

MEASURE Evaluation PRH

Working Paper Series

**A Qualitative Study of the Acceptability of
and Barriers to Routine Screening for Intimate
Partner Violence in Health Care Settings in
Artibonite, Haiti:
Implications for Training, Practice, and
Research**

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April 2014

WP-14-151



MEASURE Evaluation PRH is funded by the U.S. Agency for International Development (USAID) through cooperative agreement associate award number GPO-A-00-09-00003-00 and is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with Futures Group, Management Sciences for Health, and Tulane University. The opinions expressed are those of the authors and do not necessarily reflect the views of USAID or the U.S. government.

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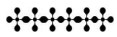


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EXECUTIVE SUMMARY

Recognizing the critical role that health care providers can play in addressing intimate partner violence (IPV), this study examined the acceptability of and barriers to routine screening for IPV in health care settings in the Department of Artibonite, Haiti. Semi-structured, face-to-face in-depth interviews were conducted in May to July 2013 among 41 health care providers and 43 female clients of reproductive health services who were recruited in six health facilities, and among 21 community members, 12 of whom were male. Interviews were conducted in Haitian Creole and transcribed for analysis using a grounded theory approach. Views on IPV screening were complex and are summarized below.

Is routine screening for IPV acceptable to female clients and community members?

- There was overwhelming support for routine screening of all women among community members but only half of female clients were in favor of the practice, with some preferring an indicator-based enquiry driven by signs or symptoms of IPV.
- In general, female clients and community members found screening beneficial as it was perceived to help reduce women's exposure to IPV, improve access to health care and treatment, improve victim's health and wellbeing, and provide women with an environment in which they could talk freely about abuse without fear of their husbands/partners.
- Screening for IPV may lead some women to disclose abuse and may facilitate help seeking.
- Female clients and community members were concerned about negative repercussions of IPV screening including breach of confidentiality, increased risk of re-victimization if an abusive partner found that the woman was discussing the relationship; and feelings of shame and humiliation.
- Acceptability of screening would depend on providers' interpersonal communication skills.
- Women's acceptance of routine screening and likelihood of IPV disclosure may vary depending on the type of abuse experienced and the woman's relationship with the perpetrator.
- Some women were concerned that health care providers do not have the time to discuss clients' IPV experiences and called for more community-based responses to domestic violence.

Is routine screening for IPV acceptable to health care providers?

- There was wider variation in the degree of acceptability of IPV screening among health care providers than among community members. Routine screening for IPV was acceptable to slightly more than half of health care providers but a substantial number preferred an indicator-based approach to asking women about IPV.

- Providers believed that asking women about IPV would improve care and treatment. Other perceived medical benefits for the victim included increased access to psychological care and support, increased knowledge of the consequences of IPV, and prevention of sexually-transmitted infections and HIV. Non-medical benefits perceived by providers included secondary prevention of IPV and enhancing women's safety.
- Providers felt that client's reactions to IPV screening would depend on how screening was conducted, the types of questions asked, the provider's ability to make the client comfortable, and the client's history of abuse.
- Providers believed that IPV screening should be handled by doctors and nurses but that a team approach was optimal.
- Training for IPV screening was considered important as some providers did not feel competent to screen for IPV and many identified training needs in the following areas: Types, causes and consequences of violence; screening approaches; interpersonal communication; victim support; appropriate care and treatment of IPV cases; psychological care; and counseling.
- Screening for IPV needed resources in terms of screening tools/materials, trained providers, client follow-up and community outreach.
- Some providers were concerned about women's safety if a routine screening policy was adopted but none of the screening questions proposed by providers asked about whether the client was in imminent danger.
- There were concerns about time, long screening tools, and increased workload associated with routine screening without a commensurate increase in remuneration.

What are the barriers to routine screening implementation and IPV disclosure?

- In actual practice, routine screening was lacking.
- Provider-related barriers included time constraints; absence of short, clear and valid screening tools and materials; fear of increasing clients' risks of IPV re-victimization; fear of re-traumatizing victims; fear of offending or stigmatizing clients; lack of training and communication skills for discussing IPV with clients; and judgmental attitudes, especially with regard to adolescent girls.
- Client-related barriers included decreased economic security upon disclosure of IPV, disclosure distress (including shame, embarrassment and humiliation), safety concerns, a perceived lack of confidentiality, invasion of privacy, and lack of understanding about the importance of screening.

- Community-related barriers included the culture of silence around IPV, lack of awareness of IPV, lack of availability and accessibility of community-based services for victim support, and social norms supportive of IPV and victim blaming.
- Structural barriers included lack of economic opportunities for women, which made it difficult for them to leave abusive relationships, and lack of punishment for perpetrators.

What are the implications of the study?

- Barriers to routine screening need to be addressed at the provider, client, community, and structural levels.
- Non-health sources of assistance for IPV victims/survivors need to be established at the community level as the study demonstrated that community resources for IPV are lacking and where they exist, they provide a limited range of services.
- There is a need to strengthen health care provider support for IPV survivors in the absence of routine screening.
- In terms of the health care delivery system, a team approach is needed to address IPV in a systematic manner.
- To improve the health sector response to IPV increased collaboration is needed between health care providers, the legal system, the *Ministre à la Condition Féminine et aux Droits des Femmes* (Ministry of Women’s Affairs and Women’s Rights) , and the community.
- Community awareness-raising is needed to improve the health-care response to IPV.
- Health care providers have training needs that must be met with regard to the identification, care, treatment and counseling of IPV survivors.
- Strict confidentiality and ensuring women’s safety and security are essential when addressing IPV in health care settings.
- Multi-pronged strategies that include women’s economic empowerment and social norm interventions, in addition to routine screening, are needed to prevent IPV.
- Further research is needed on the impact of IPV screening and disclosure on victims, the impact of IPV training on providers’ perceived self-efficacy regarding IPV screening, and factors associated with the safety of women who experience IPV.

INTRODUCTION

Background

Intimate partner violence (IPV) (also referred to as domestic violence and spouse abuse) is a serious public health problem. Recent estimates from the Haiti 2012 Demographic and Health Survey (DHS) showed that about 6 percent of women aged 15-49 years who had ever been pregnant experienced IPV during pregnancy. The proportion of currently married women aged 15-49 years who reported emotional, physical or sexual violence was 29 percent (Cayemittes et al., 2013). In 2005-2006, the Departments of Artibonite and Grande-Anse reported the highest prevalence of IPV – at least 36 percent. Although IPV victimization rates among currently married women of reproductive age in Artibonite had declined to 28 percent in 2012, they were still unacceptably high. Half of currently married Haitian women who experienced physical IPV in the past 12 months had injuries resulting from the violence.

Recognizing the critical role that health care providers can play in addressing IPV through an assessment of the patient's immediate risk, the provision of care and treatment, appropriate referrals and advising patients on self-protection (Ashford and Feldman, 2010), a number of health professional organizations in developed countries are endorsing universal screening for IPV in health care settings (American Medical Association, 1992; American Psychological Association, 2002). Proponents of universal screening argue that it increases identification of women who have experienced IPV and who may not otherwise disclose IPV and that routine screening could contribute to reducing the severity and frequency of violence (Spangaro et al., 2009). However, the evidence base on the benefits of routine screening for women's health outcomes is inconclusive leading some to argue that screening in health care settings is not warranted (Nelson et al., 2004) and should only be conducted if health care providers have been trained on IPV and have enough knowledge about local resources to improve the health response (Webster and Holt, 2004). However, screening for IPV victimization is encouraged because IPV increases the risks of injuries and chronic health conditions, victims may not show signs of abuse, and most victims may not report abuse unless they are asked (Gerlock et al., 2011).

In general, studies have found a high rate of support among female clients for screening in health care settings (Christofides and Jewkes, 2010; Webster, Stratigos, and Grimes. 2001). In a systematic review of screening practices, for example, the proportion of female patients who considered screening to be acceptable ranged from 38% to 99%. By comparison, the acceptability of partner violence screening among health care providers ranged from 15% to 95% (Feder et al., 2009). In a study in South Africa, reasons for supporting IPV screening in voluntary HIV testing and counseling services included women's belief that being asked about violence could help women in abusive relationships to access services and help and without gender power inequalities that impede partner communication. Some women believed that talking about experiences of violence could be beneficial by breaking the silence around IPV, facilitate disclosure, and provide the stimulus women needed to change their lives (Christofides and

Jewkes, 2010). Women's concerns about IPV screening have included stigmatization, breach of confidentiality, and legal repercussions (Feder et al., 2009). Among health care providers, barriers to universal screening for IPV have included attitudes, including the belief that it is not appropriate for health care professionals to intervene, fear of offending patients, fear for own safety, lack of provider training on IPV screening, concern about taking too much time away from other health care matters, and lack of effective interventions (Colarossi, Breitbart, and Betancourt, 2010; Todahl and Walters, 2011; Waalen, et al., 2000). Health system barriers have included lack of organizational support for routine screening and lack of time to conduct screening due to high workload (Colarossi et al., 2010).

Although many organizations and practitioners endorse universal screening of clients for intimate partner violence (IPV) and although pilot studies have been conducted on the integration of IPV into health services (Garcia-Moreno, 2002), little is known about barriers to the implementation of universal screening for IPV as perceived by health care providers, clients and community members in low income countries. Most of the existing studies have focused on physicians and few studies have examined how perceived barriers to IPV screening differ by provider type and the socioeconomic characteristics of potential clients and community members. Little information also exists on whether women and men in low-income countries endorse IPV universal screening in health care settings. This study is an exploratory qualitative investigation of the acceptability of IPV universal screening among health care providers, female clients and community members in selected health facilities in Haiti.

Objectives

The objectives of the study were to expand knowledge of opportunities for and barriers to routine screening for IPV among physicians, nurses and community health workers and to shed light on community members' and female reproductive health clients' support for IPV universal screening in health care settings. Specifically, the proposed study sought to:

- I. Identify barriers to IPV universal screening as perceived by health care providers
- II. Assess the extent to which perceived barriers to screening for IPV differed by health provider category and type of health care facility.
- III. Ascertain how female family planning/reproductive health clients and community members felt about discussing IPV with health care providers
- IV. Outline key recommendations for maximizing the effects of provider training on screening practice and the healthcare response to IPV.

Methods

This study was qualitative and conducted in the Department of Artibonite, Haiti in May-July 2012 using semi-structured face-to-face in-depth interviews. Participants were recruited from six health facilities: one public hospital; one private hospital; two private primary health care (PHC) facilities (one urban and

one semi-urban); and two public PHC facilities (one urban and one semi-urban). A total of 41 health care providers, 43 female clients of reproductive health services, and 21 community members, 12 of whom were male, participated in the study. Only female clients attending family planning (FP)/reproductive health (RH) services without a partner were approached for participation in the study as they exited the health facility. Participants were informed that they were at liberty to refuse to participate in the study, or to discontinue participation at any time, without prejudice. Written consent was used to document participants' agreement to participate in the study and to have the interview audio-recorded. All respondents were aged 15 years and older.

The sampling design for the in-depth interviews with health care providers was purposeful. Only health workers providing FP/RH services were invited to participate in the study. In-depth interviews were conducted among the following groups of health care providers: doctors; nurses; auxiliaries; residents; and community health workers. The sample for the in-depth interviews among female clients was selected purposely on the basis of age and education. Four female clients aged 15-24 (two educated and two uneducated) and four female clients aged 25-49 (two educated and two uneducated) were selected in each health facility for interview. The sample for the community-based in-depth interviews included both males and females and a mix of age groups and educational levels. The modified random walk method was used to select community members for interview. Sample households were selected by randomly choosing a starting point in the community, interviewing one community member who met the selection criteria in the nearest household, and then moving on to neighboring households until the target sample number and characteristics were reached. A map of the sample cluster was used to indicate a number of possible starting points at locations in the cluster that were easily identifiable.

Following written informed consent, each participant completed an in-depth interview lasting between 60 and 90 minutes. Participants were asked a series of open-ended questions, with probes to encourage more in-depth discussion. The interview guide for health care providers collected information on current practices and procedures for addressing IPV in health care settings; perceived advantages and disadvantages of IPV screening; acceptability of routine screening for IPV; perceived attitudes of patients towards IPV screening; opinions regarding how IPV screening should be conducted in health care settings; perceived barriers to IPV screening and patient disclosure and how they may be overcome; ideal screening questions, procedures and outcomes for women, men, and adolescent girls; needs and strategies for future training in the area of IPV screening; and the perceived usefulness of proposed IPV screening tools (see Appendix 1). One proposed tool was a modified version of the Haiti national form for reporting domestic violence allegations. It was shown to health care providers to ascertain their opinions about the feasibility of its use for routine screening. Health care providers were also shown an illustration of a proposed stamp for recording information on IPV on the client intake form.

The interview guide for female clients and community members collected information on perspectives on the nature and context of IPV in the community; community responses to IPV; community-based sources of help/assistance for IPV survivors; perceived barriers to help-seeking for IPV; perceived acceptability of routine screening for IPV in health care settings; perceived advantages and

disadvantages of IPV screening; perceptions as to how health care providers should address IPV in health care settings (questions they could ask, who they should ask, what would not help); factors that might influence IPV disclosure during encounters with health care providers and how these factors could vary depending on the type of IPV experienced by the client (see Appendix 2). As female clients or community participants could be reluctant to talk about IPV due to the sensitive nature of the topic, specific scenarios were used to stimulate discussion. The scenarios were hypothetical cases of women living in violent situations or who had experienced gender-based violence. It was felt that the scenarios would increase participants' level of comfort with the topic and help create an atmosphere conducive to sharing the stories and experiences of victims in their communities.

The study procedures received ethical approval from the Haiti Ministry of Health, National Ethics Committee and from the Tulane University Human Research Protection Program, Biomedical Institutional Review Board. A letter of approval was obtained from the Health Department of Artibonite authorizing the researchers to conduct the study at the three government health facilities of study. Individual letters of collaboration were also received from each of the four private/mixed (i.e., government subsidized) health facilities of study.

The scenarios and in-depth interview guides were translated into French and Haitian Creole and pretested to guide the language and expressions used, with a focus on using terms and expressions that were widely understood in the study sites. Other objectives of the pretest were to assess how participants interpreted and responded to the questions and to increase interviewers' familiarity with the recording device, primary research topics, and questions. The pretest consisted of a few mock interviews among a convenience sample of health care providers, female clients, and community members.

Indepth interviews were conducted in Haitian Creole and audio-recorded upon the participant's consent. The interviews were conducted by an interviewer and a notetaker of the same sex as the participant, and transcribed verbatim. The transcripts were then translated into English and reviewed by two members of the study team. Initial data analysis included content analysis, open coding, thematic analysis, and thematic building. All qualitative data were read several times and manually double-coded to increase the reliability of thematic identification, using a grounded theory approach to develop categories and themes emerging from the participants, as recommended by Strauss and Corbin (1990). Distinct codes were then categorized to reflect the commonalities between coders (level 1 coding) in order to ensure reliability and that the data reflected the categories identified. Through a constant comparative method, themes and subthemes were identified (level 2 coding). The themes were then classified into broader categories (level 3 coding) and the coding scheme finalized. The analysis involved comparing responses across participants and was conducted using the NVivo version 10.

Ethical Considerations

One ethical concern of the study was related to the potential for inflicting harm on women participating in the study. A respondent could be physically harmed if an abusive partner found out that she had been talking to others about violence, even though the questions in the in-depth interviews did not require women to report on their personal IPV experiences. Breach of confidentiality was a potential risk of the study. Even though the in-depth interviews were not geared towards collecting data on individual experiences but towards individuals' perspectives about beliefs, practices and group reactions about a particular issue, the scenarios and questions may have prompted recollection and sharing of own experiences. There was also a possibility that some participants may have become emotionally upset by discussions about IPV.

The following measures were taken to minimize such risks to participants, in accordance with World Health Organization guidelines for conducting research on violence against women (Ellsberg and Heise, 2005):

- Not interviewing female clients who were accompanied by male partners to the health facility
- Not conducting community-based interviews with men in the same clusters in which women were interviewed
- Not informing the wider community that in-depth-interviews include questions on respondents' perceptions about violence in the community
- Not conducting in-depth interviews in the community among multiple women from the same household in order to avoid a situation in which other female household members may have informed potential abusers about the nature of the study
- Protecting privacy and confidentiality by conducting in-depth interviews in complete privacy, with the exception of children under the age of 2 years
- Training interviewers to recognize and deal with a respondent's distress during interviews. The project recruited a social worker as part of the field research team. All participants interviewed were informed that they could contact a provider in the health facilities of study to discuss their personal experiences of IPV with a (another) health professional, if they so desired. Interviewer training included practice sessions on how to terminate an interview if the impact of the questions on the respondent was negative. Interviewer training also included explicit exercises to help field staff examine their own attitudes and beliefs around rape and other forms of violence.
- Providing respondents with information about available services in the area that could help a woman who had experienced violence
- Referring respondents in need to health facilities.

- Ending each interview in a positive manner, which provided participants who may have experienced IPV with a positive outlook and helped reinforce their coping strategies

The study was cognizant of essential ethical considerations when working with youth. Recent research has revealed that being under the age of 24 years is one of the factors that increase the likelihood that a person will experience IPV. Anecdotal evidence suggested that IPV among adolescents younger than 18 years was not socially acknowledged and that rates of health services utilization by IPV survivors in this age group were low. Given the perceived surge in sexual violence in the aftermath of the 2010 Haiti earthquake, it was of critical importance for the study to maximize the likelihood of obtaining information about youths' perceptions of violence in their communities and of barriers to seeking health care for violence in order to tailor health care service provision to their needs. As parental consent could jeopardize this process, parental consent was not sought for youth aged 15-17 years.

Privacy and confidentiality are of critical importance when addressing gender-based violence because breaches of confidentiality can have life-threatening consequences for women living in situations of violence. To assure privacy, confidentiality, and participant safety, interviews were conducted at a time and place chosen by the respondent -- a place where the respondent felt most comfortable, be it the health center, her home, or a public place if privacy could not be ensured at home or if the respondent was unable to talk freely there. Interviews conducted at the health center took place in a private room in the health facility rather than in a reception area to prevent participants from being seen or heard by others. Interviewers were not allowed to conduct interviews in their own communities. Interviewers were also trained on research ethics using the French version of the FHI 30 Research Ethics training curriculum on fundamental considerations in the design and implementation of human-subjects research (available at <http://www.fhi360.org/training/fr/Retc/>).

RESULTS

Perceptions about the Prevalence of Intimate Partner Violence

Two out of three female clients reported that IPV occurred in their communities. Although the interview guide requested that participants not mention names or indicate anyone specific in their responses, some respondents referred to their own experiences as well as to those of family members, neighbors, and girlfriends. A few participants specified that they had never witnessed IPV but had heard about it: *"I usually hear about it but I never see it with my own eyes (Government hospital, 30 years, elementary education)."* Female clients were asked to give examples of IPV in their communities. Beatings were the most commonly reported act of IPV followed by rape. Other reported acts perpetrated by males included incest (*"a dad gets their daughter pregnant"*); and economic violence (*"If they had an argument, he can spend a week not giving any money to the woman"; "He leaves his wife hungry and doesn't take her with him"*). About half of female clients named multiple acts of IPV:

Violence is when you are in a relationship with someone, when the person does not want sex, he forces her. When the woman cheats on the man, he beats her up. (Government health center, 28 years, uneducated)

Well, the example that I can give is men that hold women down and have sex with them; women who men beat up; and the ones men don't give money. (Government health center, 27 years, educated)

Yes, I actually see them kick, slap, beat them with unshapen side of a machete, and throw away all their things out in the sight of everybody. (Private/mixed health center, 30 years, 9th grade education)

All female community members except one were aware that IPV occurred in their communities although one stated that the prevalence of IPV had declined over time: *"That used to happen in the community but it's been a long time since it doesn't happen anymore"* (Female, 20 years, education not stated). By comparison, all but two male community members felt that IPV did not take place in their communities. However, a few responses suggested that some men were not clear as to what behaviors were defined as partner abuse.

I am aware of that. I know of a woman in my neighborhood who is living with a man that beats her all the time. Sometimes he wounds her in her head. I think that's violence. (Male, 16 years, 6th grade)

Well, according to me, in this community I don't know of men beating their women. Most of the time, the women are always kicking the men when they try to beat them. (Male, 27 years, 10th grade)

When asked to give examples of IPV in the society, female community members reported sexual abuse, beatings, verbal abuse (*"Beat up and cuss"*), and isolation. More males than females could not provide examples of acts of physical violence partly due to men's perception that abuse did not occur or was rare or hidden in their communities. With the exception of economic and physical violence, acts mentioned by men differed from those mentioned by women in terms of the inclusion by one respondent of jealousy and controlling behaviors.

Well, examples of violence: When you have a woman you're not supposed to ill-treat her like, you're not supposed to expose her to jealousy. Some clear examples are: you are not supposed to control her life too tight. When she wants to work you shouldn't stop her from that. These are some clear examples. (Male, 23 years, university education)

There were two underlying themes in responses regarding the occurrence of IPV in the community: (1) female IPV perpetration or retaliation; (2) discourse around whether men or women were to be blamed for the abuse; and (3) the private nature of IPV. The men in-depth interviews revealed that some respondents felt that there was no justification for violence even in a situation in which the woman was suspected of being unfaithful.

Well, sometimes you touch her, not because you really want to do it but because of unjustified jealousy. Sometimes you beat her but it's not your fault. You may give her money to prepare food. She goes hanging around with friends instead. That can be a reason to hit her. That's all I can say about the subject. (Male, 23 years, university education)

Reread the question for me. These things they're personal people don't talk about them. I don't see these cases. (Male, 24 years, university education)

Under no circumstance are men supposed to be violent to women. A woman can't be responsible when she is victim of violence. (Male, 32 years, high school education)

Both of them can be responsible. It depends on the situation that brings up. Sometimes women are the ones who start with violence (Male, 59 years, elementary education)

The man is to blame. (Male, 15 years, elementary education)

Community-based Sources of Help Seeking for Violence Survivors

There was a perception among a few female clients that women experiencing IPV did not seek help from anyone and that there was a culture of silence around IPV: *"Women don't look for help. They don't talk to anyone."* Others female clients reported that when IPV survivors disclosed violence, they did so mostly to family members and friends. Only 2 participants mentioned the police as a source of help. Most participants did not provide reasons non-help seeking or non-disclosure of IPV. One participant did mention that when women disclosed to family members, the only thing that families do is blame the perpetrator, which reflected some level of dissatisfaction with the familial response.

Community members were divided on their perceptions about victims' responses to IPV. Women's responses revealed a struggle between the need for help and the desire for privacy, which contributed to the silence surrounding IPV. *"Yes, they need help. No they don't tell others about their business so they don't know their business"* (Female, 27 year, 6th grade). Another sub-thematic area centered on the lack of knowledge of existing services, the absence community-based sources of support for victims, and the types of community-based services that could be established to clarify what constitutes IPV. Only one female community member made reference to services in Saint Marc.

Aaah! Really, there is nowhere to talk about that in the community and no one talks about these things. (Female, 27 years, 3rd grade education)

In the community, they can establish a center of training to help people know that it is not only when a woman gets beaten you talk about violence, but also when someone is saying unkind words. (Female, 20 years, education not stated)

I don't know normally where the public services are. It is more about making money. (Female, 20 years, 5th grade education)

More than half of the male community members could not provide a response to this question because of the perceived absence of IPV in their communities, with one respondent alluding to the private nature of IPV: *"I haven't seen that kind of scandal in public in our area"* (Male, 21 years, 11th grade education). Based on the remaining responses, it appeared that some male community members perceived women's responses to IPV to depend on the type of union, availability of services in the community for IPV victims, and whether women were perceived to "deserve" the violence. *"Well, it depends on the way they live. If they are married, they should sit together and talk; but if they are not married, it's the police"* (Male, 16 years, 6th grade education); *"They don't have an office to go to. And a lot of time when this happens, the people don't know what to do"* (Male, 44 years, primary education); *"In our community, we don't have women's groups to help other women because they are the guilty ones. We men don't do that."* (Male, 26 years, 10th grade education)."

In response to the questions as to where women could get help for IPV in the community and what the community would do, some female clients reiterated that women tend not to seek help for intimate partner violence, a general observation that has prompted some researchers to argue that abused women may engage in learned helplessness. A few female clients identified psychosocial barriers that could explain why women who experienced violence did not seek help: *"It hurts"*; *"the police will blame her for the violence."* Overall, half of the female clients stated that women did not seek help for IPV, with one respondent claiming that *"In Haiti it's hard to find help"* (Government Hospital, 20 years, uneducated), a probable reflection of the dearth of services for IPV survivors. Reports indicated that IPV survivors who sought help tended to turn to members in their informal networks – family members and friends. Mothers, fathers, and sisters were the most frequently mentioned sources of help seeking. Brothers and other male relatives were not mentioned at all. Three female clients identified formal networks, specifically the police, *"Judge Mathias's home"*, unspecified associations, churches, and *"the Women Ministry"* as sources of help seeking, with one respondent suggesting that the police might be the last resort: *"They go to the police when the situation is very bad."* Apart from the apportioning of blame for IPV by informal sources of help seeking, no female client mentioned what kind of support was provided by personal networks – whether emotional, or financial, or social. Formal sources of help were associated with legal recourse (jailing of perpetrators) and health care and treatment for victims. Only one female client indicated how to improve services for problems associated with physical violence – *"Education."* However she did not explain how education could improve services for IPV victims/survivors.

We don't have any place here for that. The community supposed to organize itself to create an association to fight against violence, but we are not able helped to do it. (Private/mixed health center, 20 years, uneducated)

I don't know of any place in my area where she could get help. (Government health center, 23 years, uneducated)

The Women Ministry helps them. Sometimes they take the men to jail and force them to pay for their actions. (Government hospital, 23 years, 9th grade education)

At the Women Ministry, then to court while the follow up is done with hospitals. (Government hospital, 19 years, uneducated)

Yes, there are people responsible for that, but they ridicule us, and if we don't have money they don't want to serve us. (Private/Mixed Health Center, 30 years, 9th grade education)

Community members' responses to the question as to where women could get help in the community for IPV also highlighted the unavailability of services for IPV victims at the community level and the lack of visibility of existing services. The police and "Women's Ministry" were reported as sources of help seeking by two female respondents, one of whom had an 11th grade education and the other no education. The following responses were provided by some of the female respondents: "*Here there is none (Female, 20 years, 5th grade education)*"; "*There isn't any here... there is no way to do that (Female, 20 years, education not stated)*"; "*No. Nowhere (Female, 27 years, 3^d grade education)*"; "*They say there are offices for women (Female, 37 years, uneducated)*"; "*Yes, there are some places where the woman can find some help, but we don't have them in this region (Female, 27 years, university education)*."

Male community members' responses also referred to the absence of community-based services for IPV, although some suggested where victims could go for help: "*Ministry of Women's Rights*"; "*Community Courts*") and where women would have to go (Port-au-Prince; the police). The following excerpts illustrated the perceived absence of formal and informal sources of help seeking among male community members with varying levels of education:

The community doesn't offer anything to women. (Male, 28 years, 10th grade education)

The committee should talk to the intimate partners if they need but if they don't have it in the community they should go to the Ministry of Women's Rights. (Male, 16 years, 6th grade education)

Well in this area there isn't. If a woman is experiencing violence she would have to go to Port-au-Prince because in this area there aren't things like that. Or she would go to the Police. (Male, 23 years, university education)

Well in our community, the people don't have an office available for them. Maybe they do need help but they don't have an office like that in the community to go to. (Male, 44 years, primary education)

Some of the male respondents also displayed a lack of widespread knowledge about services for IPV: "*I know there are women's groups that are supposed to defend women (Male, 32 years, high school education)*"; "*I don't know (Male, 15, elementary education)*."

The lack of services for IPV and the limited role of women's organizations in supporting victims/survivors were further emphasized in responses to the question: In this community, do women's support groups exist to help women who have been beaten by their partners? What social and legal services exist to help address problems associated with physical violence (e.g., health, police, legal counseling, social counseling, or psychological counseling)? Among female clients, the most frequently mentioned sources of assistance for problems associated with physical violence were health facilities and the police, with lawyers being mentioned by one respondent. About a third of female clients did not know of the existence of support groups for physical violence victims: "We don't have things like that in my area"; "I have nobody"; "If there are some, I don't know. I don't hear about them"; "There are some women associations. I don't know exactly where they are." Only two women's associations were named as a source of help seeking "Courageous Women" and Odelfia. One respondent stated that women's organizations existed "but they do their own thing and they mostly exist to make money" (Government Hospital, 20 years, uneducated), implying that IPV may not be fall within the scope of activities of such organizations. Lack of knowledge, distance to existing services, lack of funding, having children, and the inability of community authorities to establish services for IPV were described by some female clients as constraints to services utilization.

Well, we have a group called Odelfia. When these problems happen in the neighborhood, we call for them or the police. We have to find people that have more knowledge than us. (Private hospital, 34 years, 11th grade education)

Yes, there is support. If the partner is still committing violence on the women you call the police or the organizations that give those services with the police help. (Private/Mixed Health Center, 25 years, 9th grade education)

We have here "Courageous Women", but when they [our husbands/partners] beat us we sometimes have compassion for them because we have children with them. (Private/mixed Health Center, 33 years, 4th grade education)

There is no that kind of offices near my house, they are far from here. (Private/mixed Hospital, 40 years, education not stated)

We did have it, but it is no longer functional because they didn't support it. When someone faces a problem, she must go to St-Marc. Those services depend on "Casec" and the community representative. Private/Mixed Health Center, 20 years, not education)

Community members' comments revealed other constraints to help seeking. There was a perception that existing women's support groups or organizations were not functional and lacked commitment and support, with one participant hinting that the police could not be considered as a support group to help women who have been beaten by their partners, and another stating that people who provide security may re-victimize IPV survivors. One community member stated that outside the community, an organization called "Strong Women" served women who had been beaten by their partners but did not provide residential services and food to victims.

There are organized women group but I don't know if they exist to support women who are violence victims. (Female, 35 years, elementary educated)

There was. There is one but it is a little bit out of function because of lack of support. So it is hidden. They lack devotion. There is none here but if you need help in this case you can go to Saint- Marc. It depends on the local authority, the deputy, or the mayor of the block. I wish the authority would have created a place to train people, to help them know what to do and not to do to improve (Female, 20 years, education not stated.)

Well I think like you said to put the effort. In certain areas there are women that are very strong women. They don't have food, and also they don't have a place to go when these things happen. (Male, 44 years, primary education)

Well, not really where I am at. I don't feel that. People giving security commit acts of violence on women. (Male, 42 years, elementary education)

Female RH clients and community members were also asked what factors might help or prevent women who are beaten by their husbands/partners from improving their situation? Responses did not specify whether "improving their situation" was understood to refer to protecting oneself from an abusive partner or getting out of an abusive relationship. There was no consensus in the responses, most of which referred to facilitating as opposed to inhibiting factors. Fear, shame and women's financial dependence on men were singled out as inhibiting factors, with the latter problem being considered as a risk factor for sexual coercion and physical violence victimization".

They are scared of men and ashamed that people don't make fool of them. (Government hospital, 20 years, uneducated)

The men are proud, especially when they give all at home and the women are unable to financially help. For any reason, they beat us. (Government health center, 32 years, 4th grade education)

Especially when the men are in the house and they are the ones working, they have priority over you. When they tell you to sleep with them, you have to. If we could find help to do our own little business, they can stop making us do foolish things (Private hospital, 34 years, 11th grade education)

There was a belief among one out of six female clients that government/public services could help battered women improve their situation, with specific reference to the "Women's Ministry", the police, and health facilities. Health facilities and the police were sometimes mentioned in the same sentence, implying an existing or potential collaboration between these two services. Responses often made a distinction between interventions for battered women and interventions for perpetrators. Activities to increase women's economic independence and ability to call for help were often perceived as ways to

help battered women improve their situation: *“They [women] need to do something for a living that could create respect from men”* (Government hospital, 25 years, uneducated); *“They would find help if they had a cell phone to call for help”* (Private health center, 32 years, education not stated). Facilitating battered women’s access to advice on how to deal with violent relationships was also perceived as a way to help. Only two female clients suggested that women must leave abusive relationships, which indicates that union dissolution was not universally a desired outcome of help seeking.

Some female clients mentioned that *“blaming men”* would help improve battered women’s situation, which suggested that male perpetrators may not take responsibility for their violent behaviors and that female IPV victims might be considered responsible for their own victimization. The justice department was named as an institution that could help battered women improve their situation but jailing perpetrators was not mentioned by any female client. One female client wanted perpetrators punished for two or three days while others revealed a preference for counseling perpetrators. Based on female clients’ responses, the desired outcome was generally for men to take responsibility for their actions and stop abusive behavior(s): *“They just need to talk to the partner to stop the violence and fighting”* (Private/Mixed Health Center, 32 years, 10th grade education). For two other female clients, potential solutions include creating institutions to help victims, educating people, and investing in organizations that work to address violence.

Create a committee to help people to face those problems. (Government hospital, 21 years, 12th grade)

We need to educate the people and invest in organizations which work against violence. (Private/mixed health center, 20 years, uneducated)

One female community member’s response implied that an abusive male partner would change his behavior if the female IPV victim changed her behavior, which suggested that the victim was considered to be fully responsible for the perpetrator’s actions. Other responses stressed that lack of knowledge about what to do and lack of money/financial independence often prevented women from ending abusive relationships or trying to improve them. One woman commented that *“what could help is a man that won’t hate a woman (Female, 21 years, 11th grade education)”*, implying that abusive partners could have deep emotional/psychological problems which need to change if an abused women’s situation is to improve.

If I had a man and I did not have any clue concerning violence nor what can’t I do, if he becomes violent I wouldn’t do anything. But after having training if one of us becomes violent I would tell him that we need to be conscious about the fact that we are violent. We need to educate people in the community. Lack of support can hinder them from having success because almost everything is sterile with no money. (Female, 20, education not stated)

If the person is working or has a business, they won’t suffer from those types of violence. (Female, 27 years, university education)

Some male community members also provided a range of factors that could help or prevent battered women from improving their situation, including lack of strength/courage, lack of security, and feelings of embarrassment. More than half of the male community members talked about what needed to be done to help battered women improve their situation, including the creation of women's groups in the community to support battered women, establishment of services for battered women at the community level, and disseminating messages such as *"Tell the men to respect the ladies"* (Male 15 years, elementary education); *"Let the men know that women are human beings and not objects"* (Male, 32 years, high school education)", with the latter respondent assigning the government that responsibility. One respondent stated *"Provide jobs to women so that they may stop being dependent on men"* (Male, 59 years, elementary education), which suggests that women may not leave abusive relationships because of lack of economic resources to survive on their own. Law enforcement was cited as factor that could influence battered women's ability to improve their situation but male responses also alluded to the need for women's groups that provide help for female perpetrators of IPV: *"If they train some strong women to help those women that are doing acts of violence on their husbands, maybe there will be an agreement to lower it"* (Male, 42 years, elementary education).

Acceptability of Routine Screening

Routine Screening versus Indicator-based Approach

All participants were asked the following question: Some professionals argue that every client should be screened for intimate partner violence, a practice called universal or routine screening. Others look for specific signals and then screen when those signals raise concern. What is your position?" Half of female clients agreed that health care providers should ask women about IPV but only about one in five were unquestionably in support of universal screening, as judged by responses such as, *"ask all women"* or *"question everybody"* or *"I think they should question every woman"*. Three women felt that women should be questioned about IPV only if they present with specific signals that are of concern. Only one female client supported both approaches (*I think they can use both ways. Both might work*). Although an additional 24 percent of female clients supported asking women questions about IPV, their responses did not clarify whether they were supportive of universal screening or a signal-prompted screening approach.

Six female clients found routine screening unacceptable, one of whom engaged in victim blaming, stating *"No. Nowadays, the women don't respect themselves regarding their behaviors and sometimes, they provoke the violence. They have the bad habit to go in men's room; so they will be normally raped."* (Private/Mixed Health Center, 19 years, uneducated). Almost one in three female clients stated they did not understand the question or did not know which approach should be implemented, with one of these conceding that *"There are some question they [health providers] must ask to let us understand what they want to do"* (Mixed Health Center, 32 years, 4th grade education) and another stating that *"It would be a good thing to have a responsible person taking care of the victims (Private/Mixed Health Center, 34 years, 6th grade education)." The latter responses suggested that these conditions must be met when health facilities institute universal screening or a signal-based approach. The first condition had to do*

with interpersonal communication – providers must clarify what they want to do and why they want to do it. Second, IPV survivors/victims needed to be taken care of by someone who is perceived to be responsible.

With the exception of one woman, all community members interviewed were in favor of health care providers asking women questions about IPV. The woman who opposed routine screening did so because of doubts regarding the existence of support for IPV victims: *“I don’t know if I would find people to support us”*, a perception that screening would not be useful unless assistance could be provided to victims. Most of the female community members believed that questioning women was the only way to find out whether they were experiencing IPV: *“If no one comes and asks you questions about what you are going through with your husband, how would they know?”* (Female, 20 years, 5th grade education). One respondent stated emphatically *“They should question women about rape”* (Female, 27 years, university education) but it was unclear as to whether rape was singled out because it was considered more severe or hidden than other forms of IPV.

Male community members provided various reasons why they supported the idea of health care providers asking women questions about IPV, including: (1) improving the wellbeing of women who are IPV victims; (2) facilitating secondary prevention of IPV; (3) helping victims access sources of help; and (4) the perception that it would be relatively easy for women to disclose IPV to health care providers. The following excerpts are illustrative: *“He should interview them because sometimes they may be alive but are not living well”* (Male, 16 years, 6th grade education); *“I think they can question them so they won’t continue to be victims of intimate partner violence”* (Male, 21 years, 11th grade education); *“Oh yes, because if they don’t ask them questions, they can’t find help”* (Male, 32, high school education); *“Yes, they need to ask them questions, because they will feel it easier saying that to the physicians”* (Male, 15 years, elementary education).

Like female clients, providers were divided on this issue. Slightly more than half of providers interviewed (54 percent) were supportive of asking women questions about IPV but only two providers stated explicitly that they were supportive of routine/universal screening while 15 percent stated that it would be preferable to look for specific signals and then screen when those signals raise concern: *“It is only when you see violence signs on her that you should do the screening test”* (Mixed Health Center, 29 years, Doctor). An additional two providers stated that both approaches would be important. The vast majority of providers who supported asking women questions about IPV did not indicate a preference for a given approach but justified asking women those questions because it could potentially increase identification of women who have experienced IPV and their likelihood of receiving appropriate care and treatment.

Yes, it’s because it will be good for the person; if she is sick, they will help her. It will also be good for the health center to show that they are doing their job, especially for people who live in country side and are seeking a better life in Dominican Republic. (Mixed Health Center, 40 years, Nurse)

Some of the health care providers who objected to routine screening referred to the private nature of IPV and lack of familiarity with either screening approach (e.g., *“I am not used to that practice. So I’d rather not comment on it.”*). Others expressed concerns about lack of disclosure due to the silence around IPV and providers’ fears about offending clients.

No, it is not normal. If the partner asks for help, you can help him. It is incorrect to ask questions about her lover, which should be an intimate affair. (Mixed Health Center, 39 years, Attending Physician)

Some people may think that it is wrong for them to tell you that their husbands did such a thing. (Mixed Hospital, 36 years, Nurse)

When a girl comes into a clinic, it is not easy to engage these issues with her; she may not want people to know. (Mixed Hospital, 27 years, Doctor)

Characteristics of Women Who Should be Screened for IPV

Female clients and community members were asked the question: If health care providers were to ask about intimate partner violence, which women should be asked and why? The responses of female clients were divided. Some female clients felt that all women should be asked questions about intimate partner violence with no exceptions (e.g., *“They can ask questions to any women even if she has not experienced intimate partner violence.”*). This universal approach to asking questions about IPV was considered justifiable because every woman was perceived to be a potential victim of IPV (e.g., *“Every woman because they can all suffer violence.”*). A second group of clients felt that questioning should focus on IPV victims (e.g., *“I think the victims should be questioned more but the other women have to take positions too.”*). A third group of female clients felt that women who are asked questions about IPV should not be victims of IPV but “calm and strong women” (e.g., *“They should question calm women - those who live an ordinary life.”*; *“Women who are used to facing problems – strong women”*). Another two female clients added that questions should be asked of women with partners and male partners should be questioned as well. One female client mentioned that it is important to recognize that *“some women are victims but they don’t go to hospital”*, which implied that consideration should be given to strategies for identifying victims outside of health care settings.

Most community members provided insights into who should be screened and the conditions under which screening should be implemented. These conditions included (1) if the doctor suspected that the woman has been a victim of violence; (2) if the woman has reached the age of majority; (3) if the woman was married or living with her partner: *“They should question women who live with their husbands at home” (Female, 21 years, 11th grade education)*; *“The responsible woman, the ones living as couples. They shouldn’t talk to young girls but to women living as couples” (Male, 44 years, primary education)*; (4) if the woman presented with physical signs and symptoms of abuse: *“If the doctor sees marks on your body” (Female, 27 years, 6th grade education)*. We did not detect any differences in community members’ responses in regard to educational background.

Perceived Reactions of Clients to Routine Screening

Participants were also asked their perceptions regarding how women might feel if a health care provider were to ask them questions about IPV. Female clients provided a range of emotions in response to this question: embarrassment (e.g., *"She'd feel embarrassed."*); shame (e.g., *"They will feel ashamed because they shouldn't be in such a situation."*); normalcy (e.g., *"They might feel it is normal because they are helping them."*); and comfort. Some female clients referred to how women were supposed to feel if a health care provider were to ask them questions about IPV (e.g., *"They are supposed to feel comfortable."*; *"They should not feel ashamed because it is for the best."*; *"She should feel good because she is getting help."*). One female client stated emphatically that women would not be ashamed to disclose IPV but this view was not unanimous. Almost one out of four female clients interviewed stated that they did not know how women would feel about being asked questions about IPV. Another two stated that *"we must have strong arrangements against everyone who makes violence on women"* and *"provide facilities and training for the people"*, suggesting that asking women about IPV should not be a stand-alone intervention but should be accompanied by strong sanctions against perpetrators and provider training.

Similarly, community members did not unanimously consider being asked questions about IPV to be a potentially positive experience for women. Feelings of shame, sadness, discomfort, humiliation, and fear were considered to result from women being asked about IPV by health care providers: *"I think the woman can feel ashamed (Male, 59 years, elementary education)"*; *"They can be sad, they can cry (Male, 15 years, elementary education)"*; *" They can also be afraid that their husbands hear about that (Male, 32 years, high school education)"*; *"I would feel humiliated if I was asked those types of questions (Female, 27 years, university education)"*. Four male community members believed women would be proud and happy if a health care provider were to ask them about IPV but another expressed doubts as to whether women would disclose their IPV experiences due to a desire for privacy: *"Well, I think she should be happy because this is for her wellness. If she was miserable that will help her out" (Male, 16 years, 6th grade)*; *"I think it would be a pride to be able to talk about what she's being victim of from her intimate partner, all she's been experiencing" (Male, 23 years, university education)*; *"There are certain people, when things happen between them and their husband, they can't tell people what happened because they want to keep it personal" (Male, 24 years, university education)*.

Community members felt that asking women about abuse in health settings was important because some women may not show signs of abuse and the mere process of asking questions could help a victim's mental state. One respondent stated that all women who present to a health center should be asked questions on IPV *"because it is not written on their faces that they are getting beaten" (Female, 27 years, 3rd grade education)* while another mentioned that *"Also, it's good for their partners to know that they [women] have that right" (Male, 21 years, 11th grade education)*. Two female community members also mentioned that it was important to consider that children can be victims of violence and that it would be important for health care providers to go to the homes and question parents because child victims will be unable to explain what had happened to them.

The sub-themes of privacy, shame, fear, embarrassment and women's economic dependence on men also emerged in health care providers' responses to the question as to whether clients would approve or disapprove of routine screening and under what conditions: *"There are patients who are reluctant, who*

do not want to denounce their husbands to avoid having problems with them because it is the husband who provides everything to her” (Mixed Health Center, 29 years, Doctor); “It’s hard because women are mostly afraid talking about it” (Mixed Health Center, 27 years, Resident); “No, the partner can come and give you word [tell you off]” (Mixed Health Center, 47 years, Doctor); “They may think that the questions are too embarrassing for them to answer” (Mixed Hospital, 36 years, Nurse). One provider also felt that questions on IPV could be considered “taboo” by some clients. Rural women and violence survivors were considered likely to approve of universal screening for IPV by some providers. Only 15 percent of providers felt that most women would approve of routine screening.

More than half of providers believed that whether the client approved of routine screening would depend on the how routine screening was done, the types of questions that are were asked, the provider’s interpersonal and counseling skills – the provider’s ability to make the client comfortable—and on the client herself, particularly the client’s history of victimization and perception of IPV as a private matter. Some providers based these beliefs on their clinical experiences.

Some will take it without any problem, but there are others who may think that this is because we want to know their private life. Some will think that it will go nowhere; they think that it is not something serious. There are some who can experience it. In the same way there are some who can be in all the options where there is violence. (Government Health Center, 32 years, Nurse)

They always give some problems; because of that, it is after much counseling that she accepts, sometimes she does not agree. (Mixed Health Center, 40 years, Nurse)

“They would regard it as embarrassing. People think anyone has the right to come into their intimate life? Some can approve it, some not. It depends on the strategy we use. I think that should be led in an intimate environment in order to make the clients feel comfortable. And, we must have high-level professionals who know what questions to ask.” (Private/mixed health center, 34 years, Nurse)

The other important thing we need to focus on is the way we welcome the victims and sympathize with them. That could reject or make them feel free to talk to us frankly. (Private Hospital, 34 years, Nurse Supervisor)

Perceived Advantages and Disadvantages of Routine Screening

Perceived Advantages of Routine Screening

While most female clients thought there were some advantages to routine screening (74 percent), a few felt there were no advantages (9 percent) and the remainder stated that they just did not know if there are any (17 percent). Overall, simply screening for IPV was perceived to enable health care providers to offer help to victims and information that could help women protect themselves. The following

specific advantages of routine screening were mentioned by female clients: (a) reduction in women's exposure to IPV; (b) increase in women's ability to protect themselves; (c) improved access to health care and treatment; (d) improved wellbeing for victims/survivors; (e) increased identification of victims of IPV and localities with the highest rates of IPV; (f) provision of an environment where women could talk freely about their IPV experiences without fear of their husbands/partners.

The advantage is that it could help [the woman] to be no more victim of being beaten. (Government hospital, 26, uneducated)

The woman will have security. (Government hospital, 27 years, 6th grade education)

They will find out all the victims of violence and the way to help them. The health care provider will know how to help. (Government hospital, 25 years, uneducated)

The advantage is you will find out how many people suffered from violence and will also know where there is most violence done to women. (Private Hospital, 34 years, 11th grade education)

According to a few others, screening could help identify women who have been raped and are in serious need for help: *"You will know all the people they rape and you can help those people"*. They also believed that screening could help prevent violence against women. The following quotes are a few samples among many similar statements: *"One of the advantages is to make prevention"*. For some female clients, screening for IPV merely by asking questions was not considered sufficient. One female client maintained that physical examinations were preferable to asking questions about IPV, while another maintained that women should be asked what kind of help they would like to receive from health care providers, *"otherwise there is no advantage at all."*

Physical examination is the best thing because you can't just trust the person that reports. For example, if someone comes to me and says that she has been raped, I can't tell if it's true or not. (Private/mixed health center, 29 years, uneducated)

A few female community members could not articulate advantages of routine screening. The advantages most mentioned were the improved health and safety of victims, with one respondent alluding to the fact that health care settings provide safe environments for women to answer questions about their IPV experiences: *"The advantages the person has are when they come to the hospital. They come to the hospital but will be able to answer questions. In front of her husband, she will be scared"* (Female, 20 years, 5th grade education); *"The advantage is that the woman will have security"* (Female, 27 years, 6th grade). One female community member stated emphatically that there were no advantages to routine screening while two asserted that having health care providers ask women questions about IPV was advantageous because *"men love beating women."* However, it was unclear as to whether those respondents meant that routine screening could improve the identification of IPV victims.

Secondary prevention of IPV was mentioned by male community members as one of the advantages of routine screening. Male community members also felt that screening would help improve the quality of

intimate relationships, increase women's knowledge of their rights and increase women's access to legal redress. Some male community members stressed the health benefits of routine screening, with one mentioning the potential of IPV screening for identifying whether the victim was HIV-positive but responses also showed that some male community members recognized that feelings of shame could inhibit disclosure of IPV and prevent women from reaping the benefits of routine screening.

The advantage is for the woman because when your husband is beating you up, if you can find a solution with that, I think that's very good. (Male, 16 years, 6th grade)

The advantage is when you ask questions: If they [women] find someone who asks questions, they [women] think that one day they will find deliverance especially in Haiti and their particular community. (Male, 23 years, university education)

The advantage is for the person to know their rights, for the healthcare providers to ask them how they are living at home with their husband and for them to have a good behavior. (Male, 44 years, primary education)

The woman should not be ashamed, she should come forth and take the person to justice, so they can punish them [him] and take care of her. (Male, 42, elementary education)

One out of ten providers felt that there were no advantages of screening women for IPV in health care settings. Advantages mentioned by the other providers fell into three groups: medical benefits for the victims; non-medical benefits for victims; and advantages for providers themselves. Medical benefits for the victim included: (1) timely provision of care to victims; (2) to increase victim's access to psychological care and support; and (3) to improve victim's overall health and receipt of appropriate care and treatment; (4) increase victim's knowledge of the consequences of IPV; and (5) to prevent sexually-transmitted infections and disease. For some providers, routine screening was inexorably linked to STI and HIV-testing with the perceived benefit of enabling women to know their HIV status, preventing further transmission of sexually –transmitted infections, and enabling IPV victims who are found to be HIV-positive to “live better”, “take more precautions”, “take his or her medication”, and “make prevention for him or herself.”

The advantage with the screening and prophylaxis that they do is that it may happen that the person who is raped gets a disease. Using this process, she will have time to get proper care. (Mixed Hospital, 45 years, Head Nurse)

This would promote adequate care and support; it would help them [victims] to know what can happen when they do violence against you. (Mixed Hospital, 38 years, Nurse)

The staff can help her psychologically, as well as for the medicines. (Mixed Hospital, 32 years, Doctor)

It was also felt that the advantages of routine screening also extended to providers. One of the advantages mentioned was to enable doctors to provide correct diagnosis and treatment for IPV victims. The process was also seen as an opportunity for doctors to help victims, with the following added benefit: *“It opens doors to new ways of seeing women in the community”* and provides health care providers with some sense of the *“living conditions”* of their patients.

Almost one in three providers mentioned non-clinical advantages of routine screening for IPV. Protecting women from violence, reducing the rate of IPV and the number of victims, reducing violence incidents and enhancing women’s safety were the most frequently mentioned non-clinical benefits of routine screening. Prevention of sexual abuse was mentioned specifically by one health care provider. One provider qualified the protective benefits of routine screening, stating that *“when the person does not have anything in her hands [doesn’t work] and depends on the man for everything, she has to accept [IPV]”* (Mixed Health Center, 38 years, Head Nurse), signifying that women’s economic independence mediated the expected association between routine screening and a reduction in IPV. Routine screening for IPV was also perceived to enhance women’s safety and dignity and enable them to be a model for their children, and help victims *“find justice.”*

The advantage that I see is the example she will leave for the children because the way that a child sees his parents live will have impact on him or her. (Government Health Center, 25 years, Nurse)

Perceived Disadvantages of Routine Screening

Overall, female clients were surprised that people could even think about disadvantages of IPV routine screening. A respondent even stated: *“I don’t understand because I don’t see why they talk about disadvantages”*. The majority of female clients saw no disadvantage of routine screening (e.g., *“According to me, the disadvantage is insignificant, because if I am a victim of rape, I would know how to protect myself.”*; *“But there is no disadvantage in that, since asking questions is good for the woman.”*). Some respondents talked about the disadvantages of routine screening in terms of health conditions that the process could reveal such as HIV infection or a positive pregnancy test. Another perceived disadvantage was that routine screening could compromise women’s safety (e.g., *“If the environment is not safe, the attacker may beat the victim because she complains about him.”*). Lack of disclosure was another perceived disadvantage of asking women questions about IPV in a health facility: (e.g., *“If the person is suffering, she won’t answer the questions.”*). It was obvious through the answers that what female clients considered as disadvantages had nothing to do with screening itself but the environment and the situation in which abused women were living. The stated reasons were mostly related to fear, safety concerns, shame, and personal life exposure to the public.

Female community members were unanimous in their view that there were no disadvantages of routine screening. Half of the male community members could not see any disadvantages but the other half were concerned that routine screening might stigmatize women, that women would be embarrassed answering questions about the violence, and that there may not be a positive outcome of routine screening, with the partner going unpunished. Responses ranged from *“I don’t see any disadvantage*

because it's for her wellness (Male, 16 years, 6th grade education); "The only thing is a Haitian would probably be embarrassed but there is no disadvantage in that. If the person goes to the hospital, they wouldn't know what to do. So there is no disadvantage (Male, 44 years, primary education). One university-educated male respondent considered routine screening as an infringement on victims' privacy, with a less educated male respondent stating that people may laugh at or make fun of the victim if her IPV experience is known, again highlighting the significance of privacy and confidentiality if routine screening were to become policy. Another disadvantage mentioned by a male community member was that lack of punishment for the perpetrator in spite of disclosure "The disadvantage is when the women suffer violence from their partners and talk about it but they don't know if the person will get punished for their action" (Male, 42, elementary education).

Forty-two percent of providers interviewed stated that there were no disadvantages of routine screening. Provider' concerns had to do with the potential of routine screening to increase women's further victimization if their husband found out and with the unintended psychological impact of routine screening on the victim: For example, *"The only disadvantage is that can be a psychological shock for the person; everything else is advantage."* (Government Health Center, 26 years, Nurse); *"Men may beat the women if they become aware about that"* (Mixed Health Center, 41 years, Community Health Worker). The identification of IPV victims who may have sexually-transmitted infections or HIV was seen as an additional disadvantage of routine screening, in that knowledge of their status could lead to further psychological trauma for victims and further disease transmission if victims knowingly or deliberately infect others: For example, *"This is when the person did the test and found that it was positive"; "If the person knows, sometimes he or she may want to infect other people."* Routine screening was considered disadvantageous if women refused to disclose IPV due to their economic dependence on their partners or feelings of shame, and if victims refused to get tested for HIV: For example, *"There is no disadvantage. But, sometimes we meet some difficult persons, who are not willing to tell us the true because they are ashamed"* (Private/mixed health center, 34 years, Nurse)

Current Screening Practices

In order to determine current screening practices, providers were asked: To what extent are health care providers currently asking female clients questions about intimate partner violence and when they do screen, what do they tend to do? The responses revealed that asking women questions about IPV was not common practice in health care settings. Some health care providers asked women about IPV and other forms of violence if they presented with physical signs and symptoms such as wounds or scars. When IPV screening was performed it was for the purpose of helping a client who was believed to be a victim of violence, identifying victims of sexual violence, or finding out if a client was infected (assumedly with HIV, as one health care provider mentioned that screening for IPV is done at the VCT center). In some cases, women were questioned about IPV only if they presented with vaginal infections.

Yes when the patients come in, they are afraid to talk about this subject. But when they have body injuries/lesions or face swelling, we ask them questions about it, and they admit after many hesitations. (Mixed Health Center, 29 years, Doctor)

Yes, they ask questions because even when you are married, there can be rape. So when we do the screening this is to know the status of the individual. (Mixed Health Center, 25 years, Nurse)

The presence of “red flags” (wounds, scars) was a deciding factor for asking female clients about IPV. Other factors considered were: (1) information provided by the client at intake; (2) the client’s physical and emotional state; (3) confidentiality; (4) the provider’s perceived self-efficacy in making the client comfortable; and (5) the client’s possession of a legal complaint certificate.

“Usually, health care providers, nurse or doctor, they do not screen only for domestic violence, but for all kinds of violence. First of all, the victim must have a legal complaint certificate, or she can have scars, scratches and wounds. We take into account the emotional aspect – what she is afraid of.”(Private/mixed health center, 34 years, Nurse)

Proposed Screening Approaches and Questions and Desired Outcomes

Providers were asked questions as to who should conduct routine screening for IPV, the most salient information to collect, and the best ways to screen, men, women and adolescents about IPV. Regarding the types of health care providers that were considered to be best positioned to screen and in what settings, physicians and nurses were the most frequently recommended providers for conducting routine screening. One out of four providers felt that a nurse would be ideal because of the close interactions nurses have with patients: *“She is the one who is in contact with the patients, who spends more time with them”*; *“they have better intimacy with patients than doctors”*. One out of five providers felt that the physicians working in collaboration with nurses were best positioned to screen because of their training. Respondents who singled out doctors qualified their response, with one preferring general practitioners and another, female doctors because *“women are always more comfortable with other women.”*

Five providers felt that all health workers could conduct routine screening for IPV, with one asserting that this was feasible as long as screening could be conducted in a private setting. When counselors and social workers were singled out as ideal providers for routine screening, their role was restricted to psychological screening. Four providers emphasized the importance of ensuring that screening for IPV was done by a provider who had received training for that purpose: *“The person who is best positioned to do it should be someone well trained on what he or she is doing and giving. He or she must know it well to do it well.”* One provider mentioned that routine screening should be done in the maternity, gynecology, and surgery units of a health care facility. In three cases, a team approach was recommended as it was felt that some female clients may be more comfortable with a given type of provider than with another and as a way of providing comprehensive services.

"I think it is a team work to be involved in the screening and treatment process. It depends on the person. Some may be comfortable with the nurse, others with the doctor, some with the psychologist, others with the social worker; it is a matter of team." (Private Hospital, 38 years, Nurse)

Providers were also asked what would be the best way to screen women for IPV and most important information to gather in an IPV screen of women. One out of four providers interviewed stated that they did not know what information should be gathered in an IPV screen of women. Some health providers maintained that it was important not to address IPV directly but to start with questions on the client's physical and psychological state, life circumstances, and the couple relationship.

"The first questions should be: How is your couple intimate life? Do you have a job? What is your education level? How many children do you have? These questions will help us to find out if their lives are balanced. We need to talk to the victim, and depending on the information, we can check to see if what she said is true. At the same time, we can observe the physical aspect to see if it is matched, like if she has scars on her skin."

Three providers talked about the importance of making the client feel at ease during the routine screening process and ensuring confidentiality, and asking the victim if she needs help: *"Approach them with nice words so that they may tell you all about their living condition at home with their husband"; "Create confidence with the person. Make her feel that she is sharing her ideas with someone who will not disclose her situation to others"; "He or she should ask the person if she has already been [a victim and if she needs help."* Some providers suggested that questions could be asked to find out if women had been victims of various forms of violence, not only by intimate partners but by other perpetrators as well. Although physical and sexual violence were the most frequently mentioned forms of violence proposed for inclusion in the routine screening process, a few providers suggested asking women about economic violence (for example, *"Does he provide you some food?"*) and emotional violence.

Ask them questions on how they live, how their partners live with them, if the partners used to beat them when they have discussion, if they used to beat them without any reasons or when they are in the streets are they used to finding people who attack them. (Mixed Health Center, 40 years, Nurse)

Ask them questions about the relationship that they have with their husbands, if they work, if the partners are used to forcing them to have sex; but it is not every time that they will give the answer. (Mixed Health Center, 38 years, Head Nurse)

Ask them questions about intimate violence, sexual abuse, sex with no consent, yelling from husband or partner, etc. (Mixed Health Center, 27 years, Resident)

None of the proposed questions covered the impact of IPV on the health of the client or her family, the resources available to the client to cope with IPV or the risk of reprisal (whether the client was in imminent danger, whether the perpetrator had threatened the kill the victim). None of the proposed questions considered other risk factors for IPV, such as alcohol or drug use.

As men could be victims of IPV as well, providers were asked the following question: If routine/universal screening were applied to men, what would be the best way to screen men for IPV? What questions should health care providers ask men? Please describe the most important information to gather in an IPV screen of men. Two health care providers stated that men should not be screened for IPV, one of whom justified this position by stating that women deserve to be victims of IPV, a position that suggests that provider attitudes towards female victims of violence need to be addressed in IPV screening programs: *“No because, nowadays, women do not have self-control; and sometimes the woman deserves what happens to her. Whenever a woman enters a boy’s room, he will always intend to abuse her”* (Government Health Center, 38 years, Nurse). Three other providers felt that it would be difficult for men to talk about their IPV experiences, especially if they were perpetrators of IPV: For example, *“Men will never tell the truth. They will not tell you they beat their women. But you can always talk to them.”* However, one provider felt that it would be easier for men to disclose IPV victimization: *“They would complain easier to say that they have experienced violence from a woman.”*

Half of the providers who were supportive of IPV screening for men felt that that screening questions should pertain to male IPV perpetration while the other half thought that questions should pertain to male IPV victimization and be parallel to those asked about women’s victimization experiences. Proposed questions about male IPV perpetration sought to obtain information on how men treat their female partners, marital quality, whether men consider women as their equals (*“Do they respect women; how they treat them; do they see them [women] as equal to them”*), conflict resolution skills, history of sexual and physical violence perpetration, and causes of IPV perpetration (*“Did you use to hit your wife? Why?”*). Some proposed questions had a strong counseling component and touched on partner reduction (*“Ask the men to reduce their number of partners to better manage their life”*), and the need to respect women’s rights to refuse sexual relations (*“They must respect the women. They must accept when a woman tells them that she cannot [have sex]”*). Four providers stated that they did not know the best way to screen men for IPV.

Several issues arose in the discussions about the best way to screen adolescent girls for IPV. One out of four providers acknowledged that talking with adolescents/youth about IPV was challenging due to the sensitive nature of the topic and adolescents’ lack of maturity and mistrust and fear of adults. Adolescence was described as *“a psychologically uncertain age group”* and *“a crazy period”*. Even though some providers felt that adolescents could be asked the same questions about IPV as adult women, one mentioned that bringing in a psychologist would be especially useful when screening adolescent girls about IPV. Other issues included: (1) asking questions indirectly as some adolescent girls may not want their parents to know that they are abused; (2) asking adolescent girls about their living arrangements; (3) finding out who the perpetrators are (for example, is it a relative?); and (4) asking whether the adolescent girl consented to sexual intercourse. A few providers stressed the importance of maintaining strict confidentiality when questioning adolescent girls as they were perceived to have inhibitions towards IPV disclosure. In a few instances, parental presence during gynecological exams was recommended.

“The adolescent girls are the most difficult group willing to share, especially when they are facing intimate partner violence. It is difficult when they do not decide to complain against their

partner. If they do it, we can question them about their home and school life. We can try to find out if the partner is a relative or not, then we can do the follow-up.” (Private/Mixed Hospital, 34 years, Nurse)

Some of the proposed screening questions for adolescent girls and related comments (for example, *“I hate talking to teenagers” (Mixed Health Center, 46 years, Community Health Worker); “They are never happy. They always cry” (Government Hospital, 38 years, Nurse)*) suggested that some providers require training on how to talk to adolescents about IPV and other sensitive matters. A few providers suggested starting with questions on the periphery of the topic, most of which had to do with adolescents’ living arrangements (for example: *“For me I would ask if his or her parents were there; if they live with their parents because when a kid lives alone, he or she begins to ask for money and he or she may become victim of violence” (Government Health Center, 25 years, Nurse)*), before asking questions about t IPV experiences (*“Ask her questions about bruises, scratches. What kind of violence have you been victim from your partner? What has he done that make you sad?”*). However, a good number of providers proposed questions that appeared to be admonitions and that were judgmental (for example, *“For me what brings her to have a husband? Because as [an] adolescent, what problems did you have that brought you to get a husband?” (Mixed Hospital, 45 years, Head Nurse)*); adopted a tone that was accusatory (for example, *“There is a link if you do not really ask why she has a partner who provides a lot of money in an economic society.” (Mixed Health Center, 39 years, Auxiliary)*); and proposed advice that dictated what adolescents should or should not do (for example, *“Practice abstinence with men because they are too aggressive; be careful, you should not accept everything that men say.” (Mixed Health Center, 40 years, Nurse)*). Experience in some settings have shown that adolescents may become embarrassed or uncomfortable by these types of conversation or questioning and that these approaches may make it difficult for providers to get their messages across to young people.

In order to determine providers’ expectations about the outcomes of routine screening, the following question was asked: If universal/routine screening for intimate partner violence were to become policy, what would be a successful screen? What are its hoped-for outcomes? The desired outcomes of routine screening were as follows: (1) the ability to reach as many HIV-infected women as possible; (2) reduction in the rate of IPV; and (3) psychological care and treatment for violence survivors; and (4) IPV screening outreach to the community. Although one out of five providers mentioned that a reduction in IPV risk was a desired outcome of routine screening, some skepticism was expressed as to whether this outcome was attainable: *“The result that we should expect is that there is no more violence; but it would be a dream, a utopia!” (Health Facility Type not state, 29 years, Doctor)*. Some providers stated that the desired outcomes would depend on the client’s willingness to disclose IPV and for these providers (16 percent), women’s agreement to be screened and disclosure of IPV were the desired outcomes of a routine screening policy. For example, three providers mentioned that that the success of routine screening would depend on the client’s willingness to talk about IPV and the degree to which there was public education and awareness about IPV.

“Even though it becomes an obligation, I think we should have awareness about that issue and the importance of a screening. The outcome is to uncover the reality on that issue because many people are victims of [violence]. Many are ashamed to lodge a complaint against their partners

after a rape. Now, they need to know it is helpful when they express their situation in order not only to receive appropriate treatment and care, but also to help decrease that action [IPV] in our society.” (Private/Mixed Hospital, 34 years, Nurse)

In order to pretest routine screening tools, providers were shown a modified questionnaire that had been developed in Haiti before the earthquake to record violence allegations and were asked their perceptions about health care providers’ reactions to using the modified tool to screen women routinely for IPV. The tool was originally developed by the *Concertation sur la Lutte Contre La Violences Faites aux Femmes* (National Round Table on the Prevention of Violence against Women). The tool was modified by adding three questions to enable the identification of cases detected through routine screening. Providers were divided about the value of the tool for routine screening. While one provider found the questions to be well-formulated and precise, the length of the tool was of concern in the context of high client volume.

It is a way to screen but it will have an impact on the care provider, especially if he or she has many people to see. (Government Health Center, 26 years, Nurse)

I will not have time to read it because I am working. (Mixed Hospital, 53 years, Nurses’ Aide)

It could be shorter. (Mixed Health Center, 41 years, Community Health Worker)

I think that those who are accustomed to do counseling will have no problem with the questionnaire. When we begin to use it, we will see how to improve it. (Mixed Hospital, 38 years, Nurse)

Some felt that the questionnaire could be simplified (*for example, “Make it simpler; formulate clearer and more direct questions” (Government Hospital, 34 years, Nurses’ Aide)*) while others emphasized that the questionnaire needed to be pretested in order to find out what changes need to be made or whether the original format should be retained. One provider did not like the reference period of the past 12 months for reporting of IPV victimization but it was unclear as to whether a shorter or longer reference period was preferred.

Providers were also shown a picture of a stamp that was being proposed for recording information on intimate partner violence in a woman’s clinical record and asked how health care providers might react to using the stamp. Two thirds of providers interviewed did not respond to the question. One provider stated that the stamp was *“more or less acceptable”* and another that *“the stamp is not too bad.”* The other provider admitted that he/she did not review the stamp. Those providers who reviewed the stamp felt that it needed to be pretested. As one provider stated, *“after gathering all the complaints and we make a synthesis, we will see what needs to be changed.”* *“The other provider stated that it can be used, but make it clearer.”* The third provider stated *“I don’t have time to read it.”*

The study also collected information on female clients’ and community members’ perspectives on the types of questions that health care provider should ask women about IPV. Health care providers were generally described by female clients as knowing best what questions to ask although some female

clients maintained that the government should take on the responsibility of training health care providers, explaining what constitutes violence, and providing health care providers with a better working environment so that they could improve their performance. A few of the female clients offered example of questions that health care providers could ask about IPV but almost all proposed questions were about physical and/or sexual violence. A few proposed questions (for example, "Ask what they did to deserve a thrashing from their husband.") suggested that female clients and the larger community needed to be sensitized that IPV victims are never to be blamed for the violence and that such questions could be reformulated to ask about circumstances that may have led to IPV.

Are you a victim of violence? What kind of violence?

They can ask them: What they are doing in life? What they are doing for a living? How do they react to the violence?

What happened? Where were you raped -in a public place or somewhere else? Did he ask you and rejected him?

Ask her if her partner beats her and why.

How many times did they rape you? Do they beat you?

They should ask her if she has a partner and how she is living with him. Is he violent towards her?

What do you usually do when your husband beats you?

Similarly, female community members proposed questions pertaining to forced sex and rape (for example, "If the man did something sexually inappropriate to her without her consent" (Female, 28 years, 10th grade education)) and the frequency of physical violence (for example, "Is your husband beating you all the time or is it the first time he's beating you? (Female, 21 years, 11th grade)). Questions proposed by male community members pertained not only to physical and sexual violence but also to women's safety/security, economic violence, marital quality, and jealousy, with one community member stating, contrary to recommendations, that providers should find out about women were to blame for the violence.

Well, the first questions that should be asked are: Does her intimate partner beat her? Do they have protection? If yes, where can they find it? (Male, 23 years, university education)

How do their husbands treat them at home? Are their husbands jealous? (Male, 59 years, elementary education)

I think he/she can ask questions like: Does her husband feed her? Do they get along well? Are they happy or does her husband beat her? (Male, 16, 6th grade)

Female clients' suggestions for what health care providers should do to help women who disclose IPV fell into five general categories: (1) provide general help; (2) provide care and treatment; (3) act to ensure a woman's safety; (4) work with the community to address IPV; and (5) counsel victims, as revealed by some of the following excerpts.

"If they are infected, they could help them find treatment and advice."

"Talk to women about how they must behave with men."

"Cure them."

"Give them advice to know what to do or not."

"Come in the area and create a committee, and train people."

"Help to find justice."

"Help them get out of the bad situation they are in."

"Show them how to better approach people."

Community members' perceptions as to what health care providers should do to help female IPV survivors overlapped with female clients' responses in the areas of general provision of help, helping to create community-based committees to educate people about IPV, and health care provision including physical examinations, but differed in some respects. First, it was highlighted in three instances that some victims are unable to seek care and treatment for IPV (e.g., *"Sometimes, their husbands keep them from going to hospital"* (Female, 20 years, education not stated). Second, it was mentioned that health care providers should help women leave abusive relationships and prevent further abuse. One male community member expressed some skepticism in this regard: *"Well, some women are beaten so hard by their intimate partners that they decide to break up but others are being punished by their partners but still want to stay with them (Male, 16 years, 6th grade education)*, which could suggest that health care providers should not be held accountable for battered women's stay-leave decisions. Many male community members could not respond to the questions precisely because of reasons such as *"I can't talk for women"*; *"How can I know? I am not a woman!"* Third, some male community member's responses highlighted referrals of female IPV victims to shelters and sources of assistance, with some skepticism that women would get the support that they need.

Well, they should know exactly if there is a place nearby they could go in case they were victims of intimate partner violence, and if they found that place and went to complain, could they expect something in return? (Male, 23 years, university education)

The question as to "What would not help?" did not elicit a lot of responses from female clients. Most respondents said they did not know. However, three specific concerns were mentioned that had to do with health providers taking control of the situation, asking an inappropriate question, and failing to have a counselor or someone to provide counseling on staff. A concern raised by a female client was a

potential increase in health care providers' workload without a commensurate increase in salaries: *"If the work is coming bigger, the salaries must be improved."*

(1) *"Talking to the police."*

(2) *"Don't ask her if she loves her husband because if she didn't love him she wouldn't still be with him."*

(3) *"If there is no one for giving advice."*

Female community members talked mostly about what could help – social workers, the police, anyone. One specific factor that would not help was humiliating the victim, especially in front of others, which was mentioned by two participants, one uneducated and the other with university education. Another sub-theme underscored women's lack of economic independence: *"If you don't have anyone to help you, you will die of hunger (female, 27 years, 6th grade)*, highlighting the need to improve IPV victims' overall economic situation. Although most of the male community members stated that they did not know what would not help, responses provided were clear about the importance of ensuring the availability of non-health services for IPV victims and privacy and confidentiality: *"If they don't have a place to report, that would not help" (Male, 21 years, 11th grade education); "What would not help is having a person in the community to know when there is violence done on a woman" (Male, 42 years, elementary education).*

Female clients and community members were also asked: If there were things that you could tell health care providers in this community about intimate partner violence or about helping women who have been sexually abused, what would they be? A third of female clients stated that they had no idea. Responses provided suggested that female clients wanted health care workers to provide information about IPV and counsel not only victims but men in general and perpetrators as well. A couple of female clients wanted providers to know that there were no community-based associations that provided help to victims but it was unclear as to whether clients wanted providers to take on the responsibility of addressing IPV in the absence of such committees and to use their influence to create committees against violence in the community.

The community does not have a committee to talk to the health care providers about violence, neither to help victim women in the area. Yes, they can have advertising everywhere to aware the people about violence against women and telling that that women are very important in our society. (Mixed Health Center, 27 years, 9th grade education)

Walk around with a mega phone telling men not to commit violence on women. (Government Hospital, 25 years, no education)

Talk to them in order [so that] they will stop beating us. (Private/Mixed Health Center, 34 years, 6th grade education)

Community members brought up several issues about IPV and helping abused women. First, it was important to set up sustainable systems for addressing IPV at the community level and provide HIV-

testing and counseling and support to women who have been abused. Second, rapists should be arrested. Third, health care providers should link women with job opportunities. Fourth, consultation times tended to be short and may be insufficient for health care providers to discuss clients' IPV experiences.

According to me, the people that are providing health care are not going to stay. They should train others that will train others in the community. (Female, 20 years, 5th grade education)

To me, the health care providers won't stay with us; in this they should make a group of disciples to help people in the community. The more teachers we have the less violent people become. (Female, 20 years, education not stated)

The doctor should send the person to the hospital to get tested, then gives them some counseling and support. (Female, 27 years, university education)

Yes, the health care provider can question the ladies, assist them, give them jobs if possible... (Male, 21 years, 11th grade education)

Barriers to IPV Disclosure and Routine Screening Implementation

Female clients and community members were asked: Is there anything that makes it difficult for women to tell a health care provider about intimate partner violence? Does the type of violence matter? What types of violence would women find it easier to talk about? What types of violence would women find it difficult to talk about? What would make it easier for women to talk about these types of violence? Most female clients could not think of specific factors that would make it easier for women to talk about types of violence that were perceived to be difficult to disclose. One participant stressed that it was important to have individual-oriented provider-client interactions (e.g., *"We need to talk to them [health care providers] on one and one. They [women] might be ashamed."*), which alluded to the importance of privacy and confidentiality in provider-client interactions. Another stated that she was not sure because women may disclose under certain circumstances but in other situations, intentions to disclose may not translate into actual behavior (e.g., *"I am not sure because sometimes I would tell it to others if I was victim, but when the reality comes you decide differently."*). The desire for privacy was an emerging subtheme in these discussions *"Most of the time they keep it secret. They don't want people to know about that. But a few share that with their close friends or parents"; "but they don't want to say anything so they don't get criticized"; "we don't tell anyone about it so they don't know our business"; we don't tell people so they talk bad about us"; "What I think is difficult is when my husband beats me and I don't want people to know because I don't want them to have a bad image of him. But I think it is an education problem."*

Other female clients believed that organizational/structural change was needed in order to facilitate the disclosure of certain types of violence: (1) create jobs for women; (2) create more women's associations;

(3) establish an association in the community to train people and raise awareness about IPV: *“We need an office or an association in our community. The people need to be trained and aware of violence. They need to know what they should or should not do.”* Most of the female clients felt that there would be no barriers to disclosure as IPV was common in their communities. However, a few identified circumstances that would make it difficult for women to tell a health care provider about IPV: (1) concern for personal and patient safety: *“if the attacker is present while the victim is talking to the health care provider”*; (2) if a woman’s partner forbids her to talk about the violence; (3) feelings of shame, which was the factor most frequently mentioned; and (4) the impact on victims of IPV disclosure (e.g., *“sharing their stories may impact them. The person who works for the intimate partner violence department must be reliable.”*). However, responses did not clarify how women may be impacted by sharing their stories.

There was no consensus as to whether the type of violence would affect disclosure as most female clients qualified their statements. While some felt that it would be easier for women to talk about physical violence perpetrated by their partners, at least one mentioned that women may not disclose such violence if they did not want people to have a bad image of their husbands. Some female clients felt that it would be easier for women to talk about rape if it resulted in an unintended pregnancy. However, most felt that rape was the most difficult type of violence to disclose, especially in the case of stranger rape (e.g., *“if a thief has sex with a woman making her ashamed.”*), forced sex perpetrated by someone who was not a husband/partner (e.g., *“The most difficult case is when they force them to come in their car and they go somewhere with them to rape them”*) or if rape occurred after a woman enters a man’s room on her own free will. Psychological violence perpetrated by women was considered by one female client to be easy to disclose.

If the women go in the men’s room and they rape them, even their mothers cannot react about that. The intimate partner violence women talk the most about is when they are raped and pregnant unintentionally. What could help women talk about their intimate partner violence is when they behave themselves. (Government Health Center, 19 years, no education)

We don’t have any obstacle. Some men rape and beat them. They beat them for meal. For a Haitian woman to live happy, we should not have Haitian men on earth. (Government Health Center, 34 years, educated)

Female community members suggested that the degree of IPV disclosure could depend on the perpetrator, with women being less likely to disclose violence when the perpetrator was their husband/cohabiting partner: *“Yes, they can talk. They won’t like that to happen when the man lives with them” (Female, 49, uneducated)*. Fear of the perpetrator, the setting of disclosure and type of violence were also considered to be key factors in influencing disclosure. Women were considered to be most likely to disclose sexual violence and least likely to disclose emotional violence. Some female community members felt that economic violence would be the most difficult type of violence to disclose due to feelings of shame and the fact that men typically only provide economic support to women with whom they have sexual relations. It was felt that with appropriate training, levels of disclosure would improve. The belief that nothing would result from disclosure was also cited as a barrier, with the case

being provided that numerous surveys and research on violence have never resulted in programmatic actions.

They don't accept to talk about the violence when it's their husband that does it. It's also a harsh violence when it's the women always in a way. When they have seminars, while everyone is talking, the women can say what's going on at home or with the people in their neighborhood. (Female, 20 years, 5th grade education)

Fear of those who make the violence. At home, her husband can become violent. Therefore she might fret and decide not to talk. It would be better if they could meet that woman in the street. There are many kinds of violence: sexual, physical. Generally women talk about sexual violence the most. Sometimes being beaten by their husbands appeared very bad but they never consider saying bad words as violence. They prefer crying. When there is specific time of training, women express themselves with less fear than if they were before he who became violent. (Female, 20 years, education not stated)

No, nothing can stop the women from talking. There are many types of violence: when he doesn't give money to eat. He makes me suffer when he doesn't give me food to eat. It's more difficult for me to say. I will be ashamed. (Female, 27 years, 6th grade)

"No. There's nothing that can prevent her. It's not important not to talk about it. The easiest violence to talk about is when she breaks his stuff. What I think is difficult is when my husband beats me and I don't want people to know because I don't want them to have a bad image of him. But I think it is an education problem. (Female, 40 years, high school education)

Contrary to some of their female counterparts, male community members felt that rape was the type of the violence the women would be least likely to disclose, especially if the perpetrator was the husband or cohabiting partner. However, disclosure in these circumstances was considered to be facilitated by having well-trained interviewers. Shame, fear of the perpetrator, shyness, a desire for privacy (which was mentioned by males with university education) and lack of confidentiality were also considered to inhibit IPV disclosure. Factors precipitating the violence were also a consideration, with women being considered less likely to disclose IPV if "they were caught cheating on their husband and he commits violence on them" (Male, 42 years, elementary education). One male community member stressed that if nothing was done as a result of the present study and there were no organizations in the community to address IPV, women would also be less likely to disclose victimization.

Well, the most difficult case is if the victims we're talking about are not "street raped" but are at home. So if the interviewer is well educated he/she can talk to them. (Male, 21 years, 11th grade education)

Well, there are some kinds of violence that a woman might be afraid or ashamed of talking about, for example, if she's been raped or experiencing some other types of home violence... because if she really loves her partner, she may not want people to talk about that [i.e., the violence]. (Male, 23 years, university education)

I don't think the person could have an inconvenience if the person talks about what they suffer. At the same time there are people that don't like to talk about what happens in relationship with their boyfriend. (Male, 24 years, university)

They can be ashamed or scared of people in their community or their husbands. (Male, 32 years, high school education)

The question administered to providers focused more on barriers to and challenges in implementing routine screening for IPV: What factors would make it difficult for health care providers to implement universal/routine screening practices for intimate partner violence? What challenges would health care providers face when implementing universal/routine screening for intimate partner violence? Patient-related factors included clients' disapproval of routine screening, lack of disclosure of IPV experiences (e.g., for fear of losing the husband if he is her primary source of economic support), and lack of understanding about the advantages of routine screening. Health system-related barriers included lack of tools and materials for conducting routine screening and helping the patient. Provider-related resource barriers included lack of basic training in routine screening. Lack of community awareness of IPV and the availability of services to address it were perceived to be major challenges to implementing routine screening for IPV.

When they do not have basic training and structure for that, the screening practices become difficult. The challenges are the lack of materials and tools for doing the job. The human resources may be available, but we do not have enough materials to do it. (Private/Mixed Health Center, 34 years, Nurse)

I think if the health care provider is trained, he will do it. And, it is the same for others. Education. They need to inform the people about the service they have, and when they come, they should find it. (Private/Mixed Hospital, 34 years, Nurse)

The difficult thing is because the woman doesn't have any income-generating activities. She is in embarrassment to tell her situation to others. So she resigns herself to not lose her husband even if he treats her badly. (Private/Mixed Health Center, 34 years, Nurse Supervisor)

Providers were also asked: what can be done to overcome these challenges? Responses indicated that creating an overall culture of IPV awareness in the community was important for overcoming the challenges that providers might face in implementing universal screening as were “*soliciting the authority's help*”, addressing women's economic situation, ensuring confidentiality, creating a climate of trust, patience on the part of providers, “*help[ing] the women understand if they don't talk they won't find help*”, client counseling, and “*help[ing] them [women] get justice when they are abused.*” Education, awareness- raising and the media were considered to play a crucial role in overcoming barriers to IPV disclosure and were mentioned by approximately 35 percent of providers. Addressing health providers' roles and responsibilities was also mentioned as a component of a plan to overcome identified challenges.

People who are willing to listen to you, you can talk to them; organize small meetings, small gatherings, and small groups to talk to them. (Mixed Health Center, 40 years, Nurse)

Information, educate the population so that they know what violence is and what it contains. (Mixed Health Center, 25 years, Nurse)

This is the confidentiality of the provider; and then, create a climate of trust between the patient and the doctor. (Mixed Health Center, 29 years, Doctor)

At first, we need to plan it. With a health care provider roles description [and] media divulgation before we start...to reach the people for their collaboration, we will surely succeed. (Private Hospital, 34 years, Nurse)

To determine whether safety and security were barriers to the implementation of routine screening, providers were asked: How can universal/routine screening for intimate partner violence affect women's safety? Under what conditions can universal/routine screening for intimate partner violence increase or decrease client safety? A third of health care provider interviewed stated that they did not know how routine screening could affect women's safety. Other providers felt women's safety could be compromised if a violent partner found out that the woman had been questioned about violence. A few providers felt that a victim's safety could be enhanced by the way the health care system dealt with her case, if health care providers counseled perpetrators, and if the victim took legal action against the perpetrator.

In this way, they could feel safe or unsafe. They should take action toward [reach out to] the health care and justice providers. The health care can screen them, but it is not enough. When it happens, they may [abusive partners] want to react violently too. The routine screening for intimate partner violence decrease the woman's safety, especially when the man knows someone else has questioned his partner about the way he treats her. We also think we can make sure the partner won't be informed about what the other said. We believe the screening should take place in confidentiality all the process long. (Private Hospital, 34 years, Nurse)

The impact is that for some men if you do a home visit, they will beat the woman again; some will not accept that. This has a big impact; you may think that you have done well, and yet you have worsened the situation of the woman. (Mixed Health Center, 38 years, Head Nurse)

Because the abuser is in the area, the person will be afraid to return home. If they would take care of the perpetrator, it should be for a moment. (Mixed Hospital, 38 years, Nurse)

When she goes back home, she expects the violence will be over, but it is not guaranteed. We should talk to the man to help him see the consequences of the violence. We can increase the client safety when we meet the man and talk to him, helping him to not use violence because it is not fruitful. (Private/Mixed Health Center, 34 years, Nurse Supervisor)

Training Needs for Implementation of Routine Screening for IPV

To identify training needs for the implementation of routine screening for IPV, providers were asked: What are the needs for future training or professional development for health care providers in the area of universal/routine screening for intimate partner violence? The following training needs/topics were identified:

- Violence – all types of violence
- Sex education
- Interpersonal communication (e.g., *“Training on how to talk to the client, which methods to use to approach these victims”*)
- Screening for domestic violence; questioning techniques; *“questions that you should ask a woman about violence”*
- Support for IPV victims; developing support groups
- Appropriate care and treatment of IPV cases
- How clients should react if they find themselves in a violent situation; how women can protect themselves
- Confidentiality
- Psychological care; psychology
- Sexually-transmitted infections
- Counseling

In one instance, ongoing training was seen as instrumental for improving health care providers’ abilities to screen women for IPV. Although there was a specific question as to what topics should be included in health care provider training on universal/routine screening for intimate partner violence, most responses were a repeat of those provided above, with one provider stating that health care provider training should cover *“How to do a screening without hurting the client”*, a recognition that a well-intentioned IPV intervention such as routine screening may lead to harm.

In terms of what other strategies should be combined with health provider education, many providers believed that it was important to raise public awareness about IPV in order to increase the identification of victims in health care settings and to implement prevention and mitigation strategies at all levels of society. Other strategies mentioned in addition to public education included: (1) home visitation; (2) multi-sectoral approaches involving, for example, *“Police officers, judges, pastors, women*

organizations”; (3) development of IPV surveillance systems; (4) establishing and strengthening partnerships; (5) reinforcing patient safety; and (6) increasing providers’ salaries.

They should form groups to identify [IPV victims], going from house to house to talk to people and tell them that if they are abused to go to the hospital; so they can track the number of victims per month. Most of the women in this society do not work, men are doing everything. Then if a woman decides to file a complaint, the man can decide not to give anything anymore and tell her “go to the person to whom you complained to get help. (Mixed Health Center, 24 years, Nurse)

They must do advertising on radio, banners, and education clubs. But mass education should be done with every group like churches, schools, clubs, and any place where people are gathering. (Private Hospital, 47 years, Doctor)

Better collaboration between social services and the Women’s Ministry with the health centers. (Mixed Health Center, 29 years, Doctor)

If the providers’ workload will increase, their wages should also increase. (Government Health Center, 32 years, Nurse)

DISCUSSION AND RECOMMENDATIONS

Overall, half of providers and female clients and almost all community members expressed positive attitudes about routine screening for IPV.

Acceptance of routine screening was high among community members but lower among female clients of FP/RH services and providers, half of whom supported routine enquiry about IPV. Providers stated that the advantages of asking female clients about IPV were: (1) to enable health care workers to provide appropriate care and treatment if the client is pregnant or has tested positive for HIV; (2) to enable women to know their rights; (3) to improve the victim’s health; (4) to prevent sexually-transmitted infections and HIV; and (5) to improve the victim’s psychological health. Female clients who supported universal screening felt it would be beneficial to all women. They stated that such a policy would: (1) reduce women’s exposure to IPV; (2) increase IPV survivors’ access to health care, treatment, and assistance; (3) increase women’s ability to protect themselves from IPV; (4) enable women to get advice and counseling to cope with IPV; and (5) improve survivors’ overall wellbeing. Some providers and female clients felt that only women who present with signs and symptoms of and women who are currently married or in intimate relationships should be questioned about IPV by health care providers.

Barriers to routine screening need to be addressed at the provider, client, health system, and community levels.

Potential stigmatization of IPV survivors was one of the most frequently mentioned disadvantages of IPV screening. Provider-related screening concerns included infringement of clients' privacy, lack of punishment of perpetrators, disclosure distress, and increased perpetration if an abusive partner discovered that a female client had disclosed IPV. The data also suggested that women may not disclose IPV due to a desire for privacy and the dangers associated with disclosure. In the female client and community member interviews, the following additional factors were felt to reduce women's likelihood of disclosure of IPV to health care providers: (1) interviewing women in the presence of the abusive partner; (2) feelings of humiliation and shame (most frequently mentioned); (3) impact on victims of reliving their experiences during disclosure; and (4) inability to find needed help after disclosure, especially if there is no one to counsel IPV survivors.

Non-health sources of assistance for IPV victims/survivors need to be established at the community level.

The study demonstrated that community resources to address IPV were lacking and where they exist, a limited range of services was provided. It is essential to strengthen the ties between providers and community agencies and incorporate these collaborations into a formal IPV response model. In addition, efforts could be made to create/update a referrals directory and make that available to all health facilities. There is also a need to provide educational resources about IPV in Haitian Creole to community-based and women's organizations to help increase public awareness about IPV, its definition, causes and consequences, and community-based sources of help seeking.

There is a need to strengthen health care provider support for IPV survivors.

When asked what they would like health care provider to do in order to help IPV survivors, female clients and community members mentioned the following:

- Provide care, treatment and medicines
- Help women prevent IPV, protect themselves, and avoid re-victimization
- Provide advice/counseling not only to survivors but also to abusive partners
- Tell women where to go for help, food, things they need, and support to earn a living
- Come to the region, form committees, and educate people about IPV

These desired aspects of IPV care and support overlapped somewhat with providers' own desired outcomes of IPV screening, which included: 1) the ability to reach as many HIV-infected women as possible; (2) reduction in the rate of IPV and women's risk of re-victimization; and (3) psychological care and treatment for violence survivors; and (4) IPV screening outreach to the community.

In terms of the health care delivery system, a team approach is needed to address IPV in a systematic manner.

This study showed that, in actual practice, routine screening for IPV is lacking. The presence of "red flags" (wounds, scars) and the client's possession of a legal complaint certificate are deciding factors for asking female clients about IPV. Although psychologists, doctors and nurses were the most frequently

recommended providers for conducting routine screening, a team approach that included health workers, lawyers, and the Ministry of Women's Affairs was recommended and has the potential to improve comprehensive care.

To improve the health sector response to IPV increased collaboration is needed between health care providers and the community.

Strengthened linkages between health care providers and communities were perceived to be crucial to raising awareness about IPV and the importance of screenings. There was considerable confidence in providers' ability to address IPV outside of health care settings. Many female clients alluded to the possibility of collaboration between health care providers and communities in order to address violence and highlighted the role of health care providers in referring IPV survivors to community-based organizations that could help them. The possibility of home visits for follow-up care of IPV survivors was mentioned by providers, female clients, and community members and is feasible given the widespread availability of community health workers in the region. Local IPV experts should be identified from community based organizations and the Ministry of Women's Affairs and Rights for decision support as health care providers need to know where victims could obtain non-health services at the community level.

Health care providers have training needs that must be met with regard to the identification, care, treatment, and counseling of IPV survivors.

Providers were found to have training needs to improve not just knowledge of IPV but communication skills for discussing IPV, and appropriate care and treatment of IPV cases. Ongoing as opposed to one-off trainings can be instrumental for improving health care providers' abilities to screen women for IPV and provide effective care and treatment to IPV survivors. Providers felt unprepared to talk to adolescent girls about IPV, a finding that suggested that routine screening training for providers should include the dos and don'ts of talking to youth about sensitive health issues and that it would be critical to set up youth-friendly IPV screening policies.

There is a need to sensitize communities in order to reduce the culture of silence around IPV and increase awareness of services and sources of support for IPV survivors.

Creating an overall culture of IPV awareness in the community was considered important for overcoming the challenges that providers might face in implementing universal screening for IPV in health care settings. Although many female clients and female community members had heard about or witnessed intimate partner physical, sexual and economic violence against women in their communities, most male community members felt that IPV was rare in their communities. Few IPV survivors were perceived to get the help they needed due to: (1) the culture of silence around IPV; (2) the tendency to blame the victim; (3) lack of knowledge about where to go for help; and (4) dissatisfaction with existing services. Some female clients believed that it was important to create

community-based committees to address violence against women at the community level and raise public awareness about IPV in order to increase disclosure of IPV to health care providers and improve survivors' wellbeing.

Increased confidentiality and ensuring women's safety and security are essential when addressing IPV in health care settings

Alarming, a third of providers stated that they did not know how routine screening for IPV could affect clients' safety. Yet, lack of confidentiality and problems ensuring women's safety and security were frequently mentioned disadvantages of IPV screening and barriers to IPV disclosure. Furthermore, none of the routine screening questions proposed by providers assessed whether the client was in imminent danger, whether the perpetrator had threatened to kill the victim, or whether the client faced the risk of reprisal. None of the proposed questions determined the resources available to IPV victims/survivors and how the victim's safety could be ensured. As disclosure of IPV can put a client at risk of further violence if the perpetrator finds out about the disclosure, functional systems must be established outside the health sector to ensure that women who disclose IPV experiences receive assistance with ensuring their safety and that of their children.

Multi-pronged strategies that include women's economic empowerment are needed to prevent intimate partner violence.

An important patient-related barrier to IPV screening and disclosure was women's economic dependence on men and decreased economic security that could result from an abusive partner's knowledge of the disclosure. These findings implied that economic empowerment strategies such as improved opportunities for women's employment, group savings, finance and microfinance must be combined with routine screening programs and interventions addressing social norms and gender equity as an essential component of any IPV-prevention strategy.

CONCLUSIONS

Low sample sizes for each participant group and the use of purposive sampling limited the generalizability of this study's findings. Despite these limitations, the study's finding provided data to inform decisions about IPV screening and identify factors to consider in the planning and implementation of IPV screening interventions in health care settings. The findings call for multi-component programs that implement a comprehensive approach to routine screening, improve providers' knowledge and self-efficacy regarding routine screening (through short, clear and effective protocols, initial and refresher training, interpersonal communications skills building, etc.), increase access to community-based support services for victims, and strengthen partnerships between health facilities and communities. The findings suggest that widespread communication of information about the prevalence of IPV, community resources for victims, and the health care-based response to IPV could help break the silence around IPV and facilitate IPV disclosure and victim identification and support.

Further research is needed on the impact of IPV screening and disclosure on victims, how to change social norms around IPV and its disclosure, the availability and quality of community-based resources for IPV victims, and community-based strategies to secure the safety of IPV victims and their children. Research is also needed on the impact of IPV training on provider -perceived self-efficacy regarding IPV screening and factors associated with the safety of women who experience IPV. Any research and IPV screening intervention should be governed by safety considerations.

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APPENDICES

Appendix 1

In-depth Interview Guide for Healthcare Providers

Participant Identification No. :		Date:
Name and Address of Health Facility:	Time Discussion Started:	Time Discussion Ended:
Type of Health Facility: <input type="checkbox"/> Government Health Center <input type="checkbox"/> Private Health Center <input type="checkbox"/> Mixed Health Center (Government-subsidized NGO-run) <input type="checkbox"/> Government Hospital <input type="checkbox"/> Private Hospital <input type="checkbox"/> Mixed Hospital (Government-subsidized NGO-run)	Type of Provider: <input type="checkbox"/> Doctor <input type="checkbox"/> Nurse <input type="checkbox"/> Head Nurse <input type="checkbox"/> Auxiliary <input type="checkbox"/> Resident <input type="checkbox"/> Community Health Worker	
Participant's Age:	Participant's Education	
Participant's Sex:		
Name of Interviewer:	Name of Note Taker:	

1. To what extent are healthcare providers currently asking female clients questions about intimate partner violence and when they do screen, what do they tend to do?
2. What factors do health care providers consider when deciding to conduct or not conduct a screen for domestic violence?
3. What are the advantages of screening women for intimate partner violence in healthcare settings?
4. What are the disadvantages of screening women for intimate partner violence in healthcare settings?

5. Some professionals argue that every client should be screened for intimate partner violence, a practice called universal or routine screening. Others look for specific signals and then screen when those signals raise concern. What is your position?
6. How do you think clients/patients would regard routine/universal screening for intimate partner violence? Would they approve or disapprove? Under what conditions?
7. What types of healthcare provider are best positioned to screen and in what settings?
8. What factors would make it difficult for health care providers to implement universal/routine screening practices for intimate partner violence? What challenges would health care providers face when implementing universal/routine screening for intimate partner violence?
9. What can be done to overcome these challenges?
10. What would be the best way to screen women for intimate partner violence? What questions should healthcare providers ask women? Please describe the most important information to gather in an IPV screen of women.
11. If routine/universal screening were applied to men, what would be the best way to screen men for IPV? What questions should healthcare providers ask men? Please describe the most important information to gather in an IPV screen of men.
12. What would be the best way to screen adolescent girls for intimate partner violence? By adolescents we are referring to those aged 15-24 years. What questions should healthcare providers ask adolescents? Please describe the most important information to gather in an IPV screen of adolescents.
13. If universal/routine screening for intimate partner violence were to become policy, what would be a successful screen? What are its hoped-for outcomes?
14. What are the needs for future training or professional development for healthcare providers in the area of universal/routine screening for intimate partner violence?
15. What topics should be included in healthcare provider training on universal/routine screening for intimate partner violence?
16. What other strategies should be combined with health provider education to increase the identification of victims of intimate partner violence in healthcare settings?
17. How can universal/routine screening for intimate partner violence affect women's safety? Under what conditions can universal/routine screening for intimate partner violence increase or decrease client safety?

18. Now I would like to show you a questionnaire that has been developed to screen women routinely for intimate partner violence. How do you think health care providers would react to using this tool to screen women routinely for intimate partner violence?
19. How can the questionnaire be improved?
20. Now I would like to show you a picture of a stamp that has been proposed for recording information on intimate partner violence in a woman's clinical record. How do you think healthcare providers would react to using this stamp in client records?
21. How can the stamp be improved?

Appendix 2

In-depth Interview Guide for Female Clients and Community Members

Participant Identification No. :		Date:
Name and Address of the Health Center:	Time Discussion Started:	Time Discussion Ended:
Type of Health Facility: <input type="checkbox"/> Government Health Center <input type="checkbox"/> Private Health Center <input type="checkbox"/> Mixed Health Center (Government-subsidized NGO-run) <input type="checkbox"/> Government Hospital <input type="checkbox"/> Private Hospital <input type="checkbox"/> Mixed Hospital (Government-subsidized NGO-run)	Name of the Commune: Name of the Section of the Commune :	
Participant's Age:	Participant's Education:	
Participant's Sex:		
Name of Interviewer:	Name of Note-taker:	

1. Without mentioning names or indicating anyone specific, are you aware of any girls and women in your community who are experiencing problems with intimate partner violence and with their safety and security?

IF THE PARTICIPANT SAYS THAT THERE ARE NO PROBLEMS WITH INTIMATE PARTNER VIOLENCE OR VIOLENCE AGAINST WOMEN IN HER COMMUNITY, READ THE THREE SCENARIOS OF ROSE, CLEMENTINE, AND ACÉPHIE. THEN ASK THE PARTICIPANT IF THERE ARE ANY WOMEN OR GIRLS WHO MAY HAVE HAD SIMILAR EXPERIENCES IN HER COMMUNITY.

2. Can you give examples of intimate partner violence in your community?
3. In situations where couples have a conflict and become violent, who is to blame or at fault? Who is responsible for the violence? Under what circumstances might people think that a woman is

responsible for physical violence, emotional violence, or sexual assault? Under what circumstances might people think that a man is responsible for physical violence, emotional violence, or sexual assault?

4. What do women in this community do when they have to deal with intimate partner violence? Do they tell anyone (family members, other women, health worker, community leader, police/security people/authorities, someone else)? Why or why not?
5. In this community, where would women get help for intimate partner violence? What would the community do?
6. In this community, do women's support groups exist to help women who have been beaten by their partners? What social and legal services exist to help address problems associated with physical violence (e.g., health, police, legal counseling, social counseling, or psychological counseling)? Who provides these services? How could these efforts be improved?
7. What factors might help or prevent women who are beaten by their husbands/partners from improving their situation?
8. Do you think health care providers should ask women about intimate partner violence? Why or why not?
9. How do you think women might feel if a health care provider were to ask them about intimate partner violence?
10. If health care providers were to ask about intimate partner violence, which women should be asked and why?
11. Some people argue that every woman who comes to a health facility should be asked questions about intimate partner violence, a practice called universal or routine screening. Others think that healthcare providers should look for specific signals and then screen when those signals raise concern. What is your position?
12. What are the advantages of asking every woman who comes to a health facility questions about intimate partner violence?
13. What are the disadvantages of asking every woman who comes to a health facility questions about intimate partner violence?
14. What questions do you think a healthcare provider should ask women about intimate partner violence?
15. What would women like a healthcare provider to do to help women who admit that they have experienced intimate partner violence?

16. What would not help?
17. Is there anything that makes it difficult for women to tell a healthcare provider about intimate partner violence? Does the type of violence matter? What types of violence would women find it easier to talk about? What types of violence would women find it difficult to talk about? What would make it easier for women to talk about these types of violence?
18. If there were things that you could tell health care providers in this community about intimate partner violence or about helping women who have been sexually abused, what would they be?

Appendix 3

List of Interviewers, Note Takers, and Research Assistants

Team	Name of Field Staff	Role
Team A	Widlyn Armand Rebecca Cole	Note taker Interviewer
Team B	Lethicia Dorsainville Rose Luzette Charles	Note taker Interviewer
Team C	Sonia Pierre Nadege Rock	Note taker Interviewer
Team D	Sonitha St. Aude Guirlaine St. Louis	Note taker Interviewer
Team E	Rose Marie Andre Marilaise St. Pierre	Note taker Interviewer
Team F	Gerlie Beauge Rachelle Simon	Note taker Interviewer
Team G	Venise Louis Stephanie Marie-Antenor	Note taker Interviewer
Team H (Male)	Schiller Zamor Francisco Gedeus	Note taker Interviewer
Tulane University	Delayo Zomahoun Charles Fatoma Daniel Lauture	Research Assistant Research Assistant Research Assistant