Utilization and acceptance of services for survivors of Sexual and Gender-Based Violence: Knowledge, Attitudes, Practices and Perceptions (KAP) in MSF catchment areas in Port-au-Prince, Haiti

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Study proposal

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Study sites	Port au Prince, Croix-des-Bouquets.
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ACF	Action Contre la Faim
AFASDA	Haitian Women's Sun Association/ Association Femmes Soleil d'Haiti
ANC	Ante-natal care
ATFC	Ambulatory therapeutic feeding programme
CEDAW	Committee on the Elimination of Discrimination against Women
CI	Confidence interval
CTC	Cholera treatment centre
FAVILEK	Women Victims Rise Up/ Fanm Viktim Leve Kanpe
FETP	Formation en Epidémiologie de Terrain (FETP), Haiti
FGD	Focus group discussion
GHESKIO	Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections
HIV	Human immunodeficiency Virus
HUEH	Hôpital de l'Université de l'État d'Haïti (Haïti University Hospital)
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross and Red Crescent
ICRW	International centre for research on women
IDI	In-depth interview
IDP	Internally displaced person
IEC	Information, education and communication
INGO	International non-governmental organisation
IPV	Intimate partner violence
IQR	Inter-quartile range
IRC	International Rescue Committee
ITFC	Intensive therapeutic feeding programme
KAP	Knowledge, attitude and practice
KOFAVIV	Women Victims for Victims/ Komisyon Fanm Viktim pou Viktim
LGBT	Lesbian, gay, bisexual, and transgender
LSHTM	London School of Hygiene and Tropical Medicine
MCFDF	Ministère à la Condition Féminine et aux Droits des Femmes
MDR-TB	Multi-drug resistant tuberculosis
MedCo	Medical Coordinator
MINUSTAH	United Nations Stabilization Mission in Haiti

MJSP	Ministère de la Justice et de la Sécurité Publique
MoH	Ministry of Health
MoWCD	Ministry of Women and Child Development
MSF	Médecins Sans Frontières
MCFDF	Ministère à la Condition Féminine et aux Droits des Femmes
MSJP	Ministère de la Justice et de la Sécurité Publique
MSPP	Ministère de la Santé Publique et de la Population
NFI	**Non-food items**
NGO	Non-governmental organisation
NP-SV	Non-partner sexual violence
OCA	Operational centre Amsterdam
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan-American Health Organisation
PaP	Port-au-Prince
PEP	Post-exposure prophylaxis
PEPFAR	(U.S.) President's Emergency Plan for AIDS Relief
PHC	Primary health care
PMTCT	Prevention of Mother to Child Transmission
PNH	Police Nationale d'Haïti
SD	Standard deviation
SES	Socio-economic status
SGBV	Sexual and gender-based violence
SOFA	Solidarité Fanm Ayisyèn
SRS	Simple random sampling
STI	Sexually transmitted infection
SV	Sexual violence
SVS	Sexual and Gender-Based Violence survivors
UCS	Unité Central de Santé
UN	United Nations
VAW	Violence against women
WatSan	Water and Sanitation
WHO	World Health Organisation

1 Introduction

1.1 Background

Sexual and gender-based violence (SGBV) is a serious and sometimes life-threatening public health and human rights issue. Available data suggest that in some countries nearly one in four women may experience sexual violence by an intimate partner and up to one-third of adolescent girls report their first sexual experience as being forced. In the context of armed conflict and displacement, sexual violence, including exploitation and abuse, is a well-known and high risk problem. SGBV is often used as a weapon of war, targeting civilian women and children.
SGBV has a profound effect on both physical and mental health; in addition to causing injury, violence increases long-term risk of many other health problems, including chronic pain, physical disability, drug and alcohol abuse, and depression. Women with a history of physical or sexual abuse are also at increased risk for unintended pregnancy, sexually-transmitted infections including HIV, and miscarriages. They may also face complications linked to abortions (including unsafe/high-risk abortions), pregnancy (due to trauma or infections) and complications of delivery and neonatal problems such as low birth weight. Social and familial stigma and rejection secondary to SGBV may exacerbate mental health outcomes experienced by survivors.
Appropriate and accessible health services providing immediate assistance for survivors can minimise the harmful physical and psychological consequences of sexual violence. Such care involves treatment of injuries; prevention and treatment of STIs (including post-exposure prophylaxis (PEP) to prevent transmission of HIV); vaccination against tetanus; management of unwanted pregnancy or referral to ante-natal care (ANC) for continued pregnancy; psychological support and mental health care; and support for social and legal issues.

1.1.1 Definitions of SGBV

Many definitions of sexual violence and SGBV exist. Generally, it is understood to be an umbrella term for any harm that is perpetrated against a person's will, and that results from power inequities that are based on gender roles. Definitions are generally based on the United Nations definition first presented in 1993 when the General Assembly passed the Declaration on the Elimination of Violence against Women. It was later defined by The Inter-Agency Standing Committee (IASC) in 2005 as '*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'*
MSF uses the UNHCR definition of SGBV: '*SGBV refers to any harmful act that is perpetrated against one person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life' .* This can incorporate a wide range of sexually violent acts taking place in different circumstances and settings. These include, but are not limited to: rape within marriage or dating relationships; rape by strangers; systematic rape during armed conflict; unwanted sexual advances or sexual harassment, including demanding sex in return for favours; sexual abuse of mentally or physically disabled people; sexual abuse of children; forced marriage or cohabitation, including the marriage of children; denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases; forced abortion; violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity, forced prostitution and trafficking of people for the purpose of sexual exploitation.
Whilst we recognize the full range of abuses the term SGBV includes as per the UN Declaration and other international agreements this definition is considered too broad for the purposes of this study. At the same time MSF SGBV services focus on the provision of care for physical and psychological consequences of sexual violence as well as physical violence linked to gender. Therefore, this study will focus on **physical and sexual violence in an intimate partnership (IPV), and non-partner sexual violence (NP-SV)**.
Sexual violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

Intimate partner violence: Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including physical and sexual violence, emotional (psychological) abuse Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, including physical and sexual violence, emotional (psychological) abuse and controlling behaviours(10).
The term 'domestic violence' is often used to refer to partner violence but can also encompass child or elder abuse, or abuse by any member of a household(10).
Whilst we recognise that these definitions may imply an emphasis on violence against women (VAW), we aim to actively incorporate both genders in this study. There is some evidence to suggest that men are also targets of sexual violence, particularly during conflict, and that men also play a role in (female) survivors accessing services.

1.1.2 Other definitions

Definition of household

A household will be defined as a group of people who slept under the same roof the previous evening and have all been living under the same roof for the past month (this is in order to exclude visitors to the household).

Definition of head of household

The head of household will be defined as an adult household member aged ≥18 years, who states that s/he is responsible for the household members and is present at the time of the survey

Definition of a survivor

Survivor will be defined as individuals (male or female) who have experienced SGBV.

NB. In using this definition we recognise that experiences of violence do not define the individual, but rather are a piece of a larger self-identity and that labels which focus on experiences of violence can limit individual self-agency and identity.

1.2 Context in Haiti

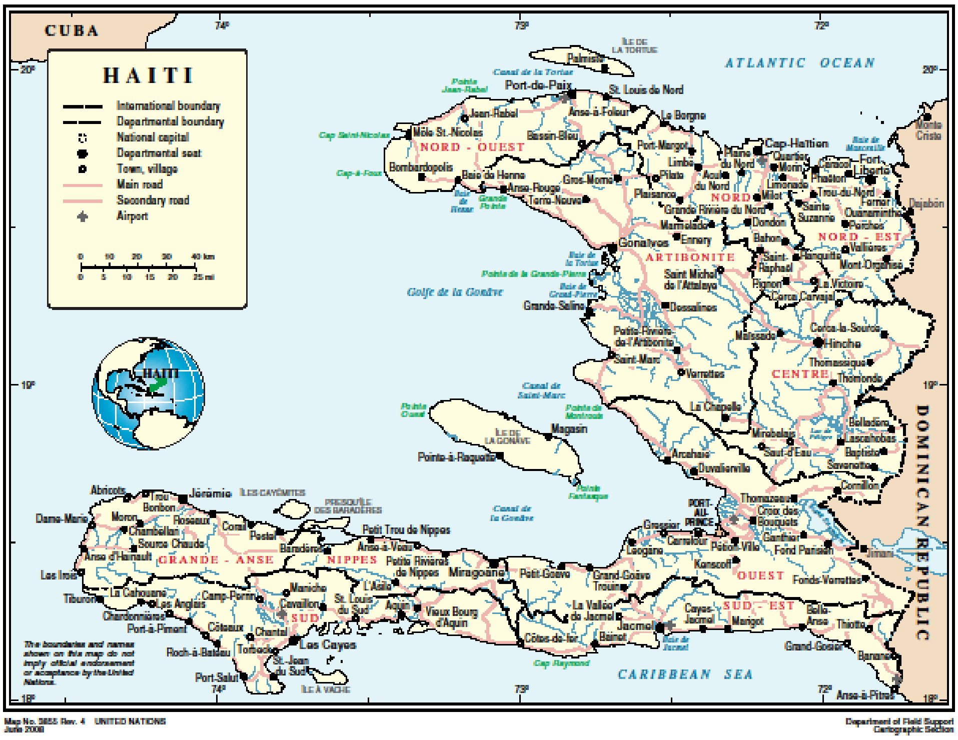

Figure 1: Map of Haiti

The earthquake that struck Haiti in January 2010 took the lives of between 220,000 and 250,000 people, left 1.5 million people internally displaced, and led to over 600,000 cases of cholera in an ensuing epidemic. Parts of the capital, Port-au-Prince (PaP), were totally destroyed and provincial towns nearby were equally badly affected. Some 105,000 homes were completely destroyed and over 208,000 damaged, including more than 50 hospitals and health centres that collapsed or became unusable. Government buildings destroyed included the Presidential Palace, Parliament, the Law Courts, and most of the Ministry and public administration buildings; severely affecting the country's economic and administrative capacity. The total value of the damage and losses is estimated at US$7.8 billion, more than the country's GDP in the whole of 2009.

It is important to note that the earthquake occurred in a country with the highest levels of poverty in the Western hemisphere (out of a total population of 10,579,230, 58.6% live with less than US$2.5 a day). In addition Haiti had experienced decades of political instability, particularly following the violent ousting of the popular president Jean-Bertrand Aristide in 2004, when crime and systematic abuse of human rights escalated to unprecedented proportions. Since that same year, foreign troops of the United Nations Stabilization Mission in Haiti (MINUSTAH) have been in country to assist in restructuring and reforming the Haitian National Police and to provide basic security for a growing UN humanitarian and development community, the transitional government and a population that has, however, grown increasingly ambivalent to MINUSTAH's presence.

In PaP, gang violence in particular increased significantly. A survey conducted between 2008 and 2009 documented the dynamics of mobilisation of youth in Cité Soleil, PaP. Powerful actors used disenfranchised youth as tools for achieving political and financial gain, in exchange for arms, funding, and protection from arrest. Importantly, the survey notes that youth found in their access to gangs and in their participation in violent acts, what was widely denied to them by society: opportunity, respect and material benefits.

Gang violence and political instability remain a security problem in PaP, most recently demonstrated in the last presidential and legislative elections in 2015 which were marred by violence, social unrest and a political impasse amidst accusations of fraud and corruption.

In the health sector, the Pan-American Health Organisation noted that some of the challenges the Ministry of Health (MoH) faced at the time of the earthquake persist, including retention and remuneration of health workers; constraints at implementing a decentralization policy; and an effective procurement, management and distribution of drugs and medical supplies. Existing health services are mostly private, with a small public sector, faith-based groups, and Non-Governmental Organisations (NGOs) among others. In the capital, private, for-profit health clinics and pharmacies offer often unaffordable services for the majority of the population, and the elite often seek treatment abroad.

According to the Pan-American Health Organisation (PAHO), approximately 47% of the Haitian population lacked access to basic health care, with this figure rising to over 50% for women. Barriers to access include financial constraints, but also poor quality of services when available, both of which have taken a toll on the population's health status. Under-five mortality rate at 69/1000 live births, is more than twice that of neighbouring Dominican Republic (31/1000 live births); and the maternal mortality ratio with 359/100,000 live births is the highest in the region.

1.3 SGBV in Haiti

In order to examine SGBV in Haiti, it is important to review the links between SGBV and a series of periods of political upheaval, which over time have turned cases of sexual violence not only into incidental but also into deeply entrenched structural issues.

Rape as a punitive and intimidating weapon against opposing political factions was employed during the two dictatorships between 1957 and 1986, and later again during the Haitian coup of 1991 to 1994 amidst widespread repression and violence. Notably, the phenomenon of 'zenglendos' or groups of aggressors breaking into private homes, raping and beating girls was punitive practice between rival political groups either as a method for creating fear and destabilisation or for controlling territory.

Sexual violence was documented particularly following the departure of President Aristide in 2004. A survey conducted in the greater PaP area during that period recorded kidnappings, extrajudicial detentions, physical assaults, death threats, physical threats, and sexual violence. Although criminals were the most identified perpetrators, officers from the Haitian National Police accounted for 13.8% and armed groups against Aristide's political party Lavalas accounted for 10.6% of identified perpetrators of sexual violence.

While SGBV was prevalent before the earthquake, displacement and subsequent loss of community and family protection structures, combined with the loss of livelihoods and impunity for perpetrators certainly increased the vulnerability of many women and girls following the disaster. The local women's Non-governmental organisation (NGO), Commission of Women Victims for Victims (KOFAVIV), registered over 250 cases of rape in several internally-displaced person (IDP) camps during the first 150 days following the earthquake. A University of Michigan survey conducted in March 2010 estimated that 3% of all people in Port-au-Prince had been sexually assaulted since the earthquake; all but one of the respondents surveyed in that study were female and half of the victims were girls under the age of eighteen . MSF reported treating 212 victims of sexual violence in the 5 months following the earthquake . SOFA, a well-known Haitian women's health organization, documented 718 cases of gender-based violence against women and girls in its clinics from January to June 2010, including 114 rapes and 540 cases of physical abuse.

A survey conducted by the local NGO PotoFanm+Fi documented that unwanted and early pregnancies, unsafe abortions, child abandonment and transactional sex significantly increased after the disaster. The survey indicated that 64% of 981 interviewed adolescents in PaP in 2011 reported becoming pregnant from rape. Another survey conducted in IDP camps in PaP the same year, found that the phenomenon of women and adolescent girls engaging in transactional sex within camps was widespread, most commonly used as a method for women to feed their families.

Before and after the earthquake, sexual violence has been heightened by gender disparity, patriarchal burdens, and particularly an acute power imbalance between men and women. According to a study to determine how power and control in intimate relationships influenced women's exposure to sexual violence in Haiti, husband's jealousy and controlling behaviour, and women's endorsement of traditional norms particularly concerning a man's rights to beat his wife were positively associated with intimate partner violence.

The government of Haiti has acknowledged the extent of domestic and intimate partner violence in the country within its most recent report to the Committee on the Elimination of Discrimination against Women (CEDAW), in which it identified a number of surveys that establish the widespread nature of domestic violence in Haiti. One of the earliest empirical studies on violence against women carried out in Haiti dates from 1996, when the Haitian Centre for Research and Actions for the Advancement of Women, financed by UNICEF, evaluated physical, sexual, psychological, social, financial and political violence inflicted on women and girls. The study concluded that while 70% of Haitian women stated that they had suffered some form of violence, men claimed not to have committed violence against women (though they acknowledged their belief that such violence is sometimes justified). A 2000 study, which was repeated in 2005 and 2007 with similar results, concluded that 30% of Haitian women have suffered acts of violence from husbands or partners. Although this 30% figure appears substantially lower than the 70% reported by UNICEF in 1996, the discrepancy can be explained by the earlier study's broader definition of 'violence.' .

Stigma of survivors of sexual violence is generally very high. As elsewhere in the world Haiti is no exception to the commonly held perception, by both women and men, that there are circumstances in which men's violence against women is justifiable. A national-level survey conducted in 2012 found that almost half of all of the female and male participants between the ages of 13 and 17 years said they believed that a man has a reason to hit his partner if she leaves without notifying him; neglects children; argues with him; refuses to have sex with him; or makes a mistake when cooking.

The perception that violence can be justified is commonly accompanied by views that a woman or girl is to blame for the violence committed against her, which then leads to stigmatizing behaviours, not only reflected by community members but also by local authorities responsible for protecting victims. Amnesty International reported that some of the survivors they interviewed following the earthquake, described discriminatory and dismissive attitudes towards them among police officers when reporting cases.

1.3.1 Local definitions of SGBV

There are differences and similarities in the language and words used to describe SGBV in Haiti. A 2014 study conducted in Cité Soleil found 'kadejak' and 'dappiyanmp' to be common descriptions of sexual violence or rape. However, different terms were used to describe gang rape for example, including 'tren' (train) 'Kantè,' 'Vòldazi,' and 'gèdè' ('together') .

Definitions of SGBV are linked to 'a woman getting attacked and raped by a stranger', and as such IPV is not generally defined or perceived as rape .

1.3.2 At risk locations and populations

Survivors of sexual violence are primarily women and girls; few cases of male survivors are reported, but this can be attributed to the stigma and fear of being labelled a homosexual upon disclosure. Several surveys suggest that sexual violence also targets young men, which is supported by data collected during MSF OCA's 2014 SGBV situational analysis ; all key informants mentioned that boys (and men) were also at risk of being raped, but the associated stigma (notably homosexuality) was so high that the crimes remain usually unreported. However, there is very little data on male survivors; whilst most under 18s seeking care at MSF and other clinics are girls, there are also boys . The current response, however, targets mostly women, and even if shelters accept boys and girls, there is no specific prise en charge for them.

Street children and children who work as domestic servants or 'restaveks' (Haitian Creole for 'to stay with') are also identified as vulnerable groups . While the practice of 'restaveks' was originally conceived to send children from disadvantaged backgrounds to live with wealthier families and benefit from a better life, these children are nowadays often subjected to physical, verbal and sexual abuse and exploitation by their host families. According to the International Programme for The Elimination of Child Labour, approximately one in ten Haitian children is a 'restavek'.

It is assumed that camps and deprived neighbourhoods represent more at risk areas, because there is a higher rate of violence combined with a lower protection than in other areas. However, the phenomenon seems to touch all socio-economic levels; there is no evidence that people of a 'higher' socio-economic level are more likely to report SGBV and/or to have lower prevalence . A recent survey by Action Contre la Faim (ACF) shows that in camps transactional sex is a common survival strategy for women. Data collected during MSF OCA's SGBV situational analysis in 2014 confirms this, as key informants stated that transactional sex represented a widespread coping mechanism in circumstances of poverty, and not restricted to camps or deprived areas of Port-au-Prince. The most likely to engage in this are poorer, single women, young women, adolescents and girls (usually the eldest of a family), in order to contribute to household costs .

1.3.3 SGBV services in Haiti

Prior to the earthquake, a wide range of national actors working within the domain of SGBV existed in Haiti. Women's organisations like Women Victims Rise Up/ Fanm Viktim Leve Kanpe (FAVILEK), the Commission of Women Victims for Victims/ Komisyon Fanm Viktim pou Viktim (KOFAVIV), Haitian Women in Solidarity/ Solidarite Fanm Ayisyèn (SOFA), Women's House (Kay Fanm) and Haitian Women's Sun Association/ Association Femmes Soleil d'Haiti (AFASDA), mobilised within weeks of the disaster. Activities included awareness campaigns, distribution of hygiene kits, and the establishment of a network of volunteers to find and refer survivors to emergency services, among others.

Another important local actor is the National Dialogue on Violence against Women (Concertation Nationale Contre les Violences Faites aux Femmes), established in 2004 to serve as an advisor to the Ministry for the Status of Women and Women's Rights (Ministère à la Condition Féminine et aux Droits des Femmes, MCFDF). The 'Concertation' as it is referred to in Haiti, carries the key role of coordinating, communicating and advocating for initiatives and norms aimed at promoting gender equality and reducing violence against women. The actors it coordinates include the Haitian Government (MCFDF, Ministère de la Justice et de la Sécurité Publique, MJSP and Ministère de la Santé Publique et de la Population, MSPP), civil society and international agencies.

Although present before the disaster, both the Concertation and the MCFDF were severely affected by the earthquake having lost both material assets and personnel. As a provisional measure, a UN

Sub-Cluster on gender-based violence led by UNICEF, UNFPA and other UN groups stepped in to provide coordination among actors. However, local groups soon after echoed concerns expressed in other sectors, about the difficulty of participating in meetings at the UN logbase that were often conducted in English. This progressively created frustration and a feeling of exclusion among experienced national actors. Referring to the myriad of NGOs and volunteers who set up response efforts, Danielle Magloire, the leader of Concertation said, 'One of the difficulties has been that so many groups have come here and started activities without informing anyone… People weren't even aware that Haiti had had a women's movement and groups here who have been working on this issue of violence against women for many years'.

As the acute emergency phase passed many INGOs ended programmes and funding for local organisations progressively started dwindling. However, existing local women's organisations continued to provide some level of social and legal assistance, referring survivors for medical care primarily to GHESKIO (Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections) or to the General University Hospital (Hôpital General Universitaire de l'Etat Haitïen (HUEH)).

GHESKIO offers free medical and psychological care, social support, and community sensitisation in the area of Bicentennaire. However, GHESKIO opens only on weekdays, and Bicentennaire is a difficult-to-access area, with an often unstable security situation. HUEH often faces shortages of emergency contraception and pregnancy tests, which thus become out-of-pocket payments by the patient. As in other large public hospitals, anti-retroviral drugs are available in HUEH, provided in line with their HIV/AIDS program funded by PEPFAR. It is important to note, nonetheless, that HUEH does not offer any mental health services for survivors of SGBV. Mental health services in the whole country are centralised in two understaffed and under-equipped psychiatric hospitals.

GHESKIO, with some sensitization in the Bicentennaire area only, received an average of 23 survivors per month over ten years (2000-2010) years. Notably, the period after the earthquake was reportedly a period of higher risk due to violence in IDP camps, but this is not reflected in their data. GHESKIO has been a key actor caring for survivors in PaP, treating about 300 cases per year and with most of their survivors coming from the municipalities of Delmas and Croix-de-Bouquets.

HUEH shared unofficial statistics with MSF in late 2015, indicating that they receive about 37 survivors per month (January-October 2015). In addition to being the most widely known public health structure in the country, many people including both survivors and members of the judicial system often believe that only HUEH is entitled to issue medical certificates to survivors (see section 1.3.3).

Nowadays, numerous Haitian civil society and international actors work in the field of SGBV on advocacy, prevention, awareness raising, social and medical case management, referrals to medical and legal structures, shelter and re-localisation of SGBV survivors. In particular, the Concertation has made important progress on advocating for a now-approved SGBV medical national protocol, for the establishment of a uniform medical certificate, and for reforms that have made rape a punishable crime. Some of the challenges that remain include ensuring an active coordination of efforts in order to reinforce a quality multi-sectorial response; data collection; and a general understanding of and adherence to the norms and policies that are established through the collective work of actors to provide survivors with the best available assistance.

1.3.4 Legal framework

Until 1986, rape was legally not considered as forced sexual intercourse. Rape is now defined in the 2005 Haitian penal code under articles 279-281 as 'sexual assault'. In addition Haiti is party to a number of international treaties that require states to combat domestic and sexual violence,

including the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the American Convention on Human Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, among others. The 'Plan national de lute contre les violences faites aux femmes' has been developed by the Ministere de la Condition Feminine,and the MOH and the Concertation Nationale, and aims to ensure prevention, welcoming care and support to women and girls victims of specific violent acts. The plan should be finalised by the end of 2017.

Whilst rape is considered as a crime, it is not considered a 'most serious crime[1]'. The maximum sentence for rape is 10 years of imprisonment if the survivor was 15 or over when the crime was committed, and 15 years of imprisonment if the survivor is under 15 when the crime was committed. In the case of gang rape, the maximum penalty is lifelong forced labour. Actual sentences are often less rigorous, and prosecution frequently was not pursued due to lack of reporting and follow-up on survivors' claims. In 2012 the Haitian National Police reported 546 allegations of rape, of which female minors brought 360 cases. In the cases of the 54 men convicted for rape in 2010-11, judges handed down sentences ranging from eight months to 15 years; one man–a priest–received life in prison. In addition the penal code does not provide an accurate definition of rape or a list of constitutive elements and only provides for sentences. Therefore, judges have to resort to external definitions, making the application of penal code incoherent and protection for survivors is low. Also, whilst the law prohibits rape it does not recognize spousal rape as a crime.

Numerous reports have described serious deficiencies in Haitian authorities' ability or willingness to investigate and prosecute domestic and sexual violence allegations, and described inherent underlying discrimination within the legal system. Attorneys who represented rape survivors said that authorities were reasonably responsive to cases involving the rape of minors, as the law is clear and judicial measures exist to deal with such cases, which were often accompanied by outrage from local communities. However, major shortfalls have been noted in other cases (when the offender was also a minor or the survivor was an adult) due to the lack of clear legal or administrative structures to deal with such cases . Despite increasing numbers of 'complaints' being lodged, many legal proceedings are withdrawn, either by survivors or their families or the judge themselves, following (financial) pressures from aggressor. If the complaint is not withdrawn, very few files end up on the desk within the final authority: the assizes.

Poor handling of survivors and by the police and justice system is also reported as investigators sometimes ask the victims what she did to provoke or invite the assault, or would otherwise blame the victim. A 2009 Report by the Inter-American Commission on Human Rights highlights survivors' disinclination to seek legal remedy, declaring 'victims and their families have no confidence in the ability of the justice system to right the wrongs committed, and are often mistreated when attempting to avail themselves of judicial remedies. This combination of factors leaves the victims with a sense of insecurity, defencelessness and mistrust in the administration of justice.'

Additionally, for sexual assault cases, police require a medical report to be completed within 72 hours after the alleged assault and policemen say they sometimes refuse to transfer file if there is no medical certificate. Medical certificates can be issued by any qualified doctor entitled to practice in Haiti, and do not necessarily need to come from HUEH or any other public health structure. In 2012, PotoFanm+Fi documented that Haiti's courts and judges often refused to accept certificates issued by providers other than HUEH.

A number of organizations have proposed different remedies for shortfalls in the legal system, including strengthening the current rape laws to include specific mention of marital rape and adopt

1 Those being murder *(crime de sang*) and political crime.

an internationally recognized definition of rape and sexual assault; this includes the adoption of certain laws already proposed in the Haitian parliament. In addition, there have been several calls for the adoption of legislation criminalizing domestic violence and sexual harassment. Furthermore, Haiti has been called upon to strengthen the capacity of its institutions to better respond to complaints of domestic and sexual violence in order to ensure that such crimes are punished, and to provide free legal, medical, and psychological services to victims. A number of these different strategies have been pushed forward by Haitian women's groups and the few female legislators that have been elected to Haiti's parliament . In addition the BAL (Bureau d'Aide Légale) is a new structure supported by MINUSTAH, supposed to provide victims of violence with a legal and free support. They are currently 5 offices in PaP. BAL will also provide trainings to different actors (notably civil society organizations in different locations).

1.3.5 Barriers to care

Various barriers to accessing SGBV services in Haiti have been documented, including fear of stigmatization; lack of awareness of the potential medical consequences of SV and of available services for care; an often undignified and complex reporting process; fear of retaliation from perpetrators; and limited access to legal aid. Practical issues such as transport, distance and lack of funds as well as access to rural communities, infrastructure, language, safety and community factors have also been reported. Time has also been reported as a barrier, both to reach the hospital and because survivors have to wait for a long time at the facility (sometimes they have to wait a whole day at GHESKIO, according to MOFKA), as well as security and travel difficulties (for example for survivors in Cité Soleil).

The General Hospital of Port-au-Prince provides free services to victims of SGBV but few seek care because of feelings of shame, fear, insufficient services in the absence of law enforcement investigation (Amnesty International, 2011) and the perceived impunity of perpetrators. This is exacerbated when the perpetrator is a family member or when the violence is gang related, as people prefer to avoid the conflict and fear reprisals . A lack of trust in medical services, particularly in regard confidentiality has been noted. Stigmatisation and other social consequences are reportedly high; women are considered 'spoiled' and risk of not finding a husband anymore; survivors risk losing employment or being excluded from school, and a boy or young man will be perceived as homosexual, which is highly stigmatized in Haiti. survivors are more at risk of further aggressions.

According to MSF OCA's 2014 situational analysis, survivors are often not aware that they can or should seek medical care or where care is available (most survivors accessing medical are referred by associations or directly by medical structures when they present to health structures for other issues. In case of assault by stranger, survivors are more likely to seek legal action, and largely do not seek medical care unless they have to (to obtain medical certificate) or if they are encouraged to by women associations. Moreover, health issues as a consequence of SGBV are still not considered a priority for survivors themselves. Health care is too risky in comparison with what they think they have to lose should their circumstances be known by other community members. Another issue preventing survivors from seeking health care is the physical access to medical structures (mostly distance) and even if those services are supposed to be provided for free economic constraints (if they have to pay for certificate, pregnancy test, drugs…). In other cases, survivors and relatives know the importance of medical care within 72 hours (mostly without knowing why, though), but do not know where to seek care.

Poor care in medical facilities has also been cited as a barrier, including discriminatory treatment by medical staff, breaches in confidentiality, and incomplete where cases are referred and subsequently abandoned. Age can also be a barrier, specifically in the case of 'restaveks', as victims below 18 often lack a legal guardian at presentation to a clinic so cannot receive treatment.

Anecdotal evidence also suggests that survivors and/or their families may be more likely to seek justice and/or 'medical service' from a Voudou priest, who are often also alternative practitioners, which may delay access to medical services.

Enablers to access have included using local partners, established experts, organisations and agencies to implement projects. Public education to promote awareness and prevention of SGBV was also cited as key to the success of SGBV projects; evidence collected from beneficiaries, outreach workers, staff, and an on-site survey suggests that organisations successfully raised awareness of SGBV and its prevention through public awareness events, radio broadcasts, and training sessions. Addressing women's civic participation through improved leadership, networking, and advocacy made significant contributions to SGBV-related law reform efforts.

1.4 MSF in Haiti

MSF's activities in Haiti started in 1991 when MSF-OCP partially rehabilitated the Fort Liberté Hospital, followed by the Justinien Hospital in 1994. In the same year MSF-OCB provided an emergency response to Hurricane Gordon (water supply and latrine construction) and rehabilitated Saint Nicola's hospital in Artibonite (staff training and surgery) as well as providing support to the Bureau Communal de santé by reinforcing health care in Saint Marc, Desdunes and Grande Saline. In 1996 MSF-OCA supported the Unité Central de Santé (UCS) with a primary health care (PHC) program and in 1997 MSF-OCP rehabilitated and constructed 6 health centres in Port-au-Prince. In 1998 MSF-OCB responded to Hurricane Georges in Artibonite and Port-au-Prince (water supply, plastic sheeting, support to health centre, etc).

MSF's support of Haiti continued into the next decade. In 2000 MSF-OCB initiated programmes to reduce maternal mortality and improve access to health care in Artibonite. In 2004 MSF-OCB responded in Gonaives to Hurricane Jeanne (WatSan, mental health, PHC) and started a programme responding to social violence in Port Au Prince (Saint Francois de Salle Hospital) and Saint Marc (Saint Nicolas Hospital). Meanwhile MSF-OCP had a surgery programme (violence) in Saint Joseph's hospital. In 2005 MSF-OCA provided support to health structures in Decayette, MSF-OCP initiated an Orthopaedic Rehabilitation Centre in La Trinité Hospital in Delmas 19 and MSF-OCB supported Choscal hospital with PHC in Cité Soleil. In 2006 MSF-OCA opened an emergency obstetric programme that moved to Solidarité Hospital in Delmas 18 and is ongoing in CRUO in Delmas 33. In 2006 MSF-OCB started an emergency stabilization centre for trauma in Martissant which is ongoing. MSF-OCB responded to Cyclone Hanna in Artibonite through the construction of a hospital, PHC, nutrition, mental health and water point rehabilitation.

In January 2010 a large earthquake struck Haiti leading to large emergency response initiatives by all MSF sections. MSF-OCA provided PHC in 2 major camps (Petionville Golf Club & Aviation Camp), WatSan, nutrition & NFI distributions, whilst in Carrefour, an orthopaedic hospital and paediatric hospital were constructed. The destruction of MSF-OCA's Solidarité Hospital led to construction of a new obstetric hospital (CRUO) in Delmas 33. MSF-OCP activities were transferred from Trinité Hospital (destroyed) to a new inflatable hospital in Delmas 31 (orthopaedic & visceral surgery). Post-surgery care was carried out in Tabarre. MSF-OCB returned to a MoH hospital in Cité Soleil (CHOSCAL) to support the emergency room, surgery, paediatrics, maternity, internal medicine and pharmacy. Patients were transferred post-op to another OCB run facility in Sarthe. MSF-OCBA arrived quickly after the earthquake thanks to its Panama office and started a small hospital in Bicentennaire and provided support to the hospital in Jacmel. MSF-OCG built a container hospital in Leogane which is ongoing with planned closure at the end of 2015.

A huge cholera outbreak followed the devastating earthquake and again MSF initiated large emergency response initiatives. MSF-OCA built cholera treatment centres (CTCs), supported

WatSan, and carried out community sensitization. MSF-OCBA did the same in Artibonite, the West, South and the South East of Haiti, MSF-OCP focussed on the West and Artibonite and MSF-OCG supported the West and the North of Haiti.

In 2011 MSF-OCP built a container hospital in Drouillard. The inflatable hospital activities were transferred to this hospital. MSF-OCA added neonatal emergency care (including incubators and kangaroo maternity care) to its CRUO hospital services. In addition MSF-OCA built an 80 bed cholera facility next to CRUO to support the continued annual cholera outbreaks. In 2012 MSF-OCB opened a container hospital in Tabarre for emergency orthopaedic and visceral surgeries. In 2015 MSF-OCA continued to provide a Nationwide Surveillance and a Rapid Response team for cholera. In May 2015, OCA launched a vertical SGBV programme in PaP. Under the name of Klinik Pran Men'm (Haitian creole for 'Take my hand'), the clinic offers 24 hour confidential medical and psychosocial care to survivors of SGBV seven days a week, and a team of community health workers conduct a range of awareness activities in the metropolitan area.

1.4.1 MSF SGBV data in Haiti

Over the period from 2011 to 2012, MSF-OCB received a total of 459 cases, referred from all over the city but predominantly from the Martissant area, where the health structure is located. When their SGBV component came to an end, survivors were referred to GHESKIO. Since May 2015, OCB Martissant refers survivors to OCA's Pran Men'm.

Before ending the availability of services for survivors in Drouillard Hospital (in order to become a specialised hospital for burns), MSF-OCP received an average of 12-15 survivors per month over 2012-2013. During that period they received a total of 317 survivors of sexual violence (85% anal or vaginal penetration), of which 79% arrived within 72 hours. Survivors came from all over the city, but particularly from the municipality of Cité Soleil (26%), which may be linked to the hospital's location there. 52% of all patients were referred by the National Police (PNH) or UN peacekeepers (MINUSTAH).

Prior to the opening of Klinik Pran Men'm, OCA's CRUO recorded throughout 2011-2013 a total 1,911 incomplete abortions which accounted for about 11% of all admissions. CRUO's mental health team also received 59 cases of full-term pregnancies that resulted from rape.

MSF OCA, SGBV clinic Pran Men'm~~'men~~: between May 2015 and December 2016, MSF provided care to 1000 survivors of which 97.2% were female. Of these survivors, 52% (n=520) were under 18 years, followed by the 18-25 aged group (n=256, 26%). Among the minors, 24% were under 10 years old (n=124), 34% between 10 and 14 (n=175) and 40% between 15 and 17 years old (n=206). Most of the patients were survivors of rape (n=827).

Data shows that 83 % of survivors presented within three days after the incident. For those under 18 years of age, 60 % presented within three days which shows more delay.

FIGURE 2: OCA, OCP AND OCB PROJECTS IN HAITI AS OF 2015.

(OCA PRAN MENM: Clinic for sexual and gender-based violence survivors; OCA CRUO: Referral Centre for Obstetric Emergencies; OCA HCERU: Haiti Cholera and Emergency Response Unit; OCB Martissant: Emergency and stabilization centre; OCB Tabarre: Referral centre for surgical and orthopaedic care; OCP Drouillard: Centre for the treatment of burns).

1.5 Rationale for the study

It is acknowledged that SGBV services are under-utilized across contexts, yet factors affecting this are not well understood. Until recently, most research on SGBV consisted of anecdotal accounts or exploratory studies performed on non-representative samples of women. However, the subject has received increased international attention in recent years, and ground-breaking research in the field has greatly expanded international awareness of the dimensions and dynamics of violence. Research and operational literature on SGBV stems from a variety of different disciplines, including, among others, political sciences and international relations, gender studies, anthropology, neuropsychology and law. Prevalence or baseline studies are also increasingly available in a wide range of contexts and focus on social norms around gender and violence and SGBV prevalence, as well as various guides for programming, monitoring and evaluation. However, little research has tackled the gap between service provision and uptake; data about people who do not seek services is sparse; in many contexts there is limited information on knowledge and perceptions of SGBV services available; and there is no systematic information about survivors' experiences and perceptions of the services to allow for feedback and adaptions.

Whilst there has been some research conducted on SGBV in Haiti it tends to focus on the increase of SGBV Haiti post-earthquake in 2010; the prevention and response to SGBV in Haiti more generally; and the conditions in which SGBV emerges, the locations in which it is most likely to emerge and the impact it has on women. However, there is comparatively little literature available on knowledge, attitudes and practices towards care for SGBV. Moreover, ensuring SGBV services are accessible for target groups and in hard-to-reach areas, particularly in ways that involve local stakeholders in problem identification and solving, has been identified as a gap in programming necessitating further research and innovation.

At the same time, MSF's Pran Men'm'~~mem~~ team has questions about how to ensure services are accessible to the most vulnerable groups, and how to increase uptake amongst certain groups. For example, currently the majority of survivors coming to the clinic are under 18; uptake of services by adults (male and female) remains low despite evidence of a high prevalence of SGBV. As a result a deeper understanding of MSF's target population, particularly knowledge of SGBV and related services and factors obstructing and driving service utilisation is needed. Furthermore developing innovative strategies for reaching out to survivors and ensuring sensitive and appropriate services necessitates an in-depth understanding of the local context and sociocultural issues around SGBV.

This study will provide information on the knowledge and understanding of target communities in regards to the medical and psychosocial consequences of SGBV, the barriers to accessing services for survivors, and the types of services available. This evidence will allow us to develop, through community consultation, strategies for improving uptake of SGBV services and to advocate for improved care more generally. By analysing factors influencing service uptake for SGBV we aim to provide practical recommendations for the improvement of SGBV policy and programming both for MSF and national level agencies. The findings will support the adaptation and development of strategies to improve utilization of SGBV services, such as SGBV Information, Education and Communication (IEC) strategies, and services in each site to improve uptake and ensure services are accessible and appropriate.

As a result, and following thorough reflection and consideration of existing literature, we believe this study could make a significant contribution to addressing the information gaps and adding to the existing literature on various aspects of SGBV, and also providing in-depth ~~regarding~~analysis of knowledge, attitudes and perceptions around SGBV services and how to improve their uptake in the context of PaP, Haiti. Moreover, by consulting with affected communities and defining possible strategies/activities people consider would be effective in improving access and uptake we and bridging this gap between barriers and service provision this study will provide valuable new information that will be beneficial to MSF as well as other entities responding to SGBV.

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2 Research question and objectives

2.1 Research question

To identify factors that could improve SGBV service utilisation and acceptance amongst MSF's catchment population in Port-au-Prince, Haiti

2.2 Primary objective

To understand how to improve utilization of SGBV services for the population in MSF catchment area Port-au-Prince, Haiti

2.3 Specific objectives

1. To understand community knowledge related to SGBV, including its causes, consequences, treatment and services
2. To understand attitudes towards SGBV
3. To explore practices related to SGBV care seeking pathways, including barriers and enablers affecting service access and uptake
4. To understand which strategies/activities people consider would be effective in improving uptake of SGBV services
5. To understand which strategies/activities people consider would be effective in preventing SGBV

3 Methodology

3.1 Study design

A sequential mixed methods study is proposed as most appropriate in meeting the study's objectives. With this multi-phased sequential mixed methods approach we aim to optimise the validity of the study. It is suggested that a mixed methods approach can offer the most comprehensive and informative data related to SGBV.
Error: Reference source not found gives an overview of the study design.

Phase	Approach	Objectives	Methods
1. Formative community-based (exploratory)	Qualitative	• Inform design of KAP survey (questionnaire responses; phrasing of questions etc.) • Enhance understanding of the subject /context • Inform design of training of survey data collection team • Inform development of SOPs including systems for identifying and managing adverse events	• IDIs with key stakeholders • FGDs with groups of men and women
2. KAP survey	Quantitative	• Provide context specific quantitative data on KAP • Inform design of explanatory qualitative phase	• KAP survey
3. Explanatory research and community-based design of strategies to improve uptake	Qualitative	• Explore/explain tensions and divergences in the findings of each data set and develop a richer understanding of KAP survey data • Identify strategies to overcome barriers identified and improve uptake	• IDIs • FGDs with individuals/ groups identified based on results of phase 1 & 2

TABLE 1: OVERVIEW OF STUDY DESIGN

The first phase of formative explorative research will ensure that our approach and tools for the KAP survey are appropriate, comprehensive and adapted to the context. The second quantitative KAP survey will identify trends related to community knowledge, attitudes and practices and establish statistics related to SGBV, care and services. The third phase will allow us to explain key quantitative findings within the study context, providing concepts and explanations to complement numerical data or putting 'flesh on the bones of quantitative results, bringing results to life through in-depth case elaboration'. This phase will provide an opportunity to explore potential strategies to improve service utilization in a participatory way. Furthermore, the mutual validation, convergence and triangulation of findings resulting from different methods will enable us to view the subject from different perspectives and look for potential inconsistencies, so enhancing reliability, validity and utility.

3.2 Study area and population

The study will be conducted in the catchment areas of the MSF-OCA project in Port-au-Prince.

TABLE 2: MSF OCA CATCHMENT AREA IN PORT-AU-PRINCE

Metropolitan area as defined by the IHSI (only including

	Commune	Total
1	Commune De Port-au-Prince	**927,575**
2	Commune de Delmas	**377,199**
3	Commune de Cité Soleil*	**252,960**
4	Commune de Tabarre	**124,330**
5	Commune de Carrefour	**467,909**
6	Commune de Pétion-Ville	**320,789**
	Total	**2,470,762**
Haiti catchment area		
1	Metropolitan area (only urban areas)	**2,470,762**
2	Commune de la Croix-des-Bouquets	**238,222**
	Total population KAP Survey **Total overall catchment population**	**2,456,024** **2,708,984**

*Based on context and security analysis only qualitative data will be collected in Cité Soleil; the KAP survey will not be conducted.

3.3 Phase 1: Formative research (exploratory qualitative)

3.3.1 Methods

This phase will involve the following methods:

a) In-depth interviews with key stakeholders (MSF team members; other organisations involved with SGBV and service provision; community leaders)
b) Focus group discussion with community members (groups of women and men from selected communities)

3.3.2 Sampling and recruitment strategy

Stratified purposeful sampling will be used to select participants who will provide the richest testimonies and ensure a diverse sample in terms of relevant parameters such as age, gender, ethnicity, etc, and may be supported by snowball sampling should participants recommend further potential candidates to the researcher. MSF teams will facilitate the recruitment of MSF staff and those working with other organisations.

FGDs will involve +/- 8 participants sharing the same characteristics, selected with the aim of ensuring maximum homogeneity within groups (in terms of age, education, social background etc.) to create optimum conditions for participants to be at ease discussing sensitive issues. Notably, discussions with men and women will be held separately.

FGD participants will be selected at study sites (identified to ensure diverse locations within the Pran Men'm catchment area, e.g. different communes, socio-economic status etc.) and ~~be~~will be recruited through appropriate local gatekeepers (e.g. local leaders~~, MSF staff~~)~~, aiming to ensure representative samples from the community, rather than those with previous knowledge or experience of SGBV and/or MSF services~~. After the consent process and discussions with the local leaders, we will explain that we wish to conduct FGDs within the community, and outline the groups we wish to hold (specific groups will be delineated in the field, but could consist of for example: two groups aged 18 to 30 (one of men and one of women); two groups aged 31 to 45 (one of men and one of women); and two groups aged 46+ (one of men and one of women). We will then ask the local leader(s) to facilitate the recruitment of participants. There is a risk that this method of recruitment will imply a bias (see section 4); this will be carefully observed during data collection and mitigated by conducting a robust sample through different community leaders and carefully explaining the study and its objectives to both participants and community leaders.

FGDs will involve +/- 8 participants sharing the same characteristics, selected with the aim of ensuring maximum homogeneity within groups (in terms of age, education, social background etc.) to create optimum conditions for participants to be at ease discussing sensitive issues. Notably, discussions with men and women will be held separately.

For both FGDs and In-Depth Interviews (IDIs) we aim to reach theoretical saturation through concurrent data generation and analysis, or an iterative process, and so the final number of participants will only be known when this occurs and no new information is being generated. However, generally it is estimated that theoretical saturation can be reached after twelve to fifteen interviews and two to five FGDs.
Key stakeholders involved in Phase 1 will include:

- GHESKIO, the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections
- BPM Brigade Protection des Mineurs
- OFAVA, Oganzayon Fanm Vanyan an Aksyon
- POZ Promoteurs Objectives ZeroSIDA
- MICECC Mission Communautaire des Eglises Chrétiennes des Cites
- IBESR Institut du bien-être social et de recherche
- PESC Pair éducateurs sociales et culturels

3.3.3 Inclusion and exclusion criteria

In-depth interviews
Inclusion criteria:

- Key stakeholder (staff of organisations involved with SGBV/service provision; community leader etc.); OR
- User of MSF services; AND
- Over 18 years old; AND
- Well enough to participate (based on assessment of MSF team/other gatekeeper); AND
- Consents to participate in the IDI

Exclusion criteria:

- Under 18 years old; OR
- Does not consent to participate in the IDI

Focus group discussions
Inclusion criteria:

- Resident of Pran Men'm catchment area; AND
- Fitting criteria of group stratification (e.g. male or female); AND
- Over 18 years old; AND
- Well enough to participate (based on assessment of MSF team/other gatekeeper); AND
- Consents to participate in the FGD

Exclusion criteria:

- Under 18 years old; OR
- Does not consent to participate in the FGD

NB: The inclusion of minors (<18 years of age) is foreseen in the third phase of the study, allowing us to ensure methods and study processes are adapted and appropriate given the sensitivity of the study subject.

3.3.4 Data collection and analysis

IDIs and FGDs will be conducted using flexible participatory techniques. IDIs will take the format of a discussion and allow participants to focus on the issues they self-prioritise, although a topic guide will be used to ensure all relevant components are covered and so allow thematic comparison (see

appendix 3). Interview questions may be reviewed and refined in response to themes arising during the course of interviews. Interviews will be used to understand the current SGBV and service provision 'landscape' as well to inform design of study processes (training, SOPs, community engagement etc.).
FGDs will be guided by a facilitator who will introduce topics for discussion and will facilitate lively and natural discussion amongst participants, based on a topic guide (see appendix 3). FGDs will explore normative perceptions (rather than seeking information in actual behaviours or individual lives) and will focus on perceived options for and barriers to care to ensure optimum design of the KAP survey. Given the sensitive nature of the topic various techniques will be used to facilitate discussion, including 'free-listing' (where participants are asked to list as many types of a given phenomenon as they can; these can then we ranked in order of priority/importance) and 'story completion' (where the beginning of a story is told and participants are asked to reflect on it and complete it as they see fit).
Topic guides for both IDIs and FGDs will be back-translated to ensure that meaning and context are captured. Local MSF teams will be involved to ensure appropriate and acceptable terms and expressions are used, and these will be back-translated and checked by another team member familiar with the study.
Both IDIs and FGDs will be conducted by the qualitative coordinator, with the assistance and translation support of a research assistant/translator (and possibly a note taker should all participants not consent to the audio recording of the FGD).
These activities will be audio recorded and transcribed and translated when necessary from Creole or French to English, including careful translation of idioms, metaphors etc. Translation/transcription will be undertaken by a team of transcribers recruited and trained for this purpose. Permission for recording will be asked at the start of the interview or FGD and if any participants do not consent to recording ~~in case of negative answer,~~ notes of the interviews/FGDs will be taken.
Field notes will be taken throughout the data collection period and analysis will be ongoing. Data will be analysed using the Nvivo qualitative data analysis computer software package. Consent for recording the activities is explicitly mentioned in the consent form (see appendix 2). Analysis will be rooted in grounded theory; text data will be coded and recoded and emerging patterns, themes and relationships will be identified and labelled, allowing repeated patterns of meaning and conceptual categories to emerge from the text rather than from the mind of the researcher. Data gathered with different methodologies will be triangulated and negative or deviant cases analysed, and a subset of the data will be analysed by a second researcher in order to enhance reliability.

3.3.5 Interview language

Data collection will be conducted in the language in which participants feel most comfortable (Creole or French).
Topic guides will be back-translated to ensure that meaning and context are captured. Local MSF teams will be involved to ensure appropriate and acceptable terms and expressions are used, and these will be back-translated and checked by another team member familiar with the study.

3.4 Phase 2: KAP survey

3.4.1 Survey topics

The household interviews will be based on a KAP questionnaire. A template is available in appendix 3; however, this will be adapted based on information gathered during the formative research phase (e.g. wording of questions and answers, available responses etc.). It will consist of the following sections:

- Socio-demographic information (age, sex, education etc. of the interviewee)
- Knowledge and perceptions about medical and psychosocial consequences of SGBV
- Knowledge and perceptions about availability of medical and psychosocial services for survivors of SGBV
- Barriers and enablers to seeking health care after SGBV

The survey will not ask participants about their individual experiences of SGBV or service use, and will explicitly state at the outset that this is not the aim.

3.4.2 Inclusion and exclusion criteria

We include both adult male and females (aged ≥18 years) to be interviewed. We aim to alternate in each household from adult woman to adult man in the next household, to ensure both female and male participation. We will select a man in the first, third, fifth household etc., and a woman in every second, fourth, sixth household.

A person will be included in the survey if s/he satisfies all of the following criteria:

- Member of the randomly selected household (see section Error: Reference source not foundfor the definition of a household)

and

- Adult male or female (aged ≥18 years). If there is more than one qualifying adult of the household, one will be selected at random using a random number table

A person will be excluded from the survey if s/he satisfies one of the following criteria:

- Refusal to participate in the survey
- Participation in the formative phase

3.4.3 Sample size

The proportion of the population that know that MSF provides SGBV services is unknown so the conservative estimate of 50% was used (this provides the largest sample size). With a precision of 5%, an α-error of 5% and a design effect of 1 (due to the simple random sampling design), n=370 households are required. Assuming a non-response rate of 10%, the total sample size needed is n=407 households per site.

In order to have adequate power in any sub-group analysis, we have increased this sample size 3-fold to allow precise estimates for variables with up to 3 categories (e.g. socio-economic status with categories high, medium and low). This also negates the need for population estimates of different strata that would be required for stratified sampling. The final sample size is thus 1221 households.

Sample size was calculated using OpenEpi Sampling.

3.4.4 Sampling

A simple random sampling (SRS) survey, with the household as the sample unit, can be carried out as Port-au-Prince is a uniformly populated urban setting.

We will use a GPS-based sampling method: Using satellite imagery, an electronic outline of the study site will be replicated in software such as Google earth or Epop. Using this outline, the software can create random points within this perimeter corresponding to the number of households that need to be visited. Teams using either GPS receivers or android phones with GPS localisation functionality, visit the households that coincide exactly with randomly generated GPS points (to prevent selection bias) and interview these households. If the random GPS point does not land on a household, we will replace with another GPS point until we achieve the required number of households. This would exclude commercial and abandoned buildings but not multi-family dwellings. Here we would apply the definition of a household (a group of people who slept under the same roof the previous evening and have been living under the same roof for the past month). The GPS coordinates will be discarded after each KAP interview. They will not be retained with the questionnaire data.

It is very unlikely that participants randomly selected for the survey also participated in the formative qualitative phase. Should this occur we would exclude them from the KAP and replace the household with another randomly selected household~~approach it in the same way as asking KAP survey participants to be re-interviewed for the third qualitative phase, and ensure a thorough consent process and that the individual has option to decline if this is too burdensome for the individual participant~~.

3.4.5 KAP data collection

Quartiers selected according to the sampling frame (see section) will be informed beforehand of the planned study using a letter of information for local leaders (see Appendices). They will be invited to discuss any concerns with the study coordinators. Furthermore, it will be made clear that they are freely allowed to decline the participation of their quartier without any consequence or penalty. Any refusals will be documented (and reported as a limitation of the study).

To be sure that the survey population in the selected quartier is present on the day of the planned interviews, local leaders will be informed at least one or more weeks prior to the interview day (e.g. using motorcyclists delivering letters to the local leaders).

Surveys data will be collected by KAP data collectors, working in pairs. In the households randomly selected according to the above methodology, the purpose of the survey will be explained to the interviewee in the language in which s/he is most familiar and ~~written~~ verbal informed consent obtained to conduct the interview (see section 6.10). The consent form will be written in Creole. S/he will be offered the opportunity to refuse participation in the study at any time during the interview without penalty, and no incentives or inducements will be provided to respondents. If s/he declines to participate this will be accepted, documented and the next household approached; the number of household refusals will be included in the survey report.

All data will remain anonymous throughout the data entry and analysis process. Identifiable data will not be distributed outside the study location, or appear in any report or publication.

The KAP questionnaire is provided in the Appendices

3.4.6 KAP data analysis

The KAP questionnaires will be administered, when possible using smartphones/tablets to ensure high quality data collection, collation and rapid analysis. This will also reduce data entry errors and the need for duplicate data entry as well as saving time in post-field analysis. Data will be uploaded at the end of each day to a secure server and subsequently removed from the tablet so no data is kept on the tablets. In areas where the use of such electronic devices is not possible/feasible, a paper version of the questionnaire will used. In a recent large household survey exploring traumatic events and mental health issues in Kashmir, there was some curiosity around the tablets but once reassured that it was not a recording device and no photos would be taken, participants were very receptive and the team felt there was a perception of importance associated with the tablets which helped rather than inhibited cooperation. However, if participants feel at all uncomfortable about electronic data collection, paper versions of the questionnaires will be administered and entered into the database by the data clerk (supervised by the study coordinator).

All data will be anonymous (names are not collected) and electronic files stored password-protected by MSF. Only survey investigators will have access to these data files. Data cleaning will be done to check for inconsistencies in data entry and responses followed by data analysis using Stata 14. Data will be analysed using the survey specific commands in STATA (svy) which allow for finite population correction factors and adjustment for survey structure (multilevel, staged sampling). Although we aim for a self-weighting sample, we may also need to apply post-estimation survey weights.

After the survey, the questionnaires and ~~written~~ consent forms will be archived for at least 5 years in headquarters.

The descriptive survey results will be presented as number (%) for categorical variables such as sex and mean (SD) for continuous variables such as age. Where continuous variables are highly skewed, they will be presented as median (IQR). Estimates of the objectives of the survey, e.g. the proportion of households that know that MSF provides SGBV services, will be shown as the estimate with 95% confidence interval (95% CI).

Comparisons of differences in the study objectives between selected sub-groups will be reported as an estimate of the difference, the 95% CI of the difference and the relevant p value. For tests of proportions this will be a Chi square test or Fisher's exact test. For differences in continuous study outcomes between two categories a t test will be used unless the data are not approximately normally distributed (in which case a Wilcoxon-Mann-Whitney test will be used). If there are more than two categories for comparison a linear regression analysis will be performed for data approximately normally distributed and a Kruskal-Wallis test for non-normally distributed data. The impact of the clustered design will also be reported as the estimated design effect.

3.5 Phase 3: Explanatory qualitative phase

3.5.1 Methods

The methods and participants of this explanatory phase will be refined based on the results of the KAP survey and the findings and experiences of the first qualitative phase and the KAP. However, potential methodologies include:

a) In-depth interviews with individuals to explore and explain the results of the KAP survey (specific participant groups will be identified based on survey results)

b) In-depth interviews with MSF (/other) service users to explore the 'critical path' that enabled them to access services (and how this could be further facilitated for other survivors)

c) FGDs with groups of women and men to develop potential solutions to overcoming barriers and facilitate service uptake (again, demographics of groups will be refined based on survey results)

d) FGDs with groups of women and men to identify potential SGBV prevention strategies that may contribute to behaviour change

e) FGDs with minors (<18 years of age) to explore perceptions of SGBV, health seeking behaviour and strategies to overcome barriers to services.

3.5.2 Sampling and recruitment strategy

As for the first qualitative phase, stratified purposeful sampling will be used and participant recruitment facilitated by appropriate local gatekeepers (e.g. local leaders, MSF staff).

Selection of participants for IDIs will be based on preliminary analysis of the survey data in order to explore key themes emerging and to optimise integration of quantitative and qualitative data. Selection will be made based on preliminary analysis of survey data.

Should interviews with MSF service users be included in the third phase of data collection, recruitment will be facilitated by MSF team members who will identify potential participants (and evaluate those that are unwell or may be at particular risk of re-traumatisation due to participation), aiming to ensure inclusion individuals with a variety of characteristics (e.g. geographical area of origin, age, etc.). They would then be approached initially by a member of the MSF team who would give a brief introduction to the study and explain that a member of the research team would like to talk with them to explain it further and respond to their questions, after which they will have the option to consent to or decline participation (with no adverse consequence to their ongoing treatment with MSF). Should the individual agree, they will arrange a convenient time and ensure a safe and confidential location for the initial meeting (foreseen to be a room in the MSF clinic). The research team (qualitative study coordinator and translator/research assistant will then meet with the service user and explain the study in detail using the information sheet, including risks and benefits and with a particular emphasis on the voluntary nature of participation. Language will be

used carefully in order not to presume consent, and after both meetings the individual will be given the option to decline, and/or take time to think about whether they would like to participate. Should the individual wish to participate the researchers will conduct the consent process and begin data collection.-

FGDs will involve +/- 8 participants sharing the same characteristics, selected with the aim of ensuring maximum homogeneity within groups (in terms of age, education, social background etc.) to create optimum conditions for participants to be at ease discussing sensitive issues.
Should young people (aged 12-17) be identified as priority group for MSF interventions it is possible that this phase of the study may incorporate them in data collection. If they are included specific provisions will be made (adapted consent/assent processes; appropriate methodology etc. See appendices 1 to 3 for provisional templates).

The estimated sample size will depend on the participant groups selected based on the findings of the first two phases of the study. The same principles of theoretical saturation will be applied; estimated to be reached after twelve to fifteen interviews and two to five FGDs.

The inclusion and exclusion criteria will be adapted based on final methods/participant groups identified but as a minimum for IDIs and FGDs are as follows:

Inclusion criteria:

- Member of participant group identified after Phase 1 and 2 of the study; AND
- Over 18 years old; OR
- Under 18 years old and gives assent to participation; AND
- Under 18 years old and parent/caregiver gives consent to participation; AND
- Well enough to participate (based on assessment of MSF team/other gatekeeper.

Exclusion criteria:

- The participant does not consent to participate; OR
- For participants aged under 18, the parent/caretaker does not consent to participation; OR
- For participants aged under 18, the participant does not give assent; OR
- The participant is identified as too unwell to participate by the MSF team or other gatekeeper.

3.5.3 Data collection and analysis

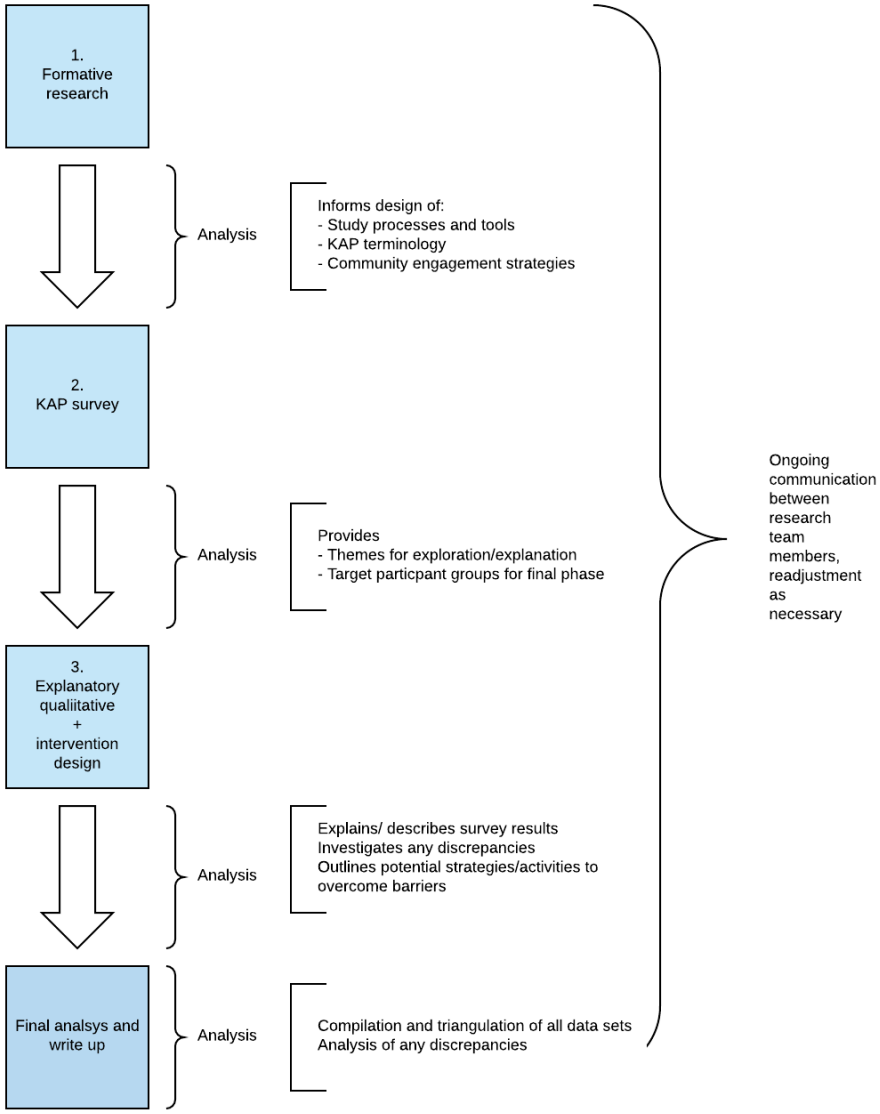
Data collection will use the same qualitative techniques outlined in the first phase of the study. Topic guides will be developed based on the findings of the first two phases and will be used to explain the findings of the KAP survey (IDIs) and possible ways to prevent SGBV, and overcome barriers and facilitate service uptake (FGDs).
Templates of these topic guides are outlined in appendix 3.
If adolescent groups are incorporated additional specific methodologies will also be used to ensure they are engaging and appropriate. They may incorporate ‘icebreaker’ activities as well as community mapping (see draft framework in appendix 3).
Activities will be recorded, transcribed, and analysed as outlined in the first qualitative phase (see section 3.3.4).

3.6 Data integration

In this study, analysed qualitative and quantitative data will be integrated at different points during the research chronology. Formative qualitative research will inform the design of the KAP survey. Questions arising from the analysis of KAP survey data will be used to feed into iteration of themes explored in qualitative activities in the third phase of the study.
Practically this means close collaboration between the qualitative and quantitative leads throughout the data collection period, with fixed points for interim analysis (e.g. post-testing of tools; after each data collection phase).

Please see Figure 3 for an overview of our data integration plan.

FIGURE 3: DATA INTEGRATION PLAN



Due to the sequential design of this study, we will have the opportunity to explore any divergences between quantitative and qualitative data in the final qualitative phase of the study, should any significant discrepancies arise. Should it remain impossible to reconcile the two data sets the final phase may be extended in order to explain this phenomenon. However, in the likely event that significant divergence remains or the results remain inconclusive, another study will be conducted to test the resulting hypothesis.

3.7 Procedures if the research is stopped/ incomplete

It is possible that for reasons beyond our control the research is stopped before data collection is finalized (security, natural disaster etc.). We recognize this may compromise the validity of analyses and raise questions about dependability of any substantive conclusions generated from the incomplete data. Management of incomplete data will depend on the type of data already collected and the extent to which each data set is incomplete; however, to optimise input from participants we aim to utilize this data as far as possible.

For both quantitative and qualitative data, available data will be analysed and presented alongside a clear explanation of the limitations arising from its incompleteness. Should for example either

qualitative phase not be completed and the quantitative phase proceed, it may still be possible to provide useful reflections on quantitative data collection and results. Similarly, if the quantitative phase cannot be completed, the available analyses may still produce interesting findings that lead to exploration in the final qualitative phase.

4 Study limitations

Results are not generalizable: This study aims to give an analysis specific to the context of PaP, Haiti. The results will not be generalizable to the whole country, nor other regions in Haiti. However, it may be possible to draw out themes or considerations relevant to SGBV programming in different contexts.

No documentation of prevalence: The study will not allow for conclusions to be drawn about the prevalence of SGBV in this area, as the focus is on knowledge, attitude, practices and perceptions related to SGBV, care-seeking behaviour, and improving uptake.

Limited/biased disclosure: Due to the sensitive nature of SGBV it is possible that participants will not feel comfortable discussing the issue openly, particularly given low disclosure rates in many contexts, which may affect the data gathered. Whilst we are not asking participants to recount personal experiences of SGBV it is possible that the same factors affecting disclosure (e.g. fear of reprisals; feelings of shame or stigma; different understandings of what constitutes SGBV or the possibility of 'accepted' violence) may limit the information they are willing to share.

Particular attention will be paid to these issues during formative data collection; ensuring careful attention is paid to understanding and using appropriate local terminology and definitions around SGBV. Specifically, the wording of introductory sections and questions, and the sequence of questions will be carefully considered in order to establish a rapport and trust, as well as elicit honest and complete responses whilst ensuring robust processes and tools that ensure that participation is voluntary and no obligation is felt by the participant to consent. Efforts will be made to ensure participants feel comfortable to speak as openly as possible (e.g. recruiting FGD participants that share the same characteristics; reiterating issues around confidentiality, anonymity and disclosure etc.). Interviewers and translators will be selected to be as accessible as possible to participants (for example experience has shown that women and girls tend to prefer talking to other women).

Translation/transcription issues: Using translators and transcribers may influence the quality of the research findings. The translation of standard tools may also influence local interpretations, definitions and questions, and so affect the comparability of data. However, this will be minimised by thorough training and ongoing supervision of the study team; careful translation including establishing local glossaries of agreed terminology; and cross-checking transcriptions through back-translation of a subset by another transcriber.

5 Quality control and best practice

5.1 Minimising researcher bias

Mechanisms will be put in place to minimise analytical bias from the researcher's perspective (for example, a sub-set of qualitative data will be coded by a second researcher; ensuring an 'audit trail' which shows the development of the methodology and analysis through field notes etc.) Reflection of the role of the researcher as a confounding factor will be documented through field notes and considered throughout the analysis, acknowledging the potential for bias. Triangulation will take place by searching for convergence among the different sources of information gathered to form themes or categories within the analysis, and will include collaboration between quantitative and qualitative researchers. Validation will also be established by including deviant cases and testing emerging theories, instead of only selecting examples which reiterate desirable points.

Ongoing collaboration between researchers and supervision will also ensure multiple perspectives are incorporated into data collection and analysis. Practically this will include regular debriefings with the research team and a feedback session with local co-investigators and MSF teams upon conclusion of each data collection phase and prior to analysis. Peer debriefing, including oversight by an impartial researcher who will examine the transcripts, final report and general methodology and provide sparring and feedback will enhance credibility and ensure validity. Furthermore, sharing the study outcomes with participants can also enhance validity of our research by allowing respondents to comment on the accuracy of our data and interpretations.

For the qualitative phase, data collection teams will be trained in interview techniques that do not lead or influence participants. The questionnaire instrument is also based on objective question structure (see section 5.2).

5.2 Development and pre-testing of tools

Template tools have been developed based on thorough desk review, including of current international standard data collection instruments, combined with the input of MSF and external stakeholders at various levels. The KAP survey is designed to balance clear, understandable, easily answered questions for respondents in a format that is easily followed by interviewers. These tools will be adapted based on the findings of the formative research. Tools will also be pre-tested in a pilot survey to refine methodology, sequence of questions and response categories, and ensure that interpretation of questions and translation of specific terminology and definitions is consistent and clear. It will also assess the way the activities are perceived by participants in terms of emotional response, burden and sensitivity to the topics discussed. Any context-specific modifications will be justified and documented.

5.3 Selection, training and supervision of study team

The study team will be carefully selected to ensure appropriate characteristics (gender, language etc.) as well as 'soft skills' such as an ability to use non-judgemental language and tone; communication skills and empathy.

A thorough training will be conducted. This will include an orientation on SGBV; ethics; research methods; consent process; study protocol and tools; practical exercises and role-plays; stress management; managing difficult situations (e.g. distressed participants or community members), Psychological First Aid (PFA), etc.. The content for the second and third phase teams will be refined based on information gathered during the formative research phase. The training will be given by MSF in French, with translation if needed. An interviewer's manual will also be developed to complement the KAP survey and qualitative methodologies to provide easy guidance notes for data collectors. Please see section 11 for details of the proposed training.

Pre-testing the tools will also provide an opportunity for on-the-job training and to share challenges faced and lessons learned amongst the study team, and so ensure early resolution of any concerns or discrepancies in using the research tools. Regular debriefings will be conducted during data collection to ensure a consistent approach and ongoing quality checks, and provide the opportunity for continued training and mentoring.

5.4 Data quality control

For quantitative data, the study coordinator and/or quantitative researcher will review samples of questionnaires each day to check for inconsistencies in the responses recorded and for questions that were not completed. The study teams will also check each other's surveys at the end of each day to ensure consistency and accuracy.
For the qualitative data, a subsection of the transcriptions will be double-checked by another transcriber to ensure that transcription is consistent and of a high quality. If there are inconsistencies found, then transcribers will work together to finalise the transcription. For the analysis, a sub-set of data will be re-coded by a second researcher.

6 Risks, ethical and safety issues

The study protocol will be submitted to the Ethics Review Board of MSF and to the Comité National de Bioéthique in Haiti.

The study will be conducted in accordance with the World Health Assembly of 1975 concerning ethical aspects in human tests. The Helsinki declaration principles will be followed, including:

- Researchers will protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of participants.
- The study is based on thorough knowledge of the literature and other information.
- A research protocol has been established and submitted for consideration, comment, guidance and approval to the research ethics committee of MSF, and will be reviewed by the ethics committee of the designated country of study.
- The research team has appropriate qualifications to fulfil their role; they will be trained where applicable and supervised by the co-investigators.
- The population stands to benefit from the results of the research; through improved access to SGBV services.
- The predictable risks and benefits for study participants have been assessed and described in this protocol. The importance of access to health care for survivors of SGBV outweighs the risk which can come with this study (emotional reactions, reliving experiences of SGBV, confidentiality breach – e.g. in FGD) and the risks can be mitigated: Confidentiality rules, no questions asking for disclosure, emotional support available.
- Participation is voluntary, and precaution will be taken to protect the privacy and confidentiality of personal information of participants.
- All participants will be informed on the aims, methods, potential risks and benefits of the study, as well as their right to refuse to participate and to stop at any time. Only hereafter, informed consent will be requested.
- The results of the study will be shared with participating communities through a report/poster.

Specific attention has been given to ethical issues linked to researching SGBV given its sensitive nature and the specific challenges data gathering poses, and to ensure the physical, psychological and social well-being of participants, communities, and those involved in gathering the information itself, in line with existing guidance and best practice.

Procedures to manage any ethical or safety issues will be refined with MSF teams during the first formative phase of data collection, in line with existing MSF protocols and procedures (security, medical etc.) and MSF management lines (see draft SOP in appendix 4).

Based on thorough literature review and discussion with MSF team the following ethical issues and risks common to all data collection methods have been identified:

6.1 Risk of distress to participants

Whilst participants will not be asked to explain their own experiences of SGBV during this study, questions may be intrusive and upsetting for those who may have personal experience of the issue and may result in participants disclosing incidences of SGBV. There is also a risk that participation may be associated with instances of SGBV, such that participants may be stigmatised, either during the data collection or following the dissemination of results. The following mitigation strategies are foreseen:

Comprehensive explanation and informed consent process: we will ensure clear and thorough explanations are given to both communities and participants, including the rights of participants, the implications of partaking and explain that there is no consequence for people who decline participation. In addition, we will ensure it is clear at the outset that the aim is not to discuss personal experiences of SGBV, but to collect general information to improve our understanding of barriers and collect potential solutions. We will ensure that our consent process is carefully phrased and does not assume consent.

Community engagement and consent: By ensuring community-level understanding of the study (including participant recruitment) we hope to minimise the risk that any individual would be stigmatised as a result of participation. Equally, dissemination of findings will be carefully managed to ensure participants cannot be identified from their stories, see section 6.9.

Appropriate and pre-tested tools and questions: we have developed questions for both qualitative and KAP data collection focus on capturing social norms and care seeking and do not tacitly imply disclosure of experiences. Tools will be strengthened by data collected during formative research and again refined through pre-testing, including checking with data collection teams and participants how they feel during data collection and any pressure to disclose personal experiences.

Preparation of research team: we will ensure that interviewers and translators are carefully selected, are appropriate to the context, receive proper training and support and have appropriate interviewing skills (including an ability to use non-judgemental language and tone; communication skills and empathy). Interviewers will be trained to be aware of the effects the questions may have on participants and how to respond, including role-plays and managing situations of distress. Training will also include exercises to help field staff examine their own attitudes and beliefs around SGBV to be aware of any potentially harmful attitudes or perceptions which may distress participants or affect findings.

Sensitive data collection: A good rapport and environment of trust will be established and carefully worded explanations and introductions to the study and particularly sensitive questions will be used, including reminding the respondent that s/he has the right to refuse to answer any question and can choose not to continue the interview or to stop at any time. If a participant becomes upset during the interview, the interviewer will offer the opportunity to take a break or discontinue. Given that research shows that trauma survivors see their participation as important in helping others we will explain thoroughly the potential this study has in this regard and aim to end the interview on a positive note.

Foreseen psychosocial support: we will also ensure that both immediate and longer terms support is available for any participants that become distressed. This will include that the data collection teams are trained in psychological first aid. As the study will take place in MSF's catchment population, participants can also be referred MSF services for medical and psychosocial support as needed. We will also ensure that both communities and participants have access to information about MSF's SGBV services and support irrespective of participation, should the presence of the MSF team or awareness of the study subject cause distress to non-participants.

6.2 Risk of distress to study team

There is a risk that the study team might also suffer from stress or distress through hearing potentially upsetting stories or managing difficult situations.
To mitigate this, training will include a stress management component and emotional support will be provided through regular debriefing sessions. Counselling/psychosocial follow-up will be available through routine MSF activities should it be requested/needed by any team members. Particular consideration will be given to the possibility that members of the study team may have experienced some form of SGBV themselves so may need specific support.

6.3 Risk to safety/of harm to participants and study team

It is noted that in researching violence 'the safety and even lives of women respondents and interviewers may be at risk'. Given the sensitive nature of SGBV it is possible that research activities may trigger issues affecting the safety of participants, for example they may fear of reprisal and recriminations, as well as stigma and shame in discussing such issues. Equally, in the instance that there is a situation of past/ongoing SGBV within the household/community, there is a potential risk of harm to the participant should the perpetrator react badly to the discussion (e.g. with aggression or violence, during or after our visit). There is also the risk that discussing this sensitive topic could create a 'backlash' amongst the community or a strong reaction amongst more conservative groups who consider the study inappropriate or threatening, which may pose a risk to participants and/or the data collection team and/or other MSF staff.
The safety and security of all those involved in the study is of paramount concern, and will be continuously monitored. Whilst standard MSF security protocols will be strictly observed additional safeguards linked to the study have been considered:
Community engagement and consent: See section 8.2.
Careful framing of study subject: Much guidance on researching SGBV suggests framing studies using a 'safe' name, for example WHO suggests presenting SGBV studies as research on health, well-being and life experiences.23 However, in the PaP context 'sexual violence' has been the subject of ongoing communication campaigns by various (I)NGOs and national groups. The term has been used openly when communicating with the community and stakeholders and this is seen to pose minimal risk to participants, research teams or MSF. However, during the formative phase of the study potential risks or harms, including the risk of stigma/discrimination, or risk to safety/wellbeing of any individual or groups of individuals, linked with conducting the subsequent data collection will be carefully evaluated (and weighed against the risk of limited disclosure should framing the study under a 'safe' name be re-considered).
Training of study team: Training of the study team will include understanding of and sensitivity to political, sociocultural, security and economic factors that may affect the safety and security of those involved. Interviewers will also be trained to terminate or change the subject of discussion should an interview be interrupted at a sensitive moment.
Confidentiality, privacy and anonymity: This will be protected as far as possible; see section 6.99.
Ongoing monitoring and follow up: The safety and security aspects of data collection will be monitored and evaluated on an ongoing basis. All concerns or incidents will be reported through standard MSF incident reporting mechanisms, and if it is deemed that the safety of the participants or the study team is compromised in any way the activity will be stopped or restructured to address any concerns. Strategies for responding to potential security threats will be formulated in advance, in line with MSF security protocols (see draft standard operation procedure in appendix 4). We will also explain that participants may approach the MSF team at a later date should any negative unintended consequences (including risks or harm to their safety or wellbeing) occur as a result of their participation. This will be managed on a case-by-case basis with the project team, in the same way as patients experiencing ongoing risks to their safety in their home/community.
Careful sharing of results/dissemination: Sharing findings may imply risks to individuals, communities or MSF staff or programmes, so reporting results and/or disseminating data will also be subject to the same process of continuous review and evaluation to ensure that it is both safe and appropriate to do so.

It is also possible that in conducting the study, researchers may come across illegal activity or situations requiring medical care. In such a situation they will decide a course of action on a case by case basis, in collaboration with the project team. In the instance of participants or study community members requiring medical care, referrals will be managed in the same way as by the outreach team when they work in the community. In case of coming across illegal activities, the situation and its potential risks will be evaluated (with the project coordinator) and the research activities may be stopped or postponed in the area, whilst ensuring a good communication with community leaders and other relevant stakeholders on the reasons and way forward. Potential risks to the team linked to these issues will also be mitigated by conducting a thorough community engagement and consent process prior to data collection (as outlined in section 8.2), in order to ensure that key community members are aware of MSF, its principles, and the objectives of the study. The neutral and impartial position of MSF will be emphasised along with the focus (and limits) of MSF's work in Port-au-Prince, and referral options will be provided for those requiring medical treatment.

6.4 Risk of disclosure of personal experience of SGBV

It is possible that participants may disclose their own experiences of SGBV, despite clear explanation that this is not the aim of the study. To mitigate/manage this, the following measures are foreseen:

Careful explanation of the study: Interviewers will explain the objective of the study, including the risks and benefits. It will be made clear that the aim is not to document personal experiences of SGBV; however, they may share them only if they would like to and feel comfortable to. It will also be explained that assistance is not linked with participation; information about MSF services will be shared verbally and with a short information sheet; and people may request assistance without disclosing details of their experiences to the research team or participating in the interview/FGD. They may also approach a member of the research team following the interview/FGD and confidentially request assistance, again without disclosing any details of their experience.

Support and referral: The data collection team will be prepared for the immediate support of any participant disclosing an instance of SGBV through basic psychological first aid (included in training of data collection team). Following that, this will be available through referral to the Pran Men'm clinic, managed in line with the MSF SGBV guidelines and including medical care and emotional support. Referrals for follow-up services will be confidential and only made with the consent of the individual. Interviewers will be trained in how to handle a disclosure of this nature in a sensitive and ethical way. This will include consideration of any legal issues or obligations around reporting abuse, MSF protocols and respecting the principles of autonomy and confidentiality.

In line with best practice we also plan to use a short information sheet for participants with details of MSF services and other resources. This will be developed with the MSF team during the formative research phase of the study. The study team will also be briefed on appropriate referral pathways should they encounter individuals requiring medical attention unrelated to SGBV during the study.
Note: Based on previous SGBV research it is suggested that there is little uptake of available referral services, although there only anecdotal information available about the reasons why . Thus, should a participant be referred to MSF services we will also ask if they consent to follow-up and to their data being kept for this purpose. We will then follow up with the MSF team at a given point post data collection to establish how many of those referred actually sought services.
Legal management of disclosure: There are no specific legal obligations in Haiti for the researchers to either represent or report disclosing survivors to the government. If a participant asks assistance to report a case of SGBV to the police or other authorities, MSF will provide information and support, in line with MSF SGBV guidelines and according to practices as set up in the MSF SGBV clinic.

6.5 Risk of disclosure of knowledge of SGBV

It is also possible that participants may disclose knowledge of instances of past/ongoing SGBV between third parties. Management of this situation will be carefully considered in line with MSF protocols. In such an instance, expert advice would be sought aiming to respect the principles of confidentiality and do no harm, whilst also avoiding collusion and putting others in situations of ongoing risk. Information will be provided about the private and confidential services available in the MSF SGBV clinic, in line with MSF protocol .

6.6 Risk of disclosure of perpetration of SGBV

It is possible that during our activities a participant discloses they have committed or perpetrated an act of SGBV. As above, management of this situation will be carefully considered on a case-by-case basis, in line with MSF protocols and seeking expert advice if necessary. Counselling will be offered and will be available, either in the Pran Men'm'~~mem~~ SGBV clinic or in CRUO (the hospital), where MSF has trained counsellors.

6.7 Risk of stoppage of study due to community opposition

Given the sensitive nature of the research, one possible reason for stoppage of the study is community reaction to the questions asked to participants, particularly linked to resistance from church groups and in Cité Soleil. This issue will be considered in more detail in collaboration with the mission team during the formative research phase, and its management will depend on the exact circumstances or manifestation of the opposition. Mitigating this risk will involve working community groups MSF is already working with, such as local organisations and associations; community leaders; schools; churches etc. MSF community health workers are also well known in the community and exchange regularly so will be able to convey information between MSF and community and alert the study team early of any concerns arising from the study.
Other risks include political and social instability and as result difficult security situation (difficult access) and natural disasters. These will be managed on a case by case basis.

6.8 Risk of low participation rates

It is possible that participation rates for the survey and/or interviews fall below expectation. Should significant problems be faced in recruiting participants we will pause the study and go through a process of consultation with communities and/or relevant stakeholders to ascertain the reasons for these difficulties. If this can be overcome through a change in our approach/recruitment processes, then this will be made and we will recommence the study (with a careful analysis of any ethical issues and the voluntariness of participation).
If this cannot be overcome we will a) ascertain if/how data collected this far can be analysed (see above section on incomplete data), and b) assess if the study as a whole can proceed without this component, albeit with modified objectives/results (for example, if recruitment for the KAP survey is problematic, it may still be possible to utilize qualitative data to meet some of the study objectives and inform MSF activities; if recruiting for the IDIs and/or FGDs is problematic, the KAP data will still provide useful insight; etc.).

6.9 Confidentiality, privacy and anonymity

Protecting confidentiality and ensuring privacy and anonymity is essential to ensure both participants' safety and data quality. The following provisions are foreseen:
Private interview locations: All individual interviews and group discussions will be held in carefully selected locations appropriate to the study site to optimise safety and privacy and minimise unnecessary attention or suspicion. These locations may vary depending on the methodology and area of PaP, but we will aim complete privacy (except for children under the age of two). Achieving

this level of privacy may be difficult and may require more careful consideration and/or resources than might be needed for research on less sensitive topics; this will be given careful consideration during the formative research phase. Previous strategies such as holding interviews outside or in other appropriate spaces will be considered, in collaboration with the mission team.

Confidentiality limitations for FGDs: Prior to commencing the FGDs participants will be asked not to repeat anything discussed outside the group, and not to divulge the identities of other FGD participants. However, all participants will be made aware that confidentiality cannot be guaranteed and this is specified in the consent forms and information sheets.

Training of research team: All members of the research team (including transcribers) will be thoroughly briefed on issues of confidentiality during the training and required to sign a confidentiality agreement. Interviewers will be trained to guide the discussion away from stories of personal experiences or any conversation that may identify individuals in the community.

Anonymization and confidentiality of data: All data will be anonymised to ensure it cannot be linked to a specific individual or group of individuals, including documents and audio recordings, and will be stored with an individual code. All data will be stored in password protected files. Upon completion of the study, the identifiers and the household lists will be destroyed. Recordings, notes and consent forms will be stored securely by MSF OCA for 5 years after which point they will be destroyed.

Mitigating risk of residual disclosure: Particular care will be taken during the presentation of the research findings to ensure that the information is sufficiently aggregated so that no single community or individual can be identified. Informed consent will be obtained from all participants on whether or not they agree to be quoted. Specific quotes and examples will be considered and if they could lead to identification of respondents via deductive disclosure the details in the data will be modified.

Breaking confidentiality: In certain very exceptional circumstances confidentiality may be broken, in line with MSF protocols and best practice, should disclosure present a serious and potentially life-threatening risk to the participant or another individual or group. For example, if a participant threatens his/her own life; a participant threatens to seriously harm another person; or when child abuse or neglect is suspected and it is in best interest of the child .

6.10 Informed consent

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the study and the implications of participation and be legally able to give their consent. In Haiti the legal age in Haiti is 18 years.

~~Written~~ Verbal consent will be sought from all individuals participating in the study. Comprehensive information sheets and consent forms have been prepared and adapted to each activity and participant group ~~(see appendix 2)~~, as well as a detailed process for obtaining verbal consent (see appendix 2).

Environment: The environment where the process of consent is conducted will be a private, confidential, and 'safe' setting.

Explaining the study: The study will be explained in detail to all participants in French/Creole (as the participant prefers), including the objectives, risks, benefits and voluntary nature of participation, and they will be given the opportunity to ask questions. Participants will also be informed that data collected will be held in strict confidence. To ensure that the participant is aware that the study includes questions on potentially sensitive topics, the interviewer will forewarn the participant that some of the topics are difficult to talk about. The respondent will be free to terminate the interview at any point and to skip any question that he/she does not want to answer.

Emphasizing voluntariness: Researchers will take necessary steps to minimize the possibility that participants (especially from vulnerable communities) will feel obliged to participate either due to pressure from community/MSF gatekeepers or from the researchers themselves. It will also be explained that assistance will be available regardless of participation (or refusal) and that no adverse consequences will occur as a result of refusal to participate. Questions regarding consent

in the ICF are phrased in a way that does not predicate consent, and ensures potential participants have the space to ask questions and/or decline to participate.

Ensuring participant's comprehension: Rresearchers will aim to ensure that the prospective participant has sufficient knowledge and comprehension of all the elements of informed consent to enable him/her to make an informed decision whether to participate in the research. The fact that an individual is prepared to ~~sign~~ verbally agree to the ICF and has no unanswered questions does not necessarily represent sufficient evidence of an adequate level of comprehension . Rather than simply confirming the participant's consent, the prospective participant will be asked to explain in his/her own words their understanding of the research and implications of participation. Should comprehension be lacking or inaccurate the team will provide further explanation until they feel it is adequate.

Documentation of informed consent: The verbal consent process will be conducted as outlined in consent forms in Appendix 2; the researcher assumes responsibility for documentation of informed consent, and will do so by dating and signing a verbal consent form for each participant, in the presence of the participant~~The individual who assumes responsibility for documentation of informed consent and the consenting participant should sign and date the ICF, in each other's presence. Should the participant be unable to sign his/her name a thumbprint will be used.~~

Consent/assent process for participants under the age of 18: For any participants under the age of 18 involved in the final qualitative phase of the study, a parent or caretaker will be required to provide ~~written~~ verbal consent, in addition to the informed assent of the participant themselves. ~~In the case of illiteracy, the respondent/caretaker can consent via a fingerprint.~~

Particular attention will be taken to ensure the process is adapted and appropriate to the age of the participant, including adapted ICFs and consent/assent forms.

Should the caretaker/parent refuse consent or the potential participant refuse assent, the interview/activity will not take place.

Consent for audio-recording: Both IDI and FGD participants will be asked specifically to consent to the audio-recording of interview/discussion. Should one or several participants decline, notes will be taken of the activity.

Consent process for illiterate participants: Should a potential participant be unable to read the information sheet and consent form, additional care will be taken to ensure these documents are read and explained in detail to the participant. In addition, they may request that a third person of their choosing (e.g. friend, family member) reads/checks and explains this information to them, should they wish. The researchers will then cross check with the participant for clarity and resolve any discrepancies in interpretation that arise.

7 Benefits

Overall we feel that the benefits of this study - with the potential to safe life, alleviate suffering and restore dignity- outweigh the potential risks. Benefits can be seen at multiple levels:

Individual level: Participation may benefit individuals as it provides opportunity to share information about SGBV and MSF's services, and so may lead to improved access to/uptake of support and services (e.g. by handing out referral information in annex 5). ~~Furthermore, e~~Evidence from literature also suggests that participation in research can in itself be felt to be beneficial to women surviving violence (for example cathartic, empowering, contributing to longer term change) . Furthermore, whilst it is possible that there is no direct benefit to the research participant, they may benefit indirectly as their participation may help to identify factors that could improve SGBV service utilisation and acceptance of such service in the near future.

Community level: Communities will benefit from participating in the study through raised awareness of SGBV and the treatment, services and support available. It is also possible that the study will catalyse change in the medium/longer term; for example, raising awareness of the issue of SGBV may open dialogue/lessen taboo/stigma and so facilitate access to services for survivors, and potentially prompt communities/other local organisations to contribute to improving the situation.

MSF programming: The study will provide essential data for the MSF team in Haiti. It will establish an evidence base on which to create strategies for improving the uptake and effectiveness of the

SGBV services provided. Specifically it will provide insight into how to target and improve access for vulnerable groups and to develop potentially innovative strategies to increase service utilisation and inform prevention activities. Furthermore, by extrapolating themes and considerations, it is possible that findings may also contribute to new ways of understanding and responding to SGBV in different countries and contexts.

Policy and provision of services: This study will also provide important data to support policy development and advocacy to work with the MoH towards provision of services and increased uptake, specifically through publication and sharing outcomes with other key stakeholders such as the *Concertation national,* the MCFDF & UNFPA.

8 Collaboration and community engagement

8.1 Institutional collaboration

This study will be carried out as collaboration between MSF-OCA, the MSPP, and the FETP in Haiti.

MSF-OCA is the study sponsor and is responsible for the funding. It oversees data collection, analysis and report writing. Permission for publication must be obtained from the PI of the study.

A Data Sharing Agreement per MSF protocol will be signed between MSF and the collaboration partners.

Data collectors from the FETP will be recruited (as daily workers) and trained to collect KAP data, in collaboration with the FETP.

Study results will belong to MSF-OCA.

8.2 Community engagement

Community-engaged research approaches involve members of the community in various aspects of a research endeavour to improve the health of populations, and have shown to have had many benefits, learning new insights about the community and facilitating development of community-engaged interventions. In addition, engagement of the community has led to community empowerment and generated a deeper interest in the health problem under study among the participants, and had enabled community members to act upon other problems of interest to the community.

We aim to engage with, and gain community support for the study. Community consent will be carefully negotiated in close collaboration with MSF project teams and the community, and informed by the first formative research phase for the second and third phases of data collection. Authorities and communities ~~(~~(including local administration for example Conseils d'Administration des Sections Communales (CASEC) and Administration des Sections Communales (ASEC); religious leaders (Christian and Voodoo); and leaders of community based organizations). ~~such as local leaders, religious leaders, opinion makers)~~ in the study area will be informed (information sheet shared) about the purpose of the study and their endorsement will be sought e.g. through a community meeting. As MSF is working in both metropolitan Port au Prince and Croix des Bouquets the team has a good understanding of, and relationship with, community leaders and will ensure the appropriate official and unofficial leaders are consulted in each data collection site in order to ensure community-level understanding and support for the study. They will have the opportunity to ask questions and express thoughts and concerns about the study subject and processes, and it will be clearly stated that community leaders are freely allowed to decline the participation of their quartier without any consequences or penalty. For each data collection site we aim for community leaders to agree to support the study; should any leaders oppose the study or wish their community does not participate, further consultation would take place aiming to reach a consensus of participation. However, should resistance continue, a decision will be taken on whether or not to include the specific community in the study, after consultation with the mission team and careful consideration of the risks and benefits. It is possible that the community in question may be withdrawn from the study, and this will be acknowledged in the limitations.

The team will meet also with other community key stakeholders such as Traditional Birth Attendants (matrones), community health workers, etc., and to be informed what role they would like to play in the study, as well as beyond the study. We will use existing MSF contacts and links, for example. MSF also has links with the police in PaP after conducing sensitisation in all police stations, and other entities such as the *Brigade de protection des Mineurs*. Stakeholders will be invited to discuss any concerns with the study coordinators.

Thank you. 'Community leaders' in this context refers to three main groups: local administration for example Conseils d'Administration des Sections Communales (CASEC) and Administration des Sections Communales (ASEC); religious leaders (Christian and Voodoo); and leaders of community

based organizations. As MSF is working in both metropolitan Port au Prince and Croix des Bouquets the team has a good understanding of, and relationship with, community leaders and will ensure the appropriate official and unofficial leaders are consulted in each data collection site in order to ensure community-level understanding and support for the study. Their authority is either official in the case of local administration, or comes from the recognition of their role by community members. For each data collection site we aim for community leaders to agree to support the study; should any leaders oppose the study or wish their community does not participate, further consultation would take place aiming to reach a consensus of participation. However, should resistance continue, a decision will be taken on whether or not to include the community in the study, after consultation with the mission team and careful consideration of the risks and benefits. It is possible that the community in question may be withdrawn from the study, and this will be acknowledged in the limitations.

9 Dissemination and implementation of findings

Beyond the benefits of the study, the obligation to ensure results are properly interpreted and benefits are optimised and used to feed into advocacy, policy and programmes is recognised. Through the development of a dissemination and implementation plan and the involvement of consultative stakeholders in its design we will outline how findings will disseminated and implemented. The exact content of this plan will depend on the study results and where/how we consider maximum impact can be achieved, but as a minimum it will include the following steps:

1. Pran Men'm ~~P~~project level: Findings will be shared with MSF mission and project teams through a presentation and summary booklet (in addition to the full study report).~~used~~ They will be translated into practical recommendations and discussed with the mission/project team, in order to identify which can be implemented in order ~~to inform~~ enhance MSF service provision, specifically through adapted IEC strategies (and which require action from other stakeholders and so should form part of the mission advocacy strategy). These points will then be integrated into the project/mission planning during the annual planning process.
2. National ~~P~~policy level: Through collaboration with the MoH and sharing of findings with national level stakeholders, findings will be used ~~to inform policy and~~ advocate for improvements/changes ~~in~~ linked with study results and to suggest policy development linked to SGBV service provision. This will be done by holding meetings with relevant stakeholders to explain the findings and sharing a 'policy brief' containing a summary of relevant findings, identifying recommendations in the context of current national policy. We will ensure that the findings reach relevant users (for example other SGBV service providers, national ministries, women's NGOs), and that they are communicated and understood clearly through clearly produced documents/outputs, meetings and presentations, anonymised and appropriate in each of the locations per their context. This may involve presentation at national conferences, as appropriate.
3. Community level: Meetings will be held with community leaders and a summary of the results will be shared alongside recommendations/ plans/efforts to improve services by MSF. In addition small group meetings will be organised in the community to share the study findings. These will be integrated into ongoing MSF activities in the community combined with information about services available to survivors. From the outset, we will also explain clearly that as MSF we cannot respond to all needs but are working with the MoH and other partner organizations to support the establishment of health services. By sharing findings with participants and communities we hope to increase awareness and uptake of services. Findings will also be critical in informing appropriate MSF community engagement and health promotion/education strategies, aiming to equip women with information that will facilitate decision making. An important part of the study explores how the community themselves see the best strategies to improve utilisation and acceptance of services. We will use these findings as part of a consultative process to ensure the community are part of the solution and continue to monitor their perspectives with regards to how we plan, offer and implement services.
   The content of the summary will be carefully reviewed by MSF teams and collaborators, and any highly sensitive or problematic results may be excluded should they pose a potential risk to individual participants or communities. We will also 'pilot' the dissemination of findings and ask feedback to ensure the material and presentation is acceptable; should any concerns be raised the content or presentation will be altered and the summary re-piloted.
4. MSF policy level: Findings and recommendations may also be translated into the development/ amendment of MSF SGBV policy and guidelines. They will be shared with key members of MSF OCA headquarters staff and also intersectionally with SGBV referents and other relevant personnel.
5. International policy/academic level: Findings and recommendations may be developed into a manuscript and submitted to a journal for publication, and may be presented at appropriate international conferences, with the aim of contributing to the global knowledge base about

SGBV and the improvement of service provision and response. They may also be shared with specific organisations and entities working with SGBV on an international level, should pertinent recommendations emerge.

6. Participants: Individual participants will be given the option to receive a summary of findings, and to leave their contact details for this purpose, as part of the consent process. This will be reconfirmed at the end of the interview. The exact strategy for this will be adapted based on the content of the findings and the participant group.
7.

10 Implementation of the study in the field

10.1 Study team

The human resources foreseen for the study is as follows:

1 x principal investigator
Qualitative team
1 x qualitative coordinator
2 x research assistants/translators
4 x transcribers/translators
Quantitative team
1 x quantitative coordinator
12 x KAP data collectors

The study will be overseen by the **principal investigator.** They are overall responsible for the final version of the protocol, overall quality of the study and data analysis, and the final report. They will oversee the whole study including:

- Preparation of all necessary documents (protocol, questionnaires, informed consent forms)
- Preparation of the field component of the survey (training of the data collection teams, logistics, materials) together with the MSF team in the field
- Follow-up of the field component of the survey
- Data entry
- Data analysis
- Report writing

Study coordinator-quantitative (x1): Leads the quantitative component of the study, including protocol development; recruitment and training of study team; supervision of data collection and survey team; data analysis and contribution to write up. They directly lead one data collection team and supervise the other quantitative team leader and ensure quality control and consistency between the two data sets.

Study coordinator-qualitative (x1): Leads the qualitative component of the study, including protocol development; recruitment and training of study team; supervision of data collection and survey team; data analysis and contribution to write up. They directly lead one data collection team and supervise the other qualitative team leader and ensure quality control and consistency between the two data sets.

KAP survey team: Each data collection team will be composed of two data collectors. Given the timeframe of the study it is estimated that 6 data collection teams of two people will be needed, so a total of 12 data collectors. They will be responsible for conducting the surveys, accurately recording data and contributing to planning and debriefings.

Qualitative data team:
Two research assistants/translators will be recruited to translate interviews and assist the qualitative researcher with data collection as needed. This will include one male and one female, who will assist/translate interviews/FGDs as appropriate to the participant/group (e.g. all activities with female participant's will be conducted with a female translator; activities with men with a male). They will be responsible for supporting recruitment of participants, translating interviews and FGDs, and contributing to debriefings and ongoing analysis.

A team of four transcribers will be recruited to transcribe the interviews and FGDs and translate them into English. Terms of reference for the qualitative research team are in appendix 6.

10.2 Training of data collection team

Quantitative component

Four days training will be given to all data collectors to familiarise them with the background of the survey, the questionnaires, the tablet and software, the information sheet and the informed consent form. The training will be given in French with translation if needed by the study coordinator. It consists of an intensive review of the questionnaires and the information sheet including role-plays. As the interviews will be held in the regional language, the principal investigator should ensure that all data collectors are using the same and correct wording for providing information to the households and for the interviews.

The 2-day training will be followed by 2 days for a pilot survey. The pilot will be conducted in a section not included in the study and selected after study cluster allocation has been performed. The pilot survey allows for the testing and possible final adaptation of the questionnaires and informed consent to field conditions.

Qualitative component

For the first qualitative component, a 4-day training will be conducted followed by a one day pilot of the topic guides and a further 1 day of debriefing and revision of tools if necessary (6 days in total).

Pilot interviews /FGDs will be held to pre-test the tools with each participant group. Following the pilot a debriefing/review of the pilot will be conducted to ensure appropriateness of tools, consistency between data collection teams and address any challenges faced. Throughout the data collection tools may be refined through daily discussions of interviews and issues emerging.

TABLE 3: OVERVIEW OF TRAINING/PILOT PLAN FOR QUALITATIVE DATA COLLECTION

Day 1	• Introduction to MSF and MSF in Haiti
	• Introduction to study and methods
	• Introduction to qualitative research
	• Introduction to SGBV
	  · Preconceptions/risk of bias
	  · Dynamics in Haiti

Day 2	• Risks and obligations of research team (brain storming)
	• Ethical considerations, including:
	  · Confidentiality
	  · Informed consent
	  · Disclosure and referral
	  · Risks and benefits

Day 3	• Interviewing and translating skills • Managing difficult situations (role play) • Stress management • Psychological First Aid • Practical planning of data collection (daily plan, community engagement etc.)
Day 4	• Run through and discussion of topic guide • Role play consent process • Practical exercises with topic guide, audio recording • Feedback, questions and lessons learned
Day 5	• Pilot of topic guides
Day 6	• Review of pilot: challenges and lessons learned • Discussion of topic guide and amendments necessary (language, discussion flow etc.) • Definition of ongoing supervision and support

Transcribers will also receive a one day training including background information on MSF, the study, and practically focussing on transcription techniques and research ethics, with a focus on privacy and confidentiality, and data management and storage.

Training materials developed specifically for this context will be used, and training methods will be participatory with a focus on practical exercises (e.g. role play, problem solving, discussion etc.) and provide opportunities for the team to reflect upon and share their existing knowledge and experience. This will be supported with ongoing supervision and support, largely through daily debriefings, to address any issues arising.

For the third qualitative phase of the study, training will be adapted if the same team are involved in data collection. A recap of the training will be provided, followed by roles plays with topic guides (1 day), piloting tools (1 day) and debrief (1 day), as per the training plan outlined above.

10.3 Suggested MSF support in the field

- Support in contextualising the study and tools as appropriate for the study site, including establishing referral pathways, security analysis, context briefings etc.
- Administrative support for study preparation at the field level and during the field component, such as presentation of the survey protocol to the ethics committee of the MoH and payment of data collection teams.

- Human resource support, such as recruiting the data collection team as needed.
- Logistical support for study preparation at the field level and during the field component, such as organizing sufficient cars and drivers, providing communication tools and MSF ID (e.g. aprons, vests or arm bands should these be deemed necessary after local consultation during formative data collection) to the data collection teams, providing stationary and printing the questionnaires and consent forms.

10.4 Study planning

See Table 4 for a preliminary timeframe of the field component per study site. Please note, this will vary according to factors specific to each study site (e.g. transport, in-country travel, limitations on accessing target groups etc.).

TABLE 4: PRELIMINARY PLAN OF THE FIELD COMPONENT

Date ***[2017]***	Phase	No. of working days	To do
	Phase 1: formative qualitative	1	Travel days for arrival
		2	Final preparation
		4	Training including the piloting tools
		6	Data collection
		2	Buffer days / debriefing
		1	Travel days to return
		10	Data analysis and write up
	Phase 2: KAP	1	Travel days for arrival
		4	Final preparation of the study
		4	Training including the piloting tools
		30	Data collection
		3	Buffer days / debriefing
		1	Travel days to return
		20	Data analysis and write-up
	Phase 3: Explanatory qualitative	1	Travel days for arrival
		2	Final preparation of the study
		2	Training including the piloting tools
		10	Data collection
		3	Buffer days / debriefing
		1	Travel days to return
		10	Data analysis and write-up
		30	Final analysis and write up
		30	Manuscript preparation and feedback to partners and study participants
		Total: 178 days	

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12 Logistics

12.1 Supplies needed

Supplies to conduct the study will be purchased via the country management.

See Table 5 for a list of required supplies.

Photocopies of all necessary documents will be coordinated by the Country Management Team.

Item	No. needed per team	Total needed [6 x survey teams 1x qualitative team 4 x transcribers]
Back pack/shoulder bag	1	7
Clipboard	2	14
Pencil	3	21
Rubber	2	14
Sharpener	2	14
Ink pad	1	7
MSF ID (aprons/vests if required)	2	14
Plastic folder	3	21
Random number table (see appendix 7)	1	6
Electronic tablets for KAP data collection	1	6
Computers (for transcription of qualitative activities)	4	4

TABLE 5: SUPPLIES NEEDED FOR THE STUDY

12.2 Transport needed

Phases 1 & 3 (qualitative data collection): 1 x car and driver
Phase 2 (KAP survey): 2/3 x cars

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