

**KNOWLEDGE, SCREENING AND REPORTING PRACTICES OF HEALTH
PROFESSIONALS TOWARDS GENDER BASED VIOLENCE AMONG WOMEN IN
KABWE DISTRICT, ZAMBIA**

BY

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DECLARATION

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CERTIFICATE OF APPROVAL

This dissertation of Jennipher Akebu N. Soko on Knowledge, Screening and Reporting practices of Health professionals towards Gender Based Violence among Women in Kabwe, Zambia, has been approved in partial fulfillment of the requirements for the award of the degree of Master of Science in Nursing by the University of Zambia.

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DEDICATION

To all the health professionals who share the slogan of zero tolerance to Gender Based Violence.

To all victims of Gender Based Violence who look unto the health professionals for help.

To my true friend and husband Paul Raphael Soko, your support gave me courage to continue with my studies amidst hardships.

To my children: Philip, Martha, Paul, Joshua and Deborah, you inspired me to work hard and be your role model of hard work and perseverance.

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ACRONYMS

ASAZA	- A Safer Zambia
CSO	- Central Statistics Office
GBV	- Gender Based Violence
GIDD	- Gender in Development Division
HPs	- Health Professionals
IPPF	- International Planned Parenthood Federation
MOH	- Ministry of Health
NGO	- Non Governmental Organization
PHO	- Provincial Health Office
UN	- United Nations
UNICEF	- United Children's Emergence Fund
UNIFEM	- United Nations Development Fund for Women
USAID	- United States Agency
VSU	- Victim Support Unit
WHO	- World Health Organization
WHR	- Western Hemisphere Region
WILSA	- Women in Law in Southern Africa

ABSTRACT

Identification of victims of gender based violence and reporting GBV to legal authorities are key steps in management of gender based violence.

The purpose of the study was to examine the knowledge, screening and reporting practices of Health Professionals towards gender based violence in the form of physical abuse from an intimate partner among women in Kabwe District.

A quantitative cross-sectional study was conducted with 207 Health professionals (19 doctors, 43 Clinical officers and 145 Nurse/Midwives) from 6 randomly selected clinics and 1 hospital in Kabwe district. Nurse/midwives were randomly while doctors and Clinical Officers were conveniently selected. A structured questionnaire was used to collect data and analysed using SPSS version 20. Chi-square test was used to determine association between the independent (Demographic variables, knowledge levels) and dependent variables (Screening and reporting). The statistical significance was set at 5% (0.05) and confidence interval was set at 95%.

Majority, 79.9% of the respondents had high knowledge level on gender based violence. Screening for and reporting cases of gender based violence to legal authorities were low, 54% and 31.4% respectively among the Health professionals. Screening and reporting practices of the respondents were inadequate, 83.6% and insufficient, 87.0% respectively. A statistically significant relationship was observed between respondents' profession and their screening practices for gender based violence ($p = 0.020$), training and reporting practices of gender based violence ($P = 0.039$), knowledge levels on gender based violence and their reporting practices ($p = 0.022$).

Knowledge levels of health professionals were high despite the majority not been trained in gender based violence. However, their screening for and reporting practices of gender based violence to legal authorities were insufficient and inadequate respectively. Training / ongoing sensitization in gender based violence is recommended to improve the situation.

More research is required to establish factors contributing to the Health professionals' insufficient screening for and inadequate reporting practices of GBV to legal authorities despite the HPs having high levels of knowledge on GBV.

Key words: **Gender Based Violence, knowledge, Reporting, Screening**

CHAPTER ONE

1.0 INTRODUCTION

Chapter one discusses the knowledge, screening and reporting practices of Health Professionals (HPs) towards gender based violence in the form of physical abuse among women from an intimate partner. It also explains the health consequences of physical abuse to the victims. The statement of the problem and the theoretical framework guiding the study are explained. The justification of the study, research objectives and questions, research hypothesis and study variables are also discussed in this chapter. The chapter also provides the conceptual and operational definition of terms used in the study, the study variables and their cut off points.

1.1 BACKGROUND INFORMATION

Gender Based Violence (GBV) is any physical, mental, emotional, social or economic abuse against a person because of that persons' gender and includes sexual or psychological harm or suffering to a person, threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Ministry Of Gender and Child Development and Central Statistical Office (2012) It is often known as Gender Based Violence because it evolves in part from women's subordinate status in society, although the term GBV also encompasses men (Ministry of Gender and Child Development (2014). The World Bank (2019) GBV has cited GBV against women as a global pandemic that affects 1 in 3 women in their life time. Furthermore, GBV is reported to be the most wide spread violations of human rights that includes physical, sexual, psychological, verbal and economic abuse, and cuts across boundaries of age, race, culture, wealth and geography (UN women, 2013). As already alluded to, there are five main forms of abuse that women experience: physical, psychological, sexual, verbal and economic. Sexual abuse refers to using physical coercion to force participation in unwanted sex acts (Huecker and Smock, 2019). Economic abuse refers to utilization of money to undermine a woman's rights, for example, withholding money, questioning what the woman does with her money, denying medical aid or destroying property in the home whenever there some disagreement (Agisanang Domestic abuse Prevention and Training, 2019). Psychological violence refers to any act which causes psychological harm to an individual. Psychological violence can take the form of, for example, coercion, defamation, verbal insult or harassment

(European Institute for Gender Equality, 2020). Verbal abuse, also known as verbal attack or verbal assault, refers to the act of forcefully criticizing, insulting, or denouncing another person. Physical abuse refers to any act which causes physical harm as a result of unlawful physical assault. Physical violence may take the form of serious and minor assault, deprivation of liberty and manslaughter (European Institute for Gender Equality, 2020).

Statistics reported by the World Bank (2019) are shocking:

- Slightly above one third, 35%, of women worldwide have experienced either physical and / or sexual intimate partner violence or non-partner sexual violence
- Globally as many as 38% of murders of women are committed by an intimate partner

The patterns and consequences of GBV in men and women are different as women are more likely than men to be injured by someone close to them and they comprise the overwhelming majority of survivors of GBV (Bott et al, 2010). Therefore GBV in this study was restricted to physical abuse of a woman by their intimate partner. An Intimate partner refers to a person with whom a woman has or had a close personal or sexual relationship. Intimate partner violence affects millions of women each year in the United States (U.S. Women's Health, 2018).

Table 1: Summary Report on GBV Cases in Zambia (2015).

AREA	TOTAL
Lusaka Province	4 502
Copperbelt Province	3 347
Central Province	2 100
Western Province	2 066
North western Province	1 700
Southern Province	1 224
Eastern Province	1 219
Luapula Province	960
Muchinga Province	605
Northern Province	195
Tazara township	131
Airport area	39
Grand total	18, 088

Source: (Ministry of Gender – Zambia, 2016)

Zambia like any other country has not been spared by GBV. The Police Victim Support Unit recorded a total of 18 088 country and Central province was ranked third with 2, 100 cases of GBV in 2015 (Ministry of gender – Zambia 2016).

Table 2: Cases of spousal physical abuse seen at ASAZA, Kabwe

Year	Gender	Frequency	Percentage
2016	Males	162	13.7
	Females	1 020	86.3
Total		1 182	100
2017 (9 months only)	Males	122	13.2
	Females	799	86.8
Total		921	100
2018	Males	127	11.5
	Females	974	88.5
Total		1 101	100
Grand Total		3 206	100

Source: ASAZA monthly Returns (2016, 2017 and 2018).

Table 2 shows that out of a total of 3, 204 cases of GBV in the form of physical abuse from an intimate partner, the majority, 86.3%, 86.8% and 88.5% in 2016, 2017 and 2019 respectively were females.

Kabwe District has not been spared from the scourge of GBV in the form of physical abuse in women as cases remained persistently high for three consecutive years (table 2). As earlier stated, GBV in the form of spousal physical abuse in women is prevalent and victims pass through health facilities to seek medical services for physical complaints related to the abuse suffered. Most likely, HPs might be the first and only point of contact to a formal sector outside the home for women experiencing GBV (UN women, 2011). Therefore, it is cardinal for HPs who come in contact with women to play a critical role in prevention and responding to GBV by identifying any underlined physical abuse during history taking and physical assessment. This is in view of a background of silence where most victims do not disclose their experiences of GBV to HPs unless they are asked. Without screening for GBV, many cases are likely to pass through

the hands of HPs and health facilities unidentified (Huecker and Smock 2019). This implies that the victims will not be linked to a comprehensive programme of multisectoral approach designed to mitigate the root causes of GBV in women. Blank and Rosslhumer (2015) also acknowledge the importance of screening women for GBV in a professional and supportive manner as a means of breaking feelings of isolation, guilt and shame that victims of GBV may experience. Furthermore, screening women for GBV conveys the message that help is available (Blank & Rosslhumer, 2015). Screening can be implemented routinely as part of history taking for all women seeking health care services or selectively. Selective screening is limited to high risk groups such as pregnant women and upon an index of suspicion for GBV.

The role of HPs in the management of victims of GBV does not end at screening and provision of medical services. Reporting GBV to legal authorities is another cardinal step closely related to screening for GBV. The National Crime research (2012) cites failure to report GBV cases to law enforcement agency as one of the greatest barriers to prevention and control of GBV. Reporting of GBV to legal authorities such as the police facilitates prosecution of perpetrators and improves HPs' responsiveness (WHO, 2013).

Application of selective screening entails that HPs have knowledge of the magnitude, presentation of and the high risk groups for GBV. Therefore HPs are required to be knowledgeable of the referral system, protocols and available sources of social services including those outside the Health sector. Capacity building of HPs in the form of ongoing training / sensitization on GBV in general is necessary to enhance HPs with the knowledge and skills required to effectively manage victims of GBV

There are many barriers that hinder HPs from screening and reporting GBV to legal authorities. Controversial attitudes towards screening for GBV that undermine the medical response have been reported among HPs (Natan 2011). Hewins and Maula (2013) also report that some of the HPs believe that it is not their role to screen for GBV.

The Government of the Republic of Zambia has made some progress in the fight against GBV and is determined to create a fairer and more equal society for all. This includes the establishment of fast track courts to deal with cases of Gender Based Violence. The Zambian government in partnership with USAID through the STOP-GBV project has conducted several training /sensitization workshops of police officers, magistrates, politicians, doctors, nurses and

traditional leaders on what Gender Based Violence is, how to respond to it, and most importantly how to stop it. This is in an effort to strengthen governmental and traditional leadership's commitment to GBV prevention and response, mobilizing communities for gender norms change, strengthening the capacity of legal and law enforcement systems to respond to GBV, and providing quality one-stop GBV response care (USAID / Zambia 2020). The government of Zambia has also enacted the Anti-Gender Based Violence Act No. 1 of 2011 and the Penal Code Amendment Act No. 15 of 2005 to criminalize GBV and to stiffen penalties for sexual offences (Ministry of gender and child development, 2014).

1. 2 STATEMENT OF THE PROBLEM

Identification of victims of physical abuse among women who seek health services is a challenge to HPs (Blank & Rosslhumer, 2015). This challenge is attributed to low levels of knowledge on GBV, low rates of screening for GBV by HPs (Gutamis et al., 2007) and non-disclosure of GBV by victims.

Further, reporting GBV to police or a relevant agency is a key step in the fight against GBV (Hayden 2010), yet victims of GBV and HPs are reluctant to report GBV to legal authorities even in nations where mandatory reporting laws exist (European Union Agency for Fundamental Rights (FRA) 2016). In Zambia, the knowledge, screening and reporting practices of HPs towards physical abuse in women is not clear as there is limited literature to support this. The researcher therefore sought to establish Health Professionals' knowledge levels, screening and reporting practices towards physical abuse in women in order to identify any gaps that needed to be addressed for HPs to make significant contributions towards the fight against GBV.

1.3 JUSTIFICATION OF THE STUDY

The purpose of the study was to examine the knowledge, screening and reporting practices of HPs towards GBV in women in Kabwe District with the aim of strengthening the best practices among HPs in the fight against GBV in women.

This study is of great relevance to the Community, Ministry of Health, Health professional bodies and non-Governmental organisations dealing with GBV as it has given an insight on HPs knowledge, screening and reporting practices towards physical abuse in women.

The findings of the current study provide a frame of reference upon which Ministry of Health (MoH), Health professional bodies and Non-Governmental Organisations that deal with GBV

can base their decisions to monitor, evaluate or revisit the protocols / policies on management of physical abuse in women and possibly plan staff training /sensitization programmes on GBV to improve the situation. The study laid a foundation for other researchers and added to the existing body of scientific knowledge by revealing the HPs levels of knowledge, screening and reporting practices towards physical abuse in women. The findings of the current study have provoked further questions and analysis calling for more research to establish factors contributing to insufficient screening and inadequate reporting practices of GBV to legal authorities despite the HPs having high levels of knowledge on GBV.

1.4. CONCEPTUAL FRAME WORK

A framework is a “group of concepts that are broadly defined and organized to provide a rationale or structure for interpretation of information (Weller, 2005). It acts like a map in research, determining what constructs need to be measured and what statistical relationships are to be considered. In this study, the KAP model was applied.

1.4.1 THE KAP MODEL

The model is known as the Knowledge, Attitudes and Practices model” (KAP). The letter “K” stands for knowledge of a problem or disease. “A” stands for attitude towards the problem or disease, and “P” for practice or preventive behavior to protect against the problem or disease (Rav – Marathe et al, 2016).

KAP surveys were first developed in the 1950s. After 1960 KAP surveys were extensively used in many countries to research family planning practice. The KAP studies are more cost-effective and conserve resources more than other social research methods due to their tightly focused and limited scope (Eckman and Walker, 2008).

This research framework has been widely used in the health education field and as a guide to understanding the mechanisms of health education for patient behavioral changes and uptake of family planning (Jaccard et al, 1996). The KAP model has also been used to assess Health professionals’ behavioural change. In 2012, the KAP model was used to assess the reporting of adverse effects of drugs to government agencies by Indian physicians (Kharkar and Bowalekar, 2012).

1.4.2 Reasons for choosing the KAP model

The KAP model is suitable for the current study since it is not limited to assessment of patients' health behavioural outcomes and uptake of health services but also to Health professionals' behavioural and practice outcomes. This is evidenced by its application in an Indian study that assessed the reporting of adverse effects of drugs to government agencies by Indian physicians (Kharkar and Bowalekar, 2012). The model assumes that the only obstacle to acting "responsibly" and rationally is ignorance, and that information alone can influence behaviour by "correcting" the lack of knowledge. This entails that change in knowledge will result into change in attitudes/beliefs and consequently change in behavior. Critics have however argued that although Knowledge influences behavioural change, it is not a sufficient factor in changing individual or collective behavior and that there should be some motivational factors in addition to knowledge.

1.4.3 Constructs of the KAP model

The model consists of three constructs which are knowledge, attitudes and practices. Knowledge refers to the acquisition, retention, and use of information or skills (Bradran, 1995). Attitude refers to a psychological tendency that result from evaluation of a particular situation with some degree of favor or disfavor (Eagly and Chaiken, 2007). Attitudes can arise from true and false beliefs. This implies that acquisition of correct information through training or ongoing health education is cardinal in correcting negative attitudes.

Practice refers to behaviors or actions that can avert a disease or delay its progression. Practice is therefore a demonstration of the acquired knowledge (increased understanding of a problem/disease) and any change in attitude caused by the removal of misconceptions about problems or disease that translates into preventive behaviors. Practice is therefore a reflection of a reciprocal relationship between knowledge and attitude (Rav – Marathe et.al 2016).

1.4.4 Application of the KAP conceptual model

The current study focuses on knowledge, screening and reporting practices of HPs' towards GBV in the form of physical abuse among women from an intimate partner. Guidelines for management of GBV victims state that HPs have the responsibility of screening women for GBV arising from the reluctance of women to disclose the physical abuse underlining their physical complaints. Furthermore, GBV should be reported to legal authorities. The process of reporting

is accomplished by two parties, the victim and the HPs. The HPs' reporting obligation involves filling in a police medical report form to confirm and notify the legal authorities of a case of GBV. According to the assumptions of the KAP model, knowledge translates into behavioural change. According to Bradran (1995), knowledge can be acquired through learning and experience. Training is a form of learning. Based on the KAP assumptions, HPs who have received some form of training/ sensitization on GBV are expected to have high levels of knowledge on GBV which should translate into adequate screening practices for GBV and sufficient reporting of GBV to legal authorities. Those HPs who have longer experiences on the job are also expected to have high levels of knowledge on GBV.

Furthermore, it is assumed in this study that HPs who have been trained or sensitized on GBV have acquired correct information on GBV and are therefore likely to have positive attitudes towards victims of GBV. It is further expected that the positive attitudes would motivate the HPs to sufficiently screen women for GBV. Furthermore, the HPs are expected to adequately report GBV cases to legal authorities than those who have not been trained/ sensitized on GBV. Although attitudes of HPs have not been explored in the current study, the assumption is that those HPs who have been trained on GBV automatically have positive attitudes

The current study did not find a statistically significant relationship between respondents' screening practices for GBV and training / sensitization on GBV ($p = 0.444$). Further there was no significant association observed between respondents' screening practices and their knowledge levels on GBV (P value 0.376). The finding is contrary to the assumptions of the KAP conceptual model that assumes that change in knowledge will result into change in attitudes / beliefs and consequently change in behavior. There is need to explore possible barriers to screening despite the HPs' high levels of knowledge.

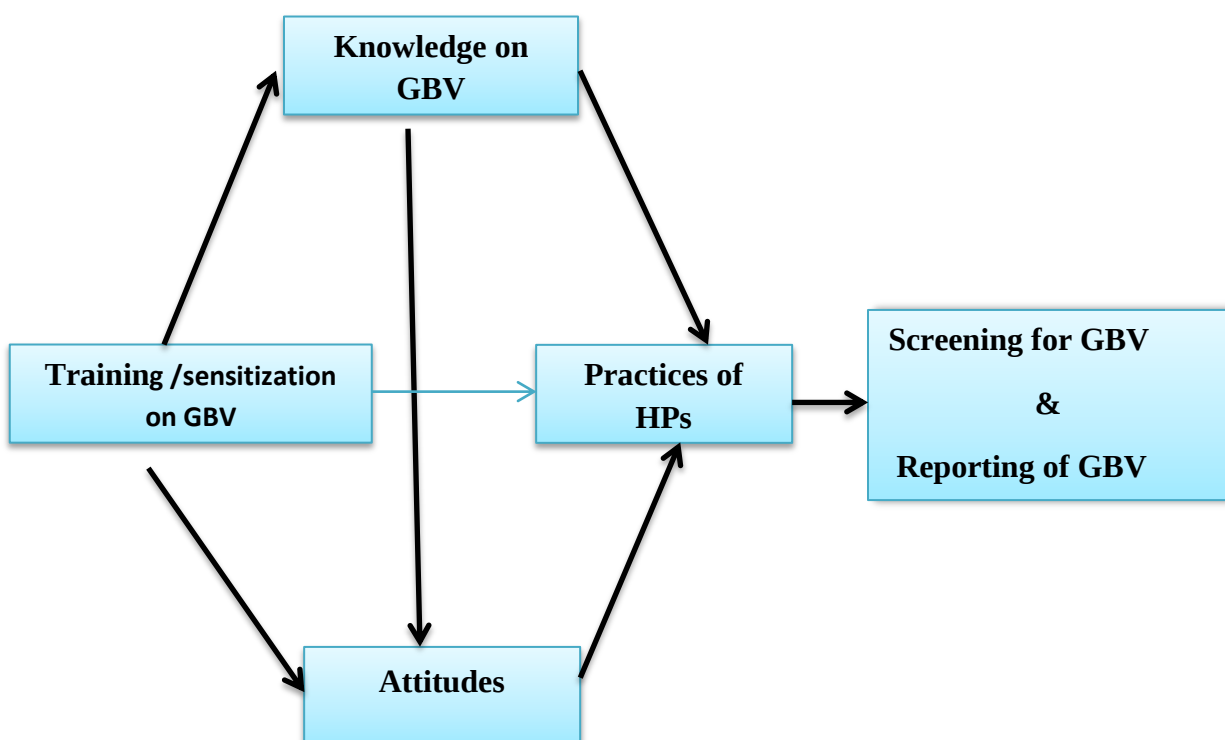
The current study revealed a significant relationship between respondents' profession and their screening practices for GBV. The proportion of adequate screening practices was higher in respondents who were Clinical officers (27.9%) and Medical doctors (26.3%) in comparison with those who were Nurses/Midwives (11.7%). This finding can be explained by the type of training and work which doctors and Clinical Officers do. Screening patients is part of their routine work and they are the first ones to interact with women who seek health services.

This may also mean that doctors and Clinical Officers are able to formulate questions to inquire about GBV compared to Nurses who spend most of their work hours performing other nursing duties. It is therefore expected that nurses were the least in terms of screening for GBV.

The study also revealed a statistically significant relationship respondents' training and their reporting practices for GBV. A higher proportion of respondents who had received training on GBV (23.1%) exhibited adequate reporting practices as compared to those who had not received training, where adequate reporting stood at 10.7%. ($p < 0.05$). This finding is in line with the KAP conceptual model assumption because training increases knowledge on GBV and translates into positive attitudes towards victims of GBV, consequently reporting of GBV to legal authorities. A statistically significant relationship was observed between respondents' knowledge levels on GBV and their reporting practices ($p = 0.121$). The proportion of sufficient reporting was higher in respondents with high knowledge levels (15.8%) than in those with low knowledge levels (2.4%). This finding is also supported by in line with the KAP conceptual model.

The KAP model was helpful in predicting and explaining the HPs' reporting practices of GBV to legal authorities but not the screening practices. In conclusion, Knowledge alone is not a sufficient factor in predicting HPs' screening practices for GBV. Other motivational factors such as having clear policy guidelines, levels of confidence should all be considered.

Figure 1: The KAP Conceptual Model



Adapted from (Rav – Marathe et..al 2016).

1.5 RESEARCH QUESTIONS

1. What is the level of knowledge on GBV for Health professionals in Kabwe District?
2. What are the screening practices of HPs towards GBV in the form of physical abuse in women?
3. What are the reporting practices of HPs towards GBV in the form of physical abuse in women to legal authorities in Kabwe District?

1.6 RESEARCH OBJECTIVES

1.6.1 GENERAL OBJECTIVE

The aim of this study was to examine the Knowledge, Screening and Reporting practices of HPs towards gender based violence among women in Kabwe District, Zambia.

1.6.2 SPECIFIC OBJECTIVES

1. To assess the HPs level of knowledge on GBV
2. To establish the screening practices of HPs towards GBV
3. To establish reporting practices of HPs towards GBV to legal authorities in Kabwe District.
4. To identify the relationship between HPs screening and reporting practices towards GBV and knowledge levels, some demographic variables (gender, age, marital status, highest professional qualification, profession type and duration of working at current job, and training/ sensitization on GBV).

1.7 HYPOTHESIS

There is no association between HP's levels of Knowledge and the following factors:

- HPs' screening practices for GBV
- HPs' reporting practices of GBV to legal authorities

1.8 CONCEPTUAL DEFINITION OF TERMS

- **Gender based violence:** This refers to any physical, mental, emotional, social or economic abuse against a person because of that persons' gender and includes sexual or psychological harm or suffering to a person, threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Ministry of Gender and Child Development 2012).
- **Health Professionals (HPs):** This refers to Health care providers who are trained and knowledgeable in health and provide health care services in a systematic way (Deker et al 2014)
- **Knowledge:** This refers to information and understanding of a subject which a person/people have (Collins English dictionary, 2018).
- **Reporting GBV:** This refers to disclosure of GBV incident/case by a service provider; sharing information about a GBV case to other institutions/organizations during the process of referral (UNFPA, 2015).

- **Mandatory reporting:** This refers to legislation passed by some countries that requires some professionals or individuals to report (usually to police or legal system) any incident of actual or suspected domestic violence (UNFPA, 2015).
- **Practices:** The actual application or use of an idea, belief or method as opposed to theories relating to it (UK dictionary, 2020).
- **Screening:** this refers to the use of a test, examination or other procedure that is rapidly applied in an asymptomatic population to identify individuals with early disease (Deker et al 2014).
- **Victim:** This refers a woman or girl who has experienced or is experiencing physical abuse violence. A victim is also known as survivor (Deker et al 2014).

1.9 OPERATIONAL DEFINITION OF VARIABLES

- **Gender based violence:** This refers to physical abuse of a woman by their intimate partner.
- **Health Professionals (HPs):** this refers to doctors, Nurses and Clinical officers
- **Knowledge:** This refers to having information on GBV and its management. The respondent's knowledge levels on GBV were measured by asking the respondents a total of 8 Knowledge questions on GBV in general, screening and reporting GBV to legal authorities. Each correct response to a knowledge question was assigned a score of 1. An incorrect response or 'I don't know' response carried 0 marks. The total knowledge score was 8. The variable was further classified as high and low knowledge levels. High knowledge level was assigned scores of 5 – 8 correct responses out of the knowledge questions while low knowledge level consisted of scores from 1- 4 points.

- **Reporting GBV:** this refers to filling in of a police medical report form by a health professional upon disclosure of GBV or informing the police victim support unit or ASAZA by other modes of communication such as making a phone call.

The HPs reporting practices were measured by a “yes” and “no” responses as to whether the HP reports GBV to legal authorities. The responses were then scored: “yes” - 1 and ‘no’ - 0. Respondents were also asked about the type of reporting they utilized and scores were assigned to type of reporting: mandatory – 3, voluntary – 2 and other – 1. Respondents were asked about their frequency of reporting GBV to legal authorities in

the previous year. The frequency of reporting was also awarded scores: never – 0, rarely / a few times -1, often / very often -2 score. The total practice score was 6. The reporting practices were further categorized as sufficient and insufficient. Sufficient reporting practices denote a score of 4 and above out of the total reporting practice score of 6. Scores of less than 4 out of 6 denoted Insufficient reporting practices. All the respondents who indicated that they do not screen report GBV to legal authorities were also included under the insufficient reporting category.

- **Mandatory reporting:** this is when HPs are required by law to report to police or fill in a police medical report form for any identified or disclosed case of GBV without the victim's consent. It is also known as involuntary or obligatory reporting.
 - **Practices:** this refers to screening for GBV and reporting of GBV to legal authorities. Screening practices were measured by a “yes” and “no” response to the question, “in your practice do you screen for GBV?” The type of screening and frequency of screening were also used as measurements of HPs' screening practices for GBV. The responses were scored. Yes response to screening was scored and a “no” carried no score. Responses to the type of screening were scored as follows: routine – 3, upon suspicion – 2 and self-disclosure / other – 1. The frequency of screening carried scored as follows: never – 0, rarely/ a few times – 1, often/ very often – 2. The total screening score was 6. Screening practices were categorized as adequate and inadequate. Scores of 5 - 6 on screening questions were categorized as adequate screening practices while scores of less than 5 denoted inadequate screening practices. All respondents who indicated that that they were not screening for GBV were included under the category inadequate screening.
- Screening:** asking women who seek health care services whether their complaints are due to GBV or not.
- **Victim:** refers to a woman or girl who is seeking medical services from a health facility due to consequences of physical abuse by an intimate partner. She is also known as a survivor.

1.10 RESEARCH VARIABLES AND CUT OFF POINTS

A variable is a measurable or potentially measurable component of an object or event that may fluctuate in quantity and quality from one individual object or event to another individual of the same general class. A variable is something that varies, properties that differ from each other such as age or sex. It is a concept defined by operational definitions in such a way that changes can be observed and measured (Basavanthappa, 2014).

1.10.1 Dependent Variables

The dependent variables for this study were:

- Screening practices for GBV
- Reporting practices of GBV

1.10.2 Independent Variables

The independent variables for this study were:

- Knowledge of HPs on GBV
- Demographic characteristics (gender, marital status, profession, highest professional qualifications, age, duration in service and Training / sensitization on GBV)

Table 3: VARIABLES, INDICATORS AND CUT OFF POINTS

VARIABLES	INDICATORS	CUT OFF POINTS	QUESTION NUMBER
DEPENDENT VARIABLES			
Screening practices	Adequate	Scoring above 4 out of the total screening practices score	8,9,10
	Inadequate	Scoring 1-4 out of the total screening practices score	
Reporting practices	Sufficient	5- 6 out of the total screening practices score	11,12, 13
	Insufficient	Less than 5 scores out of the total screening practice score	
INDEPENDENT VARIABLES			
Level of	High	Scores of 5- 8 on knowledge questions	7 a, b, c, d, e,

Knowledge on GBV	Low	Scores of 1- 4 on knowledge questions	f, g, h
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CHAPTER TWO:

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter discusses studies conducted by other researchers on Knowledge, screening and reporting practices of Health Professionals towards GBV to Police (law enforcement agency). Therefore KAP studies conducted on Doctors, Nurses or Clinical Officers were included in the literature review. Sources of literature for this study included published journals and articles from computerized database such as Jane estimator, Google scholar and PubMed to access Medline data base. Books from the University of Zambia Library and Ministry of Health (MoH) documents were also considered.

2.1 OVERVIEW OF HPS' KNOWLEDGE ON GBV, SCREENING AND REPORTING OF GBV TO LEGAL AUTHORITIES

Information on HPs' levels of knowledge on GBV, screening for GBV and reporting practices towards GBV is cardinal as it reveals what HPs know regarding GBV and what gaps exist. The results can help managers plan and tailor capacity building programmes such as clinical meetings, ongoing staff training and sensitization workshops on GBV to address the identified needs. Furthermore awareness of HPs' knowledge levels on GBV, screening and reporting practices of GBV to legal authorities can be utilized as a baseline data and changes overtime can be used to monitor evaluate the impact of training programs.

2.2 KNOWLEDGE OF HPs ON GBV

In a survey conducted in Rwanda by Bublick (2012) to assess antenatal care Nurses' knowledge, attitudes and practices towards Intimate Partner Violence (IPV) and readiness to perform routine inquiry, it was revealed that the Nurses had accurate knowledge of legislation and of the health consequences of IPV. Accurate knowledge of the health consequences of GBV is very cardinal as it triggers HPs to suspect GBV in women who present with complaints that are not clearly explained and even proceed to screen for GBV. When GBV is detected, the HP will act confidently within the confines of the law without fear or anxiety of what to do if they have accurate knowledge of legislation on GBV issues. The need to notify the legal authorities about a case of GBV is one of the factors that may cause anxiety in HPs who have inaccurate knowledge

of legislation on GBV as a result they may not inquire about GBV even when GBV is suspected. However, the survey by Bublick (2012) found that although knowledge of GBV legislation and health consequences was accurate among the HPs, their rate of screening for GBV was low, (23%). This finding was unexpected as having accurate Knowledge of legislation and of health consequences of GBV could have motivated the HPs to screen for GBV. Other possible factors such as lack of a policy on screening or low staff training levels on GBV could account for the low rates of screening.

Similarly, Ariel (2015) in his study on Barbados service providers' Knowledge, Attitudes and Practices (KAP) on gender based violence and Human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (HIV/AIDS) found that over 90% of service providers had knowledge of the laws that addressed domestic violence. The service providers were also able to correctly identify GBV as a problem that was beyond socio- economic class. This meant that the HPs were likely to screen women for GBV irrespective women's socio- economic class since GBV affects all sectors of society.

Arredondo-Provecho et al., (2012) conducted a study on knowledge of and opinions on violence against women among health professionals in specialized care in Madrid. The aim of the study was to evaluate knowledge of gender violence among health workers/medical staff in specialized health care and their opinion on the subject. A further aim was to identify the organizational barriers perceived by these workers and their proposals to enhance the early detection of GBV and care of victims. An observational, cross sectional survey of health workers/medical staff working in the Pediatrics, obstetrics or emergency departments of two hospitals was conducted in health district eight (8) of Madrid. Overall, health professionals had average knowledge about gender violence. Almost all health professionals (97.7%) considered that gender violence against women was an important problem that usually went undetected. Notable among organizational obstacles identified were workload, lack of training and information and the absence of a protocol. Therefore ongoing training / sensitization on GBV and having a written institutional protocol would reduce the organizational barriers detected and further improve the levels of knowledge on GBV.

2.3 SCREENING FOR GBV

Given the background that most victims of GBV are likely to seek health services for the GBV related complaints but are unlikely to disclose the root cause of their problems, HPs are encouraged to screen women for GBV. Cox (2016) report that while all people are at risk for GBV, women are five times more likely to be victimized than men. Therefore, Dudgeon and Evans (2014) recommend routine screening of women who seek health care services for intimate partner abuse in the form of physical abuse. They further state that routine screening does not only create opportunities for women to disclose abuse but also facilitates provision of support and assistance from Health care providers consequently curbing adverse health effects. Despite recommendations to screen for GBV in health care settings, it has been observed that most HPs are reluctant to screen for GBV (Cox 2016). The reluctance to screen could be attributed to lack of knowledge on GBV and how to proceed if GBV is identified. A number of studies affirm HPs' reluctance to screen for GBV;

Suryavanshi et al (2018) highlights HPs' reluctance to screen for GBV in health facilities. A cross sectional study by Suryavanshi et al (2018) in India on women's' opinions on GBV screening found out that of the 23% of women who reported experiences of GBV, 90% reported that they had never been asked about GBV in a health facility. This finding indicates that few HPs screened women for GBV. Identifying and addressing barriers to screening is cardinal to promote screening for GBV in health care facilities.

Even when HPs know that they have a responsibility to undertake screening for GBV, they do not do so often or consistently. Othman and Adenam (2008) affirm the inconsistency and infrequent screening of GBV in health facilities in a Malaysian survey to assess knowledge, attitudes and practices of Primary Health Care Providers (both clinicians and non-clinicians) regarding the identification and management of domestic violence in a hospital based primary health care setting at the University of Malaya Medical Center. The study findings revealed that the majority of the clinicians, 68.9% reported asking their patients about abuse at times only, 26.2% of the participants had never screened any of their patients about domestic abuse. However, most of the respondents, 86.7% of the clinicians and 73.9% of the nursing staff believed that they had a role to play in the management of domestic violence. Although, close to 70% of the HPs reported that they screened for GBV in this study, the frequency of doing so needed to be often or very often. The findings of the study confirm that HPs are reluctant to

screen for GBV. There is need to identify factors contributing to the reluctance to screen for GBV.

Screening women routinely as part of history taking is one screening approach that is likely to identify the majority of all victims of GBV including those victims who may not have overt signs and symptoms of physical abuse. Routine screening can be reserved for a small sector of clients who are at high risk of GBV such as pregnant women. This is in view of the time constraints cited by HPs as a barrier to screening for GBV. Selective screening may miss those victims who have no overt signs and symptoms but it's also recommended when the clinic is too busy or there is an index of suspicion for GBV. Waiting for the woman to self - disclose is unrealistic as most women are reluctant to disclose their experiences of GBV to HPs without being asked.

However, even routine screening meant for a small sector of society and for specific women at high risk for GBV was found not to be common. This has been affirmed by several studies: Fawole et al (2010) in a Nigerian study in Oyo state, observed that only 35% of the health workers in the study screened routinely for GBV. This finding was consistent with results from a study by Bublick (2012) in Rwanda who found that routine inquiry rates for GBV among antenatal care Nurses were low, 22%. The context of Bublick's study was limited to Antenatal women as such the Nurses may not be aware that Antenatal women are at high risk of GBV and may not see the need to screen for GBV.

A study conducted by Ramsey et al. (2012) to measure Primary care Clinicians' current levels of knowledge, attitudes and clinical skills on domestic violence showed that routine screening for GBV was not widespread even when patients presented with signs and symptoms of abuse, only about 51% of clinicians asked such patients about possibility of abuse. Clients who present with injuries or signs of abuse should be screened for GBV as physical abuse by a male partner is a common type of GBV as earlier alluded to.

2.4 REPORTING OF GBV TO LEGAL AUTHORITIES

The Zambian law empowers any citizen with knowledge about GBV to report to police (Population council, UNFPA, Government of Zambia Human Rights Commission, WILSA, and United Nations in Zambia 2017). While it is acknowledged that GBV is a crime that should be reported to a law enforcement agency such as the police and that failure to report encourages perpetrators to continue with the vice undeterred, Reynaldo's et al (2018) have noted that there is a controversy surrounding mandatory reporting of GBV among HPs and victims. Jordan and Pritchard (2018) argue that it is difficult to affirm whether such reporting protects women's interests or actually places them at more risk. Results from a study by Jordan and Pritchard (2018) in Kentucky's 15 Regional domestic violent shelters provides an insight into the negative effects of mandatory reporting rules for GBV on women's decision to seek health care. A research into how women's decision to access shelter, medical or mental health services is influenced by advance knowledge that their case would be reported if they disclosed abuse revealed that almost 2 in every 5 women reported that they would have been less likely to contact a shelter if they knew in advance that a mandatory report would be made. This finding implies that mandatory reporting is not the best option for all victims of GBV. This means that advance information about mandatory reporting given to the women to uphold her autonomy and informed consent deters victims from disclosing GBV to HPs. The best approach to deter perpetrators may not be mandatory reporting of GBV since it also acts a barrier to access medical services by the victim of GBV. Reporting of GBV in the form of spousal physical abuse to legal authorities still remains a complex issue requiring further research.

Although it has been reported and acknowledged that Health care professionals play a key role in facilitating linkages to a legal system that investigates GBV, Salcedo- Barrientos et al (2014) in a study to determine how Family Health Strategy professionals recognize and deal with domestic violence in pregnant women in SAO Paulo, Brazil, found a low number of reported cases of domestic violence. Other findings by the same study included lack of education and training of the Health Professionals on GBV. The low reporting of GBV detected by Salcedo- Barrientos et al (2014) could be associated with lack of education and training on GBV but also the relationship in which it occurs makes it difficult to report.

A US survey by Cooper et al (2009) on knowledge, detection and reporting of abuse by Health Professionals found that about 39.9% of the physicians had detected a case of abuse in the past

year but only about half of the detected cases were reported. Identifying and addressing barriers to reporting could help increase reporting of GBV to legal authorities

Davison et al (2012), in an American based study that examined 532 nurse home visitors' perspectives regarding the mandatory reporting of IPV, perceived awareness of reporting requirements, and intended reporting behaviors found that only 40% of the 532 Nurses were in support of mandatory reporting of GBV and they further indicated that they should always be required to report cases of GBV. This means that they were in favour of mandatory reporting of GBV. Therefore, almost half of the participants indicated that they would actually report GBV to authorities. In conclusion Davison et al (2012) in their study emphasized the need to reduce variations among practitioners and establish consistent practices that complied with existing policies. This implies that health institutions should have clear guidelines on how HPs should report GBV in order to maintain a standard reporting system.

Having high level of knowledge on GBV may facilitate reporting of GBV to legal authorities according to the national requirements. On the contrary, low levels of knowledge on GBV may create difficulties in reporting. Therefore, HPs who have Low levels of knowledge on GBV may experience challenges reporting of GBV cases to legal authorities as it creates low self-efficacy.

Moreira et.al (2014), in a Brazilian based study to analyze training and knowledge of professionals who worked in the family Health Strategy on reporting mistreatment of children and adolescents found that the majority, 86.3% of the professionals had not been trained on the issue as such gaps in knowledge were detected which created barriers to reporting abuse. The frequency of reporting abuse was low, 17%. Among the 37.2% of the professionals who had identified abuse reporting was at 60%. The variables identified in the final model showed a direct association between the act of reporting and matters related to knowledge and training about abuse. Therefore, knowledge is very cardinal if HPs are to effectively report GBV. Training HPs on GBV issues is important as it increases knowledge levels of HPs to enable them meet the standard reporting requirements for GBV.

The US survey by Cooper et al (2009) on knowledge, detection and reporting of abuse by Health Professionals also found that Professionals who had received training on GBV were likely to report the detected abuse than those who were not trained. This finding could be attributed to the fact that training increases levels of Knowledge on GBV reporting requirement and also

increases self-confidence with likelihood of taking an action of reporting GBV to legal authorities.

2.5 CONCLUSION

Literature review indicates that screening rates for GBV by Health care Professionals remain low. Research studies on reporting practices of GBV to legal authorities are scarce. A few studies were conducted way back in the 1990s and have become outdated. A few studies use the term “referral” to convey similar meaning as reporting. Literature reviewed indicates that gaps exist in knowledge on GBV. Screening is not famous and most studies on knowledge and practices of Health Professionals towards screening and reporting of GBV were conducted in developed countries within a different socio-cultural background. This study was conducted locally within a different socio-economic cultural background.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter describes the study design, study setting, study population, sample selection methods and size. The data collection technique, data collection tool as well as validity and reliability and ethical and cultural considerations for the study are also discussed in this chapter.

3.1 RESEARCH DESIGN

This study was a cross-sectional descriptive study design and data was collected from the study participants at one point in time. This study design was chosen because it involved the systematic collection and presentation of data to give a clear picture of the situation. Furthermore, the study was conducted in a natural setting without manipulating the environment and phenomena were observed as they occurred.

3.2 RESEARCH SETTING

The study was conducted in six clinics and one hospital in Kabwe district, Central province of Zambia. The health facilities included Makululu, Kasanda, Railway, Katondo, Mahatma Gandhi and Natuseko and Kabwe General hospital. Kabwe district is the provincial headquarters for the Central Province of Zambia. The district was selected due to persistently high cases of GBV in the form of spousal physical abuse (table 2). The clinics are situated right in the densely populated communities where GBV takes place and are important entry points for victims of GBV into a formal system that would link them to a comprehensive package of care that includes medical counseling and legal services as required. The Central Province of Zambia consists of 12 districts and Kabwe is the Provincial headquarters. The District had seventeen Public Health Centers and eight clinics distributed under Ministry of Defence, Correctional Services and Home Affairs as well as the private sector respectively. Kabwe district was unique in terms of health care delivery in that the provincial district did not have a District hospital at the time of collecting data. It only had a General hospital that acted as a first and second level referral handling both complicated and uncomplicated cases (Action Plan, 2016). The General Hospital housed a Non-Governmental Organization named A Safer Zambia (ASAZA) that facilitated legal and social services for victims of Gender Based Violence. All cases of GBV from Health Centers within Kabwe District were referred to Kabwe General Hospital (KGH) via ASAZA to

access services within the one stop center. The Out Patient Department (OPD) was the first point of contact between victims of GBV and Health Professionals. This is where screening and referral of victims to ASAZA / Police Victim Support Unit took place. Victims who needed admission for critical injuries arising from GBV were admitted to female wards. However every entry point for women to a health facility is a potential point to identify victims of spousal physical abuse by alert HPs. Kabwe district was therefore a suitable site for the study as HPs were in contact with women and victims of GBV who were admitted, nursing their children or sought services under the one stop center for GBV related health complaints..

3.3 STUDY POPULATION

The study population included all Doctors, Nurses and Clinical Officers.

3.3.1 Target Population

The target population for this study was Doctors, Nurses and Clinical officers working in Kabwe District.

3.3.2 Accessible Population

For this study, the accessible population was Doctors, clinical Officers and Nurses from the seven health facilities that were selected, available and willing to take part in the study.

3.4 SAMPLE SELECTION

The study population was 379 (Provincial Health Office, 2016). Stratified random sampling was applied to come up with a total of 207 participants, (19 Doctors, 43 Clinical Officers and 145 nurses). Three separate sampling frames were made for each clinic of the 3 groups of health professionals. However since the doctors and clinical officers were few and manageable, they were all included in the study making a total of 62 participants. The remaining 145 participants were selected from the nurses to make the required sample size of 207. A list of all the 17 public facilities was made in an alphabetical order with a serial number assigned to each clinic. Small equal size 17 pieces of paper each bearing a serial number of each clinic was cut, folded and put into a closed box. Then one piece of paper was blindfold picked at a time without replacement until the required 7 number of clinics was reached. This method ensured that each clinic had an equal chance of being selected for the sample.

The remaining 145 nurses were selected by adding the total number of nurses for the 7 health facilities which was 330, which was the denominator, the numerator being the total number of nurses at each facility multiplied by 145 as follows:

Kabwe General: $230/330 \times 145 = 101$

Mahatma Ghandi: $19/330 \times 145 = 8$

Makululu: $11/330 \times 145 = 5$

Kasanda: $22/330 \times 145 = 10$

Katondo $23/330 \times 145 = 10$

Natuseko $14/330 \times 145 = 6$

Railway $11/330 \times 145 = 5$

Total 145

The nurses were randomly selected with each facility having its own sampling frame. The names of the nurses at each facility were listed in alphabetical order with a serial number against each name. Small pieces of paper bearing a serial number of each nurse were cut into identical size, folded and put into a box. The pieces of paper were thoroughly mixed by shaking the box, and then one piece of paper was blindfold picked at a time without replacement until the required number of nurses was reached from each health facility. This method ensured that each clinic had an equal chance of being selected for the sample. All the Nineteen doctors and forty-three Clinical Officers were included in the study as they were few and manageable while hundred and forty five Nurses were randomly selected. Stratified sampling was to ensure even representation of Doctors and Clinical Officers, who are few in number compared to the Nurses who would have been the majority if one sampling frame was used for sample selection. Doctors are highly vested with knowledge and experience on management of GBV victims and their input shed more light on the subject.

3.4.1 Inclusion Criteria

- Doctors, Nurses and clinical officers working in Kabwe district public Health facilities.
- All Doctors, Nurses and clinical officers who come in contact with women during their work operations including during on call duties

3.4.2 Exclusion Criteria

- Doctors, Nurses and clinical officers from other districts who were found on attachment to Kabwe General Hospital.
- Doctors, Nurses and clinical officers were not in contact with women during their work operations and those who did not consent to be involved in the study.

3.5 SAMPLE SIZE

A sample size of 207 HPs from Public Health Facilities in Kabwe District were considered. Population size for HPs in Kabwe District was 379 (Provincial Health Office, 2016). The Expected frequency was set at 59% which was the highest knowledge levels in a study finding on knowledge and attitudes of Health Care Workers towards gender based violence conducted by Vieira et al, (2009). At 95 % CI, sample size was 207. A sample size of respondents was calculated using **Krejcie and Morgan 1970s** formula for a finite population below.

$$n = \frac{Z^2 NP (1-P)}{d^2 (N-1) + Z^2 P (1-P)}$$

Where:

n = Required Sample size

Z = Standard normal variate at 95% confidence level = 1.96

N = Population Size of HP in Kabwe District =379

P = highest knowledge level proportion on knowledge levels of Health care workers towards GBV = 59% or 0.59

d = Degree of accuracy or margin of error = ±5% =±0.05.

Therefore

$$n = \frac{1.96^2 \times 379 \times 0.59 \times (0.41)}{0.05^2 (379-1) + 1.96^2 \times 0.59 \times 0.41}$$

=187

Adjusting for a 10% non-response rate =187/0.9 =207

Therefore Sample size is **207**

3.6 DATA COLLECTION TOOL

A Self-administered questionnaire designed and adapted from the International Planned Parenthood Federation/ Western Hemisphere Region's Provider Knowledge, Attitudes and Practices Survey Questionnaire (Bott et al, 2010) was used to collect data. The knowledge questions were adapted to the Zambian National Gender Based Violence Multi - Sectoral training Manual (Ministry of Community Development, Mother and Child Health, 2013). The advantage of using a self-administered questionnaire was that HPs were able to carry it and filled it in at their own convenient time within the stipulated time frame. The only disadvantage the researcher encountered was that some respondents took long to complete the questionnaire. The researcher had to intensify follow-ups to individual residential homes before all the questionnaires were returned.

The self-administered questionnaire had a set of pre-determined closed ended questions with the same wording and order of questions. Respondents were allowed to express their views and opinions in the space provided under any other if the available options did not offer their preferred response. The data collection tool consisted of five sections. Section A consisted of questions on socio- demographic data. Questions in this section included age, sex, marital status, profession, highest professional qualifications and duration on current job as well as training on GBV. Section B contained questions that captured Health Professionals' Knowledge on GBV in general while Section C and D had questions designed to evaluate HPs' screening and reporting practices for GBV to legal authorities respectively.

3.6.1 Validity

Extensive literature review was conducted on recent literature on knowledge, screening and reporting practices of HPs towards GBV in the form of spousal physical abuse in women. GBV experts examined the questions to determine whether they would elicit the desired responses on the variables to be measured so that conclusions would be drawn with respect to the study population. The questions were constructed in a simple, clear and precise way in order to give respondents chance to give clear and precise answers which brought out their knowledge, screening and reporting practices towards GBV.

3.6.2 Reliability

Reliability was ensured by conducting a pilot study at Ngungu, Mukobeko, and Bwacha clinics as well as Mine Hospital. These Health facilities had almost similar settings with the other Kabwe district health facilities included in the main study in terms of type of health professionals, physical and geographical location, Socio – economic characteristics of the population and social determinants of health. The pilot study was carried out to check whether the instruments were able to bring out consistent information about Health Professionals' knowledge, screening and reporting practices towards physical abuse in women. The respondents were asked if there were any questions they could not understand so that alterations could be made where necessary. Adjustments to the data collection tool were made appropriately. The questions were simple and brief. All the questionnaires had similar questions with probes and prompts made at the same points.

3.7 DATA COLLECTION TECHNIQUE

The researcher distributed the questionnaires to the respondents in a period of 1 week. A letter of permission to collect data from the Permanent Secretary – Kabwe, Provincial Health Office, Medical Superintendent – Kabwe General Hospital and a letter of ethical approval was obtained as proof of permission to collect data. Data was collected from the health professionals from December 20th January to 7th February 2017 using a self-administered questionnaire. Self-introduction to the participants was done to make them less anxious and create a good rapport before giving them the self-administered questionnaire. The purpose of the study was explained to each participant for them to give informed consent. The Questions were read out to each participant and clarification on questions not fully understood was done before signing of the consent form. Both verbal and written consent was obtained before giving the questionnaire. Confidentiality was assured with the use of identification codes and not names. The participants were informed that participation was voluntary and that they were free to decline participation or withdraw from the study at any point without giving any explanations or fear of any consequences. The participants were allowed to complete the form on their own and return them within two weeks. All of the participants who met the inclusion criteria returned the questionnaire. A period of one week was the minimum time allowed for respondents to return the questionnaires and a maximum of 3 weeks.

3.8 PILOT STUDY

A pilot study was conducted at clinical sites that were not participating in the study which are Ngungu, Mukobeko, Bwacha and Mine Hospitals. The pilot study sample was twenty (20) participants which was a 10 percent of the study population. The purpose of the pilot study was to test the data collection tool, detect flaws such as ambiguous and illogically sequenced questions as well as to check spaces provided for open ended questions if they were adequate enough. The following adjustments were made to the data collection tool:

1. The questionnaire was too long, therefore some questions were of no value to the study were deleted
2. Questions on availability of protocols / policy on screening and reporting GBV were deleted as there was no specific objective necessitating such questions.
3. There were errors in numbering the questions and these were corrected

3.9 ETHICAL CONSIDERATION

As such, before conducting the study, ethical clearance was obtained from the Excellence in Research Ethics and Science (ERES) Converge, reference number 2015-Apr-005. Written permission was obtained from the Permanent Secretary Ministry of Health and sister Ministry of community Development, Maternal and Child Health, Kabwe District Permanent Secretary, Kabwe Provincial Medical Officer, and the District Community and the Medical Officer for Kabwe District. An informed consent form prepared according to the Excellence in Research Ethics and Science (ERES) Converge IRB guidelines was issued to the participants in order to guarantee voluntary participation and confidentiality. The researcher gave the address of the Excellence in Research Ethics and Science (ERES) Converge and her contact phone numbers to participants of the questionnaire in case they wanted further clarity on the study. The purpose of the study was explained to each respondent. Those that did not consent to participate in the study were reassured that they would suffer no consequences as a result of not participating. Those who consent were asked to sign a consent form, which was explained fully to them and that they would not be remunerated in any way. Study subjects were told that they were free to withdraw from the study at any time without suffering any consequence. Respondents' names were not written on the questionnaires. No one apart from the researcher was allowed unnecessary access to the collected data. Participants were not subjected to any physical harm as the study

CHAPTER FOUR:

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.0 INTRODUCTION

In chapter 4, the research findings are presented and analyzed. Data was collected from a total of 207 respondents who completed a self-administered questionnaire. The response rate was 100%

4.1 ANALYSIS OF DATA

Data was collected for a period of two weeks from 20th January to 7th February 2017. It was checked for consistency and entered into SPSS version. Chi-square test was used to determine the association between the independent (Demographic variables, knowledge levels) and dependent variables (Screening and reporting). The statistical significance was set at 5% (0.05) and confidence interval was set at 95%.

4.2 PRESENTATION OF FINDINGS

The study findings are summarized and presented in the form of tables and cross tabulations. The findings of this study have been presented according to the sequence of the questions and categories in the questionnaire. Data has been presented in four sections which are A, B, C and D. Section A represents demographic data. Section B represents data on Health Professionals' Knowledge on GBV. Section C and D denotes HPs' screening and reporting practices towards GBV respectively.

4.2.1 SECTION A: RESPONDENTS SOCIO-DEMOGRAPHIC DATA

Section A presents the respondents' socio- demographic data. The socio-demographic data include age, gender and marital status of the respondents. The other socio-demographic variables include professional type, highest qualifications obtained, duration in the current job and training / sensitization in GBV.

Table 4: Respondents socio-demographic data (n=207)

Characteristic	Frequency	Percent
Age		
≤ 26 years	46	23.6
27 – 37 years	86	44.1
38 – 48 years	45	23.1
≥49 years	18	9.2
Total	195	100%
Gender		
Male	65	31.4
Female	142	68.6
Total	207	100%
Marital status		
Single	68	32.9
Married	121	58.5
Divorced	2	1
Widowed	16	5.6
Total	207	100%
Health care practitioner		
Nurse/midwife	145	70
Clinical officer	43	20.8
Medical Doctor	19	9.2
Total	207	100%
Highest professional qualification		
Degree	31	15
Advance Diploma	10	4.8
Diploma	100	48.3
College certificate	66	31.9
Total	207	100%
Duration of working in the current Job		
< 5 years	69	35.0
5 – 10 years	58	29.5
> 10 years	70	35.5
Total	197	100%
Received training or sensitization on management of GBV		
Yes	39	18.8
No	168	81.2
Total	207	100%

Table 4 shows that majority 44.1% of the respondents were aged between 27 to 37 years. Most (68.6%) of them were females and 58.5% were married. Most respondents, 70% were Nurse/Midwives with a Diploma qualification (48.3%). The majority, 70% of the respondents had worked for more than 10 years in their current job and 81.2% had not received training or sensitization on management of GBV.

4.2.2 SECTION B: HEALTH PROFESSIONALS' KNOWLEDGE LEVELS OF GBV

In section B, the respondents' knowledge levels on GBV are presented. Respondents were asked a total of 8 statements with response options ranging from true, false and I don't know. The results are presented in table 4. Further, the respondents' knowledge levels on GBV were measured by creating a knowledge score by adding all knowledge questions to come up with a knowledge total score of 8. Each correct response was awarded a score of 1 while a wrong response and "I don't know responses" were not awarded any score. HPs who obtained scores of 5 – 8 of the total score were categorized as having high levels of knowledge while those who scored less than 5 (1-4) were considered as having low levels of knowledge.

Table 5: Knowledge of Health Professionals on GBV (n=207)

Q 7	Variable	Category	Frequency/ percent
A	A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband	Knowledgeable	144 (69.6)
		Not Knowledgeable	63 (30.4)
B	GBV is very rare among women seeking health services at health institutions	Knowledgeable	117 (56.5)
		Not Knowledgeable	90 (43.5)
C	Domestic violence affects all sectors of society irrespective of social, economic, cultural and religious values	Knowledgeable	187 (90.3)
		Not Knowledgeable	20 (9.7)
D	Most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers	Knowledgeable	184 (88.9)
		Not Knowledgeable	23 (11.1)
E	It is mandatory for Health professionals to report identified cases of GBV to police	Knowledgeable	93 (44.9)
		Not Knowledgeable	114 (55.1)
F	Victims of GBV are required to obtain a police medical report form (medico-legal examination report form) from the police or ASAZA before provision of medical services (except in emergencies).	Knowledgeable	31 (15.0)
		Not Knowledgeable	176 (85.0)
G	It is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it	Knowledgeable	162 (78.3)
		Not Knowledgeable	45 (21.7)
H	Clinical care for survivors of GBV require Health care Professionals to obtain an informed consent from victims for any notifications or referral	Knowledgeable	166 (80.2)
		Not Knowledgeable	41 (19.8)

Table 5 shows that majority of the respondents, 88.9% knew that most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers. Close to half, 43.5% of the respondents endorsed to a false statement that GBV is very rare among women seeking health services at health institutions as true. More than half (55.1%) of the health professionals did not know whether it was mandatory for Health professionals to report identified cases of GBV to police. Further, the majority (85%) of the respondents endorsed to a false statement that victims of GBV were required to obtain a police medical report form from the police or ASAZA before provision of medical services. The Majority of the HPs, 78.3%

knew that it is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it. However, most (80.2%) of the HPs knew that Clinical care for survivors of GBV required them to obtain an informed consent from victims for any notifications or referral.

Table 6: Health professionals' Knowledge levels of GBV (n=207)

Knowledge levels	Frequency	Percent
High	165	79.7
Low	42	20.3
Total	207	100

According to table 6, 79.7% of the respondents' in the current study had high knowledge level of GBV while 20.3% had low knowledge levels on GBV.

4.2.3 SECTION C: HEALTH PROFESSIONALS' SCREENING PRACTICES

This section present health professional's screening practices. The screening practices were measured by a "yes" and "no" question, type of screening and frequency of screening. Scores were allocated to each of the mentioned variable to come up with a total practice score of 6. Furthermore those who obtained scores of 5 - 6 out of the total screening score were considered as adequate screening while scores of less than 5 were considered as inadequate screening practices.

Table 7: Screening for GBV by HPs (n = 207)

Screened clients	Frequency	Percent
Yes	112	54
No	95	46
Total	207	100
Type of Screening (n = 112)		
Part of routine history	16	14.3
Upon suspicion for GBV	81	72.3
Self-disclosure	13	11.6
Other	2	1.8
Total	112	100%
Frequency of GBV screening (n = 112)		
Never	10	8.9
Rarely	28	25
A few times	45	40.2
Often	19	17.5
Very often	10	8.9
Total	112	100%

Table 7 shows that slightly more than half (54%) of the health professionals screened women for GBV. The majority, 72.3% of the HPs screened upon suspicion for GBV while 14.3% screened as part of routine history taking. The frequency of GBV screening was often, 17.5% and very often, 8.9%.

Table 8: Health professionals' screening practices (n-207)

Screening practices	Frequency	Percent
Adequate	34	16.4
Inadequate	173	83.6
Total	207	100

Table 8 shows that 83.6% of the respondents in the current study exhibited inadequate screening practices for GBV.

4.2.4 SECTION D: HEALTH PROFESSIONALS' REPORTING PRACTICES TO LEGAL AUTHORITIES

Section D presents information on HPs reporting practices of GBV cases to legal authorities. The HPs' reporting practices of GBV were measured by a "yes" and "no" response to a question that sought to find out whether HPs screened for GBV, the type of reporting and frequency of reporting in the past year. Scores were allocated to each of the mentioned measurement criteria to come up with a total reporting score of 6. Furthermore scores of 4 and above out of the total reporting score were considered as sufficient reporting while scores of less than 4 were considered as insufficient reporting practices.

Table 9: Reporting of GBV by HPs (n = 207)

Reports GBV	Frequency	Percent
Yes	65	31.4
No	142	68.6
Total	207	100
Type of reporting (n = 65)		
Mandatory	22	33.8
Voluntary	36	55.4
If victim has severe injuries	3	4.6
Other	4	6.2
Total	65	100%
Frequency of GBV reporting (n = 65)		
Never	8	12.5
Rarely	23	35.4
A few times	22	33.8
Often	8	12.3
Very often	4	1.4
Total	65	100%

According to table 9, close to one third, 31.4% of the HPs reported GBV to legal authorities. Types of reporting were voluntary, 55.4% and mandatory, 33.8%. The HPs' frequency of reporting GBV was often, 12.3% and very often 1.4%

Table 10: Health professionals reporting practices (n= 207)

HPs' reporting practices	Frequency	Percent
Sufficient	27	13
Insufficient	180	87
Total	65	100

Table 10 shows that majority, 87% of the HPs exhibited insufficient reporting practices of GBV.

Table 11: Availability of written policy / protocol on screening and reporting of GBV (n=207)

Variable	Frequency	Percent
Written institutional policy on screening GBV available		
Yes	65	31.4
No	79	38.2
I don't know	63	30.4
Total	207	100
Policy statement on GBV screening (n = 65)		
Part of routine history taking	22	33.8
upon suspicion for GBV	27	41.5
upon self-disclosure	16	24.6
Total	65	100%
Written Reporting policy for reporting GBV available		
Yes	61	29.5
No	74	37.7
I don't know	72	34.8
Total	207	100%
Policy statement on GBV reporting (n = 61)		
Health professionals should fill in a police (medico - legal examination) report form even if the victim does not want or has not given consent	11	18.0

Health professionals should only fill in a police (medico - legal examination) reporting form if the victim has consented and wants to report	46	75.4
Other	4	6.6
Total	61	100%

Table 11 shows that the majority of the respondents, 38.2% indicated that they did not have written institutional policy / protocol on how to screen for GBV while close to one third, 30.4% of the health professionals did not know whether their institutions had one. When asked if they had a written policy/ protocol on how to report GBV to legal authorities, the majority, 35.7% of the respondents indicated that there was none and 34.8% did not know if there was one.

Table 12: Levels of Confidence on screening and reporting GBV cases (n = 207)

Variable	Frequency	Percentage
Confidence on screening GBV		
Not at all confident	28	13.5
Slightly confident	52	25.1
Moderately confident	69	33.3
Very confident	47	22.7
Extremely confident	11	5.3
Total	207	100
Confidence on reporting GBV		
Not at all confident	37	17.9
Slightly confident	50	24.2
Moderately confident	55	26.6
Very confident	50	24.2
Extremely confident	15	7.2
Total	207	100

According to table 13, few of the HPs were very confident, 22.7% or extremely confident 5.3% that they could screen women for GBV. Further, very few, 24.2% of the participants reported that they were very confident, 24.2% or extremely confident, 7.2% that they could report GBV to legal authorities.

4.2.5 SECTION E: ASSOCIATION BETWEEN INDEPENDENT AND DEPENDENT

VARIABLES

This section presents associations between health professionals' demographic variables, knowledge levels, screening and reporting practices for GBV.

Table 13: Association between screening practices for GBV and some demographics (n=207)

Characteristic	Screening practices for GBV			P-value
	Adequate n(%)	Inadequate n(%)	Total	
Male	12(18.5%)	53(81.5%)	65	0.593
Female	22 (18.5%)	120(84.5%)	142	
Total	34 (16.4%)	173(83.6%)	207	
Marital status				P-value
Single	7(10.3%)	61(89.7%)	68	
Married	25(20.7%)	96(79.3%)	121	0.260
Divorced	0(0.0%)	2(100.0%)	2	
Widowed	2(12.5%)	14(87.5%)	16	
Total	34(16.4%)	173(83.6%)	207	
Profession				P-value
Nurse/midwife	17(11.7%)	128(88.3%)	145	
Medical doctor	5(26.3%)	14(73.7. %)	19	0.020
Clinical officer	12(27.9%)	31(72.1%)	43	
Total	34(16.4%)	173(83.6%)	207	
Highest professional qualification				P-value
Degree	7(22.6%)	24(77.4 %)	31	
Advanced diploma	2 (20.0 %)	8(80.0 %)	10	0.721
Diploma	16(16.0%)	84(84.0%)	100	
College certificate	9(13.6%)	57(86.4 %)	66	
Total	34(16.4%)	173(83.6%)	207	
Age at last birth day				P-value
≤ 26 years	5(10.1%)	41(89.1%)	46	
27 – 37 years	16(18.6%)	70(81.4%)	86	0.547
38 – 48 years	9(20.0%)	36(80.0%)	45	
≥49 years	2(11.1%)	16(88.9%)	18	
Total	32(16.4%)	163(83.6%)	195	
Duration of working at current job				P-value
< 5 years	7(10.1%)	62(89.9%)	69	
5 – 10 years	13(22.4%)	45(77.5%)	58	0.167
> 10 years	11(15.7%)	59(84.3.%)	70	
Total	31(15.7%)	166(84.3%)	197	

Received training or sensitization on GBV			P- Value
Yes	8 (20.5%)	31(79.5%)	
No	26(89.3%)	142(84.5%)	
Total	34(16.4%)	173(83.6%)	

From table 13 above, a statistically significant relationship was observed between respondents' profession and their screening practices for GBV ($p = 0.020$). The proportion of adequate screening practices was higher in respondents who were clinical officers (27.9%) and medical doctors (26.3%) in comparison with those who were nurses/midwives (11.7%). We therefore rejected the null hypothesis and concluded that there is a relationship between respondents' profession and their screening practices for GBV ($X^2 = 7.818$, $N = 207$, $p < 0.05$, 2-tailed).

No statistically significant relationship was observed between respondents' screening practices for GBV and their sex ($p = 0.593$), marital status ($p = 0.260$), professional qualifications ($p = 0.721$), age ($p = 0.547$), job duration ($p = 0.167$), training or sensitization on GBV ($p = 0.444$) and knowledge levels ($p = 0.376$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships.

Table 14: Association between screening practices and knowledge levels on GBV (n=207)

Variable	Screening practice GBV			P-value
	Sufficient n (%)	Insufficient n (%)	Total	
Knowledge levels on GBV				
Low	5 (11.9%)	37(88.1%)	42	0.376
High	29(17.6%)	136 (82.4%)	165	
Total	34(16.4%)	173(83.6%)	207	

According to table 14, respondents with high knowledge levels were more likely to screen adequately, 17.6% for GBV compared to those with low knowledge levels, 11.9%. However, the relationship was not statistically significant ($P = 0.376$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships.

Table 15: Association between reporting practices for GBV and demographic variables (n=207)

Characteristic	Reporting practices for GBV			P-value
	Adequate n(%)	Inadequate n(%)	Total	
Sex				
Male	11(16.9%)	54(83.1%)	65	0.262
Female	16(11.3%)	126(88.7%)	142	
Total	27(13.0%)	180(87.0%)	207	
Marital status				
Single	5(7.4%)	63(92.6%)	68	0.202
Divorced	0(0.0%)	2(100.0%)	2	
Widowed	4(25.0%)	12(75.0%)	16	
Married	18(14.9%)	103 (85.1%)	121	
Total	27(13.0%)	180(87.0%)	207	
Health care practitioner				
Nurse/midwife	18 (12.4%)	127(87.6%)	145	0.758
Medical doctor	2(10.5%)	17(89.5%)	19	
Clinical officer	7(16.3%)	36(83.7%)	43	
Total	27(13.0%)	180(87.0%)	207	
Highest professional qualification				
Degree	5(16.1.1%)	26(83.9 %)	31	P - value
Advanced diploma	1 (10.0%)	9(90.0%)	10	
Diploma	12(12.0%)	88(88.0%)	100	
College certificate	9 (13.6%)	57(86.4 %)	66	
Total	27(13.0%)	180(87.0%)	207	n a78
Age at last birth day				
≤ 26 years	3(6.5%)	43(93.5%)	46	0.496
27 – 37 years	13(15.1%)	73(84.9%)	86	
38 – 48 years	7(15.6%)	38(84.4%)	45	
≥49 years	2(11.1%)	16(88.9.%)	18	
Total	25(59.7%)	170(40.3%)	195	
Duration of working at current job				
< 5 years	6(8.7%)	63(91.3%)	69	P-value
5 – 10 years	12(20.7 %)	46(79.3%)	58	

> 10 years	8 (11.4%)	62 (88.6%)	70	
Total	26(13.2%)	171(86.8%)	197	
Received training or sensitization on GBV				P- value
Yes	9 (23.1%)	30 (76.9%)	39	
No	18 (10.7%)	150 (89.3%)	168	
Total	38(13.0%)	180(87.0%)	207	0.039

Table 15 shows a statistically significant relationship between respondents' training and their reporting practices for GBV ($p = 0.039$). A higher proportion of respondents who had received training on GBV (23.1%) exhibited sufficient reporting practices as compared to those who had not received training, where sufficient reporting stood at 10.7%. We therefore rejected the null hypothesis and concluded that there is a relationship between respondents' training or sensitization on GBV and their reporting practices for GBV ($p < 0.05$).

No statistically significant relationship was observed between respondents' reporting practices for GBV and their sex ($p = 0.262$), marital status ($p = 0.202$), profession ($p = 0.0758$), professional qualifications ($p = 0.928$), age ($p = 0.496$) and job duration ($p = 0.119$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships.

Table 16: Association between reporting practices and knowledge level on GBV (n=207)

Variable	Reporting practices GBV			P-value
	Adequate, n (%)	Inadequate, n (%)	Total	
Knowledge levels on GBV				
Low	1(2.4%)	41(97.6%)	42	0.121
High	26(15.8%)	139(84.2%)	164	
Total	27(58.5%)	180 (41.5%)	207	

From table 16 above, a statistically significant relationship was observed between respondents' knowledge levels on GBV and their reporting practices ($P = 0.121$). The proportion of adequate reporting was higher in respondents with high knowledge levels (15.8%) than in those with low knowledge levels (2.4%). We therefore rejected the null hypothesis and concluded that there is a relationship between respondents' knowledge levels and their reporting practices for GBV ($p = 0.121$).

4.3 Summary of findings

The study participants were drawn from Doctors, Nurses /midwives and Clinical Officers. The majority, 44.1% of the respondents were aged between 27 to 37 years. Most, 68.6% of the participants were females and 58.5% were married. The majority, 70% were Nurse/Midwives with a Diploma qualification (48.3%). Most, 70% of the respondents had worked for more than 10 years in their current job and 81.2% had not received training or sensitization on management of GBV.

The majority, 88.9% of the respondents, were aware that most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers. Close to half, 43.5% of the respondents endorsed to a false statement that GBV is very rare among women seeking health services at health institutions as true. More than half, 55.1% of the health professionals did not know whether it was mandatory for Health professionals to report identified cases of GBV to police. Further, the majority, 85% of the respondents endorsed to a false statement that victims of GBV were required to obtain a police medical report form from the police or ASAZA before provision of medical services. The Majority of the HPs, 78.3% knew that it is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it. However, most (80.2%) of the HPs knew that Clinical care for survivors of GBV required them to obtain an informed consent from victims for any notifications or referral. Overall, the majority, 79.7% of the respondents' in the current study had high knowledge level of GBV.

Slightly more than half, 54% of the health professionals screened women for GBV. The majority, 72.3% of the HPs screened upon suspicion for GBV while 14.3% screened as part of routine history taking. Regarding the frequency of screening for GBV, few, 17.5% of the HPs' screened often, and very often, 8.9%. The majority of the respondents, 38.2% indicated that they did not have a written institutional policy / protocol on how to screen for GBV and close to one third, 30.4% of the health professionals did not know whether their institutions had one.

Few, 22.7% of the HPs were very confident or extremely confident, 5.3% that they could screen women for GBV. Overall, HPs' screening practices for GBV were inadequate, 83.6%.

The proportion of adequate screening practices was higher in respondents who were clinical officers (27.9%) and medical doctors (26.3%) in comparison with those who were Nurses/Midwives (11.7%). The observed relationship was found to be statistically significant (P

= 0.020). We therefore rejected the null hypothesis and concluded that there was a relationship between respondents' profession and their screening practices for GBV ($P > 0.05$). There was no statistically significant relationship observed between respondents' screening practices for GBV and their sex ($p = 0.593$), marital status ($p = 0.260$), professional qualifications ($p = 0.721$), age ($p = 0.547$), job duration ($p = 0.167$), training or sensitization on GBV ($p = 0.444$) and knowledge levels ($p = 0.376$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships.

Close to one third, 31.4% of the HPs reported GBV to legal authorities. Types of reporting GBV to legal authorities engaged by the HPs were voluntary, 55.4% and mandatory, 33.8%. Few, 12.3% of the HPs reported GBV to legal authorities often, 12.3% and very often 1.4%. Overall, the HPs reporting practices of GBV were insufficient, 87%. A statistically significant relationship was observed between respondents' knowledge levels on GBV and their reporting practices ($p = 0.022$). The study revealed a statistically significant relationship between respondents' training and their reporting practices for GBV (0.039). There was no statistically significant relationship observed between respondents' reporting practices for GBV and their sex ($p = 0.262$), marital status ($p = 0.202$), profession ($p = 0.0758$), professional qualifications ($p = 0.928$), age ($p = 0.496$) and job duration ($p = 0.119$).

When asked if they had a written policy / protocol on how to report GBV to legal authorities, the majority, 35.7% of the respondents indicated that there was none and 34.8% did not know if there was one. Further, very few, 24.2% of the participants were very confident, or extremely confident, 7.2% that they could report GBV to legal authorities.

CHAPTER FIVE:

DISCUSSION OF FINDINGS AND IMPLICATIONS ON THE HEALTH CARE SYSTEM

5.0 INTRODUCTION

Discussion of findings is based on the data collected from the questionnaires of 207 HPs working in Kabwe District Health Facilities. The discussion of the findings focuses on demographic characteristics, Knowledge on GBV, screening and reporting practices towards GBV, as well as relationship between the dependent and independent variables.

5.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The sample of this study was drawn from Doctors, Clinical Officers and Nurses working in public Health facilities in Kabwe District. The findings revealed that there were more females, 68.6%, than male Health Professionals, 31.4%. The majority were married, 58.5%. The majority, 70.0% were Nurses seconded by Clinical officers 20.8%. The possible explanation for having more females is that most health professionals are Nurses / Midwives and Nursing is a female dominated job. This is because Nursing and Midwifery were previously regarded as female careers. Furthermore, culture ascribes the role of caring for the sick to females and hence more females were joining the Nursing profession. The finding that the majority of the HPs in the study were nurses implies that nurses are the ones found at most of the health facilities and can be instrumental in screening women for GBV. The HPs' mean duration of working on the current job was 9.6 ± 8.6 years and on average, they were above 30 years old. The age and sex of a Health Provider might be cardinal feature if women victims of physical abuse are to feel comfortable and gain trust of the HP to discuss their experiences of abuse. It has been reported that women prefer to be screened by a fellow woman HP aged between 30 and 50 years (Theckeray et al 2007). This entails that it is critical that nurses being the majority among the other Health Professionals should be equipped with knowledge on GBV through ongoing training and sensitization on GBV management. In the absence of a clinical officer or a doctor,

Nurses screen and make critical decisions over patients' management. Nurses who are not knowledgeable or trained may not suspect abuse and would not know how to respond to a disclosure of GBV.

The study findings indicate that most of the professionals, 81.2%, did not receive any training / sensitization on GBV. This is because issues of GBV were not in the HPs' curriculum as they were culturally considered as private family issues. These findings are similar to a study conducted by Ariel (2015) in Barbados which found that 81% of the Service providers surveyed had no training related to GBV in the last three years. This meant that the service providers were not updated on any policy changes on GBV management that could have enacted in the past three years. However, the finding is contrary to results from a 2015 exploratory study of Australian Midwives' knowledge of intimate partner violence against women during pregnancy by Baird et al that indicated that almost 88% of participants had some education or training on intimate partner violence. This study was limited to Midwives and possibly pregnant women were considered to be a high risk group for GBV, hence it was seen as necessary to train the Midwives in GBV. Others have also observed that generally HPs do not receive formal pre-service and in-service training or professional development on addressing GBV (WHO, 2012). This may result into lack of knowledge on GBV issues and negative attitudes towards victims of GBV. It is therefore cardinal for professional bodies to strengthen and include GBV issues in HPs curriculum to enable equip them with knowledge and skills on GBV management,

5.2 HEALTH PROFESSIONALS' LEVELS OF KNOWLEDGE ON GBV

The first Objective of the study was to assess HPs' knowledge levels on GBV. Sufficient level of knowledge on GBV is very cardinal for HPs to effectively identify and manage victims of GBV who seek health services for GBV related health consequences.

The majority of the respondents in this study knew that most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers. This knowledge is critical if HPs are to be convinced to screen women for GBV instead of waiting for them to spontaneously disclose abuse without being questioned.

Close to half, 43.5% of the respondents endorsed to a false statement that GBV was very rare among women seeking health services at health institutions as true. This statement underestimates the magnitude of GBV among women seeking health facilities. This could be the explanation of reluctance to screen women for GBV.

More than half (55.1%) of the health professionals did not know whether it was mandatory for Health professionals to report identified cases of GBV to police.

Further, the majority (85%) of the respondents endorsed to a false statement that victims of GBV were required to obtain a police medical report form from the police or ASAZA before provision of medical services.

The Majority of the HPs, 78.3% knew that it is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it.

However, most (80.2%) of the HPs knew that Clinical care for survivors of GBV required them to obtain an informed consent from victims for any notifications or referral. Obtaining informed consent is very important as it upholds the victim's autonomy and right to choices. Informed consent is still applicable even where reporting to legal authorities is mandatory. This is achieved by giving advance information so that the victim is made aware of the steps that would be undertaken following a disclosure of abuse. In Zambia, HPs are required to fill in a medical report form which is used to confirm the abuse and also to notify the police or any organization that deals with GBV.

Overall, the majority, 79.9% of the respondents had high levels of knowledge on gender based violence. This finding was unexpected as most of the professionals, 81.2% were not trained on GBV as such lower levels of knowledge were expected. However, knowledge can also be acquired through long duration of practicing on the job as well as social media. The majority, 35.5% of the respondents had been on the job for more than 10 years. This long working experience could also be the source of their knowledge.

Further, a statistically significant relationship was observed between respondents' levels of knowledge on GBV and their reporting practices ($p = 0.121$). This means that those who had higher levels of knowledge were reporting GBV adequately to legal authorities. This is because Knowledge gives confidence and facilitates reporting of GBV to legal authorities.

Other studies found that HPs had medium levels of knowledge on GBV. A related cross sectional study by Sanchez (2016) involving 167 nurses from Urban Health centers to determine the Knowledge and attitudes of Nurses in Primary care on gender Violence and their relationship with socio-demographic factors and cases detected found medium levels of Knowledge.

Other studies found lack of knowledge on GBV among nurses. Clark et al (2017) in a study on practices, policies, barriers and opportunities for a coordinated and routinized response to IPV revealed that HPs acknowledged GBV to be a serious health threat and believed that screening for GBV was within their scope of work. Yet over two thirds of the participants reported lack of Knowledge among other identified barriers to screening for intimate partner violence.

5.3 SCREENING PRACTICES OF HEALTH PROFESSIONALS TOWARDS GENDER BASED VIOLENCE

The second objective was to establish screening/reporting practices of health care providers towards GBV.

Screening women for GBV is a critical step in identification of those victims of GBV who may want to conceal the root cause of their complaints. Health professionals who screen women who seek health care services at health facilities for GBV can help identify victims who suffer in silence and can reduce victimization and positively impact women's health and well-being (Clark, 2017).

The current study revealed that slightly more than half (54%) of the health professionals screened women for GBV. This finding means that screening for GBV was low among the HPs. The majority, 72.3% of the HPs screened upon suspicion, which is also known as selective screening, followed by routine screening, 14.3%. Overall the HPs' screening practices were inadequate, 83.6%. In summary, the HPs' screening rates for GBV was low. Overall, the respondents screening practices for GBV were inadequate. The possible explanation for the findings is that the majority of the respondents had not received training sensitization on GBV. Although the majority of the respondents had high levels of knowledge on GBV, the source of their information or knowledge on GBV was not known as such they could still be harbouring some negative attitudes towards GBV victims and screening for GBV. The low screening rates could further be attributed to the HPs' low confidence levels on screening for GBV as the study showed that only few of these Health professionals reported that they were very confident, 22.7% or extremely confident, 5.3% that they could screen women for gender based violence. The other contributing reason could be lack of a policy / guidelines or lack of knowledge if one existed on GBV. Knowledge of policies and the implementation of an appropriate protocol increases the likelihood of screening for GBV (Rodriquez-Blanes 2017). The current study

revealed that 38.2% of the Health professionals in the current study reported that they did not have a written policy (procedures and protocols) on screening women for GBV while close to one third 30.4% of the health care professionals did not know whether their institutions had written policies on screening for GBV.

Several research studies have also reported low rates of screening for GBV. A Californian survey of 137 primary care physicians' self-reported screening practices by Tavrov et al (2017) revealed that only 14% of the health providers in their study always screened female patients for IPV, about one third of the health care providers appeared never to screen. The reason for the low screening rates was that most Health care providers in the study lacked self confidence in screening.

Another cross sectional study by Suryavanshi et.al (2018) in India on women's' opinions on GBV screening found that among 23% of women who reported experiences of GBV, 90% had never been asked about GBV in a health facility. This finding indicates that victims of GBV pass through Health facilities but HPs fail to identify them due to reluctance to screen for GBV.

Low screening rates were also revealed by Ramsey et al. (2012) in a study to measure Primary care Clinicians' current levels of knowledge, attitudes and clinical skills on domestic violence. The study found that screening for GBV was not widespread even when patients presented with signs and symptoms of abuse, only about 51% of clinicians in their study asked such patients about possibility of abuse. It is cardinal for HPs to inquire about GBV in female patients who present with signs of abuse in view of the high prevalence of spousal physical abuse. GIDD (2011) encourages Health care Professionals to ask about abuse upon noting inconsistencies in the victim's history and the indicators of abuse.

Although the current study revealed that the majority, 72.3%, of the HPs' screened for GBV upon suspicion, (also known as selective screening), others have recommended routine screening. Dudgeon and Evans (2014) state that routine screening does not only create opportunities for women to disclose abuse but also facilitates provision of support and assistance from Health care providers consequently curbing adverse health effects.

Several studies affirm the importance of having an institutional policy to guide HPs on screening for GBV. A related Jamaican study by Pitter (2016) that assessed midwives' knowledge and

attitudes when encountering GBV in their practice revealed that the midwives acknowledged the importance of screening for GBV and expressed willingness to intervene but identified barriers in form of gaps in the institutional framework to guide their practice. This notion is supported by a study by Bender (2016) that revealed that knowledge and attitudes may not predict screening, rather the number of hours of previous training on abuse and the organizational protocols of the health facility where HPs are employed significantly increase the frequency of Intimate Partner Violence (IPV) screening. In conclusion, Bender (2016) suggests that external factors such as national policies mandating IPV screening in clinics may be an effective way to increase provider identification of IPV.

A Zambian study in Northwestern Province conducted in two study sites revealed that the study sites did not have written protocols to guide coordination, case management and harmonization of referral pathways and follow-up between the various service providers on providing care and assistance to survivors of GBV (Avocats Sans Frontiers 2017). It is therefore important for health institutions to have a written policy/ protocol to guide HPs on how to screen for GBV.

A statistically significant relationship was observed between respondents' profession and their screening practices for GBV ($p = 0.020$). The proportion of adequate screening practices was higher in respondents who were clinical officers (27.9%) and medical doctors (26.3%) in comparison with those who were Nurses/Midwives (11.7%). We therefore rejected the null hypothesis and concluded that there is a relationship between respondents' profession and their screening practices for GBV ($X^2 = 7.818$, $N = 207$, $p < 0.05$, 2-tailed). This finding could be attributed to the fact that clinical Officers and doctors are adequately trained to screen patients during their professional training. Clinical Officers work closely with medical doctors and are mostly found in the out- patient department screening patients while Nurses implement the orders among other nursing duties more especially in big facilities such as hospitals where there is division of labour. However due to shortages of Clinical officers and Doctors, the division of labour in terms of screening patients is not strictly adhered to as nurses being the majority are found at various entry points of Health facilities screening and interacting with female clients. Therefore regardless of where they work, nurses need to be equipped with knowledge on GBV to enable them to screen and intervene appropriately to a disclosure of GBV. Women might even be more comfortable to discuss GBV issues with fellow women. On the other hand nurses being

women are not immune to GBV and may have accepted their own experiences of GBV as such may not see any reason to screen other women for GBV.

There was no statistically significant relationship was observed between respondents' screening practices for GBV and their sex ($p = 0.593$), marital status ($p = 0.260$), professional qualifications ($p = 0.721$), age ($p = 0.547$), job duration ($p = 0.167$), training or sensitization on GBV ($p = 0.444$) and knowledge levels ($p = 0.376$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships. Conducting an in-depth GBV training may improve screening for GBV.

5.4 HEALTH PROFESSIONALS' REPORTING PRACTICES OF GBV TO LEGAL AUTHORITIES

Reporting GBV to legal authorities in this study refers to filling in a police medical report form or referring a victim of GBV to another level such as ASAZA or the Police victim support unit. Sometimes HPs use a phone call to inform the Police when a victim has sustained severe injuries and require admission. The Police officers follow the victim at the Hospital. Nurses and many of the Clinical officers are not authorized to fill in a police medical report form, but they are mandated to refer cases of GBV to another level where there is a medical doctor, usually to Kabwe General Hospital via ASAZA. Medical doctors are the ones who are authorized to fill in a police Medical report form for victims of GBV. It is therefore, cardinal for HPs and the law enforcement agency to coordinate in managing cases of GBV. A one stop center for GBV victims is located within Kabwe General Hospital to ease off the reporting of GBV cases to legal authorities.

The current study revealed that close to one third, 31.4% of the HPs reported GBV to legal authorities. The types of reporting engaged by the majority, 55.4% of the respondents were voluntary, followed by mandatory, 33.8%. The HPs' frequency of reporting GBV was often, 12.3% and very often 1.4%. Overall, the HPs reporting practices for GBV to legal authorities were insufficient, 87%. The reason for the HPs' low reporting rates of GBV and insufficient reporting practices could be explained by lack of training on GBV as revealed by the study.

Further, the study revealed a statistically significant relationship between training on GBV and reporting practices for GBV ($p = 0.039$). A higher proportion of respondents who had received training on GBV (23.1%) exhibited sufficient reporting practices as compared to those who had not received training, where sufficient reporting stood at 10.7%. We therefore rejected the null

hypothesis and concluded that there is a relationship between respondents' training or sensitization on GBV and their reporting practices for GBV ($p < 0.039$). The explanation for this finding is that HPs who are trained are aware of the reporting and referral requirements for cases of GBV and they implement the required behavioral action when GBV is disclosed. Victims of GBV are referred to a higher level Hospital where there is a medical doctor via ASAZA to obtain a police medical report form. Doctors are obliged to fill in a medical report form which is given to the victim to return to ASAZA to facilitate opening of a docket. Although, some victims of GBV may not return the form to ASAZA or Police, the HP would have accomplished their role.

No statistically significant relationship was observed between respondents' reporting practices for GBV and their sex ($p = 0.262$), marital status ($p = 0.202$), profession ($p = 0.0758$), professional qualifications ($p = 0.928$), age ($p = 0.496$) and job duration ($p = 0.119$). We therefore failed to reject the null hypotheses and concluded that there was no sufficient evidence to prove the said relationships

The finding of low reporting rates for GBV is in line with reports that GBV is under reported and that HPs are reluctant to report GBV to legal authorities even in nations where mandatory reporting laws exist (European Union Agency for fundamental Rights, 2016).

According to the Zambian Anti Gender Based Violence Act of 2011, a Medical practitioner such as a nurse or an institution with information concerning the commission of an act of GBV can obtain for the victim or advise the victim how to obtain shelter, medical services or other services that may be required in the circumstances of GBV. This entails that HPs may obtain police services for the victim among other services required in the multidisciplinary management of GBV. The act under part 6, sub section 1 and 3 further stipulates that a victim of GBV may file a complaint about gender based violence but also a complaint of GBV may be filed by any other person or institution with information about the gender based violence where the intervention is in the interest of the victim (Anti GBV ACT, 2011). This statement implies that HPs can report GBV to police authorities and even file a complaint on behalf of the client in circumstances where this is in the interest of the client.

Moreira et al (2014), in a Brazilian based study to analyze training and knowledge of professionals who worked in the family Health Strategy on reporting mistreatment of children and adolescents also report that 86.3% of the professionals were not trained on GBV as such gaps in knowledge were detected which translated into difficulties in reporting identified abuse.

Reporting of abuse was low, 17%. The study also showed that among 37.2% of the professionals who had identified abuse, 60% reported the abuse to authorities. The variables identified in the final model showed a direct association between the act of reporting and matters related to knowledge and training about abuse.

The US survey by Cooper et al (2009) on knowledge, detection and reporting of abuse by Health Professionals also found that Professionals who had received training on GBV were likely to report the detected abuse than those who were not trained. This finding could be attributed to the fact that training increased Knowledge levels and confidence on GBV reporting.

5.5 APPLICATION OF THE CONCEPTUAL FRAMEWORK TO THE RESEARCH FINDINGS

The conceptual framework that was adapted to guide this study was the KAP conceptual Model. Lack of training on GBV: most of the professionals, 81.2%, did not receive any training or sensitization on GBV, although they had high levels of knowledge on GBV. The high levels of knowledge did not translate into adequate screening of women for GBV. Perhaps the source of the respondents Knowledge did not offer in-depth factual information to change the myths and misconceptions held the HPs that justify GBV. There is need to explore other possible barriers to screening and reporting GBV such as of lack of a policy guideline or lack of knowledge of whether there was any at the institution. Further, the HPs' low confidence levels on screening and reporting GBV are also barriers to the expected behavior

In conclusion, knowledge alone does not automatically translate into action as predicted by the KAP model. However the model was helpful in predicting the HPs reporting practices of GBV to legal authorities as predicted by the KAP model in that a statistically significant relationship was observed between respondents' levels of knowledge on GBV and their reporting practices ($p = 0.121$). Further, the study revealed a statistically significant relationship between training on GBV and reporting practices for GBV ($p = 0.039$).

5.6 STRENGTH AND LIMITATIONS OF THE STUDY

5.6.1 STRENGTHS OF THE STUDY

This study has achieved the main objective of examining the knowledge and practices of Health Professionals towards screening and reporting GBV among women to legal authorities in Kabwe District.

There has been no study focusing on the variables, knowledge, screening/ reporting practices, locally in Zambia. Most of the studies that have been conducted by other researchers on the subject regionally and globally only discuss whether HPs screen women for GBV or report GBV but do not bring out the actual screening and reporting practices engaged by HPs.

Apart from categorizing the HPs' responses into high and low levels of knowledge, this study also highlights performance of the study participants on individual knowledge questions. This is helpful in guiding capacity builders as to what issues need to be address and clarified in their training programmes.

- Victims of GBV are required to obtain a police medical report form from the police or ASAZA but they are entitled to medical services even without a medical form. The medical form could still be obtained afterwards.
- The requirement for HPs to refer victims of GBV to a higher level health facility via ASAZA for the purpose of obtaining and having a police medical report form filled in and signed by a medical doctor.

The need for advance information to the victim during screening including the filling in of a police medical form and its use

5.6.2 LIMITATIONS OF THE STUDY

The limitations for this study are as follows:

- The study was only conducted in Kabwe District and therefore results cannot be generalized to other Districts in Zambia. There is need to conduct a similar study on a national scale to generalize the findings
- The knowledge, screening and reporting practices were self-reported, therefore follow up questions were included as necessary to probe further and allow self- expression
- There was no methodological triangulation for data collection, however a category under 'any other' was created where necessary to allow free self- expressive statements to supplement on the data or clarify issues.
- Doctors and clinical Officers were very few in the study; a larger sample size was desirable however their responses have shed light on the subject.

- Doctors and Clinical Officers were selected using of convenient sampling which is a non-probability method that is prone to selection bias and the study sample may not be representative of the study population making it difficult to generalize of study finding.

5.7 IMPLICATIONS OF THE STUDY FINDINGS TO NURSING

5.7.1 Nursing education

The study findings indicate that 40% of the health professionals had low levels of knowledge on Gender Based violence, implying that there is need to raise the levels of knowledge on GBV. The study also revealed that most of the professionals, 81.2%, did not receive any training or sensitization on GBV. This implies that Ministry of Health (MoH) in conjunction with General Nursing and Midwifery Council of Zambia (GNMCZ) needed to address the identified training needs for HPs on GBV in order to improve the levels of knowledge and screening for GBV. There is need for strengthening the GBV content in Nurses' curricula on GBV to enable them to effectively manage GBV cases. Medical students, student Clinical Officers and student nurses should be given quality time to gain experience on GBV management by exposing them to a one stop center during their clinical experience to trauma center. This will improve their skills on management of victims of GBV

5.7.2 Nursing administration

The study found diverse responses from HPs on whether their institutions had written policies on screening and reporting of GBV, for instance, 31.4% stated that their institution had a written policy on screening for GBV, 38.2% indicated that there was none, while 30.4% did not know if there was any written policy. Those HPs who indicated that their institutions had a policy on screening equally gave divergent responses to what the policy stated regarding screening for GBV.

Similarly various responses were also given on whether their institution had a written policy on reporting GBV; 29.9% indicated that their institutions had written policies on reporting GBV to legal authorities, slightly above one third 35.7% of the study participants indicated that their institutions did not have any, while 34.8% did not know whether their institutions had any. Those who claimed to have written policies on GBV could not also agree on what the policy stated

regarding screening and reporting of GBV implying that MoH as a policy marker needed to orient the HPs to the policies in place or establish some where none exist. Health facility administrators should ensure that the policies are disseminated and displayed in strategic places to guide the HPs on GBV management. In addition, administrators should conduct monitoring and evaluation of the screening and reporting practices of HPs to ensure adherence to policy standards.

5.7.3 Nursing research

The study findings indicate that the majority of the HPs are female nurses and most of them were married implying that some of them could also be experiencing GBV in their homes. Research is needed to investigate GBV experiences among the Nurses, and whether they disclose it to other HPs or report to Police authorities. The findings will assist in gaining an understanding of how Nurses deal with their own experiences of GBV before they can be expected to effectively manage victims of GBV. It would also be important to conduct qualitative studies on HPs who screen adequately and sufficiently report GBV to legal authorities in order to identify the motivating factors.

5.7.4 Clinical practice

The study findings showed that slightly more than half (54%) of the health professionals screened patients for GBV. Among the HPs who screened for GBV, a variety of screening practices were noted such as routine, selective, self-disclosure and others. Among the HPs who reported GBV to police, reporting practices were not standard as 55.4% of the HPs were practicing voluntary while 33.8% were practicing mandatory reporting.

There is need to improve the rates of screening and reporting of GBV to legal authorities and to standardize the HPs' practices by displaying protocols on the clinical area to guide HPs on screening and reporting of GBV

Medical students, student Clinical Officers and Student nurses should be given quality time to gain experience on GBV management by exposing them to a one stop center during their clinical experience to trauma center and out - patient Department to sharpen their skills on management of victims of GBV.

5.8 CONCLUSION AND RECOMMENDATIONS

5.8.1 CONCLUSION

The main objective of the study was to examine the knowledge, screening and reporting practices of HPs towards GBV in women in Kabwe District.

The study participants were drawn from Doctors, Nurses /midwives and Clinical Officers. The majority were Nurse / Midwives. The findings showed that a high percentage of the HPs had not been trained or sensitized GBV.

Slightly more than half of the HPs screened women for GBV, mostly upon suspicion for GBV which is also known as selective screening. Regarding the frequency of screening for GBV, few of the HPs' screened often, and very often. The majority of the respondents indicated that they did not have a written institutional policy / protocol on how to screen for GBV while close to one third of the HPs did not know whether their institutions had one. The study also revealed that few of the HPs were very confident or extremely confident that they could screen women for GBV. Overall, the HPs' screening practices for GBV were inadequate. A significant relationship was observed between profession and screening. The proportion of adequate screening practices was higher in respondents who were clinical officers and medical doctors in comparison with those who were Nurses/Midwives.

Close to one third of the HPs report GBV to legal authorities using a variety of reporting types, Over half of the HPs use voluntary and slightly above one third use mandatory type of reporting. Very few of the HPs reported GBV to legal authorities often, and very often. Overall, the HPs reporting practices of GBV were insufficient. A statistically significant relationship was observed between respondents' knowledge level on GBV and reporting practices, training and reporting practices for GBV. When asked if their institution had a written policy/ protocol on how to report GBV to legal authorities, the majority of the respondents indicated that there was none and slightly over one third of the HPs did not know if there was one. Further, very few of the participants were very confident, or extremely confident that they could report GBV to legal authorities.

5.8.2 RECOMMENDATIONS

As a measure to strengthen the role of HPs in the fight against GBV in Kabwe District, the following recommendations are suggested:

1. MoH should review and periodically disseminate updated written guidelines / protocols on GBV management on screening and reporting requirements for GBV by HPs to all health institutions to keep HPs abreast on current GBV management practices.
2. MoH and GNMCH needed to address the gaps identified in screening women for gender based violence by including in depth information on screening and reporting policies and requirements on GBV in the Nursing curriculum.

5.9 DISSEMINATION AND UTILIZATION OF FINDINGS

The findings were disseminated at UNZA post graduate seminar week on 5th June 2019. Bound approved copies of the dissertation were submitted as follows:

- School of Nursing Sciences (UNZA).
- The Medical Library (UNZA)
- In the peer reviewed journal

The abstract of the study will be distributed to MoH, PHO and DHO – kabwe, and Kabwe Central Hospital. The researcher also intends to disseminate the study findings in meetings and seminars that will be taking place in Central province, specifically in Kabwe concerning GBV issues. Information will also be disseminated to the Police victim Support Unit in Kabwe and Non-governmental organizations that deal with GBV such as ASAZA.

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21/52019

APPENDICES

APPENDIX 1: PARTICIPANTS' INFORMATION SHEET

TITLE OF STUDY: KNOWLEDGE, SCREENING AND REPORTING PRACTICES OF HEALTH PROFESSIONALS TOWARDS GENDER BASED VIOLENCE AMONG WOMEN IN KABWE DISTRICT.

INTRODUCTION

My name is Jennipher Akebu N..Soko; a student of Masters of Science in Nursing at the University of Zambia who is kindly requesting for your participation in the research study mentioned. This study is important as it will identify Health Professionals' levels of Knowledge and practices towards Gender Based Violence in women

PURPOSE OF THE STUDY

The study will identify the levels of Knowledge screening and reporting Practices of Health Professionals towards Gender Based Violence in Kabwe District. The information obtained will help the policy makers and implementers of the programme in the Ministry of Health to re-direct programme implementation in order to strengthen the fight against Gender based violence and improve the management of gender based victims in Zambia.

PARTICIPATION

Participation in this study is voluntary. If you are not interested in participating in this study you are free to do so. Even after you have joined the study you are free to withdraw as you wish, and this will not affect your working relationship at this center.

If you are willing to participate, you will be asked to sign a consent and agreement to participate, will not result in any immediate benefits. Please ask where you do not understand.

PROCEDURE

The study involves a set of questions using a structured questionnaire. After signing the consent form, you will be given a self-administered questionnaire to fill in at your convenient time within a period of 2 weeks.

RISKS AND DISCOMFORTS

There is no risk involved in this research though part of your time will be utilized to answer some questions. Some questions may seem to be sensitive and personal. If you will need further discussion, it will be offered to help you understand the topic more.

BENEFITS

There is no direct benefit to you by participating in this study, but the information which will be obtained will help the policy makers to take measures that will ensure that Gender Based Violence is given priority as one of the major public health problems in Zambia. Health Professionals shall receive the necessary training on gender based violence through ongoing capacity building, provision of manuals and management protocols, improved and strengthened networking system. No monetary favors will be given in exchange for information obtained.

CONFIDENTIALITY

Your research records and any information you will give will be confidential to the extent permitted by law. You will be identified by a number, and personal information will not be released without your written permission except when required by law. The Ministry of Health, the ERES Converge IRB or the School of Nursing Sciences may review your records again but this will be done with confidentiality

APPENDIX II: CONSENT FORM

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and discomforts and confidentiality of the study. I further understand that: If I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntary.

I _____ (Names)

Agree to take part in this study.

Signed/thumb: _____

Date: _____

(Participant)

Signed/thumb: _____

Date: _____

(Witness)

Signed/thumb: _____

Date: _____

(Researcher)

PERSONS TO CONTACT FOR PROBLEMS OR QUESTIONS

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APPENDIX III: DATA COLLECTION TOOL (QUESTIONNAIRE)

Questionnaire Number

|_|_|_|_|

**SELF ADMINISTERED QUESTIONNAIRE FOR HEALTH CARE PROVIDERS
THE UNIVERSITY OF ZAMBIA
DEPARTMENT OF NURSING SCIENCES**

**KNOWLEDGE, SCREENING AND REPORTING PRACTICES OF HEALTH
PROFESSIONALS TOWARDS GENDER BASED VIOLENCE IN WOMEN IN KABWE
DISTRICT**

Date of interview (DD/MM/YYYY):|_|_|_|_|/|_|_|_|_|/|_|_|_|_|_|_|_|_|

Clinic/health center Name: _____ Code |_|_|_|_|_|

INSTRUCTIONS FOR THE RESPONDENT

- **Do not** write your name on the questionnaire.
- Answer all the questions in the order they are arranged.
- For questions provided with alternatives, **tick** in the box provided against the most appropriate response(s).
- For questions without alternatives, **write down** your responses in the spaces provided.
- Be assured that all the information will be treated strictly **confidential** and only be used for the intended purpose.
- In this survey, Gender Based Violence means physical abuse by an intimate partner.

SECTION A: DEMOGRAPHIC PROFILE

1. What was your age on your last birthday?

2. What is your sex?

a. Male ☐

b. Female ☐

3. What is your highest professional qualification?

a. Degree ☐

b. Advanced Diploma ☐

c. Diploma ☐

d. College Certificate ☐

4. What is your profession?

a. Nurse/Midwife ☐

b. Medical Doctor ☐

c. Clinical Officer ☐

5. What is your marital status?

a. Single ☐

b. Married ☐

c. Divorced ☐

d. Widowed ☐

6. How long have you been working on your current job?

Question 7

Below is a list of statements about gender based violence, screening and reporting. Indicate whether these statements are true or false, by ticking under yes or no respectively or I don't know if you don't know the answer.

7		Yes	No	I don't know	
A	A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband				☐
B	GBV is very rare among women seeking health services at health institutions				☐
C	Domestic violence affects all sectors of society irrespective of social, economic, cultural and religious values				☐
D	Most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers				☐
E	It is mandatory for Health professionals to report identified cases of GBV to police even if the victim has not agreed or consented to reporting				☐
F	Victims of GBV are required to obtain a police medical report form (medico-legal examination report form) from the police or ASAZA before provision of medical services (except in emergencies).				☐
G	It is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it				☐
H	Clinical care for survivors of GBV require Health care Professionals to obtain an informed consent from victims for any notifications or referral				☐

SECTION C: HEALTH PROFESSIONALS SCREENING PRACTICES

8. In your practice do you ever screen women for GBV?

- a. Yes ☐
- b. No ☐ *IF 'No', skip to Question 11*

☐

9. Below is a list of statements on screening options for GBV. Indicate which statement best describes your practice by ticking one option from the screening options below (**choose 1 option only**)

I screen (ask about GBV) under the following circumstances:

- a. As part of routine history taking for all women who seek medical services ☐
- b. Upon suspicion of GBV e.g. if the woman consults for injuries that are not well explained ☐
- c. Upon self-disclosure, if the woman voluntarily brings up the topic ☐
- d. Any other (explain) _____

☐

10. In the past year how frequent did you perform the screening option chosen in question number 9 above?

- a. Never ☐
- b. Rarely ☐
- c. A few times ☐
- d. Often ☐
- e. Very often ☐

☐

SECTION C: HEALTH PROFESSIONALS REPORTING PRACTICES OF GBV TO LEGAL AUTHORITIES

(NB: reporting can be through a referral, phone call or through a written police medical report form).

1. In your practice do you ever report GBV to legal authorities (Police or ASAZA)?

a. Yes ☐

b. No ☐ **IF 'No', go to Question 14**

12. Below is a list of statements on options for reporting GBV to Police or ASAZA. Indicate the statement that best describes your practice by ticking against the option (**choose 1 option only**)

a. I report GBV to Police/ASAZA even if the victim does not want or consent to reporting ☐

b. I only report GBV if the victim has consented and wants to do so ☐

c. I only report if the injuries are severe and victim is at risk ☐

d. Any other (specify) _____

13. In the past year how frequent did you carry out the reporting option chosen in question number 12 above?

a. Never ☐

b. Rarely ☐

c. A few times ☐

d. Often ☐

e. Very often ☐

14. Does your institution have a written policy (procedures and protocols) on screening women for GBV?

- a. Yes ☐
- b. No ☐ *IF 'No' skip to Question 16*
- c. I don't know ☐ *IF 'you don't know' skip to Question 16*

☐

15. What does the policy state about screening women for Gender Based Violence? (**Choose 1 option only**)

- a. Screening for GBV should be done as part of **routine history** taking for all women who seek medical care ☐
- b. Screening for GBV should be done **on suspicion for GBV** ☐
- c. Screening for GBV should be done **upon self-disclosure**, if the woman voluntarily brings up the topic ☐
- d. Any other (specify)

☐

16. Does your institution have a written policy (procedures and protocol) on how to report Gender Based Violence to Police or ASAZA?

- a. Yes ☐
- b. No ☐ *IF 'No' skip to Question 18*
- c. I don't know ☐ *IF 'you don't know', skip to Question 18*

☐

17. What does the policy state regarding reporting Gender based violence to police or ASAZA (**Choose 1 option only**)

- a. Health professionals should fill in a police (medico - legal examination) reporting form even if the victim does not want or has not given consent. ☐
- b. Health professionals should only fill in a police (medico - legal examination) reporting form if the victim has consented and wants to report ☐
- c. Any other (specify)

☐

18. How confident are you that you can screen women for gender based violence?

- a. Not at all confident ☐
- b. Slightly confident ☐
- c. Moderately confident ☐
- d. Very confident ☐
- e. Extremely confident ☐

☐

19. How confident are you that you can report gender based violence to Police or ASAZA?

- a. Not at all confident ☐
- b. Slightly confident ☐
- c. Moderately confident ☐
- d. Very confident ☐
- e. Extremely confident ☐

☐

20. Do you have any comments on Knowledge, screening and reporting practices of Health Professionals towards GBV in women?

☐

Thank you for participating, you have come to the end.

APPENDIX V: MARKING KEY FOR KNOWLEDGE QUESTIONS

Q7	Variable	Correct response	Score
A	A woman is more likely to be assaulted on the street by unknown men than in her own home by her husband	True	1
B	GBV is very rare among women seeking health services at health institutions	False	1
C	Domestic violence affects all sectors of society irrespective of social, economic, cultural and religious values	True	1
D	Most women victims of GBV would not disclose GBV as the source of their injuries to Health Care Providers	True	1
E	It is mandatory for Health professionals to report identified cases of GBV to police	True	1
F	Victims of GBV are required to obtain a police medical report form (medico-legal examination report form) from the police or ASAZA before provision of medical services (except in emergencies).	False	1
G	It is the role and responsibility of Health professionals to enquire about gender based violence where the victim tries to conceal it.	True	1
H	Clinical care for survivors of GBV require Health care Professionals to obtain an informed consent from victims for any notifications or referral	True	1

Cut off points for levels of knowledge

Low levels of Knowledge: 1 - 4 scores

high levels of knowledge: 5 – 8 scores

APPENDIX VI: SCORE SHEET FOR HPs' SCREENING PRACTICES

Screened clients	Scores
Yes	1
No	0
Maximum score	1
Type of screening	
Part of routine history	3
Upon suspicion for GBV	2
Self-disclosure/ other	1
Maximum score	3
Frequency of GBV screening	
Never	0
Rarely / A few times	1
Often / Very often	2
Maximum score	2
Total screening practice score	6

APPENDIX VII: SCORE SHEET FOR HPs' REPORTING PRACTICES

	Scores
Reported GBV	
Yes	1
No	0
Maximum score	1
Type of reporting	
Mandatory	3
Voluntary	2
Other	1
Maximum score	3
Frequency of GBV reporting	
Never	0
Rarely / A few times	1
Often / Very often	2
Maximum score	2
Total reporting practices score	6



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7th June, 2018

Ref. No. 2015-Apr-005

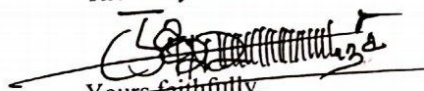
The Principal Investigator
Ms. Akebu Jennipher N. Soko
Kabwe School of Nursing and Midwifery
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

**RE: RENEWAL: "KNOWLEDGE, SCREENING AND REPORTING PRACTICES
OF HEALTH PROFESSIONALS TOWARDS GENDER BASED VIOLENCE
IN KABWE DISTRICT."**

We would like to acknowledge receipt of your end of year progress report dated 25th May, 2019.

The study is renewed for another year. The new expiry date is **12th December, 2020.**


Yours faithfully,
ERES CONVERGE IRB

Dr. Jason Mwanza
Dip. Clin. Med. Sc., BA., M.Soc., PhD
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21st December, 2017

Ref. No. 2015-Apr-005

The Principal Investigator
Ms. Akebu Jennipher N. Soko
Kabwe School of Nursing and Midwifery
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

**RE: KNOWLEDGE AND PRACTICES OF HEALTH PROFESSIONAL
TOWARDS GENDER BASED VIOLENCE IN KABWE DISTRICT.**

We would like to acknowledge receipt of your late reports. In future please ensure timely reports. The study is renewed for another year. New expiry date is **13th December, 2018.**

Please note that your next report is due before **13th June, 2018.**

Yours faithfully,
ERES CONVERGE IRB

Prof. E. Munahula-Nkandu
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16th January, 2018

Ref. No. 2015-Apr-005

The Principal Investigator
Ms. Akebu Jennipher N. Soko
Kabwe School of Nursing and Midwifery
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

**RE: AMENDMENTS "KNOWLEDGE AND PRACTICES OF HEALTH
PROFESSIONALS TOWARDS GENDER BASED VIOLENCE IN KABWE
DISTRICT."**

Reference is made to your submission dated 21st November, 2017.

The amendments are approved as submitted.

Yours faithfully,
ERES CONVERGE IRB


Prof. Esther Munalula-Nkandu
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15th June, 2018

Ref. No. 2015-April-005

The Principal Investigator
Ms. Jennipher Akebu N. Soko
Kabwe School of Nursing
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

RE: 6 MONTHS REPORT "KNOWLEDGE AND PRACTICES OF HEALTH PROFESSIONALS TOWARDS SCREENING AND REPORTING OF GENDER BASED VIOLENCE TO LEGAL AUTHORITIES IN KABWE DISTRICT".

We would like to acknowledge receipt of your 6 months progress report dated 11th June, 2018.

Please advise us when your thesis has been marked.

Yours faithfully,
ERES CONVERGE IRB

Prof. E. Munalula-Nkandu
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The Principal Investigator
Ms. Akebu Jennipher N. Soko
Kabwe School of Nursing and Midwifery
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

**RE: RENEWAL "KNOWLEDGE AND PRACTICES OF HEALTH
PROFESSIONALS TOWARDS GENDER BASED VIOLENCE IN KABWE
DISTRICT."**

Reference is made to your submission dated 6th December, 2018.

Extension for 6months is granted.

Yours faithfully,
ERES CONVERGE IRB

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14th December, 2016

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The Principal Investigator
Ms. Akebu Jennipher N. Soko
Kabwe School of Nursing and Midwifery
P.O. Box 80784,
KABWE.

Dear Ms. Soko,

**RE: KNOWLEDGE AND PRACTICES OF HEALTH PROFESSIONAL
TOWARDS GENDER BASED VIOLENCE IN KABWE DISTRICT.**

Reference is made to your corrections dated 14th December, 2016. The IRB resolved to approve this study and your participation as Principal Investigator for a period of one year.

Review Type	Fast track	Approval No. 2015-Apr-005
Approval and Expiry Date	Approval Date: 14 th December, 2016	Expiry Date: 13 th December, 2017
Protocol Version and Date	Version - Nil.	13 th December, 2017
Information Sheet, Consent Forms and Dates	• English.	13 th December, 2017
Consent form ID and Date	Version - Nil	13 th December, 2017
Recruitment Materials	Nil	13 th December, 2017
Other Study Documents	Questionnaire.	13 th December, 2017
Number of participants approved for study	207	13 th December, 2017

Specific conditions will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

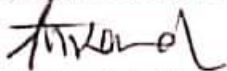
Conditions of Approval

- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review process. Any documents received less than 30 days before expiry will be labelled "late submissions" and will incur a penalty.
- Every 6 (six) months a progress report form supplied by ERES IRB must be filled in and submitted to us.
- A reprint of this letter shall be done at a fee.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of ERES Converge IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,
ERES CONVERGE IRB



Prof. E. Munalula-Nkandu
BSc (Hons), MSc, MA Bioethics, PgD R/Ethics, PhD
CHAIRPERSON



REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
KABWE GENERAL HOSPITAL

All correspondence to be addressed to the Medical Superintendent and not to individuals

Our Ref: KGH/CP/MH/101/1/1
Your Ref:

P.O. Box 80917 KABWE
Tel: 260-5-222301-6 TelFax: 260-5-223049
Cell No. 0976-776001
Email: kabwegeneral@gmail.com

21st April, 2015

Ms. Jennipher Akebu N. Soko
Kabwe School of Nursing and Midwifery
P.O Box 80784
KABWE

**RE: REQUEST FOR AUTHORITY TO CONDUCT A RESEARCH STUDY AT KABWE
GENERAL HOSPITAL**

Following your request to conduct a research study "Knowledge and Practices of Health Care Professional on Gender Based Violence in Kabwe District" at Kabwe General Hospital, I am pleased to inform you that your request has been granted.

We look forward to learn from your study.

Dr. Lango Simbeye
Ag/Medical Superintendent
KABWE GENERAL HOSPITAL

45

Kabwe School of Nursing and Midwifery
P.O Box 80784
Kabwe

4th March 2015

The Provincial Medical Officer
Provincial Medical Office
Kabwe

Pro-stands / SA
10.03.2015



Dear Madam,

**RE: REQUESTING FOR PERMISSION TO CONDUCT A RESEARCH
STUDY IN KABWE DISTRICT**

I am a student at the University Of Zambia, Department Of Nursing Sciences pursuing a Master of Science in Nursing. In part of fulfillment of this programme, I am required to conduct a research study. My topic is Knowledge and Practices of Health Care Professionals on Gender Based Violence in Kabwe District. The study will involve interviewing Doctors, Nurses and Clinical Officers in health institutions within Kabwe District. The study will be undertaken in March, 2015.

Your consideration of my request will be highly appreciated.

Yours faithfully,

Jennipher N. Soko

Cc: The District Medical Officer
Cc: The Medical Superintendent – KGH
Cc: The In charges - RHCs

Permission
granted.

Please share your
findings with
us.

11/03/15

Telephone: 224214
Telegrams: PERMSEC:KABWE
Fax: 224250



REPUBLIC OF ZAMBIA

OFFICE OF THE PRESIDENT

PROVINCIAL ADMINISTRATION
CENTRAL PROVINCE
P.O BOX 80903
KABWE

In reply please quote

No.

CPPA 101/1/18

April 17, 2015

Jennifer Akebu N. Soko
Kabwe School of Nursing and Midwifery
Box 80784
KABWE

RE REQUEST FOR AUTHORITY TO CONDUCT A RESEARCH STUDY IN KABWE DISTRICT

Reference is made to your letter dated 9th April, 2015 in which you requested my office for authority to conduct a research study in Kabwe District.

I am pleased to inform you that authority has been granted for you to do the research.

Edwidge K M Mutale
Permanent Secretary
CENTRAL PROVINCE

/cc*



THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

Telephone : +260211252641

Telegram: UNZA, Lusaka

Telex: UNZALU ZA 44370

Email: assistantdeanpgmedicine@unza.zm

P.O Box 50110

Lusaka, Zambia

22nd January, 2015

Ms. Akebu Jennipher N. Soko
Department of Nursing Sciences
School of Medicine
UNZA
LUSAKA

Dear Ms. Soko,

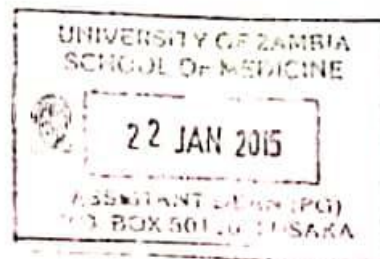
RE: GRADUATE PROPOSAL PRESENTATION FORUM

Having assessed your dissertation entitled "Knowledge and Practices of Health Professionals Towards Gender Based Violence in Kabwe District". We are satisfied that all the corrections to your research proposal have been done. The proposal meets the standard as laid down by the Board of Graduate Studies.

You can proceed and present to the Research Ethics.

Yours faithfully,

Dr. S.H. Nzala
ASSISTANT DEAN, POSTGRADUATE
CC: HOD, Nursing Sciences



The Provincial Medical Officer
Kabwe Provincial Health Office
KABWE.

02/03/2015

UFS: The Head of Department
Department of Nursing Sciences
School of Medicine (UNZA)
LUSAKA.

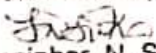
Dear Sir/Madam,

Re: Requesting for Permission to Conduct a Research Study in Kabwe District

I am a student at the above mentioned institution pursuing a Master of Science in Nursing. In part of fulfillment of this programme, I am required to conduct a research study. My topic is entitled "Knowledge and Practices of Health Care Professionals Towards Gender Based Violence in Kabwe District". The study will involve interviewing Doctors, Nurses and Clinical Officers in health institutions within Kabwe District. The study will be undertaken in March, 2015.

Your consideration of my request will be highly appreciated.

Yours Faithfully,


Jennipher, N. Soko