

TESTING THE WOMAN ABUSE SCREENING TOOL
IN PRIMARY HEALTH CENTERS
IN JAKARTA, INDONESIA

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DEDICATION

For my past, present and future....

For my past generation- grandmother- the trailblazer, whose legacy I am continuing...

For my present- Mom and Dad- without you both I would not be where I am today- thank you for always being there for me, rooting and cheering and urging me on.

For my husband- this journey is about us- for we have been partners every step of the way. We persevered through all the hardships, grew and thrived.

For my future- Alief and Aidan- who bravely stood by their Mother in this decision that affected all our lives. My wish is for you both to continue her legacy to make a difference for the lives of many...

And for all women and men- our collective task is to jump over the psychological hurdles that different cultures and societies have put in place towards the path to women's self-actualization...

This work is for all who believe that change starts with passion and commitment within oneself...

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ABSTRACT

Intimate Partner Violence (IPV) is a common occurrence that poses health risks to individuals, especially women, and to families and communities. The Indonesian National Commission on Violence Against Women compile annual reports on reported violence against women, yielding an estimated prevalence of 1%. However, based on IPV studies in other parts of the world, it was hypothesized that IPV is underreported in Indonesia.

IPV can be detected through self-administered screening tools or questions posed by primary health providers. However to date, screening has not been implemented in Primary Health Centers (PHC) in Indonesia.

The first study involved 240 female patients in two PHC in South Jakarta in a cross-sectional survey to estimate IPV prevalence. We tested the eight-item (24-point) Woman Abuse Screening Tool (WAST) against an in-person diagnostic interview by a trained psychologist following the Domestic Violence Initiative Screening (DVIS) Interview Guide (the gold standard). Although the psychologist interview is the gold standard (yielding an IPV prevalence of 36.25%), it is expensive to use as a screening tool. The WAST proved reliable and valid, using a cutoff score of 10, which would identify most of the IPV cases.

The second study gathered qualitative data to gauge the acceptability of the WAST compared to the psychologist interview guided by the DVIS and to gauge method of screening preference of the 240 research participants. Both the WAST and the psychologist interviews were accepted by research participants. Although the preferred method of screening was the psychologist interview, 91% of the women said they would not mind being screened with the WAST on an annual basis.

The third study included key informant interviews of PHC heads in the five municipalities of Jakarta on their perceptions of supports and barriers of screening at the PHC level. The majority of PHC heads who agreed to be interviewed were willing to screen for IPV at their PHC, especially if they had screening tools and training, and knew where to refer women for assistance.

Combined research findings from the three studies provide support for the institutionalization of routine screening for IPV in Indonesian PHCs.

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LIST OF ABBREVIATIONS

- DVIS Domestic Violence Initiative Screening
- IPV Intimate Partner Violence: “*Actual or threatened physical, sexual, psychological, emotional or stalking abuse by a current or former spouse (including common-law spouses), dating partner, or boyfriend or girlfriend. Intimate partners may or may not be cohabitating*” (Thompson, Basile, Hertz, & Sitterle, 2006, p. 151).
- MOH Ministry Of Health
- PHC Primary Health Center
- VAW The United Nations defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (WHO, 2012)
- WAST Woman Abuse Screening Tool
- WHO World Health Organization

CHAPTER 1

INTRODUCTION

Problem Statement

The World Health Organization (WHO) defines violence against women as “*any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.*” Intimate Partner Violence (IPV) is violence against women perpetrated by intimate partners, defined as “*behavior in an intimate relationship that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behavior*” (WHO, 2011). WHO has declared violence against women and IPV to be a global public health problem, and that IPV is a violation of human rights (Harvey, Garcia-Moreno & Butchart, 2007).

IPV is a major cause of fatalities and disabilities for women in the 16-44 year age group (The United Nations Development Fund for Women or UNIFEM, 2009). It can have serious consequences on women’s physical, mental, sexual, and reproductive health, including death, physical injuries, depression, suicidal ideation, unwanted pregnancy, and other gynecological impacts (WHO, 2007). Campbell, Webster, Koziol-McLain, Block, Campbell & Curry (2003) found that about 40-50% murders in the US are IPV related, with 70-80% of the murdered women experiencing abuse prior to being murdered.

Although a global phenomenon, the WHO Multi Country Study (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005) found that the percentage of women reporting physical violence by their intimate partners at some point in their lives varied greatly across countries. Data from this study, which included 24,000 women respondents in urban and rural areas in ten countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, Tanzania), found that the lifetime experience of IPV ranged from 13-61% (Garcia-Moreno et al, 2005). Women in Japan were the least likely to report physical violence perpetrated by their partners (about 13%), in comparison to 61% in rural Peru. Forty-two percent of respondents in rural Bangladesh reported IPV, while 40% reported IPV in urban

Bangladesh. In Thailand, a South East Asian country, the prevalence for rural areas was 34%, compared to 23% in urban areas.

In the United States (US), 1 to 4 million women, including pregnant women, suffer from physical, psychological, emotional and sexual abuse by their intimate partners annually (Falsetti, 2007), and 31% of all women report experiencing abuse in their lifetime (The Commonwealth Fund, 1993).

IPV in Indonesia

IPV is a pervasive threat to women around the world, including Southern and South East Asia, where Indonesia is situated. Indonesia is the fourth largest populated country in the world, with 237,641,326 people (Bureau of Statistics of Indonesia, 2011). This three-paper dissertation focuses on IPV in Indonesia and presents findings on three studies exploring the potential to institute routine IPV screening and brief intervention in Primary Health Centers (PHC) in Indonesia.

In September 2004, Indonesia passed a law criminalizing IPV (Law on the Elimination of Violence Against Women, Indonesian Department of Justice, 2004). As part the Indonesian Ministry of Health (MOH)'s endeavor to translate the Elimination of Domestic Violence Law into operational procedures, in 2006 the MOH started an initiative promoting awareness about IPV in its PHCs. PHCs are found in districts and sub-districts in all 33 provinces of Indonesia. PHCs are equivalent in purpose, mission, and service delivery to Community Health Centers in the US. PHCs are a strategic first point of contact for Indonesians needing health or wellness care. Currently, district-level PHCs are mandated to treat women reporting IPV (although treatment is often limited to medical interventions), while sub-district PHCs are mandated to refer women reporting IPV to district-level PHCs (MOH Policy, 2009)

The National Commission on Violence Against Women, known as the National Women's Commission (*Komnas Perempuan*), tracks and reports cases of violence against women perpetrated by intimate partners. Of the 113,878 reported cases of domestic violence in 2011, husbands perpetrated 97% of them, and 94% were psychological in nature (Indonesian National Commission on VAW, 2012). Looking back at the 2010 annual report, psychological violence accounted for 88% of

the total reported IPV cases of 98,577 (Indonesian National Commission on VAW, 2011). Similarly, in 2009, the Commission compiled a total of 143,586 reported cases and 95% (or 136,849) of them were classified as IPV. In 2009, the majority of IPV cases were psychological and sexual violence, while physical violence was reported in less than 2% of the documented cases (Indonesian National Commission on Violence against Women, 2010).

Although 136,849 reported cases of IPV seem large, put in context of the population of Indonesia, this suggests an estimated country prevalence for IPV of less than 1%.¹ Given WHO's household survey findings of lifetime IPV risk, this low prevalence likely suggests that IPV is underreported in Indonesia. Underreporting of IPV is common in many countries. In the US, underreporting for IPV has been detected in various contexts. For example, it is estimated that only 20% of rapes or sexual assaults perpetrated by intimate partners, 25% of physical aggression, and 50% of stalking are reported by female victims (Tjaden & Thoennes, 2000; Todahl et al, 2008). In Hawai'i, about 10,000 (1.7%) women report IPV-related incidents annually, with many more incidents going unreported (Bernardo, 2005).

In Indonesia, underreporting is likely due to cultural and geographical barriers, as well as the lack of or limited scope of interventions currently available in the health sector. For example, culturally, women are reluctant to report their husbands' violence for fear of bringing shame to the family. Geographically, Indonesia is an archipelago consisting of 17,506 islands, thus a countrywide reporting system remains a challenge. In addition, current intervention programs in the PHCs rely on women to report IPV. Those who seek attention for IPV must travel to a district PHC, and then services often are limited to medical interventions. Outside of the PHC, services for women experiencing IPV are provided by non-government organizations, which are struggling to sustain their operations due to limited funds allocated for women experiencing violence.

¹ Number of reported cases of IPV in Indonesia in 2009 [136,849] divided by the number of people at risk or the number of adult females in Indonesia, estimated at half of Indonesia's 114,124,104 adults.

The Role of Primary Care Providers

Primary care providers have a unique role in identifying and supporting victims of IPV. While not all providers inquire about IPV, patients favor being asked whether they feel safe at home or not (Bradley, Smith, Long & O'Dowd, 2002; Boyle & Jones, 2006; Koziol-McLain, Gardiner, Batty, Rameka, Fyfe & Giddings, 2008). A study of reported frequency of domestic violence in Ireland involving 1,871 women attending general practice showed that 39% (651 of 1,692) had experienced violent behavior by a partner, but only 12% (78 out of 651) of the women in the study reported that their primary care physicians (PCP) had inquired about IPV (Bradley et al., 2002). Direct questions about IPV were found to increase self-disclosure about violence (Naumann, Langford, Torres, Campbell & Glass, 1999). In another study, findings indicated that women did not react negatively when asked about IPV (Koziol-McLain et al., 2009). In another study, 77% of women surveyed for IPV by their PCPs favored routine inquiry (Boyle & Jones, 2006). Thus, although some patients may be reluctant to disclose violence by their partners, most would appreciate being asked about IPV directly by the physician (Boyle & Jones, 2006).

Screening Tools for Intimate Partner Violence

Different IPV screening tools have been developed for different contexts, including emergency rooms, community health settings, and primary care. Table 1 lists some of the common screening tools, and indicates the number and type of items included in each.

The number of items on each screening tool ranges from two to ten. Some screening tools ask only about feelings of safety and experience of physical violence, such as the 2-question tool developed by Kaur & Herbert (2005), the 4-item Partner Violence Screen (PVS), and the 10-item Women's Experience in Battering (WEB) (Thompson, Basile, Hertz, & Sitterle, 2006). The 3-item tool by Paranjape and Liebschutz (2003) and the 4-item Hurt, Insult, Threaten and Scream (HITS) only ask about physical and verbal abuse. The Woman Abuse Screening Tool (WAST) is the most comprehensive tool and includes questions about verbal and sexual abuse, which are the most common forms of IPV in Indonesia (Indonesian National Commission on VAW, 2012). The WAST was used to screen women

attending PHCs in Malaysia (a south-east Asian country with a large Moslem population, like Indonesia), which found an IPV prevalence of 5.6% in their sample of 710 female patients (Wong & Othman, 2008).

Table 1 Screening Questions/Tool Matrix

	Kaur & Herbert (2005)	Paranjape & Liebschutz (2003)	PVS	HITS	WAST	WEB
Number of items	2	3	4	4	8	10
Safety • Do you feel safe/unsafe at home? • Do you feel safe in your relationship? • Does your partner make you feel frightened?	√		√		√	√
Physical Abuse • Has anyone hit you? • Have you been in a relationship with pushing or slapping?	√	√	√	√	√	√
Verbal Abuse • Have you been in a relationship with insults, cursing, threats		√		√	√	
Sexual Abuse • Has your partner ever abused you sexually?					√	

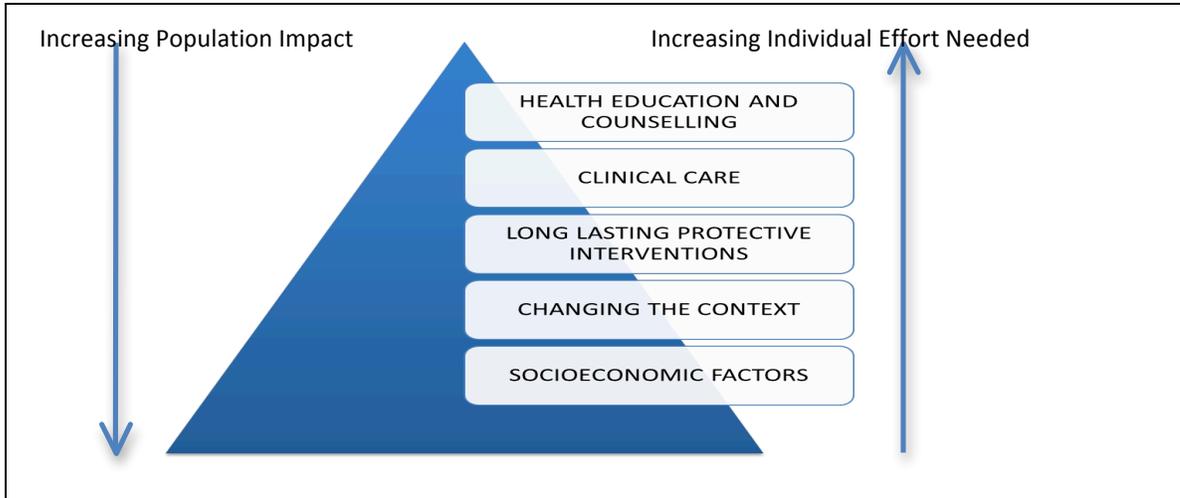
Community Engagement

This dissertation was a participatory research endeavor involving three community partners. The first is PULIH Center for Trauma Recovery and Psychosocial Empowerment, a national non-profit organization in Jakarta that I co-founded in 2002, which assists women experiencing violence, including IPV. The second partner in this dissertation research is a district PHC in South Jakarta that recorded 71,296 patients' visits during 2009 (average of 5,941/month). The district level PHC is mandated to treat women experiencing IPV as one of its many responsibilities. This particular district PHC has a Domestic Violence clinic in a private consultation room, which is open 8 am to 12 noon on weekdays. The third partner is a sub-district PHC in South Jakarta that recorded 16,086 patients' visits in 2009 (average of 1,340/month). The sub-district level PHC is mandated to refer women experiencing IPV to the district-level PHC as one of its many responsibilities. Because of this arrangement, it can be hypothesized that women seeking treatment at the district level PHC would have reported a higher prevalence of IPV than the sub-district PHC.

Conceptual Framework

Public health problems, like IPV prevention and control, must be addressed from multiple levels. Thus, the Health Impact Pyramid by Thomas Frieden (2010), current Director for the Center for Disease Control and Prevention (CDC), is used as a conceptual framework for this dissertation.

Figure 1.1. Health Impact Pyramid

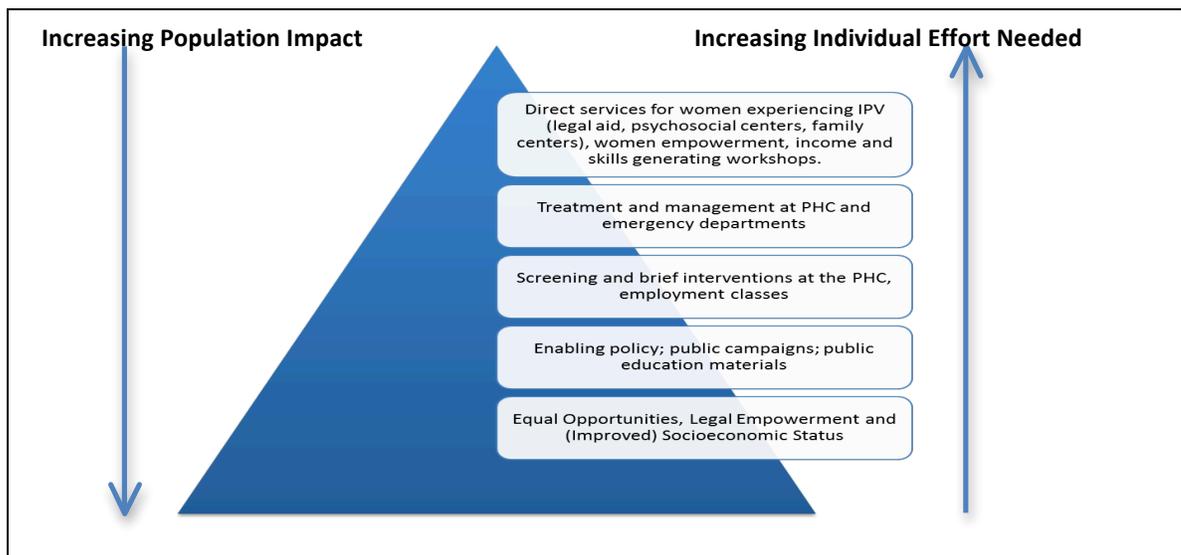


The pyramid shows five levels of interventions that can affect public health. The arrow from the tip to the base signifies that interventions in the lower tiers have increasing impact on population health. The arrow from the base to the tip signifies that interventions in the higher tiers require increasing individual effort. In other words, interventions at the bottom level of the pyramid have the greatest population impact and require the least individual effort, whereas interventions at the top level of the pyramid require more individual effort and have a smaller population impact.

In this five-tier health impact pyramid, the bottom tier represents interventions that address socio-economic factors with the greatest population impact. For example, by reducing poverty and improving educational attainment, there will be improvements of the health of many people in the population. The next tier includes interventions that change the context. These interventions also impact many people in the population, and include examples such as increasing availability to clean drinking water and safe roads. The middle-tier refers to long-lasting

protective interventions with long-term benefits. Examples of interventions at this level include routine universal immunizations and screening. These middle-tier interventions can help many people, but also require a moderate amount of individual effort. The next tier includes clinical interventions, such as interventions to prevent cardiovascular disease. The fifth tier of the pyramid includes individual counseling and education. Counseling has been found to be less effective than other interventions in the tiers, like education, which have demonstrated good impact, although public education efforts are labor intensive (Frieden, 2010). An example of a successful educational intervention is educating men who have sex with men on ways to reduce HIV risk.

Figure 1.2. Health Impact Pyramid Applied to IPV Interventions



The Health Impact Pyramid can be applied to IPV interventions as shown in Figure 1.2. The bottom tier is for interventions that do not require individual efforts. For IPV, these are legal empowerment, equal opportunity, and improved socioeconomic status for women. For the next tier, enabling policy (for example requiring health providers to report IPV so that perpetrators can be punished) and public education campaigns are examples of interventions that can change the context within which IPV is interpreted. A long-lasting protective intervention at the third tier might be the establishment of routine IPV screening and brief intervention at the PHC. Examples of IPV programs in the second tier are clinical

programs for women experiencing IPV, such as care provided in the PHC and emergency departments. Examples of IPV-related programs at the top tier are counseling and education of individual women who experience IPV. Some experts would argue that counseling and education by service providers are not proven effective in reducing IPV. The challenge identified by Frieden (2010) is that, in the IPV field, there have been limited evidence-based programs thus far to suggest which interventions are most effective (T.R. Frieden, personal communication, April 3, 2011).

Nevertheless, this three-paper dissertation focuses on the third tier of long-lasting protective interventions, specifically exploring the feasibility of establishing routine IPV screening and brief intervention at the PHC. The rationale is that the earlier women experiencing IPV are detected, the sooner they can be connected to IPV service providers and the more likely IPV can be controlled. In addition, routine screening also sends a message to the community that IPV is not normal and will not be ignored, which will ultimately change the context towards zero tolerance of Violence Against Women.

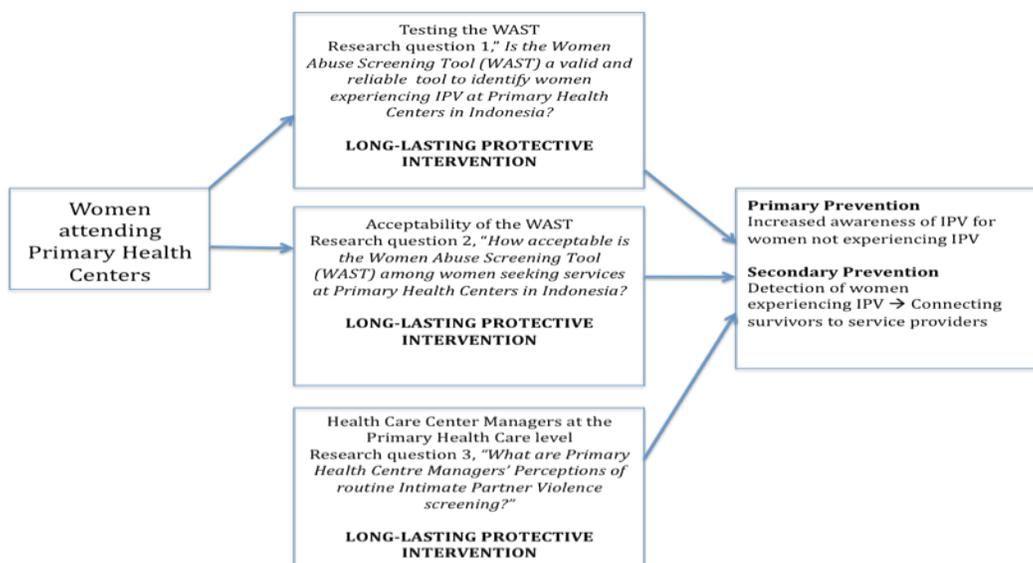
Chapter 2 reports on a study to estimate the prevalence of IPV in two PHCs in Jakarta. Chapter 3 reports on a study examining the acceptability of the WAST as an instrument for routine IPV screening compared to psychologist interview using the Domestic Violence Initiative Screening (DVIS) questions among women seeking services at the two PHCs in South Jakarta. Chapter 4 reports on key informant interviews with heads of PHCs on their perceptions of supports and barriers to routine IPV screening in the PHC. The dissertation framework (Figure 1.3) shows how all the studies in the dissertation endeavor to realize primary and secondary prevention IPV outcome objectives.

Purpose and Research Questions

The overall purpose of this dissertation is to conduct empirical research to test the reliability, validity, and acceptability of the translated Woman Abuse Screening Tool (WAST) in two PHC in Jakarta, Indonesia, to estimate IPV prevalence, and to gauge PHC heads' perceptions of supports and barriers to implementing routine IPV screening in their PHC. Three questions were addressed:

Question 1. Is the translated WAST a valid, reliable tool to identify women experiencing IPV at two PHC in Jakarta, Indonesia? There are two specific aims for this research question: 1) to determine the validity and reliability of the translated WAST; and 2) to estimate the prevalence of IPV among adult women coming to two PHC. This question was addressed through a quantitative study in which 240 women in two PHC completed the self-administered WAST. They also were interviewed by a psychologist using the Domestic Violence Initiative Screening (DVIS) interview guide, which serves as the “gold standard” for identifying IPV, and allows an estimate of IPV prevalence. The specificity and the sensitivity of the WAST were then estimated in relation to the gold standard. The internal reliability of the WAST also was estimated.

Figure 1.3. Dissertation Framework



Question 2. How acceptable is the Woman Abuse Screening Tool (WAST) among women seeking services at two PHCs in South Jakarta, Indonesia? Qualitative data for Chapter 3 about the acceptability of the translated WAST were collected after the women completed both the self-administered WAST and the psychologist interview. This interview gathered data on difficult questions in the

WAST, perceptions of the screening tool and interview, and whether women should be routinely asked to complete one or the other when they visit the PHC.

Question 3. What are the perceptions of PHC heads of supports and barriers to routine Intimate Partner Violence screening in their Centers? Chapter 4 presents findings from a qualitative study, which entailed key informant interviews of 10 district and 10 sub district PHC heads to understand their perceptions of supports and barriers to routine IPV screening in their centers.

Findings from these three studies were used to develop recommendations related to incorporating IPV routine screening and brief interventions into PHC services throughout Indonesia. Recommendations are being shared with the Ministry of Health and the Training Unit under the Ministry of Health.

CHAPTER 2
TESTING THE WOMAN ABUSE SCREENING TOOL (WAST)
TO IDENTIFY
INTIMATE PARTNER VIOLENCE
AT TWO PRIMARY HEALTH CENTERS IN JAKARTA, INDONESIA

Abstract

Intimate Partner Violence (IPV) is a common occurrence that poses health risks to individuals, especially women, and to families and communities. It can be detected through self-administered screening tools or questions posed by health providers. Two Primary Health Centers (PHC) in South Jakarta were community partners in this cross-sectional study to test the eight-item (24 point) Woman Abuse Screening Tool (WAST) against an in-person diagnostic interview by a trained psychologist following the Domestic Violence Initiative Screening (DVIS) interview guide (the gold standard).

Female PHC patients age 18 years and older were asked to participate in the research. They were either married or involved with a partner, but attended the PHC unaccompanied by the partner. Of the 240 participants, 120 completed the self-administered WAST first, followed by the psychologist interview. The other 120 were interviewed first by the psychologist, and then completed the WAST. IPV prevalence was calculated based on findings from the psychologist interview, and sensitivity and specificity of the self-administered WAST were estimated. Characteristics of women experiencing IPV were also examined.

The overall prevalence of IPV identified by the psychologist interview (gold standard) was more than two times higher (36.3%) than prevalence estimated by the WAST when using the recommended cutoff score of 13 (17.1%). At this recommended cutoff, the sensitivity of the WAST was 41.9% and the specificity was 96.8, meaning that many cases of IPV would be missed at this high cutoff. Using a lower WAST cutoff score, like 10, would identify more cases. With 10 as the cut-off score, the WAST had a sensitivity of 84.9% and specificity of 61.0% in this Indonesian population. At this score, 55.4% of the women would be identified as abused, yielding more false positives than desired, but identifying most of the true cases. Psychological IPV (DVIS item 3), which included controlling behavior, was found in

85% of IPV cases. In contrast, physical abuse (DVIS item 2) was found in 24% of IPV cases. Therefore, psychological abuse is much more prevalent than physical abuse.

Compared to the literature, both IPV estimates were much higher than prevalence estimated from reported cases compiled by the Indonesian National Commission on Violence Against Women (about 1%) and the prevalence estimated in a the neighboring country of Malaysia (about 6%), based on a study using the WAST with a cutoff score of 13.

Women who reported IPV were more likely than those who did not report it to be unemployed. Of the 87 females (out of the 240) that disclosed their IPV experiences to psychologists during the interviews, 20 refused assistance while 67 accepted assistance, which included brief counseling and provision of hotline numbers and contact information for a local center for trauma recovery.

The research findings provide support for the institutionalization of routine screening for IPV in Indonesian PHCs. Although the psychologist interview is the gold standard, it is expensive to use as a screening tool. Using the WAST with a cutoff score of 10 would identify most of the IPV cases. When identified as positive, the woman should be provided brief intervention and referred to a behavioral health provider (nearby mental health unit or psychologist).

Introduction

Intimate Partner Violence (IPV) has been declared a global public health problem and a violation of human rights (Harvey, Garcia-Moreno & Butchart, 2007). Screening for IPV has been found to increase IPV reporting (The Family Violence Prevention Fund's Research Committee, 2003). The Institute of Medicine (2011) recommended IPV screening and counseling for women and adolescent girls, hence screening is part of the Affordable Care Act as a preventive health service. Furthermore, the American Medical Association has recommended that physicians routinely screen for physical, sexual and psychological abuse, as exposure to IPV may have adverse health effects in patients (Nelson, Bougatsos and Blazina, 2012).

IPV prevalence in Indonesia has been estimated to be less than 1%, based on reported cases compiled by the National Commission on Violence Against Women (2012) from service providers nationally. Routine screening by way of a self-

administered questionnaire may result in a more realistic IPV estimate for Indonesia.

Several tools have been developed to facilitate IPV screening in different healthcare contexts. Based on a structured literature review (Iskandar, 2010), the Woman Abuse Screening Tool (WAST) was felt to be the best IPV screening tool to use in Indonesian PHCs because: a) It asks about physical, psychological/emotional and sexual abuse, which are the types of abuse reported most frequently by women in Indonesia; b) Several studies have reported that the WAST has high reliability (Ernst et al., 2002; Weiss et al., 2003); c) The English-language version has good specificity and fairly good sensitivity; and d) In addition to its full 8-item format, the WAST can be applied in a short form, or the WAST-Short, which may be useful in a busy PHC setting. The WAST was also used successfully by Wong and Othman (2008) to screen women in Malaysia. These authors found an IPV prevalence of 5.6% in their sample of 710 female patients, and the WAST was found acceptable among the women screened.

Although the WAST has been found to have good sensitivity and specificity in US study populations, the sensitivity and specificity of an Indonesian language version of the WAST has not been established. The best way to establish validity of IPV screening tools is to compare a self-administered tool against a clinician-administered verbal screening which is considered superior to written screening questions (Anderst, Hill & Siegel, 2004).

The purpose of this study is to answer the research question: *Is the Indonesian-language version of the WAST a valid and reliable tool to detect women experiencing IPV at two Primary Health Centers in Jakarta, Indonesia?* There were two specific aims of this study: Specific Aim 1 was *to test the sensitivity, specificity, and reliability of the WAST translated into Indonesian among women seeking services in two PHC in South Jakarta, Indonesia.* Specific Aim 2 was *to determine the prevalence of IPV among women seeking PHC services in two PHC in South Jakarta, Indonesia.* The study was approved by the Institutional Review Board of the University of Hawai'i and by the Indonesian Ministry of Health.

Methods

Sample

This study utilized a convenience sampling method of women attending the two participating PHC: a district PHC and a sub-district PHC in South Jakarta, Indonesia. Between the two PHC, about 7,281 patients are seen each month, of which we estimated that at least 50% (3,600) are female. To be eligible for the study, the woman had to be: 1) a client attending the PHC; 2) 18 years of age or older; 3) married or involved with a male partner; 4) not accompanied by husband/partner at the time of the study; 5) in good physical condition as self-reported by the women; 6) able to read and write Indonesian; and 7) willing to spend 20-30 minutes for the study. Only if she met the inclusion criteria and agreed to undertake research procedures was she asked to sign the consent form. (Appendix A includes the Consent Form for women attending PHC.)

Sample size calculation was based on findings from the Malaysia PHC study of IPV prevalence, estimated at 6% (Wang & Othman, 2008). We estimated that 6% of women attending the sub-district PHC would be experiencing abuse. We also estimated that 10% of the women at the district-level PHC would be experiencing IPV, because women experiencing IPV are referred to district PHCs by several sub-district PHCs. Thus, in order to identify at least 20 women experiencing IPV, we would need to sample 240 women, at least 100 women from the sub-district PHC to identify at least 6 (6%) women with IPV, and 140 women from the district-level PHC to identify at least 14 (10%) women with IPV.

Measures

Woman Abuse Screening Tool

The English-language version of the WAST has good reliability and validity. For example, Brown, Lent, Brett, Sas & Pederson (1996) found that the WAST was able to correctly classify 100% of non-abused women and 91.7% of abused women in a US sample. WAST scores were also highly correlated ($r=0.96$) with scores on the Abuse Risk Inventory. In a later study, Brown, Lent, Sas (2000) found that the WAST had good internal consistency (alpha coefficient of 0.75), and that more than 90% of women reported being comfortable or very comfortable when the WAST was

administered to them. Two other US studies also found good internal reliability (Ernst et al., 2002; Weiss et al., 2003). Ernst et al. (2002) also documented that the WAST had concurrent validity and differentiated well between abused and non-abused women. Wathen et al. (2008) found the WAST was more sensitive in detecting IPV survivors than the 30-item Composite Abuse Screening (CAS).

As noted above, in addition to its full 8-item format (Table 2.1), the WAST can be applied in a short form, called WAST-Short. When using the short form, the screener starts by asking the first two questions, which inquire about the level of tension a woman feels in her intimate partner relationship and the amount of difficulty she experiences working out conflicts with her partner. Only if the woman answers these two questions with “a lot of tension” and “great difficulty,” respectively, will the screener ask her to complete the other six WAST items. The latter six items ask specifically about a woman’s experience with feeling put down or frightened or being physically, emotionally, or sexually abused. As PHC workers may feel overburdened and may be reluctant to spend extra time with patients, the WAST-Short can be the critical point of buy-in for PHC workers. In this study, we used the 8-item version of the WAST so that we could correlate the score of the first two items with the score on the last six items, as well as with the psychologist’s determination of IPV.

All eight WAST items are scored 1 to 3. For example, if one answers “a lot of tension” to the first item, she is given a score of 3, while “some tension” is scored 2, and “no tension” is scored 1. If she answers “often” or “a lot” to all items, then her total score would be 24. If the respondent answers “never” or “none” to all items, her total score would be 8. In the literature, various cut-off scores have been used to indicate IPV. For example, the tool developer used a cut-off of 13 (Brown et al., 1996). This cutoff score also was used in Wong and Othman’s (2008) IPV study in Malaysia.

For this study, the Principal Investigator (PI), an Indonesian native speaker, translated the WAST into Indonesian. The WAST was then back-translated into English by an Indonesian bilingual certified translator.

Psychologist Interview, guided by the Domestic Violence Initiative Screening (DVIS)

The judgment of a trained PULIH psychologist after conducting a diagnostic interview was considered the gold standard against which to compare results of the translated WAST. The six psychologists on the research team were trained counselors who each had at least three years of experience working with women experiencing IPV in Indonesia. To assure consistency across psychologists, they were trained to use the Domestic Violence Initiative Screening (DVIS) interview guide (Basile, Hertz & Back, 2007), which prompted them to ask about being afraid or being physically, emotionally, or sexually abused by their partner (Table 2.1).

The Queensland government developed this clinician-administered tool, and reliability and validity data for this tool are unavailable (Basile, Hertz & Back, 2007). In addition to following the DVIS, PULIH psychologists were free to ask other questions to ascertain the existence of and extent of IPV. Based on the interview, the psychologist categorized each participant into one of three categories: 1) those not experiencing IPV; 2) those experiencing IPV, but refusing assistance; and 3) those experiencing IPV and accepting of assistance. If the woman accepted help, the psychologist provided brief intervention, as described below. Notes from their interview were written on the DVIS interview guide.

For this study, the Principal Investigator (PI), an Indonesian native speaker, translated the DVIS into Indonesian. The DVIS was then back-translated into English by an Indonesian bilingual certified translator.

Socio-demographic Questionnaire

Items on the socio-demographic questionnaire are shown in Table 2.2. The Demographic Short Questionnaire was adapted from Thormar et al. (in press). They included age group (18-24, 25-34, 35-44, 45-54, 55-64, and 65+), educational level (collapsed to elementary, middle school, high school, and > high school), work status (collapsed to yes/no), ethnicity (collapsed to Jakarta/Java, Sumatran, and other), and help-seeking behavior (Table 2.3). Response options for the latter included: visit a PHC, visit an Emergency Response Unit, visit a service provider, call a hotline service, report to a policewoman's desk, and other.

Table 2.1. The 8-item WAST and the 4-item DVIS

Woman Abuse Screening Tool (WAST)	Domestic Violence Initiative Screening
<p>1. In general, how would you describe your relationship? A lot of tension Some tension No tension</p> <p>2. Do you and your partner work out arguments with Great difficulty Some difficulty No difficulty</p> <p>3. Do arguments ever result in you feeling put down or bad about yourself? Often Sometimes Never</p> <p>4. Do arguments ever result in hitting, kicking or pushing? Often Sometimes Never</p> <p>5. Do you feel frightened by what partner says or does? Often Sometimes Never</p> <p>6. Has your partner ever abused you physically? Often Sometimes Never</p> <p>7. Has your partner ever abused you emotionally? Often Sometimes Never</p> <p>8. Has your partner ever abused you sexually? Often Sometimes Never</p>	<p>Health worker to explain the following in own words: “At this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home. The reason is because violence is very common, and we want to improve our response to families experiencing violence. Please answer yes or no to each question.”</p> <p>1. Are you ever afraid of your partner? YES NO</p> <p>2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? YES NO</p> <p>3. In the last year, has your partner put you down, humiliated you, or tried to control your actions in any way? YES NO</p> <p>4. In the last year, has your partner threatened to hurt you physically or sexually? YES NO</p> <p>DV Risk Status: <input type="checkbox"/> Domestic Violence not identified <input type="checkbox"/> Domestic Violence identified, refused help <input type="checkbox"/> Domestic Violence identified, help provided</p> <p>Provided with: <input type="checkbox"/> Contact phone numbers for DV <input type="checkbox"/> Referral to PULIH Trauma Recovery Centre <input type="checkbox"/> Referral to hospital-based service <input type="checkbox"/> Referral to other community DV service <input type="checkbox"/> Referral to general practitioner <input type="checkbox"/> Other: _____</p>

Data Collection Procedures

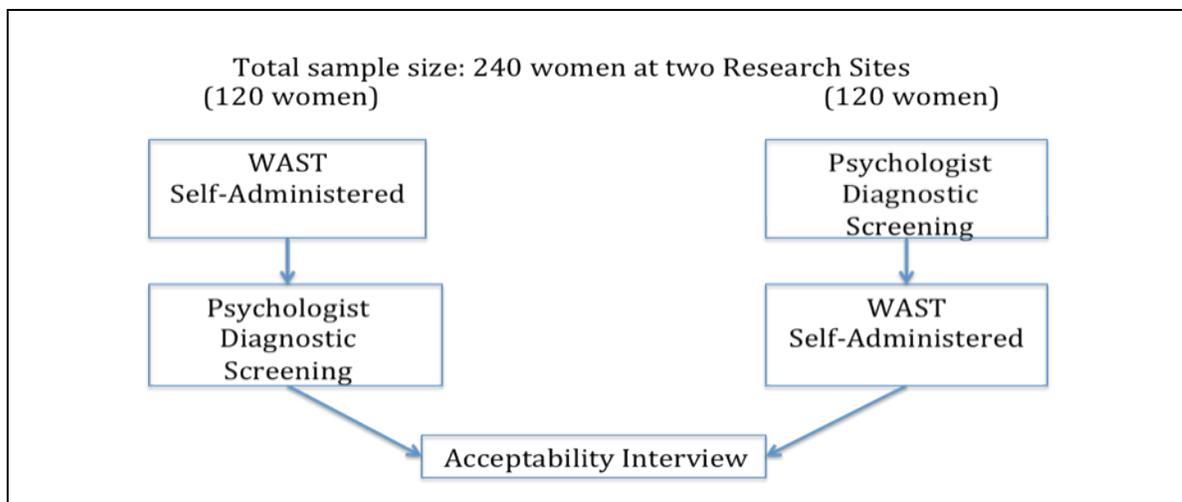
At the start of the study, the Research Team received four hours of training by the Principal Investigator. The training included a didactic presentation about the purpose and importance of the study, a discussion of the recruitment and testing protocol, and hands-on training with the WAST, psychologist interview, and other data collection tools. The psychologists were trained to provide women identified as experiencing IPV with brief intervention, which included counseling, providing information on IPV services, helping the women develop a safety plan and other necessary safety promoting behaviors, and referring the women to appropriate service providers as requested. Psychologists also were equipped to provide women with wallet-sized hotline cards with a Trauma Recovery Center's contact details and flyers explaining the different types of IPV.

The 8-member research team consisted of six psychologists (including the Principal Investigator and Research Assistant) and two non-psychologists who recruited study participants. All six psychologists had training and experience working with women who had experienced IPV. For each participating PHC, there were three psychologists (two on duty on a daily basis) and a recruiter. The recruiters were tasked to check participants' eligibility, ensured they understood and signed the consent form, and assigned them to one of two study arms. In one arm, participants completed the WAST, and then were interviewed by a psychologist (method 1). In the other arm, participants were first interviewed by the psychologist, and then completed the WAST (method 2). This was done to test if taking the WAST before the interview might increase the likelihood of reporting IPV. The psychologist interview was done in a private room.

As recommended by the partnering PHC, participants at the district PHC were approached as they waited at the pharmacy for their prescriptions, while participants at the sub-district PHC were approached as they waited for their appointments. Only recruiters were aware if method 1 or method 2 was in effect with each research participant, and the psychologists also were blinded to the WAST results. Study subjects received a package of basic food necessities (rice, sugar, flour, salt, soy sauce) for their participation.

During February-March 2012, recruiters approached PHC female patients in the two research sites and confirmed their eligibility and obtained informed consent in private. Participants were told that the research was on women’s health and involved completing two short questionnaires (the WAST and the Demographics Short Questionnaire) and two short interviews (one with a psychologist and another with the Research Associate about the acceptability of the IPV screening methods. Results of the latter are presented in Chapter 3. Figure 2.1 depicts the flow of research participants.

Figure 2.1 Flow of research participants



Data Analysis

Statistical analysis was done using SPSS version 19. Participants were compared across the two PHCs on socio-demographic variables, using χ^2 to test for differences in categorical variables (age group, education, ethnicity, whether working or not, and help-seeking behaviors) and unpaired t-tests to test for differences in continuous variables (years of marriage and number of children).

IPV prevalence was estimated based on the psychologist interview. We examined if prevalence varied by whether the participant was interviewed before (method 1) or after (method 2) completing the WAST. To determine the sensitivity and specificity of the WAST, two-by-two tables were constructed, noting proportions of true and false positives and negatives when comparing the psychologist’s

determination against the WAST determination. Both were expressed as a percentage (Hebel & McCarter, 2006):

$$\text{Sensitivity} = \frac{\text{Women positive by the "gold standard" and positive by WAST} \times 100}{\text{Total number of women "with condition" according by to gold standard}}$$

$$\text{Specificity} = \frac{\text{Women negative by the "gold standard" and negative by WAST} \times 100}{\text{Total number of women not with condition according to "gold standard"}}$$

Although the recommended WAST cut-off for IPV is 13, we estimated sensitivity and specificity for the WAST at various cut-off points, from 9 to 13. Reliability of the WAST was calculated using Cronbach coefficient α . Pearson correlation was used to correlate the score from the WAST-Short (the first two items) with the score from the other six WAST items. To further examine differential findings from the two IPV screening methods, item-by-item and total-score analyses of the WAST and DVIS were conducted. Finally, we compared women who experience IPV against those that did not by socio-demographic variables and clinic using χ^2 and unpaired t-tests.

Results

Comparison of socio-demographic variables of research participants from the two participating sites

A total of 250 adult patients from the two participating PHC in South Jakarta were approached to participate in the study. Of these, 240 consented (96%). The 10 who did not consent said they were too busy (3), could not participate because they had children they needed to attend to (5), and/or had their husbands waiting for them at the PHC's parking lot (2). Of the consenting participants, 122 (50.8%) were from the district PHC and 118 (49.2%) from the sub-district PHC.

As shown in Table 2.2., the participants in the two sites differ significantly on demographic characteristics. In general, participants at the district PHC were younger and better educated, with fewer years of marriage and fewer children, than participants at the sub-district PHC. Specifically, at the district PHC, 71.3% participants were under 35 years of age, compared to only 33.2% participants at the

sub-district PHC, and 57.4% of participants at the district PHC completed education through high school compared to only 37.3% of the sub-district PHC participants. Although not shown in table, women in the district PHC had a mean of 9 years of marriage, compared to 17 years for women in the sub district PHC ($p<.001$), and they had a mean of 2 children, while women in the sub district PHC had a mean of 3 children ($p<.05$).

Although the majority of participants at both clinics were from Jakarta and Java, at the district PHC there were fewer Sumatrans (5.8%) and none from the other islands (Sulawesi, East Nusa Tenggara, West Nusa Tenggara, Maluku and West Papua), while at the sub- district PHC, there were more Sumatrans (16.1%) and a few from other islands (2.1%). The majority (80%) of participants in both PHCs were unemployed. Those who worked were working as professionals (teachers and office staff), in the service and food industries, as entrepreneurs, and in the private sector without identifying the kind of work.

Table 2.2. Description of Research Participants

	All (N=240)	District PHC (N=122)	Sub district PHC (N= 118)	p value
Age				
18-24	15 (6.2%)	12 (9.8%)	3 (2.5%)	$p<0.001$
25-34	110 (45.8%)	75 (61.5%)	35 (29.7%)	
35-44	80 (33.3%)	29 (23.8%)	51 (43.2%)	
45-54	29 (12.1%)	6 (4.9%)	23 (19.5%)	
55-64	6 (2.5%)	0	6 (2.5%)	
Education				
≤ Elementary school	30 (12.5%)	5 (4.1%)	25 (21.2%)	$p<0.001$
Middle school	62 (25.8%)	30 (24.6%)	32 (27.1%)	
High school	114 (47.5%)	70 (57.4%)	44 (37.3%)	
> High school	34 (14.2%)	17 (13.9%)	17 (14.4%)	
Ethnicity				
Jakartans, Javanese	208 (87.0%)	109 (90.1%)	99 (83.9%)	$p<0.005$
Sumatrans	26 (10.8%)	7 (5.8%)	19 (16.1%)	
Others	5 (2.1%)	0	5 (2.1%)	
Working Status				
Working	48 (20%)	34 (27.9%)	14 (11.9%)	$p<0.005$

Help-seeking behaviors of research participants

The last question on the demographic questionnaire asked women where they would be likely to seek help if they ever encounter IPV. Responses are shown in Table 2.3, and significant differences were seen between women at the two PHCs. At the district PHC, 42.6% of women said they would report IPV to a healthcare provider, hotline, police woman, or some other official entity compared to only 26.3% of women at the sub-district PHC ($p < .005$). Keeping IPV within family and friends was the choice of more women at the sub-district PHC than the district PHC (52.5% vs. 36.1%).

Table 2.3. Help-seeking behaviors of women at the 2 PHC

	All (N=240)	District PHC (N=122)	Sub district PHC (N= 118)
Would Report			
Report to PHC	26 (10.8%)	17 (13.9%)	9 (7.6%)
Go to ER	3 (1.3%)	2 (1.6%)	1 (0.8%)
Talk to service provider	20 (8.3%)	13 (10.7%)	7 (5.9%)
Go to a police woman's desk	24 (10.0%)	17 (13.9%)	7 (5.9%)
Hotline	3 (1.3%)	0	3 (2.5%)
Report	7 (2.9%)	3 (2.5%)	4 (3.4%)
Total	83 (34.6%)	52 (42.6%)	31 (26.3%)
Would not report, but would:			
Talk to family and friends	106 (44.2%)	44 (36.1%)	62 (52.5%)
Remain quiet, solve own problems	32 (13.3%)	18 (14.7%)	14 (11.9%)
Leave husband	4 (1.7%)	2 (1.6%)	2 (1.7%)
Practice self defense	6 (2.5%)	0	6 (5.1%)
Total	148 (61.7%)	64 (55.1%)	84 (71.2%)
Missing	9 (3.8%)	6 (4.9%)	3 (2.5%)

Prevalence of Intimate Partner Violence by PHC by psychologist interview

The prevalence of IPV as determined by psychologist interview was 36.3%. As shown in Table 2.4, there was no difference in prevalence between those women who completed the WAST before the interview and those women who completed it after the interview ($p=0.50$). However, a greater proportion of women in the district PHC (41.8%) were determined to be experiencing IPV than in the sub-district PHC (29.7%, $p=0.05$).

Turning to the WAST, the number of women who scored at various cut-offs or higher are shown in Table 2.5. About 74.2% of the women had a score of 9 or higher, 55.4% had a score of 10 and higher, 40.8% of the women had a WAST score 11 or higher, 26.3% had a score of 12 or higher, and 17.1% had a score of 13 or higher (the cut-off recommended by the WAST developer).

Table 2.4. Women experiencing IPV as determined by psychologist interview, by research method and clinic

	All (N=240)	IPV identified (N=87)	IPV not identified (N= 153)	p value
Research method				
1-WAST first	122 (50.8%)	42 (34.4%)	80 (65.6%)	p=0.50
2-Interview first	118 (49.2%)	45 (38.1%)	73 (61.9%)	
Clinic				
District PHC	122 (50.9%)	52 (42.6%)	70 (57.4%)	p=0.05
Sub district PHC	118 (49.2%)	35 (29.7%)	83 (70.3%)	

Sensitivity and specificity for the WAST and the associated positive predictive values (the proportion of positive test results that are true positives) at different cut-off values are shown in Table 2.5. At a cut-off point of 9, the sensitivity of the WAST is 91.9% and the specificity was 35.7%. At increasingly higher cut-off points, the specificity increased, but the sensitivity decreased. For example, at a cut-off of 13 (recommended by WAST developers) the sensitivity was 41.9%, and the specificity was 96.8%. In the Indonesian population, a cut-off score of 10 may be best, as the sensitivity was almost 85% with a specificity of 61.0%. Based on the positive predictive value, with a cut-off of 10, 55.4% of the women would be identified as abused, yielding more false positives than desired, but identifying most of the true cases.

Reliability of the WAST

Cronbach's coefficient alpha to test the reliability of the WAST yielded the following results: 0.801 for the eight items, 0.713 for WAST items 3-8, and 0.667 for WAST-Short or items 1-2.

Table 2.5. Sensitivity and Specificity at Different WAST Cut-Off Points

	Number of Women with a WAST Score at the Cut-Off or Higher	Sensitivity	Specificity	Positive Predictive Value
Cut-off point of 9	178 (74.2%)	91.9%	35.7%	44.3%
Cut-off point of 10	133 (55.4%)	84.9%	61.0%	54.9%
Cut-off point of 11	98 (40.8%)	75.6%	78.6%	66.4%
Cut-off point of 12	63 (26.3 %)	58.1%	91.6%	79.4%
Cut-off point of 13	41 (17.1%)	41.9%	96.8%	88.3%

Correlation of WAST-Short and WAST-Long

Correlation between the WAST-Short (items 1-2) and the WAST-Long (1-8) was moderately significant with an $r = 0.581$.

Item by item WAST and Psychologist Interview Analysis

In the next tables, the frequencies for each item in the DVIS (Table 2.6) and the WAST (Table 2.7) are displayed. This was done to examine which items in the DVIS and the WAST were able to distinguish women experiencing IPV from those without IPV.

Table 2.6. DVIS items by IPV Status, as determined by Psychologists

	Total (N=240)	Women with IPV (n=87)	Women without IPV (n=153)	P Value
Q1. Are you ever afraid of your partner? YES	71 (29.6%)	57 (65.5%)	13 (8.5%)	$p < 0.001$
Q2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? YES	22 (9.2%)	21 (24.1%)	0	$p < 0.001$
Q3. In the last year, has your partner put you down, humiliated you, or tried to control in any way? YES	75 (31.2%)	74 (85.1%)	0	$p < 0.001$
Q4. In the last year, has your partner threatened to hurt you physically or sexually? YES	27 (11.2%)	26 (29.9%)	0	$p < 0.001$

Table 2.7. Responses of WAST items for women with and without IPV as determined by the psychologist

	Total (N=240)	Women with IPV (n=87)	Women without IPV (n=153)	p Value
W1. In general, how would you describe your relationship?				
A lot of tension	12 (5%)	10 (11.5)	2 (1.3)	p<0.001
Some tension	58 (24.2%)	37 (42.5)	21 (13.7)	
No tension	170 (70.8%)	40 (46.0)	130 (85.0)	
W2. Do you and your partner work out arguments with				
Great difficulty	12 (5%)	10 (11.5%)	2 (1.3%)	p<0.001
Some difficulty	58 (24.2%)	35 (40.2%)	23 (15.0%)	
No difficulty	170 (70.8%)	42 (48.3%)	128 (83.7%)	
W3. Do arguments ever result in result in you feeling put down or bad about yourself?				
Often	17 (7.1%)	15 (17.2%)	2 (1.3%)	p<0.001
Sometimes	125 (52.1%)	57 (65.5%)	68 (44.4%)	
Never	98 (40.8%)	15 (17.2%)	83 (54.2%)	
W4. Do arguments ever result in hitting, kicking or pushing?				
Often	3(1.2%)	3 (3.4%)	0	p<0.001
Sometimes	27 (11.2%)	22 (25.3%)	5 (3.3%)	
Never	210 (87.5%)	62 (71.3%)	148 (96.7%)	
W5. Do you feel frightened by what your partner says or does?				
Often	6(2.5%)	5 (5.7%)	1 (0.7%)	p<0.001
Sometimes	81 (33.8%)	42 (48.3%)	39 (25.5%)	
Never	153 (63.6%)	40 (45.0%)	113 (73.9%)	
W6. Has your partner ever abused you physically?				
Often	3 (1.2%)	3 (3.4%)	0	p<0.001
Sometimes	26 (10.8%)	21 (24.1%)	5 (3.3%)	
Never	211 (87.9%)	63 (72.4%)	148 (96.7%)	
W7. Has your partner ever abused you emotionally?				
Often	11 (4.6%)	10 (11.4%)	2 (1.3%)	p<0.001
Sometimes	72 (30%)	44 (50.6%)	28 (18.3%)	
Never	156 (65%)	33 (37.9%)	123 (80.4%)	
W8. Has your partner ever abused you sexually?				
Often	3 (1.2%)	3 (3.4%)	0	p<0.001
Sometimes	19 (7.9%)	14 (16.1%)	5 (3.3%)	
Never	218 (90.8%)	70 (80.5%)	148 (96.7%)	

All the items in the DVIS were able to distinguish women experiencing IPV from those not experiencing IPV. All women answering “yes” to Questions 2, 3, and 4 were categorized as abused by the interviewing clinician. Of all 87 women determined to be experiencing IPV, 85.1% reported that their partner had put them down, humiliated them, or tried to control them in any way, 65.5% reported that they were afraid of your partner, 29.9% reported that their partner had threatened to hurt them physically or sexually, and 24.1% reported that their partner had hit, kicked, punched or otherwise hurt them.

All the items in WAST were able to distinguish women experiencing IPV from those who were not. Women were most likely to answer yes to Question 3 on whether arguments ever resulted in them feeling put down or bad about themselves, with 17.2% answering often and 65.5% answering sometimes. The fewest women answered often and sometimes to Question 8 (on sexual abuse), with 3.4% answering often and 16.1% answering sometimes.

Correlations among WAST and DVIS Scores and the Psychologist’s Determination

Correlations among the WAST and DVIS scores and the psychologist’s determination were examined (Table 2.8). All correlations were significant at $p < 0.001$. However, the highest correlation was seen between the psychologist’s determination of IPV and the DVIS total score.

Table 2.8. Correlations among WAST and DVIS Scores and the psychologist's determination

	IPV as determined by psychologist	WAST short	WAST long	WAST total	DVIS total
IPV as determined by psychologist	1				
WAST short score (2 items)	.411	1			
WAST long score (6 items)	.555	.561	1		
WAST total score (8 items)	.564	.799	.946	1	
DVIS total score (4 items)	.810	.460	.639	.645	1

Characteristics of Women with and without IPV as Determined by the Psychologist

Finally examined were socio-demographic characteristics that might distinguish women experiencing IPV from those who were not. As shown in Table 2.9, only one variable was significant. Specifically, of the 87 women who were determined to be experiencing IPV, 31.4% were working outside the home, compared to only 13.6% of women who were not determined to be experiencing IPV.

Discussion

Research findings suggested that one in three women were experiencing IPV in the population studied. The 36.3% prevalence found through the psychologist interview indicated that IPV is more common occurrence among PHC patients than expected based on the Malaysian WAST study of 5.6% (Wang & Othman, 2008) and reports of IPV made to the Indonesian National Commission on Violence Against Women (1%).

Table 2.9. Characteristics of those with and without IPV as determined by the psychologist

	All (N=240)	Women with IPV (n=87)	Women without IPV (n=154)	p value
Age				
18-24	15 (6.2%)	4 (4.7%)	11 (7.1%)	p>0.250
25-34	110 (45.8%)	47 (54.7%)	63 (40.9%)	
35-44	80 (33.3%)	23 (26.7%)	57 (37.0)	
45-54	29 (12.1%)	9 (10.5%)	20 (13.0)	
55-64	6 (2.5%)	3 (3.5%)	3 (1.9%)	
Education				
≤ Elementary school	30 (12.5%)	9 (10.5%)	21 (13.6%)	p>0.088
Middle school	62 (25.8%)	15 (17.4%)	47 (30.5%)	
High school	114 (47.5%)	47 (54.7%)	67 (43.5%)	
> High school	34 (14.2%)	15 (17.4%)	19 (12.3%)	
Ethnicity				
Jakartans, Javanese	208 (87.0%)	70 (82.4%)	138 (89.6%)	p>0.098
Sumatrans	26 (10.8%)	14 (16.5%)	12 (7.8%)	
Others	5 (2.1%)	1 (1.2%)	4 (2.6%)	
Working Status				
Working	48 (20%)	27 (31.4%)	21 (13.6%)	p<0.001

However, the type of IPV most commonly found in our study—psychological abuse—concur with the type of IPV most commonly reported to the National Commission on Violence Against Women. Of the 113,878 reported cases of domestic violence in 2011, husbands perpetrated 97% of them, and 94% were psychological in nature (Indonesian National Commission on VAW, 2012). Looking back at the 2010 annual report, psychological violence accounted for 88% of the total reported IPV cases of 98,577 (Indonesian National Commission on VAW, 2011).

The overall prevalence of IPV identified by the psychologist interview (gold standard) was two times higher (36.25%) than prevalence estimated by the WAST when using the recommended cutoff score of 13 (17.1%). At this recommended cutoff, the sensitivity of the WAST was 41.9% and the specificity was 96.8, meaning that many cases of IPV would be missed at this high cutoff. Using a lower WAST cutoff score, like 10, would identify more cases. With 10 as the cut-off score, the WAST had a sensitivity of 84.8% and specificity of 61.03% in this Indonesian population. At this score, 55.4% of the women would be identified as abused, yielding more false positives than desired, but identifying most of the true cases.

The two participating sites were a district PHC, mandated to treat women reporting IPV, and a sub-district PHC, responsible to refer women reporting IPV to a district PHC (Ministry of Health, 2009). Women at the two centers differed significantly, with women from the district PHC more likely to be self-employed or employed, were better educated, and younger than women at the sub-district PHC. There also was a difference in willingness to report between women who came to the two research sites, with more women from the district PHC saying they would report their IPV experience to a health provider or policewoman. It is likely that women in the district PHC were more likely to agree to report IPV because they were younger and better educated than women in the sub-district PHC. Also, because the district PHC serves more women from a larger catchment area, these women may feel more anonymous than women attending the smaller, community-specific sub-district PHC.

We were surprised that only one socio-demographic variable—employment outside the home—helped distinguish women with IPV from those without. In the Malaysia study, ethnicity, income, urban/rural residence, and husband/partner

taking alcohol/drugs were significantly different in those with IPV and those without IPV. Future research in Indonesia should examine these variables.

Not surprisingly, interviews with women experiencing abuse took longer than interviews with non-abused women. Because the PHC setting is very busy, it was gratifying that a self-administered screening tool, such as the WAST, can be used to identify IPV (rather than a psychologist interview, which is more time consuming and expensive). However, because the WAST-Short score did not correlate as well with the gold standard determination ($r=.410$), it is recommended that the full 8-item WAST be used as a screening tool, and a cutoff of 10 be used to identify women who may be experiencing IPV. We found that the WAST-Long has good internal consistency in the Indonesia population, at .80.

Most importantly, findings indicate that women talk with their friends and family about their IPV experience (Table 2.3.) This finding may suggest that intervention strategies that engage family and friends may be effective. Also, future research should work with women to determine their perspectives on IPV, their responses, and their needs regarding this health issue.

Limitations of the research

Although this study has many strengths, it has several limitations. First, this research was done in two participating PHC in South Jakarta, which is home to Jakartans in higher income brackets than in other municipalities of Jakarta, so findings may not be generalizable to PHCs in other areas of Jakarta. Findings from these urban PHCs also may not be generalizable to women in other parts of Indonesia. A probability household sample would be able to provide a more accurate estimate of IPV prevalence in the country. Geographically, Indonesia is an archipelago consisting of 17,506 islands with more than 300 ethnic groups and 365 active languages spoken. Thus, the prevalence of IPV is likely to vary by region.

Also, urban areas like Jakarta are more likely than rural parts of Indonesia to have services to assist women identified with IPV. This raises questions about the ethics of identifying IPV in communities with no support services. However, identifying IPV will help raise awareness, which can help raise demand for services and help change social norms about the unacceptability of IPV.

Because IPV is not openly discussed outside of family and friends, we were surprised by the high rate of participation in the research (96%). We believe that women were attracted by the opportunity to consult with a psychologist at no cost, as well as the free bag of basic food commodities.

CHAPTER 3
ACCEPTABILITY OF THE WOMAN ABUSE SCREENING TOOL
COMPARED TO PSYCHOLOGIST INTERVIEW
AT TWO PRIMARY HEALTH CENTERS IN JAKARTA, INDONESIA

Abstract

Intimate Partner Violence (IPV) screening in health centers and physician offices increases self-disclosure of IPV experiences, however no routine screening tools have been validated for the Indonesian population. Two screening methods were compared, the self-administered Woman Abuse Screening Tool (WAST) and the psychologist interview guided by the Domestic Violence Initiative Screening (DVIS) interview guide. After administration of the two screening tools, an interview was conducted to gauge the acceptability of using the WAST as a screening tool in Indonesia.

Female patients aged 18 years and older attending two Primary Health Centers (PHC) in Jakarta were asked to participate in the research. They were either married or involved with a partner, but attended the PHC unaccompanied by their partners. Half of the 240 participants (120 women) completed the self-administered WAST first, followed by the psychologist interview. The other half were interviewed first by the psychologist, and then self-completed the WAST. After completing both the self-administered WAST and the psychologist interview, each of the 240 women participated in an acceptability interview, which solicited impressions of the two screening methods and preference for IPV screening method at the PHC.

Overall, 209 (87%) of research participants found the WAST to be acceptable, and 204 (85%) research participants found the psychologists' interview to be acceptable. When asked for their preferred method, 165 (69%) research participants preferred the interview compared to 31(13%) that preferred the self-administered WAST. Thirty-seven (15%) women felt that both methods of screening were fine, and 7 (3%) did not give answers or were neutral. When asked how they would feel about completing the WAST annually at the PHC as a screening tool, 219 (91%) women said they would not mind it

These findings suggest that the WAST would be an acceptable tool to use in PHCs for routine screening for IPV. This will be considered along with other research findings in this dissertation to recommend to the Indonesian Ministry of Health an IPV screening tool for PHC setting.

Introduction

Screening for IPV has been found to increase IPV reporting (The Family Violence Prevention Fund's Research Committee, 2003). The Institute of Medicine (2011) recommended IPV screening and counseling for women and adolescent girls, hence screening is part of the US Affordable Care Act as a preventive health service. Furthermore, the American Medical Association recommended physicians to routinely screen for physical, sexual, and psychological abuse, as exposure to IPV may have adverse health effects in patients (Nelson, Bougatsos and Blazina, 2012).

Researchers have studied women's perceptions of being asked by a health professional about IPV. Bradley et al. (2002) conducted a study of reported frequency of domestic violence in Ireland involving 1,871 women attending general practice. The researchers found that 39% (651 of 1,692) had experienced violent behavior by a partner. However, only 12% (78 out of 651) of the women reported that their primary care physicians (PCP) had inquired about IPV. Koziol-McLain et al. (2008) conducted a qualitative study that found that women do not react negatively when asked about their IPV experience. Research findings by Boyle & Jones (2006) indicated that 77% of women surveyed for IPV by their primary care providers favored routine inquiry.

The Woman Abuse Screening Tool (WAST) is an 8-item screening tool for IPV that can be administered by a health care staff member or used as a self-screening tool (Basile et al., 2007). Judith Brown, the developer of the WAST, conducted research involving both physicians and patients to assess their comfort levels related to the WAST. Patients were asked how comfortable they were with their physicians asking them each of the eight WAST questions, and findings indicated that at least 91% of the women felt comfortable to very comfortable with each of the eight items (Brown, Lent & Sas, 2000). Using the WAST in Malaysia, Wang & Othman (2009)

found that the tool was perceived by patients to have clarity and to be easily understood. More importantly, patients felt comfortable answering the questions.

Since no published work has been found on the WAST in Indonesia, this research aimed to gauge acceptability of the WAST in women attending PHCs in Indonesia. Reactions to the WAST were compared to reactions to the determined gold standard in IPV reporting, the psychologist interview. The research question posed is, *“How acceptable is the Woman Abuse Screening Tool (WAST) among women seeking services at two PHCs in South Jakarta, Indonesia?”*

Methods

Study Design

A qualitative research design was used to assess the acceptability of the WAST (translated into Indonesian) among women attending two PHC in Jakarta, Indonesia. Specifically, semi-structured interviews were conducted after women had completed both the WAST and the psychologist interview about their IPV experience. This qualitative study was part of a larger research initiative that also investigated the reliability and validity of the Indonesian translation of the WAST (Chapter 2).

Sample

This study utilized a convenience sampling method of women attending the two participating PHC: a district PHC and a sub-district PHC in South Jakarta, Indonesia. Between the two PHC, about 7,281 patients are seen each month. It was estimated that at least 50% (3,600) of these patients were females' age 18 and older and eligible to participate in this study. Eligibility criteria of research participants were: 1) a client attending the PHC 2) 18 years or older; 3) married or involved with a male partner); 4) not accompanied by husband/partner at the time of the study; 5) in good physical condition as self-reported by the women; 6) able to read and write Indonesian; and 7) willing to spend 20-30 minutes for the study. Only if she met the inclusion criteria and agreed to undertake research procedures, was she asked to sign the consent form (Appendix A includes the Consent Form for Chapter 2 and Chapter 3).

Measures

The Woman Abuse Screening Tool

The WAST is an eight-item IPV screening tool designed by Brown et al. (1996) that can be used as a self-administered screening tool. Items are shown in Table 3.1. Using a score of 13 (out of 24) as a cut-off for IPV, Brown et al. (1996) found that the English-language version of the WAST was able to correctly classify 100% non-abused women and 91.7% abused women in a US sample. In a later study, Brown et al. (2000) found that the WAST had good internal consistency (α coefficient of 0.75) and that more than 90% of women reported being comfortable or very comfortable when the WAST was administered to them.

For this study, the Principal Investigator (PI), an Indonesian native speaker, translated the WAST into Indonesian. The WAST was then back-translated into English by an Indonesian bilingual certified translator.

The Domestic Violence Initiative Screening questions

The Domestic Violence Initiative Screening (DVIS) is a clinician-administered tool developed by the Queensland Government with reliability and validity data for this tool unavailable (Basile, Hertz, & Black, 2007). Items are shown in Table 3.1. In addition to using the DVIS as guidance, study psychologists were free to ask other questions to ascertain the existence and extent of IPV. Based on the interview, the psychologist categorized each participant into 1) those not experiencing IPV; 2) those experiencing IPV, but refusing assistance; and 3) those experiencing IPV and accepting assistance. If the woman accepted help, the psychologist provided brief intervention, including a leaflet on IPV and information about a local psychological service provider and other service providers that may be helpful. The DVIS was translated into Indonesian by the PI, and successfully back-translated into English by an Indonesian bilingual certified translator.

Table 3.1. 8-item WAST and the 4-item DVIS questions

Woman Abuse Screening Tool (WAST)	Domestic Violence Initiative Screening Questions
<p>1. In general, how would you describe your relationship? A lot of tension Some tension No tension</p> <p>2. Do you and your partner work out arguments with Great difficulty Some difficulty No difficulty</p> <p>3. Do arguments ever result in you feeling put down or bad about yourself? Often Sometimes Never</p> <p>4. Do arguments ever result in hitting, kicking or pushing? Often Sometimes Never</p> <p>5. Do you feel frightened by what partner says or does? Often Sometimes Never</p> <p>6. Has your partner ever abused you physically? Often Sometimes Never</p> <p>7. Has your partner ever abused you emotionally? Often Sometimes Never</p> <p>8. Has your partner ever abused you sexually? Often Sometimes Never</p>	<p>Health worker to explain the following in own words: “At this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home. The reason is because violence is very common, and we want to improve our response to families experiencing violence. Please answer yes or no to each question.”</p> <p>1. Are you ever afraid of your partner? YES NO</p> <p>2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? YES NO</p> <p>3. In the last year, has your partner put you down, humiliated you, or tried to control your actions in any way? YES NO</p> <p>4. In the last year, has your partner threatened to hurt you physically or sexually? YES NO</p> <p>DV Risk Status:</p> <p><input type="checkbox"/> Domestic Violence not identified</p> <p><input type="checkbox"/> Domestic Violence identified, refused help</p> <p><input type="checkbox"/> Domestic Violence identified, help provided</p> <p>Provided with:</p> <p><input type="checkbox"/> Contact phone numbers for DV</p> <p><input type="checkbox"/> Referral to PULIH Trauma Recovery Centre</p> <p><input type="checkbox"/> Referral to hospital-based service</p> <p><input type="checkbox"/> Referral to other community DV service</p> <p><input type="checkbox"/> Referral to general practitioner</p> <p><input type="checkbox"/> Other: _____</p>

The Acceptability Interview

Research participants completed both the WAST and the psychologist interview guided by the DVIS prior to undertaking the Acceptability Interview. The Acceptability Interview was a semi-structured interview guide in three parts developed by the PI (Table 3.2). The first part consisted of questions related to WAST, the second consisted of questions about the psychologist interview, and the third part consisted of questions comparing their experiences of the self-completion of the WAST and the psychologist interview.

Table 3.2 Acceptability Interview Guide

<p>Questions about WAST</p> <p>One of the things that you did was the Woman Abuse Screening Test.</p> <ol style="list-style-type: none">1. What is your overall impression of the WAST?2. How did the WAST affect you?3. In your opinion, which were difficult items?4. How did you feel after filling it out?5. How do you think other women would feel about filling out the WAST when they visit the PHC?6. If we were to recommend that the PHC ask every woman to fill out the WAST once a year, how would you react? <p>Questions about Psychologist's Diagnostic Interview</p> <p>You also completed an interview by a psychologist.</p> <ol style="list-style-type: none">7. What is your overall impression of the interview?8. Were there any difficult items?9. How did you feel after the interview?10. How would other women feel about the interview?11. What were your feelings after the interview? <p>Comparison between the WAST and the psychologist's interview</p> <ol style="list-style-type: none">12. If you had your choice of filling in the WAST or talking to a psychologist about IPV, which would be more comfortable for you? Why?13. Which method do you think most women would be more comfortable with?14. Do you think the PHC should ask women if they experience IPV? Why or why not?

In total, the Acceptability Interview consisted of 14 questions and took approximately 10-15 minutes to complete. As was the process with previous measures, the PI translated the Acceptability Interview into Indonesian, which was

successfully back-translated into English by an Indonesian bilingual certified translator.

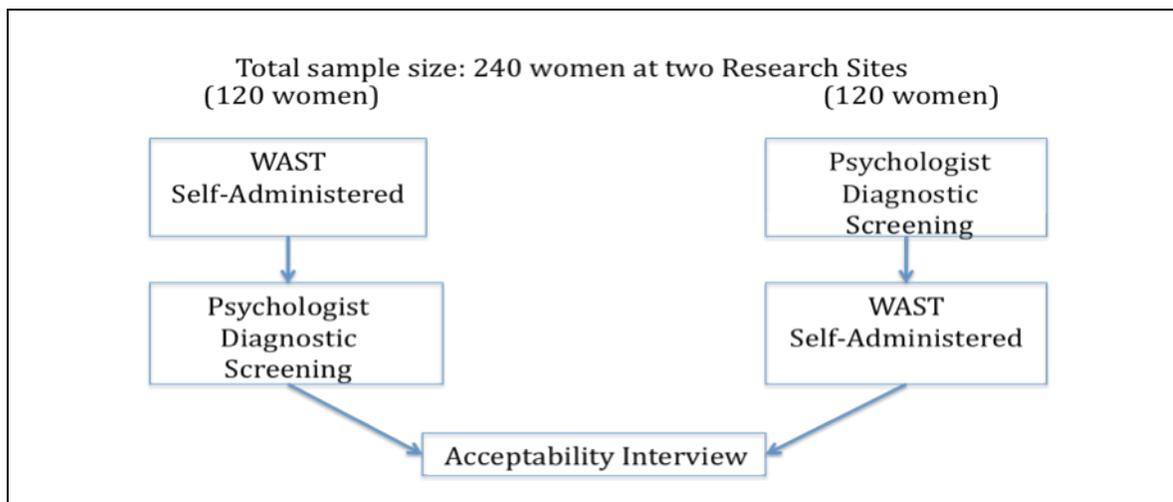
Two women were recruited to pretest the interview tool, and they provided feedback for improvement. Their suggestions were incorporated, and the tool was retested with two more women. The process was repeated three times before no new suggestions were offered.

Data Collection Procedures

The Acceptability Interview was conducted after women had completed both the WAST and the interview by the psychologist. There were two methods of administration. In both PHCs, about half of the women completed the WAST before the psychologist interview, and the other half completed the psychologist interview before the WAST. The flow of participants is shown in Figure 3.1.

The Research Assistant (RA) administered the Acceptability Interviews at the sub-district PHC, and the PI administered the Acceptability Interviews at the district-level PHC. The interviews were conducted in private rooms at the PHC. After completion of the acceptability interview, women were each given their incentives of a basic food package, which consisted of rice, sugar, salt, soya sauce, tea, coffee and flour.

Figure 3.1 Flow of research participants



Cresswell (2009) outlined a list of qualitative data collection approaches. Although it is recommended to audio record interviews, we did not use a recording device because it was believed that this would intimidate participants. Instead, the researchers used a qualitative response data collection sheet to note women's responses to the questions (Table 3.3), taking notes during the interview. Information from the response sheets for the 240 participants was entered into Excel for analysis.

Table 3.3 Qualitative Response Sheet for Data Collection

Answers on the WAST		
1	Overall Impression of WAST	
2	How WAST influenced you	
3	Difficult items	1 2 3 4 5 6 7 8
4	Feelings after filling it out	
5	Other women's willingness to fill WAST when visiting PHC?	
6	Feelings about recommendation for screening for adult married women at the PHC?	
Psychologists' Diagnostic Interview		
7	Overall Impression of Interview	
8	Difficult questions	
9	Feelings after the interview	
10	Other women's feelings about the interview	
11	Reaction after the interview	
Comparison between the WAST and the psychologist's interview		
12	Which was more comfortable? Why? WAST or Interview	
13	Method other women prefer: WAST or Interview	
14	Screen or not?	

Data Analysis

At the end of the research data collection period, the RA and the PI read all collected qualitative data responses in the Excel spreadsheet. The researchers then developed codebooks separately based on what emerged from the interview transcripts, and these were merged and used for coding the data. Weekly meetings were conducted to discuss codes and discrepancies until high coding agreement was achieved. After coding was completed, the PI drafted a written description of the

research findings and had a final discussion about findings with the RA to correct and contextualize the draft.

Results

Comparison of socio-demographic variables of research participants from the two participating sites

A total of 250 adult patients from the two participating PHC in South Jakarta were approached to participate in the study. Of these, 240 consented (96%). The ten who did not consent said they were too busy (3), could not participate because they had children they needed to attend to (5), and/or had their husbands waiting for them at the PHC's parking lot (2). Of the consenting participants, 122 (50.8%) were from the district PHC and 118 (49.2%) from the sub district PHC.

As shown in Table 3.4, the participants in the two sites differ significantly on demographic characteristics. In general, participants at the district PHC were younger and better educated, with fewer years of marriage and fewer children, than participants at the sub-district PHC. Specifically, at the district PHC, 71.3% participants were under 35 years of age, compared to only 33.2% participants at the sub-district PHC, and 57.4% of participants at the district PHC completed education through high school compared to only 37.3% of the sub-district PHC participants. Although not shown in table, women in the district PHC had a mean of 9 years of marriage, compared to 17 years for women in the sub district PHC ($p=.001$), and they had a mean of 2 children, while women in the sub district PHC had a mean of 3 children ($p=.03$).

The majority (80%) of participants in both PHCs were unemployed. Those who worked were working as professionals (teachers and office staff), in the service and food industries, as entrepreneurs, and in the private sector without identifying the kind of work. In all, 87 (36.25%) were determined by the psychologist to be experiencing IPV, and the prevalence was slightly higher in the district PHC than in the sub-district PHC. See Chapter 2 for more detail on IPV prevalence.

Themes Emerging from the Interviews

Presented in this section are emergent themes from the 240 Acceptability Interviews with female patients attending two participating PHC sites, supported with direct participants' quotes to illustrate selected themes.

Table 3.4 Description of Research Participants

	All (N=240)	District PHC (N=122)	Sub district PHC (N= 118)	P value
Age				
18-24	15 (6.2%)	12 (9.8%)	3 (2.5%)	0.000*
25-34	110 (45.8%)	75 (61.5%)	35 (29.7%)	
35-44	80 (33.3%)	29 (23.8%)	51 (43.2%)	
45-54	29 (12.1%)	6 (4.9%)	23 (19.5%)	
55-64	6 (2.5%)	0	6 (2.5%)	
Education				
< Elementary school	30 (12.5%)	5 (4.1%)	25 (21.2%)	0.000*
Middle school	62 (25.8%)	30 (24.6%)	32 (27.1%)	
High school	114 (47.5%)	70 (57.4%)	44 (37.3%)	
> High school	34 (14.2%)	17 (13.9%)	17 (14.4%)	
Working Status				
Working	48 (20%)	34 (27.9%)	14 (11.9%)	0.002*
Determined by Psychologist Interview to be experiencing IPV	87 (36.25%)	51 (41.8%)	35 (29.7%)	p>0.05

Reactions towards the WAST

Overall, 203 (85%) of research participants found the WAST to be acceptable. From all participants, only ten (4%) of the women had negative responses to the WAST. Out of the ten, two women found the items to be too intimidating because they had never heard of IPV, one was surprised about the questions asked, six women reported being tense or confused by the questions, and one did not give an answer when they were asked about their overall impression of the WAST. For the 209 who found the WAST acceptable, the detailed breakdowns per sub-themes are as follow:

WAST is fine. In all, 112 (47%) participants described the WAST as “fine, comfortable, clear, useful, and easily understood”. Some of their responses were “I feel there was no burden,” “they were not difficult” and “this can be easily understood.”

WAST Helps Express Marital Problems. Forty-eight women said that the tool allowed them to answer truthfully about what they experienced in their marriages. One said, “I could just unload my problems without having to talk about it directly,” and another said, “I can just get my issues out in the open through answering the items.” Seventeen women said that they were experiencing all the WAST items at home. One said, “It’s not difficult to answer because it’s just like what I experience at home,” and another said, “I have experienced all of what’s mentioned in the items.”

WAST Raises Awareness about IPV. Twenty-three women said that the WAST raised awareness of what IPV constitutes. For example, six had been experiencing IPV, but did not realize that psychological abuse was also considered as IPV. One said, “I now know what IPV is”. Another said, “It’s good to be open about husband and wife relationship.” Not only was the WAST useful in raising awareness among women experiencing IPV, it prompted those not experiencing it to express thanks that they did not experience behaviors described in WAST’ items. Nine women expressly reported that they did not live with a violent partner, and two of them said, “I am grateful to have a husband who doesn’t like to hit me” and “I don’t feel scared because I do not experience any of what was described.” Twenty-two others said they would be ready to recognize IPV if it ever occurs in their marriage or in relatives and friends’ relationships. Furthermore, there were feelings of protection and that other people cared enough about them.

Three women admitted that they had difficulties managing their own anger and would express their anger by breaking plates or by hurling verbal abuses towards their husbands.

When asked how they would feel about completing the WAST annually at the PHC as a screening tool, 219 (91%) women said they would not mind it. Twelve people said they would not want to complete the WAST once a year, while eight women admitted that the WAST reflected their daily realities at home so frequent administration of the WAST would make them more aware of what IPV constitutes.

A few women found some items on the WAST that were difficult to answer. Eleven participants found item 2 (*Do you and your partner work out arguments with great difficulty- some difficulty- no difficulty*) to be the most difficult. Fewer women

found item 3 (*Do arguments ever result in you feeling put down or bad about yourself?*) and item 7 (*Has your partner ever abused you emotionally?*) to be difficult.

In summary, women did not object to filling out the WAST once a year and found items contained in the screening tool to be acceptable.

Reactions of the Psychologists' Interviews

The majority of women (208, 86%) did not feel there were difficult questions asked by psychologists, with ten saying that the interview helped them understand IPV better and eight women saying they gained insight about the different forms of IPV, including verbal, sexual, emotional, and economical abuse. Detailed breakdowns of sub-theme are as follow:

Psychologists' interviews were comfortable. Of the 214 women, 104 (43%) women said they accepted the psychologists' interviews and thought these interviews were comfortable, pleasant, helpful and similar to the questions posed on the WAST.

Psychologists' interviews were useful to pour women's heart out and to explore solutions to their problems. Fifty-nine (24.5%) of the 214 women expressed their relief in having a psychologist to consult with, who could offer direct solutions to their problems. "I feel calm because anytime I have a problem, I can call on a psychologist to consult with (commenting on the hotline service 24/7 provided by PULIH Center for Trauma Recovery)." Seven women were able to express that this was the first time they disclosed their experiences to someone outside of their family and friends (psychologists are external to participants' network of family and friends), saying "I have been reluctant to speak up because I don't want it to be just gossip material with relatives and neighbors. I feel assured that my information will be kept safe." Others said, "Usually we need to pay to talk to a psychologist, now it is free and very convenient at our nearest PHC;" "We feel protected by being asked how we were;" and "We can get direct alternative solutions to our problems, and that feels relieving."

Psychologists' interviews provided information on where to report and where to seek help. Information where to seek help was appreciated by the women who

were experiencing IPV. They were glad to know that there were people outside of their family and friends who were ready to help out when they need it.

Comparison of preferred method by research participants

One hundred and sixty five (69%) research participants preferred the interview over the WAST. Their reasons varied. Seventy women felt comforted by the fact that they could speak directly to a psychologist on-site and receive ideas for solutions they could try at home. Ten women remarked that talking to a psychologist was different than chatting with their friends, relatives, or neighbors in terms of confidentiality. Five women stressed that the PHC is where psychologists should be because “those middle lower socio economic class face more problems than most.”

The WAST was preferred by 33 (14%) of research participants. Thirty-seven (15%) participants felt that both methods of screening were fine with them. Only seven women reported to be unsure about answering which IPV screening method they preferred.

Discussion

Overall, the findings from this research suggest that the translated WAST is acceptable to women attending the PHC. Fully 209 (87%) research participants found the WAST to be acceptable. On the other hand, 204 (85%) research participants also found the psychologists’ interview to be acceptable, and 165 (69%) women said they preferred interviews, while 31(13%) said they preferred the self-administered WAST. Thirty-seven (15%) women felt that both methods of screening were fine, and 7 (3%) did not give answers or were neutral.

Brown et al. (2000) asked patients how comfortable they were with their physicians asking them each of the eight WAST questions, and findings indicated that at least 91% of the women felt comfortable to very comfortable with each of the eight items. Our research finding are similar to Brown’s in that 87% of female patients found the WAST to be acceptable.

A cultural explanation about why participants preferred the interview rather than the self-administered screening tool was that because Indonesian society is more an oral society rather than a written one. Also, only 62% of the sample

completed high school, and only 14% attended college, so they may not have been used to completing written screening instruments. When examining research participants' help-seeking behaviors (see chapter 2), most said they talked about IPV within their immediate family and friends' circles. They warmed to psychologists, who they had never met before, disclosing their painful IPV experiences. This signifies that women were seeking sounding boards and solutions to solve their marital problems that can be kept confidential.

In terms of method of preference for IPV screening, other researchers also have found that direct questioning is superior to self-administered tools (Anderst, Hill & Siegel, 2004; McFarlane, Christoffel, Bateman, Miller & Bullock, 1991). Only one study, by MacMillan et al. (2006), found that self-administered approaches were preferred over face-to-face questioning.

Recommendations for Practice

Findings from this study suggest that the translated, self-administered WAST can be used as an IPV screening tool in the PHC, and that it would be acceptable to women who attend PHCs. Thus, it is recommended that the Ministry of Health mandate the use of the WAST in PHCs as a routine IPV screening tool.

If a woman is identified as positive, the woman should be referred to a behavioral health provider (nearby mental health unit or psychologist). The DVIS can be used when psychologists are present at the PHC as a clinician-administered tool. If possible, psychologists should be placed at the district PHCs mandated to provide treatment for women experiencing IPV. A recent development that occurred in the first of September 2012 was that there is now an agreement to place clinical psychologists in PHC in Jakarta.

Limitations

The generalizability of the research findings is limited to urban settings similar to Jakarta; therefore it does not extend to Indonesia's less urban, more rural areas. The provision of basic food necessities was a pull factor for women participating in the research, although all contents were wrapped in nontransparent plastic bags.

Conclusions

Instead of being offended, women accepted and even felt protected when screened for IPV by psychologists at the PHC setting. However, they also felt that the translated WAST was acceptable for use in PHCs and that they wouldn't mind completing the WAST annually if it were administered at the PHC. Women who screen positive would need to be referred to a psychologist for further intervention, and district PHCs should have a psychologist on staff to counsel women identified by the WAST to be positive and refer them to other appropriate services.

CHAPTER 4

**HEADS OF PRIMARY HEALTH CENTERS' PERCEPTIONS OF
SUPPORTS AND BARRIERS TOWARDS
ROUTINE INTIMATE PARTNER VIOLENCE SCREENING**

Abstract

In September 2004, Indonesia passed the Law on the Elimination of Violence Against Women, which criminalized IPV perpetrators. In efforts to translate the law into operational procedures, the Indonesian Ministry of Health started an initiative promoting IPV management in Primary Health Centers (PHC) in 2006. These centers have a similar purpose, mission, and service delivery system as Community Health Centers in the US. Among their many responsibilities, staffs at Indonesian PHCs are tasked with identifying and supporting women experiencing IPV. Several district PHCs have designated IPV treatment rooms, and sub-district PHCs are to refer identified IPV cases to district PHCs for follow-up. However, specific screening tools and referral protocol have not been determined or put in place. Providers rely on women to report their IPV experience when they visit their nearest PHCs.

In this study, administrators of ten districts and ten sub district PHCs across Jakarta's five municipalities were identified through stratified random sampling without replacement. They were interviewed about perceptions of supports and barriers to institutionalizing routine IPV screening of female patients attending their PHCs. Five psychologists conducted semi-structured interviews in March 2012.

Five barriers and three supports emerged from the interviews. The five barriers are that: women experiencing IPV do not report it; PHC staffs have limited knowledge and awareness of IPV; when IPV is encountered, many staffs tend to "blame the victim;" there are no specific written guidelines on IPV; and there is little community socialization on IPV. Three supports are that: some PHC heads are enthusiastic to routinely screen for IPV; some PHC already are assisting IPV victims especially in providing medical support; and there is a growing number of active community groups willing to play an important role in IPV prevention and management.

Findings can inform the development of education and training for PHC staff to improve their knowledge about IPV and attitudes toward victims. Findings also suggest that routine IPV screening could be integrated into PHC services, especially if an easily administered screening tool were available. Community groups concerned about IPV should approach and partner with PHCs so that staff knows where they can refer IPV victims for further counseling and support. Researchers should develop and test intervention strategies that will help PHCs incorporate IPV screening as a long-lasting protective intervention.

Introduction

Intimate Partner Violence (IPV) is a global public health problem and a violation of human rights (Harvey, Garcia-Moreno & Butchart, 2007). Women participating in a WHO multi-country study of IPV in 2005, found a range of lifetime experience of IPV from 13% in Japan to 61% in rural Peru, confirming that IPV is a pervasive phenomenon affecting women around the world (Garcia-Moreno, Jansen, Elsberg, Heise & Watts, 2005)

In September 2004, Indonesia passed the Law on the Elimination of Violence Against Women, which criminalized IPV perpetrators (Department of Justice Republic of Indonesia, 2004). In efforts to translate the law into operational procedures, the Indonesian Ministry of Health (MOH) started an initiative promoting IPV management in Primary Health Centers (PHC) in 2006 (MOH Training Module, 2006; PULIH, 2007). These centers have a similar purpose, mission, and service delivery system as Community Health Centers in the US. Among their many responsibilities, staff members at Indonesian PHCs are tasked with identifying and supporting women experiencing IPV. Several district PHCs have designated IPV treatment rooms, and sub district PHCs are to refer identified IPV cases to the District PHC for follow-up. However, specific screening tools and referral protocol have not been determined or put in place. Providers rely on women to report their IPV experience when they visit their nearest PHCs.

In general, PHCs have the mandate to promote and to build community participation as well as to provide complete and comprehensive services to the people in its catchment area (*Airlangga University*, 2004). Density of the population

and geographical and infrastructure conditions determine the coverage area of the PHC. A typical PHC serves 30,000 people. In remote areas with accessibility issues, a mobile PHC may manage the function of a PHC.

PHCs have faced human resource challenges that affect operations. For example, the ratio of medical staff to PHC staff varies, depending on whether the PHC is located in the western (more developed) part of Indonesia or the eastern (more rural) part of Indonesia. In fact, more than 40% of PHCs might not have medical staff (*Republika* online newspaper, 2011).

Nevertheless, almost all Indonesians attend PHCs for first-line health care. This makes the PHC a strategic entry point for early IPV detection. The institutionalization of IPV screening and brief interventions at the PHC could serve as a long-lasting protective intervention against IPV (Frieden, 2010). Simultaneously, screening would benefit women in the community by raising awareness of what constitutes IPV and by sending a message that IPV is unhealthy and that it is not an acceptable practice.

Support by PHC administrators is needed to put in place routine IPV procedures to identify women experiencing IPV and connect them to available service providers. In fact, other researchers have found that administrative buy-in is a key factor in changing clinical practice and institutionalizing new protocols (Simpson, 2002). This research is intended to answer the research question of *“What are PHC heads’ perceptions of supports and barriers to routine IPV screening in their centers?”* In this paper we present the findings of interviews with ten district and ten sub-district PHC administrators across Jakarta’s five municipalities to provide insight on this question.

Methods

Study design

This qualitative study employed key informant interviews to collect data from 20 (ten district and ten sub district) PHC heads to gauge their knowledge and attitudes concerning IPV, their past and current experience with IPV in their practice settings, and their perceptions of the barriers to integrating IPV screening in the PHC.

Research permits were obtained from two government departments: the Indonesian Ministry of Internal Affairs and the Office of the Governor of Jakarta. University of Hawai'i's Institutional Review Board also approved this study prior to data collection in March 2012.

Sample

An Excel database was created of the 333 PHC in the greater Jakarta area, including 57 district PHCs and 282 sub district PHCs. PHC were stratified by geographical area according to Jakarta's five municipalities and type of PHC (district PHC and sub district PHC). Within each of the ten cells (five geographical areas X two types of PHC), PHC were enumerated and then assigned a random number using the Uniform Distribution function in Excel, which assigns a number between 0 and 1. Then PHCs were sorted by random number within each cell, and the two with the lowest random number were selected for inclusion in the sample. Administrators of these two PHC were contacted. If one refused to participate, the next PHC on the list in that cell was approached.

For each selected PHC, the Principal Investigator (PI) sent a letter attached with copies of the research permits to the administrators, inviting them to participate in the study. The Research Assistant (RA) followed up with a phone call to further explain the study and to schedule an interview time. If a PHC decided not to participate, the next PHC from that stratum was approached, until two interviews were completed in each of the ten cells.

PHC participation by geographical district is shown in Table 1. For example, in South Jakarta, the first two district PHCs and first two sub-district PHCs approached by the researchers agreed to participate. On the contrary, in East Jakarta, four district PHCs were approached before two consented, and 11 sub-district PHCs were approached before two consented. Taking the five municipalities together, 17 of the district PHCs were approached before ten consented, yielding a participation rate of 59% at the district level. The participation rate was lower (only 27%) for sub-district PHCs, as 37 were contacted before ten consented. Taken as a whole, 54 PHCs were approached to find 20 consenting PHCs, a participation rate of 37%.

Table 4.1. Selection of PHC through stratified random sample without replacement

	PHC total	District PHC	Selected PHC and consent status	Sub district PHC	Selected PHC and consent status
South Jakarta	79	14	1 - consented 5 - consented	65	25 - consented 57 - consented
East Jakarta	88	14	13 - refused 11 - consented 2 - refused 7 - consented	74	32 - non responsive 37 - non responsive 12 - non responsive 17 - non responsive 25 - non responsive 27 - non responsive 4 - non responsive 31 - non responsive 58 - non responsive 15 - consented 3 - consented
Central Jakarta	42	9	5 - non responsive 2 - consented 1 - consented	33	25 - non responsive 10 - consented 17 - non responsive 4 - consented
West Jakarta	75	8	4 - consented 8 - non responsive 1 - consented	67	20 - non responsive 42 - non responsive 23 - consented 51 - non responsive 59 - non responsive 37 - non responsive 35 - non responsive 47 - non responsive 38 - non responsive 53 - non responsive 29 - consented
North Jakarta	49	6	5 - non responsive 4 - consented 1 - non responsive 2 - non responsive 3 - consented	43	39 - non responsive 31 - consented 1 - non responsive 4 - non responsive 28 - non responsive 43 - non responsive 2 - non responsive 6 - non responsive 35 - consented
Total	333	57	17 contacted 10 consented Participation rate = 59%	282	37 contacted 10 consented Participation rate = 27%

Measures

A semi-structured interview guide consisting of 11 questions was used. The draft guide was developed in English. The English-language version of the interview guide was pretested with two colleagues in November 2011, and several modifications were made as a result of the pretesting. This version was translated into Indonesian, and was back translated successfully into English by a certified translator. The Indonesian-language version was pretested with two PHC staff members with general practitioner degrees in February 2012 in Jakarta, and a few non-substantive changes were made. The final interview guide is shown in Table 4.2.

Table 4.2 Semi-structured interview guide for PHC heads

<p>IPV defined by the World Health Organization (2005) is <i>violence experienced by a woman from a husband or partner, including physical, sexual and emotional abuse</i>. IPV is a worldwide problem. The purpose of this interview is to learn what PHCs do to find out if female patients are experiencing IPV and how PHCs help women who are experiencing IPV. We are interviewing 20 PHC administrators in Jakarta about what supports them in helping IPV victims and what barriers PHCs encounter. We really appreciate your willingness to participate. Your findings will help us learn more about preventing and treating IPV in Indonesia.</p> <ol style="list-style-type: none">1. How familiar is your staff with IPV?2. How often do you or your staff hear about or learn about a woman experiencing IPV?3. If a female patient complains of IPV, what kind of help does your staff offer?4. What services are available in this community or in Jakarta to link her to?5. Do you have or do you know about patient education or resource materials on IPV that can be posted or provided to patients?6. Are you aware of any staff training on this topic? To your knowledge, have any of the staff members in this PHC received training or have expertise on IPV?7. Does this PHC have any written guidelines or policies regarding IPV?8. If there were an IPV screening tool in Indonesian that has worked in other Jakarta PHCs, how interested would your PHC be to learn about it?9. What would make it easier? (Probes: staff training, funding for IPV services, hearing positive things about IPV screening from another PHC)10. If IPV training were available for your staff, which topics would you want your staff to learn about? (Probes: dangers of IPV, how to screen for IPV, how to help female patients experiencing IPV, where to refer them, other)11. How would you feel if screening all female patients for IPV becomes mandatory?
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Five psychologists affiliated with PULIH Center for Trauma Recovery and Psychosocial Empowerment, a psychological services provider in South Jakarta,

collected data through face-to-face interviews in Jakarta in March 2012. All psychologists possess excellent interviewing skills and had at least 3 years of experience in working at the health sector setting with clients experiencing IPV. A sixth member of the research team, a PULIH-affiliated RA, contacted PHC heads and scheduled interviews. The team received an orientation to the project, training in the interview tools, and educational materials and research incentives to share with PHCs.

Prior to the interview, informed consent was received from the PHC head being interviewed. Sixteen of the 20 PHC heads also consented to having the interview recorded. Qualitative response sheets also were used to capture responses, and this tool was especially critical in capturing the interviews that were not recorded. The response sheets also solicited short demographic information about the key informant, and included two observation questions for psychologists to answer at the end of each interview.

Table 4.3 Socio Demographics for PHC heads

<p>1. Your age range is... <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+</p> <p>2. Level of education <input type="checkbox"/> Bachelor's degree in _____ <input type="checkbox"/> Master's degree in _____ <input type="checkbox"/> Doctoral degree in _____</p> <p>3. Years working at the PHC <input type="checkbox"/> 1-5 years <input type="checkbox"/> 6-10 years <input type="checkbox"/> 11-15 years <input type="checkbox"/> 16-20 years <input type="checkbox"/> 21-24 years <input type="checkbox"/> more than 25 years</p> <p>4. Has anyone around you/a friend, neighbor or relative ever experience Intimate Partner Violence? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Observation of the PHC</u></p> <p><input type="checkbox"/> Is there a room especially for IPV Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Are their promotional materials on Family Health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Interviews took about 25-30 minutes to complete. At the end of each interview, research psychologists provided the PHC heads a set of IPV educational

materials, as well as a list of IPV-related service provider institutions to which women experiencing IPV could be referred. They were also given incentives for participation in the study in the form of a gift certificate to a national bookstore chain.

Data Analysis

Interviews were translated and transcribed from Indonesian to English, noting the name of the PHC and whether it was a district or a sub-district PHC. The PI and a member of the research team read all transcripts to consider potential themes and structures in the data and to develop a codebook of themes and sub-themes per question. The first cycle of coding was question-based, which is suitable for interview transcripts (Saldana, 2009). Several discussions were conducted to reach consensus on the developed codebooks. The two researchers coded each transcript, and then discussed possible meanings, perspectives, and frames of reference about the findings. In general there was high agreement between the two researchers on themes and underlying meanings, and any disagreement was discussed until consensus was reached.

Demographic data (e.g., age, gender, length of PHC career, whether they knew someone who had experienced IPV) and answers to two observation items (was there an extra room for an IPV clinic suitable for counseling and were there family health education materials at the PHC) were inputted and analyzed with SPSS (SPSS 20,2012).

Results

Demographic Profile of Participants

Eighty percent of PHC heads interviewed were females, and 40% were in the 55-64 year age range (Table 4.4). Half of the PHC heads interviewed were dentists, 35% were general practitioners, and 15% had Master's degrees in Public Health. Thirty percent had only been at the PHC for 1-5 years, whereas 15% have been at the PHC for more 25 years. When asked if they knew of any close relatives who experienced IPV, 25% answered yes. Out of the five who answered yes, one was a PHC head who had personally experienced IPV in her first marriage. She admitted

that her experience made her more sensitized towards female patients presenting with symptoms that may be IPV-related. This PHC head also appeared to be very willing to engage in IPV preventative efforts. Of the ten district PHCs, only five (50%) had extra rooms for counseling, two of which had announcements on the availability of a Family Consultation room. However, we learned that these were rarely used. Ninety percent of all PHCs did not have public education materials on IPV and information on where to seek for help.

Table 4.4. Demographic Profile of Participants

	District	Sub district
Gender		
Female	8 (80%)	8 (80%)
Male	2 (20%)	2 (20%)
Age		
25-34	1 (10%)	1 (10%)
35-44	3 (30%)	1 (10%)
45-54	3 (30%)	5 (50%)
55-64	3 (30%)	3 (30%)
65+	0	0
Level of Education		
General Practitioners	4 (40%)	7 (70%)
Dentists	3 (30%)	3 (30%)
MPH	3 (30%)	0
Knowledge of any close relatives who experienced IPV	2 (20%)	3 (30%)
Extra rooms for counseling	3 (30%)	2 (20%)
IPV public education materials	1 (10%)	1 (10%)

Emergent Barriers and Supporting Factors from the Interviews

Five barriers and three supporting factors emerged from the interviews with 20 PHC heads in the five municipalities of Jakarta. Themes presented in this section are supported with participants' direct quotes.

Barriers to Routine IPV Screening at the PHC

Women Experiencing IPV Do Not Report It. Fifteen (75%) PHC heads reported that they had not seen any, or had seen very few IPV cases at their PHCs. One sub-district PHC head said:

That I really don't know... I've been working here just for the past 3 years, and the Domestic Violence issue is something just recently brought up more openly to the surface to deal with. Previously it was treated as some hidden issue that we can only assume was happening from what people say or something like that. If it was happening anyway, the authoritative personnel that is appointed to handle it is usually the district head officer whom provides advice and directs the victim and the perpetrator in more family-oriented solutions.

Another sub-district PHC head said that "the quantity [of cases] can be counted only by fingers whoever came here in the PHC to consult on Domestic Violence issue, and the only reason she came here is for us to attend to her physical wounds."

Four PHC heads (two sub-district and two district PHCs) commented that even though a woman's injuries suggest the presence of IPV, female patients were reluctant to disclose their experience of IPV. One district PHC head said that "there are not too many cases, but there are many who do not disclose nor report because they are afraid, they have so many children already, do not work, and do not want to do a visum et repertum.² Plus do not have plans to get divorced from their husbands.

PHC heads suggested that women who suffer injuries that may be related to IPV are reluctant to disclose how they sustained injuries. One said, "Women experiencing IPV would not want to report it to the PHC." Another said, "Last time we had one case like that whereas this woman has bruises on the area of her eyelids, but still she refused to tell us of what happened."

Another PHC head said he might report IPV to the police if a woman decides to disclose her IPV experience. He also noted there was not much they could do for her.

We might not serve her with any special treatment. If anyhow she speaks up, we might make a report to the police. But if she insists to keep silent, we probably were not supposed to get involved. Besides, there is no anamnesis or treatment device to conduct any follow-up treatment for the victim over here. Of course we would examine and treat her based on her main problem.

² A letter about the injuries on the body made by medical doctors as evidence in legal proceedings

Furthermore, unsupportive parents can discourage women from reporting. A PHC head recounted this story of a woman with an eye bruise who refused to disclose how she sustained her injury even when probed by the health provider.

...up to the point, even we asked her parents to leave the room for more privacy reasons – since this particular girl was a newlywed, just recently got married – still she didn't dare to explain to us of what had happened (in front of her mom); she still refused to open up whenever she was alone with us only,.

PHC Staff Has Limited Awareness and Knowledge about IPV.

Although trainings have been conducted for PHC staff, there is still limited knowledge about IPV, with very little awareness about the psychological or economic aspects of IPV. Nine PHC heads reported that IPV training had been provided to them by the Health Agency and the Mayor's office. However, PHC staff member's understanding of IPV centers around the husband being physically abusive towards his wife. Two quotes illustrate this theme:

If it is about physical kind of domestic violence, it is clear, I guess. But if it is about the non-physical one, not yet... rarely. Although I am sure that domestic violence happens anywhere. But so far there has been no one coming to us due to becoming victim of such action, and the reports themselves are so rare.

Well, my staff here, their knowledge on issues so called domestic violence, what they considered as a case it's when they find any marks on this woman's body.

Due to this limited awareness and knowledge, PHC staff has rarely identified IPV-related cases outside of physical abuse and, even if they did, they would not know how to manage them or where to refer them. As one PHC head said, "...if it is more physical, we could help. But if it is any other kind, there is nothing we could do since we ourselves do not know how to handle such case, where should one go if one is a victim..."

Blaming the Victim Attitude. Even when IPV-related physical abuse was so obvious, there was a tendency to blame the victim, diagnosing her as neurotic and telling her that she needs to improve herself. Three PHC heads reported how they would advise the victim to stay in the relationship to maintain harmony. This quote, from one sub-district PHC head illustrates this theme:

Even if things pointing towards that direction, it is usually the case of emotional condition or the patient's psychological situation [being] depressed due to dispute happening in her marriage. For instance, after this patient's health record was handled, we followed up with advice. Pretty much towards things related to spiritual issues, for her to improve herself being better, [to be] more patient; [and] to maintain her relationship with her husband in more harmonious mode. This kind of patient is usually showing neurotic or psychosomatic symptoms.

No Specific Written Guidelines Existing on IPV. PHC heads gave conflicting information about the availability of IPV guidelines. Eight (40%) PHC heads reported that they had no written guidelines for identifying and managing IPV. Another three PHC heads mentioned the existence of the Standard Manual of Services, but then commented that the manual does not mention IPV or IPV services. The district PHC head in Central Jakarta said that, "it's in the book and I have to be honest with you, I haven't had time to read it. No, it's not included in the clinic's service standards." Two other district PHC mentioned that a guideline does not formally exist, but that an IPV reporting system and a job description for main tasks and functions related to IPV are in place. As one district PHC in West Jakarta explained, "There are training books from the Ministry of Women's Empowerment but not specific for health. There is the 2004 about how to report, but there are no procedures in terms of how to provide services, how to refer etc".

All 20 (100%) PHC heads said there was no special funds' allocation for IPV-related services at the PHC level. As noted above, although district PHCs are mandated to provide IPV services, in fact five of the ten (50%) district PHCs did not have extra counseling rooms for private consultations. Out of the five that had extra rooms, two had announcements on the availability of Family Consultation sessions, but in fact these sessions were not being offered. Three PHC heads mentioned that they cannot do much to address psychological issues, and two mentioned a lack of places to refer IPV victims for counseling. One PHC mentioned the desire to refer to a psychological support provider of mental health unit, but that there was a paucity of mental health units.

Little Community Socialization. Five PHC heads said that women are not aware that PHCs have IPV-related services due to the lack of community socialization. They also admitted that the PHCs do little to let the community know

about IPV-related services available at the PHC, and so far there has been no outreach about IPV into the community. One PHC head said, “We admit that we have acted passively in a way, [and] that the patient must come here to visit us and not the other way around.”

Eight PHC head said had no IPV materials at all and did not remember ever having any. Two PHCs mentioned having had a poster about IPV, but these were not posted now. Eight had materials, like poster or leaflets. However, these did not appear to be very effective. One sub district PHC head in Central Jakarta with IPV materials observed that,

Since in our PHC a lot of people are sitting and waiting, they let their kids play with those brochures. Talk about not well-educated people. I observed that they didn't even read it or if they did, they didn't seem to understand. Those brochures ended up as paper toys for their kids while they were waiting.

Supports for Routine IPV Screening at the PHC

In addition to the barriers described in the previous section, three supports for routine IPV screening at the PHC emerged from the data.

Some PHC Heads were Enthusiastic toward Screening. In response to the question about their readiness to routinely screen for IPV if there was a tool, nine (45%) PHC heads said they were ready and willing to try it (Table 4.5). Another nine (45%) would be willing to try screening if certain conditions were met. For example, one PHC would be willing if patients were willing to have longer appointments, another wanted authorization from the MOH, another wanted help increasing community and staff awareness about IPV and the availability of services, and another wanted to know more about what to do and where to refer women identified with IPV. Only two PHC heads were reluctant to try routine, noting that they had limited resources and needed to focus on their main tasks.

Some PHCs Already Are Assisting IPV Victims, Especially Those Who Need Medical Support. Although, PHCs said that they did not see many IPV cases and that they had limited capacity to assist women experiencing IPV, a few PHCs said they treated a few IPV cases. The primary type of assistance offered was physical/medical support in response to physical violence. One PHC head said

she provided counseling and prescribed medicine herself. Another referred the patient’s husband to the mental health hospital, saying “For example a husband had been hitting the wife because he was having hallucinations. So we referred him to *Cipayung* [a mental health hospital] through general insurance for the poor, after conferring with the family.”

Table 4.5. Enthusiasm level for screening per municipality in Jakarta

PHC municipality	Enthusiastic without requirements	Enthusiastic with requirements	Reluctant
North	3	1	
Central	3		1
South	2	2	
East	1	3	
West		3	1
Total	9 (45%)	9 (45%)	2 (10%)

Active Community Groups Are Playing an Important Role. Three PHC heads commented on the positive role of the community in assisting women experiencing IPV. They identified organized community groups active in their neighborhoods that could be further strengthened to provide services for families with violence issues. For example, two North Jakarta PHCs and one Central Jakarta PHC were involved in strengthening the Family Information Centers around their areas to support their programs

...that is from Family Information Center from which we can intervene; through Family Health Education groups as well so that it does not only covers the homeless, poor people issue; but yet also this Domestic Violence issue can be attached.

Other organized groups whose roles can be strengthened included the Community Unity Units (Posyandu), the Family Health Education (PKK) groups, and the Family Information Center (PIK). There are groups regular conducting community gatherings and providing information for women in the communities.

I think this is a great idea to be presented for mothers in Posyandu (Community-Unity Post) or ladies in PKK (Pendidikan Kesehatan Keluarga/Family Health Education), which is best target for this

matter. Those ladies are involved actively in this forum; and also often conduct community gathering. Our PIK has won second place upon Trafficking issue. If you really want it; I can give you contact number of Mrs. _____ to be able for you to reach PIK.

Discussion

Screening involves asking women about their IPV experience whether or not they show symptoms of IPV. Research findings by Boyle & Jones (2006) indicated that 77% of women screened by the primary health providers favored routine inquiry. In Indonesia, PHC director-level buy-in to routine screening would be necessary in order to institute routine IPV screening at the PHC.

Our study collected data from 20 PHC heads in Jakarta. Five barriers and three supports emerged from the interviews. The five barriers were that: women experiencing IPV do not report it; PHC staffs have limited knowledge and awareness; when IPV is encountered, many staff tend to “blame the victim;” there are no specific written guidelines on IPV; and there is little community socialization on IPV. Three supports are that some PHC heads are enthusiastic to routinely screen for IPV; some PHC already are assisting IPV victims; and active community groups are playing an important role in IPV prevention and management.

Several of the barriers are interrelated. For example, the fact that heads of PHCs reported seeing few, if any, IPV cases is because many women are reluctant to report and because PHC staff has a limited interpretation of IPV. Although they can recognize physical violence, they are not recognizing psychological abuse or they are counseling victims of psychological abuse to “improve herself.” It is clear that primary health providers need to be trained on mental health issues related to trauma and its effects on health, and this problem is not specific to Indonesia. Many providers are not aware of trauma exposure and its mental health effects to physical health (Alpert, 1992).

The second major finding is that there is limited infrastructure in the PHC and perhaps in the community to support routine IPV screening. PHC staff is unaware of guidelines, existing guidelines are not specific, education materials are lacking, and PHC staffs do not have the skills to provide counseling or know where to refer women to counseling. Liebschutz et al (2008) identified characteristics of a helpful provider, including explicit acknowledgement of patient’s disclosure, display

of caring, specific referral to other resources, and providing space for the patient to choose which alternative action she would be most comfortable with. All of these characteristics can be enhanced through training.

The third major finding is a relatively high level of willingness to routinize IPV screening and recognition that community groups could play a role in increasing IPV-related awareness and services. Oneha, Magnussen and Shoultz (2009) emphasized how much community and its resources are vital in working with those affected with IPV. Community-based programs highlight strengths and resources from the community to ensure appropriateness and ownership.

Furthermore, it is interesting to note that PHC are not among Indonesian service providers requested to submit annual patient statistics to the National Commission on Violence against Women.

These findings suggest some changes to practice and policy. First, a nationwide public campaign is recommended to break the culture of silence around IPV and to encourage more women to come forward and report it. This campaign would be a collaborative endeavor, working with multi-sector ministries and organizations such as the Ministry of Health, Ministry of Women's Empowerment, National Commission on VAW, UNFPA, UN Women, and the World Health Organization. Engaging family and friends in intervention strategies also may help to support women, to raise awareness, and to increase help-seeking behaviors to end the abuse.

Second, PHCs need better guidelines and tools for IPV identification, management, and referral. Selection of screening tool to be used at the PHC is necessary. The recommendation in Chapter 2 is to use the self-administered WAST with cut-off point of 10 or, if psychologists are available, to have them use the four-item Domestic Violence Initiative Screening as a clinician-administered tool. Further research is required to gauge whether the four-item DVIS could be used as a self-administered screening tool.

Along with screening, there needs to be a development of a referral system linking medical, psychological, and legal services (including reporting to policewomen's desks). PHC also should be required to report IPV patient statistics to the National Commission on VAW.

PHCs also need training on these guidelines and tools. The training unit under MOH is working with our community partner, PULIH Center for Trauma Recovery and Psychosocial Empowerment, on a new IPV training module (in press). There is a chapter in the training module on screening tools, the importance of IPV screening, the role of PHC providers in screening and referral, and information on where and how to refer PHC patients to appropriate services. PHCs also need to promote their IPV services in their communities, and to encourage women to seek help external of their family and friends.

Finally, community organizations interested in IPV and women's health should be encouraged to work in partnership with PHCs. Active community groups play an important role in supporting women experiencing IPV. Local NGOs and service providers can assist by identifying active groups, developing a database of active women's groups, and providing training on identifying IPV by utilizing a community-based approach.

Limitations of the research

The generalizability of research findings may be limited because research was conducted in Jakarta, the most urban and most developed city in Indonesia. Also, Jakarta is located in the western part of Indonesia. Anecdotal evidence from primary care providers suggests that the eastern part of Indonesia has more violent practices than the western part, specifically in terms of violence against women. Thus the characteristics of IPV may differ in other parts of Indonesia, awareness of IPV may be even lower than in Jakarta, and infrastructures less developed.

Second, the PHC list provided by the Ministry of Health was not the most current, thus addresses and phone/fax numbers were not always correct. Thus, PHC did not refuse participation, but they were more unresponsive towards the invitation to participate in the study because of incorrect contact details.

Third, this research enrolled PHC heads that agreed to be interviewed, and only 37% of PHC heads initially recruited to the study consented to participate. Many said they were too busy to participate, but it also is likely that findings reflect the perceptions of PHC heads that are more interested in or sensitive to the issue of IPV.

Conclusion

The barriers perceived by PHC heads in institutionalizing routine IPV screening at the PHC include lack of reporting by women experiencing IPV (individual level), limited knowledge, awareness, and blaming victim attitude at PHCs (organizational level), lack of community socialization on IPV (community level), and no specific written guidelines on IPV (policy level). Thus, interventions are needed at different levels. At the individual level, a public campaign is needed to break the cycle and encourage reporting outside of family and friends. At the organizational level, there should be more training of PHC staff. At the community level, external community socialization on IPV can increase involvement of active community active community groups, which can play an important role in IPV prevention and management (a supporting factor). At the policy level, the MOH must mandate routine IPV screening and establish protocol. PHC heads who are enthusiastic about routine IPV screening can be involved in a pilot program on institutional IPV routine screening, and PHC currently providing medical support to assist women with IPV can be involved in an action research to develop clearer guidelines on IPV management.

CHAPTER 5 CONCLUSION

Key Findings

Taken together, these three studies result in several key conclusions. First we learned that the prevalence of IPV is much higher than expected. The IPV estimate from the gold standard (36.3%) was much higher than the prevalence estimated from reported cases compiled by the Indonesian National Commission on Violence Against Women (about 1%) and the prevalence estimated in a the neighboring country of Malaysia (about 6%), based on a study using the WAST with a cutoff score of 13.

Second, although the psychologist interview is the gold standard and preferred by women over the WAST, it is expensive to use as a screening tool. A self-administered screening tool would be a practical solution to be recommended.

Third, we learned that IPV screening with the WAST was perceived to be acceptable and protective by female PHC patients in the two research sites. Women were not offended by being screened with the WAST on an annual basis.

Fourth, we learned that many PHC heads were willing to implement routine IPV screening, especially if they were provided with guidelines, training, funding, and links to existing services.

Overall, findings confirm that screening for IPV can be useful in primary and secondary prevention of IPV. Screening is helpful in primary prevention because it increases awareness that IPV is unacceptable. It is helpful in secondary prevention because it detects women experiencing IPV and connects them to service providers for assistance. It is hoped that through routine screening at the PHC level, the next tier of intervention, which is changing social norms about IPV, can be achieved. Thus, as suggested by the Health Impact Pyramid described in the introduction, IPV screening can be a long-lasting protective intervention from a population-based public health perspective (Frieden, 2010).

Directions for Future Research

The findings also suggest some areas for follow up research. These include examining the use of the shorter four-item DVIS interview guide as a self-administered tool to gauge whether it would be able to discern women experiencing IPV from those not experiencing IPV. The DVIS score correlated best with the gold standard, and it is shorter, suggesting that it might be a better screening tool than the WAST.

Also, IPV research should be conducted in other parts of Indonesia. It would be important to assess the IPV situation in Eastern Indonesia; for example, as anecdotal evidence suggests that the level of violence against women is higher in eastern parts of the country.

Directions for Future Advocacy

The study also suggests avenues for future advocacy. For example, it is recommended that the Indonesian Ministry of Health mandate routine IPV screening in PHCs, perhaps starting in Jakarta and in other large cities in Indonesia.

Also, the MOH should support training programs about IPV for PHCs. In fact, the Training Unit of the Ministry of Health currently is collaborating with PULIH Center for Trauma Recovery and Psychosocial Empowerment to develop a training module for health workers on IPV identification and management. Included in the module are preliminary findings from this research, use of the WAST and DVIS as screening tools, and how to provide brief intervention to victims. PULIH psychologists had been invited to be guest presenters at health provider trainings.

Third, the MOH training unit needs to collaborate with other MOH training units across Indonesia to disseminate the IPV training curriculum with screening as part of the prevention mechanism. The MOH also should mandate that PHC providers report IPV cases as part of the annual reports published from a health perspective.

Fourth, the MOH and other funders should support community groups in efforts to educate on IPV and assist IPV victims. This can help overcome the

limitations experienced by PHC in providing assistance to victims. Active community groups on women's health have important roles to play in a community-based IPV prevention and management program.

APPENDIX A- Consent Form and Measures for Study #1 and #2 (English)

Consent Form

University of Hawai'i

Consent to Participate in Research Project:
Implementing Screening and Brief Interventions in Indonesian Primary Health Centers

My name is Livia Iskandar, MSc. I am a DrPH student at the University of Hawai'i at Mānoa (UH), in the Department of Public Health. As part of the requirements for earning my graduate degree, I am doing a research project. The purpose of my current research project is to test screening tools for women attending Primary Health Centers. I am asking you to participate in this project because I am looking for women over 18 years of age, married, who is seeking services for her own health.

Project Description – Activities and Time Commitment: If you agree to participate, you will be explained about the research procedures then you will be asked to sign a consent form (5 minutes), to fill out an 8-item questionnaire (5 minutes), followed by an interview by a psychologist (10-20 minutes), then you will be interviewed on your acceptability of either the 8-item questionnaire or the psychologist's interview (10 minutes) and lastly, you will be asked to fill out a demographic short questionnaire (5 minutes). The research will last from 35-45 minutes.

Benefits and Risks: There will be no direct benefit to the study participant for participating in this research. However, information provided to you may increase your awareness about your relationship with your husband. You will be provided information to access services should you feel you need to follow up. You may experience discomfort in answering any of your questions, you may then ask to stop filling out the questionnaire or the interview. The research team consists of trained psychologists who can help you should you feel any discomfort during the research process.

Confidentiality and Privacy: During this research project, I will keep all data from the interviews in a secure location. Only I and my research assistant will have access to the data, although legally authorized agencies, including the University of Hawai'i Committee on Human Studies, have the right to review research records.

When I report the results of my research project, and in my typed transcripts, I will not use your name or any other personally identifying information. Instead, I will use an ID number. If you would like a summary of the findings from my final report, please contact me at the number listed near the end of this consent form.

Voluntary Participation: Participation in this research project is voluntary. You can choose freely to participate or not to participate. In addition, at any point during this project, you can withdraw your permission without loss of benefits.

As compensation for time spent participating in the research project, I will provide you with a package of basic food necessities, such as rice, sugar, powdered milk, tea, coffee and dried noodles.

Questions: If you have any questions about this project, please contact me via cell phone (+6281310446157). If you have any questions about your rights as a research participant, in this project, you can contact a Ministry of Health official (Jakarta number) or the University of Hawai'i, Committee on Human Studies (CHS), by phone at (1)(808) 956-5007 or by e-mail at uhirb@hawaii.edu.

Please keep the prior portion of this consent form for your records.
If you agree to participate in this project, please sign the following signature portion of this consent form and return it to the Research Assistant.

Tear or cut here

Signature(s) for Consent:

I have read and understand the information provided to me about participating in the research project, *Implementing Screening and Brief Interventions In Indonesian Primary Health Centers*.

My signature below indicates that I agree to participate in this research project.

Printed name: _____

Signature: _____

Date: _____

You will be given a copy of this consent form for your records.

Woman Abuse Screening Test (WAST) English

1. In general, how would you describe your relationship?

A lot of tension Some tension No tension

2. Do you and your partner work out arguments with

Great difficulty Some difficulty No difficulty

3. Do arguments ever result in you feeling put down or bad about yourself?

Often Sometimes Never

4. Do arguments ever result in hitting, kicking or pushing?

Often Sometimes Never

5. Do you feel frightened by what partner says or does?

Often Sometimes Never

6. Has your partner ever abused you physically?

Often Sometimes Never

7. Has your partner ever abused you emotionally?

Often Sometimes Never

8. Has your partner ever abused you sexually?

Often Sometimes Never

Domestic Violence Initiative Screening Questions

Note: this tool will not be used word for word, but will be used as a guide for psychologists conducting the diagnostic interview.

Health worker to explain the following in own words:

- In this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home;
- This is because violence is very common, and we want to improve our response to families experiencing violence.

Health worker to ask the following questions of ALL female patients on their own:

- | | | |
|---|-----|----|
| 1. Are you ever afraid of your partner? | YES | NO |
| 2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? | YES | NO |
| 3. In the last year, has your partner put you down, humiliated you or tried to control what you can do? | YES | NO |
| 4. In the last year, has your partner threatened to hurt you physically or sexually? | YES | NO |

If domestic violence has been identified in any of the above questions, continue to questions 5 and 6.

- | | |
|--|-----|
| 5. Would you like help with any of this now? | YES |
| NO | |
| 6. Would you like us to send a copy of this form to your doctor? | YES |
| NO | |

Signature of Client _____ Date _____

DV Risk Status:

- Domestic Violence not identified
- Domestic Violence identified, refused help
- Domestic Violence identified, help provided

Provided With:

- | | |
|---|---|
| <input type="checkbox"/> Contact phone numbers for DV | <input type="checkbox"/> Written information for DV |
| <input type="checkbox"/> Referral to PULIH | <input type="checkbox"/> Referral to hospital-based service |
| <input type="checkbox"/> Referral to other community DV service | <input type="checkbox"/> Referral to General Practitioner |
| <input type="checkbox"/> Other: _____ | |

Screening Not Completed Due to:

- | | |
|---|--|
| <input type="checkbox"/> Presence of partner | <input type="checkbox"/> Presence of family member/friend |
| <input type="checkbox"/> Absence of interpreter | <input type="checkbox"/> Woman refused to answer the questions |

Additional Comments:

Signature of Health Professional: _____ Date: _____

Acceptability Interview Guide

Questions about WAST. One of the things that you did was the Woman Abuse Screening Test.

1. What is your overall impression of the WAST?
2. Did you have any trouble filling it out?
3. Did you understand all of the WAST items?
4. Was there any item that you didn't like or was more difficult than the others?
5. Would you be willing to fill this out every time you visit the PHC?
6. How do you think other women would feel about filling out the WAST at the PHC?
7. If we were to recommend that the PHC ask every woman to fill out the WAST, what would you think?

Questions about Psychologist's Diagnostic Interview.

You just completed an interview by a psychologist.

8. What is your overall impression of the interview?
9. Did you understand all of the questions?
10. Did you have any trouble answering any of the questions? Was there any question that you didn't like? Was there any question that was more difficult than the others?

Comparison between the WAST and the psychologist's interview

11. If you had your choice of filling in the WAST or talking to a psychologist about IPV, which would be more comfortable for you? Why?
12. Which method do you think most women would be more comfortable with?
13. Do you think the PHC should screen women for IPV? Why or why not?

Demographics Short Questionnaire (DSQ)

Research Participant's Information

1. What is your age?

- 18-24 25-34 35-44 45-54 55-64 65+

2. Education Level

- If Elementary School, up to which grade _____
- If Middle School, up to which grade _____
- If High School, up to which grade _____
- If Vocational High School, which concentration _____ up to which grade _____
- If Academy/Diploma, which concentration _____ up to which semester _____
- If college/university, which concentration _____ up to which semester _____

3. Are you working? Yes No

- Student
- Professional (e.g. doctor, lawyer, psychologist, social worker, nurse, accountant, architect, engineer, pharmacist)
- Office Staff (e.g. secretary, sales and marketing, manager)
- Factory Staff (e.g. technical staff)
- Home maker
- Not working (receiving compensation)
- Others, _____

If working, please write where and when:

4. Ethnic background (mark all those that apply to you)

- Sumatera (write area): _____
- Jawa (write area): _____
- Kalimantan (write area): _____
- Sulawesi (write area): _____
- Bali (write area): _____
- Nusa Tenggara Barat (write area): _____
- Nusa Tenggara Timur (write area): _____
- Maluku (write area): _____
- Papua (write area): _____
- Lainnya (write area): _____

If you answered more than one ethnic groups, please state one ethnic group that you think represent you _____

5. Years of marriage _____

6. Number of children _____

7. If you ever experience Intimate Partner Violence, what would you do?

- Visit a PHC
- Visit the Emergency Room
- Visit a Service Provider, mention _____
- Call a hotline service
- Report to a policewomen ' s desk
- Others _____

APPENDIX B- Consent Form and Measures for Study #1 and #2 (Indonesian)

Consent Form

Universitas Hawai'i

Permohonan kesediaan untuk berpartisipasi dalam studi penelitian:
*Implementasi Skrining dan Intervensi Singkat untuk Kekerasan Dalam
Rumahtangga di Pusat Kesehatan Masyarakat (Puskesmas) Indonesia*

Nama saya Livia Iskandar, MSc, Psikolog. Saya adalah mahasiswi program doktoral kesehatan masyarakat di Universitas Hawai'i di Mānoa, Departemen Ilmu Kesehatan. Sebagai bagian dari persyaratan mendapatkan gelar S3, saya mengadakan studi penelitian. Tujuan dari penelitian saya ini adalah untuk melakukan pengetesan terhadap alat skrining untuk perempuan yang datang ke Puskesmas. Saya memohon kesediaan Ibu untuk berpartisipasi dalam studi ini karena saya mencari perempuan diatas usia 18 tahun, yang sudah menikah dan datang ke puskesmas untuk jasa layanan kesehatan untuk dirinya sendiri.

Deskripsi Studi – Aktivitas dan Kesediaan Waktu: Bila Ibu bersedia untuk berpartisipasi, Ibu akan diberi penjelasan mengenai prosedur penelitian. Setelah itu Ibu akan diminta untuk menandatangani formulir kesediaan berpartisipasi dalam penelitian (5 menit), diikuti dengan mengisi kuesioner berisi 8 butir pernyataan (5 menit), kemudian diikuti dengan wawancara oleh seorang psikolog (10 menit), setelahnya Ibu akan diwawancara untuk menentukan preferensi Ibu antara kuesioner atau wawancara oleh psikolog (10 menit). Yang terakhir, Ibu akan diminta untuk mengisi kuesioner data diri Ibu yang singkat (5 menit). Penelitian ini akan berlangsung sekitar 30 menit.

Keuntungan dan Resiko: Informasi yang diberikan kepada Ibu akan meningkatkan pemahaman Ibu mengenai hubungan Ibu dengan suami Ibu. Ibu akan diberikan informasi bagaimana dapat mendapatkan jasa layanan apabila Ibu merasa membutuhkan tindak lanjut. Ibu dapat mengalami ketidaknyamanan dalam menjawab pertanyaan yang dilontarkan, Ibu kemudian dapat berhenti mengisi kuesioner atau menjalani wawancara. Tim penelitian terdiri dari psikolog yang terlatih yang dapat membantu Ibu mengatasi rasa ketidaknyamanan yang mungkin Ibu alami selama proses penelitian.

Kerahasiaan dan Privacy: Selama studi penelitian, saya akan menyimpan semua data di lokasi yang aman. Hanya saya dan asisten penelitian saya yang dapat mengakses data, walaupun institusi yang secara hukum berhak, termasuk Komite Pengkajian tentang Manusia di Universitas Hawai'i di Mānoa, memiliki hak untuk merevie data penelitian.

Setelah transkrip dari wawancara selesai, saya akan menghapus rekaman audio. Ketika saya melaporkan hasil dari penelitian saya, dan dalam transkrip yang tertulis, saya tidak akan menggunakan nama atau informasi yang dapat mengidentifikasi pribadi. Saya akan menggunakan nama samaran untuk nama Ibu.

Apabila Ibu membutuhkan kesimpulan dari hasil di laporan akhir, Ibu dapat mengkontak saya di nomer yang saya tuliskan di bagian bawah formulir kesediaan ini.

Partisipasi Sukarela: Partisipasi di studi riset ini bersifat sukarela. Ibu dapat memilih secara bebas untuk berpartisipasi atau tidak berpartisipasi. Sebagai tambahan, Ibu dapat berubah pikiran untuk berpartisipasi tanpa adanya sangsi kapan saja semasa studi penelitian ini.

Sebagai kompensasi untuk waktu yang Ibu habiskan untuk studi penelitian ini, saya akan memberikan Ibu satu paket sembako yang terdiri dari beras, gula, susu bubuk, teh, kopi dan mi kering.

Pertanyaan: Apabila Ibu memiliki pertanyaan mengenai studi ini, Ibu dapat mengkontak saya di hp (+6281310446157). Apabila Ibu memiliki pertanyaan akan hak Ibu sebagai peserta penelitian, Ibu dapat mengontak pejabat Depkes (nomor Jakarta) atau Komite Pengkajian tentang Manusia, Universitas Hawai'i di Mānoa per telpon di nomor (internasional) 1- 808- 956-5007 atau lewat e-mail di uhirb@hawaii.edu.

Ibu dimohon menyimpan bagian dari formulir kesediaan ini sebagai bukti keikutsertaan dalam penelitian ini.

Kalau Ibu setuju untuk berpartisipasi dalam studi ini, mohon tandatangan dibagian yang tertera dibawah ini dan kembalikan ke Asisten Peneliti.

Potong disini

Tandatangan untuk kesediaan:

Saya sudah membaca dan memahami informasi yang diberikan kepada saya mengenai partisipasi saya di studi penelitian *Implementasi Skrining dan Intervensi Singkat di Puskesmas Indonesia*.

Tandatangan saya dibawah merupakan indikasi saya bersedia berpartisipasi dalam studi penelitian ini.

Nama tertulis: _____

Tandatangan: _____

Tanggal: _____

Anda akan diberikan bagian dari formulir kesediaan ini untuk disimpan.

Woman Abuse Screening Tool (Indonesian)

Berilah tanda cek (√) di depan jawaban yang sesuai dengan kondisi Ibu

1. Secara umum, bagaimana Ibu menggambarkan hubungan Ibu dengan pasangan?

- Penuh Ketegangan Agak ada ketegangan Tanpa ketegangan

2. Apakah Ibu dan pasangan Ibu mengatasi pertengkaran mulut dengan

- Sangat kesulitan Agak kesulitan Tanpa kesulitan

3. Apakah pertengkaran mulut mengakibatkan Ibu merasa direndahkan atau merasa tidak nyaman dengan diri sendiri?

- Sering Kadang-kadang Tidak pernah

4. Apakah pertengkaran mulut mengakibatkan pasangan Ibu memukul, menendang atau mendorong?

- Sering Kadang-kadang Tidak pernah

5. Apakah Ibu merasa ketakutan pada yang dikatakan atau dilakukan oleh pasangan Ibu?

- Sering Kadang-kadang Tidak pernah

6. Pernahkah pasangan Ibu melakukan kekerasan fisik pada Ibu?

- Sering Kadang-kadang Tidak pernah

7. Pernahkah pasangan Ibu melakukan kekerasan emosional pada Ibu?

- Sering Kadang-kadang Tidak pernah

8. Pernahkah pasangan Ibu melakukan kekerasan seksual pada Ibu?

- Sering Kadang-kadang Tidak pernah

Domestic Violence Initiative Screening Questions (Indonesian)

Pertanyaan Skrining Kekerasan Dalam Rumah Tangga

Catatan: pertanyaan-pertanyaan ini tidak digunakan kata per kata, namun digunakan sebagai kerangka acuan bagi psikolog yang melakukan wawancara diagnostik.

Pekerja kesehatan diminta untuk menjelaskan dengan perkataan sendiri pernyataan berikut:

- Dalam memberikan layanan kesehatan, kami sangat peduli mengenai kesehatan dan keselamatan Anda, oleh karena itu kami bertanya kepada semua perempuan tentang kekerasan yang mungkin terjadi dalam rumah tangga;
- Ini dikarenakan kekerasan sangat sering terjadi dan kami ingin memperbaiki layanan kami bagi keluarga yang mengalami kekerasan.

Pekerja kesehatan diminta untuk menanyakan pertanyaan-pertanyaan berikut kepada SEMUA pasien perempuan yang datang sendiri:

1. Apakah Anda pernah merasa takut kepada pasangan Anda? YA TIDAK
2. Dalam tahun terakhir, apakah pasangan Anda pernah memukul, menendang, meninju atau menyakiti Anda? YA TIDAK
3. Dalam tahun terakhir, apakah pasangan Anda pernah merendahkan, mempermalukan atau mengontrol apa yang Anda lakukan? YA TIDAK
4. Dalam tahun terakhir, apakah pasangan Anda pernah mengancam untuk menyakiti Anda secara fisik ataupun seksual? YA TIDAK

Apabila KDRT telah teridentifikasi dari pertanyaan tersebut di atas, teruskan ke pertanyaan 5 dan 6.

5. Apakah Anda ingin dibantu [sehubungan] dengan apa yang Anda alami sekarang? YA TIDAK
6. Apakah Anda ingin formulir ini diberikan kepada dokter puskesmas? YA TIDAK

Tandatangan klien: _____ Tanggal: _____

Status Resiko KDRT:

KDRT tidak diidentifikasi KDRT diidentifikasi, menolak bantuan KDRT diidentifikasi, bantuan diberikan

Materi yang diberikan:

Leaflet PULIH Leaflet penyedia layanan lain Brosur keselamatan Kontak PKT-RSCM

Skrining tidak dilaksanakan karena:

Kehadiran pasangan Kehadiran anggota keluarga/teman Klien tidak menjawab pertanyaan Catatan lain: _____

Psikolog yang menangani: _____ Tandatangan psikolog: _____

Acceptability Interview Guide (Indonesian)

Panduan Wawancara Penerimaan

Pertanyaan mengenai WAST. Salah satu yang Ibu lakukan adalah mengisi tes skrining untuk Penganiayaan Perempuan.

1. Apakah kesan keseluruhan terhadap tes skrining tersebut?
2. Apakah Ibu mengalami kesulitan dalam mengisinya?
3. Apakah Ibu memahami semua pernyataan dalam tes tersebut?
4. Apakah ada pernyataan yang Ibu tidak sukai atau yang lebih sulit dibanding yang lain?
5. Apakah Ibu bersedia mengisi tes skrining ini setiap kali mengunjungi puskesmas?
6. Menurut Ibu, apa yang akan dirasakan Ibu lain dalam mengisi tes skrining ini di puskesmas?
7. Bagaimana menurut Ibu, jika kami memberikan rekomendasi agar puskesmas akan meminta setiap perempuan diatas usia 18 tahun yang menikah untuk mengisi tes skrining ini?

Pertanyaan mengenai wawancara diagnostik oleh psikolog. Ibu baru saja menyelesaikan wawancara oleh seorang psikolog.

8. Apakah kesan keseluruhan Ibu akan wawancara tersebut?
9. Apakah Ibu memahami semua pertanyaan yang diajukan?
10. Apakah Ibu mengalami kesulitan dalam menjawab pertanyaan-pertanyaan tersebut? Apakah ada pertanyaan yang tidak disukai Ibu? Apakah ada pertanyaan yang lebih sulit daripada yang lain?

Perbandingan antara tes skrining dan wawancara oleh psikolog

11. Apabila Ibu mendapat pilihan untuk mengisi tes skrining sendiri atau diwawancara oleh psikolog mengenai kekerasan dalam rumah tangga, yang mana yang membuat Ibu merasa lebih nyaman? Mengapa?
12. Metode yang mana yang lebih disukai Ibu-Ibu lain?
13. Apakah menurut Ibu, puskesmas sebaiknya melakukan skrining untuk kekerasan dalam rumah tangga? Mengapa ya dan mengapa tidak?

Demographic Short Questionnaire (Indonesian)

Data Diri Responden Penelitian Kesehatan Perempuan di Puskesmas

1. Berapa usia anda?

- 18-24 25-34 35-44 45-54 55-64 65+

2. Tingkat pendidikan

- Jika SD, sampai kelas _____
 Jika SMP, sampai kelas _____
 Jika SMU, sampai kelas _____
 Jika SMK, bidang studi _____ sampai kelas _____
 Jika pendidikan akademi / diploma, bidang studi _____ sampai semester _____
 Jika pendidikan universitas / kesarjanaan, bidang studi _____ sampai semester _____

3. Pekerjaan Ya Tidak

- Pelajar/mahasiswa
 Profesional (mis. dokter, pengacara, psikolog, pekerja sosial, perawat, akuntan, arsitek, insinyur, guru, apoteker)
 Pekerja kantor (mis. sekretaris, SPG, manager madya)
 Buruh (mis. teknisi, pekerja pabrik, mekanik)
 Pekerjaan rumah tangga (dan/atau perawat anak)
 Tidak bekerja (menerima tunjangan)
 Lainnya, tuliskan: _____

Bila Ya, tuliskan di mana saja, dan kapan:

4. Latar belakang etnis/suku bangsa (beri tanda X pada semua yang sesuai dengan Anda)

- Sumatera (tuliskan nama daerahnya): _____
 Jawa (tuliskan nama daerahnya): _____
 Kalimantan (tuliskan nama daerahnya): _____
 Sulawesi (tuliskan nama daerahnya): _____
 Bali (tuliskan nama daerahnya): _____
 Nusa Tenggara Barat (tuliskan nama daerahnya): _____
 Nusa Tenggara Timur (tuliskan nama daerahnya): _____
 Maluku (tuliskan nama daerahnya): _____
 Papua (tuliskan nama daerahnya): _____
 Lainnya (tuliskan nama daerahnya): _____

Jika Anda menjawab lebih dari satu kelompok etnis, sebutkan satu yang menurut Anda paling tepat mewakili Anda? Saya menyebut diri saya sebagai orang dari (sebutkan) _____

5. Berapa tahun usia pernikahan Anda? _____

6. Berapa banyak anak Anda? _____

7. Kalau Anda sampai mengalami kekerasan dalam pernikahan Anda, apa yang akan Anda lakukan?

- Mengunjungi Puskesmas
- Mengunjungi Unit Gawat Darurat
- Mengunjungi penyedia layanan, sebutkan, _____
- Menelpon jasa hotline
- Melaporkan ke polisi perempuan
- Lainnya _____

APPENDIX C - Consent Form and Interview Guide for Study #3 (English)

Consent Form

University of Hawai'i

Consent to Participate in Research Project:

Indonesian heads of Primary Health Centres' perceptions of supports and barriers to routine Intimate Partner Violence screening

My name is Livia Iskandar, MSc. I am a DrPH student at the University of Hawai'i at Mānoa (UH), in the Department of Public Health Sciences. As part of the requirements for earning my graduate degree, I am doing a research project. The purpose of my current research project is to gauge perceptions of supports and barriers to routine screening for Intimate Partner Violence. I am asking you to participate in this project because you are a Primary Health Center manager. Your PHC was randomly selected, along with 15 other PHCs out of more than 300 PHC in the Jakarta area, to participate in this study.

Project Description – Activities and Time Commitment: If you agree to participate, the research procedures will be explained to you. You will be asked to sign a consent form (5 minutes) and complete a Demographic Short Questionnaire (5 minutes). This will be followed by an interview that will last approximately 20-30 minutes.

Benefits and Risks: There will be no direct benefits to you for participating in this research. However, your participation will help us understand the experience of Primary Health Centers with Intimate Partner Violence, how it is handled now, and perceptions of routine screening for Intimate Partner Violence. We do not anticipate any risk to your participation in this interview. However, the research team consists of trained psychologists who can help you should you feel any discomfort during the research process.

Confidentiality and Privacy: During this research project, I will keep all data from the interviews in a secure location. My research assistant and I are the only people that will have access to the data. However, legally authorized agencies, including the University of Hawai'i Committee on Human Studies, have the right to review research records.

When I report the results of my research project, I will not use your name or any other personally identifying information. I will use an ID number for your PHC, and all the data will be reported together, not by individual PHC. If you would like a summary of the findings from the final report, please contact me at the number listed near the end of this consent form.

Voluntary Participation: Participation in this research project is voluntary. You can choose freely to participate or not to participate. In addition, at any point during this project, you can withdraw your permission without loss of benefits.

As compensation for time spent participating in the research project, I will provide you with a gift voucher from a hyper mart.

Questions: If you have any questions about this project, please contact me via cell phone (+6281310446157). If you have any questions about your rights as a research participant, in this project, you can contact a Ministry of Health official (Jakarta number) or the University of Hawai'i, Committee on Human Studies (CHS), by phone at (1) (808) 956-5007 or by e-mail at uhirb@hawaii.edu.

Please keep the prior portion of this consent form for your records.
If you agree to participate in this project, please sign the following signature portion of this consent form and return it to the Research Assistant.

Tear or cut here

Signature(s) for Consent:

I have read and understand the information provided to me about participating in the research project,

My signature below indicates that I agree to participate in this research project.

Printed name: _____

Signature: _____

Date: _____

You will be given a copy of this consent form for your records.

Interview Guide for PHC Head

Hi, my name is Livia Iskandar, a doctorate student from Public Health at University of Hawai'i at Mānoa. Thank you for agreeing to this interview about Intimate Partner Violence or IPV. The interview should take about 20-30 minutes to complete.

IPV is defined by the World Health Organization (2005) is *violence experienced by a women from a husband or partner, including physical, sexual and emotional abuse*. IPV is a worldwide problem. The purpose of this interview is to learn about what PHCs do to find out if female patients are experiencing IPV and how PHCs help women who are experiencing IPV. We are interviewing 16 PHCs in Jakarta about what supports them in helping IPV victims and what barriers PHCs encounter. We really appreciate your willingness to participate. Your findings will help us learn more about preventing and treating IPV in Indonesia.

1. How familiar is your staff with IPV?
2. How often do you or your staff hear about or learn about a woman experiencing IPV?
3. If a female patient complains of IPV, what kind of help does your staff offer?
4. What services are available in this community or in Jakarta to link her to?
5. Do you have or do you know about patient education or resource materials on IPV that can be posted or provided to patients?
6. Are you aware of any staff training on this topic? To your knowledge, have any of the staff members in this PHC received training or have expertise on IPV?
7. Does this PHC have any written guidelines or policies regarding IPV?
8. If there were an IPV screening tool in Indonesian that has worked in other Jakarta PHCs, how interested would your PHC be to learn about it?
9. What would make it easier?
 - a. What if staff training were provided?
 - b. What if you heard positive things about IPV screening from another PHC?
 - c. What if there were funding from IPV services?
10. If IPV training were available for your staff, which topics would you want your staff to learn about?
 - a. The dangers of IPV
 - b. How to screen female patients for IPV
 - c. How to help female patients experiencing IPV
 - d. Where to refer female patients experiencing IPV
 - e. Other _____
11. How would you feel if screening all female patients for IPV becomes mandatory?

That is the end of my questions. Do you have any questions or comments for me? Would you like a copy of the findings of this study?

APPENDIX D - Consent Form and Interview Guide for Study #3 (Indonesian)

Consent Form

Universitas Hawai'i

Permohonan kesediaan untuk berpartisipasi dalam studi penelitian:
Persepsi kepala Puskesmas mengenai faktor pendukung dan penghambat terhadap skrining rutin Kekerasan Dalam Rumah Tangga

Nama saya Livia Iskandar, MSc, Psikolog. Saya adalah mahasiswi program doktoral kesehatan masyarakat di Universitas Hawai'i di Mānoa, Departemen Ilmu Kesehatan. Sebagai bagian dari persyaratan mendapatkan gelar S3, saya mengadakan penelitian. Tujuan dari penelitian saya ini adalah untuk mencari tahu persepsi faktor pendukung dan penghambat terhadap skrining rutin Kekerasan Dalam Rumah Tangga (KDRT). Saya meminta kesediaan Anda untuk berpartisipasi dalam studi ini karena Anda adalah kepala dari Puskesmas. Puskesmas Anda terpilih untuk berpartisipasi dalam penelitian ini yang dilakukan dengan 15 Puskesmas lainnya yang dipilih secara acak dari 300 lebih Puskesmas di Jakarta.

Deskripsi Studi – Aktivitas dan Kesediaan Waktu: Bila Anda bersedia dari berpartisipasi, Anda akan diberi penjelasan mengenai prosedur penelitian. Setelah itu Anda akan diminta untuk menandatangani formulir kesediaan berpartisipasi dalam penelitian (5 menit), dan diminta untuk mengisi kuesioner data diri Anda yang singkat (5 menit). Lalu Anda akan diwawancara selama sekitar 30 menit.

Keuntungan dan Resiko: Anda tidak akan mendapat keuntungan langsung dari berpartisipasi dalam penelitian ini. Namun, partisipasi Anda akan membantu kami memahami pengalaman Puskesmas dalam menangani KDRT, bagaimana penanganan KDRT yang dilakukan saat ini, serta persepsi dari skrining rutin untuk KDRT. Kami tidak mengantisipasi adanya resiko yang diakibatkan dari partisipasi Anda dalam wawancara ini. Namun, tim peneliti yang terdiri dari psikolog-psikolog yang terlatih akan dapat membantu Anda apabila Anda mengalami ketidaknyamanan selama proses penelitian berlangsung.

Kerahasiaan dan Privasi: Selama studi penelitian, saya akan menyimpan semua data dari hasil wawancara di lokasi yang aman. Hanya saya dan asisten penelitian saya yang dapat mengakses data, walaupun institusi yang berhak secara hukum, termasuk Komite Pengkajian tentang Manusia di Universitas Hawai'i di Mānoa, memiliki hak untuk meninjau data penelitian.

Ketika saya melaporkan hasil dari penelitian saya tidak akan menggunakan nama atau informasi yang dapat mengidentifikasi data pribadi Anda. Saya akan menggunakan nomor identifikasi untuk Puskesmas Anda, dan semua data akan dilaporkan secara bersamaan, tidak secara individual. Apabila Anda membutuhkan kesimpulan dari hasil di laporan akhir, Anda dapat mengkontak saya di nomer yang saya tuliskan di bagian bawah formulir kesediaan ini.

Partisipasi Sukarela: Partisipasi di studi riset ini bersifat sukarela. Anda dapat memilih secara bebas untuk berpartisipasi atau tidak berpartisipasi. Sebagai tambahan, Anda dapat berubah pikiran untuk berpartisipasi tanpa adanya sangsi apapun kapan saja selama penelitian ini.

Sebagai kompensasi untuk waktu yang Anda habiskan untuk studi penelitian ini, saya akan memberikan Anda voucher belanja dari sebuah hypermart di Jakarta.

Pertanyaan: Apabila Anda memiliki pertanyaan mengenai studi ini, Anda dapat mengkontak saya di hp (+6281310446157). Apabila Anda memiliki pertanyaan akan hak Anda sebagai peserta penelitian, Anda dapat mengontak pejabat Depkes (nomor Jakarta) atau Komite Pengkajian tentang Manusia, Universitas Hawai'i di Mānoa melalui telpon di nomor (internasional) 1- 808- 956-5007 atau lewat e-mail di uhib@hawaii.edu.

Anda dimohon untuk menyimpan bagian dari formulir kesediaan ini sebagai bukti keikutsertaan dalam penelitian ini.

Kalau Anda setuju untuk berpartisipasi dalam studi ini, mohon tandatangan dibagian yang tertera dibawah ini dan kembalikan ke Asisten Peneliti.

Potong disini

Tandatangan untuk kesediaan:

Saya sudah membaca dan memahami informasi yang diberikan kepada saya mengenai partisipasi saya di studi penelitian *Persepsi kepala Puskesmas mengenai faktor pendukung dan penghambat terhadap skrining rutin Kekerasan Dalam Rumah Tangga*.

Tandatangan saya dibawah merupakan indikasi saya bersedia berpartisipasi dalam studi penelitian ini.

Nama jelas: _____

Tandatangan: _____

Tanggal: _____

Anda akan diberikan bagian dari formulir kesediaan ini untuk disimpan.

Interview Guide for PHC Head (Indonesian)

Panduan wawancara untuk Kepala Puskesmas

Selamat pagi/siang/sore, nama saya Livia Iskandar, mahasiswa doktoral Kesehatan Masyarakat dari Universitas Hawai'i di Mānoa. Terimakasih atas kesediaan Anda untuk diwawancara mengenai Kekerasan Dalam Rumah Tangga atau KDRT. Wawancara ini akan berlangsung sekitar 20-30 menit.

KDRT didefinisikan oleh Organisasi Kesehatan Dunia (2005) sebagai kekerasan yang dialami seorang perempuan dari suami atau pasangannya, termasuk kekerasan fisik, seksual dan emosional. KDRT adalah sebuah masalah global. Tujuan dari wawancara ini adalah untuk belajar mengenai bagaimana Puskesmas menangani perempuan yang mengalami KDRT. Kami akan mewawancarai 16 Puskesmas di Jakarta mengenai faktor pendukung dan penghambat dalam membantu korban KDRT. Kami sangat menghargai kesediaan Anda untuk berpartisipasi. Penemuan dari wawancara ini akan membantu kami dalam mencegah dan menangani KDRT di Indonesia.

1. Sejuahmana staf Anda paham mengenai KDRT? (memancing pengetahuan kepala Puskesmas tsb)
2. Seberapa sering Anda atau staf Anda mendengar atau mengetahui tentang perempuan yang mengalami KDRT (yang datang ke Puskesmas)?
3. Apabila seorang pasien perempuan mengeluh soal KDRT, bantuan macam apa yang ditawarkan staf Anda?
4. Apa sajakah jasa layanan yang ada dalam komunitas ini atau di Jakarta yang dapat Anda hubungkan kepada pasien Anda?
5. Apakah Anda memiliki atau mengetahui mengenai materi pendidikan mengenai KDRT yang dapat dipasang di Puskesmas Anda atau diberikan kepada pasien?
6. Apakah Anda mengetahui akan adanya pelatihan staf untuk topik ini? Sejuah pengetahuan Anda, adakah staf Anda disini yang telah mengikuti pelatihan atau memiliki keahlian untuk KDRT?
7. Apakah Puskesmas ini memiliki panduan tertulis atau kebijakan mengenai KDRT?
8. Apabila ada alat skrining KDRT dalam bahasa Indonesia yang telah diterima oleh Puskesmas lain di Jakarta, seberapa berminatkah Puskesmas Anda untuk mengetahuinya?
9. Apa yang dapat mempermudah skrining untuk dilakukan di Puskesmas Anda?
 - a. Bagaimana bila pelatihan staf diberikan?
 - b. Apabila Anda mendengar hal-hal positif mengenai skrining KDRT dari Puskesmas lain?
 - c. Apabila ada dana untuk jasa layanan KDRT?
10. Apabila pelatihan KDRT tersedia untuk staf Puskesmas Anda, topik apa yang staf Anda akan minati?
 - a. Bahaya KDRT
 - b. Bagaimana melakukan skrining KDRT untuk pasien perempuan

- c. Bagaimana membantu pasien perempuan yang mengalami KDRT
- d. Kemana harus merujuk pasien perempuan yang mengalami KDRT
- e. Lainnya _____

11. Bagaimana perasaan Anda apabila skrining KDRT untuk semua pasien perempuan menjadi suatu kewajiban bagi Puskesmas di seluruh Indonesia?

Demikian pertanyaan-pertanyaan dari kami. Apakah Anda memiliki pertanyaan atau komentar? Apakah Anda ingin dikirimkan hasil akhir penelitian ini?

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