Health Care Providers' Readiness to Screen for Intimate Partner Violence in Northern Nigeria

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Research on screening for intimate partner violence (IPV) within health care in a sub-Saharan African context is rare. This paper assessed factors associated with the readiness to screen for IPV among care providers (HCP, $n = 274$) at Kano hospital, Nigeria. Readiness was measured using the Domestic Violence Health Care Providers' survey instrument, which measures grade of perceived self-efficacy in screening for IPV, fear for victim/provider safety, access to system support to refer IPV victims, professional roles resistant/fear of offending clients, and blaming the victim for being abused victim. Social workers perceived a higher self-efficacy and better access to system support networks to refer victims than peers in other occupation categories. Female care providers and doctors were less likely to blame the victim than males and social workers, respectively. Younger care providers of Yoruba ethnicity and social workers were less likely to perceive conflicting professional roles related to screening than older providers of Hausa ethnicity and doctors, respectively. Implications of our findings for interventions and further research are discussed.

Keywords: health care providers; intimate partner violence; screening; Nigeria

Researchers and health organizations have advocated for screening for intimate partner violence (IPV) owing to its inimical effects on the social, physical, and psychological well-being of victims of such abuse (Heise et al., 1999; Lawoko, 2006, 2008; WHO, 2001). Perhaps the most appropriate location to screen for IPV is within health care. There are several reasons motivating this point of view. First, exposure to IPV among women globally is exceptionally high with prevalence ranging between 11% and 52% (Ameh & Abdul, 2004; Coker & Richter, 1998; Ellsberg et al., 2000; Gage, 2005; Ilika, Okonkwo, & Adogu, 2002; Jewkes, Penn-Kekana, & Levin, 2002; Kishor & Johnson, 2004; Koenig et al., 2003). Yet such figures could entail an underestimation considering that these data often are based on responses to questionnaires administered

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at the women's homes. Disclosure could be jeopardized under such circumstances where anonymity and protection of women cannot be totally secured. Indeed, data suggest that women feel more comfortable responding to IPV inquiries in health care settings (Stenson, Saarinen, Heimer, & Sidenvall, 2001; Stenson, Sidenvall, & Heimer, 2005; Swahnberg & Wijma, 2007) than at home. Second, health care providers themselves agree that screening in health care settings could improve identification and secondary prevention of IPV (Bair-Merritt, Mollen, Yau, & Fein, 2006; Furniss, McCaffrey, Parnell, & Rovi, 2007) suggesting a consensus between both the potential victim of IPV and health care providers. Third, screening for IPV could further health care providers, understanding and ultimate control of certain health complications such as gynecological complications, terminated pregnancies, and preterm deliveries as well as health behaviors including abortions. Evidence suggests that such reproductive health problems occur more frequently among women exposed to IPV (Emenike, Lawoko, & Dalal, 2008; Evins & Chescheir, 1996; Rachana, Suraiya, Hisham, Abdulaziz, & Hai, 2002). In addition, physical injuries as a result of IPV (Bonomi, Anderson, Rivara, & Thompson, 2007; Ellsberg, Jansen, Heise, Watts, & García-Moreno, 2008; Fikree & Bhatti, 1999), mental and social consequences including substance abuse, depression, and suicide have been documented among victims of IPV (Bradley, Schwartz, & Kaslow, 2005; Carbone-Lõpez, Kruttscgnitt, & Macmillan, 2006; Coker et al., 2002; Houry, Kemball, Rhodes, & Kaslow, 2006; Reviere et al., 2007; Ruiz-Pérez & Plazaola-Castaño, 2005). Finally, identification of IPV within health care settings at an early stage could enhance prompt referral of abused women to other instances where they could be assisted, for example, psychosocial counseling resources, police, and legal action agencies.

Despite the strong advocacy for screening as well as gains outlined herein, data suggest that health care professionals seldom screen for the phenomena. Barely 15% of health care professionals within obstetrics and gynecology, pediatrics, nursing, general practice/family medicine, and dentistry (Fikree & Bhatti, 1999; Furniss et al., 2007; Love et al., 2001; Mazza, Dennerstein, & Ryan, 1996; Owen-Smith et al., 2008) screen for IPV. This raises concerns as to whether barriers to screening among health care providers may be apparent. Though the literature in this regard is scarce, the limited data suggest that several challenges to screening such as insufficient knowledge and skills in screening for IPV, lack of confidence, fear of offending patients and professional roles governing provider/client relationships, lack of adequate privacy to enable questioning during consultation period, and timing of patients' visits (Chamberlain & Perham-Hester, 2000; Davis & Harsh, 2001; Elliot, Nerney, Jones, & Friedmann, 2002; Erikson, Hill, & Siegel, 2001; Furniss et al., 2007; Ortiz & Ford, 2005; Owen-Smith et al., 2008; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Roelens, Verstraelen, Van Egmond, & Marleen, 2006; Scholle et al., 2003; Stenson et al., 2001) could work to impede screening for IPV. Some studies have identified forgetfulness or refusal of clinicians to follow guidelines on domestic violence as factors responsible for failures in screening (Chamberlain & Perham-Hester, 2000; Erikson et al., 2001) suggesting that factors incumbent in health care providers' attitudes and beliefs about IPV could play a role. This could also be an indication of lack of knowledge in screening or using guidelines to screen for IPV (Cabana et al., 1999).

Whereas screening is gradually an emerging practice in the industrialized world, the screening behavior of health care providers (HCP) and factors associated with such behavior in sub-Saharan Africa remains largely elusive due to lack of research in the field from this region. There are several reasons to hypothesize that screening in this part of the world may be affected by the providers' capacity and willingness to screen for IPV. First, health

care facilities in the developing countries are scarce. This, coupled by the limited number of qualified health care personal serving a rapidly growing population, could entail a high work load on practitioners that would impede screening for IPV. Second, studies based on nationally representative data from different countries in sub-Saharan Africa have shown consistently that the majority (between 65% and 80%) of adults justify IPV (Lawoko, 2006, 2008; Lawoko, Dalal, Jiayou, & Jansson, 2007) implying that the phenomena could be generally accepted in many communities and possibly even among health care professionals. This is likely to affect screening behavior. Moreover, nondisclosure of abuse may be expected among patients (Fawole, Aderonmu, & Fawole, 2005; Lawoko, 2008; Rani, Bonu, & Diop-Sidibe, 2004), particularly where IPV is an acceptable societal norm, further compounding effective screening. Finally, facilities for referral of victims of IPV are less developed in resource-poor countries and this is likely to influence screening.

Based on this background, the current paper sought to investigate health care providers' readiness to screen for IPV in health care in the Nigerian context.

OBJECTIVE

To investigate health care providers, perceived self-efficacy in screening, access to system support to refer IPV victims, conflicting professional roles (e.g., fear of offending clients) and conflicting attitudes with regard to screening (e.g., blaming the victim for being abused victim), and to scrutinize how these factors are related to demographic and occupational characteristics of providers.

METHOD

Study Settings, Design, and Participants

This cross-sectional study was carried out at the Amino Kano Teaching Hospital, in Kano, Nigeria, which is the largest multidepartmental federal health institution in Kano state. The staff and patients are of multiethnic constitution. In general, the staff members at this hospital have not undergone any specific training in screening for IPV. All health care providers having regular contact with patients (i.e., $n = 430$) were informed of the study by department heads and invited to participate. Self-administered questionnaires were sent to the eligible participants of which 274 (response rate of 64%) returned the questionnaire. Voluntary participation was emphasized and informed consent given. The participants included internists, psychiatrists, obstetricians and gynecologists, pediatricians, physicians, laboratory scientists, opticians, nurses, and midwives.

Ethical Consideration

This study received ethical approval from the Nigerian Institute of Medical Research, Lagos, Nigeria, and the authorities of Aminu Kano Teaching Hospital, Kano. The aims and relevance of the study were further emphasized in a separate document accompanying the questionnaires. Questionnaires were delivered to all the clinical and laboratory departments within the hospital. Voluntary participation was emphasized, privacy guaranteed, and informed consent given. Participants dropped the filled questionnaires at a special collection point centrally located at the hospital.

Questionnaire Measures

Dependent Variables. The Domestic Violence Health Care Provider Survey Scales (Maiuro et al., 2000) was used to assess several health provider characteristics. The instrument has been previously validated with promising results. However, internal consistency for the Nigerian sample was tested. The items were scored according to recommendations by the instrument authors (Maiuro et al., 2000). The scale consists of the following 5 subscales: Perceived Self-Efficacy subscale (7 items), which assesses for, for example, providers' knowledge/capabilities in screening. High scores on this subscale imply the providers' perceived self-proficiency in handling domestic violence; Victim/Provider Safety subscale (10 items) assessing for, for example, provider fears for their own or clients' safety. High scores suggest fears/concerns for own/clients safety; System Support subscale (4 items) assessing, for example, provider awareness of/access to support networks to refer abused clients. High scores on this subscale imply good access to social and mental support for victims of IPV; Professional Roles Resistant/Fear of Offending Clients subscale (7 items) assessing, for example, fear of offending clients. High scores on this subscale imply a cautious professional role; Blame Victim subscale (7 items) assessing, for example, provider attitudes toward victims of IPV. High scores on this subscale imply demeaning/accusatory attitude toward victims.

Response alternatives for all items ranged from 1 (*strongly disagree*) to 5 (*strongly agree*).

Independent Variables. The independent variables in this study included demographic (i.e., age, gender, marital status, and religion) and occupational (i.e., profession, department, and work experience) characteristics.

Statistical Analysis

The five subscales were subjected to reliability test using Cronbach's alpha coefficient.

Univariate associations between demographic/occupational factors and the subscales were assessed using *t* test and one way analysis of variance (ANOVA). Linear regressions analyses were employed to assess the independent predictors of the outcome variables (i.e., readiness measures) and independent variables.

RESULTS

Reliability of Instrument

All but Victim/Provider Safety subscale showed satisfactory internal consistency. Cronbach's alpha coefficients for the subscales were as follows: Perceived Self-Efficacy = .76; System Support = .67; Blame Victim = .74; Professional Roles Resistant/Fear of Offending Clients = .75; Victim/Provider Safety = .13. The overall scale had an alpha coefficient of .52.

Demographic and Occupational Characteristics Participants

As shown in Table 1, the majority of participants were doctors, males, under 31 years of age, married, Muslims, from the Hausa ethnic groups, and working at the general practice department.

TABLE 1. Characteristics of Participants

	N	%
Profession		
Doctor	156	58.0
Nurse/midwife	73	27.1
Social worker	29	10.8
Others	11	4.1
Gender		
Male	147	56.5
Female	113	43.5
Age (Years)		
21–30	116	45.1
31–40	105	40.9
41–60	36	14.0
Marital status		
Married	145	55.1
Single	108	41.1
Divorced/separated	10	3.8
Religion		
Muslim	114	42.7
Catholic	47	17.6
Protestant	76	28.5
Others	30	11.2
Ethnicity		
Hausa	84	31.5
Ibo	70	26.2
Yoruba	28	10.5
Others	85	31.8
Department		
Medicine	41	15.0
Surgery	41	15.0
Pediatric	44	16.1
Obstetrics/gynecology	36	13.2
General practice	81	29.7
Others	30	11.0

Note. N = absolute number, % = percentage of total within the group.

Health Care Providers, Average Scores on Self-Efficacy, System Support, Attitudes Toward Screening, Professional Roles, and Victim/Provider Safety

As indicated in Table 2, health care providers scored on average moderately on Self-Efficacy, System Support, Attitudes Toward Screening, Professional Roles, and Victim/Provider Safety subscales, indicating that these factors may to some extent constitute barriers to screening for IPV.

Associations Between Demographic Variables and Health Care Providers, Self-Efficacy, System Support, Attitudes Toward Screening, Professional Roles, and Victim/Provider Safety

As indicated by the correlation coefficient (Pearson's $r = 0.281$; $p < .001$), increasing age of providers increased the likelihood of blaming the victim. As indicated in Table 2, female participants scored higher than male peers on Professional Roles scale, $t(241) = –2{,}363$, $p < .01$, indicating that they were more cautious of their professional roles with regard to screening for IPV than male peers. There was significant association between religion and access to system support, $F(3, 249) = 2{,}613$, $p < .05$), where Muslims scored higher than Catholics ($p < .05$), indicating that the former perceived a better support network to refer IPV patients than the later.

Associations Between Occupation and Health Care Providers, Self-Efficacy, System Support, Attitudes Toward Screening, and Professional Roles

As shown in Table 3, there was significant associations between Profession and Self-Efficacy, $F(3, 219) = 5{,}210$, $p < .005$, where social workers tended to score higher than doctors and nurses/midwives, indicating a higher efficacy for the former. In addition, there was association between Profession and Blame the Victim subscales ($p < .001$) where social workers scored higher than doctors, $F(3, 229) = 7{,}611$, $p < .001$, indicating that the former were more likely to blame victims of IPV. Regarding Professional Roles and Profession, $F(3, 241) = 12{,}089$, $p < .001$, Doctors tended to score lower than nurses/midwives ($p < .001$) indicating that the latter were more cautious of their professional roles regarding screening for IPV. Years of working experience was significantly associated with Blame the Victim subscale (Pearson's $r = 0.224$; $p < .001$), that is, with increasing experience, the likelihood of blaming the victims increased.

Demographic and Occupational Predictors of Health Care Providers, Self-Efficacy, System Support, Attitudes Toward Screening, and Professional Roles

After controlling for other demographic and occupational factors, profession remained significantly associated with perceived self-efficacy where social workers perceived a higher efficacy than doctors, midwives/nurses, and other professions, as indicated by the Beta coefficients and p values (Table 4). Likewise, social workers perceived a better support network to refer victims of violence than other professions (Table 4). Gender and profession were significantly associated with blaming the victim when other factors were controlled for. Female care providers and doctors were less likely to blame the victim than males and social workers, respectively. Age, ethnicity, and profession

TABLE 2. Total Scores on Subscales and Associations Between Demographics and Subscales (Health Care Providers' Self-Efficacy, System Support, Attitudes Toward Screening, Professional Roles)

	Self-Efficacy[a]		System Support[b]		Blame Victim[c]		Professional Role[d]	
	M (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*
All participants	22.89 (5.80)		13.86 (3.83)		20.82 (6.34)		15.65 (5.49)	
By gender		*ns*		*ns*		*ns*		*ns*
Male	22.89 (5.75)		14.14 (3.66)		20.36 (5.60)		14.91 (4.97)	
Female	22.44 (5.92)		13.88 (3.55)		19.67 (6.20)		16.59 (6.14)	
By marital status		*ns*		*ns*		*ns*		<.01
Married	22.92 (6.47)		14.06 (3.70)		20.57 (6.02)		15.79 (5.90)	
Single	22.67 (5.08)		13.99 (3.62)		19.31 (5.58)		15.46 (5.16)	
Divorced/separated	20.90 (4.82)		13.60 (2.91)		20.55 (5.34)		15.00 (4.03)	
By religion		*ns*		<.05		*ns*		*ns*
Muslim	22.38 (6.29)		14.60 (3.67)		19.85 (5.98)		15.62 (5.89)	
Catholic	22.90 (5.56)		12.89 (3.70)		20.70 (6.23)		16.66 (4.90)	
Protestants	23.25 (5.50)		14.00 (3.40)		20.84 (6.01)		15.45 (5.32)	
Others	22.56 (5.25)		13.50 (3.51)		19.88 (6.47)		15.33 (6.23)	
By ethnicity		*ns*		*ns*		*ns*		*ns*
Hausa	22.56 (6.21)		14.45 (3.72)		19.80 (5.91)		16.62 (5.89)	
Ibo	22.35 (5.65)		13.27 (3.58)		19.95 (6.12)		15.73 (4.53)	
Yoruba	24.20 (5.70)		14.46 (3.77)		20.88 (5.89)		14.70 (5.48)	
Others	22.83 (5.51)		14.02 (3.47)		20.87 (6.30)		15.24 (6.08)	

Note. SD = standard deviation.
[a]Total: 7–35. [b]Total: 4–40. [c]Total: 7–35. [d]Total: 7–35.
**p* values according to a *t* test for gender and to *F* test for marital status, religion, and ethnicity; *ns* = nonsignificant ($p < .05$).

TABLE 3. Associations Between Occupation Factors and Health Care Providers Self-Efficacy, System Support, Attitudes Toward Screening, Professional Roles

	Self-Efficacy[a]		System Support[b]		Blame Victim[c]		Professional Role[d]	
	M (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*	*M* (*SD*)	*p* Value*
Profession		<.001		*ns*		<.001		<.001
Doctor	22.55 (5.74)		14.10 (3.56)		19.01 (5.98)		14.20 (5.08)	
Nurse/midwife	22.04 (5.28)		14.11 (3.57)		21.92 (5.54)		18.79 (5.38)	
Social worker	26.57 (5.24)		14.28 (3.74)		24.25 (6.26)		16.96 (5.95)	
Others	20.40 (7.21)		11.73 (3.80)		19.20 (4.26)		15.90 (4.72)	
Department		*ns*		*ns*		*ns*		*ns*
Medicine	22.44 (5.84)		13.18 (3.76)		19.24 (5.81)		14.57 (5.61)	
Surgery	22.94 (5.62)		14.29 (3.10)		19.97 (5.79)		16.76 (6.74)	
Pediatrics	23.25 (5.51)		14.42 (3.79)		20.49 (5.28)		15.76 (5.23)	
Obstetrics/gynecology	23.37 (4.22)		13.91 (2.99)		20.13 (5.46)		16.29 (5.57)	
General practice	23.10 (6.35)		14.13 (3.79)		21.99 (7.18)		15.27 (5.39)	
Others	21.55 (6.61)		14.25 (3.85)		18.65 (5.44)		16.11 (4.79)	

SD = standard deviation.
[a]Total: 7–35. [b]Total: 4–40. [c]Total: 7–35. [d]Total: 7–35.
**p* values according to *F* test; *ns* = nonsignificant ($p < .05$).

impacted significantly on professional roles related to screening for IPV. Younger care providers of Yoruba ethnicity and social workers were less likely to perceive conflicting professional roles related to screening than older providers of Hausa ethnicity and doctors, respectively.

DISCUSSION

Our study provides new data on factors associated with health care providers' (HCP) readiness to screen for IPV in the sub-Saharan African context using data from a community hospital in Kano, Nigeria. Readiness was measured as health care providers' grade of perceived self-efficacy, access to system support, professional roles, resistant/fear of offending clients, and blaming the client for being victimized. Though a few studies have attempted to address screening for IPV in the region, they have been descriptive in nature (Adeyemi et al., 2008; Kaye, 2006; Owoaje & OlaOlorun, 2005) and focused primarily on doctors (Ahmed, Abdella, Yousif, & Elmardi, 2003; Peltzer, Mashego, & Mabeba, 2003). To the best of our knowledge, this is the first comprehensive attempt at assessing different aspects of readiness and focusing on all categories of health care providers. Similar studies in other settings in Africa, however, are warranted to assess the consistency of the findings reported here.

The association between readiness to screen for IPV and profession was inconsistent across the different aspects of readiness measured in this study. While social workers perceived a higher self-efficacy in regard to inquiring about IPV than peers in other occupation categories, doctors were less likely to blame the victim of IPV for being abused. Social workers contribute to health care often as implementers of social interventions (e.g., mentoring and screening for health-related social phenomena like violence). That they are more likely to perceive a higher efficacy in screening for IPV could therefore be a reflection of their job specifications in this regard. Doctors and nurses, however, are often at the forefront of care. Their first encounter with victims of violence during the acute phase of care could explain why they to a higher degree than social workers have a more empathic attitude toward victims as reflected in the lower scores on Blame the Victim subscale. These findings have implications for further training of personnel within specific employment categorie's particularly with regard to empathy for victims and efficacy in relation to screening for IPV.

Readiness to screen for violence in health care varied depending on demographic features of the care provider. Muslim and Protestant health care providers perceived better access to support networks for referral of clients experiencing IPV than Catholic peers and other religious groups. While Muslims form between 80% and 90% of Kano inhabitants (Ehrhardt, 2007), Protestants form the majority of the evangelical migrants' population to Kano (Deegan, 2009). Owing to their majority status, therefore, the two religious affiliations are likely to perceive a better formal or informal network in which to refer IPV victims when contrasted with the minority religions in the region.

Male health care providers were more likely than female peers to blame the victim of IPV, an indication that patriarchal attitudes remain a societal norm in sub-Saharan Africa. Indeed, nationally representative studies in the region indicate that significant proportions of adult males (between 16% and 75%) would endorse abuse of a partner for reasons related to her failure in her normative domestic roles (e.g., cooking and caring for children;

TABLE 4. Linear Regression Exhibiting Demographic/Occupation Predictors of Self-Efficacy, System Support, Attitudes Toward Screening and Professional Roles

	Self-Efficacy		System Support		Blame Victim		Professional Role	
	Standardized Beta	*p* Value	Standardized Beta	*p* Value	Standardized Beta	*p* Value	Standardized Beta	*p* Value
Age	0.21	*ns*	0.13	*ns*	–0.09	*ns*	0.18	<.05
Gender								
Male	–0.77	*ns*	–0.009	*ns*	0.18	<.05	0.006	*ns*
Female								
Marital status								
Married	0.32	*ns*	0.19	*ns*	0.28	*ns*	0.06	*ns*
Single	0.30	*ns*	0.30	*ns*	0.16	*ns*	0.06	*ns*
Divorced/separated								
Religion								
Muslim	–0.16	*ns*		*ns*	–0.11	*ns*	–0.18	*ns*
Protestant	–0.001	*ns*		*ns*	–0.04	*ns*	–0.05	*ns*
Other	–0.03	*ns*	0.04	*ns*	0.01	*ns*	–0.03	*ns*
Catholic								

Ethnicity								
Hausa	0.01	*ns*	−0.01	*ns*	−0.05	*ns*	0.25	<.05
Ibo	−0.12	*ns*	−0.05	*ns*	−0.06	*ns*	0.02	*ns*
Other	−0.09	*ns*	−0.01	*ns*	0.02	*ns*	0.50	*ns*
Yoruba								
Profession								
Doctor	−0.36	<.01	−0.003	*ns*	−0.26	<.05	−0.29	<.05
Nurse/midwife	−0.35	<.01	−0.02	*ns*	0.04	*ns*	0.14	*ns*
Others	−0.19	<.05	−0.15	<.05	−0.10	*ns*	−0.03	*ns*
Social worker								
Department								
Surgery	0.03	*ns*		*ns*	−0.001	*ns*		*ns*
Pediatric	0.06	*ns*	0.13	*ns*	0.09	*ns*	0.11	*ns*
Obstetrics/gynecology	0.05	*ns*	0.03	*ns*	0.09	*ns*	0.12	*ns*
General practice	−0.09	*ns*	0.12	*ns*	0.08	*ns*	0.07	*ns*
Other department	−0.05	*ns*	0.08	*ns*	−0.06	*ns*	0.10	*ns*
Medicine								

Note. *ns* = nonsignificant ($p < .05$).

Hindin, Kishor, & Ansara, 2008; Lawoko, 2008). Unfortunately, our study indicates that such patriarchal attitudes are evident even among male health care professionals who ideally should be supportive toward abused clients. Female care providers, however, were less likely than male peers to perceive conflicting professional roles with regard to screening for IPV. As females are grossly overrepresented as victims of IPV, this finding may be reflecting circumstances where they express higher attachment to IPV-related issues than males in health care. They are therefore more apt to identify with their professional role in this regard and perceive the same as nonconflicting, consistent with previous observations (Lo Fo Wong et al., 2006).

Similarly, with regard to ethnicity, Yoruba care providers were less likely to perceive conflicting professional roles with regard to screening for IPV than peers from other ethnic groups. The reasons for this are not clear from our data. However, previous research suggest a high prevalence of IPV among ethnic Yoruba (Rotimi, 2007). Care providers of this group may therefore be more attached to the problem by experience and are therefore less likely to perceive conflicting professional roles related to screening. Deeper insight on the association between culture, violence, and screening is, however, warranted to confirm our speculation.

Older care providers perceived screening as conflicting with their professional roles to a higher degree than younger peers. Screening for violence in health care is a relatively new phenomenon and is likely to conflict with traditional ethics of the medical practice of the earlier days. While younger personnel may have a more liberal attitude toward such ethics through training modifications over time or otherwise, it seems older personnel express a more conservative professional role toward such ethics (e.g., rules governing invasion of privacy and offending the victim). These findings have important implications for further education of older personnel in screening for IPV and related ethical considerations. Further exploration of this notion is warranted.

Our results contribute to understanding factors that may hinder screening for IPV in health care, with sinister implications for prevention. Perceptions of male care providers and social workers toward victims need to be changed or modified through further sensitization. Adapting good practices that is in Conformity to screening for IPV against women may be valuable in modifying fears associated with Professional roles among specific health care providers (e.g., male, older personal, doctors and nurses) thereby encouraging screening. Screening itself should produce proactive benefits for better management of victims and advancement of knowledge rather than reinforcing cultural norms of blaming victims which may be anathema to modern medicine and public health. At the community level, perceived or actual religious inequality in availability of support networks demands further investigation. Likewise, the ethnic inequality with regard to perceived professional role in screening for IPV warrants further research.

The strength of this study lies in that it provides initial data from sub-Saharan Africa aimed at understanding factors that may foster or hinder screening for IPV in health care, using a previously validated instruments, the Domestic Violence Health Care Providers' Survey. The weaknesses of the study, however, warrant some acknowledgment. Though most subscales of this instrument could be reliably used for the Nigerian sample, the victim/provider safety questions exhibited unusually low reliability, suggesting perhaps that the items within this scale may not be measuring a single unidimensional latent construct as previously thought. Cultural biases in understanding questions with respect to safety may

have also played an important role, particularly in societies where IPV remains an acceptable norm. Owing to the low reliability, therefore, this scale was not further scrutinized in this work.

Generalization of our findings to the entire health care provider community in Nigeria should be done with caution or not at all. The Kano region has a different demographic distribution from other Nigerian cities, particularly with regard to ethnicity, culture, and religion, factors that have proven significant in health care providers' readiness to screen for IPV in this study.

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