INTIMATE PARTNER VIOLENCE SCREENING IN PREGNANT WOMEN ATTENDING ANTENATAL CARE: FACILITATORS AND BARRIERS AMONG THE HEALTHCARE PROVIDERS AT MBEYA ZONAL REFERRAL HOSPITAL.

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By

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A Dissertation Proposal Submitted in (Partial) Fulfilment for The Requirements of Degree in Master of Medicine in Obstetrics and Gynaecology

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled **"Intimate partner violence screening in pregnancy women attending antenatal care: facilitators and barriers among the healthcare providers at Mbeya zonal referral hospital"** in partial fulfilment of the requirements for the Degree Award of Master of Medicine in Obstetrics and Gynaecology of Muhimbili University of Health and Allied Sciences.

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DECLARATION AND COPYRIGHT

I, Rongóra Masoya Turuka, declare that this dissertation is my original work and that has not been presented and will not be presented to any other University for a similar or other degree award.

Signature …… Date ……

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DEDICATION

I dedicate this research to my Late father Laurent Nyambabe, my late mother Christina Mkami, my grandmother Paulina Nyabiage, and my beloved brother Warento Nyambabe.

ABSTRACT

Background: Intimate partner violence (IPV) is a global health concern. In pregnancy, IPV has maternal and foetal dire consequences. Tanzania initiated IPV screening during pregnancy in 2018. However, the uptake and implementation of this initiative have been slow and inconsistent.

Aim: The study aims to explore facilitators and barriers to IPV screening during pregnancy among the healthcare providers at Mbeya Zonal Referral Hospital

Methods: This exploratory qualitative study used in-depth interviews with eleven purposefully selected healthcare providers at a zonal referral hospital. The interviews were audio-recorded and transcribed verbatim. Data were analysed using thematic analysis with the aid of QDA-Miner.

Results: Healthcare providers reported lacking screening tools including guidelines, clear pathways for helping IPV victims, and low institutional and leadership support undermined them to screen women. Healthcare providers' knowledge, training, experience, and trusting provider-women relationships facilitate dialogue and screening of women. While, social-cultural norms, fear of negative consequences, and perceiving IPV as a family secret deter women from reporting or avoiding IPV screening. Furthermore, healthcare services are structured in a way that prioritizes organic illness and pregnancy-related care and downplays other significant but nonvisible conditions like IPV.

Conclusion: Our findings highlight the need to organize and improve coordination between the health sector, the local health facilities, and the community to empower healthcare providers to conduct thorough IPV screening. Community awareness campaigns to encourage women to shift attitudes toward IPV disclosure voluntarily are also necessary.

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LIST OF ABBREVIATIONS

ACOG	American College of Obstetrics and Gynaecology
ACN-M	American College of Nursing-Midwifery
ANC	Antenatal Care
CTC	Care and Treatment Centre
GBV	Gender-Based Violence
HCPs	Health Care Providers
IPV	Intimate Partner Violence
LMICs	Low and Middle-Income Countries
MZRH	Mbeya Zonal Referral Hospital
MUHAS	Muhimbili University of Health and Allied Sciences
PI	Principal Investigator
PTSD	Post Traumatic Stress Disorder
RHU	Reproductive Health Unit
SIGI	Social Institution and Gender Index
SWO	Social Welfare Officer
UK	United Kingdom
UN	United Nations
USA	United States of America
USPSTF	United States Preventive Services Task Force
VAC	Violence Against Children
WHO	World Health Organization

OPERATIONAL DEFINITIONS

Barriers	Programmatic obstacles that limit the effective delivery of a public health or healthcare program for the people. In this study, it will include individual and healthcare system barriers hindering intimate partner violence.
Facilitators	Factors that contribute to the sustainability of implementation, intervention, or service delivery. In this study, it will include all the individual and healthcare system factors contributing to intimate partner violence screening and its sustainability.
Healthcare Provider	An individual licensed to provide healthcare services including diagnosis and treatment of medical conditions. In this study, it includes medical specialist, medical officer, Nurse-midwife, and social welfare officer.
Intimate Partner	Refers to both current and former spouses and dating partners.
Intimate partner violence	A conduct by a current or former partner, spouse, or both, inside an intimate relationship that results in physical, sexual, or psychological harm. This conduct can include physical aggression, sexual coercion, psychological abuse, and controlling behaviours.

1.0 INTRODUCTION

1.1 Background

All human beings have civil rights without ever facing sex-based discrimination, according to the Universal Declaration of Human Rights (1). Intimate partner violence (IPV) is a form of gender-based abuse that manifests in the form of physical, sexual, economic, and psychological violence, and controlling behaviour (2,3). Although IPV affects both females and males, the prevalence of IPV against women is 30% and varies across regions (3–5). Worldwide, 28.4% of women experience IPV, and physical violence tops at 78%, (6). East African countries have IPV rates of 37% during pregnancy (7), and in Tanzania, pregnant women succumbing to IPV match the global rates (8). In the Mbeya region where all perpetrators are fathers of expected children IPV affects almost one in ten women during pregnancy (9).

Complications of IPV during pregnancy include induced abortions, pregnancy losses, preterm birth, low birth weight, infections like HIV, Hepatitis B, and urinary tract infections (10,11). More than 40% of IPV survivors experience mental health conditions like anxiety, depression, PTSD, sleep disturbances, substance abuse, self-harm, and suicidal behaviour (8). Pregnant women may also suffer from emotional detachment, which affects the way they bond with their babies; also, stigma and rejection from families; and even deaths (3,12).

Antenatal care guidelines like the World Health Organization 2016 and Tanzania Ministry of Health among others recommend IPV screening in pregnant women (11,13–15). Nevertheless, global screening rates for IPV remain relatively low, between 5 and 15% (16,17). The low screening rates mismatch the soaring rates of the global IPV. Currently, only a few studies specific to Africa show IPV screening rates throughout the continent.

Facilitators for IPV screening include women presenting with physical or emotional signs, IPV training, trusting provider-women relationships, knowledge of IPV forms and their complications during pregnancy, the presence of screening protocols, and employer support (18–20). Barriers include understaffing, time constraints, a high number of patients, lack of

referrals and linkage services, providers' safety concerns, women's underreporting, and fear of escalation (19,21–23)**.**

Healthcare providers (HCPs) ought to play a significant role in the screening and identification of IPV during pregnancy (24). Maternal HCPs should recognize the prevalence and effects of IPV in pregnant women and offer screening that may help link survivors to other related services like counselling and/or legal aids (12,25,26).

1.2 Problem Statement

The prevalence of IPV during pregnancy is 30% (6), which is the same as in Tanzania (8–10,27). Tanzania in its 2018 ANC guideline adaptions from the WHO guidelines, directs IPV screening for pregnant women in all the ANC contacts (15). The World Health Organization advises HCPs to evaluate and treat IPV survivors using a comprehensive approach (28).

Despite the widespread global directives on regular IPV screening, the reported IPV screening rates during pregnancy are as low as 15% (25,29,30). Many HCPs may not view screening as a component of their job, many feel unprepared, and there is a worry of upsetting and risking the safety of women (31–35).

Healthcare providers must understand that screening offers numerous benefits for both the mother and the expected child. It helps identify immediate safety needs and provides a unique opportunity during ANC to improve maternal and neonatal outcomes through IPV screening.

1.3 Theoretical Framework

Several factors affect IPV screening. Individual HCPs factors, healthcare system-related factors, and community factors sometimes promote or hinder IPV screening during pregnancy. These factors act at the epicentre and affect HCPs screening practices for IPV during pregnancy.

Healthcare systems may directly or indirectly foster or jeopardize IPV screening. They directly lower IPV screening for instance by failing to equip HCPs with time-to-time training and

seminars for IPV screening. Indirectly, this may occur by unintentionally posing a non-conducive environment for IPV screening for example by not employing adequate HCPs, lack of screening tools, guidelines for IPV screening, and lack of continuum of care in managing IPV victims.

Society, on the other hand, influences IPV screening in various ways. This happens due to the existing customs and traditions that have been normalized. Some of the HCPs find it challenging to screen for IPV because of this normalization. They believe that by doing so, they will be violating their cultural practices because they are a part of the larger society (34). These behaviours include, for example, husbands viewing their wives' beatings as a sign of their love (36), and having sex without the wives' consent since it is their responsibility to satiate their male partners' sexual cravings (37). Apart from making it hard for HCPs to screen for IPV in one way or another, these normalized doings also bar women from disclosing their IPV status (23,38).

As a point of reference, HCPs have a variety of characteristics that either encourage or inhibit pregnant women from getting screened for IPV. A few of these variables include the attitudes of certain providers as well as their lack of ability, expertise, and understanding of IPV screening which may be the result of inadequate IPV training and updates (34,39). Another important reason is lack of time, which is mostly caused by inadequate assistance from the healthcare system (19,40).

The figure 1, below shows how these factors interact with each other and finally influence IPV screening in pregnant women.

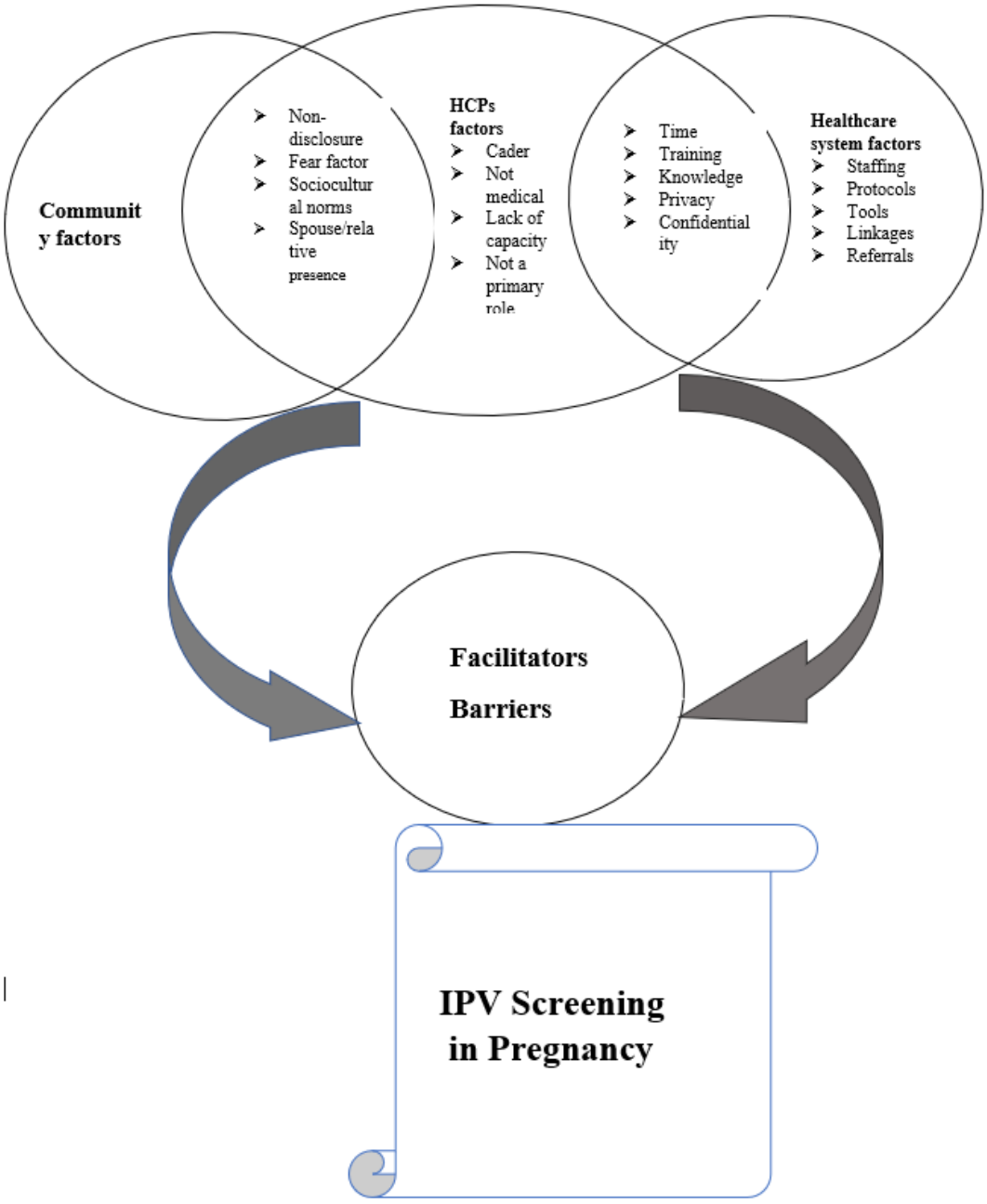


Figure 1: **The theoretical framework showing different factors that can influence intimate partner screening during pregnancy as created by the researcher**

1.4 Rationale

Few studies exist that focus on Tanzanian HCPs perceptions, practices, and experiences with IPV screening during pregnancy. Enhancing ANC services and screening of expectant mothers for IPV should go hand in hand since the IPV rates are high but screening practices seem to be low.

Findings from this study can be used by the HCPs to set strategies to ensure all pregnant women are screened for IPV during the ANC visits to reduce adverse outcomes both to the mothers and the new-borns. Furthermore, these findings can be used by policymakers to formulate policies and guidelines that can enhance IPV screening during the ANC and other contacts with the HCPs.

1.5 Research Questions

1. What facilitates HCPs to screen for IPV in pregnant women?
2. What hinders HCPs from screening pregnant for IPV during ANC?

1.6 Study Objectives

1.6.1 Broad Objective

To examine the facilitators and barriers among HCPs for IPV screening in pregnant women at Mbeya Zonal Referral Hospital.

1.6.2 Specific Objectives

1. To explore factors that facilitate IPV screening in pregnant women during ANC.
2. To explore factors that hinder IPV screening in pregnant women during ANC.

2.0 LITERATURE REVIEW

The pregnancy period is one of the few occasions that women attend healthcare facilities and interact with HCPs without raising any red flags. This is due to the expectation that pregnant women will visit medical institutions for ANC and delivery services. Yet, since going to a medical institution is not a common practice in a non-pregnancy stage and without any physical abnormalities, family members and community members may have concerns. Some HCPs might not view IPV screening as a part of their work, and many of them would feel unprepared due to a variety of reasons, including a heavy patient load, lack of screening instruments, limited time, and lack of training (19,22)**.**

2.1 Healthcare system-related facilitators and barrier factors

Training for HCPs on IPV-related issues, the level of education, and knowledge, and provider experience, may facilitate or bar IPV screening. In the USA, Canada, and Jordan training and imparting IPV knowledge on HCPs have been linked with higher levels of IPV screening (18,29,41,42). However, lack of training among HCPs has been shown to lower IPV screening in Namibia, Uganda, and Tanzania (22,36). Training on the proper use of IPV screening tools has positive impacts on spousal violence screening in Tanzania (21). Healthcare providers' timely and focused training serves as the backbone for any screening, including screening for IPV during pregnancy. Healthcare providers should be offered time-to-time IPV training, workshops, and refresher courses on the effective ways to probe for IPV during pregnancy.

The burden of inadequate HCPs varies from country to country. In LMICs like Thailand Colombia, Uganda, and Tanzania HCPs shortage is a greater barrier to IPV screening (19,22,37,43). The limited number of HCPs reciprocates to lack of time and the sheer number of patients during consultations, leading to lower IPV inquiries in our health facility settings. Regular HCPs retention, recruitment, and employment would increase the number of HCPs which will reduce the workload and hence increase screening routines.

Screening tools and IPV protocols like IPV-Screening and Assessment Tier introduced in the US which is a framework and decision-making protocol for conducting IPV screening (44), facilitate IPV screening, and give algorithms for the provision of other services to women who screen positive for IPV. Screening tools and protocols for IPV in the US, are key facilitators of IPV screening though some HCPs are unaware of their presence (45). Protocols and IPV tools knowledge by HCPs is reported in Norway, Malaysia, Thailand, and Colombia (19,34,40,43). in Tanzania, screening tools are available and have been shown to facilitate IPV screening in the eastern parts of the country (21). In South Africa and Uganda, there are no IPV screening tools and protocols in the health facilities, thus creating a barrier to IPV screening (22,37,46). The availability of IPV tools and protocols is an important component in IPV screening and thus should be made available.

Systematic reviews have reported that employer support facilitates IPV screening (47). The same findings have been echoed in the USA and (20). In Norway, poor support from the health system has staggered screening (40); same as in Thailand (43). Healthcare systems, through their respective jurisdictions, ought to offer maximum support to their HCPs to motivate them to screen for IPV. This could be in the form of positive reinforcements, providing screening tools and IPV management protocols, and ensuring a conducive and well-secured consultation environment for HCPs and their patients' engagements.

Time constraints and inadequate privacy during consultations have been reported to downgrade IPV screening. These factors have been reported to have negative effects on IPV screening in Europe, America, and Asia (39,43,48). The same experience has been reported in South Africa (46) and East African countries (21,22,37). These factors of the time limit and diminished privacy for IPV screening are explained partly by the failure to meet the doctors-to-patient ratio, especially in LMICs like Tanzania, which is 0.51 to 1.54 per 10,000 instead of the recommended 8,000 by the World Health Organization. Thus, pushes for more efforts to be invested in the retention and employment of more HCPs especially in the LMICs to meet the recommended standards.

Referrals and linking of IPV survivors are highly recommended as good clinical practice (11). Systematic reviews have pointed out that IPV screening is hindered where there are no linkages and referrals for IPV patients (47). In the USA, the availability of on-time referral services is a key factor that facilitates IPV screening (49). In the United Kingdom (UK) and Malaysia, though referral systems are in place, HCPs hesitate to link IPV patients due to safety concerns (34,50). IPV survivors during pregnancy, just like non-pregnant women, need psychological, emotional, social, and even legal support. The availability of safety on-time linkage services such as appropriate horizontal and vertical referrals for pregnant women experiencing IPV will accentuate the screening of the same by HCPs.

2.2 Healthcare providers' perceptions, facilitators, and barriers

Systematic reviews have reported that HCPs fear repercussions to IPV survivors by their spouses if they disclose violence (32). This fear of retaliation by partners has failed IPV screening by up to 82% in the USA (31), and the UK (51). In Namibia, a large percentage of HCPs claim that the fear of IPV survivors by their perpetrator spouses makes them not open up easily even if they are being probed for IPV (23). Fear factor among IPV pregnant mothers that prohibits disclosure of their IPV status has also been reported in Uganda (36,37). Lack of trust by the IPV survivors in HCPs, societal norms, customs, and traditions, and lack of adequate privacy and confidentiality in many healthcare facilities may explain the fear factor encountered by IPV pregnant patients when they are probed for IPV.

Some HCPs argue about their role in IPV screening; in the USA, HCPs deal only with physical symptoms, depression, and anxiety, and they call the police and other supportive agencies to deal with IPV issues (52). In the UK, midwives argue that IPV screening is not their role as they have a lot to do (51). In Uganda, HCPs stress that IPV screening is more for social and domestic, and less for medical or clinical HCPs (37). These arguments would be masked by the fact that HCPs are not well equipped with the knowledge, education, skills, and competence to screen for IPV, and by the sheer number of patients that force HCPs to treat symptoms instead of managing patients as a whole. Some of the IPV victims may present with physical and/or

emotional signs and symptoms; thus, holistic approaches to their management are recommended.

Scientific reviews have noted that the lack of capacity by individual HCPs blocks IPV screening (29,47). These findings are consistent with studies done in the USA and UK (31,50,53). However, within the USA, some HCPs claim to have full capacity to offer help to IPV survivors (20). In Malaysia, contrasting findings show that some HCPs can manage IPV victims while others complain of ineffective strategies to do the same (34). Diminished capacity to help IPV patients has been studied and reported in Ghana, Namibia, and Tanzania, respectively (21,23,54). Though, the lack of individual capacity by the HCPs to screen and help IPV patients is a global challenge, the problem is highly experienced in LMICs. Offering time-to-time updates on IPV screening and related issues and providing adequate training to improve HCPs' knowledge of IPV screening would ameliorate this challenge.

Different cadres and ranks among HCPs are other factors affecting IPV screening. Clinicians and obstetrician-gynaecologists in the USA have been ranked lowest among nurses in IPV screening (25,31,49). Social welfare officers are ranked first in Australia and Turkey followed by nurses in matters of IPV screening (55). This difference among the HCP cadres in matters of IPV screening could be explained by the fact that some of the cadres, like clinicians, have been trained to mainly offer treatment services to patients with physical symptoms and signs. The other reason that can explain this discrepancy is the minimal time spent by the clinicians with patients when compared with the nurses and other lower cadres. Improvement in the training curriculum and on-the-job IPV training for all HCPs is essential to deal with this notion.

2.3 Social cultural and Community factors

Reports from the World Health Organization, indicate that partner presence improves the quality of care during the birthing process and has been put in the intrapartum care guidelines (56). However, partner presence in some other services like ANC has been indicated to lower IPV screening in the USA, Australia, Norway, and Turkey (39,40,55,57). In Uganda, HCPs fear

screening for IPV in partners' presence (36). This calls for HCPs' provision of training, skills, and equipped with knowledge on how to probe for IPV in situations where partners or other relatives are present without causing further consequences to pregnant women and themselves.

Socio-cultural norms in the UK have made midwives sceptical of IPV screening and argue instead that, survivors are the ones to stand up for their rights (51). Contrary to this, in Serbia, HCPs strongly believe that violence against women is never acceptable and not justifiable by any means (58). In Uganda, arguments among HCPs are that women are inferior to men and are married to sexually entertain men, so disciplining them whenever it deems necessary is not a problem (36). Other perceived norms by the HCPs in Uganda to justify IPV are that beating women is a sign of love, a way of correcting them, and an accepted cultural practice, and even marital rape is non-existent since women should satisfy their husbands' sexual desires (37). Healthcare providers are an integral part of the entire society, and these norms and traditions may in one way, or another prevent them from screening for IPV in pregnant women.

Systematic reviews report clearly that patients' non-disclosure and bizarre presentations obliterate IPV screening (32). In the USA, patients' non-disclosure negatively impacts IPV screening by almost 78% (31). In the UK and Malaysia, on the other hand, IPV patients present with non-specific symptoms that need thorough probing for IPV disclosure (50,59). The same experience has been reported in Colombia and Ethiopia respectively (60,61). In Tanzania, HCPs believe that up to 25% of IPV victims will not disclose the abuse even if they are probed for it (62). This failure of women to disclose IPV may be partly confounded by the fact that they fear escalating IPV from their partners as has been shown in places like India (38). On the other hand, HCPs should not be reluctant; they need to employ extra efforts to persuade pregnant women to disclose their IPV status during inquiries.

Tanzania is one of the countries with the highest prevalence of IPV during pregnancy, and in almost all the reported cases, the culprits are the women's partners, husbands, or spouses. Knowing the factors that affect HCPs either positively or negatively to screen for IPV is of paramount importance. The essence of this research is to help explore the facilitators and barriers to IPV screening among the HCPs attending pregnant women in ANC clinics.

3.0 METHODOLOGY

3.1 Study Design

A hospital-based transcendental phenomenological study design was used to explore the HCPs facilitators and barriers for the screening of IPV in pregnant women attending ANC.

3.2 Study period

The study was conducted between November 2022 and June 2024. This includes the period from concept development to report writing and submission

3.2 Study Setting

The study was conducted at Mbeya Zonal Referral Hospital**,** found in Mbeya City, which is the headquarters of a southern region of Mbeya. Mbeya Zonal Referral Hospital is a tertiary zonal hospital in a catchment service area of about six million people, whereas men are three million and women are three million according to the Tanzania Population Census of 2022 report. The hospital's Obstetrics and Gynaecology (Meta Maternity Wing) is located almost 2 kilometres away from the main premises of the hospital.

Meta Maternity Wing has an inpatient bed capacity of 300 but also offers ANC and postnatal care (PNC) services averaging 60 and 20 patients daily respectively. The department is currently staffed by 117 nurse-midwives (both EN and RN) and 20 clinicians. Among these clinicians, 14 are Obstetricians-Gynaecologists, and the remaining are medical officers. This maternity wing also enjoys a vast number of intern doctors and nurse-midwives. It is also a teaching hospital department for medical students from the University of Dar es Salaam, Mbeya College of Health, and Allied Sciences. The premises of the Meta Maternity Wing also accommodate the Neonatal unit of the Paediatrics department. It also accommodates the National Blood Transfusion Services of the Southern Highlands Zone headquarters.

One of the key primary services provided at the Meta Maternity Wing is ANC to both low-risk and high-risk pregnant mothers. Antenatal care services for low-risk women are provided from Mondays through Fridays at the RHU and Nurse-midwives assigned in this area provide both consultation and other ANC services. When the Nurse-midwives at RHU encounter high-risk patients, they transfer them to the high-risk clinic which is a 100-meter walking distance within the hospital premises. For high-risk patients, official clinics are done on Mondays and Thursdays. At high-risk clinics, clinicians provide consultation services and management of disease conditions that patients present with. The total number of pregnant and pregnancy-related conditions patients attended per week in both the low-risk and high-risk ANC is almost two hundred and fifty.

The department implements the 2018 ANC guideline that directs IPV screening during the contacts. Some HCPs have attended GBV training and others are national GBV trainers. When patients screen positive for partner violence, they are investigated for infectious diseases like HIV, Syphilis, and Hepatitis B and managed accordingly. They are then linked to social welfare officers, and psychologists for more assistance and support.

Some of the clinicians and Nurse-midwives have been trained to provide services to GBV and VAC survivors using Tanzania's national gender-based violence guidelines. Since there is no national guideline for the screening and management of IPV in pregnant women, GBV guideline is used instead. Each healthcare provider attending patients is obliged to screen for GBV by using this tool if conditions allow.

Mbeya Zonal Referral Hospital was chosen for this study due to several reasons. First, it is the only tertiary referral hospital in the Southern Highlands zone and therefore is the highest referral centre for pregnant women both the high-risk and those who wish to go for specialized services from the four regions of Mbeya, Rukwa, Katavi, and Njombe. Second, some of the clinicians and nurse-midwives have been trained to screen and offer GBV services to the patients. Third, it is implementing the 2018 ANC model that requires screening for IPV in pregnant women during their attendance for ANC services. And fourth, the hospital is located in the region with

the highest lifetime prevalence of IPV which is 66.7% according to the Social Institution and Gender Index (SIGI) survey report of 2021.

Furthermore, it has the highest reported IPV prevalence during pregnancy of up to 12% in which 100% of perpetrators, are the fathers of the expected children (9).

3.3 Study Population

The study was conducted among the clinicians and nurse-midwives who attend to pregnant women during the ANC, and social welfare officers. The total number of the study participants was thirty-four. This number included 20 clinicians (both specialists and medical officers), 11 nurse-midwives from the reproductive health unit, and 3 Social welfare officers.

3.4 Sample Size and Sampling Strategy

A maximum variation (heterogenous) purposive sampling technique was used.

In this study, HCPs were purposefully chosen from among the clinicians, nurse-midwives, and social welfare officers. To maximize the variability of the participants, the categorization of the HCPs was carried out and four categories were formed. Clinicians were purposely grouped into two categories: Specialists who were 14, and medical officers II (Registrars) who were 6. The eleven nurse-midwives who are stationed at RHU were in the third category. Social welfare officers formed the fourth category.

The reason for this categorization was to have representation from both hierarchies of the HCPs in terms of levels of knowledge and years of working experience. This is because medical specialists, medical officers, and Nurse-midwives have varying degrees of knowledge, exposure, and understanding of the issues related to IPV. After all, they differ in their years of training.

At Meta maternity hospital, at the low-risk ANC (RHU clinic) women are attended by nurse-midwives, and in high-risk clinics, they are seen by clinicians. A minimum of 12 participants

were targeted from the mentioned categories but only eleven of them took part in the study. The participants who took part in this study up to the point of theoretical saturation were eleven, that is six Clinicians, four Nurse-midwives, and one social welfare officer.

To introduce the study, the principal investigator spoke with the clinicians, nurse-midwives, and social officers in their respective areas of service delivery. Interviews took place at official working hours and happened within the hospital; for clinicians, this happened in a room neighbouring the office of the head of the department; for nurse-midwives, interviews took place in one of the isolated rooms in RHU; and for social welfare officer, it happened on the SWO office. *3.*6 Inclusion and Exclusion Criteria

3.6.1 Inclusion Criteria

- Clinicians, nurse-midwives, and social welfare officers involved in ANC services.
- Healthcare providers who had direct contact with pregnant women during ANC, including screening for IPV.
- Both male and female HCPs who were physically present during the study period.

3.6.2 Exclusion Criteria

- Healthcare providers who were absent (on leave or training) during the study period.
- Healthcare providers who did not consent to participate in the study

3.7 Data collection tool.

Data collection was done by an interview guide adapted from Namibia (23). The guide was modified and translated from English to Swahili and then back to English to fit the Tanzania context. The guide had open-ended questions supplemented by prompt probing statements on the facilitators and barriers for IPV screening services from the provider's viewpoint. Other issues covered in this interview guide included familiarity with and understanding of IPV and its complications during pregnancy, IPV training received, screening practices, negative and positive perceptions for IPV screening, and suggestions for improvement.

3.8 Data Collection Process

The principal investigator (PI) attended the training session on Basic Qualitative Research engineered by the Directorate of Continuing Education and Professional Development of MUHAS. Additional training sessions were obtained online including Philip Adu, PhD, a methodology expert from the National Centre for Academic and Dissertation Excellence (NCADE), Chicago School of Professional Psychology.

Participants were contacted and details and the essence of the study were provided to each of them. In-depth Swahili interviews lasting between 33 – 57 minutes were conducted to examine the facilitators, and barriers for the screening pregnant women for IPV during ANC. With the participant's permission, interviews were audio-recorded to accurately capture the participant's responses. Each interview had field notes collected either during or immediately following it. These interviews took place during the official working hours and official working days of the week (Mondays to Fridays) within the hospital settings.

3.9 Data management and analysis process

The process of data management and analysis went through a series of steps:

3.9.1 Data transcription

All the interviews were transcribed verbatim by the PI to preserve the originality of the data. After transcription, the resulting transcripts were shared with the supervisors after redacting identifiable information of the participants.

3.9.2 Data organization

A clear and organized system of storing data was created whereby folders were formed and the audio recordings and transcribed documents were transferred and stored electronically. The recordings and transcriptions from each participant were labelled and securely stored. This electronic information (audio and transcripts) was destroyed after the analysis process was complete.

3.9.3 Data coding

Interviews were conducted in Swahili, a language fluent to both the researcher and the participants. Therefore, coding was also done in Swahili to retain the original meanings of the data. This mode of coding and analysis is supported by works of existing literature (63,64).

Computer-assisted qualitative data analysis software (CAQDAS) QDA – Miner was used for the coding process. The essence of the use of this software was that it gave room for the creation of a single code for the same response from different participants. The other advantage is that it is easy to retrieve the coded segments and their respective codes and make corrections, rearrangements, and deletions of codes whenever necessary. The last benefit of QDA–Miner is that the coded information can be retrieved and saved in an Excel sheet, and this makes subsequent process of analysis achievable.

3.9.3.1 Data coding steps

The coding process went through the following rigorous steps:

Initial coding of one transcript was done by the researcher who shared the codes with the thesis supervisors. Then another coding was conducted together by the researcher and the supervisors and the codes to be used were agreed upon. The same transcript that the researcher and the supervisors coded together with the research questions were shared with other qualitative researchers (fellow students) who were doing qualitative studies so that they could code on their own. Open coding was done by three of the five researchers who were given the transcripts and

research questions. A session was then held that brought together the PI and the other qualitative researchers to discuss the codes. Scrutiny was done by going through the coded transcript from the beginning to the end while perusing through the codes generated by each member. There were similar codes though with different words that were coded by the researcher and the other qualitative counterparts, other codes were new, that is the PI did not code them in the first place. Following a thorough discussion, some of the codes that the PI had, were rejected, some were accepted, others adapted, and new codes were created. The PI used the final codes to finalize the coding of the remaining transcripts and then proceeded with the rest of the analysis.

3.12 Data analysis.

Thematic analysis as inspired by Clarke and Braun was used which has the following six steps:

First, data was familiarized by reading through it several times. This was followed by the generation of initial codes. The third step was the creation of sub-themes that were the sub-grouped and themes were born. These themes were reviewed and refined forming the fourth and fifth steps. Finally, report writing of the key findings was done per the MUHAS guidelines, norms, and regulations. The findings were thoroughly discussed and interpreted with a connection made to the body of literature and theory already in existence.

To ensure the original meaning of data was preserved, analysis was done in Swahili up to the level of codes. Sub-themes and themes were created in English. The coded texts (excerpts) were translated into English and then back-translated into Swahili to make sure the original meaning was preserved throughout.

3.13 Ethical consideration

Ethical clearance for this study was sought and obtained from the MUHAS Institutional Review Board (IRB). Clearance and permission to conduct the study were provided by the Executive Director of MZRH through the Office of Clinical Research, Consultancy, and Training. Then the research was conducted as per the Declaration of Helsinki. Written informed consent was obtained from each respondent who had the right to withdraw from the study at any time they wished to. Privacy and confidentiality of collected data were highly upheld.

4.0 RESEARCH FINDINGS

4.1 Participants description

Six of the participants were clinicians (Four medical specialists and two medical officers), four were nurse-midwives, and one was a social welfare officer. Four participants were male. The ages of participants ranged from 30 – 53 years with an average age of 41.5 (±11.5). Years of working experience ranged from 2 – 31 years with a mean of 16.5 years. Eight of them reported having screened for IPV at the time of interviews while three were not participating in screening. Five participants have Master's Degrees, four have Bachelors, one has a Diploma, and another one has a Certificate.

Six participants are stationed in the high-risk pregnancy clinic, four are from the low-risk pregnancy clinic, and one is from the Social Welfare Office.

Table 1. Participants Description

S/No.	Participant	Sex	Cadre	Education	Ever screens
1.	P – 1	Female	N – M	Diploma	**Yes**
2.	P – 2	Male	CL	Bachelor	**Yes**
3.	P – 3	Female	N – M	Certificate	**Yes**
4.	P – 4	Female	SWO	Bachelor	**Yes**
5.	P – 5	Male	CL	Masters	**Yes**
6.	P – 6	Female	N – M	Bachelor	**Yes**
7.	P – 7	Female	N – M	Masters	**No**
8.	P – 8	Male	CL	Bachelor	**Yes**
9.	P – 9	Male	CL	Masters	**Yes**
10.	P – 10	Female	CL	Masters	**No**
11.	P – 11	Female	CL	Masters	**No**

CL: Clinicians, N – M: Nurse-midwives, SWO – Social Welfare Officer

Analysis of the data led to the generation of three themes. One was on facilitators and two were on barriers of IPV screening during ANC. The facilitators of screening for IPV: (1) Healthcare providers and women's positive attributes help to initiate the IPV screening process. Those hindering screening are: (1) Women and community's negative attributes subvert IPV screening practices and (2) Institutional challenges hinder the smooth implementation of IPV screening routines. Healthcare providers reported lacking screening tools including guidelines, clear pathways for helping IPV victims, and low institutional and leadership support undermined them to screen women. Healthcare providers' knowledge, training, experience, and trusting provider-women relationships facilitate dialogue and screening of women. While social-cultural norms, fear of negative consequences, and perceiving IPV as a family secret deter women from reporting or avoiding IPV screening. Furthermore, healthcare services are structured in a way that prioritizes organic illness and pregnancy-related care and downplays other significant but nonvisible conditions like IPV.

The themes, sub-themes, and codes are shown in Annex 5.

Theme 1: Healthcare providers' and women's positive attributes help to initiate the IPV screening process

This is a facilitating theme towards IPV screening. It has positive HCPs and pregnant women factors that help to screen for spousal violence. It also has initiatives that are done to equip HCPs with the capacity to screen for IPV. For the screening to take place it needs active participation from both the HCPs and the pregnant women attending ANC.

Providers' knowledge of subtle signs and symptoms makes them vigilant to women with IPV

One of the facilitating factors mostly mentioned by almost all the participants who took in this study was the presence of physical signs and symptoms predilecting to IPV. Some participants mentioned conducting screening in only those with signs and symptoms while disregarding

those without visible features. This is illustrated in the following excerpt provided by the participant:

> *"I screen for IPV when I encounter someone who* ***has signs showing*** *something is wrong. For those who look happy or are accompanied by their partners, I often don't ask"* ***(P – 5)***

The participants noted that physical and emotional factors facilitated spousal inquiry. Some women showed physical signs of assault, while others displayed emotional distress. These signs prompted HCPs to inquire about IPV. Difficulties arose when women showed no obvious signs of IPV. However, indicators such as assault marks, emotional distress, missed appointments, non-adherence to treatment plans, lack of partner accompaniment, failure to gain weight during pregnancy, and lack of viral suppression in seroconverted patients prompted further inquiry by HCPs.

> *"..... The first indicator is the external appearance that a woman has been abused. It may involve seeing her in an injured state; For example, she comes with a swelling or a laceration…. Some are coming limping. When you ask what happened, you may get a response that she has been assaulted by her husband or a partner"* ***(P – 8)***

During consultations, some partners accompany women to ANC to conceal violence at home. In these cases, mostly the male partners are the ones who respond to questions and seem to silence the women when they try to speak. This behaviour raises suspicion of IPV among HCPs, prompting them to probe the women further:

> *"But she may sometimes come with her partner but the way they communicate, you surely suspect that something is not right, and you need to inquire more, okay? Those are some of the signs that suggest the possibility of the presence of IPV."* **(P – 9)**

Providers' knowledge of IPV and complications helps to screen

Participants screened for IPV due to the serious complications it poses for pregnant women and their babies, such as unsafe abortions, preterm births, small-for-gestational-age infants, maternal anaemia, bleeding emergencies, and maternal and foetal deaths. Some interviewees noted that lack of awareness about IPV and its effects may hinder proper screening, emphasizing the need to understand these complications better to encourage consistent screening practices. One of them said:

> *"I think it will have contributed because one may not know first-hand the possible harm. And because if someone doesn't know the effects, s/he doesn't see the importance of screening. But if one is taught and knows the effects it (IPV) has on the mother and how to help her, it would enhance the screening."* **(P – 9)**

Attending GBV and other training and experience help providers screen for IPV

Providers who screened for IPV reported receiving prior training on GBV. Others mentioned using the knowledge gained during their school training to screen and manage IPV patients. Some of the participants have experience working with pregnant women at the ANC and have encountered cases where unusual presentations were found to be linked to IPV. The training has equipped them with the knowledge and skills to have suspicion on those instances and screen for IPV.

> ***"The training helped me. When I got back, I could ask the violence questions."*** **(P – 11).**

Both clinicians and nurse-midwives with training and experience with GBV expressed their confidence in screening for IPV. Conversely, those less experienced and with no GBV training found it challenging to screen pregnant women for IPV hence they referred them to their Healthcare colleagues with training experience. Experience also plays a crucial role in

approaching women using indirect questions to encourage disclosure without causing discomfort:

> *"..... I've never attended. I just provide services based on the guideline (GBV guideline) that is in place and that's why I have said that if I get those kinds of clients if they need more help, I send them to those people who have that training ...."* **(P – 3)**

Trusting provider-women relationship leads to disclosure of IPV during screening

Intimate partner violence requires careful handling. Our participants emphasized the importance of a trusting relationship between women and HCPs for them (women) to feel comfortable disclosing IPV. The interviewees suggested that non-formal indirect questions about the women's living situation, their partners, transportation, and reasons for being unaccompanied by their partners helped in gaining women's trust. This could open further conversations about IPV. Initially, women may withhold information, but as trust is established, they feel more comfortable sharing their IPV experiences. Some participants advised fellow HCPs to build friendships with pregnant women to make it easier to address IPV. This is what was said:

> *"When we communicate with patients, we try to build closeness and trust. We ask non-formal, family-related questions to create a comfortable environment where patients feel free to express themselves. This can lead to patients sharing important information (about IPV) without being prompted...."* ***(P – 9)***

Women's readiness to report and disclose IPV makes screening easier

While providers may be motivated to screen for violence, the readiness of women to disclose information during screening is equally important. Some women share their experiences of violence without being prompted, demonstrating their trust in the HCPs. Considering the challenges faced by HCPs, such as limited time and a high volume of patients, the willingness of women to disclose information greatly aids service providers in effectively screening and offering necessary services.

> *"Exactly, I can know if she reports. Okay, eh? She has reported maybe or maybe I see a physical sign in her body is when I will decide whether she needs to be screened for violence."* **(P – 10)**

Theme 2: Women's and the community's negative attributes subvert IPV screening practices.

This is one of the two themes that have barriers for screening for IPV. It shows how the community and women's acts, norms, and traditions affect spousal screening negatively. The way society treats women makes it hard for the latter group to disclose when asked by the HCPs. Women's perceived consequences of the effects that may follow their disclosure of IPV fall under this category as a potential barrier to routine screening. In addition, HCPs also never bother to put more effort into screening because they perceive that women seldom disclose IPV experiences. It has sub-themes that are discussed below:

The fear of negative disclosure consequences impacts IPV screening

The consequences that may follow reporting for IPV are thought to be one of the reasons women do not disclose IPV. Women fear being labelled as traitors by society if they speak out against their partners. They also fear being discriminated against by society since they are expected to keep silent to protect their partners' reputations. Another reason that makes them fear is that legal measures like going to jail may be taken against their spouses These factors make them hesitant to speak up about IPV during ANC making it difficult for HCPs to effectively probe for IPV. In the interviews, participants highlighted that women hesitate to disclose domestic abuse due to these fears preventing IPV screening:

> *"You find that violence is taking place, but mothers themselves are not ready to report it because others fear what will happen after reporting. Perhaps legal action can be taken against the partner on whom she relies for everything. So, I think to a large extent, it affects the reporting as well."* **(P – 10)**

Many women are living in fear of IPV and are hesitant to speak out due to concerns for their safety and potential retaliation from their partners. This fear makes it difficult to effectively screen for IPV, especially when women are accompanied by their partners to ANC appointments. It is crucial to create a safe and supportive environment for women to disclose their experiences of IPV without fear of repercussions. Only by addressing these concerns can we help these women break the cycle of suffering in silence. The following quote is from one of the participants:

> *"Others are victims, but they are afraid to speak because of fear of threats from their partners or they fear that if they disclose their partners might be jailed and left with the roles to care for themselves and their families".* **(P – 4)**

Intimate partner violence is perceived as a family secret.

Not all that happens in the families should find their way to the public. Some issues should remain a secret, especially to women and their spouses. Among these secrets that should be kept within the family bounds is IPV. Participants perceived that this perception of labelling IPV as a secret is one of the barriers to routine screening. Women rarely speak about IPV since by so doing they will be exposing their partners to the public, participants argued. Even the HCPs might be seen as intruders into the family's internal affairs when they ask the women about IPV experiences. That's why IPV screening is not routinely conducted.

> *"It is about keeping the secret and not giving the correct information. Sometimes as a healthcare provider, you may have an intention of screening to see if the mother is suffering from IPV regardless of presence or signs but the mother who is suspected to be affected does not give the correct information. That is one of the greatest obstacles……".* ***(P – 2)***

Social-cultural norms prevent IPV reporting during screening

Participants expressed that societal and cultural norms discourage women from reporting IPV. They perceive that most of the practices are viewed by women as normal and they are used to them. Acts like wife beating, marital rape, men dominance, and controlling behaviours are normalized and even if they are reported, no one takes them seriously thus demotivating women from disclosing. This reluctance of women to disclose IPV due to societal norms makes screening challenging. Many women are uncooperative, choosing to endure suffering rather than report abuse. This hinders HCPs' ability to assist them effectively:

> *"……. First, women believe and get used to this attitude that it is normal practice. Even if they are abused, it is not something anomalous; it is a normal thing in society. Thus, even reporting is impaired; they prevent giving some of the information and this decreases screening."* **(P – 8).**

> *"Yes, violence is being conducted but some of the societies have normalized acts like wife beating. Even if abusive language is used against them, they take it as normal. The moment society perceives this to be normal, women never bother to report it even when probed and it is because this is something that they perceive to be normal……. Therefore, how society handles this, it has a huge impact, and none gives correct information about a thing that has been normalized."* **(P – 10).**

Theme 3: Institutional challenges hinder the smooth implementation of IPV screening routines

The theme explores the barriers to IPV screening, focusing on health system factors at the facility and national government levels. These barriers impact service provision and result in lower rates of spousal violence screening. They include issues with facility infrastructure, HCPs number, lack of emphasis on IPV screening by authorities, and the absence of essential screening tools. The participants' perspectives, reinforced by quotes, provide insight into various sub-themes within this crucial area.

Lack of screening tools staggers IPV inquiry.

Participants discussed the lack of IPV screening tools in consultation rooms and at the hospital. These include the guidelines, screening questions, and protocols for IPV management. There were contrasting arguments on this as some providers stated that tools are available, but the HCPs haven't created the demand from the management. Other participants stated that they have never come across these tools and are not available at the hospital. Participants reported using GBV screening questions provided by the GBV team previously, but formal screening stopped when the questions were no longer available. Suggestions for improvement included modifying ANC cards to include an IPV screening component creating simplified IPV screening questions and making them available to the providers, especially in the consultation rooms.

> *"And maybe a checklist of what things to ask can make the screening to be more objective than the one where you just ask what you feel. There are things you may skip that might be important. There should be a checklist that directs that every patient who comes to be checked on some things…."* **(P – 9)**

One of the striking findings during the interviews is that some HCPs are unaware of the WHO 2016 and MoH 2018 ANC guidelines. These guidelines recommend IPV screening in all the contacts. The participants when asked whether they are updated with these guidelines, mentioned focused antenatal care guidelines instead. On evaluation, it was found that it is either

the guidelines have not been disseminated to this health facility since they were released by the ministry, or they are available, but HCPs have not been given. In their concluding remarks, discussants suggested the dissemination of the guidelines by the Ministry of Health so that they start using them:

> *"In the case of the Ministry, aah, I think... In part, it is the dissemination of guidelines because it may be that guidelines have been provided but have not reached the providers in some parts."* **(P – 8).**

Pregnant women are not managed holistically

Holistic patient management focuses on the patient as a whole contrary to managing only the symptoms and signs the patient presents with. This starts with history taking in which IPV screening questions should be asked. If missed during history taking, then any physical sign found during physical examination should trigger going back to history and screening for the possibility of IPV. Our participants wished for a holistic approach to managing patients instead of relying on physical features. They wish every woman who comes to ANC to be screened for IPV. They stressed that service delivery is incomplete without IPV component:

> *"For me, I call upon every provider to do screening in all those we attend. Because we may think that these problems are due to something else, but they are due to not screening them in detail to find out the source of the problems that may be disastrous in the end."* **(P – 1).**

> *"... For my colleagues, let's try our best to take time to screen for partner violence. I guess. The constraints we have like time limit are the same. For the women who come, among the services we should offer in our, one of them should be screening for IPV."* **(P – 8).**

Lack of clear chains of referral for women who screen positive for IPV

The lack of a smooth mechanism for handling IPV cases adds burdens on already stressed HCPs, demotivating them from continuing to screen for IPV. Participants in their discussions questioned why there are no clear linkages and referral services to channel women who are found to be suffering from partner abuse. They made it clear that screening for IPV cannot be complete since there are no places to link those who need further assistance, such as counsellors and psychologists within the hospital vicinity.

> *"…. We still face the challenge of what should be done after we find out. The issue of partner violence in a pregnant woman involves customs and traditions. The channels to follow for those who screen positive are lacking. There are some women whom we tried to link up with the family, but they ended up being divorced. …… So, the challenges that we have are what next after screening?"* **(P – 8)**

Poor healthcare system support deters routine IPV inquiries.

For a consistent service provision, service delivery should be monitored. We have a couple of healthcare services that are closely monitored by the respective authorities either locally, regional, or national level. The essence of monitoring is to ensure that there is sustainability in these services. According to interviewees, IPV screening is not being monitored by the healthcare system. Previously, the provision of GBV services were supported by a non-governmental organization (NGO) that provided training, monitoring, collecting and evaluating GBV data. This NGO support ended and currently, there is only minimal support by the respective health authorities. This is one of the reasons why IPV screening is staggering. This lack of monitoring is another barrier to IPV screening.

> *"I think this issue is all about strategies. As I said, for example, 5S is given much emphasis and reports are taken. So, strategies should be in place for obtaining reports*

of IPV screening just like it is in antenatal care. Screening should be one of the important issues that should be monitored." **(P – 6).**

The hospital's infrastructure is crucial for service delivery, including screening for partner abuse. The lack of privacy and confidentiality hinders HCPs from inquiring about spousal violence and undermines women's willingness to disclose IPV. Participants in the study cited inadequate privacy in consultation rooms, making it easier for other HCPs to access the rooms without any obstacles and for patients in neighbouring rooms to overhear discussions in other rooms. To address this issue, participants recommended renovating the existing rooms to ensure privacy or constructing new rooms specifically for IPV consultation services.

"Sometimes there are interactions from other providers. Therefore, patients may not be free to express themselves, be examined and screened. Some rooms have privacy somehow while others do not. Even those that seem to have some privacy, have many challenges." **(P – 9).**

The sheer number of clients overwhelms providers to screen for IPV

In discussions about the number of patients each HCP should see per day, the availability of health providers, and the time they can spend with each patient are important factors. Many participants have expressed concerns about the high patient load, particularly when it comes to screening for spousal violence. Some HCPs reported attending up to sixty patients per day, making it challenging to provide quality care and conduct IPV screenings effectively. Consequently, the screening rates remain low as other medical needs take precedence.

"I think in one way or another it is possible that if you have few patients, you can spend more time with an individual. But when you have many patients and some of them are still waiting, it may force you to skip non-essential things (IPV screening inclusive)." **(P – 10)**

Limited time makes it difficult to provide adequate care service delivery to the clients

Due to many patients and understaffing, HCPs at ANC clinics spend less time than allotted to each patient. Low-risk ANC clinics are supposed to allocate 45 minutes per patient but end up spending much less time due to the high workload. High-risk ANC clinicians spend an average of 10 to 15 minutes per patient. Patients are reluctant to discuss violence if they perceive that the providers are overwhelmed, and time is limited. The following is the quote:

> *"We don't have enough time. As I said mostly, am driven by pressure from the patients outside. You find the patients are many and I cannot spend more time doing screening for one patient. Therefore, I found myself denying them the right to screen because of time. Thus, what I normally do is minimize the time spent on a single patient."* **(P – 3)**

Healthcare providers are overwhelmed with other duties

The study took place at the zonal teaching hospital. Apart from attending to the patients at the clinics, in the wards, and doing surgeries, HCPs also reported that they have extra duties that they should fulfil. One of these duties is teaching and training medical students from the affiliated College of Health and Allied Sciences. Other participants mentioned additional MITUHA books that they should fill. They together concluded that these duties deny them chances to screen for IPV:

> *"…… You find yourself sitting with a follow-up patient for so long. If she comes today, you should go eight months back to the day of her booking to retrieve her data so that you can fill it in six different books……. Previously you could sit with a patient talk to her and find what you need, and you would hardly miss anything that you think is abnormal……"* **(P – 6)**

Understaffing undermines service provision and IPV screening

Inadequate number of HCPs nationwide affects not only the quality of healthcare services but also the successful screening for IPV. Participants identified the shortage of providers at the ANC as a barrier to screening for IPV, as it impacts the time available for patient interaction. When there are enough HCPs, IPV screening is conducted, but with the low number of staff, providers rarely screen to avoid rescheduling other patients. They recommended hiring more HCPs to address this challenge.

> *"..... Another problem is that we have a staff shortage. The provider looks at the queues that s/he has and then perceives that spending a long time with one patient is a waste since the time for breaking from work will come while s/he still has some patients. So, s/he may end up preventing the patient from expressing herself well".* **(P – 7).**

Providers' negative attributes undermine IPV screening

Healthcare providers encounter challenges in screening for IPV due to their negative attitudes and perceptions. They are more likely to conduct screening when there are physical signs of abuse or when women are open to reporting IPV. Healthcare providers' attitudes that are barriers to IPV screening as stated by participants during interviews include the absence of visible signs, forgetfulness, and not updating themselves on available screening tools and other guidelines. Participants in the study highlighted these factors and how they affect routine screening. Here are the excerpts:

> *"She has no signs, and she has not reported? Maybe those are the main issues. I don't think there is any other way I will screen if I have not seen them (physical signs)".* **(P – 10)**
>
> *"There are many reasons, but the main one is that you may forget to ask or screen for the violence. Sometimes it maybe that when you look at the patient you don't see any*

indicators of violence, and maybe she is accompanied by her partner you perceive that they are living well". **(P – 9)**

Priority is given to women's main complaints and other diseases

Healthcare providers often focus solely on physical symptoms and overlook the holistic approach to patients' care. Pregnant women are primarily treated based on their reason for visiting, rather than receiving comprehensive care. Additionally, high-risk patients may have their medical conditions prioritized over other health components that are perceived as non-essential by the providers like partner violence. This prioritization potentially neglects important services like screenings for IPV:

"It depends on the challenge that the woman whom you are attending to has. Some of them may have complications that need less time to probe and evaluate while others may need to spend a lot of time to attend to them". **(P – 11)**

5.0 DISCUSSION

This research identified factors that either support or impede the routine screening of IPV. The facilitators for IPV screening include physical and emotional indicators, HCPs' knowledge of IPV manifestations and complications. Positive trusting relationships between HCPs and mothers, and women's openness to disclosure are other facilitators. The barriers to IPV screening are negative socio-cultural norms and the perception of IPV as a family secret. Lack of screening tools, understaffing, insufficient emphasis on IPV screening, and healthcare services geared towards pregnancy and related medical conditions are the additional barriers.

Healthcare providers' ability to suspect IPV, is enhanced by their knowledge, skills, and experience. Academic and GBV training and workshops are crucial in effectively empowering HCPs to screen for IPV. The importance of training as a tool for helping HCPs screen for IPV has been shown in our study and vindicated in other studies (18,29,42). This similarity is important in IPV inquiry first because some women are hesitant to disclose their IPV status and perpetrators may cause harm in areas difficult to ascertain to avoid detection. But, relying only on physical signs and symptoms may leave out many IPV victims, thus, providers should go beyond the physical features when dealing with IPV. We have shown in this research and other research in Uganda (22), Colombia (19), and Thailand (43) that building a trusted provider-patient relationship is essential in IPV screening and stems from training. Due to understaffing, and time limits, among other challenges, a trusted relationship helps HCPs save time to attend to other patients.

Many women do not disclose IPV during screening due to fear of negative consequences for their families, partners, and themselves, as well as the stigma and hopelessness associated with it. In patriarchal societies, women are often expected to endure violent and stressful situations to protect their families, partners, and children, as seen in the Middle East (42). This sense of hopelessness leads to underreporting of IPV, as women fear stigmatization and discrimination from their communities, posing a barrier to IPV screening as shown in our study and other

studies (36,37,42). The main reason for this is women's fear of negative consequences such as partners being jailed, or retaliation both from their partners and the society at large.

Timely availability and the use of screening tools like protocols, and screening guidelines are essential in IPV screening. This study reveals that participants screened for IPV using GBV screening questions and for the period that these questions are not available screening is seldom done. The same experience is reported locally and in Uganda (21,22,43). Participants have proposed to modify ANC cards to include an IPV screening component as shown in a study done in Uganda (22). This is a good suggestion but if implemented, could put mothers in danger as the cards are accessible to their partners. Ugandans have been successful in implementing this because their IPV services are enshrined in their policies. Therefore, in our settings, alternative methods for reminding HCPs to conduct screenings should be developed.

It has been highlighted in this study that HCPs express their desire to screen for IPV but lack the necessary supportive mechanisms for positive cases including vertical and horizontal linkage services. This is supported by other research in Jordan and other places (34,38,42,46). Managing IPV-positive cases needs a robust healthcare system linked to other services like counselling, investigative agencies, and legal aids which are lacking in many settings. Centralizing IPV services and creating one-stop IPV centres have been suggested by our participants to ensure survivors' privacy and safety. This is a good suggestion as IPV is a very sensitive part of service delivery and innovations are inevitable to foster the screening in our settings. The emphasize should be that, regardless of these challenges, HCPs should routinely inquire about IPV as this may increase the identification of positive cases and create a demand for the respective healthcare jurisdictions to foster the creation of these linkages.

Limited consultation time, a high patient volume, understaffing, and deficiency in privacy are healthcare system challenges undermining IPV screening. Inadequate healthcare system and institutional support not only affects IPV screening as seen in this study, but other parts of the globe are also affected (19,22,23,42,43,59,65). This could be due to economic constraints facing the low- and middle-income countries (LMICs). These financial challenges prevent

the employment of an adequate number of HCPs and build enough and well secured consultation rooms including special rooms for IPV. Our participants suggest building additional consultation rooms with enhanced privacy and designating special rooms for suspected IPV. Governments and health institutions need to take proactive measures to tackle these factors to enable HCPs to conduct IPV screening effectively. By addressing these issues, we can alleviate patient load, improve privacy, and encourage women to disclose IPV.

Providers' safety in the workplace needs to be ensured by the employer, that is the healthcare system. The discussants of this study have said that they fear for their safety if they screen for IPV. The same findings were reported in Jordan and Malaysia (34,42). Failure to guarantee safety among the HCPs puts them at risk of harm from women's partners or other society members either within or outside the health facilities and this affects IPV screening practices. This calls for initiatives to shield providers from consequences that may result from women's partners' threats to give them a comfortable room for IPV probing.

This study had some limitations. First, the interviews were conducted in the Swahili language. Coding was also conducted in Swahili. Sub-themes and themes were done in English and the quoted excerpts to English too. This could lead to the loss of data originality. To ensure participants' views were preserved, forward and back translation of the codes, sub-themes, themes, and excerpts was done. The second limitation was that some of the participants have been working with the national GBV campaign and have been the trainers of the trainees. This might have affected the actual data due to exaggeration of responses from those participants. To mitigate this, transcribed with thoroughly examined to pick only the relevant information as per the research questions. Another limitation is that this qualitative study was carried out by medical professionals who specialize in obstetrics. This might have inclined him to subtly convey his perspectives and disregard those of the participants. However, this bias was counteracted through the practice of bracketing and acknowledging the transcendental aspect of qualitative studies.

To establish the reliability and trustworthiness of this study, the following five essential criteria, namely credibility, confirmability, dependability, transferability, and authenticity, were rigorously considered. Credibility and confirmability were pivotal in ensuring the internal validity of the data, which was realized through the purposeful selection of participants and conducting in-depth interviews using a structured interview guide within the natural settings of the study. The robustness and transferability of the research data were assured through meticulous documentation of the study's procedures, from the selection of the study settings to the data collection process, thereby addressing issues related to dependability and external validity. Furthermore, the incorporation of participants' direct quotes in this report lends an element of authenticity and credibility to our findings.

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6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion.

Screening for IPV at the MZRH was inconsistently practiced by HCPs. Several facilitators and barriers were reported. Having HCPs with good knowledge or training on IPV, or having individual women being proactive in reporting IPV facilitated screening. A trusting relationship between a woman and her provider further enhances screening. Barriers to routine screening were a lack of screening tools, and few staff to perform the screening in a non-rushed manner or prioritize screening over routine activities. In addition, healthcare services are structured to prioritize the management of organic illness, usually downgrading the importance of conditions that do not present with immediate physical illness, such as IPV.

6.2 Recommendations.

1. Mbeya zonal referral hospital strengthening is indispensable to equip their HCPs with the capacity to make routine IPV screening.
2. Mbeya zonal referral hospital can develop screening guides that suit their settings to help ease the screening roles of their HCPs.
3. Healthcare providers should use the time that they get to probe for IPV regardless of the presence or absence of signs and symptoms suggestive of partner abuse and help those who screen positive.
4. Healthcare providers should be provided with frequent training, seminars, and workshops to enable them to have capacity to screen for IPV.

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APPENDICES

Appendix 1: Interview Guide (English version).

PART A: Doctors and Nurses.

Demographics: Age, sex, level of education, years of experience

1. **Could you please tell me about your daily activities as a healthcare provider here at the hospital?**

Probe: *There are various guidelines provided to assist in the provision of health services. What is the guideline(s) you use in your ANC?*

2. **Have you ever heard about intimate partner violence? How would you recognize a woman who is experiencing intimate partner violence?**

Probe: What are your views on IPV in general?

Probe: What forms of IPV do you know? How common is IPV in society? And, who are affected mostly by IPV, and why do you think so?

Probe: How does your society perceive IPV during pregnancy?

3. **Do you or have you ever conducted any screening to women to identify intimate partner violence? Could you please explain to me your experience of conducting IPV screening in your daily routines?**

Probe: What types of training regarding screening and management of IPV patients have you ever attended?

Probe: How often do you screen for IPV and in what type of patients?

Probe: Are there any precautions you consider before screening for IPV? If yes, what are they?

Probe: What are the tools that you use when conducting IPV screening?

4. **As a healthcare provider, how do you perceive IPV in pregnant women?**

Probe: Could you please explain your experience with screening pregnant women for IPV?

Probe: Can you tell to what extent are pregnant women willing to give information about their intimate partner violence status?

5. **Do you think some factors motivate or prevent you from conducting IPV screening in pregnant women at the ANC? If yes, please explain**

Probe: How does your hospital support you in terms of screening and managing IPV patients?

Probe: Could you please explain how likely will you continue screening for IPV in pregnant women?

Probe: What advice do you give to your HCP colleagues as far as IPV screening in pregnancy is concerned?

6. **What do you think should be done to improve IPV screening in pregnant women during their ANC contacts?**

Probe: How secure are your consultation rooms to ensure privacy?

Probe: What would you recommend to be done by our healthcare system as far as IPV screening is concerned?

Part B: Social welfare officers

1. **As we all know social welfare officers are an important component in our healthcare system due to their roles of interacting and helping patients with social and other needs, what are your daily activities here at the hospital?**

Probe: What kind of patients do you receive in your daily duties? Who refers them to you?

Probe: As a social welfare officer, how do you perceive IPV in general? What about IPV in pregnant women?

Probe: How often do you come across pregnant women with IPV?

2. **How often do you receive pregnant women suspected to have suffered from IPV?**

Probe: Who do accompany IPV pregnant patients, when they come to your office?

3. **Social welfare officers are an important part in the provision of services to patients with family and social challenges, including violence. What steps do you take when you encounter pregnant women with suspected IPV?**

Probe: What assistance/services do pregnant women who screen positive for IPV receive? How fast are those services?

4. **What efforts would you recommend to be done to enhance IPV screening in pregnant women attending ANC in your facility?**

Probe: How does the hospital and healthcare system at large support you in discharging your duties when dealing with IPV pregnant patients?

Conclusion

Let me take this opportunity to thank you for voluntarily agreeing to participate in this discussion and for sharing your views on all questions. I would like to assure you again that the information shared will be treated with confidentiality and that all information shared here will be used for study purposes only and that it will not be disclosed to other people. Thank you very much and I wish you a good day

Appendix 2: Interview guide (Swahili version).

Sehemu ya A: Madaktari na Wauguzi.

Taarifa binafsi: Umri, jinsia, kiwango cha juu cha elimu, uzoefu wa miaka kazini

1. **Tafadhali unaweza kuniambia kuhusu shughuli zako za kila siku kama mtoa huduma za afya hapa hospitali?**

Swali la udadisi: *Kuna miongozo mbalimbali hutolewa kwa ajili ya kusaidia katika utoaji wa huduma za afya. Ni mwongozo gani unaotumia katika kliniki ya wajawazito hospitalini hapa?*

2. **Umewahi kusikia kuhusu ukatili wa mwenza? Unawezaje kumtambua mwanamke ambaye anapitia ukatili wa mwenza?**

Swali la udadisi*: Nini maoni yako kuhusu ukatili toka kwa mwenza kwa ujumla?*

Swali la udadisi*: Aina zipi za ukatili toka kwa mwenza ambazo unazifahamu? Ukatili huu uko kiasi gani katika jamii? Waathirika wakubwa wa ukatili huu ni akina nani, na kwa nini unafikiri hivyo?*

Swali la udadisi*: Jamii yako inachukuliaje ukatili wa mwenza wakati wa ujauzito?*

3. **Je, huwa unachunguza au umewahi kufanya uchunguzi wowote kwa wanawake ili kubaini ukatili wa mwenza?Tafadhali unaweza kunielezea uzoefu wako wa kufanya uchunguzi wa ukatili wa mwenza katika shughuli zako za kila siku?**

Swali la udadisi*: Ni mafunzo aina gani juu ya uchunguzi na matibabu ya ukatili wa mwenza umewahi kuhudhuria?*

Swali la udadisi*: Ni kwa kiasi gani unachunguza ukatili wa mwenza na kwa aina gani ya wagonjwa?*

***Swali la udadisi**: Je, kuna tahadhari zozote unazozingatia kabla ya uchunguzi wa ukatili wa mwenza? Kama ndiyo, ni zipi hizo?*

***Swali la udadisi**: Je, unatumia miongozo ipi wakati wa kufanya uchunguzi wa ukatili wa mwenza?*

4. ***Ukiwa kama mhudumu wa afya unaweza kuelezea mtazamo wako juu ya wanawake wajawazito wenye matatizo ya ukatili wa mwenza*?**

***Swali la udadisi**: Tafadhali unaweza kuelezea uzoefu wako wa kuwachunguza wanawake wajawazito ukatili wa mwenza?*

***Swali la udadisi**: Unaweza kuelezea ni kwa kiasi gani wanawake wajawazito wako tayari kutoa taarifa za hali zao za ukatili wa mwenza?*

5. **Je, unadhani kuna sababu zinazokuhamasisha au kukuzuia kufanya uchunguzi wa ukatili wa mwenza kwa wanawake wajawazito wanaohudhuria kliniki? Kama ndiyo, tafadhali eleza**

***Swali la udadisi**: Vipi unaweza eleza ni kwa kiasi gani hospitali yako inakuwezesha katika suala la uchunguzi na kuwahudumia wagonjwa wenye ukatili wa mwenza?*

***Swali la udadisi**: Je, unaweza kuelezea ni kwa kiasi gani uko tayari kuendelea na uchunguzi wa ukatili wa mwenza kwa wanawake wajawazito?*

***Swali la udadisi**: Ni ushauri gani unawapa wataalamu wenzako wa afya juu ya uchunguzi wa ukatili wa mwenza kwa wajawazito?*

6. **Unafikiri nini kifanyike ili kuboresha uchunguzi wa ukatili wa mwenza kwa wanawake wajawazito wakati wa mahudhurio yao ya kliniki?**

***Swali la udadisi**: Je, vyumba vya kuwaonea wagonjwa ni salama kiasi gani kuhakikisha faragha?*

Swali la udadisi*: Je, unapendekeza nini kifanywe na mfumo wetu wa utoaji wa huduma za afya kwa ajili ya kuboresha uchunguzi wa ukatili wa mwenza?*

Sehemu B: Maafisa Ustawi wa Jamii

1. **Sote tunajua maafisa wa ustawi wa jamii ni sehemu muhimu katika mfumo wetu wa huduma za afya kutokana na majukumu yao ya kusaidia wagonjwa wenye mahitaji mbalimbali ya kijamii na mengine, je, unaweza kutuelezea majukumu yako ya kila siku hapa hospitalini?**

Swali la udadisi*: Ni wagonjwa wa aina gani unapokea katika majukumu yako ya kila siku? Ni nani anayewaelekeza kwako?*

Swali la udadisi*: Kama afisa wa ustawi wa jamii, una mtazamo gani juu ya ukatili wa mwenza kwa ujumla? Vipi kuhusu ukatili wa mwenza kwa wanawake wajawazito?*

Swali la udadisi*: Ni mara ngapi unakutana na wanawake wajawazito wenye ukatili wa mwenza?*

2. **Ni kwa kiasi gani unapokea wanawake wajawazito wanaoshukiwa kuwa na matatizo ya ukatili wa mwenza?**

Swali la udadisi*: Ni nani anayeongozana na wagonjwa wajawazito* wenye ukatili wa mwenza, *wanapokuja ofisini kwako?*

3. **Maafisa ustawi wa jamii ni sehemu muhimu katika utoaji wa huduma kwa wagonjwa wenye changamoto za kifamilia na kijamii ikiwemo ukatili. Unachukua hatua zipi unapokutana na wanawake wajawazito wanaoshukiwa kuwa na ukatili wa mwenza?**

Swali la udadisi*: Ni msaada gani / huduma ambazo wanawake wajawazito ambao wanaokutwa na ukatili wa mwenza hupokea? Je, huduma hizi ni za haraka kiasi gani?*

4. **Ni juhudi gani ungependa kupendekeza kufanywa ili kuongeza uchunguzi wa ukatili wa mwenza kwa wanawake wajawazito wanaohudhuria kliniki katika kituo chako?**

Swali la udadisi*: Je, hospitali na mfumo wa huduma za afya kwa ujumla unakusaidiaje katika kutekeleza majukumu yako wakati wa kushughulika na wagonjwa wajawazito wenye ukatili wa mwenza?*

Hitimisho

Nichukue fursa hii kukushukuru kwa kukubali kwa hiari kushiriki katika mjadala huu na kwa kushiriki kutoa maoni yako juu ya maswali niliyokuuliza. Ningependa kukuhakikishia tena kwamba taarifa ulizotoa zitafanyiwa kazi kwa usiri na kwamba habari zote tulizozungumza hapa zitatumika kwa madhumuni utafiti huu na kwa ajili ya kujifunza tu na kwamba hazitatolewa kwa watu wasiohusika. Asante sana, nakutakia siku njema.

Appendix 3: Consent Form (English Version)

Participant Number.....

Greetings!

My name is **Dr. Rong'ora Masoya Turuka** from Muhimbili University of Health and Allied Sciences. A postgraduate student taking Master of Medicine in Obstetrics and Gynaecology. I am conducting research with the title: Intimate Partner Violence Screening in pregnant women attending antenatal care: Facilitators and barriers among the healthcare providers at Mbeya Zonal Referral Hospital.

Study Purpose This study aims to explore the facilitators, and barriers for the screening of intimate partner violence in pregnant women attending antenatal care at the Mbeya zonal referral hospital.

Participants and Methods, if you agree to participate in this study, you will be interviewed using an interview guide with accompanying probing questions so as to get your views on the subject at hand. The interviews will be audio recorded also.

Confidentiality All the information obtained from the study participants will be kept confidential following medical laws and ethics, and no one will be able to link your participation based on the information you provide during an interview. No unauthorized persons will have access to the data collected.

Benefits If you agree to participate in this study, the benefits may be direct or indirect. As a healthcare provider, you will be able to know the perceived ideas, facilitators, and barriers for the inquiry into intimate partner violence in pregnant women among other healthcare providers when the results are out. This information will also help the government and other stakeholders to take appropriate measures in fostering the healthcare system and healthcare providers to screen for intimate partner violence in pregnant women.

Potential Risks: No harm will happen to you by participating in this study as you will only give your ideas and all the information including the recordings will be kept confidential.

Costs: No payment will be requested from you as a fee in order to participate in this study.

Rights to Withdraw and Alternatives: Your decision on whether or not to participate in this study is voluntary. You can withdraw your participation at any time during the study. Refusal to participate or withdrawal from the study will not involve any penalty or loss of any benefits entitled to you.

Contacts If you have any questions about this study, you may contact the study's principal Investigator: Dr. Rong'ora Masoya Turuka or the Supervisor: Prof. Andrea Barnabas Pembe, or the Co-supervisor: Dr. Fadhlun Mohammed Al-beity of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam. You can also contact the Chairperson of the Senate Research and Publications Committee, P. O. Box 65001, Telephone: +255 22 2152489, Dar es Salaam.

Participant's agreement: I have read and understood the contents of this form. My questions have been answered. I agree to participate in this study.

Signature of the participant.

Participant signature: ……. Date ……..

Principal Investigator signature: …… Date…….……..

Appendix 4: Consent Form (Swahili version)

Namba ya utambulisho.....

Salamu!

Jina langu ni **Dr. Rong'ora Masoya Turuka** kutoka Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili. Mwanafunzi wa shahada ya pili nikichukua Shahada za Uzamili katika idara ya Magonjwa ya akina Mama na Uzazi. Ninafanya utafiti wa: Uchunguzi wa Ukatili wa ukatili wa mwenza kwa wanawake wajawazito wanaohudhuria kliniki: Mitazamo, Viwezeshaji na vikwazo miongoni mwa wataalamu wa afya katika Hospitali ya Rufaa ya Kanda Mbeya.

Madhumuni ya Utafiti

Utafiti huu unalenga kuchunguza mtazamo, viwezeshaji, na vikwazo vya uchunguzi wa unyanyasaji wa mwenza kwa wanawake wajawazito wanaohudhuria huduma ya ujauzito katika hospitali ya rufaa ya kanda Mbeya.

Washiriki na Namna ya ushiriki

Ikiwa unakubali kushiriki katika utafiti huu, utahojiwa kwa kutumia mwongozo wa mahojiano na maswali ya kusindikiza ili kupata maoni yako juu ya mada iliyopo. Mahojiano hayo pia yatarekodiwa.

Usiri

Taarifa zote zitakazopatikana kutoka kwa washiriki wa utafiti huu zitawekwa siri kufuata sheria za matibabu na maadili, na hakuna mtu atakayeweza kufahamu juu ya ushiriki wako kulingana na habari utakayotoa wakati wa mahojiano. Hakuna mtu asiyeidhinishwa atakayepata taarifa zilizokusanywa.

Faida

Ikiwa unakubali kushiriki katika utafiti huu, faida zinaweza kuwa za moja kwa moja au zisizo za moja kwa moja. Kama mtoa huduma za afya, utaweza kujua mitazamo, viwezeshaji, na vizuizi vya uchunguzi wa ukatili wa mwenza kwa wanawake wajawazito miongoni mwa wafanyikazi wengine wa huduma ya afya wakati matokeo yametoka. Taarifa hii pia itasaidia serikali na wadau wengine kuchukua hatua zinazofaa katika kuwezesha mfumo wa utoaji huduma za afya na watoa huduma za afya ili kuchunguza ukatili wa mwenza kwa wanawake wajawazito.

Hatari zinazoweza kutokea

Hakuna madhara yatakayokutokea kwa kushiriki katika utafiti huu kwani utatoa tu mawazo yako na taarifa zote ikiwa ni pamoja na rekodi zitawekwa siri.

Gharama

Hakuna malipo yatakayoombwa kutoka kwako kama ada ili kushiriki katika utafiti huu.

Haki za Kujiondoa na Njia Mbadala

Uamuzi wako juu ya kushiriki katika utafiti huu ni wa hiari. Unaweza kuondoa ushiriki wako wakati wowote wakati wa utafiti. Kukataa kushiriki au kujiondoa kutoka kwa utafiti hautahusisha adhabu yoyote au upotezaji wa faida yoyote unayostahili.

Mawasiliano.

Kama una maswali yoyote kuhusu utafiti huu, unaweza kuwasiliana na Mtafiti Mkuu wa utafiti huu: **Dr. Rong'ora Masoya Turuka** au Msimamizi Mkuu wa utafiti: **Prof. Andrea Barnabas Pembe**, au Msimamizi mwenza: **Dr. Fadhlun Mohammed Al-beity** wa Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili, S.L.P 65001, Dar es Salaam. Unaweza pia kuwasiliana na

Mwenyekiti wa Kurugenzi ya Utafiti na Uchapishaji ya Seneti, S.L.P 65001, Simu: +255 22 2152489, Dar es Salaam.

Idhini ya mshiriki

Nimesoma na kuelewa yaliyomo kwenye fomu hii. Maswali yangu yamejibiwa. Ninakubali kushiriki katika utafiti huu.

Saini ya mshiriki: ..... Tarehe.....

Saini ya Mtafiti Mkuu: ..... Tarehe.....

Appendix 5: Themes, sub-themes, and codes

S/No.	Themes	Sub-themes	Participants' Quotes
FACILITATORS FOR IPV SCREENING			
1.	Healthcare providers' and women's positive attributes help to initiate the IPV screening process	Providers' knowledge of subtle signs and symptoms makes them vigilant to women with IPV.	*"I screen for IPV when I encounter someone with symptoms showing something is wrong. For those who look happy or are accompanied by their partners, I often don't ask"*
		Providers' knowledge of IPV and complications helps to screen	*"I think it will have contributed because one may not know first-hand the possible harm. And if someone doesn't know the effects, s/he doesn't see the importance of screening. But if one is taught and knows the effects it (IPV) has on the mother and how to help her, it would enhance the screening."*
		Attending GBV and other training and experience help providers screen for IPV	*"It helped me during the time I went for the training. When I got back, I could ask the violence questions."*
		Trusting provider-women relationship leads to disclosure of IPV during screen	*"When communicating with patients, we try to build closeness and trust. We ask non-formal, family-related questions to create a comfortable environment where patients feel*

			free to express themselves. This can lead to patients sharing important information (about IPV) without being prompted....”
		Women’s readiness to report and disclose IPV makes screening easier	*“Exactly, I can know if she reports. Okay, eh? She has reported maybe or maybe I see a physical sign in her body is when I will decide whether she needs to be screened for violence.”*
BARRIERS FOR IPV SCREENING			
2.	Women’s and the community’s negative attributes subvert IPV screening practices.	The fear of negative disclosure consequences impacts IPV screening	*“You find that violence is taking place, but mothers themselves are not ready to report it because others fear what will happen after reporting. Perhaps legal action can be taken against the partner on whom she relies for everything. So, I mostly think, it affects the screening as well.”*
		IPV is perceived as a family secret	*“It is about keeping the secret …. you may have an intention of screening to see if the mother is suffering from IPV … but the mother who is suspected to be affected does not give the correct information. That is one of the greatest obstacles……”*

		Social-cultural norms prevent IPV reporting during screening	*"… First, women believe and get used to this attitude that it is normal practice. Even if they are abused, it is … a normal thing in society... they prevent giving some of the information and this decreases screening."*
3.	Institutional challenges hinder the smooth implementation of IPV screening routines	Lack of screening tools staggers IPV inquiry	*"And maybe a checklist of what things to ask can make the screening more objective than the one where you just ask what you feel… There should be a checklist that directs every patient who comes to check this and this and this…."*
		Pregnant women are not managed holistically	*"… For my colleagues, let's try our best to take time to screen for partner violence. I guess. The constraints we have like time limit are the same. For the women who come, among the services we should offer, one of them should be screening for IPV."*
		Lack of a clear chain of referrals for women who screen positive for IPV	*".... We still face challenges of what should be done after screening. Partner violence ...involves customs and traditions. The channels to follow for those who screen positive are lacking…. So, the challenges that we have are what next after screening?"*

		Poor healthcare system support deters routine IPV inquiries	*"I think this issue is all about strategies… for example, 5S is given much emphasis and reports are taken. So, strategies should be in place for obtaining reports of IPV screening just like it is in ANC. Screening should be one of the important issues that should be monitored."*
		The sheer number of clients overwhelms providers to screen for IPV	*"… if you have few patients, you can spend more time with an individual. But when you have many patients and some of them are still waiting, it may force you to skip non-essential things (IPV screening inclusive)."*
		Limited time makes it difficult to provide IPV screening services	*"We lack time. As I said mostly, am driven by pressure from the patients outside. You find the patients are many and I cannot spend more time doing screening for one patient… I found myself denying them the right to screen...*
		Healthcare providers are overwhelmed with other duties	*"…… You find sitting with a follow-up patient for so long. If she comes today, you should go eight months back to the day of her booking to retrieve her data so that you can fill it in six different books…*

		Understaffing undermines service provision and IPV screening	*"...staff shortage. The provider looks at the queues ... and then perceives that spending a long time with one patient is a time waste... So, s/he may end up preventing the patient from expressing herself well".*
		Providers' negative attributes undermine IPV screening	*"There are many reasons... the main one is that you may forget to screen for violence. Sometimes it may be that when you look at the patient you don't see any indicators of violence, and maybe she is accompanied by her partner you perceive that they are living well".*
		Priority is given to women's main complaints and other diseases	*"It depends on the challenge that the woman whom you are attending to has. Some of them may have complications that need less time to probe and evaluate while others may need to spend a lot of time to attend to them".*

Appendix 6: Ethical Clearances

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATION

Ref. No.DA.282/298/01.C/1821 Date: 24/07/2023

MUHAS-REC-07-2023-1821
DR. RONGÓRA MASOYA TURUKA
SCHOOL OF MEDICINE
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: INTIMATE PARTNER VIOLENCE SCREENING IN PREGNANT WOMEN ATTENDING ANTENATAL CARE: PERCEPTIONS, FACILITATORS AND BARRIERS AMONG HEALTH CARE PROFESSIONALS AT MBEYA ZONAL REFERRAL HOSPITAL(MZRH).

Reference is made to the above heading,

I am pleased to inform you that the Chairman has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 24/07/2023
EXPIRATION DATE OF APPROVAL: 24/07/2024

STUDY DESCRIPTION:
Purpose:
The purpose of this qualitative study is to explore the perceptions, facilitators and barriers for the screening for intimate partner violence in pregnant mothers attending antenatal care among the healthcare providers.

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided:

https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2014904.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain data transfer agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain material transfer agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country,
8. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No 23 of 1979, PART III section 10 (2)
9. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
10. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.

Dr Nahya Salim Masoud,
Chairperson, MUHAS Research and Ethics Committee

Muhimbili University of Health and Allied Sciences
DIRECTOR
Research, Publications & Innovations
Box 65001

Appendix 7: Introduction Letter

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.129/2021 21st August, 2023

The Executive Director,
Mbeya Zonal Referral Hospital,
P.O. Box 419,
MBEYA

Re: INTRODUCTION LETTER

The bearer of this letter is **Rongora Masoya Turuka** (HD/MUH/T.129/2021), a student at Muhimbili University of Health and Allied Sciences (MUHAS) **MMed. Obstetrics/Gynaecology.**

As part of his studies he intends to do a study titled: **Intimate Partner Violence Screening in Pregnant Women Attendign Antenatal Care: Perceptions, Facilitators and Barriers Among Health Care Professionals at Mbeya Zonal Referral Hospital (MZRH)."**

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of his research.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c. Rongora Masoya Turuka

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1015; Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

Appendix 8: Permission Letter

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH

Telegram "Referral Hospital"
Fax Na: +255 2503577
Tel: +255 2503456/2503351
Email: info@ mzrh.go.tz

Mbeya Zonal Referral Hospital,
Hospital Road,
P. O. Box 419,
Mbeya.

Please quote:

Ref. No. MZRH/PF.3233/62 **DATE**: 29/09/2023

Head of Division,
Obstetrics and Gynaecology,
P.O.Box 419,
MBEYA.

RE: **APPROVAL TO PROCEED WITH DATA COLLECTION**

Reference is made for your letter with reference no HD/MUH/T.129/2021.

2. I am writing to formally let you know that you have been allowed to proceed with data collection to your study titled **"Intimate partner violence screening in pregnant women attending Antenatal Care; Perceptions, facilitators and Barriers among Health Care Professionals at Mbeya Zonal Referral Hospital (MZRH).**

3. We hope MZRH will be included in your result dissemination plan.

4. Sincerely.

Executive Director
Mbeya Zonal Referral Hospital
P. O. Box 419
Mbeya - Tanzania

Dr. Mbwanji G.F
EXECUTIVE DIRECTOR

Appendix 9: Turnitin receipt

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

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File size:	2.48M
Page count:	86
Word count:	17,652
Character count:	97,253
Submission date:	28-Jun-2024 10:09AM (UTC+0300)
Submission ID:	2409756643



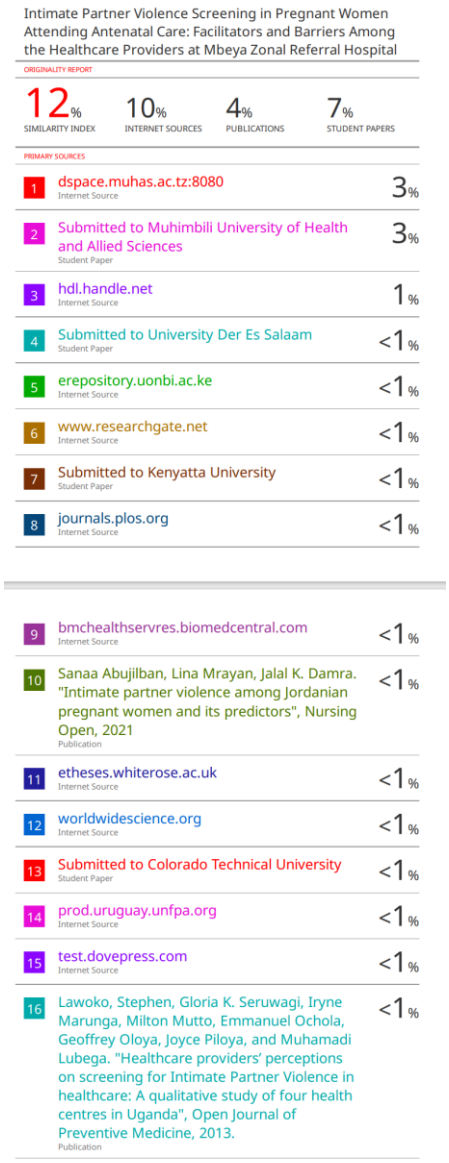
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Rong'ora Masoyu Turuka, MD

Master of Medicine in Obstetrics and Gynaecology
Muhimbili University of Health and Allied Sciences
June 2024

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Appendix 10: Plagiarism



Intimate Partner Violence Screening in Pregnant Women Attending Antenatal Care: Facilitators and Barriers Among the Healthcare Providers at Mbeya Zonal Referral Hospital

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