for self-employment place additional stresses on already challenging situations (Priestly, 2014 & Jones, et al., 2021). Thus, lower educational attainment, witnessing or experiencing violence as a child, and under-resourcing are associated with IPV in Jamaica.

### *iv. IPV Policy Measures*

There have been a variety of governmental responses regarding IPV in Jamaica. Policies and measures to IPV included the National Policy for Gender Equality of 2011, the Women's Health Survey of 2016, the National Strategic Action Plan to Eliminate Gender-Based Violence of 2017, and a 2022 meta-analysis on IPV interventions.

At the time of the development of the National Policy for Gender Equality (NPGE), Jamaica had no gender policy that addressed the needs of both men and women at the national level (NPGE, 2010). The Bureau of Women's Affairs and the Gender Advisory Committee developed the policy with the goal to enhance the status of women economically, socially, and politically by ensuring policies related to women and men are implemented in accordance with guidelines and are monitored and evaluated (Spiring, 2014). The framework of the policy identified that the legal environment in the Jamaican judicial system was facilitated by gender inequality. For example, same sex unions do not have any legal avenues for IPV, only women can be considered victims of rape, and IPV and rape cases for women are trivialized and oversimplified (NPGE, 2010). Thus, the NPGE focuses primarily on sexual harassment and IPV, with gender equality, justice, political leadership, transparency, accountability, and multi-sectoral partnerships acting as its guiding principles (NPGE, 2010; UN Women, 2016). The policy strategies included gender mainstreaming, gender responsive costing and budgeting, gender-aware monitoring and evaluation, and the implementation of a gender advisory council to strengthen institutional mechanisms and reduce gender discrimination (NPGE, 2010). There have been no evaluations on the efficacy or impact of this policy.

The Women's Health Survey of 2016 filled the information gap of national prevalence rates and the nature of violence against women in Jamaica (Williams, 2016). Notably, this survey took place after the implementation of the NPGE, yet it found that women continued to suffer high rates of sexual violence and other forms of victimization (Williams, 2016). The survey evaluated women's lifetime and most recent experiences of IPV, non-partner violence, sexual and non-sexual abuse, and provided insight on gender roles, profiles of perpetrators of abuse, factors associated with violence, the impact of violence, and the coping strategies women utilized in response to abuse (Williams, 2016). The information this survey provided has since informed subsequent policy measures, and still stands as the most recent source for data on violence against women and girls. As a result, legislation is based upon outdated survey data.

The ten-year National Strategic Action Plan to Eliminate Gender-Based Violence (NSAP-GBV) of 2017 focused on five strategic priority areas: prevention, protection, intervention, legal procedures, and protocols for data collection (UN, 2017). This plan worked in tandem with the 2030 Vision National Development Plan, the NPGE, and the UN's 2030 Agenda for Sustainable Development. Specifically, the NSAP-GBV focuses on the needs of the victims, survivors, and witnesses of violence, and the human and financial resources available to ensure sustainability (UN, 2017). It has been five years since implementation and there have been no evaluations conducted on the progress of the plan. This was a repeated pattern in IPV policies and represents a gap in policy assessment and potential effectiveness.

In 2022, a meta-analysis was conducted on nineteen low- and middle-income countries, including Jamaica, that evaluated forty-eight interventions and their impact on IPV. While the meta-analysis had a larger scope than Jamaica, Awolaran et al., (2022) found no evidence that the IPV interventions significantly impacted the rates, behaviors, or attitudes on IPV. Ultimately, they concluded that the overall effects of the forty-eight IPV interventions were small or insignificant (Awolaran et al., 2022). While none of the Jamaican policies mentioned above were evaluated, the meta-analysis questioned if current interventions and policies are adequate to reduce the rate of IPV. As noted by the NPGE (2010), legislative reform alone cannot achieve gender equality; the social change of deep-rooted traditions and customs is not solely tied to policy change.

### *v. IPV Screening and Care Delivery*

There are many tools used for IPV screening, many of which originated in the United States (U.S.). According to the U.S. Preventive Services Task Force (USPSTF) (2018), screening for IPV is commonly conducted using survey instruments that assess emotional, physical, and sexual IPV, such as the Humiliation, Afraid, Rape, Kick (HARK tool); Hurt, Insult, Threaten, Scream (HITS tool); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). The USPSTF (2018) also states that screening should be conducted separately from the patient's partner. If the screening results in the discovery of an IPV case, subsequent care may involve reporting to law enforcement (depending on reporting requirements of that jurisdiction), ongoing support services like counseling and home visits, parenting support for new mothers, providing resources for patients, and more (Feltner et al., 2018).

There was no peer-reviewed literature on screening protocols for IPV in Jamaica. Outside of the medical system, the Jamaican Ministry of Education and Youth did publish a news article on encouraging screening from the Victim Services Division (VSD), in the Ministry of Justice (Wheelan, 2021). With limited information on how the IPV screening was conducted, Wheelan (2021) stated that the screening sought to "assess whether a person's relationship is abusive and to what extent," failing to define what was categorically abusive. Additionally, the article noted that the VSD saw nearly 900 victims of IPV crimes between January 2020 and February 2021 and indicated that they provided requisite counseling and referred clients to relevant authorities, such as police or judicial systems (Wheelan, 2021).

While little information existed on screening practices for IPV in Jamaica, there have been a few studies conducted in other Caribbean countries. For example, a 2020 study among primary care providers in Barbados analyzed healthcare practitioners’ perspectives on conducting screening for IPV (Bryan, 2020). In interviews with healthcare practitioners, Bryan identified positive and negative attitudes surrounding screening for IPV. She found that most providers did not screen for IPV due to a negative sense of self-efficacy and perceived control attitudes (Bryan, 2020). Providers felt there were negative outcomes with screening, such as time inefficiency, hesitation to disclose from patients, and fear of partner finding out abuse was disclosed (Bryan, 2020). Additionally, providers faced institutional challenges with screening such as time constraints, inadequate staffing, and lack of trained staff (Bryan, 2020). Yet, despite the challenges with screening, women experiencing IPV were more likely to seek help among health care practitioners than social workers or the police (Bryan, 2020). Positive outcomes associated with screening included the opportunity for healthcare providers to be outlets for patients to speak about abuse, better attention to the management of patients’ presenting with IPV, and the ability of hospitals to determine the prevalence of IPV (Bryan, 2020).

Studies from other regions have also demonstrated provider-perceived barriers with IPV screening. In the U.S., Swailes et al., (2017) conducted a cross-sectional study on 253 women aged 18-65 with a lifetime history of IPV and past-year healthcare appointments to assess how common, guideline-concordant, and successful IPV screening was. As a result, they found that only 39% had been screened for IPV at a healthcare visit in the past year and concluded that the reason for infrequent IPV screenings was due to providers’ own perceptions of barriers to screening, rather than patients (Swailes et al., 2017).

A 2010 study in the U.S. analyzed reasons for low adherence to universal screening for IPV despite recommendations from national organizations like the CDC and the Institute of Medicine. In a sample of 75 health care staff, Colarossi et al., (2010) found that while staff felt screening was helpful to patients, they conducted it infrequently due to barriers like lack of time, insufficient training, or inadequate referral sources. Similarly, a systematic review from 2006 evaluated studies on physician, patient, and system barriers to providing care for IPV and found that rates of screening for IPV across healthcare specialties varied from 1.7% to 11% (Hamberger & Phelan, 2006). Largely, the literature demonstrated concerningly low rates of screening on a global scale.

Overall, multiple studies show how infrequently screening is conducted across the globe (Hamberger & Phelan, 2006; Colarossi et al., 2010; Swailes et al., 2017). Bryan (2020) demonstrated the detrimental impacts infrequent screening had on people experiencing IPV. Specifically, she argued that a lack of screening resulted in victims going unnoticed within the healthcare system, especially when their abuse did not present physically (Bryan, 2020). Because some victims are unlikely to reveal abuse without being asked directly, infrequent IPV screening widens the gap for help-seeking and care (Bryan, 2020).

### *vi. COVID-19 and IPV*

Without any national surveillance or data on incidence, much of the information on IPV in Jamaica is anecdotally reported and may not reflect the context of the ongoing COVID-19 pandemic. However, there is a feeling amongst public health professionals, as reflected in the literature, that increased rates of IPV are a serious issue facing Jamaica (Harvey, 2021). While the literature demonstrated limitations regarding quantitative statistics, it illuminates the effects that COVID-19 could have on IPV regarding prevalence and reporting. Four recent articles were found that discussed the impact of COVID-19 on IPV in Jamaica.

The dramatic transformation of daily life following the spread of COVID-19 and its impact on communities has been well analyzed by journalists and scientists alike. Jones et al., (2021) argued that these changes could impact IPV incidence and health outcomes. The pandemic incited waves of uncertainty and fear and in turn, personal stressors and instability heightened. In IPV situations, victims and their abusers may be confined to the same space because of lockdowns, stay-at-home orders for quarantine, and curfews (Jones et al., 2021). Thus, any volatility in an already abusive home could become even more fragile with the stressors that arose from the COVID-19 pandemic. Moreso, homes that were not previously abusive could also be affected by elevated stress levels, which potentially increased the propensity for IPV (Jones et al., 2021; Krubiner et al., 2021; Crawford et al., 2021; Bourne et al., 2021).

The literature also reflected the various intersections of COVID-19. A report from the Center for Global Development analyzed the indirect health impacts of COVID-19 on women and girls, concluding that the pandemic posed especially concerning threats for women and girls living with HIV/AIDS (Krubiner et al., 2021). Therefore, a new set of exposures rests at the intersection of violence, COVID-19, and HIV/AIDS, increasing the likelihood of all three. Exposure to sexual violence and increased economic difficulties due to the pandemic could pressure women to engage in survival sex; not only putting women at risk for HIV/AIDS and other sexually transmitted infectious, but for COVID-19 transmission as well (Krubiner et al., 2021). The findings showcase a component of the syndemic framework as well. Forced proximity due to COVID-19 could give rise to a higher occurrence of survival sex, which in turn increases contact that could perpetuate the transmission and spread of COVID-19. In nearly half of the surveys by Krubiner et al., (2021) they found an increase in violence against women during COVID-19.

Additionally, the spread of COVID-19 and the impact of the subsequent stay-at-home order on violent crime were analyzed in the literature. In attempt to reduce the transmission of the virus, the Jamaican government invoked the Disaster Risk Management Act of 2015 on March 13th, 2020, which enforced measures like border closures, curfews, mandatory masking, and physical distancing (Crawford et al., 2021). Consequently, a cross-sectional survey of 513 Jamaican women found that 31% of participants experienced domestic abuse during the pandemic (Bourne et al., 2021). As a smaller, cross-sectional study, these results cannot be applied to the whole nation, however they do provide insight into a potential increase in prevalence by 3% from the 2016 Women's Health Survey (Williams, 2016).

Crawford et al., (2021) analyzed all major violent crimes during the first year of the pandemic for any changes in trends. While all violent crimes – including rape and IPV – initially declined during the first year of the pandemic (potentially due to physical restriction measures), Crawford et al., (2021) hypothesized that underreporting played a significant role in the decrease. They cited a lack of trust in the security force and victims spending longer periods of time at home with their perpetrator as reasons why the reduction in reports of sexual offenses may be inaccurate (Crawford et al., 2021). While COVID-19 protocols for physical distancing may have reduced rates of crime and violence (Crawford et al., 2021), these findings beg the question if the protocols may have acted as an additional barrier for reporting.

Further explored in the cross-sectional survey by Bourne et al., (2021) the study found that the restrictions of the Disaster Risk Management Act severely affected victims of domestic abuse. Ninety percent of participants agreed that COVID-19 measures prevented them from accessing essential services (Bourne, et al., 2021). The literature demonstrates cause for concern regarding victims of IPV during times of infection prevention, such as the ongoing COVID-19 pandemic. IPV experience and subsequent access to healthcare and reporting services appeared to be deeply affected under COVID-19 lockdown conditions.

## B. Conclusion

Although IPV occurs in Jamaica at similar rates compared to global averages, it is still deeply stigmatized by country policies and thus often undetected by healthcare providers. There is a limited amount of research on IPV in Jamaica, especially regarding information on screening protocols at a healthcare level, COVID-19, and health system response to IPV. Literature found on IPV and COVID-19 was also limited in that they were primarily cross-sectional surveys or meta-analyses. Further, there was no literature on training or capacity building regarding IPV, resulting in a gap in knowledge regarding healthcare providers' education and practice on the subject. While COVID-19 protocols regarding physical distancing may have reduced levels of crime and violence (Crawford et al., 2021), there is also a question if COVID-19 protocols may have acted as an additional barrier for reporting. Underreporting is already an issue with IPV, so there is a gap in the literature for how COVID-19 impacted reporting. This thesis will address many of the gaps in the literature by assessing the screening and treatment protocols for IPV, the impact of COVID-19 both on the services and the perceived IPV prevalence, and provider perception of violence within the health system.

## III. METHODS

### A. Introduction

The purpose of this project was to assess how the COVID-19 pandemic impacted SRH care service delivery, as told by health care providers (EGHI Field Scholars Proposal, 2022). Thus, a cross-sectional concurrent mixed-methods approach was deployed with a variety of health care providers, which gave insight to the quantifiable impacts of COVID-19 and individual experiences of challenges and innovations for providing care, including IPV screening.

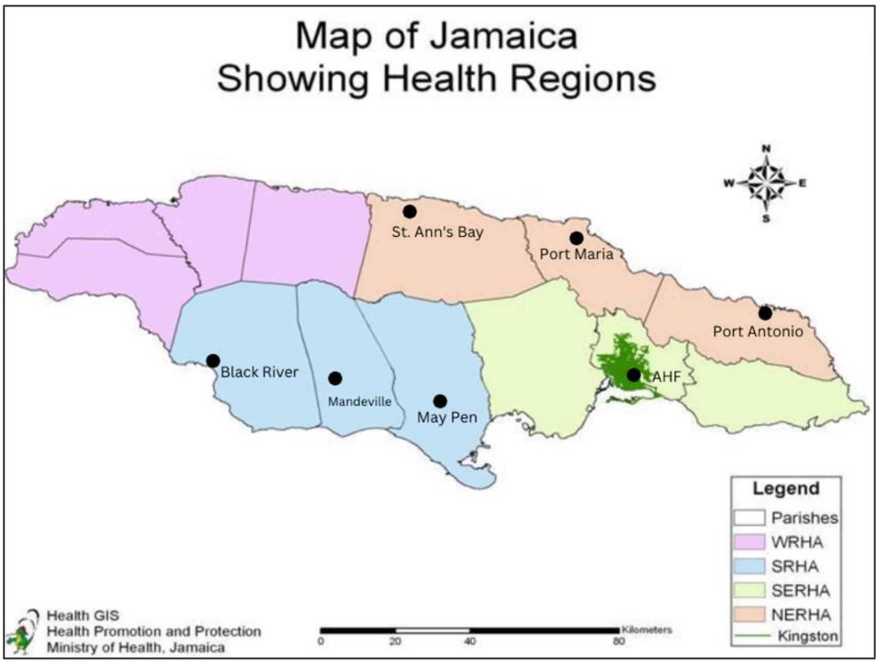
### B. Research Partners and Support

This study was conceived by Dr. Subasri Narasimhan, co-designed by a team of five student researchers, and done in partnership with AIDS Healthcare Foundation Jamaica (AHF) and the University of Technology, Jamaica (UTECH). The Caribbean regional director of AHF, Dr. Kevin Harvey, served as the project's in-country primary investigator (PI) Within the context of this study, AHF Jamaica staff worked with the research team to navigate the local health system, understand the culture context, and contribute to study design, recruitment, and dissemination. The AHF Data Quality team members, Pettia Williams and Sashane Lovelace, connected the research team with regional health authorities, the Ministry of Health (MoH), and other Jamaican stakeholders to coordinate fieldwork logistics and advertise the study. UTECH was also a partner of this study, particularly the School of Public Health and Health Technology (SPHHT). Dr. Kevin Harvey also serves as the Head of School and connected the research team with an SPHHT master's in public health student, Kimbeley Farquharson, who reviewed and adapted data collection tools to the Jamaican clinical context, aided in fieldwork, and contributed to data collection.

## C. Setting

AHF identified six health centers across the Northeastern and Southern regions for the research team to travel to and conduct their research: Port Antonio, Port Maria, St. Ann's Bay, Mandeville, Black River, and May Pen. AHF also allowed the team to conduct research at its health center in Kingston, located in the Southeastern region, for a total of seven in-person field visits (see Figure 2).

*Figure 2: Map of Health Regions (McCartney, 2015) and In-person Field Visits*



## D. Research Questions

Listed below are the broad project's research questions, however this thesis was developed from the Sub-Question two of Research Question two. Sub-Question two sought to understand the impact of COVID-19 on IPV screening protocols, management, and perspectives as told by health personnel.

### *Research Question 1*

What kinds of health services and commodities related to SRH/HIV/AIDS were available during the pandemic?

*Research Question 2*

What do healthcare service providers and administrators view as the main barriers and facilitators to accessing SRH services and HIV/AIDS care during the pandemic?

*Sub-Questions:*

1. Did clinics experience any service interruptions or changes in priorities due to the pandemic?
2. How were integral screening procedures and referrals for HIV/AIDS and violence administered or changed during this time?

This thesis seeks to understand sub-question two: how screening procedures for IPV were administered and/or changed during the COVID-19 pandemic. Data was also collected on standards of IPV services, screenings, protocols, and practices before the pandemic to establish a baseline of IPV care in Jamaica. Questions from the survey and interview related to IPV will be used for the purpose of this thesis.

## E. Research Design

This facilities-based study utilized a retrospective cross-sectional concurrent mixed method (simultaneous quantitative surveys and semi-structured in-depth interviews (IDIs)) to examine the impact of COVID-19 on SRH and HIV/AIDS health care delivery. The researchers engaged a total of 66 healthcare professionals in the study. Twenty-nine interviews and 51 surveys were conducted, although one survey was excluded because it was incomplete, for a total of 50 surveys. With the help of AHF, the research team contacted 66 providers and offered both the survey and interview to all; some declined to complete both, citing either time or job responsibility factors. Of the 66 participants, 14 completed both the interview and the survey. Most surveys and interviews were conducted in-person; however, five interviews and 14 surveys were conducted virtually over Zoom or the phone. The remaining surveys and interviews were conducted in-person at the clinics, either in administration or doctor’s offices.

Qualitative interviews were appropriate for this research to understand the complex impact of COVID-19 on SRH care delivery, including the nuances involved in the adaptations made to continue providing care (Hennink et al., 2020). Quantitative surveys were useful to systematically measure the impact of COVID-19 on the supply chain, operating procedures and processes, and organizational changes in SRH care.

## F. Recruitment, Population, and Procedure

### *Recruitment*

Purposive and convenience sampling were used to identify participants. AHF communicated the inclusion criteria to regional health authorities, who then provided AHF with a list of potential participants upon arrival to the clinics. AHF contacted these individuals to invite them to participate in the study and asked for referrals to colleagues who might be interested in participating in the survey. For each site, the AHF researchers coordinated with the Patient Treatment and Care Support Officers appointed by the Regional Health Authorities and other health managers at the clinics. The AHF team and these officers cross-referenced the positions best suited for the research questions, identified the healthcare professionals available at the centers on that day for the surveys and interviews, and approached them for study participation. Participants were informed that study participation was voluntary and there would be no penalty or renumeration if they did not want to participate. Additional participants were spontaneously identified to participate in the study via snowball sampling, when participants recommended their colleagues to participate in the study. Study participants were SRH care providers, ranging in position, age, and years of experience. The planned sample size was ten qualitative in-depth interviews and 30 quantitative surveys, and ultimately completed data collection with thematic saturation at 29 IDIs and 50 surveys.

*Population*

The study population was SRH/HIV/AIDS licensed care providers, specifically providers who could speak to how COVID-19 impacted their health care delivery. Participants ranged in positions, including public health nurses, physicians, contact investigators, social workers, adherence counselors, psychologists, pharmacists, midwives, nurse managers, and medical officers (See Figure 3). To assess how COVID-19 may have changed provision of care, respondents to work at their clinic for at least two years, or before the pandemic. Health professionals had to be aged 18 years or older to work in the clinics. There was no criterion for experience, so long as the participant could speak to clinic operations prior to the pandemic. Various positions at the clinic were excluded from the population criteria if they could not speak to clinic operations outside of their role, scope, or if they started working at the clinic after the pandemic began.

*Figure 3: Demographic Tables of Participants*

| **Health Facility** | | |
|---|---|---|
| | Survey | IDI |
| Port Antonio Clinic | 8 | 4 |
| Port Maria | 3 | 3 |
| St. Ann's Bay | 6 | 4 |
| Mandeville | 6 | 7 |
| Black River | 5 | 4 |
| May Pen | 7 | 5 |
| AHF – Kingston | 3 | 2 |
| Port Antonio Hospital | 6 | 0 |
| Ocho Rios | 1 | 0 |
| Bamboo | 1 | 0 |
| Brown's Town | 1 | 0 |
| Fellowship | 1 | 0 |
| Annoto Bay | 1 | 0 |
| Steer Town | 1 | 0 |
| Total | 50 | 29 |

| **Role in the Clinic** | | |
|---|---|---|
| | Survey | IDI |
| Physician | 3 | 8 |
| Pharmacist | 2 | 1 |
| Nurse Manager | 1 | 0 |
| Social Worker | 0 | 3 |
| Adherence Counselor | 0 | 1 |
| Psychologist | 0 | 1 |
| Public Health Nurse | 7 | 3 |
| Midwife | 24 | 3 |
| Contact Investigator | 10 | 5 |
| Nurse (Other) | 2 | 4 |
| Medical Officer | 1 | 0 |

| **Years of Experience** | | **Gender of Participant** | |
|---|---|---|---|
| < 1 year | 3 | Male | 3 |
| 2-5 years | 18 | Female | 47 |
| 6-10 years | 17 | | |
| 11-20 years | 6 | | |
| 21-30 years | 3 | | |
| 31+ years | 3 | | |

*Procedure*

Data collection took place in May and June of 2022. Surveys were administered individually, whereas interviews could be conducted in pairs, (with one interviewer and one notetaker) depending on the needs of the interview. Both the IDIs and the surveys were conducted in as private spaces as possible, with surveys lasting approximately 45 minutes and IDIs lasting 60 minutes. Before each interview or survey, a consent form was provided, read through, and signed. The team used the REDCap Mobile (Harris et al., 2009; Harris et al., 2019) application on handheld tablets to collect data for surveys and interviews, except for Port Antonio and Port Maria, where surveys were collected on paper copies and later input into the server. Handheld tablets were used to record interviews if the participant gave consent.

The team also engaged seven other health sites virtually, which included Port Antonio Hospital, Port Maria, Ocho Rios, Bamboo, Brown’s Town, Fellowship, Annoto Bay, and Steer Town (See Figure 3). AHF worked with the Northeast Regional Health Authority to obtain contact information for healthcare professionals appropriate for the study. The research team divided the list of participants into two groups, those best positioned to respond to the survey and those best suited for the interview. The team contacted the healthcare professionals through phone calls and emails to gauge interest and invite them to participate. Persons interested in participating in the study were asked to provide times they were available for either a 45-minute survey or a 60-minute interview. Once times were identified, Zoom meetings were organized to conduct the research. If a participant experienced technical issues with Zoom, researchers offered the option to complete the survey or interview over the phone.

## G. Consent

The research team and AHF emailed digital copies of the consent form to review the day before data collection. On the day of data collection, participants were asked to review the consent form again before the survey and/or interview would begin. Participants were encouraged to ask questions and informed that they could withdraw from the study at any time. If participants agreed to participate, they would sign the consent form using either paper copies or the REDCap (Harris et al., 2009; Harris et al., 2019) mobile application on tablets. In the case of virtual interviews, consent forms were signed by proxy after receiving verbal consent from the participant. Participants were given a second opportunity to review the form and provide consent if they were interested in participating in both the IDI and the survey.

## H. Instruments

### *In-Depth Interview Guide*

The IDI guide was developed by the team members as a set of questions to be probed and expanded upon during the interviews ($N$=29). The guide was semi-structured (Hennink et al., 2020) to compare clinics' service delivery prior to and after the pandemic as it related to a broad range of topics: HIV/AIDS care, STI services, IPV, contraceptives and family planning, health personnel experiences, organizational structure, and commodities (See Appendix A). Responses related to IPV were used to inform this thesis. The team developed the IDI over several rounds of editing, pulling both from COVID-19 research and Jamaican healthcare system research. The guide was edited and piloted by the AHF/UTECH team to ensure usability and comprehension with Jamaican SRH providers. The topics covered in the

IDI were identified as central aspects of the healthcare system that could be impacted by COVID-19.

*Quantitative Survey*

The survey instrument was developed by the team members as a set of introductory questions and was divided into six sections: demographic information and availability/patient utilization of the following: contraceptive methods, SRH services, HIV services, the prevalence and availability of IPV screenings both before and during the COVID-19 pandemic, and general health center information (*N*=50) (See Appendix B). Each section of the survey was initiated by asking if the participant could speak to the section topic. If the participant could not, that section was skipped. The survey utilized multiple choice, numerical, dichotomous, ordinal, and categorical questions to measure the impact of COVID-19 on health services. AHF and UTECH partners also edited and piloted the survey to ensure the survey's usability and comprehension among Jamaican SRH providers.

## I. Analysis

*Quantitative*

Fifty of the total 51 surveys were used to inform the research analysis for this thesis, as one survey was incomplete. The survey data was cleaned and analyzed using SAS software v.9.4 (SAS Institute, Cary NC). Responses related to IPV were used to inform this thesis. Thirty out of 50 participants were capable of answering questions about IPV services, and demographic frequencies were calculated with an *N* of 30. The team gathered descriptive statistics regarding both the categorical and dichotomous variables from the survey and employed bivariate and multivariate analysis to understand how the variables interacted with each other. SAS software v.9.4 was used to develop distributions and probabilities for ratio and numerical variables. Frequencies and proportions were calculated for categorical variables.

Fisher's Exact tests and two-sample t-tests were the primary tests performed for analysis of survey data, with an alpha level of 0.05 used for all statistical tests. New variables were created using SAS software v 9.4 for Fisher's Exact tests to create years of experience groups (≤1 year, 2-5 years, 6-10 years, 11-20 years, 21-30 years, and ≥ 31 years), years in current role groups (≤1 year, 2-5 years, 6-10 years, 11-20 years, 21-30 years, and ≥ 31 years), and age groups (ages 18-35, ages 36-45, ages 46-55, and ages 56+).

Fisher's exact tests were performed to determine if there were nonrandom associations between the following variables: IPV screening frequency before the pandemic and at the time of the survey; provider perception of case load for IPV patients before the pandemic and at the time of the survey; and provider training for IPV screening and frequency of IPV screening. T-tests were performed to determine if there was a significant difference between the following variables:

- Difference in age among those who could or could not answer questions about IPV
- Difference in years of experience among those who could or could not answer questions about IPV
- Difference in years working at their current clinic among those who could or could not answer questions about IPV.

*Qualitative*

IDIs were conducted with both an interviewer and a notetaker and were recorded (after obtaining consent to do so) and transcribed by a transcription service, HappyScribe$^{TM}$. The interview transcripts were checked for fidelity and de-identified by the research team. All interview transcripts were read, double-checked, and memo-ed. Team members aided in the development of a deductive codebook, using the interview guide as a starting point (Hennink et al., 2020). These codes were refined through team discussion and examination of inter-coder agreement and consensus. All transcripts were coded and analyzed using MAXQDA v.22 (VERBI Software, 2021). For this thesis, all 29 of the interviews were used in analysis. Data was analyzed using thematic analysis with a consistent comparative method (Hennink et al., 2020). Thick descriptions of codes related to IPV were developed, which contributed to the development of themes for the purpose of this thesis.

### J. Institutional Review Board (IRB), Consent, and Ethical Considerations

This study was submitted to the Emory University Institutional Research Board (IRB), evaluated, and received the Not Human Subject Research Determination (NHSR) under the designation of quality improvement in February 2022. The study was also submitted to the Ethics Board at the University of Technology (UTECH), which underwent evaluation and change and was cleared in April 2022. Further, a memorandum of understanding between the UTECH PI Harvey and EGHI program via Dr. Narasimhan established survey protocols and a procedures document. Express agreement from AHF-associated clinics were required prior to initiation of the study. After clearance from Emory University, UTECH, and AHF, the team also submitted to the MoH Ethics for admittance to health centers and permission to contact providers and received approval in February 2023 (Ministry of Health and Wellness, 2022a).

Questions were limited to asking providers about experiences of delivering healthcare during the pandemic. Additionally, each survey and IDI participant signed an informed consent form, had the opportunity to ask questions, contact the researchers, or withdraw from the study at will. Except on consent forms, names were not recorded and identifying information was removed from transcripts. In the IDIs, names were removed during transcription, and for the surveys, record IDs were assigned to maintain confidentiality.

# IV. RESULTS

## A. Introduction

IDI and survey results supported changes in IPV service delivery as a result of COVID-19. The survey assessed provider training for IPV screening, the frequency of screenings pre-pandemic and at the time of the survey, and revealed quantitatively that COVID-19 affected IPV services. Survey results indicated that most respondents felt services remained consistent with pre-pandemic service delivery. IDIs revealed four key components with current IPV care and response in Jamaica:

1. Pandemic-related changes in IPV service accessibility and frequency
2. Current protocols and services across clinics
3. Provider perception of current and pre-pandemic clinic practices for IPV
4. A need for privacy and confidentiality.

## B. Quantitative Results

### *Demographic Information*

Survey participants were primarily female (n=28, 93%), but were otherwise diverse in age, job title, and education level (See Table 4). Nearly half (n=14, 47%) of participants surveyed were midwives, followed by contact investigators (CIs) (n=7, 23%), physicians (n=4, 13%), nurses (n=3, 10%), and public health nurses (n=2, 7%). Most providers held at least a bachelor’s degree (n=27, 90%), had more than six years of experience (n=21, 76%), and been in their current role for more than six years (n=29, 70%). Of the 30 providers capable of speaking about IPV, only four were below the age of 30 (13%), three did not have bachelor’s degrees (10%), and three had less than one year of experience (10%).

*Table 4: Table of Survey Participant Characteristics (N=30)*

| | **Frequency** | **Percent (%)** |
|---|---|---|
| **Gender** | | |
| Male | 2 | 7 |
| Female | 28 | 93 |
| **Age** | | |
| 18-30 | 4 | 13 |
| 31-40 | 15 | 50 |
| 41-50 | 5 | 17 |
| 51-60 | 5 | 17 |
| 61+ | 1 | 3 |
| **Job Title** | | |
| Physician | 4 | 13 |
| Pharmacist | 0 | 0 |
| HIV Clinic Manager | 0 | 0 |
| Public Health Nurse | 2 | 7 |
| Midwife | 14 | 47 |
| Contact Investigator | 7 | 23 |
| Nurse (Other) | 3 | 10 |
| Medical Investigator | 0 | 0 |
| **Highest Education Level** | | |
| High School | 1 | 3 |
| Associate Degree | 2 | 7 |
| Some College | 0 | 0 |
| Bachelor’s Degree | 17 | 57 |
| Master’s Degree | 1 | 3 |
| Professional Degree | 3 | 10 |
| Certificate of Midwifery | 6 | 20 |
| **Years of Total Experience** | | |
| ≤ 1 year | 3 | 10 |
| 2-5 years | 6 | 20 |
| 6-10 years | 11 | 37 |
| 11-20 years | 7 | 23 |
| 21-30 years | 1 | 3 |
| 31+ years | 2 | 7 |
| **Years in Current Role** | | |
| ≤ 1 year | 5 | 17 |
| 2-5 years | 7 | 23 |
| 6-10 years | 11 | 37 |
| 11-20 years | 5 | 17 |
| 21-30 years | 1 | 3 |
| 31+ years | 1 | 3 |
| Note: Percentages may not sum to 100 percent due to rounding. | | |

*Pandemic-Related Changes in IPV Service Accessibility and Frequency*

Although interview participants hypothesized that COVID-19 had substantially impacted rates of IPV nationally, the survey found that more than half of providers reported no change in their frequency of IPV screenings since the start of the pandemic (n=17, 57%) (See Table 5). However, many providers said that there were more (n=10, 33%) or significantly more (n=2, 7%) IPV patients since the start of COVID-19.

*Table 5: Table of Changes in IPV Screening Since COVID-19 (N=30)*

| | **Frequency** | **Percent (%)** |
|---|---|---|
| **Frequency of IPV Screenings Since COVID-19** | | |
| Significantly More Frequent | 0 | 0 |
| More Frequent | 7 | 23 |
| Less Frequent | 2 | 7 |
| Significantly Less Frequent | 0 | 0 |
| No Change in Frequency | 17 | 57 |
| Don’t Know | 4 | 13 |
| **Number of IPV Patients Since COVID-19** | | |
| Significantly More | 2 | 7 |
| More | 10 | 33 |
| Less | 1 | 3 |
| Significantly Less | 0 | 0 |
| No Change | 10 | 33 |
| Don’t Know | 7 | 23 |
| Note: Percentages may not sum to 100 percent due to rounding. | | |

There were no significant associations between the following:

- Years a provider was in their current role and COVID-19 screening frequency (p=0.302)
- Years a provider was in their current role and the number of patients since COVID-19 (p=0.293)
- Age group and the number of IPV patients since COVID-19 (p=0.055).

On the contrary, there were significant associations between the following:

- IPV screening frequency and COVID-19 IPV frequency ($p \leq 0.001$)

- COVID-19 IPV screening frequency and the number of patients since COVID-19 ($p \leq 0.001$)
- Age group and COVID-19 IPV screening frequency (p=0.035).

*IPV Protocols and Services Across Clinics*

It is important to note that providers were strictly asked about their perceptions of training adequacy for and frequency of IPV screening in the past month. Most of survey participants indicated that they would be able to answer questions about IPV services (n=30, 60%), which provided the study sample (See Table 6).

*Table 6: Table of IPV Training & Service Availability*

| | **Frequency** | **Percent (%)** |
|---|---|---|
| **Ability to Answer Questions on IPV (*N*=50)** | | |
| Able | 30 | 60 |
| Not Able | 20 | 40 |
| **Staff Trained to Conduct IPV Screenings (*N*=30)** | 3 | 10 |
| All Staff | 2 | 7 |
| Most Staff | 21 | 70 |
| Some Staff | 2 | 7 |
| No Staff | 2 | 7 |
| Don’t Know | | |
| **IPV Screening Over the Past Month (*N*=30)** | | |
| All the Time | 7 | 23 |
| Some Of the Time | 14 | 47 |
| None Of the Time | 4 | 13 |
| Don’t Know | 5 | 17 |
| Note: Percentages may not sum to 100 percent due to rounding. | | |

Those who indicated they would not be able to answer questions about IPV services (n=20, 40%) skipped this section of the survey. The majority of sample participants surveyed indicated that only some staff had been trained to conduct IPV screenings (n=21, 70%). This was validated in the interviews, as many revealed that members of the psychosocial team (social workers, psychologists, and case managers) were the only providers who could answer questions regarding screening, management, and frequency. Seventeen percent of participants identified that all or most staff were trained to conduct IPV screenings (n=5), and nearly a quarter of participants found that IPV screenings were conducted all the time during the past month (n=7, 23%).

There were no significant associations between the following:

- Years of provider working experience and the staff trained to conduct IPV screenings (p=0.236)
- Years of provider working experience and IPV screenings conducted over the last month (p=0.257)
- Years a provider had been in their current role and IPV screenings conducted over the last month (p=0.202)
- Position in the clinic and staff trained to conduct IPV screenings (p=0.789)
- Age group and staff trained to conduct IPV screenings (p=0.128)
- Age group and IPV screenings conducted over the last month (p=0.273).

Additionally, there were no significant differences in the following:

- Years of experience for those who could and could not answer questions about IPV (p=0.353)
- Total time working in the clinic for those who could and could not answer questions about IPV (p=0.438).

There was a significant association between age group and ability to answer questions about IPV (p=0.026). There was also a significant difference in age for those who could answer questions about IPV and those who could not (t:40 = 2.19; CI: 8.267, 12.385; p=0.033). The mean age was 6.3 years lower in participants who could answer questions on IPV services than among those who could not, with the mean age for participants who could answer questions on IPV being 40.3 years (SD = 9.264) and 46.6 years (SD = 10.831) for those who could not.

## C. Qualitative Results

IDI participants were also primarily female (n=26, 90%) (see Table 7) and varied in age, job title, and experience.

*Table 7: Table of Interview Participant Characteristics (N=29)*

| | Frequency | Percent (%) |
|---|---|---|
| **Gender** | | |
| Male | 3 | 10 |
| Female | 26 | 90 |
| **Age** | | |
| 18-30 | 5 | 17 |
| 31-40 | 9 | 31 |
| 41-50 | 4 | 14 |
| 51-60 | 8 | 28 |
| 61+ | 2 | 7 |
| Missing | 1 | 4 |
| **Job Title** | | |
| Physician | 8 | 28 |
| Pharmacist | 1 | 4 |
| Social Worker | 3 | 10 |
| Adherence Counselor | 1 | 4 |
| Psychologist | 1 | 4 |
| Public Health Nurse | 3 | 10 |
| Midwife | 3 | 10 |
| Contact Investigator | 5 | 17 |
| Nurse (other) | 4 | 14 |
| **Highest Education Level** | | |
| High School | 0 | 0 |
| Associate Degree | 0 | 0 |
| Some College | 1 | 4 |
| Bachelor’s Degree | 16 | 55 |
| Master’s Degree | 3 | 10 |
| Professional Degree | 5 | 17 |
| Certificate of Midwifery | 4 | 14 |
| **Years of Total Experience** | | |
| ≤ 1 year | 3 | 10 |
| 2-5 years | 6 | 21 |
| 6-10 years | 3 | 10 |
| 11-20 years | 10 | 35 |
| 21-30 years | 3 | 10 |
| 31+ years | 4 | 14 |
| **Years in Current Role** | | |
| ≤ 1 year | 4 | 14 |
| 2-5 years | 13 | 45 |
| 6-10 years | 3 | 10 |
| 11-20 years | 5 | 17 |
| 21-30 years | 4 | 14 |
| 31+ years | 0 | 0 |
| Note: Percentages may not sum to 100 percent due to rounding. | | |

Over a quarter of the participants interviewed were physicians (n=8, 27%), followed by CIs (n=5, 17%), nurses (n=4, 14%), midwives (n=3, 10%), social workers (n=3, 10%), public health nurses (n=3, 10%), pharmacists (n=1, 4%), psychologists (n=1, 4%), and adherence counselors (n=1, 4%). Over half of the providers interviewed held a bachelor's degree (n=16, 55%), with nearly half holding a professional degree (n=12, 41%). The majority of participants interviewed had 11 years or more of total experience (n=17, 58%), however, over half of all interview participants were in their current position for five years or less (n=17, 58%).

### *i. Pandemic-Related Changes in IPV Service Accessibility and Frequency*

Participants described the social challenges of IPV in the wake of COVID-19 in the interviews, speaking largely about overall trends in violence and identifying the root of these trends as shelter-in-place and lockdown mandates. A secondary aspect noted by many participants was the challenge of addressing violence within the health system. Even with increased rates of violence, participants thought that patients did not feel comfortable reporting it, either due to COVID-19 or other societal challenges. A CI from the NERHA region described that while the services for IPV were still available, COVID-19 restrictions limited patients' ability to come to the clinic. He stated,

> *"Once the persons come in, they would have it available. As I mentioned, the challenge is they don't get to come in, with [COVID-19] restrictions."*

Several providers highlighted that the lockdown trapped many people in the same home with their abusers. Additionally, some providers stated that patients who were financially dependent on their abuser would feel like they could not escape because they had no other safe option, especially during COVID-19. An adherence counselor from the SRHA region stated,

> *"Because COVID has impacted them in some way financially, they find they're more dependent on their partner. Even in the case where they're being abused, it's hard for them to walk away from that relationship because they have no other means of financial support. So, we find that most of them just decide to stay and just tough it out."*

Elements of IPV were worsened and increased by COVID-19, as noted by several respondents. Violence perpetrated by family members and violence against children were highlighted as major consequences of COVID-19. Respondents noted that they could only guess what people were experiencing within their homes, but based on their experience, they believed abuse by family members and abuse against children increased during the pandemic. Regarding these trends, a psychologist from the SRHA region stated,

> *"This is not concrete, but based on what I've heard of, what I've read, gender-based violence or violence in the home or abuse was increased during the pandemic, whatever sexual violence or so. A lot of the reports came out about sexual violence against young people because they're home and their uncles and aunts are perpetrators, so they have easy access to them. So not necessarily what was happening at my clinic, per se, or in (Parish), but it was a general sense across the island that there were reports coming up that people were being abused and there were more incidents of gender-based violence or sexual abuse or so forth."*

A CI from NERHA shared this view, stating,

> *“You know, there are instances where children are abused, and if they are at home with their abusers, it’s not like they have school to escape to.”*

The CI went on to say that stay-at-home and lockdown mandates limited children’s ability to escape abuse within the home. She added,

> *“You know, some people are abused at home, the children, they are abused within their home setting. And when they go to school, they would have been, you know, away from that.”*

A physician from the SRHA region had similar thoughts, describing the ways in which she thought COVID-19 were impacting IPV. She stated,

> *“Unfortunately, you are financially in distress and psychologically in distress so tensions and frustrations are high and unfortunately persons who normally be able to get away they can't get away… it has affected adults and children alike, unfortunately. But again, we didn't have access to them, we wouldn't know. We can assume.”*

Several respondents hypothesized that rates of IPV increased during COVID-19, speaking anecdotally about how often they observed cases. A minority of respondents stated they saw no change in the frequency of IPV. A physician from the SRHA region stated,

> *“But in terms of what I think if it has increased…I think it has increased incidences of domestic violence. For a number of reasons…you're stuck at home with somebody who normally you would just- if you get upset, you would normally just go out somewhere blow off some steam, now you’re stuck at home with them so you’ll probably just take it out on them […] but I do believe the incidence has gone up.”*

A physician from the NERHA region felt differently, stating she saw no change in IPV cases since the start of the pandemic. She shared,

> *"Right, I can't think of it, but I heard on the media that children who have had to be at home facing sexual abuse and so on. (...) For us, it hasn't really come to my attention, you know, that we have had women or children facing a lot of abuse or an increase of what I should say, it hasn't come to my attention that we've had that problem."*

### *ii. IPV Protocols and Services Across Clinics*

Providers were asked a range of questions about the protocols for IPV care and the services their clinic provided. Provider training, screening, and services varied drastically across clinics, with some clinics not conducting any IPV screenings and others utilizing a holistic team of healthcare providers to deliver all-inclusive care.

#### IPV Screening

Provider perspective varied considerably regarding the frequency at which IPV was screened for and addressed in the clinic. As a result, many providers shared that they had never treated an IPV case before because it was not common in their clinic, and for that reason, their clinic conducted inconsistent screening, if any. Despite this perspective, participants also acknowledged that IPV is a critical issue in Jamaica and many people do not seek help because they do not feel comfortable reporting it. One midwife from the SRHA region remarked that the clinic she worked at never conducted screening for IPV, and that she had never seen a screening tool from her clinic before. The same midwife added,

> *"Well for me to know, they would have to come and complain. I don't have a chart where we see each patient and ask them the question. So, never heard them complain. Never see a problem."*

The process for IPV screening varied across clinics. A small proportion of providers utilized both observation-based screening and questionnaires or intake forms with questions regarding IPV. If that question was flagged, most participants stated the patients would be referred to the case manager and/or the psychologist at the clinic. A physician from the SRHA shared their clinic's protocol for IPV screening,

> *"Every single time they come to clinic they are asked since their last visit if they were exposed to any type of violence before. In fact, I'll actually read the question. So, every time they come to clinic, there's this form here. It says, since your last visit, have you experienced or been threatened with any form of violence or sexual abuse?"*

The majority of respondents described screening as observation-based. As described by participants, observation-based screening involved assessing the patient physically for any markers of violence, such as a black eye or bruising elsewhere on the face or body. In clinics where observation-based IPV screening was conducted, patients were given the opportunity to report any abuse or violence they were experiencing at home, although many noted this occurred rarely. A physician from the NERHA region stated,

> *"I don't think that part of care was really affected. As I said, if patients have complaints, they could also call team members. There's an active phone line or members of the team that they can speak personally if there are issues going on, and then those issues could be addressed."*

When asked about how screening protocols may have changed since the start of the pandemic, some providers stated they never had a screening protocol prior to it. Most providers stated that screening for IPV during COVID-19 remained consistent with pre-pandemic protocols. A CI from the NERHA region stated,

> *"Clients are still screened and still referred to the necessary agency as needed. I don't think the services have cut during or since."*

When asked if screening protocols would have been modified due to the pandemic, a public health nurse from the NERHA region stated,

> *"No, because with any situation like that, you realize that you have a set standard, and you have to follow protocols. (...) If you were to divert from it, I don't think it would be because of COVID."*

## Provider Training

Provider training on IPV varied among the clinics. Some participants described that clinics deployed holistic teams for IPV – meaning, if a case was flagged for IPV, they would be referred to the psychosocial team, which may consist of a psychologist, a case manager, and/or a social worker. Some clinics provided frequent trainings and workshops for providers on IPV. A CI from the NERHA region spoke about the training he received on referring IPV patients to his clinic's psychosocial team. He remarked,

> *"So, all of our caregivers who are charged with the responsibility to interface with clients have been sensitized, have received some level of training in screening for gender-based violence and we are told and asked to make documentations and also how to refer the clients to where they can get help."*

A physician from the NERHA region identified that beyond referrals for care, there are also safehouses for victims of abuse. She described how she and other providers were trained on these resources, stating,

> *"All right, so we have actually had training persons for staff members of different categories…and various trainings where they learned how to identify it, and referral places that they could refer and the safe places that are across the country that persons could be referred to."*

Some clinics had ongoing trainings for staff even during the pandemic. An adherence counselor from the SRHA region described the challenges both staff and patients were having with referrals amidst the pandemic and described the following training that was provided. She stated,

> *"Yes, we actually had a virtual presenter for all the staff. The psychosocial team had a workshop on that [referrals] because we do have patients coming in […] and that is a barrier for them."*

In some cases, training for staff only began after the pandemic had begun. A physician from the NERHA region shared that prior to the pandemic, most staff at the clinic did not know how to screen or refer for IPV, so it did not occur very often. She stated,

> *"So, I think before that, I don't know if we had much [screening] because it was just about the time when the pandemic was picking up that we had the trainings. So, I don't know if they had the experience of actually doing much referrals because they were just learning about this"*

Limited/Siloed Care

There were different standards of care for IPV both regarding screening and management depending on the clinic. In some clinics, lack of provider training led to limited services and care for IPV. While providers from most clinics had both the training and protocols to provide IPV screening and care, a minority of participants described a lack of services for IPV altogether. Some stated that they never do screening, which leaves the patient with the responsibility to report IPV on their own. A midwife from the SRHA region demonstrated this, stating,

> *"I: How did your clinic manage gender-based violence care and domestic violence screening for patients before the pandemic?*
>
> *P: They don't.*
>
> *I: They don't. Okay. Is there a screening tool that is used?*
>
> *P: Never seen one."*

Siloed care was a consistent issue for participants; several providers either could not answer questions about IPV or could only provide limited insight because IPV was outside of their scope. Further, the majority of participants stated that violence was either referred out to the hospital, or patients would go directly to the hospital. Therefore, some SRH clinics were not familiar with IPV care. Regarding IPV cases, a nurse from the SRHA region stated,

> *"Those are basically most seen at the hospital."*

Like many other participants, a physician from the SRHA region was unable to answer questions regarding IPV. When asked about how common IPV cases were at her clinic, she stated,

> *"No, I can't tell you. The psychologist can or some other people can deal with that."*

Referrals and Reporting

The majority of participants stated that the clinic protocol both before and during the pandemic was to refer patients out for IPV care and treatment. This included both referring to hospitals and/or immediately involving law enforcement. One public health nurse from the NERHA region stated,

> *"Once they are being suspected of being abused, in any way, I think the doctors have a protocol where they would-once they see the client, they would automatically call the police."*

If clinics did not have psychosocial teams, many participants described how they quickly referred IPV cases out to hospitals, especially in the event of physical abuse. One physician from the SRHA region stated that patients would be more likely to go straight to a hospital, rather than a clinic if they have experienced a wound from physical violence. He stated,

> *"Well, honestly, we don't really do that [screening] here. We refer to the hospital. If they come here, we just refer straight to the hospital."*

Most providers that spoke about reporting cases to law enforcement regarded it as a deterrent for patients to come forward. One public health nurse from the SRHA region described her experiences with IPV cases, recalling cases where she knew IPV was taking place, but the victim was unwilling to come forward because of what would follow. She stated,

> *“Because of that reporting system, sometimes some of them refrain to come to the health center because we told them we have to report it. They don’t want it to be reported.”*

A social worker in the SRHA region also found that people in Jamaica may be hesitant to come forward about experiencing IPV due to fear of it being reported. She shared,

> *“I haven’t met anybody that’s having that issue before. But as I said, the psychologist would speak with them basically and if I can help, then she would pull me in. We don't really have that much, though. Sometimes in Jamaica, people tend not to report it.”*

Fear and shame were common themes detailed by participants regarding patient reporting hesitancy. One CI from the NERHA region commented,

> *“Some people would have opted not to bother, because they don't want to cause any more problems because they think that the abuse will get worse, especially with physical abuse.”*

While some clinics described the treatment side of IPV taking place entirely at hospitals, some participants referred to their clinic’s psychosocial team as the primary care providers for patients experiencing or suspected of experiencing IPV. This team consisted of social workers, psychologists, and case managers. A social worker from the NERHA region said,

> *“When they come over to the treatment side, the psychologist or myself will do a little motivational interviewing to probe a bit more…to find out more about their*

> *situation…Once that is done, the victim support unit is called. We have point persons from each entity that we call, be it a child or an adult, child protection and family services. And once that is done, if it's too much for here, of course those units are called, and intervention takes its course."*

### *iii. Provider Perception of Current and Pre-Pandemic Clinic Practices for IPV*

The project's interview guide included a variety of questions on what clinic practices for IPV were like before the pandemic and at the time of the interview. Responses revealed two core beliefs held by most study participants:

1. While providers thought IPV was an important issue to address nationally, there were differences in how they reported IPV case management/care and whether they considered IPV an issue for their patients.
2. Even without direct experience, providers believed COVID-19 restrictions had an impact on IPV help-seeking.

#### Core Belief 1

While most participants acknowledged the importance of care for IPV, there was a disconnect between IPV screening frequency and the true severity of IPV. While providers stated they treated few IPV cases at their clinic, most of them still felt that IPV was a critical issue for Jamaica. One social worker from the SRHA region acknowledged this, stating,

> *"So now when they have to go leave, they say, okay, you don't have anywhere else to go for the family support. Sometimes…in Jamaica they probably go back to the situation until they are comfortable to leave. That's a big issue in Jamaica."*

Many participants stated they saw few IPV cases in their own clinic prior to the pandemic, but later acknowledged limited screening opportunities for patients and social influences surrounding IPV and reporting. When asked about how often the clinic sees IPV cases, a nurse from the SRHA region stated,

> *"We will have a few, few cases of domestic violence, but not much."*

Like many other participants, she disclosed that there was little she could speak to regarding IPV frequency and services because her clinic worked with those cases so infrequently. From the same region, a psychologist recounted her perspective on GBV case frequency more broadly, stating,

> *"To be honest, not often. Not often. I'd be lying if I said that it was often. And you have to know, I rarely see…I rarely do see gender-based violence. It occurs. I'm not saying it does not, but the clients compared to all the percentage of clients in the clinic…it is really a small number that goes through gender-based violence."*

Several participants gave their perspective on why people experiencing IPV may feel trapped or leaving the situation is not an option. Cultural norms, financial dependence on the abuser, shame, and stigma were all identified as challenges to escaping an abusive situation. A social worker from the SRHA region described this as,

> *"Because as I said, Jamaicans, we don't really tend to speak that much when it comes down to those kind of things [IPV] because sometimes they do have to…the partner is the one that they're dependent on."*

### Core Belief 2

Participants also shared their perspective on how COVID-19 impacted rates of IPV, finding that the pre-existing challenges to help-seeking and accessing care were compounded on and worsened by lockdown mandates. With the addition of financial difficulties, providers believed that patients could not come to the clinics as easily or often. One physician in the SRHA region remarked,

> *"…I think it [COVID-19] has increased incidences of domestic violence (…) If you get upset, you would normally just go out somewhere, blow off some steam. Now you're stuck at home with them, so you'll probably just take it out on them. Unfortunately, you are financially in distress and psychologically in distress so tensions and frustrations are high and unfortunately persons who normally be able to get away…they can't get away. And it also, I believe it has affected adults and children alike, unfortunately. But then because again, we didn't have access to them, we wouldn't know. We can assume…but I do believe the incidence has gone up."*

Overall, participants generally agreed that while they may not have seen IPV cases frequently at their clinics, it was a key issue in Jamaica. Providers commonly stated that they thought COVID-19 had heightened cases of IPV, even though they may not have data to prove it. While most respondents felt services did remain consistent during the pandemic according to survey data, interviews revealed that patients may experience many challenges accessing those services, reporting violence or abuse, and thus receiving care.

### *iv. Privacy and Confidentiality*

Privacy and confidentiality were critical themes identified in participant interviews. Difficulties with space availability, hence privacy, were found in nearly all the clinics. Participants described challenges regarding privacy as a lack of space, poor infrastructure (i.e. thin walls, non-sealed rooms), and service provision in which patients could be easily identified. During the interviews, the research team found that there was no protocol for privacy when a participant was in a room with someone – other providers would frequently enter rooms without notice or prior consent. A few clinics were also undergoing long-term renovations, which closed off blocks of the clinics, and led to providers sharing offices and patient rooms. According to most participants, space was foundational to providing a standard of confidentiality. One CI from the NERHA region said,

> *"Yes, this is one of our biggest issues in that the delivery of service, we need confidentiality. And without having adequate space for delivery of confidentiality, it could be a problem."*

Space was a notable challenge for most clinics. An adherence counselor from the SRHA region reflected on how lack of space impacts clients and commented that inadequate privacy can actually prevent healthcare workers from providing sufficient care. She worried that patients would be less likely to be truthful in healthcare visits in fear that their information may be overheard or not kept confidential. When asked what the greatest challenge facing her clinic was, the same adherence counselor said,

> *"Space, obviously. We literally have like…let's say 40-60% privacy. Seeing our patients…privacy plays a big role in actually reaching our patients. So, I think that would be our biggest gap, space hence privacy."*

A CI from the NERHA region similarly remarked,

> *"Yes, this is one of our biggest issues in the delivery service – we need confidentiality, and without having adequate space for delivery of confidentiality it could be a problem. So that is one of the biggest challenge. I think we would be able to focus more on- especially on IPV's especially -if we have more resources for them."*

COVID-19 was identified by some participants as a contributor to issues with privacy and confidentiality. Participants described being overwhelmed by masses of COVID-19 patients, which led to limited rooms for appointments and screenings. A psychologist from the SRHA region spoke about this, stating,

> *"There is no other space in the clinic for me to work. That is not good for confidentiality. And sometimes that space issue causes clients to feel vulnerable."*

While privacy was a challenge for many clinics, a few spoke positively about maintaining confidentiality for their patients. These clinics had established protocols for privacy, and the adequate infrastructure and space to speak to patients alone without fear of being overheard. A public health nurse from the SRHA region stated,

> *"...Each room has a lock, a door to it. It's only the annoyance of probably talking and the person constantly knocking when I'm dealing with someone. Privacy, I think we have managed that well."*

A physician from the SRHA region felt similarly, and while he primarily worked with people living with HIV/AIDS (PLWHA), he categorized privacy as a key priority for every patient at his clinic. He said,

> *"That's something that we see to be a big deal…When we see them, we ensure that they are alone in the room… only if they have a family member that already knows about it. So, every patient has privacy…So, we see them alone and we try not to shout out for everybody to hear what's happening. So, I'll say we have very good confidentiality."*

# V. DISCUSSION

## A. Discussion

Overall, this study highlighted inconsistent IPV screening, training, and care across clinics. Participants that worked at clinics with psychosocial teams and had thorough, consistent screening for IPV were more likely to categorize IPV as a significant issue for Jamaicans exacerbated by COVID-19. Clinics with limited IPV care, siloed care, and/or little provider training on IPV care were less likely to identify IPV as a critical issue. Considering the global impact of the pandemic on health systems, it follows that clinics had to quickly adapt and reprioritize their services to not become inundated and overwhelmed.

These findings contextualized provider experiences and demonstrated the respective challenges faced in both assessing and subsequently providing care for IPV patients during COVID-19. Respondents described the various protocols for IPV screening and management, perceptions of post-pandemic IPV frequency, and their personal experiences providing care for IPV. The qualitative data collected from health care providers presents a syndemic relationship between COVID-19 and IPV, revealing key themes of limitations with provider training, scope of IPV services, stigma surrounding IPV and reporting, and complications with accessing care during a global pandemic. Further, many of the challenges highlighted by participants related to IPV screening, treatment, and accessibility predated the COVID-19 pandemic. However, COVID-19 was an additional challenge for both providers and patients for a multitude of reasons, especially regarding help-seeking, reporting, and care.

### *i. Pandemic-Related Changes in IPV Service Accessibility and Frequency*

The turbulence of the pandemic overwhelmed SRH clinics across Jamaica, forcing providers to reprioritize services, adapt to ever-changing guidelines, and manage higher patient loads with decreasing staff. Participants faced several challenges with providing essential services during the pandemic, especially those that predated March of 2020 but worsened as a result of COVID-19. Participants ultimately identified two major impacts of the COVID-19 pandemic regarding IPV: service accessibility and overall IPV frequency.

With the constraints of the Disaster Risk Management Act masking policies, curfews, lockdowns, and social distancing mandates (Bourne et al., 2021), providers worked tirelessly to maintain consistent services for patients. The adaptability and resiliency of Jamaica's health care providers gave way to a flexible system. As a result, most clinics were able to maintain consistent IPV screenings and care during the pandemic. The survey validated this finding, as statistical analysis revealed a significant relationship between IPV screening before the pandemic and at the time of the interview.

While services largely remained the same, providers found that the barriers for patients to accessing them became more severe during the pandemic. Participants commonly cited financial difficulties, job loss, inability to access public transportation while maintaining COVID-19 guidelines, and mental health issues as pandemic-related barriers for accessing care. Other studies confirmed the impact of restrictions from the Disaster Risk Management Act, finding up to 90% of participants agreeing that COVID-19 measures prevented them from accessing essential services (Bourne et al., 2021). Literature also indicated experience of violence increased during the pandemic (Jones et al., 2021; Bourne et al., 2021; Crawford et al., 2021; Krubiner et al., 2021), indicating more Jamaicans experienced IPV with less access to critical help-seeking services and screenings. Many patients – especially patients from a lower socioeconomic class, as noted by respondents – lost their job due to the pandemic and lacked the financial means to take care of themselves or their families. Violence is a social issue, compounded by interactions with other societal burdens and inequalities. The literature demonstrated that concerns regarding economic inequity and violence existed prior to the pandemic but were worsened by it (Priestley, 2014). Thus, rising economic strife during the pandemic acted not only as a stressor to violence in Jamaica, but as a barrier to accessing critical IPV screening and care.

While accessibility of services declined during the pandemic, participants still believed that IPV had increased as a result of COVID-19. The qualitative interviews varied from the survey: while most participants felt IPV had increased during the pandemic, they were also likely to acknowledge that they had not necessarily seen it for themselves. This could be due to, in part, pandemic restrictions that impacted IPV service accessibility for patients. Participants understood the impact stay-at-home mandates could have for victims living with their abusers, because now, patients faced even more difficulties with coming to clinics for care. Because patients faced more barriers to accessing IPV screening and support, providers could only hypothesize what women and children experienced behind closed doors.

COVID-19 and IPV both work in consequence of and as detriment to one another. An unintended consequence of lockdown mandates resulted in many people being confined indoors with violent partners, increasing their risk for abuse (Jones et al., 2021). Synergistically, participants identified pandemic-related employment and financial instability as both a stressor for violence and made survivors of IPV more dependent on their abusers. As shown in literature, financial dependency often drives transactional and survival sex, possibly increasing the transmission of COVID-19 (Stark et al., 2020; Krubiner et l., 2021). Further, several participants indicated they feared what stay-at-home orders meant for children living in abusive environments. The impact of COVID-19-related lockdown mandates demonstrates the syndemic relationship between the pandemic and IPV; children isolated in abusive environments due to the pandemic are at risk for long-term impacts that perpetuate cycles of abuse. Even further, one of the most significant indicators for increased risk for IPV is an experience of childhood violence, with even witnessing violence between parents doubling the likelihood of experiencing IPV (Priestley, 2014). If more children are exposed to violence at home due to the pandemic, then even more children at risk for experiencing IPV later in life. Therefore, COVID-19 has not only impacted current rates of IPV, but it also poses a significant threat to children's long-term health outcomes, potentially increasing IPV rates for decades to come.

### *ii. IPV Protocols and Services Across Clinics*

Survey and interview responses revealed that IPV training, protocols, and services varied drastically across SRH clinics. In some cases, clinics implemented comprehensive, inclusive IPV training and employed holistic teams of psychosocial health care providers specifically designated to deliver IPV care. Another clinic in that same region had no protocols in place for IPV, no providers trained in handling IPV cases, and did not conduct any violence screening. Differences in screening were contextualized by provider training and reporting/referral protocols in place. Further, providers who worked at clinics with comprehensive IPV services, screenings, and trainings tended to work with more IPV cases at their clinic as opposed to those who did not have comprehensive services. Some providers subsequently reached the conclusion that there was not a high rate of IPV in their area; however, this may better reflect that the clinics do not have the proper infrastructure or protocols to identify cases, not that IPV was not occurring at all.

#### IPV Screening

While few participants described using intake tools like questionnaires to screen for IPV, clinics that did use these tools also demonstrated frequent and comprehensive provider training and psychosocial teams for IPV patients. Observation-based screening was the most common protocol in place among participants. This included assessing patients' physical appearances for any markers of violence, like looking for bruises or wounds and noting any unusual behavior. Primarily, providers emphasized looking for evidence of physical violence

– sexual, emotional, and other types of IPV were rarely mentioned, if at all. If abuse does not present physically, observational assessment could result in many victims going unnoticed within the healthcare system (Bryan, 2020). In clinics where “bservation-based IPV screening was conducted, providers also categorized self-reporting as a method for screening; however, studies have shown victims are unlikely to reveal abuse without being asked directly (Bryan, 2020). Thus, if patients do not present physically for abuse or self-report violence, it is probable IPV is being missed in SRH clinics with these protocols. Additionally, there was no literature on the efficacy of these methods of screening, as they do not necessarily qualify as them – the identification of bruising or the expectation of self-reporting are not standardized, nor do they assess their whole body. Screening requires a methodology in place that tests and examines if a patient has a particular ailment (Ramaswamy et al., 2019), and the most commonly cited methodologies in place by participants were not methodologies at all. Without a clinical, standardized methodology for screening, there is no mechanism to assess the landscape of IPV in a health region. This is especially challenging in the context of COVID-19; it is difficult to understand the impact of the pandemic on IPV and related clinic services when there is no baseline to begin with.

Furthermore, a few clinics revealed they did not have any protocols in place or did not screen for IPV at all. However, even when participants did not screen for IPV, they still recognized IPV as a critical issue in Jamaica at a national level, especially in the wake of the pandemic. Some studies argued that providers’ own biases or perceptions of barriers to screening are what keep screening rates so low (Swailes et al., 2017). On the contrary, participants demonstrated concern for IPV in Jamaica, especially in the wake of the pandemic. Personal bias was not the reason for inconsistent screening. In fact, qualitative findings from this research show that providers were constrained by system-level barriers, like lack of protocols, resources, or standardized practices, rather than perceived barriers.

Without any screening or standard practices, the only way a provider would encounter an IPV case was if a patient reported it. Some participants understandably held the belief that because they never saw any IPV cases, there must not be any violence occurring in their area. However, screening is demonstrably vital to catching IPV cases. Many studies have evaluated the efficacy of IPV screening, and results demonstrate screening significantly increases the identification of IPV (O'Doherty et al., 2014). One participant even commented that patients never complained about IPV, resulting in the belief that it was not a problem in the area. However, a lack of patient disclosure and help-seeking reveals a greater issue with the mechanisms for screening and intervention. Patients may be more likely to disclose if there were standardized avenues to receive comprehensive screening and care.

Even when screening was sufficient and comprehensive, COVID-19 limited clinic and provider capacity. A few participants identified a mass exodus of health care providers leaving the workforce once the pandemic began, leaving clinics understaffed and overwhelmed. With only 4.5 doctors and 9.4 nurses/midwives per 10,000 people in Jamaica (WHO, 2022b), there were simply too many patients for staff to be able to effectively screen at a consistent and standardized rate. Pre-existing screening practices in Jamaica were already inconsistent and unstandardized across the nation, and with the onset of COVID-19, it became even more challenging for providers to effectively screen for IPV.

### Provider Training

A potential source for lack of IPV screening was insufficient or nonexistent training for providers on IPV care. Some clinics had comprehensive training programs, which typically indicated a standardized screening protocol that utilized intake forms and questionnaires. These participants shared that their clinic ensured all health care providers were proficient in screening practices, intentional IPV support and care, referrals, and received consistent trainings to maintain consistency. Validated by the survey as well, some clinics maintained IPV trainings during the pandemic, citing the impact of COVID-19 on IPV prevalence as a main reason. Subsequently, clinics with adequate training and IPV protocols had the capacity to conduct screening all the time, demonstrating the importance of prioritizing IPV services. Further, providers with adequate training felt confident in their knowledge about IPV, which resulted in better interactions with patients, more consistent screening, and a stronger sense of preparedness in providing IPV care and support (Colarossi et al., 2010; Bryan, 2020).

While some providers had positive experiences with training and attitudes surrounding IPV screening and care, many providers expressed having very little experience or training on IPV. This was reflected in survey results, where nearly half of survey participants were unable to speak to the IPV screening practices at their clinic. Relatedly, statistical analysis demonstrated a significant association between age group and the ability to answer survey questions about IPV. Thus, a generational gap exists between the perception that IPV should be a part of the public or private sector, and ultimately, younger people are more likely to discuss IPV.

In clinics that had psychosocial teams designated for IPV care, providers commonly referred patients to that unit if they disclosed abuse. As validated in the surveys, if clinics had psychosocial teams, IPV training for all SRH providers at the clinic may not be deemed as necessary, as the psychosocial teams were primarily responsible for IPV cases. However, not all clinics had psychosocial teams, and even if they did, patients reporting IPV could have their first interaction with someone who was not adequately trained in IPV support. Literature indicates that a lack of training in enquiring about and responding to IPV may ultimately cause more harm than good, as providers could deliver insensitive solutions or unintentionally invalidate victim experiences (Kalra et al., 2017). Thus, lack of training on both screening and support could impact patient disclosure of IPV, and even with psychosocial teams, a baseline level of knowledge is needed amongst all healthcare providers.

### Limited Care

When training was identified as a weak point in clinic infrastructure, themes of limited, nonexistent, and/or siloed care were identified. Without adequate training, several providers felt IPV was outside of their scope; some participants revealed that they worked strictly within the confines of their own specialization. For example, providers who specialized in maternal and child health (MCH) or HIV/AIDS were rarely able to answer questions about IPV screening and care. The siloed nature of these clinics isolated patients with intersecting health problems. Literature demonstrated that IPV can not only increase the likelihood of HIV acquisition, but PLWHA are more likely to experience IPV (Sullivan, 2019). Thus, with the intersection of IPV and HIV not being assessed by HIV providers, patients have nowhere to turn to receive the proper and necessary care. It is possible that PLWHA, an already vulnerable population, who are experiencing IPV are being missed within the health system. Literature has demonstrated that IPV can also interfere with victims' adherence to HIV care (Sullivan, 2019), signifying that it is in HIV care providers' best interest to receive training for IPV screening and care.

Surprisingly, the pandemic brought an unexpected improvement to healthcare delivery in Jamaica – it united clinics in a common goal to stop the spread of COVID-19. For example, SRH, MCH, HIV/AIDS, chronic/non-communicable disease, and general care clinics alike all adapted seamlessly to public health mandates, changes in infrastructure, and an influx of patients. COVID-19 demonstrated that given the proper resources, community engagement, and government backing, clinics can work synergistically (Rifkin et al., 2021). Given the pandemic's impact on already high rates of IPV, the siloed nature of IPV care could benefit from that same unification of clinics.

### Referrals and Reporting

Throughout the study, some participants outlined what care for IPV cases looked like. Clinics that employed psychosocial teams defined treatment as the provision of safe houses and resources, emotional support, mental health services, and validating care. The effects of inclusive treatment are significant; literature shows that patients who felt validated, safe, and in control of their care reported better provider experiences and were more likely to seek care (Heron & Eisma, 2021). Women were also more likely to seek help among healthcare practitioners than other traditional reporting mechanisms (Bryan, 2020), so if the initial intervention point is an inclusive psychosocial team, it could benefit patient disclosure and keep the help-seeking process moving smoothly.

Moreover, IPV care was most often defined by participants as reporting cases to law enforcement and referring patients out to hospitals for physical violence. Respondents recalled that because they would report IPV to law enforcement, they thought patients felt deterred from disclosing violence. Providers saw when patients were experiencing physical violence at home, but the patients would not disclose or validate any abuse out of fear of being reported, ultimately deterring some participants from screening at all. Research on IPV disclosure identified fear of getting their partners in trouble, mistrust in the judicial system, and shame as the main deterrents to reporting to law enforcement (Crawford et al., 2021; Priestley, 2014; Wall, 2012). In fact, a study on help-seeking for women exposed to IPV in India found that only a quarter of nearly 20,000 participants sought some kind of help, and a mere 1% of them sought help from formal institutions (Leonardsson & San Sebastian, 2017). Despite clinics acting as a key intervention point for violence, their connection to law enforcement acts as a significant deterrent for IPV disclosure.

Additionally, referrals to hospitals were another key component of IPV care. Unless a clinic had a psychosocial team, most clinics indicated that treatment for IPV primarily occurred in hospitals. Providers often described the presentation for IPV as a physical wound, and as a result, patients would be referred to local hospitals for the physical emergency. It was not addressed by respondents if patients that reported IPV and were referred out to a hospital received care solely for physical wounds or additional support as well. IPV may be better understood as a chronic issue; one that can impact the physical, social, sexual, financial, and mental wellbeing of a person. Therefore, patients may be seeking help at clinics not just for the treatment of physical violence, but for other components of IPV, like sexual or emotional abuse. They may also be searching for mental health services, counseling, resources, or emotional support. Research shows that women who received IPV interventions were 60% more likely to end an unsafe relationship (Miller at al., 2015). Thus, systems that refer IPV patients to hospitals as their method of treatment may be insufficient for patients searching for emotional support, thereby halting the levels of care needed for IPV.

### *iii. Provider Perception of Current and Pre-Pandemic Clinic Practices for IPV*

The results demonstrated two core beliefs held by most study participants; 1) while providers thought IPV was an important issue to address nationally, there were differences in how they reported IPV case management/care and whether they considered IPV an issue for their patients, and 2) even without direct experience, providers believed COVID-19 restrictions had an impact on IPV help-seeking.

#### Core Belief 1

Although many participants thought IPV cases were uncommon at their clinic, nearly all providers expressed that IPV was a critical issue for Jamaica. Some providers felt IPV was extremely important to address, especially if their respective clinic was actively involved in addressing IPV. While some clinics demonstrated little involvement with IPV screening or care, other clinics actively campaigned for spreading awareness about intimate partner/gender-based violence. For example, a SRHA clinic displayed communication materials for violence awareness (See Appendix C for photos). These public health awareness campaigns symbolized many participants' perspective on IPV: a critical issue facing their country that their clinic had a key responsibility in addressing.

Some providers acknowledged IPV as a pertinent issue facing the nation but did not see it as a problem facing patients in their area. Given that estimates of lifetime IPV experience in Jamaica range from 28%-83% (Anderson, 2012; Priestley, 2014; Williams, 2016), the frequency at which providers stated they rarely, if ever, saw IPV cases is out of step with national averages. This finding may demonstrate challenges for patients with help-seeking, reporting, and accessibility to services, rather than a non-issue. The description of rarity among IPV cases in tandem with the validation that it is a national problem exposes the gap between service provision and help-seeking.

### Core Belief 2

Pre-existing challenges to help-seeking and accessing IPV care were compounded and worsened by lockdown mandates in Jamaica. While providers worked diligently to ensure clinics maintain consistent services, participants found that the real issue was patient accessibility. Participants found that COVID-19 protocols presented several challenges to accessing care: mandates impeded on public transportation, economic strife and job loss led to a reprioritization of needs, and stay-at-home orders forced victims of IPV into close quarters with abusers, making it difficult to seek help (Jones et al., 2021).

Overall, participants generally agreed that while they may not have seen IPV cases frequently at their clinics, it was a key issue in Jamaica made worse by the pandemic. Providers commonly stated that they thought COVID-19 heightened the rate of IPV and abuse, especially amongst children, even though they may not have data to prove it. While most respondents felt services remained consistent during the pandemic, according to survey data, interviews revealed that patients experienced many challenges to accessing those services and receiving care. A scoping review on access to healthcare for non-COVID-19 conditions demonstrated similar findings. Pujolar et al., (2022) identified a general reduction in service utilization, due to both new barriers to access and the exacerbation of existing ones. Likewise, economic and social challenges facing Jamaicans that predated the pandemic have snowballed into even greater difficulties accessing care. Reduced access to healthcare due to the pandemic has been identified in research as a burgeoning challenge (Núñez et al., 2021; Pujolar et al., 2022), marked by pre-existing challenges that exacerbated its effect. These findings provide relevant and critical insight to how healthcare systems work as intervention points for victims of IPV and how that has changed with COVID-19; with these data, there may be opportunities to improve the accessibility of IPV services for patients.

### *iv. Privacy and Confidentiality*

An unexpected gap in IPV service delivery identified in the qualitative interviews was privacy. Inadequate space and other challenges with infrastructure were commonly cited difficulties with providing care, making it difficult for clinics to create a private environment for patients. Some participants described excellent confidentiality and patient-provider trust at their clinic, however, clinics that experienced challenges with privacy had the issue before the pandemic began and found that COVID-19 posed as a significant contributor to the problem.

Several providers expressed fears that their patients felt uncomfortable disclosing experiences of IPV. They also felt helpless to the issue, as many of the reasons for discomfort were structural; long-term renovations that forced many providers to share offices and patient rooms led to frequent interruptions and overcrowding. While participants described trying their best to make patients feel comfortable, they ultimately felt that privacy and confidentiality simply could not exist when patient load was high and space was limited. Relatedly, several studies analyzed the environmental factors that facilitate IPV disclosure. For example, one study found that people were more likely to disclose abuse when providers could ensure confidentiality (Liebschutz et al., 2008). With so many participants expressing doubt in their clinic's ability to provide a private and confidential space for patients, it could be even more challenging to guarantee that confidentiality to their patients. Further, patient rooms with limited privacy may, in turn, make providers feel less confident in providing adequate IPV care. This, too, poses a significant challenge, as self-efficacy has been shown to be a significant facilitator of providing quality IPV screenings and support (Colarossi et al., 2010; Bryan, 2020).

Beyond space limitations, clinic infrastructure also posed a significant challenge for participants in providing confidential care. Many of the patient rooms in clinics were non-sealed and often had thin walls, making conversations just outside the room easily heard. If patients can hear people right outside their door, that may lead to patients not feeling comfortable to disclose. Research shows that the threat of having confidentiality broken, intentionally or not, can serve as a significant barrier to disclosure for IPV patients (Heron & Eisma, 2021). Thus, spaces that do not feel private can lead to patient hesitancy to disclose.

Many of the clinics facing difficulties with space and privacy had been coping with these challenges before the pandemic began. Following the spread of COVID-19, participants described that a major decrease in the health workforce and a significant influx of patients exacerbated preexisting struggles with privacy, inundating the system. In January 2022, the Jamaican Ministry of Health and Wellness reported that hospitals had surpassed 100% capacity due to COVID-19 and were restricted to solely emergency service provision (Ministry of Health and Wellness, 2022b). If clinics were struggling with adequate space before the pandemic, maximum capacity presents an even greater challenge for health care providers. As a result, overcrowding due to the pandemic and insufficient space create an environment inconducive to IPV disclosure.

Contrarily, clinics that reported good infrastructure prior to the pandemic fared better than clinics without. Some participants spoke positively about clinic organization and privacy, describing plenty of space, doors with locks, and sealed rooms. As a result, they felt patients were comfortable and would not feel hesitant to disclose IPV to them. Research demonstrated the impact that the environment of the doctor's office can have on IPV disclosure. When environments feel safe, private, and comfortable, they are significantly more likely to disclose abuse to their provider (Heron & Eisma, 2021). In fact, a common theme across the results was that many of the challenges providers faced in conducting regular screening and IPV care were not personal perception-based barriers, as some research suggests (Swailes et al., 2017), but rather system-level barriers they were working diligently against. Insufficient space, government support, resources, training, and standardized processes constrained many clinics' ability to provide quality IPV screening and care, despite the dedication and adaptability of the staff. Accordingly, COVID-19 alone was not responsible for the challenges facing IPV services; rather, it revealed the depth of the cracks in the foundation that were already there.

## B. Importance

The findings of this project should be interpreted in the larger context of international efforts to assess the impact of COVID-19 on IPV and increase accessibility and resources to services for help-seeking and reporting. While several providers worked to increase awareness about IPV and decrease stigma, there is a current gap at the clinic level to serve as intervention points. This project serves to assess this gap and will lay the groundwork to identify both provider experience and needs to understand how it can be improved. While the

MoH and other IPV stakeholders are working to improve stigma on an interpersonal level for victims of IPV, there have been limited policies or assessments of help-seeking and provider training at a clinic level (NPGE, 2010; UN, 2017; Awolaran et al., 2022). Therefore, this research study is a meaningful and significant step in identifying the gaps in provider training and screening and understanding how these gaps can be exacerbated by extraneous burdens on the system, like a global pandemic. Additionally, because the pandemic is ongoing, there have been limited studies analyzing the effects of the pandemic on SRH clinics. This research study provides insight into provider experience providing IPV care, adaptations made to continue providing care during COVID-19, and the impact of the pandemic on operating procedures, processes, training, screening, and management for IPV.

## C. Limitations

There were several limitations to this project. For example, health professionals needed at least three years of experience to answer questions about clinic operations and services before the pandemic. Because recruitment of participants for the IDI and survey predicated on who was available that day at the clinic, the research team did not vet for years of experience. As a result, new healthcare professionals who started their career during the pandemic were unable to speak to service delivery prior to the pandemic, resulting in thin data for some surveys and IDIs. Because data collection took place during clinic operating hours, frequent interruptions occurred during IDIs and surveys. Additionally, the team received approval for only two of the four health regions in Jamaica.

Further, the team faced both budget and time constraints with data collection. The organization of the Jamaican health centers did not easily allow for one person or position to speak on all the services being offered at the center; this occasionally resulted in incomplete perspectives on IPV services. As a result, the research team further identified different positions suitable for research as the data collection process continued. The research team ultimately only spoke to health care professionals who worked in areas of SRH, MCH, HIV, and psychosocial support. The team also learned from participants that victims of violence may go straight to a hospital, rather than a clinic, if they have experienced a wound from physical violence. Data from hospitals were not collected, which could demonstrate a gap in sampling. The different types of roles the research engaged with were dependent on who was available at the health centers and who responded to research calls/emails. Further, the variety of health centers engaged with was dependent on the outreach of AHF and those who engaged in the team's communications outreach.

Many participants believed COVID-19 had severely impacted IPV but stated they had not seen it personally. The research team collected data when most COVID-19 mandates were still in place, meaning many people may have not been accessing health services at that time. It is possible that it was too early for providers to have seen an increase in IPV cases. Thus, the impact of the pandemic on violence may not have been fully felt by providers yet.

Because privacy and confidentiality were an issue for many clinics, the research team found that some participants were hesitant to speak candidly about their experiences, either in fear of being overheard or having their involvement connected to the study. Some participants did not want to be recorded for this reason or stated they could not express their full sentiments on certain questions. Additionally, both the survey and the IDI had to cover a breadth of topics. Because IPV was a subset of one of the research questions, the topic was featured limitedly in both tools, impacting the level of depth achieved in the IPV section.

# VI. CONCLUSION

## A. Suggestions for Further Research

Many of the providers that the research team interviewed and surveyed specialized in HIV/AIDS care; as result, the team learned about the wide variety of services available for PLWHA and how those services were adapted during COVID-19. If a patient tested positive for HIV/AIDS, they likely saw a diverse team of providers in their visit: CIs, adherence counselors, social workers, pharmacists, physicians, and/or psychologists. This comprehensive team went beyond medical care and provided social services and support to help meet all the patient's needs. Providers described helping patients find work, offering food and care packages, even reaching into their own pockets to help their patients. During the onset of COVID-19, providers and clinics worked quickly to adapt to the mandated changes and implemented evening clinics for PLWHA, home-based care, medicine delivery, and increased social services for patients experiencing financial difficulties. HIV/AIDS providers had both the resources, support, and training to go above and beyond for their patients. It begs the question of what this level of care could accomplish for other chronic health issues, like IPV. Thus, further research about comprehensive care for IPV could greatly benefit standards of care for IPV. The model of care Jamaican SRH clinics demonstrated for PLWHA could be easily adaptable for other chronic health issues, like IPV, and should be studied and assessed.

This research evaluated how SRH clinics and providers were impacted by COVID-19, however, interviews revealed a significant challenge of patient accessibility rather than service availability. While study participants provided invaluable insight into the pandemic's interaction with health systems, there was a common sentiment that many of the challenges facing patients were related to social issues, such as financial instability or job insecurity due to the pandemic, rather than a lack of services. Additionally, interviews revealed that patients may be more likely to go directly to a hospital for physical violence, indicating that providers at hospitals would also be an important population to include in future research. This demonstrates the need for alternative perspectives; to understand the pandemic's impact on health systems, further research on both patient experience and IPV care in hospitals is critical. Furthermore, it would be beneficial to replicate this study and these evaluations in other countries to assess the impact of COVID-19 on IPV care around the world.

Challenges that research participants described predated the pandemic but were exacerbated by it. Further, findings demonstrated that infrastructural hurdles were the prominent barrier for participants in providing IPV services and support. Rather than perceived or individual-level barriers, insufficient training, understaffing, inadequate space and privacy, and limited standardized procedures and protocols surrounding IPV were all common challenges study participants identified, all of which predated the pandemic. More research on the impact of COVID-19 on IPV is necessary, however it must be contextualized by research on the health system's baseline. Even without a global pandemic impeding service provision and IPV prevalence, there was inconsistent infrastructure for IPV care in Jamaica. Thus, when the pandemic began, there was little for providers to compare regarding IPV care and prevalence before and after the pandemic. Further research on the barriers and facilitators of health system infrastructure regarding IPV should be conducted in Jamaica.

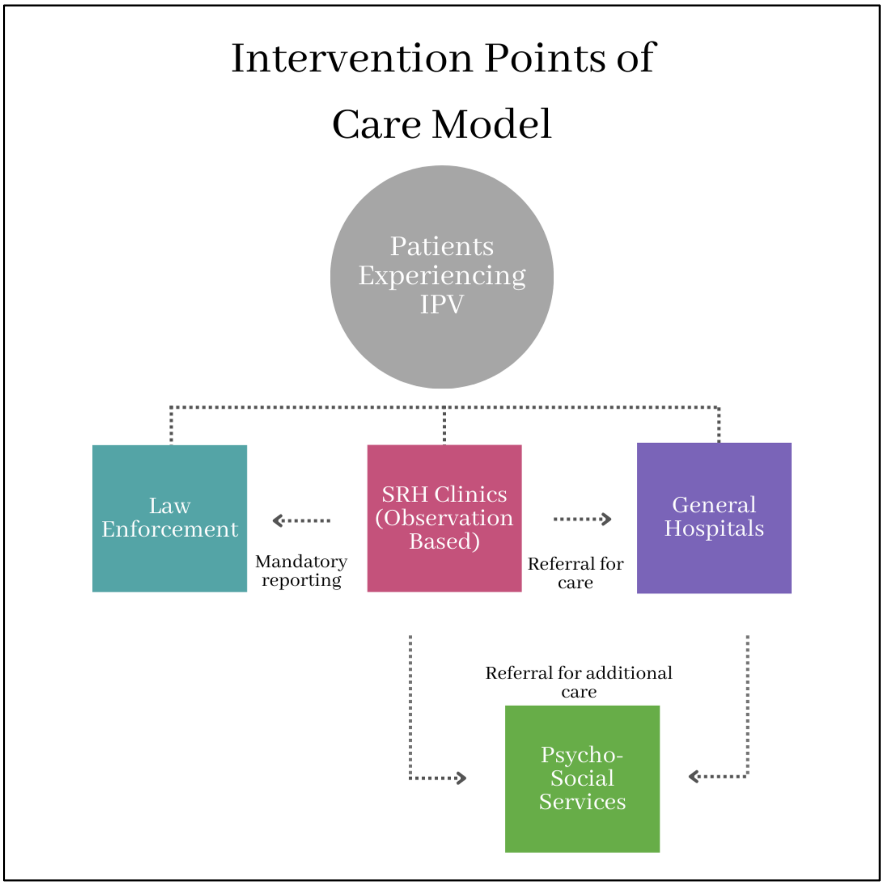
## B. Conclusions and Public Health Implications

The spread of the COVID-19 pandemic was a significant difficulty for health care systems alike in Jamaica, as the effects were made even more devastating by preexisting structural and systemic issues surrounding IPV screening and support. Ultimately, there are three layers regarding the effects of COVID-19 on IPV services. First, IPV is a significant issue in Jamaica, and preliminary research demonstrated that it increased during the pandemic. Secondly, findings from the interviews established a conflation between inconsistent screenings for IPV and perceived prevalence of it. Finally, health care providers in Jamaica successfully pushed to make care for other chronic health issues, like HIV/AIDS, more accessible and comprehensive during the pandemic, demonstrating opportunities for improvement regarding IPV services.

Violence against women and girls was a considerable issue in Jamaica before the emergence of COVID-19, and preliminary research demonstrates it worsened during the pandemic (Boserup et al., 2020; Bourne et al, 2021; Krubiner et al., 2021; Crawford et al, 2021). Participants theorized that social stressors, like poverty, job insecurity, cultural views on masculinity and sexuality, and stigma surrounding disclosure all played a significant role in IPV prevalence and underreporting. Furthermore, many clinics did not have the capacity or infrastructure to effectively screen for IPV, which could result in cases of it slipping through the cracks of the healthcare system.

As a result, there is a misalignment in provider perception of IPV. Without mechanisms for screening in place, many providers thought IPV simply was not an issue in their area. As a result, some participants demonstrated little to no involvement or ability to facilitate IPV screening or care. However, providers also felt that Jamaica’s SRH clinics sit squarely in the center of IPV intervention points. While providers varied in their perception of IPV frequency, discussion regarding IPV care and treatment revealed it was primarily initiated at the SRH/HIV/AIDS clinic. The figure below demonstrates the various intervention points a person experiencing IPV may cycle through, and while individuals may go to law enforcement or general hospitals directly, this research found that patients often initiated care with SRH clinics and would be referred to the necessary agencies by those clinics (See Figure 8). This poses a critical issue; if SRH clinics rest at the center of IPV intervention, and many of those clinics were identified to have limited IPV infrastructure, screening, or support, then those intervention points may be ineffective and potentially harmful.

*Figure 8: IPV Intervention Points of Care Model*



In some clinics, the research team found that the intervention points/methods of care and the lack of standardization of them acted as barriers for patients receiving IPV screening and support. Inconsistent training made it difficult for providers to comfortably deliver IPV screening and care, and the threat of law enforcement involvement deterred patients from disclosing abuse. The reporting hesitancy identified by participants is also important to consider through the lens of privacy and confidentiality. With limited space, crowded waiting rooms, thin walls, and frequent interruptions, patients looking to disclose abuse may be easily identifiable in a clinic setting. Fear and risks involved with being caught reporting could serve as acute barriers for victims of IPV, and a lack of or inadequate privacy and confidentiality could be a key component of that. These factors demonstrate why so many providers felt IPV was not an issue at their clinic, despite the prevalence of violence in Jamaica. Right now, there is not the infrastructure in place to support comprehensive and safe IPV screening and services. Furthermore, without consensus amongst clinics and providers, IPV remains a ubiquitous issue too slippery to address. Ultimately, systemic and infrastructural inadequacies, patient challenges, and the pandemic context all contribute to inconsistent ongoing screening. Further, there is a pattern among providers where some do not assess patients for violence because they do not believe IPV is an issue in their area. As a result, the lack of assessment leads to less recognition of IPV, which further ingrains their believe that IPV is not affecting their patients. This paradox ultimately leads to less detection of IPV overall and less impetus to create formal screening mechanisms.

However, the impact of COVID-19 has not been monolithic. While it posed several challenges to health care in Jamaica, it also provided an opportunity to improve healthcare delivery. Despite the difficult landscape of COVID-19, the adaptability and resiliency of providers led to innovative healthcare delivery strategies for other chronic health issues, like HIV/AIDS. To ensure PLWHA did not discontinue their treatments and medications, many providers described opening evening clinics, offering home-based care and medicine deliveries, and providing social services like job assistance and food/care/financial packages. The adapted healthcare model made HIV care even more accessible and comprehensive than it was before the pandemic, and as a result, most participants felt the pandemic did not negatively impact HIV services. The capacity to provide this level of care is possible when funding, resources, and consistent training are prioritized, thereby improving health outcomes for patients as a result. Ultimately, the potential to apply a similar care model demonstrates an opportunity for improvement regarding IPV services.

Notably, the research team saw clear examples of this with IPV care in Jamaica. Clinics prioritizing and allocating resources towards IPV employed psychosocial teams that provided a variety of services, like safe houses, childcare, mental health services, and counseling. Not only did these clinics have a reliable team of providers specifically for IPV, but they showcased a clinic-wide approach to care. These clinics had their entire work force undergoing frequent trainings on IPV, both before and during the pandemic, and had the space to conduct private IPV screenings. They were also active in health promotion surrounding abuse: they wore purple ribbons for DV awareness and had several posters throughout the clinic that worked to destigmatize and make IPV a more approachable topic (See Appendix C).

When clinics are given the resources and the infrastructure to deliver this level of care, it has a significant impact both on the confidence of the providers and the comfort and safety of the patients. Standardizing comprehensive and validating care across the Jamaican health clinics could be a significant step in increasing IPV case identification and ensuring patients feel safe to disclose. Further, the MoH should focus on improving capacity, establishing training programs, investing in onboarding psychosocial teams, and developing the infrastructure for private, confidential, and safe IPV care across health clinics. The pandemic revealed how necessary it is to advocate for a stronger infrastructure for IPV screening and care. Despite the unknowns the post-pandemic landscape holds, it presents an opportunity to improve not only IPV care, but the health, justice, and autonomy of women across Jamaica.

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# VIII. APPENDIX

## A. Selected In-Depth Interview Guide Sections

### *I. Opening Questions*

First, I'd like to start with a few questions about your work and role here at the clinic as well as overall clinic services.

1. Can you tell me about your role in the clinic?
2. Can you tell me about the types of patients that your center serves?
    a. Probes: demographic information (age, gender, ethnicity), patients' needs

### *II. Interview Framing Questions*

3. Can you tell me about the sexual and reproductive health services your clinic provides?
    a. Probe for unmentioned: family planning services, STI services, miscarriage management, prenatal care, antenatal care, post-abortion care, screening/referral for DV
4. Can you tell me about the HIV care services your clinic provides?

### *III. Service Delivery Prior to COVID-19*

Now, I'd like to ask you about services that your clinic provided prior to COVID-related physical distancing and lockdowns, before March 2020, if you can think back to that time.

5. How did your clinic manage gender-based violence care and domestic violence screening for patients before March 2020?
    a. Probe for: resources, intake questions, implementation, and screening/care

Thank you, I'd like to transition to asking how service delivery has changed since the onset of COVID-19.

6. How has your service delivery of sexual and reproductive health services changed since the pandemic onset?
    a. Probe: What are some common challenges that have occurred since the pandemic that the center has experienced when providing sexual and reproductive health services?
7. What were the positive improvements or innovations in your care delivery because of COVID-19, if any?

   a. Probe: Example of care innovation
   b. Probe: Ask about family planning, STI, other SRH, HIV care, and DV screening

I would like to transition to ask you about your impressions of the impact of COVID-19 on the patients you serve.

8. In what ways, if any, has COVID-19 changed how patients feel about their care?
   a. Probe: Trust in clinic services, ability to come to clinic, desire to come to clinic
9. How have patients' needs for help with domestic violence and domestic violence screening been impacted since March 2020?
   a. Probe: types of patients, change in case load, referrals, screening, and needs

Thank you, we only have a few more questions.

10. Overall, have sexual and reproductive health services returned to normal procedures?
    a. Probe: For example, what were procedures like prior to March 2020?
11. What are the current gaps in the needs in the center?
    a. Probe: services, patient satisfaction, resources, role of COVID

## B. Selected Survey Guide Sections

Section 0: Participant Screening

______________________________

**Preliminary Actions Items for Interviewer**

**Interviewer must input the following information before administering the survey with the participant.**

| | |
|---|---|
| Record ID<br>Interviewer: Please input the assigned record ID from the Consent Form. | ______________________________ |
| Today's date: Record survey date | ______________________________ |
| Survey Start Time:<br>Interviewer: Please record survey start time. | ______________________________ |

**Introduction**

**Interviewer: Read to participant to start the survey.**

**My name is [INTERVIEWER'S NAME] and I am a research assistant with Emory University. With our partners at AIDS Healthcare Foundation, we are conducting a survey with healthcare professionals in health centres across the West and Northwest regions of Jamaica. The purpose of this survey is to assess the availability of contraceptives and sexual reproductive health (SRH) services, including HIV/AIDS services, before and during the COVID-19 pandemic. By participating in this survey, you can help us understand the impacts of COVID-19 on healthcare delivery and contribute to improved patient support services in pandemic settings. The survey will take approximately 45 minutes to complete, your responses will be anonymous, and the survey is completely voluntary. Thank you very much.**

### Section 0: Participant Screening

**We will begin with a couple of questions to confirm your eligibility for this survey.**

SC1. What is your title or position at this clinic?
Select one response.

- ○ Physician
- ○ Pharmacist
- ○ HIV Clinic or Nurse Manager
- ○ Public Health Nurse
- ○ Midwife
- ○ HIV Treatment and Care Support
- ○ Other

| | |
|---|---|
| Please specify: | ____________________________ |
| SC2. What is the highest level of education you have completed? Select one response. | ○ Primary School<br>○ High School<br>○ Associate's Degree<br>○ Some College<br>○ Bachelor's Degree<br>○ Master's Degree<br>○ Professional Degree (for example: MD, DDS)<br>○ Doctorate Degree<br>○ Other |
| Please specify: | ____________________________ |

## Section 1: Demographic Information

**We will now begin with the formal survey with demographic information. I want to assure you that your identity will be anonymous and all responses are confidential. Any information you provide will not be shared outside the research team.**

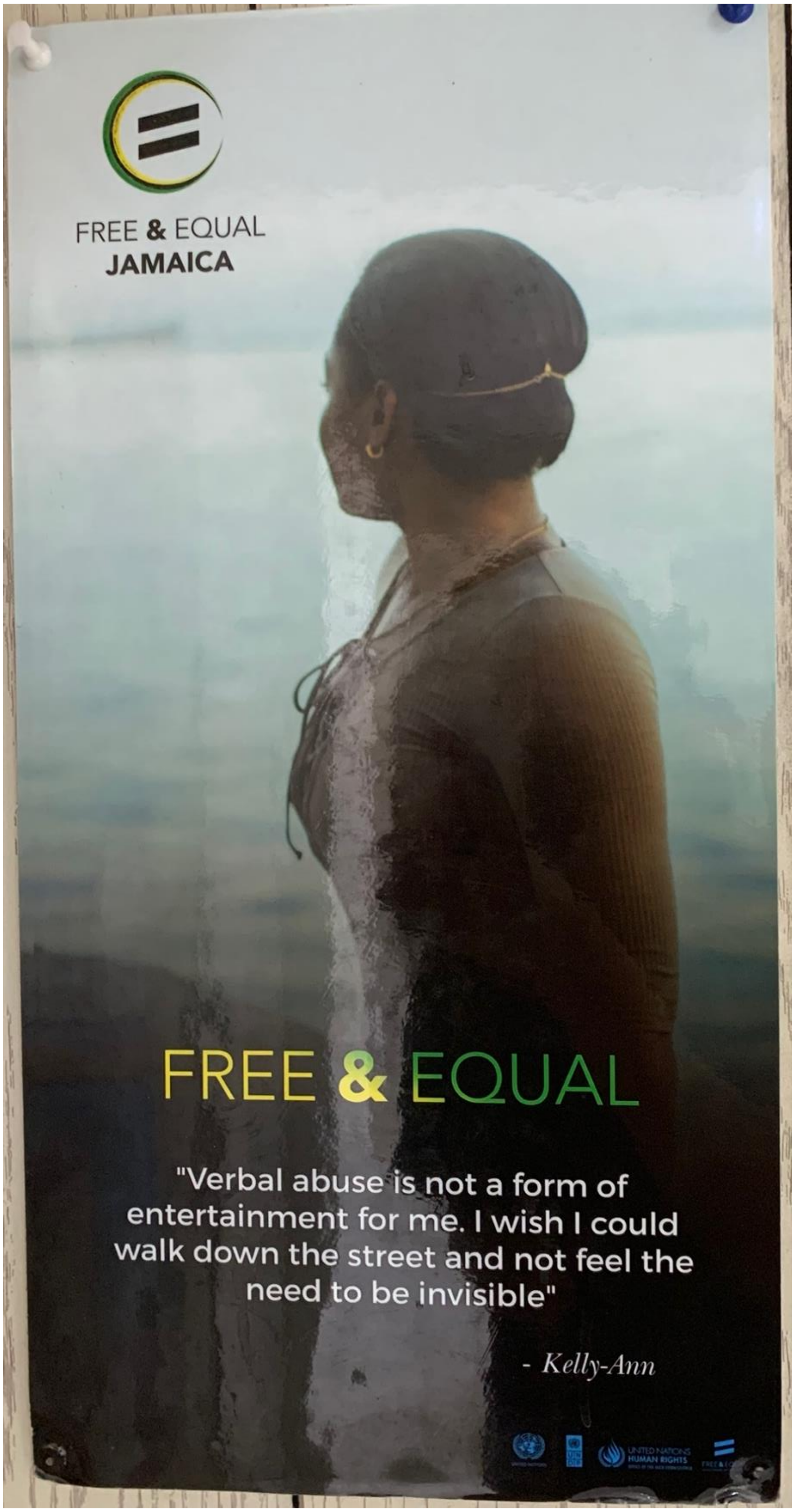
| | |
|---|---|
| DI1. What is your current age? Record response. | ____________________________ |
| DI2. What is your gender? Select one response. | ○ Male<br>○ Female<br>○ Other<br>○ Prefer Not To Say |
| Please specify: | ____________________________ |
| DI3. How many years have you worked in your field? Record response. | ____________________________<br>((years)) |
| DI4. What date did you start working at this health center? Record response. Make sure you get a month and year. | ____________________________<br>(If they do not remember the day, put the 1st of the month.) |
| DI5. Total time spent working in clinic:<br>This is automatically calculated, no action needed. | ____________________________<br>((years)) |

## Section 5: Domestic Violence Screening

| | |
|---|---|
| For the next section of the survey, I would now like to ask you some questions about domestic violence (DV) and DV screenings that are conducted at this health center.<br>DV0. Would you be able to answer some questions on Domestic Violence/DV screenings at the center? | ○ Yes<br>○ No |
| DV1. Among the staff at this centre, how many staff have been trained to conduct Domestic Violence (DV) screenings? Read list - Select one response | ○ All Staff<br>○ Most Staff<br>○ Some Staff<br>○ No Staff<br>○ Don't Know |
| DV2. Over the past month, how often do staff screen for Domestic Violence (DV)? Read list - Select one response. | ○ All of the Time<br>○ Some of the Time<br>○ None of the Time<br>○ Don't know |
| DV3. Since the beginning of the COVID-pandemic (March 2020), how has the frequency of Domestic Violence (DV) screenings changed? Read List - Select one response | ○ Significantly More Frequent<br>○ More Frequent<br>○ Less Frequent<br>○ Significantly Less Frequent<br>○ No Change in Frequency |
| DV4. Since the beginning of the COVID pandemic (March 2020), how has the number of Domestic Violence (DV) patients changed? Read List - Select one response | ○ Significantly More<br>○ More<br>○ Less<br>○ Significantly Less<br>○ No Change |

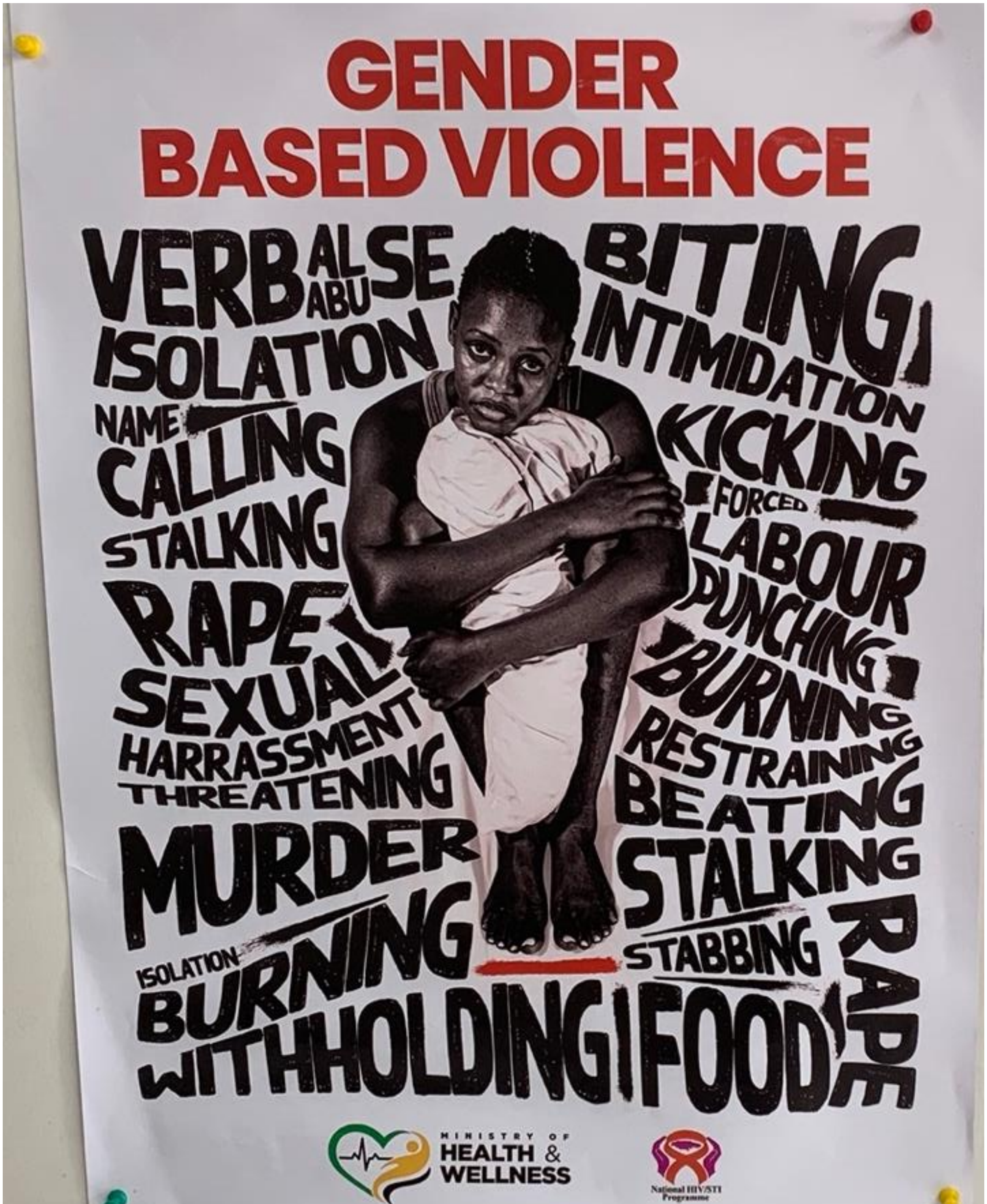
**This concludes the questionnaire. On behalf of my team, we sincerely thank you very much for your time.**

**C. GBV Awareness Ad Campaigns in SRHA clinic**



"Verbal abuse is not a form of entertainment for me. I wish I could walk down the street and not feel the need to be invisible"

- *Kelly-Ann*


GENDER
BASED VIOLENCE
VERBAL ABUSE
ISOLATION
NAME CALLING
STALKING
RAPE
SEXUAL HARRASSMENT
THREATENING
MURDER
ISOLATION
BURNING
WITHHOLDING FOOD
BITING
INTIMIDATION
KICKING
FORCED LABOUR
PUNCHING
BURNING
RESTRAINING
BEATING
STALKING
STABBING
RAPE
MINISTRY OF HEALTH & WELLNESS
National HIV/STI Programme