The University Of Sheffield.

Health Care Professionals' Roles and Experiences of Identifying and Responding to Intimate Partner Violence among Pregnant Women in Thailand

By:

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A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

The University of Sheffield Faculty of Medicine, Dentistry and Health

School of Nursing and Midwifery

October 2019

Abstract

Introduction: Intimate Partner Violence (IPV) is the most commonly reported form of violence against women and it has been reported in all parts of the world. IPV can affect women at any stage of their life but pregnant women are particularly vulnerable to IPV. Healthcare Professionals (HCPs) are likely to be the first point of contact and have a unique opportunity to respond to victims of IPV. They play a key role in addressing IPV by screening and identifying victims, offering information and support, and referring victims to appropriate agencies. There have been very few previous studies of HCPs' perception of their role and experience of identifying and responding to IPV or of their knowledge, attitudes and practice in Thailand.

Purpose: To explore the perception of Thai HCPs about their role and their experiences regarding the identification of and responses to IPV, and to better understand the barriers and facilitators which affect this.

Design and Methods: An explanatory sequential mixed methods design was adopted. A quantitative survey using adapted PREMIS questionnaire was conducted with 188 Thai HCPs in Burirum province, Thailand. Qualitative interview were conducted with nurses who were selected purposively based on their experiences of identifying and responding to IPV during pregnancy.

Findings: The findings indicate that Thai HCPs had poor knowledge regarding IPV during pregnancy. There were misconceptions among the Thai HCPs' knowledge about the leading cause of IPV during pregnancy and they lacked knowledge of law relating to IPV. Most of the participants reported a positive attitude towards identifying and responding to pregnant women who might be subjected to IPV. Nevertheless, the reported identification rate was low among both the survey and the interview participants. All of the interviewees reported that they did not routinely ask pregnant women about IPV, they asked only women who showed signs of being abused.

Interestingly, the findings showed that the interviewees used 2Q as guide for asking about IPV, which had not been reported by any previous studies.

Conclusion and Recommendations: Most participants had positive attitude towards IPV identification and response among pregnant women and perceived that IPV identification was their responsibility. However, further education, IPV training, clear policies of IPV management and organizational support is needed to enable them to identify and respond to all pregnant women about IPV.

Acknowledgements

I would like to show my deep gratitude and to thank all those people who have supported me during the tough time through my PhD.

First and foremost, I would like to express my sincere thanks and appreciation to my primary supervisor, Dr. Sharron Hinchliff, for her excellent supervision, invaluable advice, enthusiastic support and timely feedback over the years. This thesis would not had been possible without her. I would like to give my greatest appreciation to my co-supervisions, Dr. Parveen Ali. My sincere thanks to her for her expert guidance, invaluable feedback, and encouragement.

I would like to thank the HCPs who took part in my study for their participation and assistance in my study. I also like to thank to Dr. Watcharaporn Huntranee, my friend for suggesting and supporting during data collection at Burirum province.

I would like to give thanks to the Royal Thai Government, my sponsor, for funding me throughout the four years.

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Preface

Intimate Partner Violence (IPV) is the most commonly reported form of violence against women and it has been reported in all parts of the world. Several studies have shown that between 20% and 68% of women aged from 15 to 49 years have suffered from physical and/or sexual violence committed by their intimate partner at least once in their lifetime (Fulu *et al.*, 2013). According to the UK Office of the National Statistics (ONS) (2015), every week two women living in England and Wales are killed by their partner or ex-partner. Injuries, mental health problems, emotional distress and suicidal behaviour are common problems among women who have experienced partner violence. These problems highlight the fact that IPV against women remains a crucial issue to be addressed. Moreover, during pregnancy IPV is particularly recognised as an important risk factor for adverse health consequences for women, unborn babies and new-borns.

Despite continued research on IPV during pregnancy in Thailand, there remains a lack of evidence on Health Care Professionals' (HCPs) perception of their role and experiences in identifying and responding to IPV during pregnancy. Most studies have focused on the prevalence of IPV, its effect on the health status of pregnant women and the factors contributing to IPV during pregnancy (Boonnate *et al*., 2015; Thananowan *et al*., 2012; Thananowan & Heidrich, 2008).

The researcher's background and rationale

I was drawn to this particular field of research from both a professional and a personal perspective. In my professional experience prior to supervising nursing and midwifery students in clinical practice, I had participated in the routine care of all

pregnant women who visited the antenatal care clinic (ANC) in a hospital. The topic of this study was defined and developed from my broad interest in researching pregnant women's health to a narrower focus upon partner violence during pregnancy. This is because as a midwife, giving the necessary support, care and advice to women during pregnancy, labour and the post-partum period is my responsibility and one for which I am accountable. Moreover, as a lecturer, I am required to develop and maintain areas of expertise. The topic of my master's dissertation was 'The influences on the uptake of antenatal care by teenagers'. My interest in IPV during pregnancy started when I read a number of articles about IPV and these described the adverse health outcomes for both the mother and the new-born. I realised that the prevalence of IPV during pregnancy in Thailand was high and that there is lack of guidelines about identifying and responding to IPV during pregnancy for HCPs in Thailand. IPV during pregnancy goes unrecognised by HCPs in healthcare settings in Thailand, especially (and surprisingly) in antenatal care clinics. HCPs may find it difficult to identify victims of IPV and can be unclear about how to offer effective responses to the victims.

In the context of Thailand, violence between married/partnered couples has long been a problem and it is not obvious enough for people to draw attention to it because it is considered as a family and private issue (Laeheem & Boonprakarn, 2014). Over the past decade, however, in Thailand there has been increased research attention focused on the prevalence of IPV during pregnancy, the relationships between IPV during pregnancy and adverse health outcomes, the experiences of Thai women in regard to IPV, and factors influencing IPV during pregnancy. These studies have revealed that, for example, the prevalence of IPV during pregnancy in Thailand was from 4.8% to 11.7%, that the most common site of injuries among

Thai pregnant women was the face, and that the factors influencing IPV during pregnancy among Thai women were stress and marital dissatisfaction (Thananowan & Heidrich, 2008; Boonnate *et al.*, 2015). Although there is an extensive research literature on IPV during pregnancy in Thailand, much less is known about the experiences and the perceptions of HCPs about their role in dealing with this particular and widespread health need. These studies left me with many questions regarding Thai HCPs' roles and experiences in screening and helping the victims of IPV. Therefore, the specific questions which I shall address in this thesis are what are the knowledge, attitudes and practice of Thai HCPs towards IPV, how do they perceive their role in IPV identification and responses, and what are their experiences of identifying and responding to IPV during pregnancy.

Drawing on data from the initial quantitative phase of the study, I shall explore the knowledge, attitudes and clinical practice of Thai HCPs about IPV during pregnancy. The findings from the quantitative phase informed the second, qualitative part of the study which involved a semi-structured interview with HCPs who had experience of identifying and of taking care of pregnant women who were abused by their partners. The qualitative study looks at the way in which HCPs perceive their role regarding IPV identification and response, how they identify the pregnant women who might be being abused and how they respond to victims of IPV. This qualitative phase also focuses on the perceived barriers to IPV identification and responses, and on potential facilitators for overcoming these barriers.

It is expected that the findings will lead to a clearer understanding of HCPs' roles in identifying and responding to IPV during pregnancy and will provide valuable insight for ways of improving HCPs' practice in addressing IPV among pregnant

women. In addition, the findings will guide me and other HCPs in working more effectively with the women who may have experienced, or may still be experiencing, IPV. The findings will also contribute to increasing the awareness of HCPs in Thailand of the existence of IPV during pregnancy and the negative health consequences of IPV during pregnancy and will then lead to an increase in IPV screening. Moreover, by detecting the issue earlier and more effectively, pregnant women who are experiencing IPV can be made more aware of the help and resources which are available. It is also widely noted that the disclosure of IPV by pregnant women might result in preventing further violence and thus increase the safety of pregnant women and their pregnancy.

Outline of the thesis

This thesis consists of nine chapters. Chapter 1 provides an overview of the historical context of violence against women, the definition of IPV and the types of IPV. This chapter also provides an overview and general background of Thailand, addressing the prevalence of IPV, IPV during pregnancy and the overall situation of IPV in Thailand. At the end of the chapter, the research aims and objectives will be set out.

Chapter 2 is an examination of the current evidence-base relating to the knowledge, attitudes, practices, perception of roles and experiences of HCPs in identifying and responding to IPV, specifically focusing on pregnant women who are experiencing IPV. The relevant literature will be reviewed, analysed, summarised and discussed, and the identified research gaps will be highlighted. The rationale for this study will also be presented.

Chapter 3 focuses on the methodological characteristics of the study and this will be followed by an overview of the use of a mixed-method research strategy and the rationale for integrating two different research methods in the study. After this discussion of the study design and the methods chosen for addressing the research questions, Chapter 4 will present the detail of the initial quantitative phase of the study, including the methods, recruitment technique, data collection process and data analysis. This will be followed by the details of the second phase of the study which was the qualitative phase. Finally, the relevant ethical considerations and research ethics of the study will be discussed.

Chapter 5 presents the findings from the questionnaire responses and examines the levels of Thai HCPs' knowledge, attitudes and practices in identifying and responding to IPV during pregnancy. Chapter 6 will then present the findings from the qualitative data by discussing the analyses of the semi-structured interviews with Thai HCPs which explored their perceptions of their roles and experiences in regard to IPV identification and responses. It will also present the findings related to HCPs' perceptions of the barriers and facilitators for IPV identification and responses. The findings from these two studies are then brought together formally in a dedicated mixed-method analytical integration in Chapter 7.

In Chapter 8, I shall discuss the findings of the current study in the light of the evidence in the relevant existing literature. The contribution to knowledge, the strengths and limitations of the study, and suggested potential areas for future research and healthcare practice will be discussed. Chapter 9 is the concluding chapter of this thesis and I shall present my reflection and summarise the key findings of the research and then offer recommendations for improving the performance of Thai HCPs in

identifying and responding to IPV during pregnancy.

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter provides a review of the historical context of violence against women. This is followed by a definition of IPV and a survey of the types of IPV. The chapter proceeds with a description of IPV during pregnancy and the role of HCPs in identifying and addressing IPV. The risk factors and negative consequences of IPV during pregnancy are also explained. The ensuing sections discuss issues of IPV in Thailand, including an overview of Thailand, the situation of IPV and IPV during pregnancy, as well as the national health care responses to IPV.

1.2 Definition of Intimate Partner Violence

IPV is a major social and public health issue. The phenomenon has been known under a variety of terms and there has been much debate over the appropriate term for violence between intimate partners. Previously, terminologies used in research to refer to IPV included wife abuse, spousal abuse, interpersonal violence, family violence, violence between intimates, wife battering and women battering (Shipway, 2004; Nicolaidis and Paranjape, 2009; WHO, 2013). Nevertheless, the use of some terms has been controversial. For example, the term 'battered wives' has been inappropriately used as it does not relate to women who are separated or divorced from their husband/partner or unmarried couples who live together (Nicolaidis and Paranjape, 2009). In addition, this term only focuses on men as perpetrators and women as victims, whereas evidence suggests that violence can be perpetrated by women too (Hoyle, 1998). The term 'domestic violence' (DV) has usually been used to refer to IPV and is now widely accepted in several countries (WHO, 2013;

Shipway, 2004). However, there are disagreements over defining DV as IPV because DV also refers to the abuse of children, the elderly or other family members. The Department of Health, UK (2015) defined DV as the act of violent, controlling, coercive or threatening behaviour which occurs between people aged sixteen or over, who have or have had an intimate relationship in the family. Types include psychological, physical, financial and emotional abuse. According to the Centre for Disease Control and Prevention (CDC), IPV refers to the most common forms of violence, including physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner. It can occur between heterosexual or homosexual couples, thus both men and women can experience it, and it can occur in every community regardless of race, age, economic status, religion, ethnicity, sexual orientation or education background. Intimate partners may or may not be living together but they have a close personal relationship which can be characterised by their emotional connectedness, regular contact, continuing physical contact and sexual contact. These intimate partner relationships include current or former boyfriends or girlfriends, dating partners, ongoing sexual partner and spouses, such as married spouses, common-law spouses, civil union spouses and domestic partners (Breiding *et al.*, 2015). The most current term used today is IPV and it seems to have resolved many of the issues discussed above. For instance, the term is equally applicable to people living together in a marital or non-marital and/or a heterosexual or homosexual relationship. In addition, the use of this term acknowledges that women might also perpetrate violence against their male or female partners (WHO, 2013).

1.3 Historical context of intimate partner violence

Before the 1970s, wife-beating was widely tolerated in many countries as a means of controlling or punishing a woman or wife. The first known marriage laws were established in Rome by Romulus, who is credited with founding ancient Rome in 753 BC. That law stated that a married woman belonged to her husband and should always obey him in everything (England, 2007). In the fifteenth century, Christian scriptures emphasised the accepted fact that men had authority over their wives. The Rules of Marriage written by Friar Cherubino in the late fifteenth century are one example demonstrating the history of IPV. Cherubino's rules stated that a husband could use violence against his wife if she committed something wrong or if she was not obedient (Hart & Hart, 1991). In Anglo-American common law, a husband who beat his wife was not regarded as having done anything wrong if the beating did not cause any permanent injury (Siegel, 1996). English common law provided that a husband had the authority to control his wife and her property within the privacy of the family home. In 1782, the popular rule that a husband could beat his wife using a stick or rod not thicker than his thumb arose (Frost, 1997; Walker, 2015). Subsequently, the notion of the 'rule of thumb' has been cited by several authors as a tenet of British common law; for example Del Martin (1979) cited it in her book *Battered Wives* and Terry Davidson (1977) cited it in an essay. Martin's and Davidson's explanations have also been cited in many articles as authoritative fact in law journals. Despite this common assumption, however, there is no evidence whatsoever for the rule of thumb existing in British common law allowing a husband to beat his wife. Furthermore, there is a body of evidence demonstrating that English women could gain protection from a violent husband by seeking a protection order from the court (Kelly, 1994; George, 2007).

During the latter half of the nineteenth century, IPV legislation was established

in several countries primarily as a result of the efforts of the growing women's movement. In 1871, Alabama was the first state in the United States (US) to revoke the right of husbands to use physical force against their wives (Fagan, 1995). In 1878, women in the United Kingdom (UK) had the right to ask for a separation from an abusive husband if their life was at risk because of his abuse (Frost, 1997). In 1882, Maryland became the first US state to declare wife-beating a crime which was punishable by a prison sentence of one year or 40 lashes (Hart & Hart, 1991). Even so, these laws did not actively protect abused women. In reality, violence against women at that time was still not often prosecuted successfully. Most women usually suffered abuse in silence because the police would not do anything to help them (Hart & Hart, 1991; Fagan, 1995; Frost, 1997). This is because IPV was seen as a private issue, especially by the police who are responsible for protecting the public and preventing crime. Most people working in police departments believed that violence between a couple was a marital problem which should be resolved in the home (Zorza, 1993) and the police rarely arrested the perpetrators of IPV or even investigated a reported incident (Fagan, 1995).

By the late 1960s, the second-wave of the feminist movement helped to increase public awareness of violence against women as a social problem which deserved attention. Many US states improved legislation on violence against women to protect victims and punish perpetrators (Siegel, 1996; Riger *et al.*, 2002). Rape crisis hotlines, centres and shelters were set up for the victims of violence. These services were intended to help women who needed to leave abusive situations, to inform people in the community and to change people's attitudes to violence against women (Riger *et al.*, 2002). In the UK, several studies of violence against women were conducted as a result of the second- wave feminist movement. Research studies

were undertaken to acquire public and political responses to the problem and to provide statistical support for campaigns. These studies actually played a very significant role in highlighting a hidden problem and revealing the prevalence of domestic violence. For example, Hammer and Saunders (1984) found that 59% of women in West Yorkshire had experienced at least one incident of domestic violence (cited in Harne & Radford, 1995). Painter (1991) studied relationship rape and found that women were raped by their husband or male partner seven times more than by a stranger (Painter cited in Harne & Radford, 1995). Many campaigns supported by the government, the police and the criminal justice system were also established to recognise that violence between intimate partners was a crime, for example the Women's Aid Federation of England (Harne & Radford, 1995). The main aim of that campaign was to prevent and end the domestic and sexual abuse of women and children as well as to provide services for their safety (Women's Aid Federation of England, 2015).

Moreover, the United Nations (UN) organised four international conferences on women which sought to coordinate efforts to address issues of women's rights and empowerment. These conferences took place in 1975, 1980, 1985 and 1995 (UN Women, 2014). The Fourth World Conference on Women was held in Beijing in China and had a particular effect on the development of policies to address domestic violence in many countries around the world. That conference is known as the Beijing Declaration and Platform for Action of 1995; it brought together 189 countries to exchange good information and share solutions to eradicate violence against women. The outcomes of the meeting were regarded by many countries as a roadmap to eliminate discrimination against women and girls, and were used as a source of guidance to realise gender equality and human rights. Nevertheless,

no country today can claim to have succeeded in protecting women from violence and the global prevalence rate of violence against women remains high (UN Women, 2014; WHO, 2016).

There are many organisations around the world which were established to support women's empowerment, to prevent violence against women and to mitigate the effects of this violence (WHO, 2014). These organisations have a critical role in supporting the elimination of violence against women by working together in different regions of the world. The following two examples illustrate the role of these organisations in preventing and reducing violence against women and girls. The first is the United Nations Children's Fund (UNICEF). UNICEF's mission is dedicated to promoting equal rights for women and girls, supporting community integration and participation for them, and providing opportunities to obtain health care. The WHO has always played an important role in preventing violence against women and managing the impact of violence on victims' health. One of the important steps taken by the WHO was to conduct a multi-country study of women's health and domestic violence (García- Moreno, Jansen, Ellsberg, Heise & Watts, 2005). That study provided valuable data on the prevalence, health consequences and risk factors of IPV (Digest, 2000; Garcia- Moreno *et al.*, 2005).

It has been noted that although IPV is a worldwide epidemic and that one in three (35%) women have experienced either physical and/or sexual IPV or non-partner sexual violence at some point in their lives (WHO, 2017), most of the previous research studies covering IPV have been conducted in western countries. There has been little research covering this topic in the South-East Asian region where the highest proportion (37.7%) of physical and/or sexual IPV by an intimate partner among partnered women has been found (WHO, 2015).

1.4 Types of intimate partner violence

There are several types of IPV and many victims of IPV report experiencing more than one type (Breiding *et al.,* 2015). A study conducted in Washington State and northern Idaho by Thompson *et al*. (2006) found that approximately 45% of the participants had experienced IPV of more than one type in the previous five years. In the UK, most domestic abuse victims (80.5%) reported experiencing one type of abuse in the previous three years, and more than half (51.8%) of all victims reported only this type of abuse in the previous year. Non-sexual partner abuse and stalking were the two most commonly experienced types of abuse, forming 7.2% of the reported cases, and fewer than 1% of victims of domestic abuse had suffered from all four most frequent types of domestic abuse (non-physical abuse, physical abuse, sexual assault and stalking) (Office for National Statistics, 2018a). According to the UK's ONS and based on annual findings from the Crime Survey for England and Wales (CSEW), emotional and/or financial (non-physical abuse) were the most common type of abuse (72.6%) experienced by female partner-abuse victims. The next most frequent types of abuse among these female victims were physical abuse such as threat (37.8%) or force (28%) and sexual abuse by rape or penetration, including unsuccessful attempts (3.8% and 0.5% respectively). For the male victims, most of them (57%) were more likely to experience non-physical abuse than force (45%) or threats (28.7%). There was no significant difference in the prevalence of experiences of threats, indecent exposure or unwanted sexual touching, or stalking between female and male (ONS, 2018a). According to the CDC (2015), the four main types of IPV are physical violence, sexual violence, stalking and psychological aggression, and these will be discussed separately in the following

paragraphs.

Physical violence

Physical violence is the deliberate act of using physical force or power in a way which results in the physical injury, harm, disability or death of the victim (Breiding *et al.*, 2015). Physical abuse is the most visible form of IPV which can bring immediate harm to victims, but its effects can also be profound and long-lasting. A person who has experienced physical abuse, especially during childhood, may be more at risk of experiencing emotional and psychological difficulties later in life. It can also lead to poor physical and/or mental health. These negative health consequences can continue to affect the victims even after the abuse has stopped. There is mounting evidence that physical IPV is associated with an increased risk of current poor health, developing a chronic disease, a history of chronic mental illness, depressive symptoms, substance use and being injured (Coker *et al.*, 2002). There are many forms of physical abuse and anyone can be a victim of this abuse. Most child victims have usually experienced physical abuse at the hands of their parents, caretakers or siblings (Fortson *et al.*, 2016) whilst the physical abuse of adults is often perpetrated by a partner, a spouse or other family members (Breiding *et al.*, 2015). Physical abuse of the elderly is usually perpetrated by a carer or a person whom the elderly victim trusts (CDC, 2016). Forms of physical abuse can include, but are not limited to, hitting, slapping, pushing, kicking, shaking, rough handling, burning or scalding, drowning, force-feeding, inappropriate use of restraints and the misuse of medication. The indicators of this abuse might be a history of unexplained injuries, unexplained marks and bruises of varying ages, cigarette burns, unexplained burns or scalds, frequent fractures or broken bones and chronic injuries (Blackpool Teaching Hospitals, 2014; Breiding *et al.*, 2015; CDC, 2016; Fortson *et al.*, 2016).

Sexual violence

The terms rape, sexual assault, sexual abuse and sexual violence are commonly used interchangeably and are generally considered to have the same meaning. In some situations and locations, however, these terms can have a significantly different meaning. These terms can vary between countries and even within a country. For example, in the UK, the term 'sexual assault' in police records refers to one type of sexual offence which is sexual touching without the consent of the other person. In the CSEW, the term 'sexual assault' is used to describe all types of sexual offence including rape or assault by penetration (including attempts), as well as indecent exposure and unwanted touching (WHO, 2003; ONS, 2018b). The WHO (2005) stated that sexual violence is indicated by three forms of behaviour: being physically forced to have sex without consenting, having sexual intercourse in order to avoid a possible harm resulting from rejection, and being coerced to do something sexual which the victim regards as humiliating or degrading. The CDC (2013) divides sexual violence into five categories: rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact and non-contact acts of a sexual nature, and these five forms of sexual violence include both attempted and completed acts. Sexual violence has many forms and can also occur in different contexts such as armed conflicts and emergency situations. Victims may be sexually abused by one or several perpetrators and it can occur with or without being planned in advance. The perpetrator of sexual violence can be anyone, such as a date, an acquaintance, a friend, a family member, a current or former intimate partner, or a stranger, but the most common perpetrator is someone known to the victim. According to a CSEW report (2018), female and male victims are more likely to have been raped or assaulted by penetration (including attempts) by a current or former partner than by

a family member (female, 55% compared with 10%; and male, 39% compared with 13%). The most common victim/offender relationship for rape or assault by penetration (including attempts) experienced by the majority of female victims was a current or former partner, followed by someone known to them, a stranger and then a family member (ONS, 2018b). There are many forms of sexual violence, including sexual slavery, sexual harassment, forced exposure to pornography, forced pregnancy, forced sterilization and forced abortion (WHO, 2003; Jina & Thomas, 2013; Blackpool Teaching Hospitals, 2014). Sexual violence can result in immediate and medium- to long-term health consequences which can affect victims across their entire lifespan and the impact can occur at many levels (Jina & Thomas, 2013; Basile *et al.*, 2014). Many studies have shown that post-traumatic stress disorder, anxiety and panic attacks, depression, somatic symptoms, social phobia, substance abuse and suicide have been the mental health consequences after suffering sexual violence (Itzin, 2006; Jina & Thomas, 2013). For the physical and sexual impact, there can be both immediate and long-term health consequences. The immediate consequences can include injuries received during the rape, contracting sexually transmitted diseases (STDs), and unintended pregnancy. The long-term effects associated with rape and child sexual abuse can include gastrointestinal disorders, irritable bowel syndrome, chronic back, neck, head and facial pain, gynaecological problems such as irregular vaginal bleeding and discharge, painful menstrual periods and premenstrual syndrome (NHS, nd; WHO, 2003; Campbell, Dworkin & Cabral, 2009; Basile & Smith, 2011; Jina & Thomas, 2013).

Stalking

Stalking is a pattern of repeated, intrusive and intimidating behaviours which make a victim fearful or feel unsafe. Stalking can escalate to other crimes, such as assault or murder (HM Crown Prosecution Service Inspectorate, 2017; Houses of Parliament, 2018). The behaviours associated with stalking include, but are not limited to, contacting or attempting to contact a person by any means, watching or following from a distance, spying on a person, sending unwanted emails, letters or gifts, showing up uninvited at victims' house, school or work, and leaving strange or potentially threatening items for the victim to find (Melton, 2007; Breiding *et al.*, 2015; Noffsinger, 2015; HM Crown Prosecution Service Inspectorate, 2017; Jarrett, 2017; Houses of Parliament, 2018). Stalking is often associated with a psychiatric disorder of the perpetrator (Rosenfeld, 2003) and it can cause substantial damage to its victims (Mullen *et al.*, 2006; Breiding *et al.*, 2015; Houses of Parliament, 2018). The effects of stalking on a victim are variable, such as traumatic stress and other types of psychological illness, and social or career damage (Mullen *et al.*, 2006). The most common adverse effects reported by stalking victims are the emotional and mental impact of being stalked, such as feeling scared, depressed, humiliated and embarrassed, leading to a distrust of others and being angry or hateful. Some stalking victims can experience an impact on their work, social life and finances; for example increasingly needing sick leave, leaving a job, changing career, suffering a deteriorating work performance, avoiding usual activities, insecurity and an inability to trust others, loss of wages due to sick leave or changing job, and costs incurred through legal fees. These impacts can depend on the length of the stalking, the severity of the stalking, the degree of fear and intimidation induced in the victim, the victims' personal characteristics and what they know, or do not know, about the stalker (Melton, 2007; Noffsinger, 2015; Jarrett, 2017).

Psychological aggression

Psychological aggression refers to the use of verbal and non-verbal communication to harm a person emotionally or mentally, and it is the most common form of IPV (Dokkedahl *et al.*, 2019). Many terms have been used interchangeably with psychological abuse, including emotional abuse, emotional/controlling abuse, mental/psychological torture, verbal battering, verbal abuse, verbal aggression and psychological maltreatment (Follingstad, 2007; Doherty & Berglund, 2008). This violence usually co-occurs with other forms of IPV, it always precedes physical and sexual violence and it can predict the occurrence of physical abuse (Follingstad, 2009; Breiding *et al.*, 2015). Psychological aggression can be name-calling, humiliating and degrading behaviour, limiting someone's access to transport, money, friends and family, excessive monitoring of a person's whereabouts and communications, controlling someone's reproductive or sexual health and making threats to harm a loved one or a possession (Lawrence *et al.*, 2009; Williams *et al.*, 2012; Breiding *et al.*, 2015). With regard to the consequences, several studies have shown that depression, PTSD and anxiety are frequent psychological symptoms arising as a consequence of psychological aggression (Lawrence *et al.*, 2009; Dokkedahl *et al.*, 2019).

1.5 Intimate partner violence

According to data published in the 2011 National Intimate Partner and Sexual Violence Survey (NISVS), an estimated ten million women and men in the US had been the victim of physical violence in their lifetime. Moreover, these victims were abused by their intimate partners (Breiding *et al*., 2015).

1.5.1 Intimate partner violence in same-sex couples

The precise prevalence rates of IPV among lesbian, gay, bisexual and transgender women and men (LGBT) are difficult to obtain and are underestimated. IPV among LGBT can be difficult to identify and is under-reported because of denial, homophobia, prejudices, fear of stigmatisation and fear of criticism from heterosexual communities. Furthermore, LGBT people who are affected are often reluctant to disclose their experiences of abuse because of the fear of revealing their sexual orientation or gender identity to others (Banks & Fedewa, 2012; Finneran & Stephenson, 2013; Walters, Chen & Breiding, 2013). In 2010, however, NISVS reported that in the US, same-sex couples were more likely to report having experienced IPV than opposite-sex couples (Walters *et al.*, 2013). According to the National Violence Against Women (NVAW) campaign, 15% of men reporting a history of cohabitation with a same-sex partner had experience of being raped, physically assaulted, and/or stalked by their partner, and the survey found that 7.7% of men who had lived with or been married to a woman reported violence inflicted by their partner (Tjaden & Thoennes, 2000). However, Walter *et al*. (2013) reported that 26% of gay men had experienced physical or sexual abuse in their lifetime as opposed to 29% of heterosexual men. In the US, the NISVS report (2010) stated that 36.3% of lesbian women, 55.1% of bisexual women and 29.8% of heterosexual women had been physically abused by their partners at least once during their lifetime (Walters *et al.*, 2013). In the UK, Stonewall (2017), an LGBT rights charity, found that more than a quarter of LGBT people in the UK stated they had experienced partner abuse in the previous year. Most recently, Miltz *et al*. (2019) attempted to estimate IPV prevalence among gay, bisexual and other men who have sex with men (GBMSM) in the UK and reported that 44.9% of the men surveyed had been a victim of IPV in their lifetime and 19.5% had been a perpetrators during their

lifetime.

1.5.2 Intimate partner violence against women

Globally, nearly 30% of women who had been in a relationship reported being abused by at least one type of violence inflicted by a partner at some stage in their life (Bacchus *et al.*, 2018). A WHO report (2013) stated that the prevalence of physical and/or sexual violence among all ever-partnered women was highest in the South-East Asian region, at 37.7%. The eastern Mediterranean and African regions had the next highest prevalence, with 37% and 36.6% respectively. Women aged 40 to 44 years had the highest prevalence rate at 37.8%. It has been widely documented that any form of IPV can have a significant effect on women's physical and psychological health (Duvvury *et al.*, 2013; Scott, 2015). Women who have experienced IPV are more likely to experience higher rates of multiple health problems and the most common physical symptoms include injuries, headaches, chronic pain and increased association with hypertension, cancer and cardiovascular disease. The reproductive health problems include the risk of sexual transmitted infections, pre-term labour and spontaneous abortion. IPV is also linked with mental health problems such as stress, depression and increased suicide attempts (WHO, 2012; Duvvury *et al.*, 2013; Kamimura *et al.*, 2014; Dahlen *et al.*, 2018).

As has been clear from the discussion so far, IPV can occur across all areas around the world and among all socio-economic, religious and cultural groups. This form of abuse can occur between heterosexual as well as same-sex couples (WHO, 2012). However, the form of IPV perpetrated by males against females is regarded as the most common forms of violence and is one of the highest concerns and the focus of much attention because of the greater degree and severity of the violence than the other forms (Scott, 2015; Zara & Gino, 2018). The impact of IPV on a woman is

also particularly severe when she is pregnant because of the harmful effects which it has on both the mother and the unborn child (WHO, 2011). Further, IPV can be experienced for the first time during pregnancy or can escalate at that time because of women's physical and mental vulnerability (O'Shea *et al.*, 2016). I shall now turn to discuss IPV during pregnancy.

1.6 Intimate partner violence during pregnancy

IPV can affect women at any stage of their life but pregnant women are particularly vulnerable to IPV because of changes in their physical, psychological, social and financial needs (Alhusen *et al.*, 2013). Recent studies have shown that pregnancy presents an increased risk of IPV (Shamu *et al.*, 2013). The prevalence of IPV during pregnancy has varied significantly across studies and within and between global regions. According to the findings from ten countries from the WHO's multi-country study, the prevalence of IPV during pregnancy varied from 1% (in a Japanese city) to 28% (in a Peruvian province) (García-Moreno *et al.*, 2005).

A difference in prevalence rates between various studies could be due to many factors such as techniques of data collection, assessment tools for IPV victimisation, population-based studies or clinical-based studies, sample characteristics, period of observation and the type of abuse assessed (Bailey, 2010; Stöckl, Watts & Kilonzo Mbwambo, 2010; Taillieu & Brownridge, 2010; Shamu *et al.*, 2013; Onoh *et al.*, 2014). Variations could also be attributable to differences between studies in cultural aspects, the definition of IPV and the study settings (such as a clinic, a hospital or in the wider community) (Finnbogadóttir, Dykes & Wann-Hansson, 2014). Some studies have found that high prevalence of IPV during pregnancy tends to be more common in hospital and clinical samples (Shamu *et al.*, 2013), whereas

population-based studies have reported lower prevalence of violence against pregnant women (Janssen *et al.*, 2003; Guo *et al.*, 2004; Yost *et al.*, 2005; Taillieu & Brownridge, 2010). One possible reason for this is the association between pregnancy complications such as hyperemesis, vaginal bleeding and urinary tract infections and a history of sexual violence which leads abused women to antenatal hospitalisation. It may also be the case that these women are readily available as research respondents and are asked these questions and therefore the prevalence in this group appears high (Audi *et al.*, 2012; Henriksen *et al.*, 2013; M. Hassan *et al.*, 2014). The implication is that those in the community who do not require treatment are not being recorded. It is therefore difficult to compare the prevalence of IPV during pregnancy (Bailey, 2010; Finnbogadóttir *et al.*, 2014). Importantly, there is evidence that the prevalence of IPV during pregnancy is more common than the recognised pregnancy complications such as pre-eclampsia, gestational diabetes or pre-term labour (Bailey, 2010). Clearly, there is a need for HCPs to play a critical role in the early identification, prevention and reduction of IPV in their pregnant patients.

1.6.1 Risk factors of IPV during pregnancy

Several factors, such as socio-economic status (SES), education level, age, race/ethnicity, marital status, history of past IPV, exposure to violence as a child and having an unwanted or unplanned pregnancy, have been found to be associated with women's likelihood of experiencing IPV during pregnancy. Although the risk factors for IPV during pregnancy are often similar to those for IPV reported in general, the risk factors for pregnant women remain uncertain and unclear (Bailey, 2010; WHO, 2011; Fletcher, 2014). For example, there are inconsistent findings in the literature regarding the relationship between younger women and IPV during

pregnancy (Taillieu & Brownridge, 2010). Some studies have found that younger women were at increased risk of violence during pregnancy (Janssen *et al.*, 2003; Saltzman *et al.*, 2003; Dunn, 2004; Sagrestano *et al.*, 2004; Makara-Studzińska *et al.*, 2013), whereas Makatoto *et al*. (2013) found that the woman's age did not make a difference to exposure to IPV during pregnancy.

1.6.2 Effects of IPV during pregnancy

Women experiencing IPV during pregnancy usually suffer both fatal and non-fatal adverse health outcomes for both the mother and her baby (WHO, 2011). In the USA, Palladino *et al*. (2012) found a pregnancy-associated homicide rate of two deaths per 100,000 live births and a pregnancy-associated suicide rate of 2.9 deaths per 100,000 live births. Suicide during pregnancy and in the postpartum period has a profound effect on the baby (Oates, 2003; Gold *et al.*, 2012; Palladino *et al.*, 2012; Alhusen, Frohman & Purcell, 2015). Examples of the possible effects on the growing foetus or baby are given below. In a cross-sectional study involving pregnant women (24 to 28 weeks of gestation), Alhusen *et al*. (2015) found that the prevalence of suicidal ideation was 22.89% and 60.52% of these women who had suicide ideation experienced IPV.

Non-fatal adverse health outcomes following IPV suffered by women during pregnancy are negative health behaviours, reproductive problems, and physical and mental health issues (WHO, 2011). I shall explore these in turn below. Bailey and Daugherty (2007) reported that physical IPV in pregnant women was associated with rates of cigarette smoking and other substance use such as alcohol and marijuana. A study assessing the prevalence of substance use during pregnancy showed that 63% of abused women used marijuana during pregnancy. The study also concluded that women who used marijuana during pregnancy could have a Small for

Gestational Age (SGA) baby, which is defined as a birth weight less than the tenth percentile, according to population birth weights (Alhusen *et al.*, 2013).

A study of pregnant women conducted in Brazil found that 4.1% of the participants reported having unprotected sex and having multiple sexual partners, and that these sexual risk behaviours were associated with psychological violence during pregnancy (Audi *et al.*, 2012). According to a review of the academic literature in the Latin American and Caribbean region, women who reported physical and psychological abuse were more likely to report inadequate prenatal care and increased alcohol use than non-abused women (Han & Stewart, 2014).

With regard to the gynaecological problems, compared with non-abused pregnant women, abused pregnant women demonstrated more obstetric problems, which included vaginal bleeding, spontaneous abortion, premature rupture of membranes, intrauterine growth restriction, perinatal death, caesarean section and pre-term labour (Janssen *et al.*, 2003; Silverman *et al.*, 2006; Moraes, Reichenheim & Nunes, 2009; Audi *et al.*, 2012; Alhusen *et al.*, 2013, 2014; Han & Stewart, 2014; Hassan *et al.*, 2014). Furthermore, several research studies have supported the strong association between IPV during pregnancy and neonatal outcomes (Valladares *et al.*, 2009; Alhusen *et al.*, 2013). Alhusen *et al.* (2013) stated that the odds of SGA and delivery with low birth weight (LBW) were 4.81 and 4.20 respectively for women who had experienced IPV during pregnancy. These adverse neonatal outcomes, especially SGA, are associated with an increased risk of pre-term labour, poor development during childhood and consequent behavioural problems. Many studies have shown that IPV during pregnancy can directly affect the growing foetus through physical or sexual trauma. A study conducted in Tanzania found that women who experienced IPV during pregnancy were three times more likely to experience

pre-term birth and LBW (Sigalla *et al.*, 2017). Consistent with the findings of some previous studies, IPV during pregnancy has been associated with a LBW of the new born and pre-term deliveries (Chen *et al.*, 2017; Ferdos & Rahman, 2017; Laelago, Belachew & Tamrat, 2017). IPV during pregnancy also has an indirect effect by increasing maternal stress, causing inadequate nutrition and requiring greater prenatal care (Alhusen *et al.*, 2014; Donovan *et al.*, 2016).

In addition, the long-term consequences of prenatal exposure to IPV regarding the child's mental development have been well documented. Evidence has been presented to show that prenatal exposure to IPV may predispose children's externalizing and internalizing symptomatology. The externalizing symptomatology can be antisocial behaviour and conduct, and impulse control disorders, and internalizing symptomatology includes depression, anxiety and somatic symptoms (Levendosky *et al.*, 2006; Silva *et al.*, 2018). Many studies have demonstrated that physical health problems such as migraine, arterial hypertension, asthma, urinary tract infection (UTI), risk of urinary and faecal incontinence, insufficient gestational weight gain, severe nausea, severe vomiting and dehydration are consequences of IPV during pregnancy (Yost *et al.*, 2005; Moraes, Amorim & Reichenheim, 2006; Silverman *et al.*, 2006; Brown, McDonald & Krastev, 2008; Audi *et al.*, 2012). Silverman *et al*. (2006) conducted a population-based study to investigate the association of experiencing IPV around the time of pregnancy with maternal and neonatal morbidity. The results showed a positive association between IPV during pregnancy and severe nausea, vomiting, dehydration and kidney infection or UTI.

IPV during pregnancy also has significant negative mental health consequences for women and can potentially affect an unborn child (Almeida *et al.*, 2013).

Depression, post-partum depression, anxiety and PTSD are usually mental health consequences of IPV around the time of pregnancy (Almeida *et al*., 2013; Beydoun *et al*., 2012; 2010; Brown *et al*., 2008; Barcelona de Mendoza *et al*., 2015; Fonseca-Machado *et al*., 2015; Mahenge *et al*., 2013). Beydoun *et al*. (2010) found that pregnant women who reported being victims of IPV were associated with increased odds of post-partum depression compared with women who never reported being a victim.

1.7 The role of healthcare professionals in addressing intimate partner violence

Several reports have shown that women who are victims of IPV often attend healthcare settings and contact health services more frequently than any other professional agencies (Plichta, 2007; García-Moreno *et al.*, 2015; Taft, Powell & Watson, 2015). Bonomi *et al*. (2009) found that women who had suffered physical IPV were more likely to use mental health, emergency department, hospital outpatient, primary care, pharmacy and specialty services than women not exposed to IPV. HCPs are likely to be the first point of contact and have a unique opportunity to respond to victims of IPV. They play a key role in addressing IPV by screening and identifying victims, offering information and support, and referring victims to appropriate agencies (Department of Health, UK 2005; Hewins, DiBella & Mawla, 2013). Even so, it has been reported in several studies that HCPs face multiple barriers to identifying and/or addressing violence against women, such as a lack of training on screening techniques, fear of offending the patients, cultural barriers, the lack of clinical guidelines and inadequate resources and support (Beynon *et al.*, 2012; Ramsay *et al.*, 2012; Alotaby *et al.*, 2013; Hewins *et al.*, 2013). Hence, the role of HCPs is often not recognised or implemented (García-Moreno *et al.*,

2015). A study in the US demonstrated that the prevalence of screening by physicians was only 6% (Elliott *et al.*, 2002). Also in the US, Hinderliter *et al.* (2003) found that nurses who had received IPV training were still reluctant to question patients about IPV. The most frequently reported barriers to identifying and responding to IPV can be divided into three types: the attitudes and perceptions of HCPs about IPV, the healthcare system and IPV victims themselves. Some HCPs believe that IPV is a private issue because of a lack of understanding of abuse, fear of offending their patients or a lack of confidence about raising it (Hamberger *et al.*, 2004; Beynon *et al.*, 2012; Alotaby *et al.*, 2013; Hewins *et al.*, 2013; Al-Natour *et al.*, 2014). In a study conducted in 2012, it was found that nearly 60% of clinicians reported being uncomfortable discussing abuse with patients (Ramsay *et al.*, 2012). In a similar study, most nurses (59.2%) agreed that they were afraid of offending their patients by asking them about IPV; about 50% of them also believed that it was not their role to ask about IPV (Al-Natour *et al.*, 2014). Furthermore, HCPs' insufficient knowledge and training in IPV have been suggested to be among the various causes of their failure to identify violence (Beynon *et al.*, 2012; Ramsay *et al.*, 2012; Alotaby *et al.*, 2013; Hewins *et al.*, 2013; Al-Natour *et al.*, 2014).

Another barrier revealed by many studies was related to system support (Hewins *et al.*, 2013; Al-Natour *et al.*, 2014). System support barriers are a lack of referral resources, inadequate resources and support, a lack of staff, heavy workload of HCPs and a lack of knowledge of the legality of violence (Alotaby *et al.*, 2013; Hewins *et al.*, 2013).

The third type of barrier when identifying and responding to IPV is the victims themselves. Factors such as shame, embarrassment, language differences, cultural differences and the lack of knowledge of legal rights have all been found to be barriers

which prevent abused women from seeking help from HCPs (Alotaby *et al.*, 2013). Researchers in India found that nearly 62% of women who had experienced IPV did not disclose their IPV due to their embarrassment and the fear of threat and further violence from the husband or mother in-law (Vranda *et al.*, 2018). Previous studies have demonstrated various factors which influence willingness to disclose IPV and to seek help from others. These factors include the fear of negative consequences of disclosure, a lack of supportive resources, and beliefs and attitudes (Djikanović *et al.*, 2012; Al-Natour *et al.*, 2014; Taherkhani *et al.*, 2017; Vranda *et al.*, 2018). Respondents in studies by Taherkhani (2017) and Djikanović *et al.* (2012) with women from Iran and Serbia respectively stated that factors which made them afraid of the consequences of disclosing violence included bringing shame to their relatives and family, the fear of re-traumatisation, getting a divorce, and losing custody of their children (Djikanović *et al.*, 2012; Taherkhani *et al.*, 2017; Vranda *et al.*, 2018). The most frequently mentioned barriers to revealing IPV among women related to resources are unsupportive behaviour of the staff working in the relevant institutions, distrust of the institutions, being blamed as a woman and being the subject of prejudiced and inappropriate treatments. Women's beliefs and attitudes as a barrier to disclosing IPV have been identified in several studies. The most frequent barriers to disclosing IPV reported by women victims are that the violence was perceived not to be serious and that it was believed to be a normal issue in married life. In many cases, these beliefs and attitudes were rooted in cultural norms (Fugate *et al.*, 2005; Djikanović *et al.*, 2012; Evans & Feder, 2016; Taherkhani *et al.*, 2017; Vranda *et al.*, 2018).

In order to guide HCPs and to help them to screen abused women, several screening tools have been developed (Kataoka *et al.*, 2010). The most effective IPV screening

tools which have been applied when detecting IPV and used in clinical settings have been the Hurt, Insult, Threaten and Scream (HITS) technique, the Women Abuse Screening Tool/Women Abuse Screening Tool – Short Form (WAST/WAST-SF), the Partner Violence Screen (PVS), and the Abuse Assessment Screen (AAS) (Rabin *et al.*, 2009; Hussain *et al.*, 2015). However, the effective implementation of these tools is still controversial. The debate is focused on the effectivement of screening tools and appropriate methods for identifying IPV against women (Rabin *et al.*, 2009; Kataoka *et al.*, 2010; Svavarsdottir, 2010). There is insufficient evidence to confirm whether screening improves outcomes in reducing incidence of IPV or its impact on the quality of life or the health consequences to survivors (Correa, 2018). Some studies have provided evidence indicating that the screening could reduce IPV, improve the health outcomes of survivors and increase victim identification, especially among pregnant women (Nelson, Bougatsos & Blazina, 2012; O'Doherty *et al.*, 2015). Nevertheless, two systematic reviews of studies of screening tools for IPV in healthcare settings have indicated that no study had found a significant reduction in IPV in both screening and comparison groups (Feltner *et al.*, 2018) and that no study had found any benefit of screening women for IPV, such as improving their health outcomes, making referrals to supportive organisations and reducing their exposure to violence (O'Doherty *et al.*, 2015).

In order to implement effective screening tools for IPV, the methods of administering them in healthcare settings needs to be considered. Several studies have been conducted to compare the effectiveness of the methods, which include face-to- face interview, self-administered questionnaire and computer-assisted delivery (Chen *et al.*, 2007; Macmillan *et al.*, 2009; Kataoka *et al.*, 2010; Svavarsdottir, 2010). The findings of these studies have been inconsistent on the best method of

administering screening tests. In a randomised study, Chen *et al*. (2007) found that the majority of patients (93%) felt comfortable with all the methods of administering IPV screening methods, which included self-administered questionnaire, medical staff interview and physician interview. A review conducted by Hussain *et al*. (2015) found that there was no significant difference in the proportion of women who disclosed IPV using a self- administered written screen and in a face-to-face interview, however a computer- assisted screen was found to increase the rate of IPV disclosure. Svavarsdottir (2010) compared the effectiveness of a self-reporting method of screening for IPV with interview in an emergency department (ED) and prenatal clinic, and found that the face- to-face interview approach led to higher disclosure rates of physical abuse compared to a self- reporting approach at the ED. Also, disclosure of emotional and sexual abuse was higher for a self-reporting screen in comparison with a face-to-face interview at an ED. However, at the prenatal clinic disclosure rates of emotional and sexual abuse was no different for both screening approaches (Svavarsdottir, 2010).

As has already been discussed, IPV during pregnancy can occur in all settings and among all socio-economic, religious and cultural groups. It is a public-health problem across the world and in Thailand there is a need for appropriate and effective responses. The next section will present information related to the issue of IPV during pregnancy in Thailand, because, as mentioned as earlier, there is a lack of research on HCPs' perception of their roles and their experiences of IPV identification and response in Thailand. First, I shall provide a general background of Thailand in order to give the reader the cultural context to this study.

1.8 General background: Thailand

1.8.1 Geography and socio-demography

Thailand is a fertile land located in Southeast Asia, covering an area of 514,000 square kilometres (200,000 square miles). The country shares boundaries with the Lao People's Democratic Republic in the north and northeast, Cambodia and the Gulf of Thailand in the east, Myanmar in the north and west, the Andaman Sea in the west and Malaysia in the south (*see* Figure 1.1). Thailand is divided into four regions: Central, Northern, Southern and North-eastern (United Nations, 2009). According to the 2010 national census, the population of Thailand was 65,958,158, consisting of around 97% Thai, 2% Burmese and 1% others. Of the total population, 9.27 million people live in Bangkok, the capital city (Central Intelligence Agency 2015; National Statistical Office Thailand, 2010). The main religion in Thailand is Buddhism, practised by more than 92% of all Thais. Islam and Christianity are the next most common religious faiths. The official and national language of the country is Thai (Central Intelligence Agency, 2015).

Figure 1. 1 Map of Thailand (United Nations, 2009)

1.8.2 Buddhism and Thai culture

In Thailand, 95% of people identify their religion as Theravada Buddhism. The Thai cultural background and lifestyle has been deeply influenced by Buddhism for many centuries. The main beliefs of Buddhism are to be free from suffering and to live in the spirit of *Metta* (kindness) and *Karuna* (compassion) (Klunklin & Greenwood, 2006). The law of karma and the associated concept of merit accumulation are the moral principles of Thai Buddhism (Tantiwiramanond, 1997). The law of karma states that all livings beings have their own actions (karma) and that all actions have consequences which will affect the doer. The right actions will have good consequences and wrong actions will lead to bad consequences (Reichenbach, 1988).

Gender differentiation due to Buddhism in Thailand can be obviously seen. Men have authority to perform all religious activities at the temple. Only men can be ordained as monks and women are not allowed to become monks (Tantiwiramanond & Pandey, 1987). Buddhists believe that becoming a Buddhist monk brings honour and power to the family. This ordination of the son is believed to bring his parents to heaven in the next life. On the other hand, in a religious or spiritual way, women cannot pay back their parents. The tradition of repayment of the parents' goodness is perceived as a value for everyone. This value is generally taught to children right from the early years of their life, and is later passed on to the next generation. For this reason, women are generally considered inferior to men (Klunklin & Greenwood, 2006). Because most Thai people consider themselves to be Buddhists, and Buddhism plays an important role in Thai culture and society and has had its greatest impact over the Thai way of life, thoughts and behaviours,

this helps to explain the gender differences observed within Thai communities (Limanonda, 1995; Choowattanapakorn, 1999). Furthermore, gender inequality in Thailand is also historically deep-rooted and is caused by the culture and based in the family unit. Historically, Thai sons and daughters are treated and taught differently (Praparpun, 2009). Most boys are usually given more freedom and no or fewer household responsibilities than girls. They are also treated with more significant consideration because parents expect them to pay them back by becoming a monk, whilst girls are not treated in the same manner as their male counterparts. Most Thai girls have to do household chores and they are expected to give lifelong service to their parents as a means of paying them back. In terms of their sexual life, Thai women have been expected by society to be modest and passive in their relationships, and to accept having less power and less sexual desire in comparison to men. Young women are not allowed to talk about sex in public and are taught to keep their virginity until after marriage (Sridawruang, Crozier and Pfeil, 2010). For Thai women, remaining a virgin until marriage is the social norm to be a 'good lady' (Ounjit, 2011). Having a sexual relationship before getting married is unacceptable among women. In contrast, Thai men are widely perceived as having superior status to women, especially regarding the value placed on sex in society. They have the privilege of sexual freedom; they can have sex before marriage, they can have more sexual partners, or can have a sexual relationship outside marriage (Knodel, 1997; Ounjit, 2011). These beliefs have been entirely different for women, who are expected to display faithfulness and endurance, to maintain married life and to ensure the welfare of their offspring (Thaweesit, 2004).

Some Thai proverbs reflect the inequality between Thai women and men. For example, a traditional Thai proverb is '*Chai Kao-Pluenk, Ying Kao-sarn*', which

means men are rice paddy and women are rice. The rice paddy (a plot of land) is valuable and can continue to grow rice, whereas rice itself is less valuable and cannot increase any more in value because the rice itself is the final product (Praparpun, 2009). As a consequence of all these beliefs and cultural norms, Thailand has long been a male-dominated country and the social system operates as a patriarchal structure.

The transition of Thailand over the last forty years from a low-income country to an upper-middle income one, and from an agricultural to an industrial economy has brought several challenges and changes, including new technology which has greatly influenced everyday Thai life. These changes have affected the way people think, their beliefs, behaviour, conduct, manners and values as well as the value attributed to females. Thai women's social, educational, political and economic opportunities have improved significantly. Sexual expression, intimate relationships and social norms about sex among Thai people are also affected by these changes. People are more open- minded about premarital sex than ever before (Ounjit, 2011; Srijaiwong *et al.*, 2017). For example, cohabitation is an increasingly common trend in Thai society and can be found across society from students to working age people (Ounjit, 2011). However, the previously entrenched Thai beliefs and cultural traditions are still followed today in many families, especially in rural areas (Praparpun, 2009; Ounjit, 2011).

1.8.3 The healthcare system in Thailand

Health care in Thailand is organised and provided by a variety of organisations in the public, private and civil society sectors. All public health hospitals in Thailand are under the administration of the Ministry of Public Health (MOPH), which is the principal agency responsible for formulating, implementing, monitoring and

evaluating health policy. The MOPH has held both a service delivery role and a financial management role which operate on two levels, central and provincial. The central administration includes the Office of the Permanent Secretary and three clusters of technical departments: the Cluster of Medical Service Development, the Cluster of Public Health Development, and the Cluster of Public Health Service Support. The provincial administration is the responsibility of the Provincial Health Office (PHO), which oversees the regional hospitals, district hospitals and district health offices within each province.

Public hospitals in Thailand are categorised by the MOPH into four levels. The first level are regional hospitals which are located in the large provincial cities and serve as referral centres in the region. These hospitals provide tertiary care and can provide complex care. Some of these hospitals have been upgraded to centres of excellence for particular services and have a considerable range of physical facilities, medical equipment and a workplace which specialises in the treatment of numerous diseases. The second level is the general hospitals which are located in the provincial capitals and have a capacity of between 90 and 500 beds. The third level are community or district hospitals which are located in districts and have a capacity of between 30 and 120 beds. These hospitals are able to refer complex cases to general and regional hospitals within the MOPH system. The fourth level is health centres in sub-district (*Tambon*) areas which are mainly concerned with primary care and are staffed by nurses, technical nurses or public health officers. The service provides curative, preventive and promotive care, especially for maternity and child healthcare requirements (Jongudomsuk *et al.*, 2015; Ministry of Public Health, 2016).

In 2012, at district level, there were 734 district/community hospitals as the main

health-care facilities covering all districts, and there were 94 regional and general hospitals (excluding Bangkok Metropolitan) serving as tertiary hospitals located in large provincial cities throughout the country (Jongudomsuk *et al.*, 2015).

In the Thai healthcare system, the distribution of healthcare professionals, especially doctors, has been a big problem. The distribution is different between Bangkok, urban and rural areas; there are more doctors in Bangkok. By 2009, the doctor to population ratio was 1:3,427 for the whole country, 1:793 for Bangkok and 1:5,161 for other provinces (Jongudomsuk *et al.*, 2015; Sakunphanit, 2015).

1.9 The situation of intimate partner violence in Thailand

1.9.1 Prevalence of intimate partner violence

In Thailand, accurate information on the prevalence of IPV against women is difficult to obtain because of the cultural norms which keep women silenced (Han & Resurreccion, 2008). Most of the available statistics come from different agencies which take data only from victims who have sought help. Therefore the true extent of IPV in Thai communities is unknown. According to a Report on Thailand Gender- Disaggregated Statistics (2008), the number of women and children seeking help for sexual violence at the shelters provided by the Ministry of Social Development and Human Security had increased; for example cases of sexual violence against women rose from nearly 4,800 to 9,600 between 2002 and 2006 (UNDP, 2008). A wide range of prevalence rates of IPV against women have been reported, from 2.9% (National Statistical Office of Thailand 2010) to 65% (Sopikul 2006). A study by the WHO (2006) found that 28% of Thai women reported experiencing both physical and sexual violence and a further 22.9% reported experiencing only physical violence by their current and former partners (Garcia-

Moreno *et al.*, 2006). These findings correspond with those of a study conducted in the seven slum communities of Bangkok, which found a prevalence of IPV against women of 27.2% (Aekplakorn & Kongsakon, 2007). Slightly lower prevalence rates were found in studies conducted among in-patient Thai women with gynaecological problems (21.1%) (Thananowan & Vongsirimas, 2014). A recent study conducted in four regions of Thailand with 1,444 Thai married or cohabiting females found that 16% of the respondents had experienced some forms of domestic violence, including psychological, physical or sexual forms, and that all forms had been committed repeatedly (Chuemchit, Chernkwanma, Rugkua, *et al.*, 2018). As has already been discussed, the variation in prevalence rates of violence might be related to the differences in the population under study, the methodology of the studies, the area of study and the definition of abuse which is used (Aekplakorn & Kongsakon, 2007).

1.9.2 The factors associated with intimate partner violence

Many research studies have begun to look for the factors affecting the rate of partner violence in Thailand. Laeheem (2014) identified five causes of partner violence between married couples in Satun province, Thailand. The first and major causes of violent behaviour between Thai Muslim married couples were jealousy and suspicion. This finding confirmed that of Sopikul (2006), who had studied aggression within marital relationships among staff in an academic institute and found that the husband's jealousy and an aggressive wife were the usual causes of violence. The second important factor in partner violence was alcohol and drug abuse (Laeheem, 2014). This finding is also congruent with those of previous studies on IPV in Thailand. These studies found that the consumption of alcohol by either victim or perpetrator partner was associated with greater IPV (Kongsakon & Pocham,

2007; Chuemchit & Pernparn, 2014). The third cause was getting married at a young age. Couples who are very young usually face problems related to their lack of maturity to deal with tough situations and stress. One participant in the study who had married at the age of seventeen stated that he and his wife usually solved problems by using force on each other. The next cause was the lack of family activities. The findings showed that couples not having the time to do activities together could lead to feelings of distance from each other and not being able to understand each other (Laeheem, 2014). The final cause identified in that study was the husband's values and belief. Most husbands believed that they must be the head of family, own all the family assets and have authority over their wife (Laeheem, 2014; Laeheem & Boonprakarn, 2017).

In addition, a study in Thailand also found that the victim's education level was a risk factor for IPV (Aekplakorn & Kongsakon, 2007). Similarly, the National Statistical Office of Thailand (2010) has stated that women with no education or only pre-primary education were at higher risk of experiencing violence from an intimate partner. Previous research has found that witnessing and experiencing family violence in childhood was directly associated with a higher risk of re-victimisation and was indirectly associated with IPV perpetration in adulthood (Kerley *et al.*, 2010; Jirapramukpitak, Harpham & Prince, 2011; Laeheem & Boonprakarn, 2014). This finding corresponds with the result of a study by Laeheem and Boonprakarn (2015) with Thai Muslim couples that married couples who were exposed to their own parents' quarrels regularly had a higher probability of having IPV.

1.9.3 Thai criminal law on intimate partner violence

The Thai 1997 Constitution, section 276 of the Criminal Law Code, states that a

man shall be punished if he has sexual intercourse with a woman who is not his wife against her will (Penal Code Amendment Act (No. 16) B.E. 2546 2003). This implies that under Thai law, a husband who forces sex on his wife would not be recognised as having committed a crime and that the wife would not be legally protected against sexual abuse by her partner. Later, in 2007, the Domestic Violence Victim Protection Act, B.E. 2550 was introduced. The Act contained eighteen sections which related to victims, perpetrators and government officers. The provision of section 276 of the Penal Code Amendment Act (No. 16) B.E. 2546 was also repealed and replaced. The new version of section 276 stated that anyone who commits sexual intercourse with an other person against the latter's will by threatening in whatever manner shall be punished. However, when the offence has been committed between couples and they still wish to live together as husband and wife, the court will deliver a lesser punishment than that required by the law. In a case in which they no longer wish to live together as husband and wife, they must notify the court for further entry of a divorce claim (Chuencheewin, 2017).

1.10 Intimate partner violence during pregnancy in Thailand

1.10.1 Prevalence of intimate partner violence during pregnancy

The prevalence of IPV during pregnancy in Thailand ranges from 1.9% to 34%. This great variation in reported prevalence rates could be due to several factors, including differing definitions of IPV, different samples types and populations studied, and the type of questions asked. For example, in a study conducted by Waithayawongkorn *et al*. (2009) using the Abuse Assessment Screen (AAS) to detect IPV during pregnancy, the prevalence of IPV was 34% compared to a figure of 11.7% from the study by Boonnate *et al*. (2015) which used the Index Spousal Abuse (ISA).

These prevalence rates, therefore, should be viewed with caution. Regarding types of IPV, 1.9% to 15.9% of Thai pregnant women reported physical violence and 4.5% to 10.5% reported sexual violence. The prevalence of non-physical violence, including emotional and economic violence, ranged from 3% to 10.8%. The prevalence of both physical and non-physical violence ranged from 1.9% to 34% (Boonnate *et al*., 2015; Thananowan *et al*., 2012; Thananowan & Heidrich, 2008; Waithayawongkorn *et al*., 2009; Thananowan, 2008; Thananowan & Leelacharas, 2011). The face and head (86%) were the most common locations of injury from IPV against pregnant women, followed by arm or shoulder (30%) and breast (22%), whereas the abdomen (8%) was an infrequent location of injury (Thananowan & Heidrich, 2008; Waithayawongkorn, Ratinthorn & Serisathien, 2009). The husband has been identified as the most common (78.3%) perpetrator, followed by boyfriends and relatives of the victims (Thananowan and Heidrich, 2008; Waithayawongkorn, Ratinthorn and Serisathien, 2009). The above authors used the terms 'domestic violence' and 'intimate partner violence' synonymously and described the terms as a pattern of abusive behaviour by one individual over another person they have a relationship with. Therefore, other relatives of the victims were also identified as a perpetrator in these studies. However, in this thesis, IPV only refers to physical, sexual, or psychological harm to pregnant woman by a current or former partner or husband. The most common acts of physical violence reported by abused pregnant women were hitting the head, slapping the face, pushing and pulling (Thananowan & Heidrich, 2008; Waithayawongkorn *et al.*, 2009). Regarding participants' relationship with their abusive partners, most participants (54.8%) were cohabiting, followed by living with their partners as a couple (40.4%) and not living in a couple (4.8%) (Boonnate *et al.*, 2015). This result is relatively

inconsistent with that of a previous study by Waithayawongkorn and colleagues (2009) that most abused pregnant women were divorced or separated.

1.10.2 Risk factors for intimate partner violence

As previously stated, Thananowan and Leelacharas (2011) found that lower levels of women's education was significantly associated with physical abuse. Other factors included the length of the marriage, which was significantly associated with emotional violence. Also a greater number of multiple pregnancies or abortions was significantly associated with sexual abuse (Thananowan & Leelacharas, 2011). There is evidence from many studies that low socio-economic status, unemployment of women, and an unwanted or unplanned pregnancy were common characteristics of abused pregnant women (Thananowan, 2008; Waithayawongkorn *et al.*, 2009; Thananowan & Leelacharas, 2011). A connection between relationship abuse and unintended pregnancy as a consequence of being subjected to forced sex or unprotected sex was found by Thananowan and Hendrich (2008). Additionally, young age, marital instability (divorce or separation), alcohol and drug use, experiencing abuse as a child, low levels of education and living with others were identified as risk factors of IPV during pregnancy in Thailand (Thananowan & Heidrich, 2008; Thananowan & Leelacharas, 2011; Waithayawongkorn *et al.*, 2009). One study found a higher rate of substance abuse by both abused pregnant women and their husbands compared with couples without IPV. This can be explained by the fact that substance abuse among couples experiencing IPV might be related to stressful situations or financial difficulties (Thananowan & Leelacharas, 2011). However, these findings were not consistent with those made by Nareerat *et al.* (2015) who found that young age and the partner's alcohol consumption were not significant predictors of IPV during pregnancy.

1.10.3 Barriers to intimate partner violence help seeking

A range of factors impede Thai women's help-seeking behaviours, including acceptance of IPV, lack of access to resources and being unwilling to disclose it to others who are not relatives or close friends (Saito *et al.*, 2009; Waithayawongkorn *et al.*, 2009). Waithayawongkorn *et al*. (2009) explored the help-seeking behaviours of Thai pregnant women and found that thoughts of violence was a common phenomenon and not having enough resources to help and not wanting to share stories of violence with others were abused women's other reasons for not seeking help. Half of the participants who were unwilling to disclose an IPV story believed that IPV is a private or family matter and that it is a common occurrence among couples and that they can deal with the issue on their own. Close friends and colleagues were the most commonly reported informal sources of support for the participants, followed by their relatives. The participants also stated that they might disclose IPV to HCPs if the violence could directly harm their unborn baby or their own life (Waithayawongkorn *et al.*, 2009). Peltzer and Pengpid (2017) assessed different types and severities of IPV in relation to symptoms of depression and suicidal behaviour among Thai women and found that only 3.5% of IPV victims sought assistance in regard to the IPV from healthcare services, 4.3% from social services, 8.6% from the police, and 12.8% of them from a religious leader. Saito *et al*. (2009) used in-depth interviews to explore the barriers to Thai women seeking help and found that the barriers were the neglect of women's right by the police and community leaders, women's attributions of blame towards a victim, their feeling of powerlessness and their lack of knowledge and information about the available resources. One participant stated that she had reported it to the police on one occasion but they did not help; they merely suggested that she should compromise and be

reconciled with the perpetrator. So one factor which influenced that particular woman to continue to live with her partner was the failure of her attempt to receive help from a support service. Furthermore, data from a survey of Thai women's experiences of and responses to domestic violence showed that most survivors of domestic violence chose not to speak to outsiders because of the feeling of shame or fear, or concern about unexpected results. The researchers stated that this was because in Thai society, domestic violence or IPV is still considered a private issue and an internal family matter (Chuemchit, Chernkwanma, Somrongthong, *et al.*, 2018).

1.11 The response of healthcare professionals to intimate partner violence in Thailand

In response to IPV violence, the Thai government has launched various policies and initiated many programmes and centres designed to prevent and respond to domestic violence in Thailand. The Ministry of Social Development and Human Security is responsible for providing an immediate service for victims, managing the practice of temporary protective orders, collecting data and coordinating with relevant agencies (Department of International Organizations, 2011). In 2002, One-Stop Crisis Centres (OSCCs), managed under the Ministry of Public Health (MOPH) and other agencies, were established in Thailand. The goal of that project was to offer a range of services to support women and children who were experiencing violence. A pilot project was implemented in Khonkaen hospital in 1999. In 2001, the success of the project encouraged the MOPH to launch the initiative in nearly twenty hospitals across the country (Grisurapong, 2004). These centres had a multi-disciplinary team providing crucial assistance for women and children who were experiencing domestic abuse (Office of Women's Affairs and Family

Development, 2008). In 2005, under the Department of Medicine, the Department of Defence and the Police Hospital, there were 70 OSCCs across the country. Even so, although a real effort had been made to provide care for victims of violence, the results of the OSCCs were still not good enough. Possible reasons for this apparent lack of success could be that the data about existing OSCCs is not widely known or accessible.

1.12 Maternal health care in Thailand

Antenatal care (ANC) is a healthcare service which provides women and their families with appropriate information about healthy pregnancy, safe delivery and postnatal recovery, and with help to ensure the health of both mother and baby (Iino, Sillabutra & Chompikul, 2011; Lincetto *et al.*, 2013). ANC helps to reduce maternal and neonatal mortality and morbidity rates directly by giving pregnant women the appropriate treatment related to diseases, and indirectly by offering early detection of pregnancy complications (Iino *et al.*, 2011).

In Thailand, ANC services are provided free of charge in most public and government- run health services and hospitals. As a result, 98% of pregnant women have at least one ANC attendance and 93.4% have at least four attendances (Iino *et al.*, 2011). Most ANC is generally provided by medical doctors, nurses and midwives in a hospital or health centre. Pregnant women who access ANC in Thailand receive routine physical examinations, routine blood tests, voluntary counselling and testing services for HIV and thalassemia, tetanus toxoid vaccinations, health education, and routine iron and folic acid supplements. These services are recommended by WHO (WHO, 2002). WHO guidelines for standard ANC in Thailand are that ANC visiting is as follows; the first visit is as soon as possible but not later than twelve

weeks of gestation, the second visit should be between 16 and 20 weeks, the third visit is between 24 and 28 weeks, the fourth visit is between 30 and 34 weeks and the final visit should be between 36 and 40 weeks of gestation. Pregnant women with a high risk of complications should have antenatal appointments every two weeks throughout their pregnancy (Pooltananan & Luengratsameerung, 2019).

According to a new WHO antenatal care model, all pregnant women generally fall into two groups determined by a classification form which they complete at their first visit. This form is used to decide which women will follow the basic component of the new WHO model and which women will need special care. The form contains eighteen 'yes/no' questions which cover the woman's obstetric history, current pregnancy and general medical conditions (*see* Appendix 1.1). An example of the questions is 'Have you had a previous stillbirth or neonatal loss?' Women who answer 'no' to all of the eighteen questions are eligible for the basic component, whereas women who answer 'yes' to any of the questions will receive special care to ensure the best possible outcomes and will not be eligible for the basic component (WHO, 2002). The form does not include any questions about IPV during pregnancy and questions designed to identify IPV during pregnancy have never been asked in Thailand. However, there is some evidence to suggest that Thai HCPs should be aware of the issue and should screen pregnant women for IPV (Boonnate *et al*., 2015; Thananowan *et al*., 2012; Thananowan & Heidrich, 2008; Saito *et al*., 2009; 2012; Waithayawongkorn *et al*., 2009; Thananowan, 2008; Thananowan & Leelacharas, 2011; Chuemchit *et al*., 2018).

It is very clear from the discussion so far that IPV is a significant public health problem with negative health consequences for victims, especially pregnant women. IPV during pregnancy can have detrimental effects for both mother and unborn child.

Although attempts are being made all over the world to address this problem, the results are still not satisfactory because so many different factors are involved. In Thailand, this problem has been quite significant and the prevalence of IPV during pregnancy in Thailand is believed to range from 1.9% to 34%. However, the identification of and responses to IPV by HCPs are not satisfactory because of many related factors, particularly because the traditional Thai culture means that most Thais believe that IPV is a family issue and therefore it remains private. There have been very few previous studies of HCPs' perception of their role and experience of identifying and responding to IPV or of their knowledge, attitudes and practice in Thailand. It is therefore anticipated that the knowledge acquired from this current study will provide new insights into HCPs' perceptions of their role and experiences and will identify useful ways for improving HCPs' clinical practice.

1.13 Research aim and objective

1.13.1 Research aim

The overall aim of this study is to explore HCPs' perceptions of their experience of and their role in identifying and responding to IPV, and to assess their knowledge, attitudes and practice towards IPV during pregnancy.

1.13.2 Research objectives

In order to achieve this aim, the study seeks:

1. to assess HCPs' knowledge, attitudes and practice regarding IPV identification and response among pregnant women by using a questionnaire.

2. To explore HCPs' perception of their role and their experiences of

identifying and responding to IPV during pregnancy through semi-structured interviews.

3. By the two methods set out above, to identify the barriers and facilitators perceived by HCPs in identifying and responding to IPV among pregnant women.

To achieve the quantitative and qualitative nature of these three research objectives, a mixed-method research design was employed. The first phase of the study utilised quantitative methods to assess HCPs' knowledge, attitudes and practice. The subsequent phase involved a qualitative method to gain a deeper understanding of the perceptions and experiences of HCPs, including their perceived barriers and facilitators in regard to the issue. The most appropriate way to start to address the aim and objectives set out above was by generating and collecting the relevant data. The aim and objectives will be explored through a literature review in the next chapter with a focus on issues regarding the perception of their role, the experience, knowledge, attitudes and clinical practice, including beliefs about the barriers and facilitators, of HCPs regarding the identification of and responses to IPV during pregnancy. In the review in Chapter 2, the relevant literature will be summarised and discussed and research gaps will be identified.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter describes the literature search and presents a review of the existing literature on healthcare professionals' roles and experiences in regard to identifying and responding to pregnant women who are abused. This review enabled me to find out what research has already been done and to identify gaps in the existing literature. The term 'healthcare professional' (HCP) is used here to refer to an individual who provides health and social services care to people in a systematic way (WHO, 2013b). In this review, the term refers equally to nurses, midwives, doctors, obstetricians and gynaecologists. These HCPs were selected because they are most likely to be the first point of contact for and to work face-to-face with pregnant women. The HCPs' perceptions of their roles and experiences explored in this review include the identification, clinical skills, documentation and provision of referrals which are recommended by the WHO for responding to IPV and sexual violence against women (WHO, 2013b)

2.2 The aim of the review

In recent years, IPV during pregnancy and the HCP role of identifying and responding to it have gained recognition as a challenging professional issue. HCPs are required to contribute to identification, support, documentation and appropriate referral to other services (WHO, 2013b). Very little research has, however, been conducted to aggregate the available evidence in order to understand the perspectives of HCPs about their roles and their experiences with regard to the identification and management of IPV. The aim of carrying out this review is to search and review

empirical articles from around the world, including research in Thailand, in order to:

- Explore HCPs' perceptions of their role and their experiences of identifying and responding to IPV among pregnant women;
- Identify and critically evaluate existing questionnaire responses which assess HCPs' knowledge, attitudes and practice regarding IPV against pregnant women;
- Identify what is known about HCPs' role and experiences related to IPV during pregnancy in Thailand and highlight any gaps in the existing research literature.

2.3 Introduction to the review

Various systematic approaches available for reviewing published literature were considered for this review; these included the commonly used systematic review and scoping review techniques. I chose to undertake a scoping review as the best method rather than conducting a full systematic review of the relevant field as it would enable me to map more effectively HCPs' perceptions of their roles and their experiences of identifying and responding to IPV during pregnancy. A scoping review was regarded an appropriate method to adopt for this study because it helps a researcher to explore a broadly covered topic and to comprehensively and systematically map the literature and identify the key concepts, theories, evidence and research gaps (Halas *et al*. 2014; Grant & Booth 2009). Unlike a systematic review, a scoping method might typically address broader topics where study designs might be various and different, it is less likely to seek to address very specific research questions and does not require any quality assessment of the included studies

(Arksey and O'Malley, 2005). To strengthen the rigour of this review, the five-step methodological approach devised by Arksey and O'Malley (2005) was adopted as a framework to guide the review. The five-steps approach is discussed below.

2.4 Method

2.4.1 Stage 1: Identify the research question

This stage involves identifying the initial research question(s) to inform subsequent stages and to establish an effective search strategy (Arskey & O'Malley, 2005). Formulating the question is an important step in the review because without it, searching would be difficult and time-consuming. Clarity in the review question is useful to develop the protocol, to facilitate the search for relevant evidence and to provide a roadmap for the next stage of the scoping review (Joanna Briggs Institute, 2015). In this current review, the PEO format was adopted to guide the literature search and to construct a clear and meaningful question for the review. The PEO mnemonic stands for Population, Exposure and Outcome. This format is usually used to identify key concepts of the review question, to develop search terms and to determine inclusion and exclusion criteria (Bettany-Saltikov, 2012). The PEO used to identify the review question is presented in Table 2.1.

Table 2. 1 Research question broken down using the PEO format

Research question: What are HCPs' perceptions of their roles and experiences of identifying and responding to IPV among pregnant women?	
PEO format	
P- Population	Healthcare professionals (nurses, midwives, doctors, obstetricians and gynaecologists)
E- Exposure	Intimate partner violence during pregnancy
O- Outcome	Perception of role and experience

2.4.2 Stage 2: Identifying relevant studies

Literature Search Strategy

Several steps were performed first in order to gain relevant information in the form of published articles and studies available from healthcare databases. Initially, the grey literature was taken into consideration to extend this scoping review. The grey literature, including theses and dissertations, research and committee reports, government reports, conference papers, and ongoing research studies, was identified using internet searches. In addition, as suggested by Arksey and O'Malley (2005), reference list searches and hand-searching of key journals were conducted to ensure that all relevant studies were included in this review.

Parallel literature searches of three databases, PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PsycINFO, were undertaken for the period 2001-2016. These databases were selected for their quality and depth of coverage of the professional literature of nursing, allied health, biomedicine and healthcare, psychology, and behavioural and social science. These databases

are also useful for searching for dissertations, theses and conference proceedings (Bettany-Saltikov, 2012). Search terms relating to the review question were devised. To ensure an effective search, use was made of the Boolean operators 'AND' and 'OR', and truncation ($ or *). The synonyms of the terms for all PEO components of the research question are set out in Appendix 2.1. Full details of the search strategy and the results of each database are shown in Appendix 2.2. The following terms were used in this review:

(healthcare provider OR healthcare worker OR nurs* OR midwi* OR physician OR doctor) AND (intimate partner violence OR domestic violence OR partner abuse OR spousal violence) AND (pregnan* OR pregnant woman OR prenatal care OR antenatal care) AND (perception OR role OR experience OR perspective).

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria help to keep the review focused, assist the researcher to identify relevant research and provide clear information about the scope of the study (Aveyard, 2014). Studies were considered eligible for inclusion if they included healthcare professionals who worked in healthcare settings, explored at least one aspect of their role, experience and perspective about the management, identification or response to IPV in pregnancy, were peer reviewed, and were published in English or Thai language between January 2001 and November 2016. Accordingly, to ensure only peer reviewed articles which have undergone rigorous scrutiny were utilised, the grey literature was then excluded.

For finding information in Thai, I searched for information using Thai Digital

Collection (TDC)[1] and Thai Journal Online (ThaiJO).[2] TDC is a search database service in an electronic version in Thailand which accesses theses and studies from universities across the country. ThaiJO is an electronic journal database centre in Thailand which gives access to cumulative data in academic journals which were published in Thailand in all academic programmes, covering science, technology, the humanities and the social sciences. These two databases were selected because they cover all the research conducted in Thailand and they are accessible.

A follow-up search using the same steps was undertaken with an extended limit of publication date from December 2016 to April 2019 in order to identify any new research findings which might have been published after the period of the previous search to November 2016. A summary of the inclusion and exclusion criteria for this review is provided in Table 2.2.

Usually, studies published in the last five to ten years are generally accepted in a literature review because of the 'fast-changing' nature of health care (Coughlan *et al*., 2013), but in this current review, studies published in the last fifteen years were included because during that time, HCPs' awareness in terms of responding to IPV has grown. Consequently, guidelines for IPV screening had been published in several countries during this time period (Salmon *et al*., 2013). Moreover, included articles were restricted to articles in peer-reviewed journals which had undergone rigorous scrutiny as it is known that the quality of such articles is acceptable. Therefore, some grey literature such as unpublished papers and dissertation abstracts were excluded. Studies not published in English or Thai were excluded because translation would have been time-consuming and costly.

[1] TDC – ThaiLIS Digital Collection (https://tdc.thailis.or.th
[2] Thai Journals Online (https://www.tci-thaijo.org)

Table 2. 2 Inclusion and exclusion criteria

Inclusion criteria	- Studies which focused on HCPs' role, experience or perception involving the management, identification or response to IPV - Studies involving IPV against pregnant women - Study designs which were qualitative, quantitative or mixed-method - Studies published in a peer-reviewed journal - Studies published between January 2001 and the present (2019) - Studies published in English or Thai
Exclusion criteria	- Studies which focused on aspects other than the roles, experiences, perceptions, identification or response to IPV of HCPs - Studies involving other violence than IPV against pregnant women - Studies published in other languages

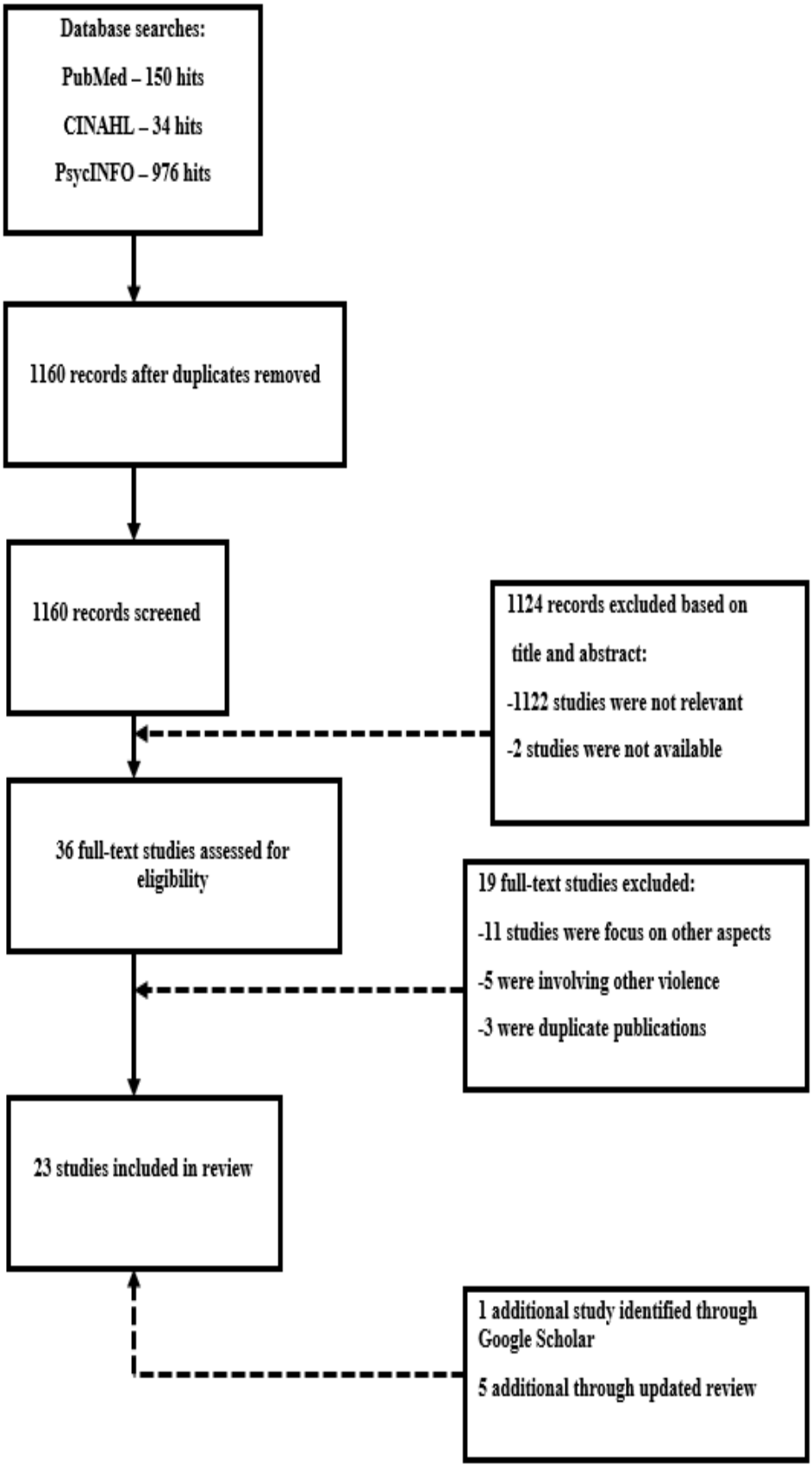
2.4.3 Stage 3: Study Selection

The study selection process of this review was designed in two separate stages. First, titles and abstracts were reviewed to determine eligibility based on the defined inclusion and exclusion criteria. In the second stage, a full-text review of the studies included from the first stage was conducted and they were then reassessed using the same inclusion and exclusion criteria. All articles meeting the criteria were included for data extraction. The literature search produced a total of 1,160 articles. After completing the initial screen for eligible articles and excluding duplicates across the databases, 36 potentially eligible articles remained. Of these, nineteen studies were excluded because they were not relevant to the research question; eleven

studies were excluded because they had focused on other aspects than the role, experience, perception, identification or response to IPV. For example, one study was excluded because it was conducted to compare the past and current abuse experiences of HCPs and pregnant women. Five studies involved violence other than IPV against pregnant women, and three studies were excluded because they were a duplicate contribution of the same project. A total of seventeen studies remained and these were selected for further review. However, none of these studies had been conducted in Thailand. No studies of HCPs' knowledge, attitude, practice, perception of their role or their experiences of identifying and responding to IPV during pregnancy were found in either of the two Thai databases. The searches were therefore repeated in Google Scholar and one study conducted in the Thai language met the inclusion criteria. Eighteen studies were therefore finally included in this review (*see* Table 2.3). Details of the selection process are shown in the flowchart of study inclusion and exclusion as Figure 2.1.

For the updated review, the search review produced the following results: PubMed-N= 28 results, CINAHL-N = 29 results, and PsycINFO-N = 69 results, a total of N = 126 results. These articles were reviewed and selected using the same steps of the scoping review following Arksey and O'Malley's methodological framework, and five studies were subsequently included (Githui *et al*., 2018; O'Reilly & Peters 2018; McCauley *et al*., 2017; Henriksen *et al*., 2017; O'Shea *et al*., 2016).

Figure 2. 1 Flowchart of the study selection process



2.4.4 Stage 4: Charting the data

This stage involved charting the relevant information from the included studies based on the focus of the scoping question. Following Arskey and O'Malley's (2005) suggestion, the process of extracting the relevant information from the selected studies comprised various stages. These stages involved synthesising and interpreting the data by sifting, sorting and charting the material according to key issues and themes. Arksey and O'Malley (2005) suggest that relevant data for extraction from individual studies should be a mixture of both general information about the study and specific information related to the review question. In this current review, a charting form was devised to summarise all the included studies in a common format in order to facilitate the synthesis and coherent presentation of data, information related to author(s), year of publication, country of origin, aims, study population and sample size, method, intervention type, outcomes and measures of the outcomes, and key findings which related to the scoping review question. A completed example of the charting form used can be seen in Appendix 2.3.

Critical review

Critical appraisal is the systematic process of examining and interpreting the validity of research methodology and findings (Booth *et al*., 2012). For the scoping review, in which the aim is to identify, retrieve and summarise literature relevant to a topic as well as to identify gaps in the literature, the function of assessing the evidence base is to identify the key concepts underpinning a research area and the main sources and types of evidence available (Weeks & Strudsholm, 2008). There is no formal quality assessment so each included study was assessed for its methodological quality and the significance of the results. For qualitative studies, the Critical Appraisal Skill

Programme (CASP) Qualitative Checklist was used for appraising the research. For quantitative studies, the CASP Cohort Study Checklist was used. For appraising a mixed-method study, the Mixed Methods Appraisal Tool (MMAT)-Version 2011 (Pluye *et al*., 2011) was used (*see* Appendix 2.4).

2.4.5 Stage 5: Collating, summarising and reporting the results

Results

The results of the scoping review are presented here in the form of a narrative summary. The perceptions, experiences, clinical practice, barriers to and facilitators of HCPs identifying and responding to IPV during pregnancy were the main focus of the analysis. The results set out below are organised into four main areas. First, the description of the studies, which is followed by the themes from the studies, the HCPs' perceptions of their role, the experience of HCPs, and the barriers and facilitators which they faced in identifying and responding to IPV during pregnancy. This is followed by the identification and evaluation of the existing questionnaire, and an evaluation of the studies.

Description of the studies: setting, population and design

Table 2.3 summarises the purpose of each study and Table 2.4 summarises the purpose of the additional studies. There were eighteen articles which had explored HCPs' roles or experiences in identifying or responding to IPV among pregnant women. After the updated review, there were 23 included articles. Six studies were conducted in the US (Furniss *et al*., 2007; Bunn *et al*., 2009; Taylor *et al*., 2007; Hindin 2006; Kaye *et al*., 2005; Edin & Högberg, 2002). Eight studies were conducted in Europe, in Northern Ireland, Belgium, Sweden, Italy and Norway (Stenson et al., 2005; Roelens *et al.*, 2006; Jeanjot *et al.*, 2008; Lazenbatt *et al.*, 2009; Finnbogadóttir & Dykes, 2012; Mauri *et al.*, 2015; O'Shea *et al.*, 2016; Henriksen

et al., 2017). Three studies were conducted in Oceania, including Australia and New Zealand (Lauti & Miller, 2008; Eustace *et al.*, 2016; O'Reilly & Peters, 2018). Three studies were conducted in Africa (Zimbabwe, Uganda and Kenya) (Ortiz & Ford, 2005; Shamu *et al.*, 2013; Githui *et al.*, 2018). Two studies were conducted in Asia, in Thailand and Pakistan (Deoisres & Peomsook, 2013; McCauley *et al.*, 2017). One study was conducted in the Caribbean island of Jamaica (Pitter, 2016). Of the selected studies, eleven were qualitative, ten were quantitative, and two combined quantitative and qualitative methods. Of the final 23 studies included in this scoping review, only one study was conducted in the UK (Northern Ireland) (Lazenbatt, Taylor and Cree, 2009). In the UK, while theoretical and policy interventions including guidelines on the care of women experiencing abuse have led to an increase in IPV studies, most of these studies have not focused on pregnant women and in those that included pregnant women the topic was virtually absent from the HCPs' perceptions of their role and experience regarding IPV during pregnancy. Most studies in the UK have focused on, for instance, evaluation of the Pregnancy Domestic Violence Programme for routine enquiry for domestic abuse, women's views and experiences of antenatal enquiry for IPV during pregnancy, caring for women who have been abused, interventions to reduce IPV during pregnancy and IPV in women living with HIV (Salmon *et al.*, 2006; Jackson and Fraser, 2009; Baird and Salmon, 2012; Leneghan *et al.*, 2012; Ramsay *et al.*, 2012; Baird, Salmon and White, 2013; Salmon, Baird and White, 2013; Dhairyawan *et al.*, 2013; Evans and Feder, 2016; Gregory *et al.*, 2017).

The most frequently used methods of data collection were questionnaire (39%), followed by interview (22%), focus group discussion (13%), both questionnaire and interview (13%), both focus group discussion and interview (9%) and mixed

focus group discussion, interview and observation methods (4%). Regarding the participants, in thirteen studies (57%), the participants were midwives and/or nurses. In five studies (21.5%), the participants were several types of healthcare professional, such as midwife, obstetrician, gynaecologist, social worker, nurse, psychiatrist or physician, and in the remaining five (21.5%) the participants were obstetricians-gynaecologists and/or GPs. All of the studies recruited participants through hospitals, antenatal care, health care centres and the College of Midwives, with sample sizes ranging from six to 983 participants. Table 2.5 shows a summary of the geographical settings, methods, participants and methods of collecting data, and Table 2.6 gives a summary of the additional studies.

Table 2. 3 Summary of the purpose of each study

ID No.	Authors/year	Purpose
1	Lauti & Miller (2008)	To investigate the opinions of midwives and obstetricians regarding their role in the identification and management of family violence
2	Finnbogadottir & Dykes (2012)	To explore midwives' awareness of and clinical experience regarding domestic violence of pregnant women
3	Stenson *et al.* (2005)	To describe midwives' thoughts and feelings regarding the task, obstacles and possible solutions and aids in routine questioning
4	Jeanjot *et al.* (2008)	To evaluate healthcare providers' attitudes toward domestic violence by assessing their habits and barriers in regard to screening for domestic violence
5	Eustace *et al.* (2016)	To identify midwives' experiences of routine enquiry, perceptions of facilitators and barriers, and suggested strategies to improve practice
6	Pitter (2016)	To explore midwives' knowledge and attitudes when encountering abused women in an antenatal clinic
7	Mauri *et al.* (2015)	To investigate midwives' knowledge and clinical experiences of domestic violence during pregnancy
8	Furniss *et al.* (2007)	To explore perinatal and emergency room nurses' perceptions of barriers to screening for IPV
9	Shamu *et al.* (2013)	To explore the perceptions and experiences of nurse midwives regarding IPV among pregnant women
10	Roelens *et al.* (2009)	To explore the role of the healthcare worker in dealing with IPV during pregnancy
11	Bunn *et al.* (2009)	To investigate physician's views on domestic violence screening during pregnancy
12	Lazenbatt *et al.* (2009)	To evaluate the views of midwives who work in hospital and community-based settings on the prevalence of domestic violence, their role in addressing domestic violence, the acceptability of routine enquiry, and barriers encountered in screening violence in pregnancy To evaluate differences in their response to domestic violence between community and hospital midwives
13	Taylor *et al.* (2007)	To identity physicians' perceptions of the importance of screening, barriers to effective prenatal screening for substance use and violence
14	Hindin (2006)	To explore the IPV-screening practices of certified nurse midwives
15	Kaye *et al.* (2005)	To explore the knowledge, attitudes and practices of health workers towards domestic violence prevention and management during pregnancy
16	Ortiz & Ford (2005)	To identify the existence of staff barriers and the frequency of partner violence screening
17	Edin & Hogberg (2002)	To assess the experience, knowledge, attitudes and routines regarding violence against pregnant women among midwives working at antenatal clinics
18	Deoisres & Peomsook (2013)	To explore nurses' attitudes and factors associated with nurses' attitudes towards the identification and management of violence during pregnancy

Table 2. 4 Summary of the purpose of the additional studies

ID No.	Authors/year	Purpose
19	O'Shea *et al.* (2016)	To assess GPs' awareness level of the prevalence and their current practice regarding domestic violence during pregnancy To identify the knowledge gaps, attitudes and barriers of GPs towards identifying domestic violence during pregnancy
20	Henriksen *et al.* (2017)	To gain an in-depth understanding of midwives' experiences with routine IPV screening during pregnancy
21	McCauley *et al.* (2017)	To explore the knowledge and perceptions of doctors working in ANC and postnatal care regarding domestic violence To investigate the barriers and facilitators of the routine screening of domestic violence from the perspective of policy makers
22	O'Reilly & Peters (2018)	To identify the domestic violence screening practices of community-based healthcare providers among pregnant and postpartum women
23	Githui *et al.* (2018)	To explore the barriers to IPV screening for pregnant women

Table 2. 5 Summary of the geographical settings, designs, participants and methods of collecting data

ID No.	Authors/year	Design	Setting and geographical location	Participants	Data collection
1	Lauti & Miller (2008)	Qualitative	Dunedin Public Hospital, Dunedin, New Zealand	28 midwives and 11 obstetricians	Focus groups and semi-structured interviews
2	Finnbogadottir & Dykes (2012)	Qualitative	Southern Sweden	16 midwives	Focus group interviews
3	Stenson *et al.* (2005)	Qualitative	Antenatal care in a city in south-central Sweden	21 midwives	Focus group discussions
4	Jeanjot *et al*. (2008)	Quantitative	Brussels, Belgium	15 gynaecologists, 27 midwives, 10 social workers, 3 neonatal nurses and 1 psychiatrist	Questionnaires and interviews
5	Eustace *et al*. (2016)	Qualitative	Australia	21 midwives	In-depth telephone interviews
6	Pitter (2016)	Qualitative	Antenatal clinic of a hospital in Kingston, Jamaica	6 practising midwives	Focus group discussion
7	Mauri *et al*. (2015)	Qualitative	Northern Italy	15 hospital and community midwives	Semi-structured interviews
8	Furniss *et al*. (2007)	Quantitative	United States	385 nurses	Questionnaires
9	Shamu *et al*. (2013)	Qualitative	Six public antenatal care in Harare, Zimbabwe	6 midwives for in-depth interviews, 64 women for focus group discussions	In-depth interviews, focus group discussions and observation
10	Roelens *et al*. (2009)	Quantitative	East Flanders, Belgium	249 board-certified obstetrician-gynaecologists	Questionnaires
11	Bunn *et al*. (2009)	Quantitative	United States	33 physicians with obstetric privileges and 25 obstetricians and gynaecologists	A six-item written survey
12	Lazenbatt *et al*. (2009)	Quantitative	Northern Ireland	983 hospital and community midwives	A postal survey questionnaires
13	Taylor *et al*. (2007)	Qualitative	Washington State, US.	8 physicians and 28 physicians who practise obstetric care	Telephone interviews and focus groups
14	Hindin (2006)	Qualitative	United States	8 certified nurse-midwives	In-depth interviews

ID No.	Authors/year	Design	Setting and geographical location	Participants	Data collection
15	Kaye *et al*. (2005)	Mixed	The Obstetrics and Gynaecology department, Mulago hospital, Uganda	48 health workers (16 doctors, 15 midwives, 10 nurse-midwives and 7 undergraduate medical students)	Questionnaires and in-depth interviews
16	Ortiz & Ford (2005)	Quantitative	United States Army Community Hospital	74 healthcare providers (55 physician and 19 advanced practice nurses)	A 26-item questionnaire
17	Edin & Hogberg (2002)	Mixed	Antenatal clinics in the country of Vasterbotten, northern Sweden	5 midwives for qualitative and 51 midwives for quantitative study	Interview and questionnaires
18	Deoisres & Peomsook (2013)	Quantitative	Thailand	230 obstetric nurses	Questionnaires

Table 2. 6 Summary of geographic settings, methods, participants and methods of collecting data of the additional studies

ID No.	Authors/year	Design	Setting and geographical location	Participants	Data collection
19	O'Shea *et al*. (2016)	Quantitative	Republic of Ireland	530 GPs	Postal questionnaire
20	Henriksen *et al*. (2017)	Qualitative	Norway	8 midwives	Semi-structured interviews
21	McCauley *et al*. (2017)	Qualitative	Islamabad, Pakistan	25 doctors working in public and private hospitals and 5 policy makers	Semi-structured interviews
22	O'Reilly & Peters (2018)	Quantitative	Australia	48 community HCPs, including 33 general practitioners (GPs), 2 private practice midwives (PPMs), 10 registered nurses (RNs); and 3 did not indicate profession	Questionnaires with twenty fixed-choice questions
23	Githui *et al*. (2018)	Quantitative	Kenya	125 nurses	Questionnaire

HCPs' perceptions of their role in identifying and responding to IPV during pregnancy

The review demonstrated that HCPs had the following perceptions of their roles regarding IPV during pregnancy: that it was too difficult to identify and to deal with, that they had an important role to identify and respond to it, that it was not a nursing role to identify it, and the need for collaboration. The review found that there were many different perspectives on HCPs' role in the identification of abuse during pregnancy. Participants in several studies said that it was too difficult for them to identify pregnant women who were subject to IPV because of the complexity of the IPV issue, the lack of a clear process, and insufficient knowledge and training (Stenson *et al.*, 2005; Lauti & Miller, 2008; Finnbogadóttir & Dykes, 2012; Eustace *et al.*, 2016; Henriksen *et al.*, 2017). The issue of the difficulty was described by the participants in one study as potentially opening a can of worms because they did not know how to manage it afterwards. They stated that IPV is a very complex issue and that it is not as easy as giving medicine (Lauti & Miller 2008).

HCP participants in several studies considered the identification of IPV among pregnant women to be an important part of their role. These HCPs believed that they were a pregnant woman's first and frequent contact, and they were also concerned about the potential negative health consequences resulting from violence (Barnett, 2005; Stenson *et al.*, 2005; Taylor *et al.*, 2007; Lauti & Miller, 2008; Lazenbatt *et al.*, 2009; Deoisres & Peomsook, 2013; Pitter, 2016). Lauti and Miller (2008) found that obstetricians in their study had concerns about their role in IPV but also felt that midwives had a more important role in helping victims of IPV than other HCPs. This was because a midwife has the time and opportunity to establish a trusting

relationship with pregnant women.

On the other hand, one study revealed that nurses did not believe that IPV identification was part of their role (Shamu *et al*., 2014) and in another study the participants did not perceive IPV during pregnancy as a major cause of ill health or a major public health issue (Kaye *et al*., 2005). In two studies, the participants displayed a negative attitude of HCPs towards the survivors of domestic violence: they mentioned that sometimes women provoke their partner into hitting them and that the survivors are the ones to blame (Kaye *et al*., 2005; Deoisres & Peomsook 2013). O'Reilly and Peters (2018) reported that some participants in their study believed that pregnant women had already been asked about IPV by other HCPs.

Responding to abuse

Two main themes were identified when HCPs' perception of their role in responding to IPV during pregnancy were explored. The first theme was to provide personal support or to act as an advocate for pregnant women and the unborn baby. The second theme was collaboration with a support network (Lauti & Miller 2008). In this review, there are two studies which showed the perception of participants about their role in responding to IPV during pregnancy. Midwives in these studies describe that their role in caring for abused women, including listening to abused women's stories, giving them emotional support, informing them about appropriate resources, providing available contacts for additional help and observing subsequent development (Stenson *et al*., 2005; Mauri *et al*., 2015). Although most HCPs believed that they played an important role in responding to abused women, the majority of them emphasised the fact that they could not deal with the situation all by themselves. An interdisciplinary approach was therefore perceived as an essential

part of responding (Mauri *et al*., 2015).

Experiences of HCPs in identifying and responding to IPV during pregnancy

From reviewing the studies, it was clear that HCPs involved in the screening of pregnant women fell into three categories: those who always screened for IPV (Ortiz & Ford, 2005), those who screened when they suspected that a woman was being abused or was at high risk of getting abused (Jeanjot *et al*., 2008), and those who never or rarely screened (Bunn *et al*., 2009; Roelens *et al*., 2009) (*see* Table 2.7). It was found that most participants who screened all pregnant women had received training on IPV and most of them had a good knowledge and attitude towards IPV identification (Ortiz & Ford, 2005; Baird *et al.*, 2015). The majority of the participants in most studies reported that they screened pregnant women for IPV but did not routinely screen all women (O'Shea *et al.*, 2016; Henriksen *et al.*, 2017; Githui *et al.*, 2018; O'Reilly & Peters, 2018). In one study, the participants gave as the reasons why they did not screen for abuse that they thought that the prevalence and the consequences were insignificant and that their actions were not required (Shamu *et al*., 2013).

For experience of IPV screening, Lauti and Miller (2008) found that it ranged from 'I don't know that I have seen it' to 'There are a lot and all the time". In that study, participants who had experience of IPV screening stated that they should ask everybody and should not assume anything about it (Lauti & Miller 2008). Ninety-six percent of the healthcare providers who participated in the study of Stenson *et al*. (2008) reported experiences of having cared for pregnant women who had been victims of IPV. Their care for these women included listening to their stories, giving emotional support, providing information about resources, offering contacts

for additional help and observing subsequent development. In most cases, the type of violence was psychological (56%), verbal (52%), physical (37%), sexual (15%) financial (23%) or a combination of these types (37%). For their experiences of IPV victims' disclosure, participants reported that women disclosed after they were asked specific questions by the HCPs and after they had been injured and required medical treatment (Jeanjot *et al*., 2008). The key findings of the experiences of HCPs are presented in Table 2.7.

Several studies reported various experiences of their participants regarding their role in screening for and responding to IPV. These included discomfort, frustration, anger, sadness, failure and anxiety (Stenson *et al*., 2005; Finnbogadóttir & Dykes, 2012; Jeanjot *et al*., 2008; Furniss *et al*., 2007). The feeling of failure and frustration occurred when they were not assessing all women for IPV, or when a woman would not accept the help which she was offered (Stenson *et al*., 2005). It also occurred when a HCP realized that there was no support and a lack of guidelines or a written plan of action for dealing with this situation (Finnbogadóttir & Dykes, 2012). The feeling of discomfort when asking questions about IPV was reported in several studies and was related to the fear of offending women (Jeanjot *et al.*, 2008; Bunn *et al.*, 2009; Lazenbatt *et al.*, 2009; Roelens *et al.*, 2009; O'Shea *et al.*, 2016).

Table 2. 7 HCPs' experiences in identifying and responding to IPV during pregnancy

Screening	1) Screened all pregnant women for violence 2) Screened only when they suspected or had high-risk patients - patients presented physical signs - patients complained of recurrent physical or psychosomatic symptoms 3) Never or rarely screened pregnant women for violence
IPV Disclosure	After asking specific questions about abuse After the patients had been injured and needed medical assistance Testified spontaneously Through a friend or relative

Barriers to or facilitators of identifying and responding to IPV during pregnancy
Barriers

In this review, the barriers can be divided into three categories: those related to pregnant woman, those related to HCPs, and those related to the healthcare system. Table 2.8 shows the barriers to and facilitators of identifying and responding to IPV during pregnancy as described by the HCPs.

Studies noted that barriers related to pregnant women, as perceived by the HCPs, included unwillingness to disclose current or a history of IPV. HCPs mentioned that there were many reasons why a woman would be unwilling to disclose IPV during pregnancy. The reasons found were the feeling of embarrassment, for the sake of her children and because of the risk to her life (Furniss *et al*., 2007). One study found that the reason for women's unwillingness to disclose IPV was related to their culture and its social norms which indicated an acceptance of men's right to abuse women (Jeanjot *et al*., 2008). Another barrier related to pregnant women's unwillingness to disclose

IPV revealed by many studies was the lack of knowledge of their legal rights (Jeanjot *et al*., 2008; Furniss *et al*., 2007; Stenson *et al*., 2005). HCPs from states with high immigrant populations stated that many immigrant women IPV survivors were faced with language barriers which could prevent survivors from reporting the abuse and seeking support (Jeanjot *et al*., 2008).

The most frequently cited barrier related to HCPs was the lack of time (Ortiz & Ford, 2005; Furniss *et al.*, 2007; Jeanjot *et al.*, 2008; Bunn *et al.*, 2009; Roelens *et al.*, 2009; Henriksen *et al.*, 2017; Mccauley *et al.*, 2017). The lack of privacy in a clinical setting and the presence of the partner were identified as barriers in several studies (Stenson *et al.*, 2005; Lauti & Miller, 2008; Finnbogadóttir & Dykes, 2012; O'Reilly & Peters, 2018). Another barrier related to HCPs was their lack of knowledge. Research found that most participants, including nurses, midwives and physicians, stated that they had never received any formal training on IPV in their undergraduate programme or after graduating and getting certified (Eustace *et al.*, 2016; O'Shea *et al.*, 2016; Pitter, 2016; Githui *et al.*, 2018; O'Reilly & Peters, 2018).

Table 2. 8 HCPs' barriers to and facilitators of screening and responding to IPV during pregnancy

Barriers	Facilitators
Related to pregnant woman	Relationship
- Cultural taboos	Time
- Feeling of embarrassment	Privacy and confidentiality
- For the sake of children and her life	Guidelines and algorithms
- Language difficulty	Training
- Lack of knowledge of legal rights	Continuity of care
Related to HCPs	
- Lack of time	
- Lack of privacy and confidentiality	
- Lack of knowledge, insufficient training	
- Lack of continuity of patient care	
- Lack of professional preparedness/low confidence	
- Fear of reporting, safety and security concerns	
- Oversight	
- Personal beliefs	
Related to the healthcare system	
- Lack of resources	
- Lack of written guidelines and protocols	
- Heavy workload of HCPs	

Three studies demonstrated poor knowledge regarding the management and prevention of domestic violence among HCP participants (Pitter 2016; Mauri *et al*., 2015; Kaye *et al*., 2005). For HCPs, the main source of information about domestic violence was the newspaper (Kaye *et al*., 2005) or reading from other sources, and observation in society (Pitter 2016). Two studies found that participants had good knowledge about domestic violence during pregnancy (Edin & Högberg, 2002;

O'Shea *et al.*, 2016). Midwives in one study showed that they had considerable theoretical knowledge about the signs and symptoms of abuse in women (Edin & Högberg, 2002). Safety and security concerns were another barrier related to HCPs which some participants mentioned. Pitter (2016) found that midwives did not ask about IPV because they were concerned about their own safety and security as well as the safety of the abuse victims. Lauti and Miller (2008) stated that several participants had reported threatening behaviour towards them from a pregnant women's abusive partner. Other barriers found in this review were the lack of continuity of patient care (Lauti & Miller 2008), the lack of professional preparedness, oversight and personal belief (Furniss *et al*., 2007; Ortiz & Ford, 2005; Roelens *et al*., 2009). Personal beliefs included the finding that some midwives thought that IPV was not a major issue to be addressed, that the problem of IPV was not a nursing issue and that it was a waste of time asking women because they would lie about it (Furniss *et al*., 2007).

The lack of resources, the lack of written guidelines and the heavy workload of HCPs were identified as barriers related to the healthcare system (Eustace *et al.*, 2016; Pitter, 2016; Henriksen *et al.*, 2017; Mccauley *et al.*, 2017). Findings suggested that midwives did not know where to refer abused pregnant women to, what care had been provided and what appropriate care the victims should receive (Pitter 2016; Kaye *et al*., 2005). Some HCPs such as midwives did not explore pregnant women's experiences of IPV as they knew that there were limited resources available for the aftercare of these women. Such experiences were a cause of frustration among HCPs, particularly those working in the rural communities (Eustace *et al*., 2016). In addition, the lack of clear processes within the healthcare system could lead the majority of HCPs to avoid becoming involved with pregnant women who are victims of IPV

and are seeking help (McCauley *et al.*, 2017).

Facilitators

Six main facilitators were identified from the review of the 23 studies: relationship; time; privacy and confidentiality; guidelines; training; and continuity of care (*see* Table 2.8) (Lauti & Miller 2008; Eustace *et al*., 2016; Finnbogadottir & Dykes 2012; Stenson *et al*., 2005; Mauri *et al*., 2015). A good practitioner/patient relationship was identified as a facilitator of identifying and responding to IPV during pregnancy. Midwives in the study by Mauri *et al.* (2015) stated that building a relationship with an abused woman is important because it can help to create a trusting environment and could lead to increased chances of the disclosure of IPV. Having time was also important and identified as a facilitator. Most of the midwives believed that if they had more time to talk to and assess women, they would recognise the more subtle warning signs of violence (Mauri *et al*., 2015).

Having practice guidelines on violence was identified as another facilitator. Most participants reported that they thought that guidelines on violence were helpful in that they would help them to make a decision about how to deal with disclosure of IPV (Lauti & Miller, 2008). Three studies reported privacy and confidentiality to be facilitators of IPV screening during pregnancy. Participants stated that IPV was not identified when the women's partner or relatives were present (Lauti & Miller 2008; Stenson *et al*., 2005; Mauri *et al*., 2015). IPV training was seen as a facilitator for identifying and responding to IPV during pregnancy in several studies (Furniss *et al.*, 2007; Lauti and Miller, 2008; Mauri *et al.*, 2015; Eustace *et al.*, 2016; O'Reilly and Peters, 2018). Most of the participants in these studies agreed that training about resources, referral agencies, signs and symptoms of abuse, and communication skills for dealing with disclosure were important in the

management of IPV. Moreover, participants in two studies (Mauri *et al*., 2015; Eustace *et al*., 2016) believed that continuity of care was a facilitator to identifying IPV during pregnancy. They stated that continuity of care provided an opportunity to create a relationship with a woman, develop a relationship of trust and ask about IPV on more than one occasion.

2.5 Questionnaire to assess knowledge, attitudes and practices of HCPs on IPV against pregnant women

One purpose of this review was to identify and evaluate existing questionnaires or guidelines used to assess HCPs' knowledge, attitudes and practices regarding IPV against pregnant women. This section presents an overview of the evaluation of the existing questionnaires used in the 23 reviewed studies.

Four studies used questionnaires created specifically by the authors to collect data (Furniss *et al.*, 2007; Jeanjot *et al.*, 2008; Lazenbatt *et al.*, 2009; Roelens *et al.*, 2009) and all of these questionnaires varied in format and focus. Lazenbatt *et al.* (2009) developed and validated the Midwives' Knowledge and Attitudes to Domestic Violence Scale, which was based on a review of the literature. This scale contained 22 items to measure only midwives' knowledge and attitudes. To measure barriers to screening for IPV during pregnancy among perinatal and emergency room nurses, Furniss *et al.* (2007) designed a short questionnaire to explore opinions about IPV, barriers to asking patients about IPV, and demographic questions about years in practice and specialty area. Only one question explored HCP's comfort with asking questions about IPV. The questionnaire was revised after piloting with fives nurses in order to increase its readability and make it easy to answer (Furniss *et al*., 2007). Jeanjot *et al.* (2008) designed a questionnaire specifically to assess the

types of violence which HCPs encountered and their practice regarding screening. The researchers also developed a questionnaire specifically to evaluate the barriers which might impede the screening of women for IPV, but the reliability and validity of the instrument were not reported (Jeanjot *et al*., 2008). The quality of the responses cannot be ensured because reliability and validity are the criteria which are most commonly used to indicate the quality and the usefulness of a questionnaire (Kember and Leung, 2008). The questionnaire used by Roelens and colleagues (2009) was primarily designed to assess the knowledge, attitudes and practice of Belgian gynaecologists in relation to IPV. This questionnaire was approved by the Ghent University Hospital Ethical Board and by the Flemish College of Obstetricians and Gynaecologists, but nevertheless the validity and reliability of the questionnaire were not presented (Roelens *et al*., 2009), as such the information provided was not sufficient to ensure the construct validity and give confidence to the reader about the instrument.

Ortiz and Ford (2005) used a questionnaire to obtain data from HCPs who provided antenatal care at two US Army Hospitals and the questionnaire was created by the staff of the Children's Hospital Medical Center in Cincinnati, Ohio. The content validity as assessed by the content validity index (CVI) was 1. The CVI is a method which uses a four-point rating scale for experts to test all of the items in a questionnaire for readability, clarity and comprehensiveness (Burn & Grove, 2005). According to Polit & Beck (2006), a CVI score of 0.9 or higher can be judged to represent excellent content validity. Nevertheless, this particular questionnaire was intended to measure only the techniques, practice and barriers of IPV screening (Ortiz & Ford, 2005).

There was one study which had adapted and modified an existing questionnaire

(Deoisres & Peomsook, 2013). The questionnaire was modified from that of Lazenbatt *et al*. (2009). This revised version of the questionnaire was focused on the attitudes of obstetric nurses towards screening for violence against pregnant women and also examined factors associated with nurses' attitudes regarding violence against women, identifying and responding to violence during pregnancy. Content validity was examined by three experts and the questionnaire was piloted with 30 Thai nurses. Cronbach's alpha for the overall questions was 0.79 (Deoisres & Peomsook, 2013). Cronbach's alpha is an index of reliability used to measure the internal consistency of a test or scale. This interpretation of reliability is expressed as a number between 0 and 1 and the acceptable values range from 0.70 to 0.95 (Tavakol and Dennick, 2011).

One mixed-method study used a questionnaire which was developed by the authors from the results of the qualitative interviews in the same study. Edin and Hogberg (2002) developed the questionnaire to assess midwives' knowledge, attitudes, routines and experiences regarding abuse. Although the questionnaire was developed from interview responses, it was piloted with only one midwife before being used to collect the data. Connelly (2008) and Hertzog (2008) recommended that the sample size for pilot studies should be 10% of the sample intended for a full study. This particular pilot study therefore represented an inadequate sample size. The reliability and validity were not presented (Edin & Hogberg, 2002), so the accuracy and consistency of the questionnaire were doubtful. The authors of two studies did not provide any detail on the procedures for the use of a questionnaire (Bunn *et al*., 2009; Kaye *et al*., 2005), so the trustworthiness of the questionnaires and research findings of these two studies have been questioned.

For the current study, there seemed to be no appropriate questionnaires identified

from this review which would achieve all the aspects of the research objectives. Importantly, however, designing a new questionnaire which is reliable and valid would take considerable time. So modifying an existing questionnaire to assess HCPs' knowledge, attitudes and practice regarding IPV during pregnancy in Thailand based on multiple sources including this literature review and research into IPV against non-pregnant women was the best choice for this study. Questions on attitudes related to IPV during pregnancy which had been modified by Deoisres and Peomsook (2013) were initially chosen for this research project because the questions were relevant to Thais and suited to the Thai culture, the purpose and the place of this current study. However, there is no survey tool for measuring HCPs' knowledge and practice regarding IPV during pregnancy in Thailand, so the questionnaire which I used to assess the knowledge and practice of HCPs was modified and translated into Thai. It was developed from the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) which was designed and validated in the US by Short *et al*. (2006). This PREMIS questionnaire was chosen for my study because it has been shown to be reliable and valid, was sensitive to change and capable of differentiating between the trained and untrained HCPs (Short *et al*., 2006; Papadakaki *et al*.. 2012; Connor *et al*., 2011). This tool has been adapted and applied to different populations in various countries and languages (Papadakaki *et al*., 2012, Ramsay *et al*., 2012; Nyame *et al*., 2013; Connor *et al*., 2011). Moreover, this questionnaire fitted my topic and it does not take too long to complete, so it can be completed even during a busy working day (Short *et al*., 2006). More details of the modified version of the PREMIS questionnaire will be given in the next chapter.

2.6 Evaluation of the studies and justification for the PhD study

The aim of this section is to critically analyse the 18 studies identified in the literature review and present the justification for the research conducted for, and reported in, this thesis. For this process, the five additional studies were not included in the process of developing the research questions of the current study.

The majority of studies used a purposive sampling approach (Pitter, 2016; Mauri *et al*., 2015; Shamu *et al*., 2013). The intention of these qualitative research studies was to inform and enrich the understanding of various midwives' experiences, knowledge and attitudes regarding IPV among pregnant women. Purposive sampling was therefore appropriate for these studies as this method enabled the researchers to select midwives who were rich with information about their experiences of IPV during pregnancy and who were responsible for providing the majority of care to pregnant women throughout their pregnancies (Burns & Grove, 2003).

A significant weakness found in this scoping review is the use of volunteer and convenience sampling. Four qualitative studies employed volunteer sampling. The explanation given by some authors about their sampling method was not clear and potential bias was not identified (Lauti & Miller 2008; Stenson *et al*., 2005; Eustace *et al*., 2016; Hindin, 2006). Volunteer sampling has the potential for bias with the result that study outcomes can be influenced and the sample's 'representativeness' of the target population is decreased (Parahoo, 2014). In this review, midwives who volunteered to participate in the studies might have felt very strongly about IPV during pregnancy and may not even have had existing experience of IPV. This kind of sample bias can reduce the validity of the findings of a study. The findings of these studies from volunteer samples may also not reflect those

of other midwives who did not participate in the study. Two studies (Stenson *et al*., 2005; Hindin, 2006) revealed a participation bias as most of the participants in the studies were older (42-62 years; median age 54 years) than non-volunteers. Thus the findings of these studies might show little or nothing of the views and experiences of midwives who were younger than the volunteers. In addition, the reasons for taking part in a study of midwives, such as a feeling of moral obligation and a fear of being labelled as uncooperative, might be influential and might create selection bias. The volunteer recruitment method is considered to be the weakest form of sampling for both qualitative and quantitative studies (Parahoo, 2014). Two quantitative studies in the review sample (Furniss *et al*., 2007; Deoisres & Peomsook, 2013) used the convenience sampling method to select participants. The participants recruited by the convenience sampling method are selected simply because they are the easiest to recruit for the study or because the topic of the study cannot be examined by probability sampling (Burns & Grove, 2007). Convenience sampling has limitations: these studies cannot ascertain that all the answers were reliable because of the low external validity.

Another strength is in the sample size of the research. The nine qualitative studies in this review ranged in number of total participants per study from six to 36 (Lauti & Miller, 2008; Finnbogadottir & Dykes, 2012; Stenson *et al*., 2005; Eustace *et al*., 2016; Pitter, 2016; Mauri *et al*., 2015; Shamu *et al*., 2013; Taylor *et al*., 2007; Hindin, 2006). The sample size of each study seemed adequate because data saturation was reached by interviewing. For focus group discussion methods, the group sizes of three studies were small for a focus group; there were only two to three participants in each group (Lauti & Miller, 2008; Finnbogadottir & Dykes, 2012; Stenson *et al*., 2005), which tends to result in an inadequate discussion (Burns & Grove, 2005).

The ideal number of participants for a focus group is six to ten participants, although four or five participants are acceptable when discussing a sensitive topic (Burns & Grove, 2007; Pitter, 2016). Nevertheless, these three qualitative studies increased the validity of the acquired data by conducting multiple focus groups. This method increases validity by enhancing confidence in focus group findings and allowing the researcher to compare and identify emerging themes from each discussion (Burns & Grove, 2005; Kidd & Parshall, 2000).

The method of data collection was clearly described in all of the reviewed studies. Using interview and focus group discussion for a qualitative study seemed appropriate. The strength in this area is that the aim of the focus group was achieved in all studies (Lauti & Miller, 2008; Finnbogadottir & Dykes, 2012; Stenson *et al*., 2005; Pitter, 2016; Shamu *et al*., 2013; Taylor *et al*., 2007). Nevertheless, a weakness was identified in the focus group discussions because of potential acquaintance bias. All of the focus group discussions were limited by establishing groups in which the participants already knew each other. These studies were therefore particularly prone to acquaintance bias, which could have affected the study findings. For example, Lauti and Miller's (2008) focus group's participants consisted of five midwives and two obstetricians who worked in the same hospital (Dunedin Public Hospital). Additionally, the reliability of the questionnaire in most studies was carried out after administering a pilot test. Piloting a study helps the researchers to identify what methods are best for pursuing it, to test the research instrument, to identify potential problems, to estimate the time and cost for the project and to know exactly what procedure to follow for the subsequent main study. Conducting a pilot study is therefore one of the most important stages in a research project. Even so, a successful pilot study does not necessarily guarantee success in

the main study (Furniss *et al*., 2007; Lazenbatt *et al*., 2009; Edin & Hogberg, 2002; Deoisres & Peomsook, 2013).

The strength of the data analysis of all studies depended on the statistics which they used being appropriate for quantitative analysis and that the thematic analysis was appropriate for a qualitative study. For qualitative research, only one study reported that a phenomenological-hermeneutic design had been used and that the research question which required an examination of the experiences of midwives related to IPV during pregnancy was addressed. So this particular methodology was considered appropriate for that study (Mauri *et al*., 2015). The analysis processes were clearly explained in most of the qualitative studies (Lauti & Miller, 2008; Finnbogadottir & Dykes, 2012; Stenson *et al*., 2005; Eustace *et al*., 2016; Pitter, 2016; Mauri *et al*., 2015; Taylor *et al*., 2007) and the mixed-method studies (Kaye *et al*., 2005; Edin & Hogberg, 2002). Four qualitative studies also employed a strategy which established trustworthiness in order to ensure the quality of findings (Eustace *et al*., 2016; Mauri *et al*., 2015; Finnbogadottir & Dykes, 2012; Stenson *et al*., 2005). These studies employed a strategy which involved the use of more than one researcher to analyse the data and to develop and test a coding scheme.

The designs of the studies included in the review were qualitative, quantitative or mixed methods and all of the studies were appropriate to answer the research questions. The purpose of each study was clearly described. The strength of the qualitative approach is the ability to investigate the richness of the motivations, the feelings or experiences of homogeneous or diverse groups of people (Parahoo, 2014). Thus an in-depth understanding of HCPs' thinking and experiences was revealed in these qualitative studies. They provide rich data which might be transferable to other settings. The strength of the quantitative technique as a survey

approach is that the findings obtained through this approach could be generalised. At the same time, however, these data might not be strong enough to explain complex issues, especially, in this case, IPV during pregnancy. Using a mixed-method approach can also improve the weaknesses of both the qualitative and the quantitative methods. Two studies (Kaye *et al*., 2005; Edin & Hogberg, 2002) employed a mixed-method study design and consequently achieved both a deeper and a broader understanding of HCPs' experiences and views regarding IPV among pregnant women. However, the weaknesses of these two methods employed in a mixed methodology were also identified. One study failed to explain the type of mixed-method research design adequately and also failed to make it clear that the results had been achieved through the combined use of the qualitative and quantitative approaches (Kaye *et al*., 2005).

The final weakness of the studies in this review is the geographical location and recruitment site of the research. Most of the studies in this review had been conducted in western countries, so these studies were limited in that it might not be possible to transfer their findings to other countries, especially developing countries. The majority of the qualitative, quantitative and mixed-method studies in this review sought to explore HCPs' experiences of managing IPV and their views on the barriers to IVP management (Lauti & Miller, 2008; Finnbogadottir & Dykes, 2012; Eustace *et al*., 2016; Pitter, 2016; Mauri *et al*., 2015; Shamu *et al*., 2013; Roelens *et al*., 2009; Lazenbatt *et al*., 2009; Kaye *et al*., 2005; Edin & Hogberg, 2002; Deoisres & Peomsook, 2013). Nevertheless, all of these studies had been conducted in maternity units or in obstetric units. Some of the HCPs in these units reported that they had no clinical experience of responding to IPV or had never met a victim of IPV during their professional career (Finnbogadottir & Dykes. 2012;

Mauri *et al*., 2015). So any information which was discussed and reflected on the basis of the theoretical knowledge from these participants might not reflect any real experience of responding to IPV. One possible reason why some HCPs had never met a victim of IPV is partly due to their lack of knowledge and effective tools and to a hospital's policy for IPV screening. So setting up specific services in hospitals for women who are the victims of violence and ensuring a fully trained emergency department to recognise IPV victims is another good way for a researcher to obtain more information about HCPs'experience of responding to IPV during pregnancy. This is because most women who attend these centres choose to identify themselves as victims of violence and to seek support or assistance from the centre. Moreover, female victims of domestic violence are more likely to seek emergency care for injuries related to abuse (Boyle & Todd, 2003; Mayer, 2000; Hewins *et al*., 2013). There is therefore a need for further research to explore the experiences of HCPs who are working in other healthcare settings than maternity and obstetric units. This will form the basis of my research in this current study.

2.7 The rational for the study, the aim, research questions and objectives

From the review of the literature set out in this chapter, it is clear that studies of the roles and experiences of HCPs in regard to responding to IPV during pregnancy have been carried in several countries, mainly high-income countries including the US, Australia, the UK and other European countries (World Bank Group, nd). Overall, however, there has been a lack of research on the topic of HCPs' roles and experiences of responding to IPV during pregnancy from low- and middle-income countries and from some specific regions, such as Southeast Asia. The review did not identify any research which had explored HCPs' roles and experiences of

identifying and responding to IPV during pregnancy in Thailand. There was one study conducted in Thailand (and published in the Thai language) which had investigated nurses' attitudes to identifying and managing violence during pregnancy (Deoisres & Peomsook, 2013), but that study had significant limitations because it did not explore the perception of the roles and experiences of HCPs in identifying and responding to IPV among pregnant women in Thailand.

Several Thai studies have investigated the prevalence of IPV among pregnant women in Thailand and have found that the rate ranged from 1.9% to 34% (Boonnate *et al*., 2015; Thananowan *et al*., 2012; Thananowan & Heidrich, 2008; Waithayawongkorn *et al*., 2009; Thananowan, 2008; Thananowan & Leelacharas, 2011), but again there has been no study which has investigated HCPs' perception of their role and experiences of identifying and responding to IPV during pregnancy. So seeking to understand HCPs' responses to IPV during pregnancy by exploring their perception of their role, their experiences and the barriers and facilitators which they encounter will have significant implications for other HCPs in the field of IPV and will increase HCPs' awareness of the impact of IPV during pregnancy.

2.7.1 Aim and research questions

Based on this review of the literature, the aim and objectives of the current study have been clarified. The aim is to explore the perception of Thai HCPs about their role and their experiences regarding the identification of and responses to IPV, and to better understand the barriers and facilitators which affect this.

To achieve this aim, the research will address the following questions:

- What are the knowledge, attitudes and clinical practice of Thai HCPs

towards IPV during pregnancy?

- How do Thai HCPs perceive their role in identifying and responding to IPV among pregnant women?
- What are the experiences of Thai HCPs in identifying and responding to IPV during pregnancy?

2.7.2 The objectives of the thesis

1. To use a questionnaire to assess HCPs' knowledge, attitudes and practices regarding IPV in pregnant women among HCPs who work in maternity units, emergency department and One-Stop Crisis Centres (OSCC).

2. To use semi-structured interviews to gain an in-depth insight into HCPs' perceptions and experiences of identifying and responding to IPV among pregnant women.

3. From the analysis of both the quantitative and the qualitative data, to identify ways to help HCPs to overcome barriers to, and thus improve facilitators for, responding to IPV during pregnancy and consequently to make recommendations to professional practice.

2.8 Conclusion

This literature review chapter has presented a critical review of the literature on HCPs' knowledge, attitudes, practices, perception of their role, experiences, barriers and facilitators regarding IPV identification and responses, and by doing so has provided the foundation for the current research topic. This review has also provided a firm foundation for the selection of an appropriate research methodology

and a justification of the methods of the research study, and these will be discussed in the next chapter (Levy & Ellis, 2006).

CHAPTER 3: METHODOLOGY

3.1 Introduction

In this chapter, I shall discuss the methodology which frames the research conducted and described in this thesis. I shall start by discussing the research paradigm, then the ontological and epistemological and the associated methodological considerations. This will be followed by a discussion of mixed methods as a study design, including the reasons for choosing the particular study design which was used.

3.2 Paradigms

Paradigms or worldviews, which can be defined as a basic set of beliefs, are a crucial guide for researchers (Tashakkori & Teddlie, 1998; Creswell, 2009). This is because the way in which knowledge is gained and interpreted is influenced by the research paradigm (Mackenzie & Knipe, 2006). A research paradigm is used to explain, interpret and understand the world (Creswell, 2009). Bryman (1992) defined a research paradigm as "a cluster of beliefs and dictates which for scientists in a particular discipline influence what should be studied, how research should be done, how results should be interpreted, and so on" (quoted in Assalahi, 2015, p. 312).

3.3 Ontology, epistemology and methodology

There are three components of a research paradigm. The first term which constructs a research paradigm is ontology, which refers to the study of the nature of existence or the nature of reality (Assalahi, 2015). The second construct of a research paradigm is epistemology, which focuses on the study of methods to gain knowledge and the

relationship between the knower and the known (Tashakkori & Teddlie, 1998); it answers the questions 'What is the nature of the relationship between the would-be knower and what can be known?' and 'What role does value play in understanding? (Maykut & Morehouse, 2005). The third construct is the methodology. This construct of the research paradigm is interested in the study of the concepts and theories which underpin the research methods. A research paradigm can therefore include at least three elements which can be different depending on the underpinning theoretical framework (Assalahi, 2015).

Creswell (2013) identified four different paradigms: postpositivism, constructivism, transformative and pragmatism. The basic characteristics of these four worldviews used in research are presented in Table 3.1

Table 3. 1 Basic characteristics of the four worldviews

Postpositivism	Constructivism	Transformative	Pragmatism
Determinist thinking	Relies on understanding	Political concern	Consequences of actions
Reductionist	Multiple participants	Empowerment and issue oriented	Built around problem-solving
Empirical observation and measurement	Social and historical construction	Collaborative	Pluralistic
Theory verification	Theory generation	Change oriented	Real-world practice oriented

Adapted from Creswell (2014)

Pragmatism is the approach most often associated with mixed methods (Teddlie & Tashakkori, 2009). In the healthcare sector, health problems are generally complex and multi-faceted and using a singular approach may not address problems adequately (Doyle, Brady & Byrne, 2009). The pragmatic worldview is therefore

appropriate for this current research. In this study, the research is underpinned by pragmatism but the values of positivism and constructivism are also recognised.

3.4 Research methodology

Research methodology refers to the specific procedures used to address the research question(s) and it is very important because it gives a work plan of the research, which involves several decisions, such as what data are actually collected and how they are analysed. Broadly, there are three common research methodologies: quantitative, qualitative and mixed methods (Williams, 2007; Creswell, 2014). The choice of a research methodology depends on the nature of the research question, the personal experience of the researcher and the intended audience(s) for the research findings (Creswell, 2014). In the following subsections, the quantitative and qualitative research techniques will be briefly explained.

3.4.1 Quantitative research

Quantitative research is a formal, objective and systematic process of obtaining information about the world by measuring a quantity. The philosophical base of quantitative research is logical postpositivism (Burns & Grove, 2005; Parahoo, 2006). Quantitative researchers believe that objective reality exists independent of human perception and that there is only one truth. They also believe that the world is governed by laws or theories which need to be tested and refined so that the world can be understood. The quantitative approach therefore starts with a theory, collects data which either support or reject the theory, makes revisions and conducts additional tests for the purpose of verification (Creswell, 2014).

In very broad terms, quantitative research is used to discover and generate new knowledge by using scientific inquiry, it relies on the collection of numerical data,

presents a view of the relationship between theory and research by deduction and has an objectivist conception of social reality. The quantitative purpose is to explain a scientific phenomenon by using the idea of postpositivism, and the explanation of the phenomenon is represented in numerical or statistical forms, such as the percentage of a population and the mean and standard deviation of satisfaction. The processes of quantitative research therefore involves collecting, analysing and interpreting numerical data by using specific statistical techniques to address research questions (Bryman, 2004; Watkins & Gioia, 2015; O'Dwyer & Bernauer, 2016; Apuke, 2017). O'Dwyer and Bernauer (2016) stated that quantitative research relies on a deductive reasoning approach, so this methods starts with the statement of a problem, the generation of a hypothesis, a review of the relevant literature, and the application of statistical tests in order to determine the significance of the acquired data. There are two primary approaches to conducting quantitative research; non-experimental research designs and experimental research designs. The objective of a non-experimental research design is to examine naturally occurring attributes, behaviours or phenomena, whereas an experimental design is adopted in order to examine the effect of treatment or interventions on some phenomena. Non-experimental research designs include survey, causal comparative, correlational and *ex post facto* designs. Experimental research designs include quasi-experimental or truly experimental and randomized experimental designs (Creswell, 2003; O'Dwyer & Bernauer, 2016).

A strength of quantitative research is that the findings are valid, reliable and can be generalised to an entire population or a sub-population. It is sometimes less time-consuming than qualitative research because quantitative data are usually gathered using a structured instrument such as computers and other information systems. Also,

it usually uses statistical software such as SPSS for data analysis, so the analysis can sometimes be faster than in qualitative research. Another strength is that it is advantageous for studies in which systematic and standardised comparisons are required (Watkins & Gioia, 2015; O'Dwyer & Bernauer, 2016; Rahman, 2016). Some limitations of quantitative research are that it does not account for the depth of the acquired data, it is objective and therefore value free, and it does not always elucidate the full complexity of human experience or perceptions. A further weakness of the quantitative research approach is that it is often limited in its ability in that it can reveal 'what' questions but it cannot explore 'why' or 'how' questions (Watkins & Gioia, 2015; O'Dwyer & Bernauer, 2016).

3.4.2 Qualitative research

Qualitative research, on the other hand, is an interpretive methodological approach for exploring and understanding the phenomenon being studied. This approach is conducted within a constructivist or social constructivist mindset. Social constructivists believe that truth is both complex and dynamic and can be found by understanding an issue from an individual's perspective, and by studying interactions between individuals as well as their historical and cultural contexts (Burns & Grove, 2005; Creswell, 2014). Qualitative research, in contrast to quantitative research, is inductive in that a theory does not precede the research but is developed and is based on the data generated by the research. Additionally, qualitative methods are flexible, the sample is (usually) small, the researcher is considered as a research instrument, and the data are generally described by words and observations rather than by numbers and calculations (Burns & Grove, 2005).

The purpose of qualitative research is to discover new knowledge by retaining complexities in natural settings and to understand the deeper meaning of human

experience and perception using words and images. Such research can refer to a study about people's lives, their lived experiences, behaviours, feelings and perceptions. It is also appropriate for studies which have more complicated phenomena as their focus, such as organisational functioning, social movements and cultural phenomena. The perspective of qualitative participants generally gives the study vivid, dense and full descriptions about the phenomenon being studied (Watkins & Gioia, 2015; O'Dwyer & Bernauer, 2016). This research method does not require a theoretical model of the issue or any prior hypotheses because it is not modeled on measurement as found in the natural sciences. Qualitative research participants are generally selected by purposive sampling and are expected to answer questions spontaneously in their own words. Qualitative research usually involves a study with only a few cases, focusing on a single case or a small number of cases, but the acquired data are analysed extensively in order to provide depth and contextualised detail (Watkins & Gioia, 2015; O'Dwyer & Bernauer, 2016). A qualitative study can employ several methods and might include interviews, focus group discussions, direct observation and the analysis of text or audio/video recorded speech or behaviour. Frequently used qualitative research designs or approaches are case study, ethno-methodology, ethnography, grounded theory, historical, narrative and phenomenology (O'Dwyer & Bernauer, 2016). Brief descriptions of each of these qualitative designs are provided in the following paragraphs.

A case study is an intensive study of a single individual, a group, a community or some other unit in order to obtain in-depth data using an intensive, systematic procedure. It is a research technique typically employed in the social and life sciences (Heale & Twycross, 2018).

Ethno-methodology is a theoretical approach intended to discover the way in which people make sense of their everyday life (O'Dwyer & Bernauer, 2016).

Ethnography is the study of the social interactions, behaviours and perceptions which occur within groups, teams, organisations and communities in participants' real-life environment. Research can be conducted by observing or participating in the lives of the people under study with the purpose of understanding the culture which these people share (Sangasubana, 2011).

Grounded theory is a research method which generates or discovers a theory from data which have been systematically collected and analysed. This research method starts with data collection because it does not test an existing theory but develops a theory from empirical data. The main advantage of the grounded theory approach is that the theory developed from the study in a specific area can be used to explain problems in other areas (Alemu *et al.*, 2015).

The historical approach is a method of discovering or examining evidence in order to understand and interpret the past. Historical analysis involves various sources of historical data which are classified into two groups; primary and secondary. Primary sources of historical data are the oral testimony of eyewitnesses, documents and records, whereas history books and encyclopaedias are examples of secondary sources. The procedures of historical research are the systematic collection of data about events which occurred in the past, the analysis and then the subsequent publication of the findings using scientific methods (Mohajan, 2018).

Phenomenology is an approach to explore how people experience a particular phenomenon from the perspective of the individual. It is used when the study is about the life experiences within a particular group whose members have original

knowledge or have had direct experience of an event, situation or phenomenon (Groenewald, 2004; Bliss, 2016; Mohajan, 2018). Example of phenomenological studies are the lived experiences of the elementary principles involved in dual-career relationship with children (Zeeck, 2012), the lived experience of leisure for caregivers in the sandwich generation who care for their children and for a parent with dementia (Schumacher, 2010), and business graduates' employment experiences in the changing economy (Campbell, 2018).

Narrative research is a method which involves generating and analysing stories of life experiences. It focuses on studying a single person, gathering the collection of stories, describing the life of the individual, and analysing the meaning of those experiences for the individual. The analysis of this narrative approach involves analysing the content of stories, how stories are told and the way in which people tell their experiences. Narrative research of this type is time-consuming so data are typically gathered from a very small number of cases (George & Selimos, 2018; Mohajan, 2018).

A strength of qualitative research is that it provides thick description of participants' feelings, opinions and lived experiences which are not accessible by quantitative methods. Qualitative research is highly flexible in that the framework is based on the available data, so the design can be constructed and reconstructed to a far greater extent. Despite the advantages set out above, some limitations of qualitative research are obvious. First, all the data collected in qualitative research are highly subjective and the results are based very much on the researcher's own approach to the study. The main disadvantage of the qualitative approach is that the findings are not generalizable because of the small sample size (Watkins & Gioia, 2015; Rahman, 2016; Mohajan, 2018). Table 3.2 sets out the differences between

quantitative and qualitative research. For this current study a mixed methodology was devised and I employed the survey and semi-structured interview methods of data collection. Details of the mixed methodology are provided in the following sections.

Table 3. 2 Quantitative versus qualitative research

Criteria	Quantitative research	Qualitative research
Purpose	Testing objective theories by examining the relationships between variables	Exploring and understanding the meaning which individuals or groups ascribe to a social phenomenon
Strategies of inquiry	Experimental designs Non-experimental designs	Narrative research Phenomenology Ethnography Grounded theory Case studies
Procedures	- Pre-determined - Instrument-based questions - Performance, attitude, observational and census data - Statistical analysis - Statistical interpretation	- Emerging methods - Open-ended questions - Interview, observation, document and audio-visual data - Text and image analysis - Themes, patterns interpretation
Data	Numbers and statistics	Words, images, or objects

(Adapted from Creswell, 2003; 2014; Apuke, 2017)

3.5 The worldview applied to mixed methods

There has been considerable debate about an appropriate paradigm or paradigms for mixed- method research (Hall, 2013). Many mixed-methods authors accept that

pragmatism is the most appropriate paradigm for mixed-method research (Creswell & Plano Clark, 2011; Hall, 2013). Pragmatism is an alternative paradigm which draws on many ideas and orients itself towards 'what works' in the real world (Feilzer, 2009; Creswell & Plano Clark, 2011). The transformative-emancipatory paradigm is another paradigm for mixed-method research and it was proposed by Mertens (2003). The main focus of this paradigm is the lives and experiences of marginalised groups such as people with disability or members of the lesbian, gay, bisexual, transsexual and queer communities. This perspective has emerged because some groups of researchers need to address social justice, discrimination and oppression in society. Hence this paradigm is not an appropriate paradigm for mixed methods because it is limited to a small group of people (Hall, 2013).

In this current study, pragmatism is the framework for the use of the mixed-method research approach. Creswell (2009) stated that many philosophical foundations of mixed methods are provided by pragmatism. Pragmatism is a philosophy which is not committed to any one system. This paradigm allows the use of many different approaches that is most appropriate and works best for the particular research problem in order to obtain knowledge. Pragmatism as a research paradigm rejects the distinction between realism and anti-realism which has been part of the paradigm 'war' between quantitative and qualitative researchers (Kaushik and Walsh, 2019). Instead, it accepts that reality does exist and knowledge in this world is socially constructed. Therfore, this pragmatism has been advocated as an alternative paradigm situated between quantitative and qualitative research (Johnson and Onwuegbuzie, 2004; Yefimov, 2004).

From the pragmatist perspective, to seek knowledge and truth human experience is important, and a richer experience can be obtained through a single or any productive

combination of methods (Johnson and Onwuegbuzie, 2004). For example, according to Morgan (2007), pragmatism allows the potential and possibility to work back and forth between induction and deduction to connect theory and data. He mentioned that in the actual process of moving between theory and data is impossible to operate by using only one direction (Morgan, 2007).

Mixed-method research addresses research questions or problems using both qualitative and quantitative methods (Creswell, 2009). Shaw *et al*. (2010) found that using pragmatism as a paradigm for mixed-method research is well suited for the research and practice of a study. This philosophy pays attention to the importance of context and in health- related studies it can address the practical nature of assessment and the patient's treatment in a variety of settings. Moreover, pragmatism can provide a philosophical framework for mixed- method research because both approaches view the nature of the world in the same way. For instance, pragmatists and mixed-method researchers use different and various ways to address the research problem (Creswell, 2009). The primary importance of both pragmatism and mixed-method study is the research question (Creswell & Plano Clark, 2011).

3.6 Definition of mixed-methods research

The meaning of the term 'mixed-method research' has been defined in many different ways. The focus of the definition is most likely to rely on methods, philosophy, methodology, purpose and research design (Creswell & Plano Clark, 2011). Johnson, Onwuegbuzie and Turner (2007) conducted a study in which they asked many leaders in the field of mixed methods to define mixed-method research. The criteria for providing a definition of mixed-method research by these current

leaders were identified and discussed. Nineteen definitions were obtained from 21 leaders and the results showed five themes of mixed-method research definitions. These five definitions were classified differently on the basis of what is being mixed, when or where the mixing occurs in the research process, the breadth of the mixing, why mixing was conducted in the research and the driving force behind the research. As a result of their study, Johnson *et al*. (2007: p.123) defined mixed methods as follows:

> *Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration,*

3.7 Reasons for conducting mixed-method research

There are several reasons for conducting mixed-method research. Teddlie and Tashakkori (2009) identified three key advantages of mixing the qualitative and quantitative approaches. The first advantage is the ability to address a range of confirmatory and exploratory questions with both approaches. Mixed-method study allows the researcher to use a qualitative approach for exploring perspectives in great depth and a quantitative approach for comparing data in a systematic way, making generalisations to the wider population or testing theories with hypotheses on the same phenomenon (Creswell & Plano Clark, 2011). The second advantage of mixed-method study compared with using a single approach design is that it can provide stronger evidence. The final advantage is that it offers a different perspective on

the study which cannot be obtained by one single approach (Teddlie & Tashakkori, 2009).

In this current study, the reasons for employing a mixed-method research strategy are the following. The use of an initial quantitative phase provided a general understanding of the research problem. Then in the second phase, qualitative research provided further explanation of the initial results in more depth (Creswell & Plano Clark, 2011). In the initial quantitative phase of this study, a questionnaire survey was administered to HCPs working in maternity units, emergency departments and OSCCs in order to gain information about their levels of knowledge, their attitudes and their practice regarding IPV during pregnancy. The second phase, the qualitative study, utilised the semi-structured interview method to gain in-depth data on HCPs' perceptions and experiences of identifying and responding to IPV among pregnant women. Exploring the quantitative data provided a general understanding on a larger scale whereas the qualitative data provided a deeper understanding of the phenomenon. Furthermore, both the quantitative and the qualitative methods have their own distinctive strengths and limitations, so carefully combining the two might help to capitalise on the strengths and minimise the weaknesses of both approaches. Moreover, the results of both the quantitative and the qualitative methods can support, provide validation of and contribute more complete data for each other.

3.8 Mixed-method research design

The strategies used for gathering, analysing, interpreting and reporting data in research studies are called study designs. The importance of a study design is to give a structure to the study and to direct systematic research (Creswell & Plano

Clark, 2011). Creswell and Plano Clark (2011) suggest that four key decisions are involved in selecting an appropriate mixed-method design. These four keys points are: (a) the level of interaction between the quantitative and qualitative strands, (b) the priority of the quantitative and qualitative strands, (c) the timing of the quantitative and the qualitative strands, and (d) the procedures for mixing the quantitative and qualitative strands.

Creswell and Plano Clark (2011) propose six major mixed-method designs, and these are shown in Appendix 3.1. These six designs comprise four basic mixed-method designs and two designs which bring multiple design elements together. The first basic mixed-method design is the convergent parallel design or convergent design. This design requires the collection and analysis of two dependent strands of quantitative and qualitative data in the same phase of the research process. The procedures of a convergent parallel design are collecting both quantitative data and qualitative data concurrently, analysing the two data sets separately, merging the results and then interpreting the combined results. In this design, the quantitative and qualitative data are weighted equally (Creswell & Plano Clark, 2011). The second design is the explanatory sequential design, which is the particular design employed in this current study, so the specific details of this design are provided below. The third design is the exploratory sequential design. This design is purposed to use the qualitative results to help to develop or inform the quantitative study. One reason for employing this design is to explore concepts related to the phenomenon of interest because the variables, theories or models are not known. Another reason is to develop an instrument which is not already available (Watkins & Gioia, 2015). In the exploratory design, data in the qualitative phase are first collected and analysed, followed by a phase of quantitative data which is related to

the outcomes from the first phase. The final phase is to integrate the data from the two separate strands of data (Creswell & Plano Clark, 2011; Watkins & Gioia, 2015). The embedded design is another basic mixed-method design. The purpose of the embedded design is to answer different questions which require different types of data or to enhance an experiment. In an embedded design, quantitative or qualitative data collection can be embedded within a quantitative or qualitative procedure. The timing of the embedded phase can occur before, during and/or after the first phase of the study (Watkins & Gioia, 2015). The next design is the transformative design. The purpose of this design is to conduct research which addresses issues of social justice and to present findings which might bring about change to under-represented or marginalised populations (Watkins & Gioia, 2015). This design uses a theoretical-based framework to advance an inquiry into the needs of an under-represented or marginalised group and then collect and analyse quantitative or qualitative data concurrently or sequentially. The transformative design framework can be implemented with any of the four basic mixed-method designs (Creswell & Plano Clark, 2011). The final design is the multi-phase design. This design is a combination of sequential and concurrent strands over a period of time and is often used in large funded or multi-year projects, such as programme evaluations or development plans. Researchers who employ this design should have experience in longitudinal research, sufficient resources and funding, a research team and emergent questions arising from the different phases (Creswell & Plano Clark, 2011; Watkins & Gioia, 2015).

As stated above, the mixed-method design chosen for this current study was the explanatory sequential design. The explanatory design is a two-phase design: quantitative research followed by qualitative research. The qualitative data acquired

in the second phase is used to provide an in-depth explanation of the quantitative results of the first phase (Creswell & Plano Clark, 2011). The purpose of using this particular design is also to identify characteristics of the participants revealed in the quantitative results and to use them to guide purposive sampling for the subsequent qualitative phase. In addition, this design is useful because the researcher can return to participants for a second phase and develop new questions from the quantitative data which could not be answered with only the quantitative data (Creswell & Plano Clark, 2011). The strengths and weaknesses of this mixed-method explanatory design have been frequently noted and extensively discussed in the literature. The advantages of this design are the following. This design consists of a two-phase structure which makes it straightforward to implement. The two methods are conducted in separate and discrete phases and each collected only one type of data at a time, so only one researcher was needed to implement this design (Creswell & Plano Clark, 2011). Moreover, this design structure makes it straightforward to describe the findings and write the report. The report can therefore be written in two distinct phases with a final discussion which brings the two-phase results together (Tashakkori & Teddlies, 2003). This design can be especially useful when the researcher wants to further explore quantitative findings. The main weakness of this design is the lengthy time required for collecting data in two separate phases. Another challenge for this design is the need to decide which results should be followed up and which need to be explained. This requires the researcher to decide the criteria for selecting participants in the second phase and also involves contacting participants in order to arrange the second round of data collection (Tashakkori & Teddlies, 2003; Ivankova, Creswell & Stick, 2006; Creswell & Plano Clark, 2011).

This study was designed to explore HCPs' perceptions and experiences of

identifying and responding to IPV during pregnancy. The initial quantitative phase used a validated data- collection tool (a questionnaire) in order to gather information on HPCs' knowledge, attitudes and practices regarding IPV in pregnant women. The quantitative results were the grounding for the study. The quantitative data were also used to identify participants and to guide the purposive sampling for the subsequent qualitative phase. In the second phase, semi-structured interviews were employed with a sub-section of the sample of the participants who had completed the questionnaire to gain an in-depth insight into HCPs' perceptions and experiences about IPV during pregnancy. Then, the qualitative data were used to explain the quantitative results more fully. Finally, ways to help HCPs to overcome the barriers and improve the facilitators of responding to IPV during pregnancy were identified based on the analysis of both the quantitative and the qualitative results.

In summary, therefore, the rationale for using both qualitative and quantitative data was that this mixed-method design would provide a more comprehensive understanding of HCPs' perceptions and experiences of identifying and responding to IPV during pregnancy. The quantitative method was used to provide a general understanding of HCPs' perceptions and experiences by assessing their knowledge, attitudes and practices regarding IPV during pregnancy. The qualitative design provided an opportunity for the researcher to understand the participants' perceptions of their role and their experiences in their own words. A qualitative design was appropriate for undertaking research on sensitive topics (Liamputtong, 2007), and the qualitative phase consequently allowed an exploration of the research topic which the quantitative phase alone would not. Additionally, this type of mixed-method design is entirely appropriate for topics which have not been

explored before.

CHAPTER 4: METHODS

4.1 Introduction

In this chapter, an explanation of the process of the mixed-method study design is provided. The chapter begins with an explanation of the research setting and then the quantitative and qualitative methods used in this project will be described. In each method, the recruitment of the participants, the procedures for sample size calculation, the data collection technique and the data management are explained. A description of the process of obtaining ethical and research governance approvals for this study will then be presented. Details of the procedures put in place to ensure that the necessary ethical requirements were fully complied with will also be presented.

As explained in the previous chapter, a mixed-method approach was employed to address the research question of this study: what are the roles and experiences of healthcare professionals to identify and respond to pregnant women who are abused by their partners? This research method and the explanatory sequential design were selected and justified in Chapter 3, leading to the two interactive phases which constitute this research study: a quantitative phase using a survey design, followed by a qualitative phase using semi-structured interviews.

4.2 Research setting

In Thailand, the hospitals under the MOPH included in this study are categorised by bed capacity and hospital level. The community hospitals (small) have a capacity of 30 to 90 beds; the general hospitals (medium) have a capacity of 90-500 beds; and the regional hospitals (large) have a capacity of more than 500 beds (MOPH,

2016). In Buriram province, there were 23 hospitals, comprising 21 community hospitals, one general hospital and one regional hospital. The study was undertaken in Buriram province for three key reasons. First, this province is one of the largest and most populated provinces in north-east Thailand, but also the poorest (the reason why this was important is explained below). Second, this province has the second highest incidence of poverty among women and also the third highest number of women giving birth in the north-eastern region. Third, the proportion of teenage mothers in this province has increased from 12.75% in 2006 to 21.71% in 2012, whilst the national figure for the increase over this same period was 10% (Office of Women's Affairs and Familly Development, 2008; Buriram Public Health Office, 2012). Several previous studies have provided strong evidence that IPV during pregnancy was associated with mothers' younger age, low income and unmarried status (Thananowan & Heidrich, 2008; WHO, 2011). This province was therefore deemed to be the most suitable setting for the study.

For the participants, I selected HCPs who were working in maternity units, including antenatal care clinics and postpartum wards, because they are the frontier in providing care to pregnant women and new mothers. According to figures published by the UK's Royal College of Emergency Medicine, up to 12% of patients visiting an emergency department were there because of injury related to domestic violence and 30% of domestic violence begins during pregnancy (Royal College of Emergency Medicine, 2017). In the US, studies have reported that up to 14% of women who present to an emergency department have conditions related to IPV and up to 38% have experienced IPV in the previous year (Plichta, 2007). For these reasons, emergency departments were also selected. In addition, HCPs in One Stop Crisis Centres (OSCCs) were recruited to the study because they are in

a unique position to contact children and women who are the victims of violence and they play a pivotal role in facilitating and encouraging these victims. The OSCC in Khonkaen hospital was the first centre for IPV in the north-east of Thailand and was established there in 1999. The purpose of this centre is to provide services for women who are victims of violence and to serve as a model for other public hospitals in Thailand. After its operation was seen to be successful, all provincial hospitals across the country were encouraged by the MOPH to establish their own OSCCs (Grisurapong, 2004). Consequently, this study was conducted in hospitals which provide a service for victims of violence at OSCCs within the hospital, in Buriram province.

4.3 The quantitative research phase

To achieve the research aim of this study, a cross-sectional survey to assess HCPs' knowledge, attitudes and practices in regard to IPV during pregnancy was conducted. The reasons for the selection of this measure were discussed in Chapter 2, section 2.5.

In this section, I shall describe the process of translating, adapting, validating and reliability testing of the Physical Readiness to Manage Intimate Partner Violence Survey (PREMIS) devised by Short *et al*. (2006) which I had used in health care settings in Thailand.

4.3.1 Questionnaire

The PREMIS is a 67-item tool originally designed to measure physicians' readiness to manage IPV in four broad areas: preparation, knowledge, opinion and practice. It is comprised of five sections: participant profile, background, actual knowledge, opinions and practice issues and it should take no longer than twenty minutes to

complete (Short *et al*., 2006). The questionnaire was adapted for use with Thai HCPs (including doctors, professional nurses and technical nurses). To do this, I made slight changes to some of the questions by rephrasing the items to make them more relevant in the Thai context. Table 4.1 shows examples of the modified statements used in the modified PREMIS alongside the original statement used in the original PREMIS. The items not relevant to the Thai setting were discarded. For example, the questions asking about the option of patients about being referred to a legal advocate or a victim witness advocate, a child therapy or support group and a batterers' treatment programme were rejected because few of these facilities or services are available in Thailand. The questionnaires were paper and pencil self-administered questionnaires adapted in English and then translated into Thai (see below).

Table 4. 1 Example of modified statements in PREMIS questionnaire

Item No.	Original statement	Modified statement
2.3.1	Ask appropriate questions about IPV	Ask the appropriate questions for pregnant women about violence by husband
3.3	Which of the following are warning signs that a patient may have been abused by his/her partner?	Which of the following are warning signs that a pregnant woman may have been abused by her partner?
4.2	I ask all new patients about abuse in their relationships.	I ask all new pregnant women about abuse in their relationships.

The adapted questionnaire consisted of five sections. Section one explored the participant's profile and comprised eight questions about the participant's age, gender, field of practice, highest degree held, years of experience and number of pregnant women cared for per week. Section two consisted of four questions about the background knowledge of the participant, perceived preparation and perceived

knowledge of IPV during pregnancy. It also included questions about IPV training. Sections three, four and five of the questionnaire consisted of 53 items relating to the participant's knowledge, attitudes and practices in regard to IPV during pregnancy. Free-text response boxes were provided at the end of each section for participants to provide a more in-depth response if they wished to do so. The participants were anonymous but they were asked to indicate their willingness to volunteer for interview by providing information including the date on which they had received the questionnaire and their ordinal number in staff daily attendance record book for an identification code (*see* Appendix 4.1). This identification code enabled me to contact participants for the qualitative phase of the study, which was conducted after the quantitative phase.

4.3.2 Translating the questionnaire

Translating a questionnaire in order to fit with the targeted populations who speak different languages can have pitfalls which can threaten the validity of the instrument. Examples of these pitfalls are the use of colloquial phrases, jargon, idiomatic expressions, the clarity of wording and word meanings normally used in English. This means there are potential different interpretations of the questions, so responses based on these ambiguous questions might not accurately reflect what they were intended to measure. Direct, word-for-word translation into another language cannot be adequately achieved because of inevitable linguistic and cultural differences. For example, the problem can arise that there is no exact equivalent word in the Thai language which expresses precisely the same meaning as the English language word, or there is a lack of equivalence at word level. The translation was therefore focused on cross- cultural and conceptual equivalence, rather than on linguistic literal equivalence (Hilton and Skrutkowski, 2002). Thus, as a researcher using this

questionnaire which had been developed in a different culture, I was aware of the potential problems regarding the meaning of concepts, instrument validity and reliability.

In order to ensure the quality of a translation, it is essential that the guideline recommendations for good translation practices are followed (Hilton & Skrutkowski, 2002). For the purpose of this study, the adapted questionnaire was translated into Thai using the forward-backward techniques which are considered very reliable for translating an instrument from the source language to another language (Sousa *et al*., 2011; McGorry, 2000). This technique was refined by the WHO (WHO, 2017) over the course of several studies across various countries and cultures in order to achieve conceptual equivalence. Forward translation was undertaken by two translators. One was an Assistant Professor at the University of Southern Mississippi in the US. Her area of expertise was technology and marketing (details of the experts are provided in Appendix 4.2). The other was myself. We worked independently to translate the adapted English questionnaire into Thai and any discrepancies between our translations were detected and discussed. According to the WHO (2017), to compare and identify ambiguous wording in the original language, forward translation should be made by at least two forward translators from the original language to the target language. It is recommended that the two translators should have the target language as their mother tongue in order that the nuances of the target language can be accurately reflected in the translation. Moreover, to ensure the best possible translation, the background or profile of the two translators should be different (Beaton *et al*., 2007; WHO, 2017). For the backward translation, the first Thai version was back-translated into English by a different team consisting of two bilingual translators fluent in both English and Thai. One translator was a health

professional and familiar with the IPV area; the other was a health professional in nursing. These two translators worked independently (*see* Appendix 4.2). As with the forward translations, this back-translation process should be performed by at least two translators who work independently. This process helps to ensure the accuracy of the translation and reveal any misunderstanding or unclear wording from the forward translation version (Beaton *et al*., 2007; WHO, 2017).

The next process was conducted by me and the expert from the forward translation process to examine the original version and the back-translated version for conceptual equivalence. After resolving any discrepancies, the final Thai version of the questionnaire were examined by one expert to verify that the instructions were clear, the words and sentences were simple, and the questions were easy to understand.

4.3.3 Validity and reliability of the questionnaire

The PREMIS original version has been tested in several studies for psychometric properties and has presented satisfactory internal consistency, high item-specific reliability, a strong construct and high repeatability. All of these psychometric tests of the PREMIS questionnaire have been conducted in developed countries including the US, the UK and Greece and these tests have demonstrated that the adapted instrument could successfully be modified for use with other groups of HCPs and in other languages (Short *et al*., 2006; Connor *et al*., 2011; Papadakaki *et al*., 2013). For example, Connor *et al*.'s (2011) study was designed to test the factor structure of the PREMIS for use in a population of students in medicine, nursing, social work and dentistry. It was found that the adapted instrument had a high level of reliability within some of the IPV constructs (Connor *et al*., 2011).

Validity of the questionnaire Validity of the questionnaire

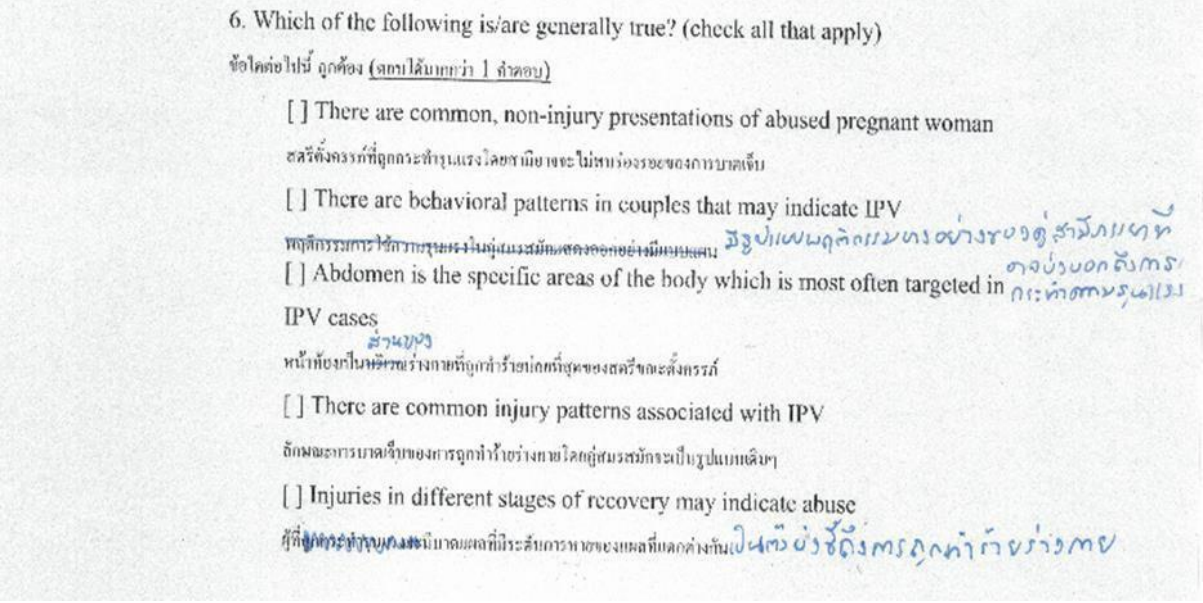
The Thai version of PREMIS prepared for the current study was translated into the Thai language for the first time, so the relevance of the questions for the Thai context and their clarity for an average participant were unknown. So before using the Thai version of the questionnaire in a Thai healthcare setting, I made sure that it was tested by experts for content validity by using the Content Validity Index (CVI) method to check the questionnaire items for readability, clarity and understandability (Burns & Grove, 2005). In addition, I piloted the questionnaire with a group of HCPs to ensure its validity.

In this study, the content validity test was applied based on the model suggested by Polit and Beck (2006). Five experts on domestic violence and maternity and child health were invited to assist me. The items in the translated questionnaire version were scored on a four-point Likert scale (1- 'not relevant', 2- 'somewhat relevant', 3 – 'quite relevant', and 4 – 'highly relevant'). The experts were asked to rate each item on whether it was relevant for the target population and the intended purpose of the questionnaire. Ratings of 3 or 4 were considered to show that an item was relevant and ratings of 1 or 2 were considered irrelevant. The relevancy rating form used for the experts is provided in Appendix 4.3. Then the CVI per item on the scale was calculated. The Individual Content Validity Index, or I-CVI, was computed as the number of experts giving a rating of 3 or 4 divided by the total number of experts. The entire questionnaire tool was assessed using the Scale Content Validity Index (S-CVI/Ave) by calculating the average I-CVI across items (*see* Appendix 4.4). Polit *et al.*'s (2007) suggested content validity scale was used to measure the appropriateness and relevance of the content provided by the experts in this study. With a panel of five experts, the CVI should be .78 or higher for each individual item and .90 or higher for the entire instrument for it to be judged as having excellent

content validity.

The results showed that the range of I-CVIs was 0.6 to 1.0 and of the S-CVI/Ave was 0.98 (*see* Appendix 4.4). According to the experts, forty items were identified as difficult to understand by one expert and other ten items were similarly identified by two experts. These experts provided new words and/or statements along with the previous items (*see* Figure 4.1), and I then examined these statements and revised them in order to make the necessary improvements.

Figure 4. 1 New words and statements providing along with the previous items by the experts


6. Which of the following is/are generally true? (check all that apply)

[ ] There are common, non-injury presentations of abused pregnant woman

[ ] There are behavioral patterns in couples that may indicate IPV

[ ] Abdomen is the specific areas of the body which is most often targeted in IPV cases

[ ] There are common injury patterns associated with IPV

[ ] Injuries in different stages of recovery may indicate abuse

Improvement in style for clarity was the main point of change to the initial question. For example, the stylistic change in item 2.4.8 ‘What questions to ask to identify IPV during pregnancy’ was that ‘during pregnancy’ was changed to ‘among pregnant women’, which was clearer but had the same meaning. In addition, for some items, the experts used more sophisticated language. For example, in item 3.8.1, ‘Alcohol consumption is the greatest single predictor of the likelihood of IPV during pregnancy’ the expert changed ‘the greatest single predictor’ to ‘one of the

strongest correlates'.

Among the number of changes which were made, there were five items (items 2.2, 5.1, 5.3, 5.4 and 5.8) in which the time frame was changed: all of these items asked participants about their experiences in the past six months. The experts suggested deleting this time frame or asking about experiences over more than the past six months because this experience is salient to the individual participant, so longer time frames can be asked for. For this version of PREMIS, the time frame was therefore extended for up to twelve months for these times.

Reliability of the questionnaire

Reliability is the extent to which an instrument would provide stable and consistent results if the same measurement were repeated by another researcher under the same conditions. It is also concerned with repeatability (Taherdoost, 2016; Taber, 2018). Reliability testing is important as it refers to the degree of accuracy or precision in the measurements made by a research instrument (Wentzel-Larsen *et al*., 2011; O'Dwyer & Bernauer, 2014). There are four types of reliability; test-retest, equivalent forms, split half and internal consistency reliability.

Test-retest reliability refers to the extent to which an instrument provides the same results across time. A good measurement of an instrument is that it should produce roughly the same results for the same individual over time. Assessing test-retest reliability requires at least two administrations of an instrument to the same person or group of people and then the correlation between the two sets of scores is tested. A test-retest reliability coefficient of +1 for an instrument is considered to indicate perfect reliability; a correlation close to zero indicates that the instrument is unreliable (O'Dwyer & Bernauer, 2014). Equivalent forms is sometimes referred

to as parallel form which requires two administrations of different versions of an instrument to the same group of individuals (O'Dwyer & Bernauer, 2014; Mohajan, 2017). Split-half correlation is a form of internal consistency which involves checking one half of the results of a set of scaled items against the other half. If the two halves of the test are strongly positively correlated or produce reliability coefficient values close to +1, the instrument is deemed to be reliable (O'Dwyer & Bernauer, 2014). Internal consistency reliability is the consistency of people's responses across the items on a multiple-item measure. This test requires only one administration so the costs are lower than two administrations of the instrument and additional access to the people being studied is eliminated. For these reasons, the internal consistency method is more appealing.

Cronbach's alpha is the most commonly used method of testing internal consistency and is widely used in the social sciences, nursing and other disciplines. It is viewed as the most appropriate measure for checking the reliability of Likert-type scales (O'Dwyer & Bernauer, 2014; Taherdoost, 2016). Coefficient alpha is a test of how well related with each other the items in a questionnaire or a section of a questionnaire are. It ranges in value from 0 to 1, with 0 indicating unreliability or no relationship among the items, and 1 indicating highly reliability or absolute internal consistency. Alpha values are excellent (0.9 and above), high (0.70-0.90), moderate (0.50-0.70) and low reliability (0.50 and below). In the social sciences, 0.7 to 0.8 is the acceptable range of alpha value (O'Dwyer & Bernauer, 2014; Taherdoost, 2016; Mohajan, 2017). The Cronbach's alpha reliability method was employed to test the reliability of the questionnaire used for this study.

In this study, the Cronbach's alpha reliability coefficients were calculated by

using SPSS statistical software to check the reliability of the PREMIS questionnaire. The three parts of the questionnaire which were Likert-scale questions were tested. These parts were perceived preparation (ten items), perceived knowledge (fourteen items) and opinions on IPV (31 items). For opinions on IPV, the items were grouped into eight sub-scales. Cronbach's alpha reliability was used to test all of the items on opinion and also each sub-scale, except for legal requirements which had only one item. All the negative statement items were reversed to positive before testing.

As a result of the analyses, it was concluded that these parts of the questionnaire had acceptable reliability. The alphas were 0.97 for the HCPs' perceived preparation part, again 0.97 for the HCPs' perceived knowledge part, and 0.76 for their opinions on IPV during pregnancy. Table 4.2 shows the details of the reliability statistics for the PREMIS questionnaire utilising Cronbach's alpha as the test.

Table 4. 2 Reliability statistics for perceived preparation, perceived knowledge and opinions on IPV of the PREMIS questionnaire

	No. of items	No. of cases	Cronbach's Alpha
HCPs' perceived preparation	10	20	0.97
HCPs' perceived knowledge	14	20	0.97
Opinions on IPV during pregnancy			
Overall items	31	20	0.76
- HCPs' preparation	3	20	0.84
- Legal requirements	1	-	-
- Workplace issues	6	20	0.84
- Self-efficacy	6	20	0.57
- Alcohol and drugs	3	20	0.50
- Victim understanding	7	20	0.44
- Victim autonomy	3	20	0.70
- Constraints	2	20	0.60

4.3.4 Pilot study

A pilot study can be defined as a small-scale study which is conducted before the main study in order to check the feasibility and the clarity of the research instrument. Results from a pilot study can be used to inform feasibility and identify any ambiguities or unclear questions in the design of a questionnaire intended for a larger study (Williams, 2003; Leon, Davis & Kraemer, 2012).

In this pilot study, twenty nurses were selected using the same criteria as for participants for the questionnaire itself and they were selected using convenience sampling from two hospitals. The purpose of this pilot study was to measure the time

needed to complete the questionnaire and to acquire feedback on its content. It was also designed to evaluate the clarity of the items in order to ensure that the questionnaire was reliable and valid in the context of IPV during pregnancy, before undertaking the larger study.

As a result of the pilot study, some additional information was provided, this involved adding a 'none' answer to the multiple choice questions, changing some wording of the questions to make them clearer, eliminating some questions which were not relevant to the respondents and giving a clearer structure to questions requiring a 'yes/no' answer which then followed on into subsequent questions (*see* Appendix 4.5). The survey instructions indicated that the questions could be completed in approximately twenty minutes. In the pilot study, participants reported that the average completion time was nearly thirty minutes. So after eliminating some irrelevant question, using simple words rather than complicated words, and adding to the structure of some questions, it was tested on one convenience respondent who had not been included in the pilot study. The completion time was nearly 25 minutes. The conclusion drawn from the participant's feedback was that it was fit for purpose and that no additional changes were required to remove any ambiguities. The pilot group data were therefore included in the research findings. Taking together the CVI of the experts and the feedback from the pilot study, I was confident that Thai HCPs' knowledge, attitudes and practices would be appropriately assessed by the revised questionnaire.

4.3.5 Questionnaire administration

The research setting was located in the Buriram province in Thailand. There are 23 hospitals in the province and some of them are very dispersed, so personally distributing the questionnaire or making direct contact with all of the hospitals would

be time-consuming and expensive. Postal questionnaires can save time and effort for the researcher, but the response rates can be low and the returned questionnaires can contain missing, unclear, incomplete or invalid items responses (Parker *et al.*, 2000; Cluett and Bluff, 2006). In this study, the process used to distribute the questionnaire involved all of the following steps (*see* Figure 4.2).

First, at a meeting of Buriram Provincial Public Health, I approached the representatives of each hospital to determine who was the responsible person and would be the primary source of contact with that hospital. There were twenty nurses from twenty hospitals attending this meeting and most of them were the managers of the OSCCs of each hospital. During a coffee break, I met with these key individuals. I provided them with details of the study, including the purpose of the study, the length of the questionnaire, the method of its completion and the procedures for distributing the questionnaire. Afterwards, these nurses were provided with two packages of documents and the envelopes for returning the questionnaires. The first package contained a permission letter, a questionnaire, an information sheet and the written ethical approval from the Ethics Committee of the University of Sheffield which required me to obtain the hospital director's permission to carry out the data collection. The other was a package of documents including questionnaires and information sheets for the potential participants. Of the twenty nurses at the meeting, fourteen were willing to help. The remaining six declined to cooperate, stating that they were either unavailable to help or were too busy. One week after the meeting, I called the fourteen cooperating nurses to ask them for the result of my request for permission to carry out the data collection. All of the directors of these hospitals allowed me to collect the data in their hospitals. After that, each hospital was requested to organise the distribution of questionnaires to potential participants. Two weeks after obtaining

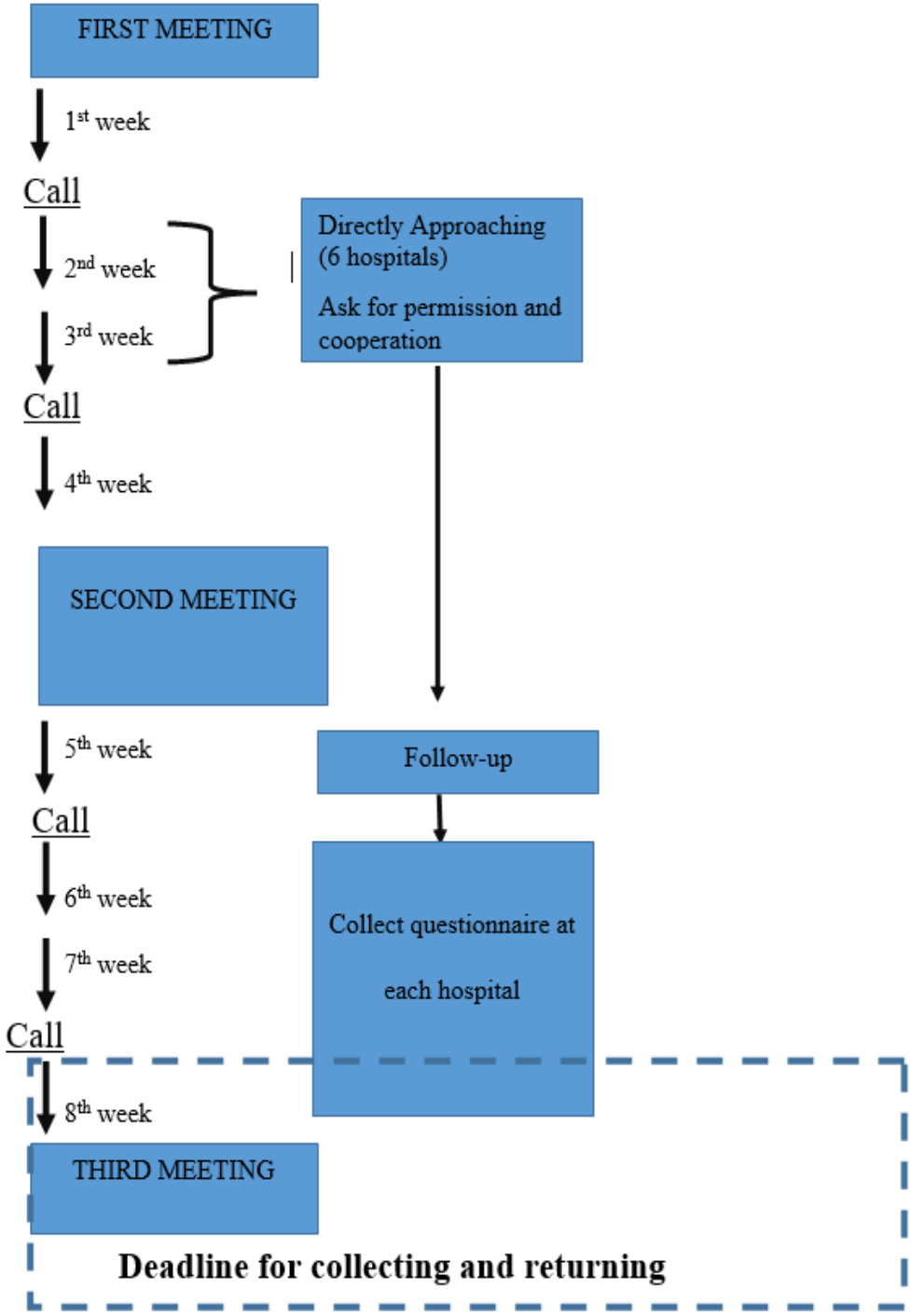
the permission, I again called these professional nurses to remind them about the deadline for returning the questionnaires.

Second, six hospitals were approached directly by myself, asking for their cooperation and permission for data collection because these hospitals are not far from each other. These hospitals allowed me to collect the data and the questionnaires were administrated by the head nurses of each hospital. Then the objectives of the study, the length of the questionnaire, the method for completing it, the procedure to distribute the questionnaire and my contact details were provided to these head nurses. One week after the initial contact, each hospital was visited again in order to answer any questions regarding the questionnaire, to follow up the progress and to remind them of the deadline for returning the completed questionnaires.

Third, the three remaining hospitals were approached at a second meeting which took place four weeks after the previous meeting. The same procedures were followed as in the previous meeting.

The first-round questionnaires were returned in the provided sealed envelopes at the second meeting. The second and third round were sent to me at the next meeting of Buriram Provincial Public Health, which usually takes place every four weeks. Some of questionnaires were collected at the hospitals by myself.

Figure 4. 2 The process of questionnaire administration



4.3.6 Distribution of the questionnaires to the participants

Questionnaires were distributed to the participants as a group in their regular work units,

which included antenatal care units, postpartum wards, emergency departments and OSCCs, by the head of the OSCC and the head nurse of each hospital. It was emphasised to the participants by the heads that the questionnaire was not a test or an examination, that it was voluntary and that refusal to participate would not result in any penalty. The participants were assured as to the anonymity and confidentiality of their responses. The need for truthful answers was emphasised and the participants were specifically instructed not to put their name on the questionnaires. In addition, a small incentive of 40 Thai baht (approximately £1) was offered for participants for returning a completed questionnaire.

An identification code for the questionnaires was required in order to identify participants for future interview. It was explained to the participants that some information, specifically the date on which they had received the questionnaire receiving and their ordinal number in the staff daily attendance record book, were necessary. These requirements were written in bold letters and placed at the beginning of the questionnaires. I assigned a unique code to each participant and wrote the code on each returned questionnaire. This unique code and questionnaire were kept in a secure place and used in the next phase in order to keep track of each participant. Table 4.3 shows examples of the identification codes assigned to the questionnaires. The same code could arise if participants were in a different department but received the questionnaire on the same date and had the same number in the attendance book, and in this case I identified them by their work place. Doctors do not have an attendance number because they are not required to be registered as working, but they could still be identified because they were only one or two doctors in each hospital.

Table 4. 3 Examples of identification codes for questionnaires

Participant questionnaire	Hospital	Date of receiving the questionnaire	Ordinal number in the daily attendance book	Code
Participant A	NR (Nangrong Hospital)	15/07/2017	2	NR15071702
Participant B	LHS (Lahansine Hospital)	20/07/2017	5	LHS20071705
Participant C	NK (Nongki Hospital)	20/07/2017	3	NK20071703

4.3.7 Sample

Doctors, nurses and technical nurses working in maternity units, emergency departments and OSCCs for one or more years were the target population. A doctor is a person who has completed a six-year course from medical school, has passed the examination held by respective schools for the diploma and has had to sit and pass the National Licensing Examination held by the Thai Medical Council in order to gain a licence to practise in Thailand (Jongudomsuk *et al*., 2015). A nurse is a person who is registered and holds a licence to be a nursing and midwifery practitioner from the Thailand Nursing and Midwifery Council after completing a four-year Bachelor of Science in Nursing programme (BSN). This programme was devised by the Thai Nursing and Midwifery Council to combine both nurse and midwife training into one single curriculum, so Thai nurses are more qualified because they can provide midwifery services (Suksiripakonchai, nd; Jongudomsuk *et al*., 2015). A technical nurse is a nurse who has graduated from a two-year nursing certification programme which was approved by the Thai Nursing and Midwifery Council; the programme was only run from 1990-2000 in order to address a nurse shortage and by the time of

the study it had already been closed down by the Ministry of Public Health (Jongudomsuk *et al*., 2015).

4.3.8 Sampling and recruitment

The sample size for the study was calculated using an online sample size calculator tool from Creative Research System.[3] The total population of HCPs who were working in antenatal care units, postpartum wards, emergency departments and OSCCs during the data collection period was 500 (Strategy and Planning Division, 2012). For a 95% confidence level and confidence interval of five, the estimated appropriate sample size was 217.

In this study, a stratified, purposive and convenience sampling procedure was used to recruit participants for the quantitative phase. Stratified sampling is a commonly used probability sampling method in which the population is first divided into sub-groups or strata and then the appropriate number from the population can be selected at random. The purpose of this sampling method is to improve the representativeness of the sample. This method is therefore more effective than simple random sampling for a large and diverse population. Stratified random sampling is also advantageous in that it can minimise selection bias and it ensures that the resulting sample is more representative of the entire relevant population (Bryman, 2012). Even so, there are limitations of this procedure which must be considered; these are its complexity, the greater effort required than simple random selection, and the strata must be clearly defined. Purposive sampling is a non-probability sampling method in which the researcher seeks to sample research participants based on a characteristic of a

[3] From https://www.surveysystem.com/sscale.htm#two

population and the aim of the research (Bryman, 2012). Convenience sampling, also called accidental sampling, is non-random sampling in which the participants are selected because they are easily accessible (Etikan, Abubakar and Sunusi, 2016).

To select the hospitals, a stratified and purposive sampling method with probability proportion to size was used. The primary sampling units were the hospitals and the secondary sampling units were the HCPs. As mentioned in the location section, all of the hospitals under the MOPH in Buriram province are categorised to three levels, small, medium and large. There was only one medium and one large hospital in Buriram province, so these two hospitals were stratified as one hospital stratum at the medium and large levels. There were 21 hospitals at the small level; twelve with 30 beds, six with 60 beds and three with 90 beds (Buriram Public Health Office, 2016). These 21 hospitals were stratified into three strata. Within each stratum, the numbers of HCPs (doctors, nurses and technical nurses) were proportionally allocated in order to reach the required sample size. Tables 4.4, 4.5, 4.6 and 4.7 show the study-stratified sample which was used in this study when the total target population was 500 and the sample size was 217.

Table 4. 4 Distribution of HCPs of each level of hospital

Level of Hospital	**Target Population Size**	**Strata Ratio**	**Sample Size**
Small			
30 beds (twelve hospitals)	184	37%	80 (seven per hospital)
60 beds (six hospitals)	134	27%	58 (ten per hospital)
90 beds (three hospitals)	86	17%	37 (twelve per hospital)
Medium (150 beds)	32	6%	14
Large (590 beds)	64	13%	28
Total	**500**	**100%**	**217**

Table 4. 5 Distribution of HCPs

HCPs	**Target Population Size**	**Strata Ratio**	**Sample Size**
Doctor	134	27%	59
Nurse and technical nurse	366	73%	161
Total	**500**	**100%**	**220**

Table 4. 6 Distribution of doctors, nurses and technical nurses of the small hospitals

Level of hospital	HCPs	Strata Ratio	Sample size
Small	Doctor	27%	21 (2 per hospital)
30 beds (twelve hospitals)	Nurse and technical nurse	73%	58 (5 per hospital)
	Total	**100%**	**79**
60 beds (six hospitals)	Doctor	27%	16 (3 per hospital)
	Nurse and technical nurse	73%	42 (7 per hospital)
	Total	**100%**	**58**
90 beds (three hospitals)	Doctor	27%	10 (3 per hospital)
	Nurse and technical nurse	73%	27 (9 per hospital)
	Total	**100%**	**37**
Total			**174**

Table 4. 7 Distribution of doctors, nurses and technical nurses of medium and large hospitals

Level of hospital	HCPs	Strata Ratio	Sample size
Medium (150 beds)	Doctor	27%	4
	Nurse and technical nurse	73%	10
	Total	**100%**	**14**
Large (590 beds)	Doctor	27%	8
	Nurse and technical nurse	73%	20
	Total	**100%**	**28**
Total			**42**

After the sample size for each stratum was calculated, I sought to avoid unrepresentative and bias by using random sampling. The method which I planned to use was to obtain the name list of the target population of each hospital. Each of the names on the list would then be assigned a consecutive number and then the samples would be selected by using a random number table. However, this sampling design was not practical in this study as it was time-consuming and reaching the selected

sample was difficult. Moreover, I found that the name lists of the target populations in the hospitals were not up-to-date. As described earlier, a combination of convenience and purposive sampling techniques was employed to recruit HCPs based on their work units. The choice was made because this method was affordable, easy and the sample participants were readily available. Convenience and purpose sampling were performed to select participants who were working on the day of questionnaire distribution and who had at least one year of work experience.

4.3.9 Demographic information of the surveyed participants

Response rate

Of the 500 target population of all nurses, technical nurses and doctors who were working at maternal care units, emergency department and OSCCs in government hospital, and 217 sample size, a total of 280 questionnaires were distributed. After the deadline for collecting and returning, 168 completed questionnaires were finally returned. The survey had an overall response rate of 60%, the response rates for the nurses and technical nurses were 74.55% and for the doctors were 30%.

Demographic details

A total of 188 participants, 149 females (79.3%) and 39 males (20.7%) completed the questionnaire. The age of the participants ranged between 22 and 59 years with a mean age of 34 years. Nearly half (48.4%) of the participants were aged between 21 and 30 years and approximately 5% were above 50 years of age. Ninety-eight participants (52.1%) identified themselves as single and 82 (43.6%) as married or in a relationship. Only five (2.7%) reported being divorced or separated and three (1.6%) were widowed. Most of the participants, 182 (96.8%) were Buddhists. Further details about the participants' demographic characteristics are presented in Table 4.8.

Table 4. 8 Demographic characteristics of the participants

Characteristics	n (%)
Gender	
Male	39 (20.7)
Female	149 (79.3)
Total	**188 (100.0)**
Age group	
21-30	91 (48.4)
31-40	45 (23.9)
41-50	43 (22.9)
51-60	9 (4.8)
Total	**188 (100.0)**
Relationship status	
Single	98 (52.1)
Married or in a domestic partnership	82 (43.6)
Widowed	3 (1.6)
Divorced/separated	5 (2.7)
Total	**188(100.0)**
Religion	
Buddhism	182 (96.8)
Christianity	5 (2.7)
Islam	1 (0.5)
Total	**188 (100.0)**

The participants comprised 162 nurses (86.2%), 24 doctors (12.8%) and two technical nurses (1.1%). Of the nurses, 135 (83.3%) were female and 27 (16.7%) were male. Of the doctors, twelve (50%) were female and twelve male, and the two (100%) technical nurses were female. Most of the participants (n = 162, 86.2%) had an undergraduate degree and fourteen (7.4%) had an additional post-graduate qualification. Over half of the HCPs had been working as a health care professional for between one and five years. The length of the working experience ranged between

1 and 40 years (mean = nine years). Sixty-eight of the participants (36%) were working in an emergency department. Further details about the participants' professional qualifications are presented in Table 4.9.

Table 4. 9 Detail of the professional qualifications of the participants

Characteristics	n (%)
Profession	
Doctor	24(12.8)
Nurse	162(86.2)
Technical nurse	2(1.1)
Total	**188(100.0)**
Academic qualification	
Doctor of Medicine	24(12.8)
Bachelor of Nursing Science	148(78.7)
Certificate in Nursing Science	2(1.1)
Other	
Advance Nurse Practitioner programme	5(2.7)
Master in Nursing	6(3.2)
Master in Public Health	2(1.1)
PhD	1(0.5)
Total	**188(100.0)**
Years of Experience	
1-5	98(52.1)
6-10	36(19.1)
11-15	13(6.9)
16-20	13(6.9)
21-25	20(10.6)
More than 25	8(4.3)
Total	**188(100.0)**
Area of Work	
Antenatal Care Clinic	43(22.9)
Postpartum Ward	46(24.5)
One-Stop Crisis Centre (OSCC)	7(3.7)
Emergency department	68(36.2)
Other (Doctor)	24(12.8)
Total	**188(100.0)**

4.4 Qualitative phase

The main purpose of the qualitative phase of this study was gain an in-depth insight into HCPs' perceptions of their role and experiences regarding the screening for and management of IPV during pregnancy in Thailand. Based on the findings from the quantitative phase, the purposive sampling procedure and interview guide for the qualitative phase was developed.

4.4.1 Semi-structured interviews

Semi-structured interviews are employed in qualitative research when researchers are interested in conducting intensive individual interviews with a small number of participants in order to explore their experiences, behaviour and understanding of a particular idea or situation. Interviews offer the opportunity for the interviewer to repeat a question if the interviewee does not understand it or misunderstand it, and allow the interviewees to describe their experiences in their own way. It is also a useful technique to use when the researcher wants to acquire additional detailed information about a person's perspectives, experiences and behaviour, or wants to identify new issues in depth, particularly when sensitive topics are being investigated (Liamputtong, 2007; Boyce & Neale, 2006). The semi-structured interview format provides participants with some guidance on what to talk about and offers a structure for the discussion during the interview, which participants can find helpful. It also helps the researcher to explore the data by collecting similar types of information from each participant (Gill *et al*., 2008). In this study, qualitative data were gathered from semi-structured interviews in order to achieve a deeper understanding of the issues under investigation. Individual interviews were chosen as the most appropriate approach for this study because they would allow me to explore each individual interviewee's views in greater depth and to explore sensitive topic which the participants might

have been unwilling to talk about in a group environment. Moreover, a group discussion may not be suitable for a study in which power differentials exist between the participants. This is because participants who are in a less powerful position may be hesitant to express their thoughts in a group interaction, especially when they oppose the views of more powerful colleagues (Jayasekara, 2012). In this study, for example, junior nurses might indicate agreement with their senior colleagues to avoid perceived reprisals or conflicts. In addition, compared with individual interviews, a focus group is generally more difficult to organise and it also requires more energy, time and money to bring participants together. An interview guide was developed which included the significant quantitative findings with the specific purpose of gaining an insight into the interviewees' perceptions and experiences of their role, experiences, and barriers and facilitators regarding the screening for and management of IPV during pregnancy (*see* Appendix 4.6). The interview guide was generated after analysing some parts of the quantitative survey results. The qualitative interviews in the study involved a purposive sampling approach once the participants had indicated their agreement to be interviewed for this study and the recruitment of participants who indicated that they had to take care of pregnant women experiencing IPV (or the participants who had answered 'yes' to question 5.1). The interview questions were also based on participants' individual responses to the questionnaire in order to explore their responses in more detail. For example, if they had answered 'no' to question 5.11, which asked about their feelings about adequate adult IPV referral resources for pregnant women in their working areas, I would ask for more details about their perceptions and experiences regarding these resources. The guide was comprised of open-ended questions which gave some structure to the interview but left it sufficiently flexible for me to be able to probe more freely into questions which required

greater elucidation. The interview questions were guided by an interview schedule which was devised on the basis of the study objectives, the literature review and the significant findings from the questionnaire in the first phase.

4.4.2 Interview process

As I had intended, the interview schedule was used flexibly to structure the collection of data and to utilise appropriate probing questions, and the questions did not need to be asked in any specific order. The questions were deliberately left open to allow the participants to provide their own answers and to think and speak freely. The participants were informed that the purpose of the interview was to find out about their views on and their experience of identifying and/or responding to pregnant women who were abused by their partners.

Sixteen semi-structured, face-to-face interviews were conducted by me in a private place selected by the participants and each interview was audio-recorded in full with the participants' permission. Ten of the interviews took place at the participants' workplace in a private room within their own offices during a lunch break or after working hours. Three interviews were conducted at the participants' homes; two interviews took place in a coffee shop and one interview took place in a restaurant. These places were private because the nearby desks and tables were not occupied.

Before each interview, the participants were reminded about the study information provided on the participant information sheet and were given the opportunity to ask questions about the study before being asked to sign a consent form. Following this, the aim and the format of the interview were explained to the participants and they were informed about the expected length of the interview.

4.4.3 Sampling and sample size

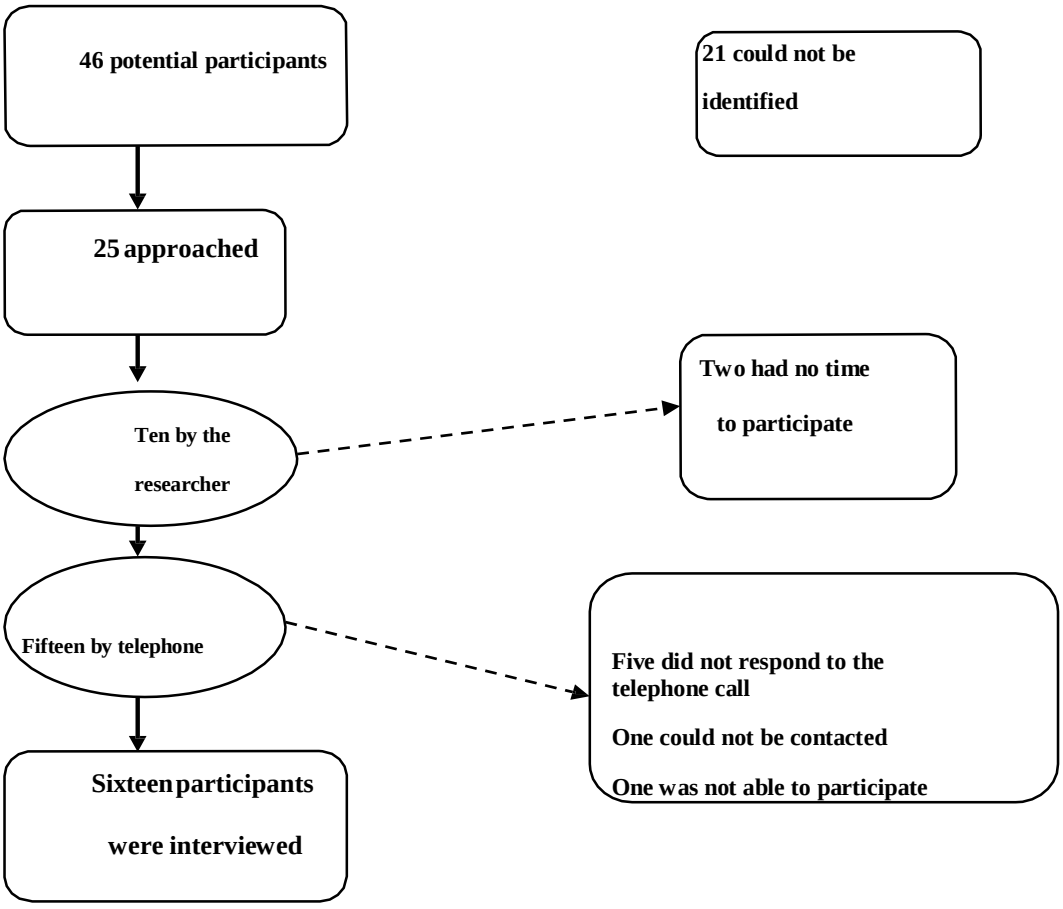
In the second research phase, semi-structured interviews were conducted with HCPs who had taken part in the questionnaire survey in order to increase the validity of the findings (Johnson, Onwuegbuzie & Turner, 2007). Using purposive sampling techniques, participants were selected from the quantitative phase based on their experiences of identifying and responding to IPV among pregnant women. Purposive sampling chooses participants on purpose because these participants have direct experience or characteristics related to the research topic and question (Matthews & Ross, 2010). HCPs who had completed the questionnaire in the first phase of the study and had provided their contact details to receive further information about the qualitative part of the study were eligible for inclusion in the second phase. There are no specific rules for determining sample size in qualitative research (Guetterman, 2015). In the explanatory design, some researchers choose to follow up in the qualitative phase with all of the participants in the first phase. However, the intention of this design is not to merge or compare the results as in other designs such as convergent design. A much smaller sample than that for quantitative data collection is therefore appropriate and acceptable (Creswell & Plano Clark, 2011). The estimated sample size for the interviews was fifteen participants or until saturation was achieved. Data saturation is defined as the point at which no new data is identified (Fusch & Ness, 2015).

4.4.4 Recruitment

Participants were selected purposively based on their experiences of identifying and/or responding to IPV during pregnancy. Forty-six potential participants were identified from the first phase as having had experience of identifying and/or responding to IPV among pregnant women. These participants comprised two doctors, 43 professional nurses and one technical nurse. There were 21 participants

who could not be traced back because there was not enough contact information provided by these participants to enable further contact following completion of the questionnaire. Possible reasons for this were that the participants forgot to fill out that section of the questionnaire or simply that they did not want to be identified. A total of 25 potential interviewee participants were approached and invited personally by telephone. Two of the ten whom I approached in person stated that they had no time to participate. Of the seven of remaining fifteen whom I approached by telephone, five did not respond to my telephone call, one was not able to be contacted because her phone was switched off, and one was not able to participate because she had moved to another hospital where she had accepted a new position. Of those approached, two were doctors and one was a technical nurse, but all three of them were not available for the reasons mentioned above, so all of the interview participants were nurses. Eventually, sixteen semi-structured interviews were conducted (*see* Figure 4.3). No further participants were contacted after the sixteenth interview because no new information was being discovered from the interviews so it was felt that data saturation had been reached.

Figure 4. 3 Interviewee recruitment



4.4.5 Demographics of the interviewed participants

By the process explained above, a total of sixteen participants took part in an interview. The general demographics of these participants are displayed in Table 4.10. All of the participants were female and registered nurses; their ages ranged from 29 to 52 years with an average age of 43 years. Fourteen (87.5%) of the participants stated their marital status as married and two (12.5%) stated their marital status as single. Regarding the participants' highest degree completed, most of them (n =13, 81.25%) had bachelor's degrees, two (12.5%) had master's degrees and one (6.25%) had a doctoral degree. The number of years of professional experience which the participants had since qualifying ranged from six to 32 years (mean = 21), with the majority of them (n = 11, 68.75%) having experience of between 20 and 29 years; only one (6.25%) participant had professional experience of fewer than ten years, and also one (6.25%) participant had experience of more than 30 years. The interviews ranged in length from around 29 to 62 minutes (mean = 46).

Regarding their professional nursing experience, six participants had had further training about IPV after qualifying in their area and the remaining participants had never been trained (six of these remaining participants had been trained in basic nursing only, three had received further training for being a nurse consultant and one had been trained as a mental health nurse). Many of the participants had worked in a female medical ward, a delivery room, an ANC, an inpatient ward, an ED, a drug addiction support service or a primary care clinic before moving into their current clinical settings. Two of them had previously been an end-of-life and a volunteer nurse. The professional experiences of the participants can be found in Table 4.11.

Table 4. 10 General demographics of the interview participants

Category	Total participants (n = 16) n (%)
Gender	
Female	16 (100)
Age group	
21-30	1 (6.25)
31-40	3 (18.75)
41-50	10 (62.5)
51-60	2 (12.5)
Marital status	
Married	14 (87.5)
Single	2 (12.5)
Highest degree completed	
Bachelor of Science in Nursing (BSN)	13 (81.25)
Master of Public Health (MPH)	2 (12.5)
Doctor of Philosophy (PhD)	1 (6.25)
Years in professional nursing	
Under 10	1 (6.25)
10-19	3 (18.75)
20-29	11 (68.75)
30+	1 (6.25)

Table 4. 11 Professional experience of the interview participants

Professional experiences	**n = 16** **n(%)**
Programmes attended	
Basic nurse training only	6 (37.5%)
Specialist training as a mental health nurse	1 (6.25%)
Specialist training as a nurse consultant	3(18.75%)
Specialist training regarding IPV/DV	3(18.75%)
Specialist training regarding IPV/DV and specialist training as a mental health nurse	2 (12.5%)
Specialist training as community nurse/mental health nurse and regarding IPV/DV	1 (6.25%)
Clinical settings	
Female medical ward	1 (6.25%)
Delivery room	3(18.75%)
Antenatal care clinic	1 (6.25%)
AIDS clinic	2 (12.5%)
Inpatient department	1 (6.25%)
Emergency room	1 (6.25%)
Drug addiction support service	1 (6.25%)
Primary care clinic	1 (6.25%)
Roles	
End-of-life nurse	1 (6.25%)
Volunteer nurse	1 (6.25%)

4.5 Data analysis

4.5.1 Quantitative data

The descriptive and inferential statistics tests were processed using the Statistical Package for the Social Sciences (IBM SPSS Statistics Version 25) computer software. For the descriptive statistics, continuous variables were summarised using the mean and standard deviation (SD) and the categorical data using frequencies and percentages. For the inferential statistics, independent-sample t-tests, one-way ANOVAs, multiple linear regressions and binary logistic regressions were conducted. These statistics were tested to examine the differences, relationships and predictors of the study variables.

Measurement tool

A 66-item, self-report questionnaire was devised to measure HCPs' preparation for, knowledge of, attitudes to and practices towards the identification of and response to IPV during pregnancy. The measurement of each part is described below.

- Preparation for identifying and responding to IPV during pregnancy

This section was in two parts; the first part asked about the participant's previous training, sources of training and total number of hours of previous training on IPV. The second asked the participant to rate how prepared she felt about IPV identification and response, and involved ten statements, each with a six-point Likert scale response ranging from, 1 = 'not prepared' to 6 = 'quite well prepared'. For the purposes of analysis, these groups were collapsed into three categories: 'not prepared', 'moderately prepared' and 'well prepared'. Those who responded 'not prepared' were put into the 'not prepared' category, responses of 'slightly prepared', 'moderately prepared' and 'fairly well prepared' were collapsed into the 'moderately prepared' category and those who responded 'well prepared' or 'quite well prepared' were collapsed into the 'well prepared' category.

- Knowledge of IPV during pregnancy

For this section, knowledge of IPV during pregnancy was examined in two parts. The first part, designed to elicit perceived knowledge, comprised fourteen statements on a six-point Likert scale (1 = 'nothing' to 6 = 'very much') to determine the perceived knowledge of the participants. For the analysis, the six-point Likert scale was again collapsed. Those who responded 'nothing' or 'a little' were collapsed into the 'poor' category; those who responded 'a moderate amount' or and 'a fair amount' were collapsed into the 'fair' category and those who responded that they had 'quite a bit' or 'very much' knowledge of IPV during pregnancy remained in the 'good' category. The second part contained three types of question: six multiple choice questions, one 'yes/no' question and ten 'true/false' and 'don't know' statements. The overall knowledge score was calculated by summing up the correct answers, and the total score was 31. The percentage of correct scores was grouped into three categories: over 80 (excellent), 60-79 (good), and below 60 (poor).

- Opinions on IPV during pregnancy

Questions regarding the participant's opinions on IPV during pregnancy comprised 31 statements. These items were rated on a seven-point Likert scale ranging from 'strongly disagree' (1) to 'strongly agree' (7). The scale was inversely recoded from 7 to 1 for the negative statements, so if a participant 'strongly disagreed' with a negative statement, this was recoded to reflect 'strongly agree' with a positive statement. These negative statements were items 1, 5, 6, 10, 11, 13, 15, 16, 20, 22, 23, 26, 27 and 31. In addition, all items of their opinion on IPV during pregnancy were grouped to form opinion sub-scales which were found to be associated with a readiness to manage IPV, which consisted of eight sub-scales: HCPs' preparation, legal requirements,

workplace issues, self-efficacy, alcohol and drugs, victim understanding, victim autonomy and constraints. All of the items in all the parts were rated on a seven-point Likert scale from 1 = 'strongly disagree' to 7 = 'strongly agree'. For the analysis, the seven response categories were collapsed into three categories: 'strongly disagree', 'slightly disagree' and 'disagree' were collapsed into one category named 'disagree'; and 'strongly agree', 'quite agree' and 'agree' were categorised as 'agree'; 'neutral' was a response signifying that the participant neither agreed nor disagreed with the statement. For the inferential statistics, opinion scores were computed by calculating a mean score on the responses on the eight sub-scales.

- Practice issues

The practice issues section had twelve items comprising questions related to the participant's experience of the identification of IPV in pregnant women in the past, her experience of routine screening, her experience of responding to disclosure and her familiarity with the policies and/or protocols on IPV used in her hospitals. Of these twelve items, two were rated on a five-point Likert scale ranging from 'never' = 1 to 'always' = 5 to describe how often she had asked about IPV when seeing pregnant women with symptoms of abuse, and a six-point Likert scale ranging from 'never' = 1 to 'always' = 5 and 'not available (N/A)' = 6 for explaining the frequency of interventions which she had done for a victim of IPV when seeing her. The six-point Likert scale of the responses was collapsed into four categories: 'never', 'sometimes', 'always' and 'not applicable'. The remaining ten items were 'yes/no' and multiple choice items. For this section, there were no right or wrong answers, therefore score options were not provided.

4.5.2 Qualitative data

Unlike quantitative data analysis, there are no universal rules about how qualitative data

analysis should be carried out and no standard procedures for analysing qualitative data have been developed (Bryman, 2004; Polit & Beck, 2012). It is therefore challenging for a researcher to select a method for analysing qualitative data which should be applied with rigour, scrutiny and integrity (Polit & Beck, 2012).

There are many computer software programmes available to assist with qualitative data analysis, for example ATLAS/TI, MaxQDA and NVivo. These programmes can help the researcher to organize, manage and analyse qualitative data (Polit & Beck, 2012). The advantages of using these programme are that they save time, they help the researcher to manage a large body of data and they enable the researcher to spend less time on manual and clerical tasks (Polit & Beck, 2012; Dollah, Abduh & Rosmaladewi, 2017). Even so, I chose to analyse the data manually for several reasons. The main reason was that manual methods would allow me to get closer to the data; another was that after I had completed two courses of NVivo training offered by the Corporate Information and Computer Services (CiCS) department of the University of Sheffield, I had realised that using the programme requires a lot of time to understand and become familiar with it. The final reason was that I did not have previous experience with any programme for qualitative analysis.

In this study, the qualitative data were analysed by thematic analysis. This method is a concept of qualitative analysis for identifying, analysing and interpreting themes from the acquired data (Braun & Clarke, 2006). The method is widely used in many fields, particularly in health and wellbeing research (Braun & Clarke, 2014) and it enables the researcher to identify and analyse patterns in a complex and large amount of qualitative information into themes, which helps the researcher to interpret the phenomenon being studied. The advantage of this method is that it offers a highly flexible approach which enables the researcher to pay attention to the data in many

different ways. The thematic analysis process has few prescriptions and procedures which makes it easy to follow and it can be relatively quick to learn for researchers who are not familiar with qualitative analysis (Braun & Clarke, 2006; Castleberry & Nolen, 2018). Because of these advantages, I chose to use thematic analysis for the HCPs' interview responses. A six-stage thematic analysis framework devised by Braun and Clarke (2006) was followed. These stages were transcription, initial coding, identifying themes, reviewing the themes, defining and naming the themes, and producing the report. The stages are described as follows.

Stage 1 Transcription

For this stage, I decided to transcribe into written form the data from each interview myself in order to ensure and to make me confident that no data would be knowingly missed out of the transcription as well as to increase my familiarity with the data. The digitally recorded interviews were re-played many times to ensure accuracy and an adequate understanding of the acquired data, and full transcriptions of each interview were made. Corrections to the transcripts were made and any personally identifiable information was removed. Sixteen transcripts were in Thai and three were translated into English by myself. All of the English transcripts and translations were checked for accuracy and equivalence by two experts (*see* Appendix 4.2).

Stage 2 Initial coding

I started this stage when I had read and familiarised myself with the data. In this process, preliminary ideas about what is in the data and what is interesting about them were also generated and marked. Then, the production of initial codes from the data was begun. For the coding, I initially intended to code the content of the entire data set. I used line-by-line coding to code every single line and every piece of text. After that, I also

approached the data which were relevant to and which captured something interesting about the research question. The codes were developed and modified throughout the coding process. All of the coding in this study was performed by hand initially, working through hard copies of the transcripts with pens and highlighters. The data were coded by writing notes on the analysed text and identified segments of data using a highlighter, then these codes and extracts of data from individual transcripts were copied into a Word document in separate computer files (*see* Appendix 4.7). When all of the data had been coded, the next step was to collate and combine all the sections which fitted into each code and the processes were continued through each transcript in this way individually.

Before moving to the next and all the rest of the transcripts, I and my two supervisors worked through the first transcript by coding it separately. When we had finished, we compared our codes, discussed and modified them. In addition, Braun and Clarke's key advice for this stage was taken. This key advice was to code for all potential codes and keep data surrounding the coded text.

Stage 3 Identifying themes

This stage began when I had coded and collated all the data. I started by looking at my list of codes and their associated extracts; I then attempted to collate the codes into broader themes. Table 4.13 shows an example of combining the codes from four transcripts into a single theme called 'barriers'.

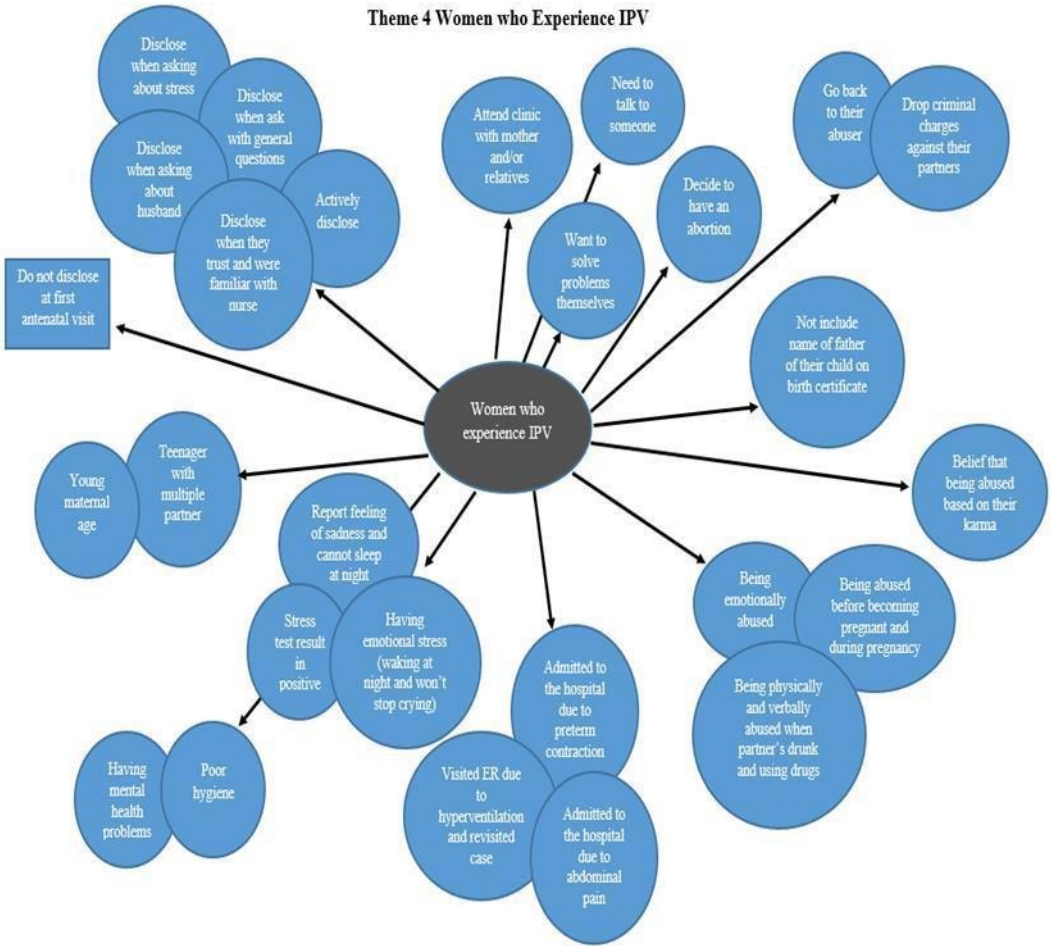
Table 4. 12 An example of combing the codes into a single theme from four transcripts

Theme 'Barriers'
Koy
- Forgot to identify
- Time constraints
- Language differences in pregnant migrant women
- No incentive
Ann
- Personal belief: IPV caused by several factors/Thai culture/IPV as private issue/ gender roles with men as superior
- No resources to screen for IPV
- Sensitive issue, time constraints, nurse busy
Joy
- New staff who are not familiar with hospital policy.
Pim
- High turnover of nursing staff
- Time constraints (nurses are unable to spend a lot of time with the identified victims)
- New staff lack knowledge and experience
- A heavy workload
- Having to see a lot of pregnant women per day
- Shortage of nursing staff

In this stage, all of the different codes were identified and grouped together across the data set. Some codes were moved around, moved back and forth to try forming different themes. In this process, I also created a map of the codes and themes which I could

move around in order to help me to visualise the relationships and the differences between the various codes and themes. Figure 4.4 shows the map of one preliminary theme which was identified in this stage, along with the codes associated with it. Ultimately, there were ten preliminary themes. Most codes were associated with one theme, some codes were associated with more than one theme and a few codes were uncertain. These uncertain codes might be of interest later, so I put them into a theme labelled 'Others'. The process of identifying all the preliminary themes and assigning the codes was also discussed with my supervisor.

Figure 4. 4 Map of the preliminary theme and codes



Stage 4 Reviewing the themes

In this stage, the preliminary themes were reviewed, modified and developed. At this point, some themes were found not really to be themes because of insufficient data to support them, others were collapsed into one theme and others were broken down into further separate themes. In order to review and refine the themes, the process involved considering whether for each theme the data within the theme were logically consistent and whether they were clear and distinct from each other. The data associated with each theme were read and I considered whether the data supported the theme. Themes were split into separate themes if there were many contradictions within a theme or if they were too broad. In addition, I added the process of creating a new theme, devising a more appropriate theme for some of the data extracts which did not fit into an already- existing theme, and discarding some of the data extracts and themes.

For example, I felt that the preliminary theme of 'Training regarding IPV' did not really work as a theme because there was not much data to support it and it overlapped with the theme 'Facilitators'. Also, some of the codes included in this theme, for example 'she had more confidence to talk about IPV after training' seem better to support the theme 'Facilitators'.

To summarise, I made a number of changes at this stage:

- I eliminated the themes 'Professional experience and training (in general)', 'Current practice regarding pregnant women and general patients' and 'Thailand'

- I changed the name of one theme from 'Views on IPV' to 'Perceptions on IPV in general and during pregnancy'

- I identified the theme 'Women who experience IPV' as a sub-theme within the broader theme 'Experiences regarding pregnant women who were abused by their

partner' and the theme 'Training regarding IPV' as mentioned above.

Stage 5 Defining and naming the themes

Braun and Clarke (2006) suggested that this stage is to identify the essence which each theme is about and to consider how the story of each theme fits into the overall story. At this point in the analysis, the consideration was whether the story could be told through the theme and could answer the research question. Each theme was therefore carefully considered in relation to the others and at the end of this stage, the themes were clearly defined. Each theme could describe its scope and content with a few words.

Stage 6 Producing the report

This stage involved the final analysis and writing up the report. This final report contained analytical narratives and quotations which best represented the theme or sub-theme which emerged from the analysis. The thematic analysis was carried out in order to explore the participants' perceptions of their roles and experiences and the barriers to and facilitators of identifying and responding to IPV during pregnancy. The results were illustrated in fourteen sub-themes which were clustered into six themes. The details of each theme are discussed in Chapter 6. The set of criteria for assessing the trustworthiness of the qualitative data is provided below.

Trustworthiness and credibility

The trustworthiness of qualitative research can be assessed using criteria outlined by Lincoln and Guba (1985) which are widely accepted for use in qualitative research. These criteria are credibility, transferability, dependability and confirmability. These four criteria are parallel to those used in quantitative research, which are internal validity, external validity/generalizability, reliability, and objectivity (Polit & Beck,

2012; Anney, 2014; Connelly, 2016; Nowell *et al*., 2017).

- *Credibility*

For enhancing the credibility, the researcher can apply many techniques such as prolonged engagement in the field with participants, triangulation, member checking and the use of peer debriefing (Anney, 2014; Connelly, 2016). In this study, the peer-debriefing technique was applied to enhance the credibility of the data. The analytical process and the qualitative findings which emerged were discussed with my supervisors, both of whom were experienced qualitative researchers. In addition, regular meetings between me and my supervisors enabled me to develop ideas and interpretations. In these discussion with my supervisors, probing from them also helped me to recognise my own biases and preferences (Shenton, 2004).

- *Dependability*

Dependability refers to the consistency of the data over the time and conditions of the study. Procedures for assessing dependability are the maintenance of an audit trail, stepwise replication, the code-recode strategy and peer-debriefings with co-worker(s) (Anney, 2014; Connelly, 2016). To demonstrate dependability, similar results would be gained when the work is repeated in the same context and with the same methods and participants (Shenton, 2004). For the current study, the following strategies were used to ensure the dependability of the qualitative findings. First, I double checked all the transcripts to make sure that there were no mistakes, and second, the processes within the study were reported in detail to enable a future researcher to repeat the work.

- *Transferability*

Transferability refers to the degree to which the findings which can be transferred to other situations and populations. To ensure the transferability of qualitative

findings, thick description of the study should be provided (Shenton, 2004; Anney, 2014). Thick description of the data was provided in the current study in order to convey the findings as accurately and as comprehensively as possible.

- *Confirmability*

Confirmability refers to the degree to which the results can be confirmed or accepted by others. An audit trail is one key strategy for establishing confirmability. The strategy of leaving an audit trail enables an auditor to study the transparency of the research procedure (Anney, 2014). Throughout the entire study, evidence of the decisions and choices which I made regarding theoretical and methodological issues were provided, as well as a clear rationale for such decisions.

4.5.3 Integration

Mixed-method data analysis is a process of analytical techniques to apply to the data acquired from quantitative and qualitative research as well as to a mixture of the two forms of data concurrently and sequentially in the same framework (Creswell & Plano Clark, 2011; Onwuegbuzie & Combs, 2011). In a mixed research study, quantitative and qualitative analytical techniques are used more or less concurrently. In this design, the quantitative and qualitative data might be merged into a single data set and analysed concurrently. Alternatively, quantitative and/or qualitative analytical techniques can be conducted at different times (sequentially). This design enables quantitative or qualitative data to be analysed, interpreted and used to inform a subsequent qualitative or quantitative phase of the study. This sequential design uses results from an earlier phase of data collection and analysis to select potential participants for further study, or to generalise findings or to explain a subsequent phase (Johnson & Christensen, 2014).

There are six types of mixed-method data analysis; merging data analyses to compare the results, merging data analyses by data transformation, connecting data analyses to explain results, connecting data analyses to generalise findings, merging or connecting data analyses depending on whether the design is concurrent or sequential, and merging or connecting the separate data analysis for each phase or project in a multiphase design (Ivankova *et al.*, 2006; Creswell & Plano Clark, 2011). The data analysis procedures in the explanatory design of this current study started by collecting and analysing the quantitative data and then connecting the two research phases by using the quantitative results to form the qualitative research questions, the sampling and the data collection. The next procedure collected and analysed qualitative data in a second phase as a follow-up to the quantitative results. Finally, the results of both the quantitative and the qualitative phases were integrated in a separated section to answer the research questions. Figure 4.5 provides an overview of the procedural steps used to implement the explanatory design of this thesis.

Figure 4. 5 Explanatory design procedures

Phase	Procedure	Product
Quantitative data collection	PREMIS questionnaire (n = 188)	Numerical data
	- Frequencies and percentages - Independent-sample t-test, One-way ANOVA, Multiple linear regression and Binary logistic regression - SPSS quantitative software version 25	- Descriptive statistics, missing data - Inferential statistics
Connecting quantitative and qualitative phases	- Purposefully selecting participants who had experience of identifying and/or responding to IPV during pregnancy - Developing interview questions	- 46 potential participants - Interview guide
Qualitative data collecting	- Semi-structured interviews with sixteen participants	- Textual data (transcripts)
Qualitative data analysis	- Thematic analysis	- Themes and sub-themes
Integration	- Explanation and interpretation of the quantitative and qualitative results	- Discussion - Implications - Future research

(Adapted from Ivankova *et al.*, 2006)

4.5.2 Reflexivity

Reflexivity is described as the researcher's awareness of whether and how her/his positionality might affect the process, the participants and the outcomes of the research. It is an important component of research which is used to monitor the stance of the researcher, who is the main research instrument, as a means of enhancing the quality of the study and its ethical status. The researcher's positioning involves her/his values, social background, personal characteristics, personal experiences and emotional responses to the participants. Reflexivity enables the researcher to be critical about what s/he has heard, written and interpreted and how far s/he can go to interpret the participants' perceptions and experiences (Holloway, 2005; Berger, 2015; Dodgson, 2019). In this section, I shall discuss what it meant to be both a researcher and a nurse when carrying out the semi-structured interviews with the participants in Thailand. I shall also discuss how my dual nature was represented in my research and how it affected the research process regarding the data collected. I had a dual role of researcher and nursing instructor so it was crucial to be carefully self-aware of the influence of my own experiences and assumptions by turning the research lens back on myself. As the interview procedure following the stage of the questionnaire procedure, all of the participants invited to be interviewed already knew about my project, so it was easy to establish the second phase with these participants. However, some participants remonstrated that they had no relevant experience and that they would have nothing to tell. I assured them that little experiences were just as valuable as big experiences for other HCPs who had no experience of identifying and responding to IPV. Some participants were reluctant to take part in an interview as they were not familiar with me. In these cases, I sought to develop rapport and trust by meeting them regularly, sharing my personal experiences related to the topic and

giving them sufficient information on the topic for them to be able to make an informed decision and judgment about whether to continue discussing the topic. Moreover, these participants were approached with the help of a facilitator. The facilitator, who had worked as an OSCC nurse in this area for over ten years, introduced me to the participants and that enabled me to establish a degree of trust with them. She also reassured the participants that there was minimal risk involved in taking part in the study. After the interviews, all participants gave me a very positive response and seemed relaxing during the interviews.

Because all of the participants had backgrounds in nursing and were working in government hospitals in Thailand, and because I held a position as an academic researcher as a Thai government sponsored PhD student and had a background as a nurse, this might have influenced the participants in the data collection process in two ways. First, some participants might have thought that I could pass on their complaints to the policy level so they might have over-stated their perceived barriers to identifying and responding to IPV. Second, other participants might have wanted to conceal their negative views or might have been reluctant to express their feelings and give me negative comments on a particular policy or hospital. So during the interviews, I was aware of a power imbalance in the relationship between me and the participants which might affect the research findings. I did not want to influence the participants' answers, nor make them feel that they had to agree with me. I attempted as much as possible to focus on asking questions, not sharing my own views, and not responding to their questions. I asked the questions which had been prepared for the interview guide and used them as prompts to encourage fuller responses, and they were generally based on the questionnaire responses and on the previous participants' experiences gathered in the quantitative phase of the study.

Furthermore, I also explained the right to confidentiality and privacy which the participants had in the interview in order to give them more power to withdraw from the process, or withhold information or not to answer any question which they were unwilling to answer.

4.6 Ethical and research governance approval

Formal ethical approval for this study was sought and obtained from the Ethics Committee of the University of Sheffield before I embarked on the study. Before collecting the data in Thailand, the research proposal, the questionnaire, the participant information sheet and the consent form for interview were reviewed and approved by the Ethics Committee of the Buriram hospital, which is the group assigned by Buriram Provincial Public Health to be responsible for human subject approval for all research projects under Buriram Provincial Public Health (*see* Appendix 4.8).

The necessary ethics application was submitted with supporting documents (the participant information sheet and the questionnaire, as well as the participant information sheet and consent form for interview), all of which were reviewed by the committee. The major ethical concerns were around participants' rights, their consent to participate, confidentiality, the security of their data and their safety (Research Ethics: General Principles and Statements, the University of Sheffield, 2017): each of these issues is discussed in the following paragraphs.

4.6.1 Providing information

In both phases of the study, a participant information sheet in Thai was provided to ensure that the participants were given adequate information which they needed to make an informed decision regarding whether or not to participate in the research.

In the quantitative phase, the information was provided briefly to the professional

nurses and head nurses who distributed the questionnaire to the potential participants. Also, information about the study was provided in written form for all participants on the first two pages of the questionnaire.

In the qualitative phase, the participants were informed of their rights to participate voluntarily and to withdraw their participation at any time without having to give a reason. The participant information sheet gave an overview of the purpose of the study, the rights of the participants, the type of information which the researcher sought from them, the procedures involved in the research, the length of time which participating would involve and the potential risks and benefits to participants (*see* Appendix 4.9).

4.6.2 Obtaining consent

For the questionnaire, consent to use the responses was obtained by virtue of completion, which was explained on the study information sheet described above. For the interviews, the participants were first asked to read the information sheet; they were given as much time as they needed to make their decision and provided with an opportunity to ask questions about anything which they needed to have clarified in regard to the study. They were then required to complete and sign a participant informed consent form before starting the interview. I also made it clear to the participants that recording devices would be used during the interview and their consent was obtained to record the interview. Before starting the interview, the participants were reminded verbally by the researcher that participation in the interview was entirely voluntary and that they were free to withdraw from the interview at any stage.

4.6.3 Confidentiality and data protection

Anonymity and confidentiality were maintained throughout the study. Several key steps

were taken to maintain the confidentiality of the participants and to protect the data obtained. Identification codes in the form of a numerical designation given to the participants were used for the questionnaires. These codes were kept and subsequently used in order to keep track of and identify potential participants for the qualitative phase. As has already been explained, the codes were constructed by the researcher and only known by the researcher and the supervisory team. By using an invented code rather than the names taken from the staff name list of the hospitals, there were no chances that any participants could be traced back to an identifiable individual by any other person. The link between the codes and the personal information of the participants was kept in a separate and secure place, accessible only by myself. The codes were destroyed as soon as the data collection had been completed. The interviews were recorded and a transcript was produced. Digital files containing the interview data were stored in password protected files and the audio recordings were erased after transcription. The transcripts of the interviews were analysed by myself and the transcripts were anonymised. All interview participants were given pseudonyms. Access to this transcript was limited to me and to my supervisors. Any summary of interview content, or direct quotations from the interview were anonymised so that no participant could be identified. Paper and other manual files were appropriately filed and stored securely in a lockable cabinet at the PGR office room, School of Nursing and Midwifery, University of Sheffield, with access restricted to me as the researcher and to my supervisors. Also, the files on the computer could only be accessed by myself and my supervisors and the computer was secured by password. Signed consent forms were separated from the participant data, including the completed questionnaires, my interview notes and the transcripts. During the period when I was conducting the project in Thailand, information from this study was kept in locked

files which only I could open.

4.6.4 The protection and well-being of the participants

The participants were informed through oral communication and written on the participant information sheet that their participation was free and completely voluntary. For the semi-structured interviews, I clearly explained to the participants that if they felt uncomfortable at any question or any stage of the interview, then the interview would be stopped. The next question or stage of the interview would continue again when and if they become comfortable. This process was particularly concerned about uncomfortable feelings with the topic of the study because some HCPs might themselves be affected by IPV. The participants were therefore provided with information regarding counselling and the service resources available to women affected by violence. Details about other appropriate sources of assistance and information to help and support abused women were provided, including a 24-hour hotline telephone number, the OSCC website and mobile apps. Moreover, if a participant were to say something which caused significant concern such as bad practice or if someone could be at risk of harm, a breach of confidentiality might be required. The duty of confidentiality in regard to the data was clearly explained to each participant at the beginning of the interview.

4.7 Conclusion

In this chapter, I have described in detail how the quantitative and qualitative research processes were undertaken. The processes of data analysis in quantitative and qualitative research were also described. Ethical considerations were highlighted and all of the participants were ethically protected and fully informed about the aims of the study. The findings of the quantitative data collection will be presented in the following

chapter.

CHAPTER 5: QUANTITATIVE RESULTS

5.1 Introduction

In this chapter, I shall present the overall findings from the quantitative analysis of the survey data. As was explained in detail in the methods chapter (Chapter 4), a questionnaire was designed by adapting the PREMIS model (Short *et al*., 2006) for use in the context of Thailand. The aim was to assess Thai HCPs' knowledge, attitudes and practices toward IPV in pregnancy and its assessment and management. The findings from this first quantitative phase of the study are presented in four sections. Section 1 presents the findings related to the participants' perceived preparation for and knowledge of IPV during pregnancy. Sections 2 and 3 present the findings related to participants' actual knowledge of IPV during pregnancy and their attitudes to IPV during pregnancy. The fourth section presents the practices of the participants in response to IPV during pregnancy.

5.1 Participants' preparation, perceived preparation and perceived knowledge towards IPV during pregnancy

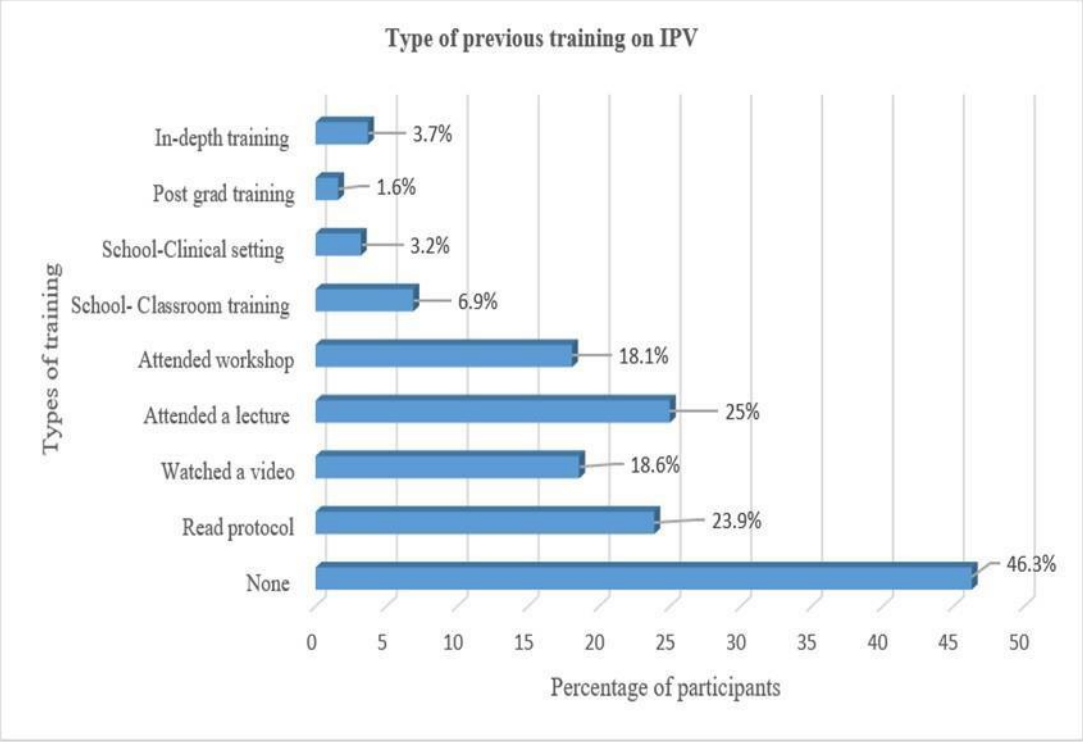
Information about the participants' perceived level of preparation and their perceived knowledge of IPV during pregnancy is presented in this section.

5.2.1 Source of preparation

Eighty-seven participants (46.3%) had not received any training on IPV. Those who had received training mentioned a variety of sources of the training. For example, a quarter of participants (n =47; 25%) mentioned attending a lecture or a talk. Other sources included reading the hospital's protocol (n = 45; 23.9%),

watching a television or video news bulletin (n = 35; 18.6%) and attending a skills-based training session or workshop (n = 34; 18.1%). Figure 5.1 presents information about the types of previous training which the participants had received.

Figure 5. 1 Type of previous training about IPV



Participants who had received any training on IPV were asked to estimate their training hours over the previous twelve months. Overall, the number of hours of training reported ranged between 0 and 60 hours (mean = 3.22 hours; SD = 8.91). A majority of participants (n = 135; 70.7%) said that they had received no IPV training in the previous twelve months. Nearly a quarter of the participants (n = 44; 23.4%) reported receiving between one and ten hours of training in the previous twelve months. A small proportion had received between eleven and twenty hours and more than twenty hours of training.

5.2.2 Perceived preparedness and perceived knowledge

The perceived preparedness of the participants was measured by asking them to rate six Likert-scale statements on the identification of and response to IPV. The scale ranged from 'not prepared' to 'quite well prepared'. Thirty-three participants (17.6%) indicated that they were well prepared with make appropriate referrals for IPV, whilst 43 participants (22.9%) felt that they were unprepared to be able to write a referral report about violence by a husband during pregnancy. Table 5.1 presents the details of the participants' responses about their perceived level of preparedness.

Because of the anticipated attitudes towards their preparation, the questions also asked the participants about their preparation for dealing with victims of IPV, their clinical skills in discussing IPV with pregnant women, and their knowledge of ways of resolving this issue. More than half (53.2%) of the participants agreed that they had not received enough training to take care of women who experience IPV during pregnancy. Eighty-five participants (45.2%) believed that most HCPs lacked the necessary knowledge to take care of pregnant women who were abused.

Table 5. 1 Perceived preparedness to respond to pregnant women who experience IPV

Statement	n (%) Not prepared	Moderately prepared	Well prepared
1. Ask the appropriate questions for pregnant women about IPV by the husband	39 (20.7)	139 (73.9)	10 (5.3)
2. Provide appropriate assistance to pregnant women who are abused by the husband	26 (13.8)	135 (71.8)	27 (14.4)
3. Identify a pregnant woman who is abused by her husband from her medical history and a physical examination	25 (13.3)	140 (74.5)	23 (12.2)
4. Assess the readiness of pregnant women who have been subject to IPV by their husband to change her situation	31 (16.5)	140 (74.5)	17 (9.0)
5. Assess the severity of violence which might cause death	29 (15.4)	131 (69.7)	28 (14.9)
6. Assess the safety of the children of pregnant women who are abused by their husband (in the case that pregnant women have a child and are living together)	30 (16.0)	133 (70.7)	25 (13.3)
7. Help pregnant women who are abused by their husband in planning for their safety	34 (18.1)	136 (72.3)	18 (9.6)
8. Record the history, violence and physical examination results found in pregnant women's files.	36 (19.1)	127 (67.6)	25 (13.3)
9. Make appropriate referrals for IPV	31 (16.5)	124 (66.0)	33 (17.6)
10. Write a referral report about violence by a husband during pregnancy	43 (22.9)	121 (64.4)	24 (12.8)

The participants were also asked to rate their perceived knowledge of identifying and responding to IPV on a Likert scale containing fourteen statements from 'I know nothing' to 'I know very much'. The responses were collapsed into three categories; poor, fair and good. Notably, the majority of the participants (n = 104; 55.3%) felt that they had good knowledge for recognising the impact of IPV on the unborn baby. Table 5.2 presents details of the responses about their perceived knowledge of IPV.

Table 5. 2 Perceived knowledge of IPV during pregnancy

Statement	n (%)		
	Poor	Fair	Good
1. Law about reporting information in the situation of helping a pregnant women who has been the victim of IPV by her husband	91(48.4)	72 (38.3)	25 (13.3)
2. Signs or symptoms of being abused during pregnancy	41(21.8)	80 (42.6)	67 (35.6)
3. How to document IPV in a pregnant woman's chart	77(41.0)	61 (32.4)	50 (26.6)
4. Referral sources for pregnant women who are victims of IPV	77(41.0)	60 (31.9)	51 (27.1)
5. Specify the characteristic or the nature of the person who may be a perpetrator of IPV during pregnancy	63(33.5)	80 (42.6)	45 (23.9)
6. The factors associated with IPV during pregnancy	61(32.4)	81 (43.1)	46 (24.5)
7. Recognising the effects of IPV during pregnancy on an unborn baby	35(18.6)	49 (26.1)	104 (55.3)
8. Appropriate question for IPV screening	69(36.7)	63 (33.5)	56 (29.8)
9. The reasons that pregnant women abused by their husband do not disclose information	68(36.2)	59 (31.4)	61 (32.4)
10. Your role in detecting IPV during pregnancy	62(33.0)	65 (34.6)	61 (32.4)
11. What should and should not be said to an abused pregnant woman	64(34.0)	64 (34.0)	60 (31.9)
12. Identify potential dangers for abused pregnant women	43(22.9)	61 (32.4)	84 (44.7)
13. Develop a safety plan for an abused woman	60(31.9)	73 (38.8)	55 (29.3)
14. The sequence of processes to make abused pregnant women aware of their own situation and be ready to change.	80(42.6)	59 (31.4)	49 (26.1)

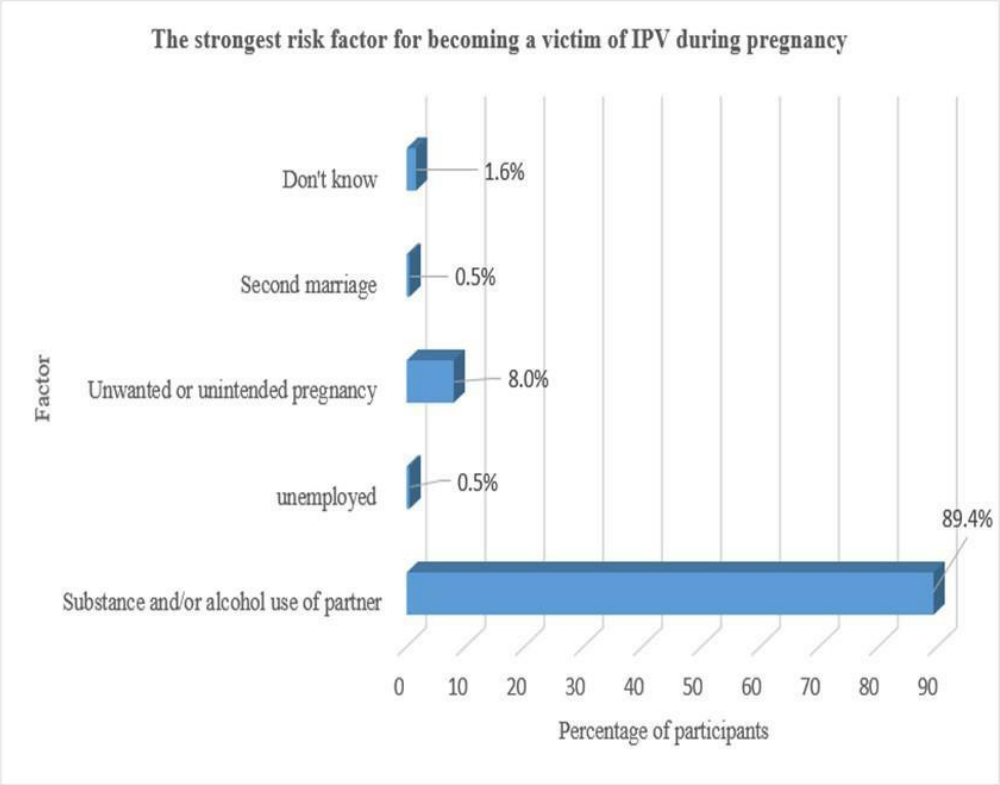
5.3 Knowledge of intimate partner violence during pregnancy

Actual knowledge of IPV during pregnancy was assessed by using six multiple-choice questions and ten ‘true/false’ and ’don’t know’ statements.

The majority of the participants identified a partner’s substance or alcohol use (n = 168; 89.4%), followed by an unwanted pregnancy (n = 15; 8%) as the strongest risk factors for IPV during pregnancy. Figure 5.2 provides details of other causes.

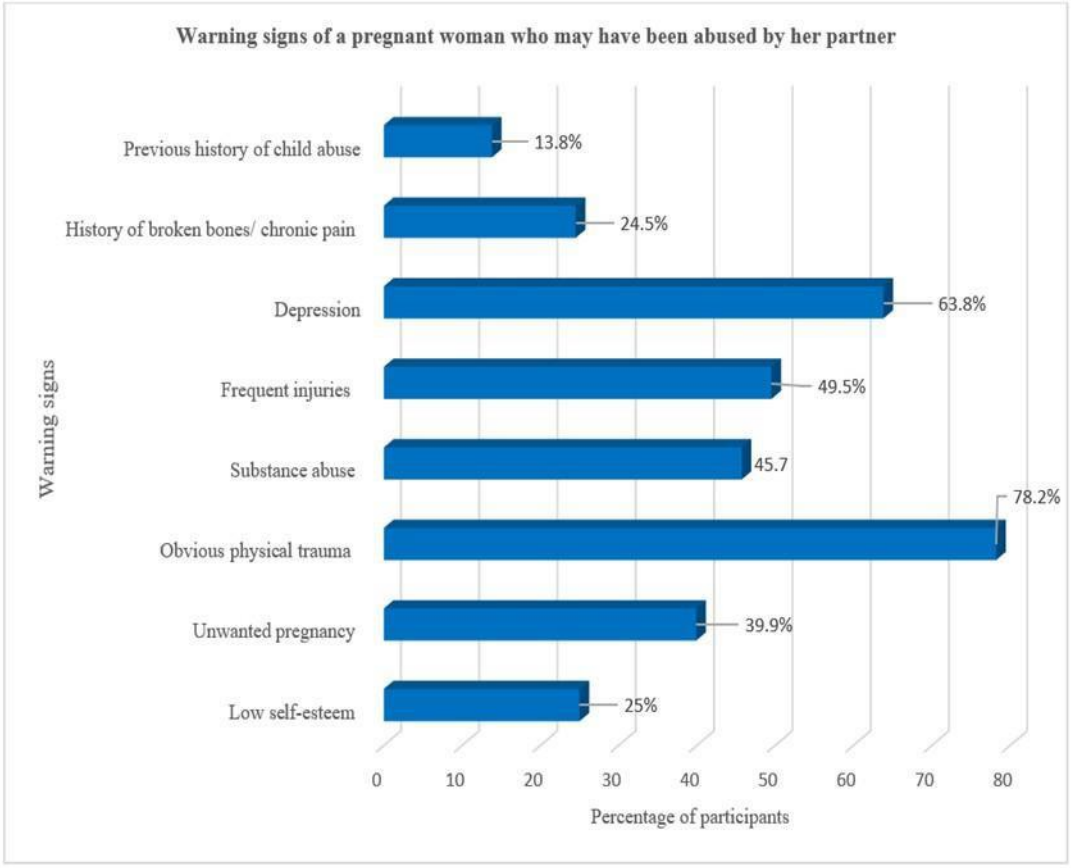
This finding is consistent with the findings from the participants’ opinions gathered from the alcohol and drugs part. This part included three statements asking about the links between alcohol and IPV during pregnancy and most of the participants agreed with all the statements. One hundred and sixty-seven participants (88.8%) agreed with the statement ‘Drinking alcohol is the one of the strongest correlate of the likelihood of IPV during pregnancy’. One hundred and fifty-seven participants (83.5%) believed that the use of alcohol or drugs is associated with IPV victimisation during pregnancy. Moreover, more than half of the participants (n = 122; 64.9%) agreed that pregnant women’s alcohol or drug use was greater in those with a higher risk of experiencing IPV.

Figure 5. 2 The strongest risk factors for becoming a victim of IPV during pregnancy



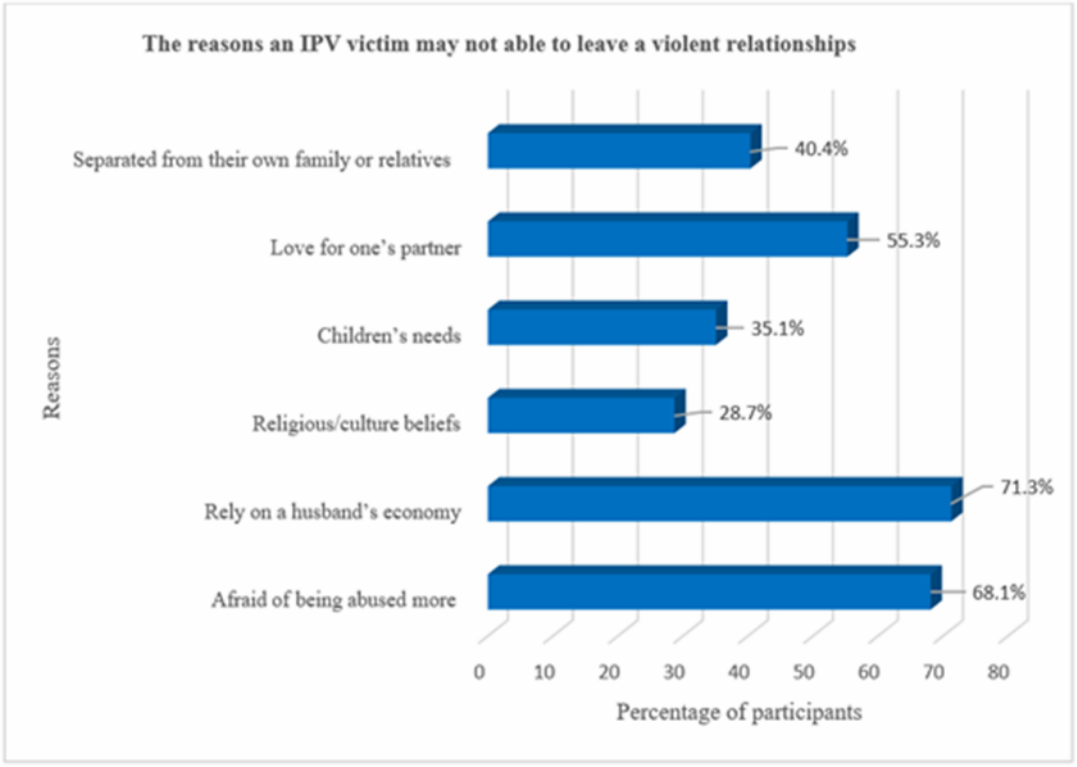
With regards to warning signs indicating that women might be experiencing abuse during pregnancy, the majority of the participants (n = 147; 78.2%) identified obvious physical trauma followed by depression (n = 120; 63.8%). Other warning signs identified included frequent injuries (n = 93; 49.5%), the women's own substance abuse (n = 86; 45.7%), the pregnancy being unwanted (n = 75; 39.9%), low self-esteem (n=47; 25%) and a history of broken bones and/or chronic pain (n = 46; 24.5%). Notably, only 26 participants (13.8%) identified a previous history of abuse as a child as a warnings sign. Figure 5.3 presents information about warning signs of abused women noticed by HCPs.

Figure 5. 3 Warning signs which might help to identify women who are experiencing IPV during pregnancy



Likewise, the participants were asked to select more than one response option for reasons why IPV victims do not leave their abusive relationships. Most participants (n = 134; 71.3%) identified 'being dependent on the husband's economy' as the reason for staying in an abusive relationship. Other identified reasons included 'being afraid of severe abuse' (n = 128; 68.1%) and religious or cultural beliefs (n = 54; 28.7%). Figure 5.4 shows the reasons why IPV victims still continue to live in an abusive relationship.

Figure 5. 4 Reasons why victims continue to live in an abusive relationship



The participants were asked to identify appropriate questions which could be asked of women in order to identify IPV. The responses suggested that 'have you ever been mentally hurt by your partner' (n = 101; 53.7%) and 'during pregnancy, have you ever been afraid of your partner? (n = 103; 54.8) were appropriate questions.

Participants were asked to select the statements which related to identifying IPV during pregnancy. The majority of participants indicated that 'There are common injury patterns associated with IPV' (n = 118; 62.8%) was a true statement relating to IPV during pregnancy, whilst 34 participants (18.1%) indicated that 'Some behaviours which partners frequently show can indicate the use of violence against the spouse' was true.

I asked a few questions to elicit participants' knowledge about IPV during pregnancy. A large proportion of the participants identified the statement 'Alcohol consumption is the greatest single predictor of the likelihood of IPV during pregnancy' (n =162; 86.2%) as a true statement, and that 'Allowing friends or a partner to be present during a physical examination ensures safety for IPV victims' (n = 129; 68.6%) was a false statement.

Table 5.3 shows the participants' responses to all of the items.

Table 5. 3 Responses of the participants to all items

Statements	n (%)		
	True	False	Don't know
True statements			
1. Pregnant women experiencing IPV are able to make appropriate choices and choose the right method for solving these issues.	158(84.0)	15(8.0)	15(8.0)
2. HCPs should not pressure pregnant woman to acknowledge that they are IPV victims.	156(83.0)	21(11.2)	11(5.9)
3. IPV victims are at greater risk of getting hurt when they are trying to escape the husband.	106(56.4)	39(20.7)	43(22.9)
False statements			
1. Alcohol consumption is the grestest single predictor of IPV during pregnancy.	162(86.2)	9(4.8)	17(9.0)
2. There are no reasons not to leave a violent husband.	59(31.4)	87(46.3)	42(22.3)
3. There should not be a record about IPV during pregnancy in a pregnant woman's medical record if she does not want to disclose information.	68(36.2)	106(56.4)	14(7.4)
4. When asking pregnant woman about IPV, HCPs should use the words 'abused' or 'battered'.	127(67.6)	40(21.3)	21(11.2)
5. Being supportive of a pregnant woman's choice to remain in a violent relationship would be deemed to promote violent action.	40(21.3)	126(67.0)	22(11.7)
6. Strangulation injuries are rare in cases of IPV during pregnancy.	39(20.7)	64(34.0)	85(45.2)
7. Allowing partners or friends to join the history taking and physical examination of pregnant women is to confirm that pregnant women are safe from violence.	27(14.4)	129(68.6)	32(17.0)

To identify the participants' level of knowledge about IPV during pregnancy, all seventeen items were scored by giving one mark for each correct answer. The highest possible score that an individual participant could achieve was 31 by answering all the questions correctly. A high score indicated greater levels of participants' knowledge on IPV during pregnancy. The participants were categorised into three group according to their scores; poor knowledge when answering fewer than eighteen items correctly, good knowledge when answering 18 to 24 items correctly, and excellent knowledge when answering more than 24 items correctly. For items testing actual knowledge about IPV during pregnancy, the scores ranged between 3 and 25 (mean = 14.39, SD = 4.25). Doctors scored a mean of sixteen correct responses, nurses and technical nurses scored a mean of fifteen. According to the overall scoring on actual knowledge, the majority of the participants (n = 151, 80.3%) had poor knowledge regarding identifying and responding to IPV during pregnancy, 36 participants (19.1%) had good knowledge but only one participant (0.5%) had excellent knowledge. Table 5.4 presents details of the actual knowledge scores of the participants.

Table 5. 4 Participants' scores showing their actual knowledge about IPV during pregnancy

Profession	**n (%)**		
	Poor	**Good**	**Excellent**
Doctor	18 (75%)	6 (25%)	0
Nurse	132 (81.5%)	29 (17.9%)	1 (0.6%)
Technical nurse	1 (50%)	1 (0.6%)	0
Total	151 (80.3%)	36 (19.1%)	1 (0.5%)

5.4 Attitudes/opinions about intimate partner violence during pregnancy

This section of the questionnaire was an opinions section comprising five parts: legal requirements, workplace issues, self-efficacy, victim understanding and autonomy, and

constraints. The opinion scale represented the participants' attitudes and beliefs about IPV during pregnancy and the details of these opinion scales are presented next.

5.4.1 Opinions: Legal requirements

Nearly half of the participants (44.1%) stated that they were not aware of the hospital regulation on reporting suspected IPV cases, whereas only 68 participants (36.2%) agreed that they were aware of their legal responsibilities.

5.4.2 Opinions: Workplace issues

Workplace issues comprised six statements on whether the clinical workplace allowed them adequate time and place to collect information, how much the hospital supported them to help victims of IPV, how much the hospital encouraged them to respond to pregnant women who might be experiencing IPV, and their ability to refer a victim of IPV to an appropriate specialist service. The majority of the participants (n= 141; 75.0%) agreed that they could gather the necessary information to identify IPV during pregnancy. Table 5.5 shows the percentage of participants agreeing with the statements on workplace issues.

Table 5. 5 Opinions: Workplace issues

Statements	n (%)		
	Disagree	Neutral	Agree
1. My workplace supports me to help pregnant woman victims of IPV.	25(13.3)	29(15.4)	134(71.3)
2. I can make referrals to the responsible agencies appropriately within the community for pregnant women IPV victims.	26 (13.8)	31 (16.5)	131(69.7)
3. My workplace gives me enough time to take care of and help pregnant women victims of IPV.	50 (26.6)	28 (14.9)	110(58.5)
4. I have contacted services within the community to establish referrals for pregnant women victims of IPV.	59 (31.4)	32 (17.0)	97 (51.6)
5. In my hospital, there are enough private places to serve and take care of pregnant women victims of IPV.	40 (21.3)	30 (16.0)	118(62.8)
6. I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient injuries (for example, bruises, fractures).	14 (7.4)	33 (17.6)	141(75.0)

5.4.3 Opinions: Self- efficacy

Self-efficacy comprised six statements regarding HCPs' comfort with and ability to identify and deal with pregnant women who might be experiencing IPV. The majority of the participants (n = 121; 64.4%) agreed that they could help a pregnant woman who was a victim of IPV. Table 5.6 presents a summary of the statement responses of the participants in regard to self-efficacy.

Table 5. 6 Opinions: Self-efficacy

Statements	n (%)		
	Disagree	Neutral	Agree
1. I ask all new pregnant women about abuse in their relationships.	72 (38.3)	25 (13.3)	91 (48.4)
2. I feel comfortable talking about IPV with a pregnant woman.	48 (25.5)	25 (13.3)	115(61.2)
3. I have the ability to identify pregnant women who are abused by their husbands from their current illness history, such as depression or migraines.	37 (19.7)	48 (25.5)	103(54.8)
4. I can identify pregnant women who are abused by their husbands without asking them about it.	105(55.9)	46 (24.5)	37 (19.7)
5. I am able to take care of pregnant women who are abused by their husbands and I am ready to help or to fix the problem.	30 (16.0)	37 (19.7)	121(64.4)
6. I know that pregnant women are abused by their husband from those pregnant women's behaviour.	63 (33.5)	53 (28.2)	72 (38.3)

5.4.4 Opinions: Victim understanding and autonomy

This section contained ten statements for assessing HCPs' understanding about victims of IPV and evaluating their attitude to victims' autonomy. The majority of the participants (n = 143; 76.1%) disagreed that pregnant women might be offended if they were screened for IPV, whilst 140 participants (74.5%) agreed that pregnant women could leave the abusive relationships if they wanted to. For HCPs' attitude to victims' autonomy, 111 participants (59%) agreed that pregnant women who are victims of IPV have the right to make their own decision to receive assistance from a medical professional. Half of the participants (n = 98; 52.1%) believed that pregnant women who were victims of IPV have many reasons why they choose to stay in an abusive relationship.

5.4.5 Opinions: Constraints

'Constraints' comprised two statements which asked about the time constraints on HCPs for responding to cases of IPV. The majority of the participants (n = 127; 67.6%) disagreed that HCPs do not have time to take care of pregnant women who are abused and some participants (n = 114; 60.6%) disagreed that they were too busy to participate in a team

which manages IPV cases.

5.5 Participants' practices in response to intimate partner violence during pregnancy

Practice issues comprised twelve items including questions related to HCPs' experience of identifying cases of IPV case during pregnancy in the past, routine screening, responding to disclosure and familiarity with the policies and/or protocols on IPV of their hospitals.

5.5.1 HCPs' experience of identifying intimate partner violence

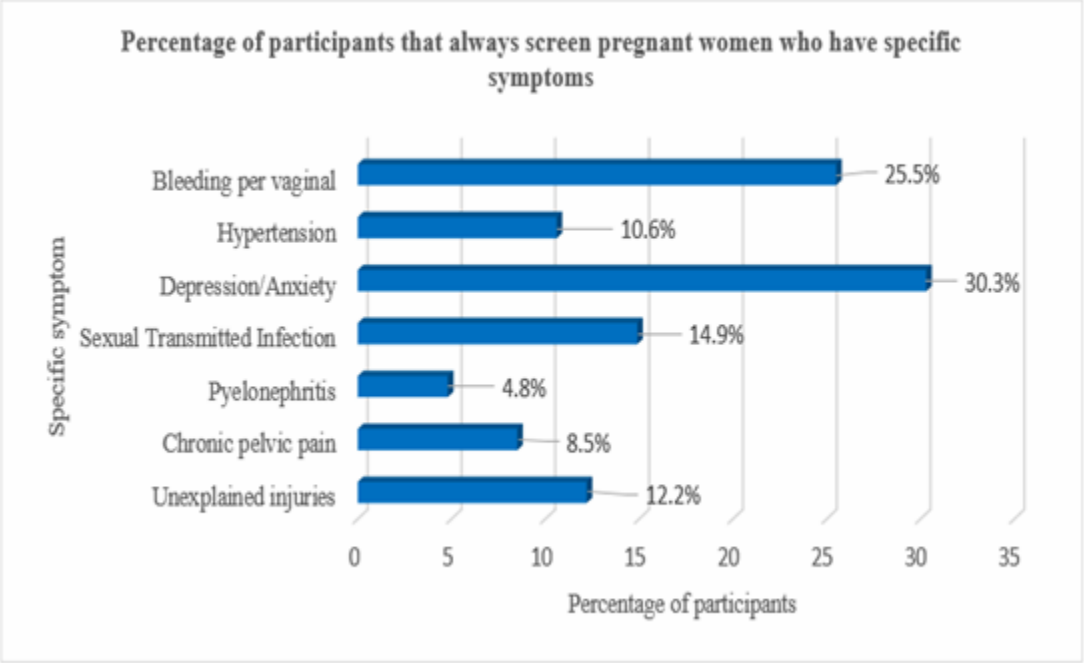
Only a quarter of the participants (n = 46; 24.5%) mentioned identifying at least one new case of IPV in their working experience. Most of them (n = 142; 75.5%) had not identified any cases of IPV in their working lives. Fifty-seven participants (30.3%) reported that they had never screened women for IPV during pregnancy in their working experience. The majority of the participants (n = 131; 69.7%) screened pregnant women for IPV. Participants who responded 'yes' to the question 'Have you ever screened pregnant women for IPV?' were then asked about what groups of pregnant women they routinely asked about IPV. The majority (n = 103; 54.8%) who had ever screened pregnant women for IPV reported that pregnant women who were depressed or suicidal were usually asked about IPV followed by pregnant women with abuse indicators in their medical history or on examination (n = 85; 45.2%) and pregnant women with a partner who drank alcohol or showed other substance abuse (n = 79; 42%). Table 5.7 presents more details of HCPs' experiences regarding IPV identification.

Table 5. 7 HCPs' experiences of IPV identification

Question	n (%)
How many new diagnoses/screenings of IPV would you estimate you have made in the past?	
None	142 (75.5)
1-5	41 (21.8)
6-10	3 (1.6)
11-20	2 (1.1)
21 or more	0
Total	**188 (100)**
Have you ever screened pregnant women for IPV?	
Yes	131 (69.7)
No	57 (30.3)
Total	**188 (100)**
What pregnant women groups are routinely asked about IPV?	
Screen all new pregnant women	36 (19.1)
Screen all pregnant women with abuse indicators	85 (45.2)
Screen all pregnant women at specific times	11 (5.9)
Screen certain pregnant women categories only	
Young adult pregnant women or teenagers	53 (28.2)
Separated from the husband/divorced women/single mother	41 (21.8)
Married women	18 (9.6)
Women with alcohol or other substance abuse	79 (42.0)
Immigrant women	12 (6.4)
Depressed/suicidal pregnant women	103 (54.8)
Pregnant women who have children with confirmed or suspected child abuse	63 (33.5)

Participants who had ever screened pregnant women for IPV were then questioned in more detail. The question asked how often the participants screened for IPV during pregnancy when they encountered pregnant women with obvious symptoms. Fifty- seven participants (30.3%) always asked pregnant women who presented as depressed and/or with anxiety about IPV. However, most participants (n = 116; 61.7%) stated that they never asked about IPV when presented with a pregnant woman with pyelonephritis. Figure 5.5 shows the percentage of participants who always screened women who have specific symptoms.

Figure 5. 5 Percentage of participants who always screened pregnant women who have specific symptoms



5.5.2 HCPs' experiences of responding to IPV disclosure

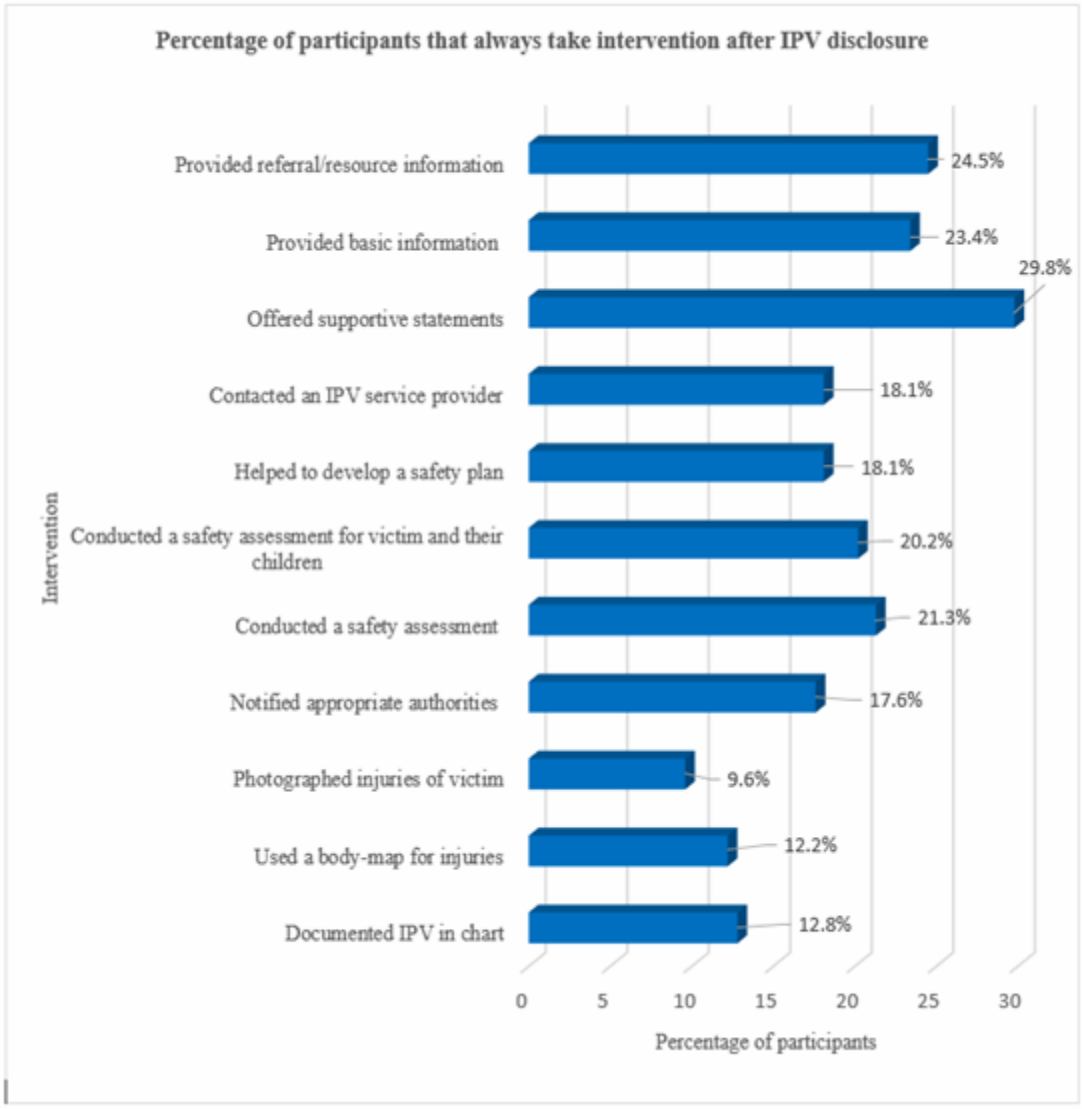
The majority of the participants (n = 140; 74.5%) reported that they had not encountered IPV cases in the past. Thirty participants (16.0%) who had identified IPV reported that they provided information to the pregnant women, and 34 participants (18.1%) reported that they conducted a safety assessment, whilst only small proportion (n = 15; 8.0%) helped the victims to develop a personal safety plan. Additionally, 34 participants (18.1%) said that they had made a referral for pregnant women. When asked for more details about referring, 28 participants (14.9%) stated that they referred victims to the OSCC and fourteen (7.4%) referred them to a police officer. Only one participant (0.5%) said that s/he referred victims to a psychiatrist. Table 5.8 presents details of the participants' experiences in responding to IPV disclosure by IPV victims.

Table 5. 8 Participants' experiences of responding to IPV disclosure

	n (%)
In the past, which of the following actions have you taken when you identified IPV during pregnancy?	
Have found IPV cases in past	48 (25.5)
Provided information to pregnant women	30 (16.0)
Conducted a safety assessment	34 (18.1)
Developed a personal safety plan	15 (8.0)
Referred pregnant woman	34 (18.1)
Other supportive actions	1 (0.5)
Referral places	
One-Stop Crisis Centre	28 (14.9)
Domestic violence's programme/shelter	12 (6.4)
National DV/IPV Hotline	7 (3.7)
Police	14 (7.4)
Housing, educational, job or financial assistance	12 (6.4)
Social worker	2 (1.1)
Psychiatrist	1 (0.5)

For the specific interventions taken following the identification of IPV during pregnancy, the intervention most commonly taken was to offer a validating or supportive statement to the pregnant women (n = 56; 29.8%). Figure 5.6 presents details of the interventions taken by the participants after the disclosure of IPV.

Figure 5. 6 Percentage of participants who always made an intervention after IPV disclosure



5.5.3 HCPs' familiarity with the policies and/or protocols of their hospitals

Regarding the hospital protocol for responding to IPV among pregnant women, the majority of the participants (n = 55; 29.3%) were unsure. Furthermore, most of them (n= 80; 42.6%) had answered the question 'Do you know the hospital policies regarding the screening and management of pregnant women who are abused by the husbands?' by marking 'not applicable'. Table 5.9 presents details of their familiarity with general practice policy and protocol.

Table 5. 9 General practice policy and protocol

Questions	n (%)
Is there a protocol for dealing with IPV during pregnancy at your unit?	
Yes, and it is widely used	48 (25.5)
Yes, and it is used to some extent	44 (23.4)
Yes, but it is not used	10 (5.3)
No	31 (16.5)
Unsure	55 (29.3)
Total	**188 (100)**
Do you know the hospital policies regarding the screening and management of pregnant women who are abused by their husband?	
Yes	70 (37.2)
No	38 (20.2)
Not applicable	80 (42.6)
Total	**188 (100)**
Is a camera available at your work site for photographing the injuries of pregnant women who are IPV victims?	
Yes	101 (53.7)
No	39 (20.7)
Unsure	48 (25.5)
Total	**188 (100)**

Fifty-four participants (28.7%) said that they were unsure whether there were educational or resources material for IPV in their unit. When asked about referral resources, 69 participants (36.7%) felt that they had scarce IPV referral resources for pregnant women. The majority of the participants (n = 85; 45.2%) indicated that they did not have adequate knowledge of the referral resources in the community, whilst some of them (n = 40; 21.3%) said they were not sure about it. Table 5.10 presents the general practices of HCPs regarding resources.

Table 5. 10 General practice resources

Questions	n (%)
Are IPV education or resource materials available at your practice site?	
Yes, there is enough	27 (14.4)
Yes, but there is not enough	25 (13.3)
Yes, but not for pregnant women	19 (10.1)
No	63 (33.5)
Unsure	54 (28.7)
Do you distribute leaflets, flyers or information about IPV to pregnant women?	
Yes, every time	29 (15.4)
Yes, when it is seen as safe	17 (9.0)
Yes, only when pregnant women request it	33 (17.6)
No, due to the referral system being not good enough	21 (11.2)
No, because I do not feel these materials are useful	29 (15.4)
No, other reasons	59 (31.4)
Other reasons	
Don't know about this project	10 (16.95)
Don't know who was abused	1 (1.69)
Never think about IPV	1 (1.69)
No poster	16 (27.12)
Not enough knowledge and skills	3 (5.08)
No time	1 (1.69)
No case	17 (28.81)
Missing data	10 (16.95)
Total	**59 (100)**
Do you feel you have adequate adult IPV referral resources for pregnant women at your work site (including mental health referral)?	
Yes	62 (33.0)
No	69 (36.7)
Unsure	57 (30.3)
Do you feel you have adequate knowledge of referral resources in the community (including shelters or support groups) for pregnant women who are IPV victims?	
Yes	63 (33.5)
No	85 (45.2)
Unsure	40 (21.3)

5.6 Inferential statistics

In this section, attention is turned to the relationship between the participants' background and the PREMIS score, as well as the effect of their background on the PREMIS score. The effect of background and PREMIS score on IPV identification behaviour will also be examined. To examine the differences, relationships and predictors of these study variables, independent- samples t-tests, one-way ANOVAs, multiple linear regressions and binary logistic regressions were conducted. A p value of less than 0.05 was considered statistically significant for all of the tests. All the assumptions of each technique were also tested and discussed when any of these assumptions were violated.

5.6.1 Independent-sample t-test

This test was performed to examine whether there was a significant difference between gender (male and female), occupation (doctor, nurse and technical nurse), previous training (trained and never) and IPV identification (had screened and had never screened) groups in terms of their PREMIS scores. These scores included the perceived preparation, perceived knowledge, actual knowledge and opinion sub-scales.

Comparison of PREMIS scores between males and females

The test revealed that there was no statistically significant difference for the perceived preparation, actual knowledge and opinion sub-scales, except for workplace issues, between male and female participants. There was a significant difference in the mean scores on perceived knowledge for males (M = 3.33, SD = 0.99) and females (M = 2.92, SD = 0.99); t(186) = 2.36, p = .019. There was also a

significant difference in the mean scores on opinion about workplace issues for males (M = 4.53, SD = 1.10) and females (M = 4.90, SD = 1.01); t(186) = 2.00, p = .047. Males had a significantly higher perceived knowledge score than females, but females had a significantly higher mean score on opinion towards workplace issues than males.

Comparison of PREMIS scores between doctors, nurses and technical nurses

The results showed no significant differences for the perceived preparation, actual knowledge and opinion sub-scales, except for opinion about victim understanding, between doctors, nurses and technical nurses. There was a significant difference in the mean scores on perceived knowledge for doctors (M = 3.41, SD = 0.79) and nurses (M = 2.95, SD = 1.01); t (186) = 0.25, p = .032. There was also a significant difference in the mean scores on opinion about victim understanding for doctors (M = 4.82, SD = 0.64) and nurses (M = 4.41, SD = 0.76); t (186) = 2.53, p = .012. Doctors had a significantly higher scores on perceived knowledge and opinion about victim understanding than nurses.

Comparison of PREMIS scores between participants who had been trained on IPV and those who had never been trained

The tests showed no significant differences for actual knowledge, the opinion sub-scale on HCPs' preparation, self-efficacy, alcohol and drugs, victim understanding, victim autonomy, and constraints between participants who had been trained and those who had never been trained. There were significant differences in the mean scores on perceived preparation and perceived knowledge. For the perceived preparation, the assumption had been violated, so test statistics from the row labelled

'equal variances not assumed' were read (Field, 2011). The mean scores on perceived preparation were for the never trained, M = 2.60, SD = 1.19, and for the trained respondents, M = 3.41, SD = 1.04; t (172.29) = 4.95, p <.001. The mean scores on perceived knowledge were for the never trained, M = 2.67, SD = 0.93, and for the trained respondents, M = 3.30, SD = 0.96; t (186) = 4.56, p <.001. There were also significant differences in the mean scores on opinion regarding legal requirements and workplace issues.

For legal requirements, the mean scores were for the never trained, M = 3.43, SD = 1.55, and for the trained participants, M = 4.04, SD = 1.55; t (186) = 2.71, p = .007. For workplace issues, the mean scores were for the never trained, M = 4.50, SD = 0.91, and for the trained participants, M = 5.11, SD = 1.05; t (186) = 4.20, p <.001. Participants who had been trained on IPV had significantly higher mean scores on perceived preparation, perceived knowledge, opinion towards legal requirements and workplace issues than those who had never been trained.

Comparison of PREMIS scores between participants who had screened pregnant women for IPV and those who had never screened

The tests revealed no significant differences on the actual knowledge and opinion sub-scales, except for workplace issues, between participants who had previously screened pregnant women for IPV and those who had never done so. There were significant differences in the mean scores on perceived preparation, perceived knowledge and opinion about workplace issues. The mean score on perceived preparation were for those who had screened, M = 3.15, SD = 1.20, and for those who had never screened, M = 2.78, SD = 1.08; t (186) = 1.98, p = .049. The mean scores on perceived knowledge were for those who had screened, M = 3.13, SD =

1.02, and for those who had never screened, M = 2.73, SD = 0.89; t (186) = 2.57, p = .011. There were also significant difference in the mean scores on opinions about workplace issues: the mean scores were for those who had screened, M = 5.00, SD = 0.95, and for those who had never screened, M = 4.42, SD = 1.10; t (186) = 3.72, p <.001. Participants who had screened pregnant women for IPV had significantly higher mean scores on perceived preparation, perceived knowledge and opinion about workplace issues than those who had never screened for IPV.

5.6.2 One-way ANOVA

A series of one-way analyses of variance (ANOVA) was conducted to determine whether there were any significant differences between the PREMIS scores on the three independent groups of IPV training. The participants were divided into three groups according to their hours of IPV training; Group1: one to five hours, Group 2: six to ten hours, and Group 3: more than ten hours. When there was a significant difference in the mean scores on the dependent variables across these three groups, the *post hoc* test was then conducted to find out where these differences lay (Pallant, 2016).

Perceived preparation for IPV identification and response

There was a statistically significant difference between the groups; F (2, 50) = 4.01, p = .024. For the *post hoc* test, Hochberg's GT2 was used because there were different numbers of participants in each group. This test showed that the mean perceived preparation of Group 3 (more than ten hours; M =4.53, SD = 0.88) was statistically significantly higher than those of Group 1 (1-5 hours; M = 3.58, SD = 1.07) and Group 2 (6-10 hours; M = 3.40, SD = 0.79). There was also no statistically significant difference between Group 1 and Group 2.

Perceived and actual knowledge of IPV during pregnancy

The results showed that there were no statistically significant differences in perceived knowledge between Group 1 (M = 3.43, SD = 1.04), Group 2 (M = 3.29, SD = 0.82), and Group 3 (M = 4.19, SD = 0.0.88); F (2, 50) = 2.67, p = .079.

For actual knowledge, Levene's test for homogeneity of variance was less than .05, which showed that the assumption has been violated. A non-parametric test called the Kruskal-Wallis test was then carried out (Field, 2011). The Kruskal-Wallis test showed that there were no statistically significant differences in knowledge scores between the groups of different levels of IPV training, H (2) = 3.47, p = .18, with mean rank knowledge scores of 24.30 for Group 1, 28.25 for Group 2 and 34.94 for Group 3.

Opinion sub-scales on IPV during pregnancy

There were no statistically significant differences in opinions about HCPs' preparation (F (2, 50) = 2.14, p = .129), legal requirements (F (2, 50) = 0.83, p = .443), self-efficacy (F (2, 50) =1.86, p = .166), alcohol and drugs (F (2, 50) = 1.49, p = .235), victim understanding (F (2, 50) = 1.26, p = .293) and victim autonomy (F (2, 50) = 2.86, p = .067) between the three IPV training groups. The mean scores and SDs on the opinion sub-scales for each group are presented in Table 5.11.

For opinions about constraints, Levene's test for homogeneity of variance was significant, which showed that the assumption has been violated. A Kruskal-Wallis test showed that there were no statistically significant differences in opinions about constraints between the three groups of IPV training, H (2) = 4.77, p = .092, with mean rank opinion scores of 23.58 for Group 1, 29.75 for Group 2, and 35.50 for Group 3.

There was a statistically significant difference of opinion about workplace issues between the three groups; F (2, 50) = 3.92, p = .026. The *post hoc* comparisons using Hochberg's GT2 test showed that Group 3 (M = 5.85, SD = 1.02) had a significantly higher score on opinion about workplace issues than Group 2 (M = 4.72, SD = 1.17) but not significantly different from Group 1 (M = 5.43, SD = 0.85). There was no statistically significant difference between Groups 1 and 2.

Table 5. 11 Mean scores and standard deviations on opinion sub-scales for each group

	Mean	Std. Deviation
HCPs' preparation		
Group 1 (1-5 hours)	4.42	1.20
Group 2 (6-10 hours)	3.72	1.15
Group 3 (More than 10 hours)	4.74	1.27
Legal requirement		
Group 1 (1-5 hours)	4.10	1.38
Group 2 (6-10 hours)	3.92	2.15
Group 3 (More than 10 hours)	4.78	1.56
Self-efficacy		
Group 1 (1-5 hours)	4.83	0.58
Group 2 (6-10 hours)	4.42	0.59
Group 3 (More than 10 hours)	4.56	1.01
Alcohol and drugs		
Group 1 (1-5 hours)	5.57	0.79
Group 2 (6-10 hours)	5.19	1.08
Group 3 (More than 10 hours)	5.07	1.04
Victim understanding		
Group 1 (1-5 hours)	4.60	0.91
Group 2 (6-10 hours)	4.25	0.90
Group 3 (More than 10 hours)	4.84	0.65
Victim autonomy		
Group 1 (1-5 hours)	4.73	0.81
Group 2 (6-10 hours)	4.75	1.00
Group 3 (More than 10 hours)	3.85	1.57

5.6.3 Multiple linear regression

To determine whether the participants' backgrounds influenced their PREMIS scores, multiple linear regression was performed. The participants' backgrounds included their age, years of work experience, hours of training, gender and occupation. Determining this statistic is a complex technique requiring several assumptions, such as adequate sample size, no multi- collinearity, no singularity, no outliers and normality, for a valid result (Pallant, 2016). If these assumptions are not satisfied, the results would provide incorrect explanations and predictions. All of the assumptions were therefore identified from the multiple regression programme using

SPSS as part of the analysis. Preliminary analyses were conducted to ensure that the data did not violate the assumptions. When there were no violations, the multiple regression analysis could be interpreted. The results of the preliminary analyses showed that there was a very high correlation between the independent variables, indicating multi-collinearity. If the VIF (variance inflation factor) values of age and years of experience are greater than ten, one of the variables should be omitted (Field, 2011). In this study, age was omitted. The procedure was then repeated by running a similar model with different dependent variables and the results was interpreted using the same step for each procedure. The steps were checking the assumptions, evaluating the model and then evaluating each of the independent variables.

Perceived preparation and participants' background

In this case, years of work experience, gender and occupation of participants were not significant predictors of the mean score on perceived preparation. Hours of IPV training and previous training were significant predictors of the perceived preparation mean score. A significant regression equation was found ($F(5, 182) = 6.97$, $p<.000$), with an R square of .161). The perceived preparation mean score was

equal to 2.33+0.028 (hours of IPV training) + 0.67 (previous training), where previous training is coded as 1 = 'never trained' and 2 = 'trained'. The perceived preparation mean score increased by 0.028 for each one additional hour of training and participants who had been trained had a preparation mean score 0.67 higher than those who had never been trained. However, the scatterplot of the standardised residuals of this model was not roughly rectangularly distributed, with the most of the scores not concentrated along the 0 axis. Hence, the assumption of homoscedasticity was violated.

Perceived knowledge and participants' background

Years of work experience, gender and occupation of participants were not significant predictors of the mean score on perceived knowledge. Hours of IPV training and previous training were significant predictors of the perceived knowledge mean score. As the significance value was less than .05, the regression model significantly predicted perceived knowledge; $F(5, 182) = 8.48$, $p < .001$, with an R square of .19. The perceived knowledge score was equal to 3.32+0.023 (hours of IPV training) + 0.53 (previous training). The perceived knowledge mean score increased by 0.023 for each additional one hour of training and participants who had been trained had a perceived knowledge mean score 0.53 higher than those who had never been trained. In this model, all the assumptions had been met.

Actual knowledge and participants' background

The results indicated that the model was a non-significant predictor of the actual knowledge mean score; $F(5, 182) = 1.72$, $p = .133$, with an R square of .045.

Opinion sub-scales and participants' background

- HCPs' preparation for IPV identification and response

The gender, occupation and previous training of the participants were not significant predictors of the mean score on HCPs' preparation. The results of the regression indicated that the model explained 9.7% of the variance and that the model was a significant predictor of opinion about HCPs' preparation mean score, F (5, 182) = 3.92, p = .002. The mean score on opinion about HCPs' preparation was equal to 3.01 + 0.028 (hours of IPV training) – 0.033 (years of work experience). HCPs' preparation mean score increased by 0.028 for each one addition hour of IPV training and decreased by 0.033 for each additional year of work experience. All of the assumptions had been met for this model.

- Legal requirements

The gender, hours of IPV training and occupation of the participants were not significant predictors of the mean score on legal requirements. The results of the regression indicated that the model explained 8.5 % of the variance and that the model was a significant predictor of the mean score on opinion about legal requirements (F (5, 182) = 3.38, p = .006). The score on legal requirements was equal to 2.61+ 0.036 (years of work experience) + 0.47 (previous training). The score on legal requirements increased by 0.036 for each additional year of work experience and participants who had been trained had a score 0.47 higher than those who had never been trained. All assumptions had therefore been met for this model.

- Workplace issues

The hours of IPV training, years of work experience and occupation of participants were not significant predictors of the mean score on workplace issues. Gender and previous training were significant predictors of the mean score on workplace issues. A significant regression equation was found (F (5, 182) = 5.27, p<.000), with an R square of .127). The mean score on workplace issues was equal to 3.26 + 0.41 (gender)

+ 0.53 (previous training), where gender is coded as 1 = male and 2 = female. The mean score on workplace issues of females was 0.41 higher than that of males and participants who had been trained had a mean score on workplace issues 0.53 higher than those who had never been trained. However, the scatterplot of the standardised residuals of this model was not roughly rectangularly distributed, with most of the scores not concentrated along the 0 axis. Hence, the assumption of homoscedasticity was violated.

- Self-efficacy

The results indicated that the model was a non-significant predictor of the self-efficacy score; F (5, 182) = 1.29, p = .271, with an R square of .034.

- Alcohol and drugs

The results indicated that the model was a non-significant predictor of the alcohol and drugs score; F (5, 182) = 1.95, p = .089, with an R square of .051.

- Victim understanding

The results indicated that the model was non-significant predictor of the victim understanding score; F (5, 182) = 2.01, p = .079, with an R square of .052.

- Victim autonomy

The gender, hours of IPV training, years of work experience and occupation of the participants were not significant predictors of the mean score on victim autonomy. The results of the regression indicated that the model explained 6.2% of the variance and that the model was a significant predictor of the mean score on opinion about victim autonomy (F (5, 182) = 2.39, p = .039). The mean score on victim autonomy was equal to 3.64 + 0.34 (previous training). Participants who had been trained had a mean score 0.34 higher than those who had never been trained. All of the assumptions

had therefore been met for this model.

- Constraints

The results indicated that the model was a non-significant predictor of the score on constraints; F (5, 182) = 2.24, p = .052, with an R square of .058.

5.6.4 Binary logistic regression

To find out which factors affected the IPV identification behaviour of the participants, a binary logistic regression analysis was conducted. This procedure is used to assess the relationship between dichotomous (dependent) variables (screened or did not screen) and the predictor variables. The advantage of this test is that it enables the researcher to accurately assess the association between an independent variable and a dependent variable (Pallant, 2016). Thus the association between each independent variable and IPV identification behaviour as the dependent variable was explored in order to ascertain whether any of the independent variables were helpful in predicting IPV identification behaviour. Table 5.12 shows all of the independent variables used in the binary logistic regression.

Table 5. 12 Independent variables and dependent variable for the binary logistic regression

Independent variables	Dependent variable
Years of work experience	
Hours of IPV training	
Gender (male and female)	IPV identification behaviour (has screened and has never screened)
Occupation (doctor and nurse)	
Previous training (never and trained)	
Perceived preparation (mean score)	
Perceived knowledge (mean score)	
Actual knowledge (score)	
Opinion sub-scales (mean score)	
- HCPs' preparation	
- Legal requirements	
- Workplace issues	
- Self-efficacy	
- Alcohol and drugs	
- Victim understanding	
- Victim autonomy	
- Constraints	

Checking assumptions

Before running a binary logistic regression, the assumptions are that linearity, multi-collinearity and independence errors have been tested (Field, 2011). For the first assumption, the interaction term between the continuous predictors and their log transformation was tested. The result of this assumption indicated that all thirteen interactions had significant values greater than .05, indicating that the assumption of linearity of the logit had been met. The multi- collinearity assumption was checked to

determine whether there was significantly high correlation between the independent variables (Field, 2011). For this assumption, a tolerance value more than .1 and a VIF value less than 10 indicate no serious problem, hence this assumption had been met. The final assumption is that the independence of errors has also been checked. For this assumption, the Durbin-Watson test was run and the result showed a value of 1.9, which was not definitely a cause of concern (Field, 2011).

Results of the binary logistic regression

The binary logistic regression showed that opinions about workplace issues and victim understanding were significant predictors of the IPV identification behaviour of the participants. The others predictors were not significant. The full model containing all of the predictors was statistically significant (chi-square = 38.95, df = 16 and p = .001 (<.05)), indicating that the model was able to distinguish between participants who had screened and those who had not screened pregnant women for IPV. The model as a whole explained between 18.7% (Cox and Snell R square) and 26.5% (Nagelkerke R square) of the variance in IPV identification, and correctly classified 73.9% of cases. The odds ratio for opinion about workplace issues was 1.93 (95% CI: 1.109-3.346), indicating that for every additional unit of agreement of the participants about workplace issues, they were 1.9 times more likely to screen pregnant women for IPV, controlling for other factors in the model. The odds ratio for opinion about victim understanding was 0.40 (95% CI: 1.002-4.027), indicating that for every additional unit of agreement of participants about victim understanding, they were 0.40 times less likely to screen pregnant women for IPV.

5.6.5 Summary of the inferential statistics findings

This section summarises the results acquired from the comparative investigation which showed the differences and relationships between the each study variable:

perceived preparation, perceived knowledge, actual knowledge and opinions about IPV during pregnancy in regard to participants' background categories of gender, occupation, previous IPV training and IPV identification behaviour. Comparisons were made using the independent-sample t-test and one-way ANOVA test. Relationships were tested using a multiple linear regression and a binary logistic regression.

The perceived preparation of participants was significantly higher among participants who had been trained on IPV than among those who had never been trained and also among participants who had screened pregnant women for IPV during pregnancy than among those who had never done so. The mean score on the perceived preparation of participants who had been trained was 0.7 units higher than of those who had never been trained. Participants who were trained for more than ten hours were more likely to prepare themselves for IPV identification and responses than those who had been given less than ten hours of IPV training. For this relationship, the mean score on perceived preparation increased by 0.03 units for each additional hour of IPV training.

The perceived knowledge of the participants was significantly high among doctors, participants who had been IPV trained, and participants who screened pregnant women for IPV. The mean score on perceived knowledge increased by 0.023 units for each additional hour of training. The mean score on perceived knowledge of participants who had been trained was 0.53 units higher than of those who had never been trained. However, perceived knowledge between participants who had been trained for one to five hours, six to ten hours and more than ten hours were not significantly different.

The actual knowledge of participants in this study was not significantly different or related to any aspect of the participants' backgrounds or other study variables.

For the participants' opinions about IPV, workplace issues was significantly different between males and females and different between those who had been trained and those who had never been trained on IPV. Female participants and those who had been trained on IPV had a higher positive attitude towards workplace issues than male participants and those who had never been trained on IPV. In addition, participants who believed that their workplaces had facilities available for IPV screening were more likely to screen pregnant women for IPV than those who did not believe that places were available.

Opinions about the legal requirements regarding IPV were significantly different between participants who had been trained on IPV and those who had never been trained. Participants who had been trained on IPV believed that they had more knowledge of the legal requirements about IPV compared with those who had never been trained. Participants who had been trained had a score on legal requirements 0.5 units higher than those who had never been trained on IPV.

Opinions about IPV in terms of victim autonomy were significantly different between participants who had been trained and those who had never been trained. The participants who had been trained had a mean score on victim autonomy 0.34 higher than those who had never been trained.

Interestingly, the participants were twice as likely to screen for IPV during pregnancy for every additional unit of agreement about workplace issue. This means that they were more likely to screen for IPV during pregnancy if their workplace had facilities available. However, the participants were less likely to screen women for

IPV during pregnancy when their mean score on victim understanding was increased.

5.7 Conclusion

This first phase of the study was designed to assess HCPs' knowledge, attitudes and clinical practice regarding the identification of and responses to IPV during pregnancy. The differences, relationships and predictors of the study variables, including the participants' backgrounds and their PREMIS scores, have also been presented and discussed in this chapter. The data demonstrated that nearly half of the participants had not received any previous training on IPV and that most of them had not received IPV training in the previous year. For the HCPs' level of knowledge, most of them had poor knowledge about IPV during pregnancy. The attitude of the participants was mainly positive toward IPV during pregnancy in terms of identification and response. For clinical practice, most of the participants reported that they did not routinely screen for IPV among pregnant women. Only 46 participants had identified at least one IPV case in their past working experience and all of these participants were invited to take part in the qualitative (interview) phase of the study. In the next chapter, I shall present the findings from the semi-structured interviews with participants who had experience of identifying and responding to IPV during pregnancy.

CHAPTER 6: QUALITATIVE RESULTS

6.1 Introduction

This chapter presents the findings of the second phase of the research conducted as part of this study. The findings presented here fulfil the research question and the study aim to gain an in- depth insight into HCPs' perceptions and experiences of identifying and responding to IPV during pregnancy. It was also relevant for identifying the barriers and the facilitators which the HCPs encountered when delivering interventions in this area of health care. The recruitment process for this phase followed the completion of the quantitative phase of data collection. Participants who had had experience of identifying and responding to victims of IPV during pregnancy were selected purposively. The presentation of the findings begins with the themes and sub-themes which were identified from the thematic analysis. Anonymised extracts from the interviewees' responses are included to enable a rich understanding of each theme and sub- themes. All of the participant codes from the interview transcripts have been changed to pseudonyms to maintain the interviewees' anonymity.

6.2 Themes and sub-themes identified from the interviews

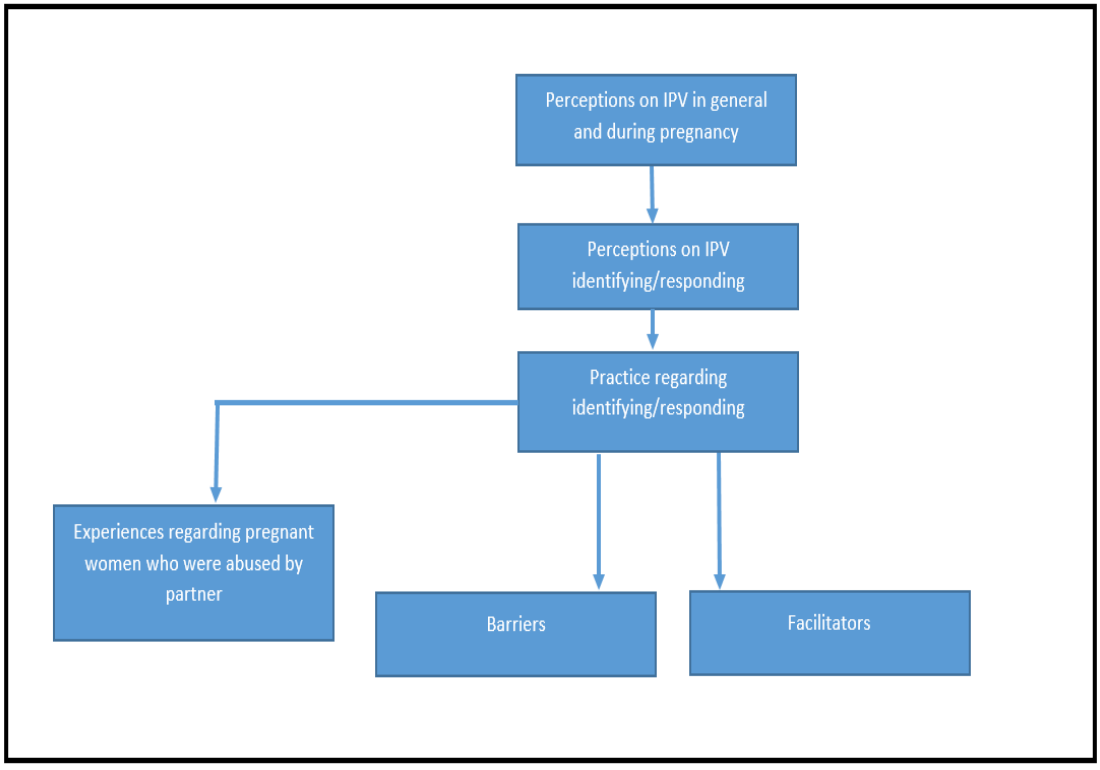
At the beginning of each interview, the participant was asked to provide details about her current practices regarding pregnant women and general patients in an attempt to explore their roles and their responsibilities in nursing. All of the participants were working in more than one clinical setting and/or had held multiple roles. Table 6.1 presents a summary of the current roles and responsibilities of each participant. All participant names or nick names were changed to pseudonyms.

Table 6. 1 Current roles and responsibilities of each interview participant

Participant (Pseudonyms)	Work at													Job role				
	NCDs Clinic	ANC	Well baby clinic	Delivery room	Postpartum ward	OB/GYN clinic	OSCC	HIV clinic	Mental health clinic	OPD	ER	Drug abuse clinic	Teen clinic	Nurse consultant	Sub-head nurse	Project lead nurse	Manager	Head nurse
Koy	√	√	√															
Ann	√	√	√						√					√				
Joy					√	√								√	√	√		
Pim							√		√					√			√	
Tan	√	√					√	√						√			√	
Nuch	√						√			√							√	√
Na	√	√	√															√
Ying	√	√	√						√			√						
Aom		√											√					
Mild		√	√	√	√													
Noy		√	√	√	√													
Tuk							√		√	√	√			√				
Jum							√		√			√	√					
Sine		√	√	√	√									√				
Ging	√	√						√	√					√				

The analysis identified six main themes: 'Perceptions on IPV in general and during pregnancy', 'Perceptions on IPV identifying/responding', 'Practice regarding identifying/responding', 'Barriers', 'Facilitators', and 'Experiences regarding pregnant women who were abused by a partner'. These themes represent the perceptions and experiences described by the participants in their interviews. A thematic map of the relationship between the themes is illustrated in Figure 6.1. In this map, it can be seen how each theme has an effect on the others and how all of the themes are interconnected. For each of these themes, several sub-themes were identified to tell the story about the data in relation to the research question.

Figure 6. 1 Thematic map of the six themes



Theme 1: Perceptions on IPV in general and during pregnancy

One theme which emerged very strongly during the interviews and impacted on the interviewees' roles and experiences regarding identifying and responding to IPV

during pregnancy was their perceptions of IPV in general and during pregnancy. This theme contained three sub-themes: 'It's Thai culture', 'It's a social problem and needs attention' and 'Social change', and these will be discussed individually in the following paragraphs.

It's Thai culture

Most of the interviewees believed that Thai women in general, whether pregnant or not, have suffered IPV. They believed that there are differences and inequalities between men and women in Thai society and that the rigid traditional gender roles can lead to acceptance of IPV. They felt that IPV in some areas or some families is common and accepted as normal as is illustrated in the following extracts:

> *'It is difficult, isn't it? It's Thai culture. We are women. As women in Thai culture, we are in a male-dominated society.'* (Ann)

> *'Thai people believe that men are superior to women, a wife should obey her husband, plural marriages or wives is permitted for men but not for women, and there are many, many things that men can do but women can't. We [men and women] were raised unequally from birth. So I think this culture needs to be changed; we have to treat girls and boys the same from birth.'* (Na)

IPV is a social phenomenon determined by social and cultural conditions, it has deep historical roots in Thailand and a traditional patriarchy which justifies male control over women. It has been prevalent in Thai society for a long time. Under this patriarchal mindset, Thais perceive that men are better than women, they are family leaders with power and rights over their wives. Even though in Thai society some

people believe that IPV is acceptable and normative, most of the interviewees realised that IPV is a complex and multi-faceted problem, especially among pregnant women.

It's a social problem and needs attention

The interviewees identified IPV as a significant problem, a complicated and unacceptable issue. Most of them said that it is important to identify IPV among pregnant women and they were aware of how IPV affects pregnant women. They described how exposure to IPV during pregnancy has numerous potential adverse health outcomes on pregnant women and on their unborn child:

> *'Um, if a pregnant woman has problems like being abused, I think it can affect the child; like having preterm labour and an unhealthy new-born. This woman can also be an unhealthy mother. Moreover, this child might have an increased risk of violence from the father – and how about their mental health of growing up in this kind of environment? They might have delayed development, mental illness and substance abuse because of the consequences of IPV during pregnancy. It's bad, isn't it?'* (Tuk)

From their interview responses, it was clear that all of the participants had some knowledge about the effects of IPV on maternal and child health. They also stated several health consequences of IPV in pregnant women, such as 'depression', 'preterm labour', 'miscarriages' and 'low birth weight'. These findings offer evidence of why the participants perceived IPV during pregnancy to be an important issue which needs attention.

Social change

Most of the interviewees reported that changes were happening in Thailand. In the context of IPV and/or other forms of domestic violence, most of the participants spoke about having a positive response and actions in all cases by both private and government organisations. They mentioned that in the past, many projects and television campaigns had been developed to reduce all types of violence, especially violence against women and children. These projects and campaigns have components seeking to change the cultural and social norms, including beliefs about predominant masculinity and violence and the notion that violence between couples is normal:

> *'In the past 2-3 years, an OSCC was established at the hospital to provide services for women and children who are victims of violence. This centre reminded me of the importance of domestic violence or violence against women and children. Also, a campaign on TV reminded me about this issue. It's like ...err ... what is this campaign? ...* (thinking) … *Oh, it is the campaign that was launched by Princess Bajrakitiyabha [Her Royal Highness Princess Bajrakitiyabha Mahidol of Thailand]. I have also learnt so much about violence from the OSCC nurses and their work. This Centre has given me knowledge about what violence is, what happens, who does it happen to ...* (thinking) *... like women, children and pregnant women, something like that. So I learned a lot from them like how to help victims of domestic violence.'* (Koy)

The findings set out above point out that over the last few years, various projects and campaigns in Thailand have been launched to raise public awareness of domestic

violence and IPV. These projects and campaigns have included developing IPV skills and knowledge for practitioners through seminars, conferences and training sessions, providing financial support to OSCCs and enhancing network agencies at all levels to improve access to services for people who need them. It seems that these projects and campaigns have been an important factor in raising awareness of and improving the response to IPV during pregnancy among the participants in this study.

Theme 2: Perceptions on identifying and responding to IPV

Most of the interviewees perceived that all HCPs in a hospital have an important role in identifying IPV among pregnant women and some of them considered themselves to be well- positioned to identify it. They believed that nurses are the HCPs who are often the first point of contact for pregnant women in the hospital and nurses also have a unique role to play in IPV identification. As one interviewee commented:

> *'I think pregnant women should be screened for IPV by nurses who are working at an ANC [Antenatal Care Clinic] because normally, taking a patient history is undertaken by nurses. They are able to access patient data in more detail than other HCPs. And nurses also have to collect information about a patient's psychology by using 2Q. So, they have more opportunity to screen for IPV.'* (Nid)

Most of the participants also noted that doctors have competencies and abilities for identifying IPV but they explained that doctors are not well positioned to identify IPV in the way that a nurse can because of nurses' prolonged interaction with the patients, as this participant explained:

> *'For the doctors, they don't have enough time because it [IPV identification] takes a bit of time. Actually, I think nurses do not have enough time either, but usually nurses spend more time with patients than any other HCPs. In some hospitals, like a small hospital, we have only two or three doctors. They have many duties towards all patients. Like ...* (thinking) *... they need to do hospital rounds in the morning and they have had to be rotated between the emergency department and the outpatient department. So they have to work very long hours, including weekends and nights. So I think a nurse is better than a doctor for this [IPV identification].'* (Pim)

This can be further explained by the fact that there are shortages and misdistribution of doctors in remote areas of Thailand. There are only two or three doctors in one hospital. Each doctor would be assigned several wards and patients, spending time moving between patients and wards, including the OPD and the emergency department. But nurses more often are assigned a fixed location which allows them to monitor the patients, gives them more time to observe signs of abuse and puts them in a good position to identify patients who have been subjected to IPV more effectively than doctors. Cleary, identifying IPV can take some time and cannot be rushed because of the sensitivity of the issue. It needs rapport and trust building with patients, which takes a lot of time.

Some of the interviewees said that everybody in the community is also important for the identification of IPV:

> *'I think community members should help each other, especially in*

> *their own community. Neighbours know each other very well. They know their neighbours' backgrounds better than us. They know their neighbours well enough to realise whether something horrible is happening in the house. So, I think they can help us with IPV screening. Nurses sometimes have a lot of work to do or some of them don't have knowledge about IPV or never think of IPV. So, we do not screen all pregnant women.'* (Tan)

As outlined above, the interviewees believed that it is impossible for them to screen all pregnant women for IPV because of various barriers, therefore the engagement of the community might help to increase the recognition of abuse. This is because neighbours are well placed to detect IPV as they know each other well. Related to this, activities to change attitudes towards gender- based violence and to increase awareness and knowledge of domestic violence and IPV for local people and the Village Health Volunteer (VHV)[4] initiative have been introduced in many hospitals. Although all of the participants believed that they themselves play a vital role in IPV identification, community cooperation was also viewed as essential to make it more effective.

For the perception of responding to IPV, almost all of the interviewees referred to this as important but recognised that it is hard to do it alone. They stated that working with others in multi-disciplinary teams would make a more effective support for victims:

[4] Village Health Volunteers (VHVs) are defined as community members who have been trained to provide self- care and health information to people in a community.

> *'I think this kind of problem is difficult, but we can accomplish it if we are working with others, for example, psychologists and social workers. However, in term of screening, personally, I think it is definitely the role of the nurse. But we should refer cases to them when those cases are complicated and difficult because they have the potential to help. For us, we can only provide basic nursing care to them [abused pregnant women].'* (Ann)

In their interview responses, most of the participants stated their belief that nursing care alone is not sufficient to address IPV during pregnancy, but rather requires links with multiple sectors including other HCPs, the community and external agencies.

Theme 3: Practices regarding identifying and responding to IPV

Within the theme 'Practices regarding IPV identifying and responding', three main sub-themes were identified. These are discussed next.

Strategies for identifying IPV

Although not all of the interviewees had been trained to identify IPV, the most commonly used methods to identify IPV during pregnancy were similar. Several approaches to identifying and asking about pregnant women's experiences of violence were indicated by the participants. These approaches were asking general questions at first, using 2Q [5]and 9Q[6] as a guide; asking open and closed questions and asking when rapport and trust are successfully established. Here are some of the methods used by interviewees who had never been IPV trained:

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[5] 2Q or PHQ-2 is the Thai version of question 2 of the Patient Health Questionnaire using to screen for depression.

[6] 9Q or PHQ-9 is the Thai version of question 9 of the Patient Health Questionnaire using to screen for depression.

> *'First, I began to ask like "How many months pregnant you are?", "Have you attended an antenatal care unit?", "Who accompanied you today?" These are the questions that I asked her. I asked her like I didn't know anything about her. Then, I asked like "Would your husband come?" and said "Because a doctor would like to explain what the symptoms are and what further treatments are, as well as to talk about the condition of your unborn baby". Start asking like this, then she is going to tell her story.'* (Joy)

Participants who had been IPV trained described a similar method:

> *'For me, most pregnant women who have a high level of stress would be screened for violence. I would gradually ask them like "Are you all right?", "Do you sleep well?", "What's in your mind that makes you stressed?" And I also tried to screen for violence after these questions. I also screened women including those who are not getting pregnant.'* (Jum)

By using a similar method of asking indirect questions, the participants' common points of views were as follows. First, they were reluctant to ask direct questions about IPV because they were concerned that these questions would lead to pregnant women having feelings of shame, embarrassment and discomfort. This could be due to the Thai social code in which IPV is considered as a private issue and a family matter. Most Thais have been taught that they should not share private family matters with outsiders or strangers. Second, the interviewees believed that most pregnant women would not spontaneously disclose their abuse, even when asked about it, if they

did not trust the person asking them. The participants thought that most pregnant women were more willing to talk about being abused to family members or close friends than to HCPs who are true strangers to them. Thus the participants believe that asking indirect questions would help them to establish a rapport with the pregnant women, to build trust, and to observe pregnant women's reactions when asking about their partners.

Pregnant women who were and were not screened

All of the interviewees reported that they felt that they did have a role in identifying IPV during pregnancy and had an understanding of the issues surrounding IPV. Even so, despite their awareness of IPV during pregnancy, they also said that they were not routinely asking pregnant women about IPV. All of them mentioned asking about IPV only when they suspected it, if a pregnant woman came in with a physical injury, if she was a teenager, or if she generated positive 2Q results. Some mentioned inquiring about IPV if a pregnant woman came in with signs of anxiety, depression or unusual behaviour:

> *'In most cases, injuries do not show. So, I would notice from their strange behaviour. Like, lack of reaction to emotional stimuli, no facial expression, no eye contact while speaking and lack of confidence. These cases were usually pregnant teenagers as well. When I notice these behaviours, I would ask them about IPV because I just have a feeling that something is wrong.'* (Sine)

Most of the interviewees agreed that IPV is not always obvious and that it is difficult to recognise because there are no specific symptoms which can facilitate case finding. So the participants usually screened for IPV during pregnancy based

on their knowledge and experience. For example, regarding knowledge, they stated that women in an abusive relationship are probably more likely to suffer from depression. Regarding experience, they mentioned that pregnant teenagers have been linked with unwanted pregnancy and were most commonly abused by an intimate partner. They also used non-verbal cues given by the women. So if a woman looks or acts withdrawn, that is a clue that something is wrong. Interestingly, although previous studies (*see* the Discussion chapter) have shown that there is a higher likelihood of IPV among immigrants than native Thais, some of the interviewees said that they had never identified IPV among immigrant pregnant women.

At the same time, most of the participants said that pregnant women who are 2Q negative can look normal and happy, show no signs of physical abuse and take good care of themselves so they were not screened for IPV. As one participant stated:

> *'Sometimes, I did not identify them for IPV. It's like …* (thinking) *… I ask myself like "Do they have problem of IPV?" And then, I thought, they might probably not be being abused because they looked so happy and they didn't have any signs of abuse. So I thought they have not experienced IPV and I did not ask them about it.'* (Nid)

The interviewees assumed that a woman who was looking happy, good at taking care of herself and had no signs of stress was probably not in abusive relationship. These women were therefore not asked about IPV during pregnancy. However, some participants also said that these women were monitored by the nurses and if significant differences were seen at the next appointment, they would be screened for IPV.

Interventions after IPV disclosure

The interviewees were asked about their current practices when IPV was disclosed. Many of them spoke about having a moral and professional duty to act in response to pregnant women who are suffering IPV. Whilst they shared a common purpose in wanting to help pregnant women who are abused there were differences in how they would do this. All of the interviewees reported that the most common interventions offered to pregnant women were providing IPV information, listening to the patients, evaluating the situation, providing mental support and making referrals to an OSCC, a mental health clinic or a social worker.

> *'She firstly told me that she definitely decided to separate from him and was unable to accept what he had done. But ultimately we are only taking care of her physical health needs and providing mental support.'* (Joy)

These interventions were usually provided as the fundamental actions for abused pregnant women. The extract is an example of the support given to a pregnant woman after she had left her husband. However, the next extract shows how the nurses often felt limited in the support which they could offer:

> *'If she knows what to do next and how to solve her problem, I will let her solve her own problem. But if she has stress or cannot solve a problem of her own or needs help, I will refer her to OSCC or to a mental health clinic where she could talk. Staff in that clinic will help her to solve the problem. This is because I am unable to sit and talk to them [pregnant women who have a problem]. I don't have much experience and I had never been trained to*

> *become a counsellor. But we can give some care because we are nurses. So we probably know how to provide basic care to patients and we can do something for them.'* (Koy)

This extract shows that the support provided for abused pregnant women depends on several factors. One factor which affects the provision of support is the consent of an abused pregnant woman. Most of the interviewees said that they usually let these abused pregnant women solve their problems themselves first. If they could not fix the problem by themselves, then the interviewees would provide some other help. But if the women do not allow them to help, then they cannot do anything, they can only provide fundamental care. The experience and competency of HCPs are another factor affecting the support which they provide to pregnant women who experience IPV. The following extract shows an example of providing support which was related to an HCP's experience and competency. Participants who had experience of responding or who were working in an OSCC would provide more help:

> *'I mean [I told her about the] OSCC, gave her some money, contacted the emergency house and helped her to find a job. I also empowered her and gave her some information about gender-based violence.'* (Tan)

This interviewee had been trained to deal with IPV and she also worked in an OSCC where services for the victims of violence are usually provided. Empowering women is one intervention which is provided by an OSCC. In this context, empowering women included encouraging financial independence and lowering the victims' tolerance of abuse. Empowerment interventions might be providing a job, giving education about human rights and offering information about other appropriate

networks for the women. However, the OSCCs in several hospitals were not well established or did not function well, so not all hospitals had facilities available for this type of intervention. The interview responses showed that only nurses who had been trained to deal with IPV would provide empowerment interventions for victims of IPV.

The interviewees who had a network connection usually responded to IPV by working together with multi-disciplinary teams:

> *'It's better to work together than alone because sometimes, I encounter problems which I cannot solve. When I met a more unusual or difficult case, I would seek for help from my team. It's actually an informal team. I asked them, like, what to do or who should I contact. So they would tell me what to do; it's very nice, I felt I can do everything because I have a team to support me. My team members are a doctor, a social worker, a lawyer and the judge whom I met during IPV training. I always ask them for help when I have trouble with a case. It's great to work as a team, so I am not working alone.'*
>
> (Sine)

Most of the interviewees raised concerns about their ability and said that the limited resources of their hospitals could affect their responses to the victims. They reported that when disciplinary teams are available, the victims would be provided with appropriate services which fully meet their needs, the best possible care and an effective response. The interviewees also commented that IPV is not just the responsibility of the HCPs in the hospitals but rather requires links with external

agencies. So in some hospitals which did not have such a coordinated approach, the most common responses were providing basic nursing care, providing mental support and referring patients to a psychologist or OSCC if that service was available. The interviewees also reported their feelings of unhappiness and disappointment when they were unable to get the required help and support from other services and when they could provide only nursing care for the victims.

Theme 4: Barriers

Three sub-themes were derived from the interviews which reflected the barriers to identifying and responding to IPV. These will be discussed next.

System barriers

System barriers related to hospital working conditions and were described in terms of lack of time and lack of clinical guidelines. As already discussed above, most of the interviewees suggested that lack of time was a big constraint and they also stated that the causes of the lack of time were related to the shortage of nursing staff, a heavy workload, having to see a lot of pregnant women each day and having more pressing issues to address.

> *'If you are asking me about IPV screening, I think we should we have to screen. But it could be better if we have more staff to help with this because we do not have enough time, we also have a lot of work to be done every day. Like, at every antenatal visit, nurses should assess all pregnant women for a high-risk pregnancy, which is approximately 40 items to work on. It's a lot of work to do. Sometimes, there were about 80 pregnant women a day but just only two or three nurses are on duty. That's why there's not enough time. We can't do it.'* (Ying)

Another challenge associated with the health care system to identifying and responding to IPV during pregnancy was the lack of clinical guidelines. The interviewees mentioned that there were no guidelines about how HCPs should ask and help pregnant women who were being abused. Interviewees' responses confirmed this, for example:

> *'Honestly, for me, I don't know what they do at the ANC. I don't really know what they are doing for pregnant women who are experiencing IPV. I know we have guidelines which are designed to provide the general care for pregnant women. The guidelines cover the care for uncomplicated and complicated pregnancies. So, we know how to do, like, what blood tests are done at twelve weeks pregnant but I don't know about violence.'* (Nuch)

Conversely, some interviewees said that guidelines or policies relating to IPV were developed but were not being fully implemented and were not specific to pregnant women:

> *'I personally think that guidelines or procedures for identifying or responding to pregnant women on IPV issue are not spread out across the country. Because I am a nurse supervisor, I can say that many younger nurses working in other hospitals aren't really aware of violence against pregnancy. They don't even know the procedures of the referral system.'* (Joy)

The interviewees' responses suggested that there are guidelines for assisting children and women who are victims of violence in Thailand, but there is no specific guideline for assisting abused pregnant women, so the management procedures for

addressing IPV during pregnancy were adapted by some HCPs from the guidelines for children and women. However, these adapted guidelines could be only acknowledged by some groups of HCPs, usually including doctors, nurses and social workers working in the OSCCs. These groups are usually trained to have an increased knowledge of IPV issues and improved skills in the provision of services to victims of violence. Some group of HCPs did not know of the existence of any guideline for HCPs working with women victims of violence, especially newcomer HCPs who had never been trained on IPV.

Provider-related barriers

This sub-theme refers to the notion that the nurse herself could be a barrier to identifying and responding to IPV among pregnant women. Some of the interviewees expressed a lack of knowledge and confidence concerning how to handle the situation if women did disclose IPV:

> *'This is because I don't have the knowledge, I don't know what to do after IPV disclosure. If we know what to do, we can tell them what to do next. It would be better. It would be good. But I don't know and I have no idea what to do, how to help them.'* (Noy)

Some participants blamed themselves for not being aware of what the pregnant women had been exposed to and for forgetting to identify it:

> *'Since the OSCC launched in my hospital, Dr T [the OSCC Manager] has taken on a lot of responsibility at the request of her manager. She has tried to emphasise to us the importance of IPV or domestic violence screening. But, we are like ...* (laughing) *... how to say? ...* (thinking) *... It's not everyone who can do*

this, sometimes we may have forgotten it.' (Koy)

Barriers related to the pregnant women

The interviewees described pregnant women themselves as a possible barrier, because some were unwilling to disclose the IPV, having the belief that IPV is a private issue and is accompanied by a feeling of shame. There was concern that pregnant women may not want to disclose IPV, as is shown in the following extract:

> *'I would ask them general questions first. When I realised that they were beginning to talk about IPV, I would ask by using direct questions related to IPV. I think these pregnant women were ashamed. I had experience of one pregnant woman who told me that she had been subjected to IPV by her husband. She said "it's really embarrassing to tell someone that my husband's abusing me", so she didn't want to talk about it. If I were her, I would feel shame as well.'* (Pim)

Some of the interviewees said that they were also faced with language barriers which prevented them from screening for IPV among immigrant pregnant women:

> *'Most of them who are not asked are probably Khmer and Burmese people. We never ask them about this. I feel, like, they are foreigners and living in our country. They've got many problems like language. If they have been abused by their husband, something will probably happen. In this case, she would probably go back to her home country. But most of them have been living here for many years, so we rarely think about it unless it is really obvious.'* (Koy)

The findings suggested that most of interviewees perceived that the majority of the barriers were related to pregnant women being unwilling to disclose IPV, but the problem of different languages was also a barrier encountered by one interviewee when she screened pregnant immigrant women for IPV.

Theme 5: Facilitators

For the facilitators theme, the sub-themes were policy implementation and nurse-patient relationships. I shall explore them separately next.

Policy implementation

In this sub-theme all of the interviewees expressed appreciation of question 2 of the patient health questionnaire (2Q) as the facilitator of IPV screening during pregnancy. They felt that the 2Q helped them to approach a difficult issue and clarify the situation of pregnant women and made it easier to raise the issue of violence. The 2Q was described as a 'guide' to help in IPV identification:

> *'I can tell that all patients did not disclose about IPV. They did not say anything we have to observe. However, now we have the aid which is the 2Q and 9Q questions. It's a policy that all patients who came to the hospital are asked by using 2Q. So, pregnant women as well, they were asked about their stress or depression using 2Q. When a pregnant woman has positive 2Q results, she would continue to be asked about the cause of the stress. That could lead to [the identification of] violence. I think it's good, it helps us a lot.'* (Pim)

Another major facilitator stated by all of the interviewees was IPV training. Participants who had received training agreed that they were more confident and

more comfortable with screening for and responding to patients who are victims of abuse as a result of having received the appropriate training:

> *'I think I can handle the case properly because I have taken two courses, so I am quite confident about working on this, both identifying and responding, somehow I don't work alone, I have my network, T [the name of the senior nurse] and the foundation, so if I found a difficult case, I can seek help from them.'* (Ann)

> *'I think that training and education of HCPs in IPV can lead to better care for survivors of IPV. The training programme will provide knowledge about IPV and improve the ability of HCPs to respond appropriately to survivors of IPV. Although I have never been trained, it's helpful if one of my colleagues is trained. Just one trained nurse in the workplace is okay. So, I think it's good to have participated in an IPV training programme.'* (Nid)

Even those who had not been trained recognised its importance, as the extract above shows. There was general agreement among the interviewees that IPV training programmes increased and improved their IPV knowledge, attitudes and practices. Interviewees who had been trained reported an increase in self-confidence and self-efficacy related to working with IPV victims following participation in IPV training. This finding suggests that IPV training has overwhelming acceptance and is regarded as beneficial to those who have received it.

Nurse-patient relationships

The importance of nurse-patient relationships was seen as a facilitator for IPV identification. The interviewees said that some nurses' characteristics, such as

showing a kindly interest and being friendly, having the ability to empathise with patients and being a trusted nurse, were important facilitators. Building a trusting relationships with pregnant women was mostly cited as a facilitator for identifying IPV:

> *'So, trust between the patients and the nurses should be developed because some women do not disclose abuse the first or second time they are screened. Some women will disclose IPV to nurses when they trust them. That may be in the fifth or sixth month of pregnancy. Moreover, nurses' characteristics like being generous, showing friendly feelings and attention to detail are crucial for women to choose whether they can disclose IPV or not.'* (Aom)

In their responses, many of the interviewees stated that in order to achieve a trusting relationship with a pregnant woman, regularly seeing the same nurse is also important. They believed that if a pregnant woman is cared for by the same nurse, a trusting nurse-patient relationship can be developed and the disclosure of IPV during pregnancy would also be increased. So most women attending an ANC usually get to see the same nurse each time they visit.

Theme 6: Experiences regarding pregnant women who were abused by their partner

All of this theme came from the interviewees' descriptions of the characteristics of pregnant women who are victims of IPV. The characteristics of those women were categorised into three sub-themes and these will be discussed separately next.

Disclosure

This sub-theme is concerned the experience of the interviewees of observing the

disclosure of pregnant women affected by IPV. They said that pregnant women tended to disclose IPV when they were asked about stress and/or their husband, when they were asked general questions, and when they trusted and were familiar with the nurse:

> *'That case I noticed from her behaviour but I didn't say anything until I realised that she trusted me. After that, I asked her general questions but not direct question in relation to abuse. I asked, like, "Is there anything you would like to tell me?" Then she disclosed that she was abused by her partner.'* (Nid)

> *'She told me that ...* (thinking) *... at that time, because her husband had not come with her. So, I asked her "Have you come here alone?" "Where is your husband?" Then she told me about her husband and started telling her story about IPV.'* (Tan)

Most of the interviewees said that they usually screened for IPV when the woman's partner was not present. They found that most women were likely to disclose abuse when their partners were not present or when they came to the ANC with their relatives, especially their mothers.

The interviewees said that some pregnant women actively shared their IPV stories:

> *'I asked them, like, "How many children do you have?" "Is this your first marriage?" "Who has accompanied you today?" So all these questions will lead to the story that they are hiding in their mind. Some of them actively share [their experiences] with me after these questions.'* (Ann)

Attendance

The interviewees stated that pregnant women who are being abused attended the clinic with others and were admitted to the hospital for problems of a trauma seemingly unrelated to IPV:

> *'In her second trimester of pregnancy, at around twenty weeks pregnant, she was admitted to a gynaecological ward following abdominal pain. The first time she was admitted, I didn't think anything about it. But when she was admitted again and again, I noticed that something was wrong. So, I asked her about IPV and she told me the story.'* (Nid)

Other experiences associated with attendance at hospital by pregnant women who were being abused by their partners were disclosing the woman's abuse, repeated admission to the hospital and having physical signs of abuse.

The interviewees provided mixed experiences of caring for pregnant women who were being abused. These women experienced different types of IPV, including physical and psychological abuse and these abuses, especially physical abuse, would be found during their attendance at an ANC:

> *'I have had one experience of taking care of an abused pregnant woman which I think was an unusual case. This case was a pregnant teenager and her partner was a teenager as well. I found bruises on her body. She told me that her partner usually picks fights with her when he drinks, but when he's not drunk he's okay, nothing happens. "He only hurts me when he's drunk" she said to me, just like that.'* (Aom)

> *'Most cases were emotional abuse which is a common form of abuse occurring in close relationships. Mostly, verbal abuse. Some cases also have been abused before getting pregnant and thought it would be better while pregnant, but it's not. They were still abused, especially verbal abuse.'* (Pim)

As can be seen from these comments, the interviewees had excountered women who had been abused when their partners were drunk. This is the most common reason that was given for physical and psychological abuse. All of the interviewees agreed that alcohol consumption by a partner is a major risk factor for IPV during pregnancy.

Behaviours attributed to pregnant women experiencing abuse

In this sub-theme, the interviewees recalled their experiences of the behaviours of abused pregnant women; this gave them as a clue that there was something wrong in the women's lives and it was usually associated with IPV during pregnancy. These clues were when a woman decided to have an abortion and when she did not include the name of the father of their child on the birth certificate. Examples of some significant statements are:

> *'But most of them [HCPs] try to avoid engaging because they think it's a private family matter. They believe that what happens in the home is a private matter. Someone can get involved in this problem and try to help, but eventually an abused wife will to the jail to visit her husband and help him. That's funny.'* (Joy)

> *'In this case, she [the pregnant woman] came to see me at the OSCC and told me that she needed to have an abortion. So, I asked her the reasons why she wanted to have an abortion. She then …*

> *she told me she was abused by her husband. Her husband also drinks every day or almost every day. Moreover, he doesn't have a job. They family had financial problems so she did not want to have the baby.'* (Tan)

The interviewees mentioned that they had encountered a variety of behaviours of pregnant women, for example dropping criminal charges and going back to live with the partner, which might make HCPs avoid getting involved in identifying and responding to IPV. They thought that the victims might still love their partners and want to maintain a relationship. The HCPs therefore did not want to interfere with the women's interpersonal relationships with the husband. Some interviewees therefore believed that IPV is a complex issue which is difficult to eradicate and needs more effort to address it.

6.3 Conclusion

In this chapter, the results of the qualitative phase of the research have been presented. Six themes emerged from the semi-structured interviews which provided new insights into the perceptions of HCPs' roles and their experiences of identifying and responding to IPV during pregnancy. Some of these findings expanded the initial findings from the questionnaire and some new findings emerged during the interviews. The integration of the findings from both the quantitative and the qualitative phases of the study will be presented in the next chapter.

CHAPTER 7: INTEGRATION OF QUANTITATIVE AND QUALITATIVE RESULTS

7.1 Introduction

This chapter brings together the quantitative (Chapter 5) and the qualitative findings (Chapter 6) from the two phases of the study. The two sets of data were integrated to facilitate a better understanding of the results overall, to identify any similarities or contradictions between them and to produce more detailed and useful information than that provided by the individual qualitative or quantitative data sets alone. This is in line with the explanatory sequential design proposed by Creswell and Plano Clark (2011) and used in this study to address the three research questions:

(1) What are the knowledge, attitudes and clinical practice of Thai HCPs towards IPV during pregnancy?

(2) How do Thai HCPs perceive their role in identifying and responding to IPV among pregnant women?

(3) What the experiences of Thai HCPs in identifying and responding to IPV during pregnancy?

These are explored in the following sections.

7.2 The integration process

Before moving to the results of integration, in this section I present the integration process and methods conducted in the current study. Integration is a key process, in the final analysis stage, when using mixed methods. In this study, the quantitative and qualitative data sets were collected and analysed separately and the integration occurred at the final point of the analysis. For this process, the qualitative and

quantitative data were brought together and compared for similarities and differences as appropriate. Table 7.1 provides an example of the analysis and comparison of both data sets.

Table 7. 1 The example of the quantitative and qualitative data analysis and comparison

Quantitative results	**Qualitative results** Quotation of participants	**Relationship**
<u>Source of training (Statistics)</u> - 25% attened a lecture - 23.9% read hospital protocol - 18.6% watched a video - 18.1% attended workshop - 6.9% learnt from school-classroom training - 3.7% attended in-depth training - 3.2% learnt from school-clinical setting - 1.6% attended post-grad training	*'I have also learnt so much about violence from the OSCC nurses and their work.' (Koy)*	Expanding
<u>Training (Inferential statistics)</u> The perceived preparation and perceived knowledge of participants was significant higher among participants who had been trained on IPV.	*'I think I can handle the case properly because I have taken two courses (IPV training), I am quiet confident about working on this both identifying and responding.' (Ann)* *'I think that training and education of HCPs in IPV can lead to better care for survivors of IPV. The training programme will provide knowledge about IPV and improve the ability of HCPs to respond appropriately to survivors of IPV.' (Nid)*	Supporting
<u>Screen for IPV</u> 19% of participants screened all new pregnant women for IPV	*'For me, I am not sure that I screen all of them, I can't say that I screen all because we have a lot of pregnant women at the clinic per day.' (Ann)* *'It's a lot of work to do. Sometimes, there were about 80 pregnant women a day but just only two or three nurses are on duty. That's why there's not enough time. We can't do it (screen all new pregnant women).'(Ying)*	Difference

7.3 Knowledge of HCPs toward IPV during pregnancy

The extent of the participants' knowledge of IPV during pregnancy was addressed in both the questionnaire survey and the interviews. Participants in the survey were asked how they learned about identifying and managing IPV in a clinical setting. Attending a lecture was stated as a source of IPV training by most participants. In the interviews, different forms or sources of knowledge on IPV were described. The interviewees said that they had acquired knowledge and/or skills related to identifying and responding to IPV from their peers and senior colleagues who taught them about the subtle signs and behavioural indicators of abuse during pregnancy as a patient might not always present with physical injuries. These colleagues and/or senior nurses also taught them how to refer victims and where the most appropriate referral place for victims is. This finding from the interviews therefore expanded the data from the questionnaire responses by adding that colleagues and/or senior nurses were another form or resources for learning about IPV.

Moreover, associated factors for IPV during pregnancy which were not mentioned in the questionnaire responses but were revealed during the interviews were related to teenage pregnancy. In the questionnaire, some participants had ticked the box to indicate that pregnant teenagers were one group of women whom they would screen for IPV. However, the reasons why pregnant teenagers were screened for IPV were not asked in the questionnaire. In the interviews, all of the interviewees mentioned that teenage girls might suffer IPV before, during and after pregnancy, in particular, teenage girls who had same-age partners or were unmarried. The following reasons were given to support this view. The unintended pregnancy of a teenager might lead to stressful events for her partner, including the disclosure of the pregnancy, the

response of both families to the pregnancy and the young couple's financial instability. They also mentioned that teenagers' relationships are often characterised by instability, financial dependency and cohabitation early in a relationship. The interviewees also stated that teenaged partners are less likely than adult partners to control themselves when they get angry. So teenage pregnancy was considered by the interviewees to be a significant risk factor for IPV during pregnancy.

Cultural attitudes were another factor mentioned by one of the interviewees. She stated that Thai women learn early in their lives that IPV is to be expected and tolerated as an unavoidable part of marriage. In addition, they also learn that a husband dominates his family and makes all the decisions, and a wife is expected to respect her husband without expressing any superiority and it is the wife's duty to endure the abuse without complaint. Based on these cultural beliefs, many Thai people view IPV as a common issue in marriages. Thai culture is therefore an important factor which is believed to influence the occurrence of IPV during pregnancy in Thailand.

Knowledge of the warning signs of IPV during pregnancy was identified in both the questionnaire responses and the interviews. The majority of the participants in the survey recognised obvious physical trauma as a warning sign of abuse, followed by the depression of pregnant women. The interviewees also highlighted, based on their experiences, that victims usually have obvious physical signs of traumatic injury and/or depression. In the survey of HCPs' practice, women who presented with depression were usually screened for IPV. The second category of pregnant women who were screened for IPV was women who had had abuse indicators in their history or on physical examination. The comments made in the interviews were similar in that the interviewees described their own clinical practice of IPV identification. They stated that pregnant women who came with a physical injury

or had a positive stress test (2Q and/or 9Q) were screened for IPV. It is clear that knowledge of the warning signs of abuse affected HCPs behaviour towards IPV identification.

Knowledge regarding the appropriate questions for identifying IPV was also revealed in the study. In the questionnaire, four framing statements of the question on IPV screening were provided as a set of response options for the participants to select from. The results showed that there was no significant difference between the four response options. However, analysis of the qualitative data revealed that none of the interviewees asked any direct questions about IPV screening, which was similar to the framing statements in the survey. It is therefore important to consider that when the questionnaire participants were faced with a choice of statements, they picked the one they *would* use, but did not actually use in clinical practice.

Interestingly, in the interviews, all of the interviewees said that they used similar patterns and types of question for asking about IPV whether they were trained on IPV or not. All of the interviewees explained that general questions were asked first, then more specific questions followed which could lead to screening for IPV. Examples of these specific questions were asking about the partner's alcohol use, the role of the partner during the pregnancy, and the woman experiencing stress during her pregnancy. When women trusted HCPs or felt comfortable with them, the nurses would ask them about IPV. The interviewees also said that using direct questions about IPV might not work because Thai women were taught to keep silent and not reveal relational conflicts to outsiders. The findings from the qualitative phase generated the complementary insight that indirect questions to screen for IPV were preferred by some HCPs.

7.4 HCPs' perception of their role, and their attitudes towards IPV identification and response

For the participants' perceptions about their role, most had a positive view of IPV identification and believed that they played an important part in identifying IPV. These views were confirmed in the findings from both the questionnaire responses and the interviews. In regard to the identification of IPV during pregnancy, participants in the questionnaire survey felt comfortable approaching women about IPV and they agreed that IPV identification is the responsibility of HCPs. In addition, most of them did not fear that women might be offended by screening. Supporting these survey findings, the interviewees' comments showed similar results as the interviewees stated that identification is important because it can lead to disclosure, and that would prevent the harmful effects of IPV on women and their children and also reduce women's stress. Most of them perceived that all HCPs in a hospital have an important role in IPV identification, especially themselves (all of the interviewees were nurses). On the other hand, the interview findings revealed that community members also have a crucial role in helping to identify IPV in their own communities.

The participants' views on the barriers to identifying and responding to IPV during pregnancy were different in the questionnaire responses and the interview comments. Most of the participants in the survey disagreed that HCPs do not have the time to assist pregnant women in addressing IPV. They also stated that they were not too busy to take part in multi-disciplinary teamwork which is responsible for the support of victims of IPV. However, the interviews produced different results. Time constraints and a heavy workload were stated by all of the interviewees as key barriers to identifying and responding to IPV. They also described that these barriers were associated with other factors such as the shortage of nursing staff,

having lot of pregnant women to deal with each day, and having to deal with other issues.

The attitudes of the participants towards IPV training were found to be similar in both datasets. Participants in the survey agreed that they did not receive enough training on IPV. The data from the survey also showed that nearly half of the respondents had not received any previous IPV training and the majority had not received training on IPV in the previous twelve months. The interviews provided more insight on this issue, and according to all of the interviewees, IPV training was considered as a facilitator which could increase knowledge about IPV and lead to better care and health outcomes for both unborn babies and pregnant women who were survivors of IPV. Ten interviewees who had never been trained on IPV believed that they could improve their ability to identify IPV during pregnancy and know how to respond after identification if they were given appropriate training.

7.5 Clinical Practices and experiences of HCPs regarding IPV identification and response

The questionnaire responses showed that 19% of the participants who had ever screened for IPV routinely screened all newly presenting pregnant women, whereas in the interviews, none of the participants reported that they routinely screened all new pregnant women for IPV. More details on this issue are provided in section 8.5.1 of the discussion chapter (Chapter 8). The interviewees said that they screened for IPV when women presented with signs which caused them to suspect that something was wrong. They explained that an abnormality is considered if pregnant women are teenagers, if they arrive with physical injuries and if they show high levels of stress. Pregnant women who did not have signs or symptoms of depression and looked happy were not screened for IPV.

Immigrants were a group of pregnant women considered to be less likely to be screened for IPV by both the questionnaire and the interview participants. Only twelve questionnaire participants said that they screened immigrant women for IPV. Only one interviewee stated that she had ever asked a Cambodian woman about whether she was experiencing IPV during her pregnancy. The following reasons were provided by the interviewees to explain why immigrant women were not screened for IPV. The nurses explained that they simply forgot to ask about abuse because they were concerned with other issues, especially health insurance. Some of the interviewees believed that immigrant women might not report IPV because their immigration status would be affected, which could lead to them being arrested, deported and/or having their visa revoked if they had problems. Another reason given was the language difficulty.

The interventions provided to pregnant women when they disclosed a story of IPV were asked about in both the questionnaire and the interviews. The questionnaire responses showed that the most frequently used interventions for women following the disclosure of IPV were providing supportive statements, referral information and basic information and conducting a safety assessment. These findings were very similar to the interview data. However, the interview results provided more detail of the interventions made for the women. From the qualitative analysis, it was found that the interventions provided to victims of IPV were affected by several factors, including the consent of abused pregnant women, the experience and competency of HCPs and the existence of a teamwork structure.

7.6 Conclusion

In this chapter, I have explored the findings from both the quantitative

(questionnaire) and qualitative (interview) phases of the study and demonstrated the way in which the qualitative findings provided much deeper explanations for the quantitative findings. Hence, the combined findings give a unique insight into Thai HCPs' perceptions and experiences of identifying and responding to IPV during pregnancy, highlighting the similarities and contradictions. In the next chapter, I shall discuss the findings in relation to the wider literature on IPV during pregnancy and on HCPs' awareness and practice.

CHAPTER 8: DISCUSSION

8.1 Introduction

The aim of this study was to explore Thai HCPs' knowledge, attitudes and practice regarding the identification of and response to IPV during pregnancy. It was also designed to examine their perceptions about their role and their experiences of identifying and responding to IPV among Thai pregnant women. Through the collection and analysis of the quantitative and qualitative data, an objective has been met which enables us to identify ways in which to help HCPs to overcome the barriers which they face and to improve the facilitators for responding to IPV during pregnancy.

This chapter presents a discussion of the key findings of the research presented in this thesis in the context of the existing literature in this field. I shall identify whether and in what ways they reflect or differ from those of previous research into the knowledge, attitudes, practices and experience of HCPs in regard to IPV during pregnancy. This study is the first mixed-methods study in Thailand to explore the topic of HCPs' perception of their roles and experiences of identifying and responding to IPV during pregnancy. It is also the first time the PREMIS questionnaire has been used in Thailand. The contributions to knowledge this thesis makes are therefore around new insight into the Thai HCPs' knowledge, attitudes and practices. This study has highlighted a poor level of knowledge of IPV during pregnancy and low screening rates for IPV among Thai HCPs. The findings contributes to work in the field by revealing a detail of how the HCPs perceive of their roles and experiences of identifying and responding to IPV during pregnancy in Thai context. The findings also enhance the understanding of the barriers of IPV identification and response faced by

Thai HCPs. The contributions to knowledge are discussed in more detail below (section 8.7).

8.2 HCPs' knowledge of IPV

The findings of the study presented and discussed in the previous chapters have shown that Thai HCPs had a moderate amount of perceived knowledge and poor actual knowledge regarding IPV inflicted on pregnant women. In comparison with other studies which used the PREMIS tool (for example, Connor *et al.*, 2011; Baird *et al.*, 2015), this finding was generally lower than those of other studies. One possible reason for this is that the participants in the present study had received a low rate of IPV training. The questionnaire responses of the present study found that approximately 46% of the participants reported receiving no IPV prior training and nearly 71% reported receiving no IPV training in the previous twelve months. Connor *et al.* (2011), however, found that 64% of their participants had received training on IPV during their years at dental school and Baird *et al*. (2015) reported that 82.2% of their participants had received training about IPV provided by their workplaces. It is therefore evident that the difference in the levels of knowledge among all the participants is directly related to the level of training received. This is discussed more fully in section 8.2.2 below.

In this present study, the nurses had lower scores on perceived and actual knowledge than doctors, which was consistent with the findings of a previous in the UK (Ramsay *et al.*, 2012) to measure primary care clinicians' current level of knowledge, attitudes and clinical skills in terms of identifying and responding to women experiencing domestic violence. In that study, GPs scored all items of perceived knowledge higher than practice nurses, and the same applied to their medial

scores of actual knowledge (Ramsay *et al.*, 2012). A possible reason for this professional difference was not provided. In the current study, there were significant differences between the mean ages of doctors and nurses. Most of the doctors (n = 21; 88%) in the study were aged between 21 and 30 years, whilst nearly 60% of the nurses were aged more than 31 years. It was suggested that most of the doctors were newly graduated and it was possible that their knowledge was therefore fresh and up-to-date. Moreover, 21% of them reported receiving IPV training at medical school compared with only 5% of the nurses who reported receiving IPV training at nursing school. This finding certainly needs further investigation.

In the present study, the scores on actual knowledge of all of the questionnaire respondents ranged from 3 to 25 on 31 items, with a mean score of 14.4 (SD = 4.25).The majority of the participants (80.3%) had a poor knowledge score, which means most of them answered fewer than 18 of the 31 knowledge question items correctly (correctly answering fewer than 18 items = poor, 18-24 items = good and more than 24 items = excellent). Most of the respondents had poor knowledge of IPV in terms of the mandatory reporting laws of IPV and were under the misconception that the strongest risk factor for becoming an IPV victim was their partner's alcohol consumption.

8.2.1 HCPs' misconceptions and lack of knowledge about IPV during pregnancy

With regard to the risk factors for being a victim of IPV, the majority of participants in the present study believed that the partner's substance and/or alcohol abuse was the strongest factor, which is consistent with the findings of a study conducted in Australia (Baird *et al.*, 2015). In that study, it was found that a quarter of Australian midwives believed that perpetrators are violent because they drink or use drugs.

A study conducted in Thailand revealed a non-significant association between IPV during pregnancy and a partner's alcohol consumption, and also reported that stress and marital dissatisfaction were predictors of IPV among these pregnant women (Boonnate *et al.*, 2015). Although the alcohol and drugs use of partners can be a significant factor in IPV, they are not considered to be the strongest factors when women are victims of IPV (WHO, 2006; Baird *et al.*, 2015). It is important to consider that alcohol may not necessarily be the cause of violence and that violence often occurs in the absence of alcohol. Another Thai study found that the factors shown to be significantly related to IPV during pregnancy included being younger, unmarried, having a low income, being unemployed, and unintended pregnancy (Thananowan & Heidrich, 2008). In South Africa, Malan, Spedding and Sorsdahl (2018) found that IPV during pregnancy was significantly associated with the age of the woman: their findings showed that women who were aged between 18 and 30 years were more likely to be subjected to IPV than those who were older than 30. Moreover, in that study, there were other factors which were identified to predict elevated IPV during pregnancy, including women with symptoms of depression, unintended pregnancy, and exposure to community violence (Malan *et al.*, 2018). Unintended pregnancy has been described as a potential risk factor significantly associated with IPV during pregnancy by several studies (Pallitto, Campbell & O'Campo, 2005; Pallitto *et al.*, 2013; Silverman *et al.*, 2007; Rahman *et al.*, 2012; Martin-De-Las-Heras *et al.*, 2015; WHO, 2011). Pallitto *et al.* (2013) explored the relationship between unintended pregnancy and/or abortion and IPV in primarily low- and middle-income countries, including Thailand. The findings showed that women who reported experiencing IPV were more likely to have an unintended pregnancy than women who reported experiencing no abuse in all of the sites included in the study, and the

differences were statistically significant almost everywhere (Pallitto *et al.*, 2013). Also, Thananowan and Heidrich (2008) found that Thai women with unintended pregnancies were 2.5 times more likely to have experienced IPV compared with women with intended pregnancies. Very few participants in the present study knew that the strongest risk factor of being a victim of IPV during pregnancy was not substance and/or alcohol abuse by the partner. This knowledge gap is important because it could affect the identification behaviour of HCPs. The obvious finding from the present study is that pregnant women whose partner drank alcohol were usually screened for IPV, whereas women who were married, immigrant or single mothers were less likely to be asked about IPV. However, IPV is a complex behavioural phenomenon in which several factors are involved, including biological, social, cultural, economic and political factors. There is no single factor to explain being either a victim or a perpetrator of IPV (WHO, 2002b). It is therefore essential that HCPs should be aware of this when they screen pregnant women for IPV. This misconception can be explained by the fact that in Thai society, most IPV incidents are caused by partner's drinking. A study conducted in Thailand to analyse forms of domestic violence found that the highest number of victims reported in Thai daily newspapers during the period 2006-2015 were wives abused by husbands who had drunk alcohol (Tongsamsi & Tongsamsi, 2018). The widespread reporting of this one study might explain the belief of Thai people that perpetrators of domestic abuse are violent because they drink alcohol.

The participants' inadequate knowledge about the laws regarding to IPV could have been because there is no mandatory reporting of IPV case in Thailand. HCPs are not legally mandated to report IPV. This is supported by a study conducted in the Philippines where statute does not require the reporting of IPV; the findings of

that study also reported low scores on participants' knowledge of IPV, including the legal requirement areas (Cortes & Quinio, 2017). Similar results were reported in a study conducted in Australia in which the participants' actual and perceived knowledge on IPV were found to be low, especially on the issue related to the mandatory reporting of IPV. It is difficult to identify the relationship between the reporting laws and those participants' low level of knowledge about the law because the participants in the Australian study were students. Lack of experience about the legal reporting of IPV may mean that they were not knowledgeable or confident in the knowledge which they did have (Sawyer *et al.*, 2017). In contrast, a study conducted in New York where HCPs are required to report IPV found that the participants had good knowledge of the mandatory reporting of IPV (Roush & Kurth, 2016). Also, Harris *et al*. (2016) conducted a study using the PREMIS to assess oral health care providers' knowledge of IPV in Boston, US, and the highest percentage of the participants who reported knowing 'quite a bit' or 'very much' were referring to the legal requirements for reporting IPV, including child and elder abuse. The same US state also requires physicians and other health care workers to report patients who have experienced IPV (National District Attorneys Association, 2010). Nevertheless, the precise reasons why the participants in the present study lacked knowledge about legal reporting requirement for IPV is unclear. This is because there is no evidence to support the direct relationship between the legal reporting requirement for IPV and knowledge regarding this issue. The HCPs' knowledge may have been affected by other factors such as lack of previous education or training on IPV or continuing education. For example, the study in Boston also found that most of participants (92%) reported attending some form of IPV education or training (Harris *et al.*, 2016).

8.2.2 HCPs' knowledge of IPV and education or training

The poor knowledge of the participants regarding IPV during pregnancy may be explained by the lack of focus on IPV in the Thai nursing and medical curriculum (Grisurapong, 2004; Prayoa University, 2010a, 2010b; Mahidol University, 2012). This can be supported by the survey findings from the present study that only 7% of the participants reported learning about IPV during nursing or medical school through classroom training, and only 3% in a clinical setting. This is consistent with the scoping review conducted by Crombie, Hooker and Reisenhofer (2017) to explore current programmes of IPV education for nurses and midwives. The results demonstrated that the existence of the programme was limited in several studies. Most of the included studies showed that IPV education was not provided to nursing and midwifery students in the undergraduate curriculum, but that most of their IPV education was gained after graduation (Crombie *et al.*, 2017). In the US, national nursing studies have shown that 30% to 70% of nurses reported a lack of IPV education or training during nursing school. Thirty percent of these nurses also indicated that most IPV- related content involved two or less than two hours and the form of learning was usually through a reading assignment (Brachley, 2008; DeBoer *et al.,* 2013). This is consistent with the findings of a GP survey conducted in the Republic of Ireland in which 84% of the participants reported that they had never had received any training or education in managing IPV at undergraduate level (O'Shea *et al.*, 2016). In Australia, it was found that the majority of midwives (85%) had never received or had received only a minimal amount of IPV education during their midwifery programme, but most of them (82%) stated that they had received IPV education from the workplace through attending a lecture or talk, reading hospital policy and attending skills-based training (Baird *et al.*, 2015). A study in South Africa (Duma & Cur, 2007), showed that there was no family

violence topic in the nursing curriculum, and a study conducted in Spain suggested that the inclusion of IPV education and training in the curriculum for nursing and midwifery students was necessary (Rigol-Cuadra *et al.*, 2015). This suggestion is consistent with those of other previous studies on IPV education for medical and nursing students (Connor *et al.*, 2012; Beccaria *et al.*, 2013; Dedavid da Rocha *et al.*, 2015; Tambag & Turan, 2015). Beccaria *et* al.'s (2013) results in Australia showed that a topic on violence against women should be integrated into the curriculum for the undergraduate nursing course. In addition, in the UK, the National Institute for Health and Care Excellence (NICE) (2014) has recommended that domestic violence and abuse should be part of the undergraduate curriculum.

It is well recognised that the more training HCPs receive the greater their knowledge of and preparedness for IPV screening will be (Connor *et al.*, 2013; Baird *et al.*, 2015; Kamimura *et al.*, 2015; Forsdike *et al.*, 2019). In the US, Connor *et al.* (2013) reported that nursing students who had been trained on IPV prior to graduate school had significantly higher perceived preparation and perceived knowledge than those who had never been trained. In Australia, the study found that increased hours spent in IPV training by psychiatrists and psychiatric trainees were significantly correlated with greater knowledge of and preparedness to manage IPV (Forsdike *et al.*, 2019). Similarly, a study of IPV education among American, Vietnamese and Chinese medical students found that students who had received training on IPV were more knowledgeable about IPV than those who had not received training (Kamimura *et al.*, 2015). The present study confirmed these findings that participants with prior IPV training had significantly more perceived knowledge and perceived preparedness for identifying and responding to IPV during pregnancy. In the current study, the quantitative data showed that the difference between the participants who

had been trained and those who had never been trained was that those who had been trained about IPV had significantly higher mean scores on perceived preparation, knowledge and legal requirements than those who had never been trained. However, the present study found no significant relationship between actual knowledge and IPV training. Similar findings have been reported in an Australian study (Sawyer *et al.*, 2017) with paramedic students to measure their knowledge, attitudes and preparedness to manage IPV patients, which found that previous training did not significantly improve their actual knowledge score. It is therefore possible that the training programme itself was insufficient for improving HCPs' knowledge. Several factors might influence the connection with improving knowledge, one of which is continuing education. Several training programme studies have suggested that although an IPV programme might be effective in improving knowledge, attitudes and skills, these improvements might nevertheless decline over time (Knapp *et al.*, 2006; Salmon *et al.*, 2006).

8.2.3 HCPs' knowledge of IPV and continuing education

Because one factor which might be related to the poor knowledge of the participants in this current study is the ongoing education of nurses, it should be noted that a commitment to lifelong learning is required for all nurses and other HCPs in Thailand: for example there are requirements set by the Thai Nursing and Midwifery Council that all Thai nurses have to continue their professional development by training or participation in education activities. In order to have their professional licences renewed, all Thai nurses are required to gain 50 credits of Continuing Professional Development (CPD) to maintain their nursing knowledge, skills and competence every five years. When this requirement has not been met, their nursing licences can be terminated. However, these continuing education activities

are based on each nurse's own interests and there are no topics of continuing education required by the council (Centre for Continuing Nursing Education, 2003). Most of these activities are annual academic meetings, lecture series, special lectures, workshops, seminars and conferences. The qualitative findings of this current study made it clear from the participants' responses that the seminars, conferences or workshops which they usually attended were related to nursing care for patients with disease and/or new technologies. Some participants mentioned that they had attended a seminar on the topic of nursing care for high-risk pregnancies, but had never attended a seminar about IPV during pregnancy. Conferences, seminars or lectures on IPV are rarely found in Thailand. In the present study, most of the participants had no previous training on IPV and nearly 70% of them had not been trained on IPV in the previous twelve months. Unsurprisingly, the HCPs' mean knowledge scores in the present study were lower than those found in some other studies, as mentioned above. The association between IPV training and a greater knowledge of IPV has been highlighted in previous studies (Mezey *et al.*, 2003; Papadakaki *et al.*, 2013; Baird *et al.*, 2015; Kamimura *et al.*, 2015; Forsdike *et al.*, 2019). Even so, there is some evidence that training can improve knowledge and change the clinical practice of HCPs but that these improvements and changes are not permanent. In the UK, a follow-up study (Baird, Salmon & White, 2013) to analyse the degree of change for routine enquiry for domestic abuse among midwives after five years of the Bristol Pregnancy Domestic Violence Programme (BPDVP) found that the improvement in knowledge after the programme had been maintained with the support of mandatory follow-up training. The results showed that most of the participants had attended annual or biannual updating sessions on domestic violence as part of their mandatory programme. Papadakaki *et al*. (2013) reported that an IPV training programme led to

significant improvements in participants' perceived knowledge measured by PREMIS and that this enhanced perceived knowledge could last for one year.

To gain knowledge and keep it current by self-directed learning using information technology was stated by the Thai Centre for Continuing Nursing Education (2003) to be achievable not only from attending seminars, conferences and workshops but also by completing the questionnaire provided by the Centre. This means that Thai nurses have a professional and legal responsibility to update their knowledge by continuing to read nursing and medical journals. However, it is one of the characteristics of Thai people, including Thai nurses, that they do not read very much. A study conducted by the Thailand Knowledge Park found that reading was low among Thais, and was lower than in other Asian countries because of Thai people's belief that they were not taught to be good readers (Burnard & Gill, 2013; Boonaree, Goulding & Calvert, 2017). Suwanraj (2010) surveyed Thai nurses on the use of evidence- based practice and found that they used fewer sources of knowledge from research and medical journals. The biggest barrier to Thai nurses reading research journals was that most journals were published in English. This barrier was also identified in the present study: some of the interviewees said that they had read a few interesting journals published in Thai but never read journals published in English because their English skills are poor. One study of Thai nurses found that colleagues, doctors and printed standards and protocols were the most sources of knowledge they needed: they rarely used libraries, read research reports or used research databases and the reasons which they gave for this were that they had no time, that such documents were unavailable or difficult to get hold of, and that the research was difficult to understand (Just *et al.*, 2008). So to improve nurses' identification of and response to IPV, it is necessary to develop nursing curricula related to IPV

knowledge, to provide more training regarding IPV and to integrate research information into standards and protocols and make it readily available.

8.2.4 HCPs' knowledge of IPV and the nursing shortage

Another possible cause of the lack of training identified among the participants in this study was the shortage of nurses. This barrier was mentioned by several nurses and several times in the interviews. Thailand has a national shortage of nurses and this problem remains unsolved. This is because the problem is not only an inadequate rate of nurse production but also a failure to retain them in the system (Khunthar, 2014; Sawaengdee, 2017). In Thailand, data from the Thail Nursing and Midwifery Council (TNC) from 2010 to 2016 has shown that more than 43,250 additional nurses were needed to meet the requirements by 2019. Moreover, the shortage of nurses is even greater in rural areas of the country (Abhicharttibutra *et al.*, 2017; Sirisub *et al.*, 2019). The shortage of nurses affects not only patients, society, the organisation and the nation but also the nurses themselves. Several studies have reported that the nursing shortage has an effect on nurses' workload, increases pressure on them to remain in the system, and affects the quality of nursing care (Kaewboonchoo *et al.*, 2014; Khunthar, 2014; Shammika *et al.*, 2015). In the present study, it was found that the perceived lack of time to spend on training not only for IPV training but also for other training was caused by the shortage of nurses. One interviewee said that she had no time to attend a conference because there were no nursing staff working on that day. Another interviewee explained that she could not attend any training that year because it was not her turn to attend the training and she had to wait until the following year.

8.3 HCPs' attitude to IPV identification and response

The views of the participants in the present study were mainly positive towards identifying and responding to IPV during pregnancy. Most of the participants (76.1%) in the questionnaire survey disagreed that women are offended when they are asked about IPV. Similarly, the interviewees supported this by saying that they were not afraid of offending women by asking them about IPV. These findings are consistent with those of a study conducted in Thailand (in the Thai language) that most Thai nurses had positive attitudes regarding identifying and responding to IPV during pregnancy. They agreed that all pregnant women should be routinely screened for IPV during the antenatal or postnatal period by nurses and they thought that women were willing to be asked about IPV (Deoisres & Peomsook, 2013). This is unlike the findings of many other studies (Jeanjot *et al.*, 2008; Bunn *et al.*, 2009; Lazenbatt *et al.*, 2009; Roelens *et al.*, 2009; O'Shea *et al.*, 2016; Sharma *et al.*, 2018; Abdullah & John, 2019); the majority of HCPs in those studies reported that their fear of offending women and the feeling of being uncomfortable about asking questions about IPV were a barrier to IPV identification.

Most previous studies have reported the association between these positive attitudes and the IPV training of participants. For example, Deoisres and Peomsook (2013) reported that the positive attitudes of Thai nurses were significantly associated with the training in IPV which they had received. However, the present study produced the different finding that a positive attitude of the participants was not associated with IPV training. Several factors were found in the present study which were associated with a positive attitude among most participants and these will be discussed in the remainder of this section.

8.3.1 HCPs' attitudes and nurse-patient relationships

The relationship between nurses and their patients was an important factor stated by most of the interviewees in the current study. They explained that they worked in rural Thai areas where people are an easy-going community very open to compromise. Most of the participants felt that they could easily build a good rapport with patients and were also confident that they could gain their trust. These feeling expressed by the participants can also be explained by the culture of Thai people. In Thailand, people can be high or low status according to their age, family background, occupation or professional rank. If you are senior, you will be treated differently. Most Thai people are taught to treat their elders with respect. Younger people do not blame older people even if they do something wrong. A nurse who is higher in status or older than a patient can therefore order the patient to do things (Burnard & Naiyapatana, 2004; Burnard & Gill, 2013). In Thailand, especially in rural areas, Thai people have a strong respect for their HCPs, especially nurses. Some rural Thais might call a nurse *khun mho*, which means 'physician'. The relationships between HCPs and patients in rural areas are generally closer than they are in urban areas. Nurses in rural areas usually participate in many different community activities and feel that they are a part of the community (Chunuan *et al.*, 2007). Most of the participants in the present study were generally older than the pregnant women whom they treated (the mean age of the interview participants was 43 years) and their hospitals were located in rural areas, so these aspects of Thai culture were important factors which made it easier for them to ask about violence and to be far less uncomfortable or worried about IPV identification than the participants in the previously mentioned studies. However, these aspects of culture might be different in other areas where people are more prone to westernisation and have more individualisation, and HCPs may have alternative perspectives or different insights.

8.3.2 HCPs' attitudes and IPV campaigns

Over the past ten years, several campaigns have been launched to end violence against women in Thailand. The most well-known campaign was initiated by HRH Princess Bajrakitiyabla Mahidol. Moreover, in 2008, another campaign to promote nationwide recognition of November as the campaign month for ending violence against women was launched by the Office of Women's Affairs and Family Development in the Ministry of Social Development and Human Security and its partner organisations. The campaign takes place every year in November, running throughout the whole month, aiming to raise awareness in Thai society about IPV and domestic violence. The campaign has been working towards addressing misconceptions in Thai society that violence is a private issue, and aims at preventing and eliminating all forms of violence against women and girls. The campaign spreads information through social media, handouts, radio and television spots and programme, exhibitions and seminars across the country (UN Women, 2016). These campaigns can be judged successful from the fact that some Thai people have changed their attitudes and values in regard to IPV and domestic violence. For example, most of the interview participants in the present study mentioned that their awareness of helping women who had been subjected to IPV had increased as a result of these campaigns. Their attitudes towards IPV had changed to regarding that IPV and domestic violence are a significant public health issue and not a private family matter as they had previously believed. These campaigns can therefore have a significant impact on public and professional attitudes towards identifying and responding to IPV.

One further factor which had positively influenced the attitudes of the interview participants in the present study was the establishment of the One-Stop Crisis Centres

(OSCCs). Having this service established in their hospital made them feel more confident and more willing to screen women for IPV. Most of the interviewees stated that they felt supported in their workplace and they knew where the appropriate place for referring IPV or domestic violence cases was. One participant confirmed that she had never asked pregnant women about IPV until her colleague who worked in the OSCC advised her to ask them about screening them for IPV. Even so, there is still an obvious need for a clear protocol for the HCPs to follow if violence is suspected and identified in some hospitals. Some of the interviewees said that they were willing to screen and help women but they did not know how to start asking and what to do if a woman revealed that she was being abused. Although most participants in both the questionnaire survey and the interviews had a positive attitude towards identifying and responding to IPV, the findings show that the majority of the participants felt that they lacked the skills and the knowledge to talk about IPV. Interviewees who had never been trained in IPV stated that they were keen for IPV training to increase their confidence to identify and manage the issue. This finding suggests that although HCPs had positive attitudes, the skills and knowledge required for discussing and managing IPV remain a distinct necessity.

8.4 Discussing the findings on HCPs' perceptions about their role in identifying and responding to IPV

One of the principal findings of the present study is that all of the interviewees felt that they had a significant role to play in identifying IPV among pregnant women, which is consistent with those of previous studies conducted in the US, New Zealand and Northern Ireland (Hindin, 2006; Lauti & Miller, 2008; Lazenbatt *et al.*, 2009). They believed that they had competence to screen pregnant women for IPV in their hospitals. Some of them stated that nurses are the most appropriate people in the

hospitals because they work very closely with patients. Lauti and Miller's (2008) study in New Zealand showed that all the obstetrician participants believed that midwives are well positioned to respond to this issue in terms of the time which they spend with patients and the good relationships which they can create with them. That result is consistent with the findings from the interviews in the current study: most of the interview participants in the current study stated that doctors are not appropriate people to screen for IPV because they might not have sufficient time to screen, especially doctors in a small hospital which has only one or two doctors. Moreover, the rationale for the perceptions of the participants in the present study that screening is a nurse's role was related to their beliefs. Most of the participants believed that early detection of IPV among pregnant women could reduce its consequences, improve their health outcomes and might help to prevent further abuse. They also believed that IPV during pregnancy can lead to serious negative health consequences for women and their babies, for example premature labour, miscarriage and low birth weight. This can be confirmed by the results from the questionnaire of the current study that the majority of the respondents felt that they had good knowledge for recognising the impact of IPV on the unborn baby. Conversely, a mixed-method study of HCPs who worked in Mulago hospital in Uganda (Kaye *et al.*, 2005) reported that the majority of the participants (approximately 67%) believed that domestic violence during pregnancy was not a major cause of ill health and not a major public health issue for pregnant women. In Zimbabwe, Shamu *et al.*,'s 2013) qualitative study found that midwives mainly relied on women coming forward and disclosing their own stories about violence. These midwives said that identifying the violence was not their role. Similarly, O'Reilly and Peters (2018) conducted a larger sequential mixed- method study of community HCPs

in Australia and found that the participants' failure to carry out IPV screening was due to their perception that IPV screening was not part of their role. Some of them believed that women who were victims of IPV would choose to self-disclose IPV and would then be screened by other HCPs (O'Reilly & Peters, 2018).

For the perception of their role regarding identifying and responding to IPV, there is some level of inconsistency regarding the perceptions of their role among the participants in this current study. Some participants perceived their role as a part of a team, others said that their role was only taking care of patients' physical health needs and then making referrals to doctors, psychiatrists or other HCPs who had responsibilities for these patients. Most of them mentioned that these interventions might not be completely effective for the victims of IPV, so working with other agencies was important for addressing the problem, and collaboration with other HCPs and external agencies was required. This was consistent with the findings of previous studies in which the participants stressed the essential need for a multi-disciplinary approach to support women who are victims of IPV (Lauti & Miller, 2008; Eustace *et al.*, 2016; McCauley *et al.*, 2017). Eustace *et al*. (2016) reported that adequate community support services are essential to support women who disclose IPV. According to a toolkit for development for services in Wales (Lloyds Bank Foundation, 2016), violence against women, domestic abuse and sexual violence are complex issues which require a multi-strand approach involving elements such as public, private, voluntary and community organisations within the health, criminal justice, social care and other arenas. The experiences of victims can be very different and cannot be met by any single organisation, so services need to be designed to meet the diverse needs by partnership working (Lloyds Bank Foundation, 2016).

Most of the interviewees in the current study, however, said that collaborative partnerships between healthcare institutions and other organisations to ensure that victims of violence can access the necessary information and support were not effective and were insufficient. This has been supported by multiple evidences (Saito *et al.*, 2009; Phollawan, 2017; Thananowan *et al.*, 2018). Most Thai women are still suffering in silence because of their dissatisfaction with legal representation, such as that which should be provided by social workers and the police who are responsible for supporting and assisting them in cases of IPV (Thananowan *et al.*, 2018). Saito *et al.* (2009) conducted a case study analysis with two Thai women who had experienced IPV during pregnancy and one participant said that she was abused by her husband and reported it to the police but that they did nothing and sent her back to talk to her husband. After that, she never reported it again either to the police or to any other formal organisation. This is consistent with the findings of a study conducted by Phollawan (2017) with people who had knowledge, expertise and professional experience of IPV in Thailand: the participants said that most women who have survived IPV do not know of any person or government agency which they can approach and ask for help. Under-reporting of IPV to the formal justice system because of poor treatment received by women was also reported in three south Asia countries, Pakistan, Nepal and Bangladesh. Women in these countries had had negative experiences with the police when they reported that they were being abused by their husbands (Samuels, Jones & Gupta, 2017). In India, some women reported that they were told by the police that being abused by their husbands was a private issue (Leonardsson & San Sebastian, 2017). Furthermore, in Thailand, inadequate or unavailable community resources have been reported; most of the organisations set up to support and encourage female victims of IPV are located in big cities, especially Bangkok (Saito

et al., 2009). Although OSCCs are currently available at almost all hospitals in Thailand, these centres do not provide emergency shelters or child-related support (Thananowan *et al.*, 2018). It is therefore necessary for the different agencies to work together.

8.5 Discussion of the findings on HCPs' experiences and practice of IPV identification

8.5.1 Clinical practice of IPV identification

In the literature review, HCPs' practices regarding screening pregnant women for IPV were classified into three categories; screened all pregnant women, screened when they were identified, and did not screen. In this study, 19% of the participants reported that they screened all pregnant women for IPV, which is lower than the proportion found by some previous studies conducted in the US, the Republic of Ireland, Kenya and Australia (Ortiz & Ford, 2005; O'Shea *et al.*, 2016; Githui *et al.*, 2018; O'Reilly & Peters, 2018). This could be explained by the lack of any specific policy or clinical guidelines for IPV screening and intervention in their hospitals. However, this prevalence rate is high compared with the 7% and 8.4% found in Belgium (Jeanjot *et al.*, 2008; Roelens *et al.*, 2009). There may be several possible reasons for this higher rate. However, it should be noted that there was inconsistency in the results of the present study between the quantitative and the qualitative data. Thirty-six participants (19.1%) responded in the questionnaire that they screened all newly presented pregnant women, whereas all of the interviewees said that they asked women about the experiences of IPV only if they observed some indicators which suggested that a woman might have been abused. Unfortunately, exploration of the perspectives of the HCPs who screened all newly presented pregnant women was limited because none of them were included in the interviews. The cause of this could

be that these participants were those who did not provide further contact details in the questionnaire which meant that they were not willing to take part in an interview. There could also have been those who simply forgot to provide contact details or were not prepared to provide information for the researcher to trace them back. So the tools, methods and definitions of IPV used by these participants to identify abuse in pregnant women are not known, nor was it possible to explore their understanding of the meaning of IPV identification during pregnancy.

The interviewees in the current study said that they would initially ask questions of pregnant women presenting with physical injuries and who had positive 2Q results; and young pregnant women, those showing signs of anxiety or stress and those displaying unusual behaviour were the next most common categories which gave the interviewees reasons for asking questions. This result is consistent with the findings from the questionnaire survey, which showed that most of the respondents believed that pregnant women with depression were more likely to be victims of IPV and that they were more likely to ask these women about IPV. Similarly, several previous studies (Hindin, 2006; Jeanjot *et al.*, 2008; Lauti & Miller, 2008; Roelens *et al.*, 2009; Shamu *et al.*, 2013; Githui *et al.*, 2018) reported that women with physical indicators of abuse and signs of stress or anxiety were recognised by the participants as an important reason for asking about IPV. The possible reason for this practice can be identified from the comments made by the interviewees in the current study; most of them stated that the reason to screen pregnant women with depression/stress for IPV was because they mainly relied on their own experiences. Most of them believed that IPV causes depression in women. This belief has been supported by some evidence documenting the link between IPV and depression in Thailand. Thananowan and Vongsirimas (2014) surveyed 550 women with gynaecological

problems who were admitted to a gynaecology ward at a university hospital in Bangkok. The results showed that IPV was positively correlated with stress and depressive symptoms. Similar findings were reported in an earlier study conducted by Thananowan and Heidrich (2008) that Thai pregnant abused women reported a higher level of depressive symptoms than those who were not abused.

Moreover, in the current study, the interviewees reported that suspicions about abuse were raised when the women were teenagers. One possible explanation for this is that in Thailand, teenage pregnancy is regarded as a national problem. The birth rate among Thai female adolescents aged 15 to 19 years in 2015 was 51 births per 1,000, which was higher than the average birth rate for adolescent females in all WHO regions (except for Africa, where it was 99.1 births per 1,000) (WHO, 2018). Teenage pregnant women are likely to be unmarried, in an unstable relationship with their partners, and to be poor and uneducated (Unicef, 2015). Not surprisingly, this group of pregnant women would be labelled as a high risk group for IPV.

The findings from both the questionnaire and the interviews in this current study showed that immigrant pregnant women and pregnant women with a previous history of abuse were less likely to be screened for IPV. The reasons for this which were identified from the interviewees' explanations were forgetting to ask, personal beliefs, the language difference and the lack of knowledge. Many previous studies, however, supported an association between these groups of pregnant women and exposure to IPV (Garcia-Moreno *et al.*, 2006; Thananowan & Heidrich, 2008; Taillieu & Brownridge, 2010; Stewart *et al.*, 2012; Gonçalves & Matos, 2016). Stewart *et al*. (2012) believed that being an immigrant is a vulnerability factor for IPV because these women may have limited use of the healthcare service and a lack of social networks and social support. According to a Thailand Migration Report (2011), migrants from

Cambodia, the Lao People's Democratic Republic and Myanmar tend to be vulnerable to exploitation and abuse because they generally lack of documentation and they face linguistic barriers and separation from family and community networks, and they lack legal protections. Most immigrants have difficulties accessing healthcare services and their health needs are not always adequately met. Moreover, women and girl migrants are more likely to encounter abusive practices than their male counterparts. There have been a significant number of well- documented reports on physical violence against women immigrants in Thailand but very few cases have led to any arrests for this violence (Huguet & Chamratrithirong, 2011). A mixed- method study conducted in Tak Province, Thailand (Meyer *et al.*, 2019) found that some women migrants were forced to be sex partners of their employers.

Also, experience of IPV prior to pregnancy was reported as a strong predictor of IPV during pregnancy (Garcia-Moreno *et al.*, 2006; Taillieu & Brownridge, 2010). A study conducted in Mexico City by Díaz-Olavarrieta *et al.* (2007) found that violence before pregnancy was strongly predictive of later violence and also during pregnancy. Most pregnant women (71%) who had a history of physical or sexual abuse reported current abuse and the severity of the violence had increased since they became pregnant. In Thailand, however, most studies have found that experience of IPV prior to pregnancy was not a significant predictor of IPV during pregnancy. These studies found that abused pregnant Thai women have significantly higher reported stress, marital dissatisfaction, incidence of separation, divorce and remarriage, unplanned pregnancy, have low income, are unemployed and are likely to indulge in alcohol abuse than non-abused pregnant women (Thananowan & Heidrich, 2008; Thananowan & Leelacharas, 2011a; Boonnate *et al.*, 2015). This factor might not therefore be highlighted as a predictor of IPV during pregnancy

among Thai HCPs. Notably, these groups of pregnant women could be missed if they are not considered to be at risk of IPV and are more likely to remain unidentified by the HCPs.

In addition, from the comments made during the interviews of the current study, one factor which can be a predictor of IPV during pregnancy was identified. This factor was a woman's decision to abort, which was mentioned by some of the interviewees. They said that in their experience, the prevalence of IPV was associated with women seeking an abortion. In Thailand, little is known about the association between IPV and seeking an abortion because abortion is illegal (except to save the life of the mother), so most abortions are carried out in illegal private sector facilities (Arnott *et al.*, 2017). So the precise relationships between IPV and abortion or seeking abortion among Thai women are unknown. However, this factor identified from the current study was consistent with those of previous studies (Wu, Guo & Qu, 2005; Taft & Watson, 2007; Aston & Bewley, 2009; Williams & Brackley, 2009; Rahman, 2015). A study in Bangladesh (Rahman, 2015) using data from women reporting IPV in the 2007 Bangladesh Demographic Health Survey, found that being subjected to physical IPV was significantly associated with a pregnancy terminated by an induced abortion. A Chinese study (Wu *et al.*, 2005) to determine the factors related to IPV among women seeking an induced abortion showed that the number of induced abortions in abused women was significantly higher than in those who were not abused. Similarly, a study in Australia comparing young women aged below 20 and women aged over 20 found that women reporting teenage terminations were more likely to be victims of IPV and women who reported later terminations were also more likely to have suffered abuse by a partner (Taft & Watson, 2007).

8.5.2 IPV assessment tools

There are several IPV assessment tools developed by professional health organisations, such as the US Preventive Services Task Force and the American College of Obstetricians and Gynaecologists (ACOG) (ACOG, 2012; Correa *et al.*, 2015). These IPV screening tools are regarded in health care as valid and reliable screening tools. The most frequently used IPV screening tools used in clinical settings include the Hurt, Insult, Threaten, and Scream (HITS) method, the Women Abuse Screening Tool/Women Abuse Screening Tool-Short Form (WAST/WAST-SF), the Partner Violence Screen (PVS), and the Abuse Assessment Screen (AAS) (Rabin *et al.*, 2009; Hussain *et al.*, 2015). However, the findings from the current study were that none of the interviewees used in their clinical practices any standard tool for screening pregnant women who might be in an abusive relationship. This finding is consistent with those of previous studies. Githui *et al*. (2018) conducted a cross-sectional study of 125 nurses in Kenya and reported that the majority of the participants used general questions for asking about IPV instead of any of the standardised IPV screening tools. Hindin (2006) interviewed eight certified nurse-midwives in the US to explore their IPV screening practices and found that none of them used a standardised screening assessment tool for IPV but they used questions which were adapted from the ACOG clinical guidelines. In the current study, most participants explained that their reasons for not using an IPV screening tool were that these screening tools include direct questions which might not be appropriate in Thai culture. Most of the participants said that women might feel uncomfortable with these direct questions because of feeling shame or their fear of being blamed. This finding of the current study is consistent with that of a study conducted with physicians and nurses working in a primary health care centre in Kuwait (Almutairi

et al., 2013), which found that indirect questions for IPV screening were preferred by most physicians (79.7%) and questions about feeling safe were preferred by most nurses (83.6%) (Almutairi *et al.*, 2013).

A tool widely described in this current study but seemingly in no other was the 2Q. Most of the interviewees reported that they used 2Q as a guide for IPV screening among pregnant women. 2Q is the question 2 of the Patient Health Questionnaire which consists of two questions. The purpose of 2Q is to screen patients for depression. At all out-patient departments in Thailand, including ANCs and emergency departments, each patient is assessed by the Thai version of 2Q, and should be further evaluated using 9Q if the 2Q result shows positive. The Thai version of 2Q contains 'yes/no' questions; 1) During the past two weeks, have you been bothered by feeling down, depressed, or hopeless? and 2) During the past two weeks, have you been bothered by little interest or pleasure in doing things? If the answer is 'yes' for either of these questions, the result is positive (DOMH, 2014).

The interviewees reported that they used 2Q as a guide for asking about IPV in suspicious cases. They explained that 2Q formed the beginning of an IPV assessment of women whom they suspected might be experiencing abuse. Some participants reported that if a woman's 2Q result was positive, they would continue to ask about IPV. The rationale given for this screening technique was based on the fact that exposure to IPV is strongly and consistently associated with depression. Most of the interviewees therefore stated that 2Q was a good question for starting the IPV identification process and also a good indicator for the detection of IPV during pregnancy.

8.6 Discussion of the findings on HCPs' barriers to and facilitators of IPV identification and response

8.6.1 Barriers

As has already been explained, in Thailand, OSCCs have been established in all hospitals across the country with encouragement and support from the MOPH to provide a comprehensive service for women who are victims of violence. The budgets and guidelines for HCPs to manage victims of violence were also provided for these hospitals by the MOPH. In the hospital where the OSCC was well-established, protocols for HCPs have been developed and promoted to assist the staff in managing victims of violence. Also, HCPs in that hospital were trained to improve their knowledge and to change their attitude regarding violence against women. However, Grisurapong (2004) stated that not all hospitals have a well-established OSCC. For example, in 2002, twenty provincial hospitals were assessed and it was found that there were only well-established OSCCs in five of them (Grisurapong, 2004). According to Thananowan *et al*. (2018), some of the OSCCs lacked trained staff and had no policies in place to encourage HCPs to screen for violence against women, so the needs of many victims of IPV in Thailand were not being met. This is consistent with the findings of the quantitative and qualitative phases of the present study which also reflected attitudes to even the well- established OSCCs. Some of the interviewees stated that they did not know anything about the OSCC in their hospitals and others stated that it was somewhere in the hospital but they did not know anything about its role or its responsibilities. The lack of guidelines and protocols and the poor implementation of guidelines and protocols about screening for and managing IPV in the hospital was therefore a barrier for some of the interviewees. They stated that they needed clear guidelines and protocols for them to follow if IPV is suspected and if it is identified. Also, in their previous study in Australia, O'Reilly and Peters (2018) showed that the lack of an IPV screening policy in the participants' hospitals was an important barrier to IPV

screening. The questionnaire data acquired in the present study supported this finding, in that most of the respondents (62.8%) were unaware of any protocols for HCPs on the subject of IPV. This is consistent with the proportion of the respondents who were unaware of any guidelines for primary care clinicians on IPV in a survey of GPs in the Republic of Ireland (O'Shea *et al.*, 2016).

In addition to the lack of a clear organisation policy, the majority of the participants in the present study reported barriers to IPV identification caused by time constraints due to the shortage of nursing staff, a heavy workload, having to see many pregnant women each day and having more pressing issues to address, which is consistent with the findings of several previous studies (Ortiz & Ford, 2005; Lauti & Miller, 2008; Bunn *et al.*, 2009; O'Shea *et al.*, 2016; McCauley *et al.*, 2017). Also, the reported lacked of knowledge, confidence and awareness, forgetting to ask, and the unwillingness of women to disclose were other barriers cited by the participants in this study which are also consistent with those of other studies (Ortiz & Ford, 2005; Lauti & Miller, 2008; Bunn *et al.*, 2009; O'Shea *et al.*, 2016; McCauley *et al.*, 2017). Unwillingness to disclose abuse was a significant barrier identified from the interviews in the current study and the results of the questionnaire presented a similar finding that many participants (46%) indicated that it was difficult to discuss IPV if women were unwilling to disclose it. Factors such as shame, embarrassment, going back to living with abuser, and fear that the abuser/husband would be arrested were given by the interviewees as reasons which prevent abused women from disclosing IPV. These results are consistent with those of previous studies on barriers to screening for IPV; Baig *et al.* (2012) conducted a qualitative study using interviews to examine provider barriers and facilitators to screening for IPV among HCPs in Colombia and found that patients' unwillingness to disclose abuse was one of the largest barriers

to detecting IPV. Most of participants in that study believed that the reason for concealing abuse was that it was not doctors' responsibility (Baig *et al.*, 2012). In Kuwait, Alotaby *et al.* (2012) used an observational cross-sectional study design to survey 210 physicians and 464 nurses; the majority of the participants identified women's determination to hide abuse as a barrier to screening for IPV.

8.6.2 Facilitators

As previously discussed, several previous researchers have highlighted the importance of training as a facilitator for assisting HCPs to identify and manage victims of IPV, and also for increasing knowledge and preparedness in regard to this issue among HCPs (Furniss *et al.*, 2007; Connor *et al.*, 2013; Shamu *et al.*, 2013; Baird *et al.*, 2015; Kamimura *et al.*, 2015; O'Reilly & Peters, 2018; Forsdike *et al.*, 2019). In the current study, the interviewees reported increased self-confidence in knowledge and a greater preparedness to discuss violence with women who might be experiencing IPV after receiving training on IPV. This result supports those of several studies which evaluated training programme efficacy in improving HCPs' identification of and response to IPV (Salmon *et al.*, 2006; Boursnell & Prosser, 2010; Jayatilleke *et al.*, 2015). In the UK, Salmon *et al*. (2006) evaluated the effects of an IPV educational programme on community midwives and found that the participants reported positive experiences of the programme and increased self-confidence in dealing with IPV as the outcome. Jayatilleke *et al.* (2015) conducted a pre- and post-intervention study in Sri Lanka to evaluate the effect of an IPV training programme on 408 public health midwives. The programme was designed to improve public health midwives' identification of, response to and management of victims of IPV. The results showed that the programme had significantly improved the participants' knowledge, responsibility and self-confidence to detect and help

IPV victims. Many studies have therefore demonstrated that HCPs need to be knowledgeable and trained sufficiently in a variety of ways to identify and respond to IPV during pregnancy.

8.7 Contribution to knowledge

The role of a doctoral thesis is to add to the relevant literature original research which increases knowledge of the significance of the field of the study. To date, most research regarding HCPs' perceptions and experiences of identifying and responding to IPV during pregnancy has been carried out in western countries. A few studies in this field have been conducted in Asian countries, especially Southeast Asia. As has been clearly demonstrated in the previous chapters, this thesis enriches the literature as it draws evidence from the Thai context. This research had produced additional knowledge which contributes to enhancing our understanding by reporting its findings from the PREMIS questionnaire which was designed for measuring HCPs' knowledge, attitudes and practice regarding IPV during pregnancy. It also adds to the literature by exploring HCPs' perceptions of their role and their experiences of IPV during pregnancy. Finally, this study has combined two parallel sets of findings so that greater accuracy and more understanding of the issue could be gained.

The present study is the first in Thailand to explore HCPs' knowledge, attitudes and practice using a version of the PREMIS which was adapted into the Thai language. It is also the first study which has explored Thai HCPs' perceptions and experience of identifying and responding to IPV during pregnancy. From the literature on HCPs' roles and experiences regarding the identification of and responses to IPV during pregnancy, it can be concluded that most of the previous studies have been carried out in developed countries and specifically western countries. There has

been hardly any research carried out in Asian countries on this topic.

The key contribution of the quantitative phase of this study was to extend understanding of HCPs' knowledge, attitudes and practice in identifying and responding to IPV during pregnancy in Thailand using the PREMIS questionnaire. The PREMIS questionnaire has been used internationally to measure HCPs' knowledge, attitudes and practice in identifying and responding to IPV. Adapted versions of the PREMIS questionnaire have been used with pharmacists (Barnard *et al.*, 2018), a group of medical, nursing, social work and dentistry students (Connor, *et al.*, 2011), practising dental hygienists and dentists (Harris *et al.*, 2016) in the US and paramedic students in Australia (Sawyer *et al.*, 2017). It has a been used for assessing the effectiveness of an IPV programme provided to dental students in the US (McAndrew *et al.*, 2014) and GPs in Greece (Papadakaki *et al.*, 2013); it was translated into Greek and tested for validity and reliability with primary care physicians (Papadakaki *et al.*, 2012). This current study is therefore the first to evaluate the suitability of the PREMIS questionnaire for use among HCPs in Thailand. It was translated into Thai specifically for this study and was tested for validity and reliability. This Thai version of the PREMIS questionnaire may be a valuable tool for the future assessment of HCPs' knowledge, attitude and practice in identifying and responding to IPV in the Thai context. Moreover, an IPV training programme will benefit from this tool as it can measure how the training has changed IPV-related knowledge, attitudes and self-reported behaviour and can be used to evaluate the success of the programme.

This study is unique in Thailand in that it has shown the benefits of a mixed-method design for addressing a complex research question which could be answered more

comprehensively than by using either quantitative or qualitative approaches alone. A wide spectrum of responses has been gathered in this study by interviewing a wide range of nurses who had worked in different healthcare settings and had varied levels of experience and the findings were used to expand and explain the questionnaire survey data in more depth. Overall, this study has made a contribution to the understanding of the information with regard to the knowledge, attitudes, practice and experiences of HCPs in Thailand towards the identification of and responses to IPV during pregnancy. This contribution will be useful by providing valuable data which can inform further studies seeking improvement in the identification of and responses to IPV among HCPs. The results have also identified key areas of Thai HCPs' knowledge of the barriers and facilitators which needs to be improved and the key points to note when planning future education or training on the whole topic of IPV. This mixed-method study is novel because of obtaining information about HCPs' knowledge, attitudes and practices regarding the screening for and management of IPV survivors using a questionnaire and then explaining the results by the findings of in-depth interviews with participants who had completed the questionnaire. The previous two mixed-method studies of IPV discussed in the literature review used different ways of combining qualitative and quantitative data and were not carried out in Thailand. The first of those studies was carried out in Sweden, and the qualitative results helped to develop the questionnaire for the quantitative phase of the study (Edin & Högberg, 2002). The second was conducted in Uganda and used the qualitative data to provide additional explanations for the quantitative data, and the interviewed participants for the qualitative follow-up phase of the study had not participated in the quantitative data collection phase (Kaye *et al.*, 2005). There were therefore a difference between that study and the current study which used the same

individuals in both samples. Using different samples in a sequential explanatory design can reduce the validity of the study if the participants who took part in the qualitative phase of the study cannot explain the significance of the results identified in the quantitative phase. To use qualitative data to provide more detail and fuller explanations of the quantitative data, the most suitable approach is to conduct qualitative follow-up with participants who have contributed to the quantitative data set (Creswell & Plano Clark, 2011).

8.8 Strengths and limitations of this study and suggestions for future research

This final section of this discussion chapter will address the strength and limitations of the quantitative and qualitative phases of this study as well as the strengths and limitations in applying a mixed-method strategy of investigation.

8.8.1 The quantitative phase

It should be noted at this point that the PREMIS survey used in this study was adapted from the original version, so the results should be considered with some caution. In this regard, there were a number of differences between the PREMIS used in the present study and that used in other studies. First, my questions were focused on IPV among pregnant women, whereas other studies have reported gathering information on perceived and actual knowledge of IPV which was not specific to pregnant women. Second, the numbers of items in each part were different. For example, I used fourteen items for assessing perceived knowledge compared with the PREMIS used for pharmacists (Barnard *et al.*, 2018) which had sixteen items. Finally, several of the items in the original version which were not relevant to IPV during pregnancy or referred to services which were not available in Thailand were omitted from my questionnaire. There was one previous study (Baird *et al.*, 2015) which had adapted

the knowledge questions from PREMIS and was focused on IPV during pregnancy, but there were several different aspects of those questions compared with my version of the questionnaire. For example, that knowledge test contained only 'true/false' or 'unsure' questions. Many of the items in this version were removed and changed, such as the items asking about the stage of change, alcohol abuse and characteristics of victims and perpetrators.

The current study was significantly limited by the small sample size which may not be representative of the broader HCP population, so the generalisation of the findings of this study to the larger Thai HCP populations should be undertaken with caution. Moreover, all of the measures in the questionnaire were participant self-reported and may have contained a strong element of social desirability bias, and the respondents might have over-reported their attitudes and clinical practice in regard to identifying and responding to IPV during pregnancy. The participants might have wanted to present the best possible version of themselves because these attitudes and behaviours are valued and widely seen as good, especially in relation to sensitive topics (Van De Mortel, 2008; Brenner & Delamater, 2016). Van De Mortel's (2008) review study found that participants' responses might be influenced by social desirability when they were asked to self-report on their competence and on socially sensitive topics. However, this limitation was overcome in the current study to some degree in that the questionnaire was carefully described to the respondents with particular emphasis being put on the fact that their responses would be voluntary, confidential and anonymous.

A further limitation with regard to the method of data collection was that participants were recruited using convenience sampling. There was likely to be some selection bias in recruitment that could lead to the under-or over-representation of particular groups

within the sample. Therfore, the results were not representative of the population being studied.

8.8.2 The qualitative phase

The recruitment of the participants for the qualitative phase of the study applied the purposive sampling method. This method involved purposefully selecting interview participants based on their responses in the questionnaire; those who had had experience of screening and of helping victims of IPV during pregnancy were approached to participate in an interview. Their questionnaire responses were completely voluntary and participants from different clinical settings were considered in order to capture diverse perceptions and experiences. However, there may have been a self-selection bias in this process as it could be that the HCPs who took part in the interviews may also have been be more interested in the topic than those who chose not to participate further after the questionnaire phase. Hence, one limitation of the qualitative phase was that data were captured only from nurses who had experience of identifying and responding to pregnant women who might be being abused by their partners or husbands. This prevented other HCPs from taking part who might have also had valuable insights to share. However, as the aim of this study was not to generalise the findings to the wider population but rather to focus on capturing the individual experiences of the HCPs, this is not a major limitation. Furthermore, the participants were an homogenous group regarding gender and professional background, so if there were distinctions between their perceptions and experiences of identifying and responding to IPV during pregnancy and those of other professionals and/or among male HCPs, their perceptions and experiences are also not reflected in the findings of this study. Interestingly, the analysis of the quantitative data did indicate some professional and gender differences in identifying and

responding to IPV during pregnancy. For example, doctors had significantly higher scores on perceived knowledge and attitudes toward victim understanding than nurses, and male HCPs had significantly higher scores on perceived knowledge than females (*see* Chapter 5, section 5.6 Inferential statistics). Future studies should try to recruit other professionals, male HCPs and HCPs who have no experience of and have never screened for IPV. It would therefore be useful to repeat this study with a more diverse group of Thai HCPs.

However, the heterogeneity of the sample overall in terms of clinical settings and their varied experiences of identifying and responding to IPV during pregnancy was beneficial in providing invaluable information which was used to inform the proposal for the development of the care and services which fit the needs of IPV during pregnancy.

8.8.3 Mixed methods

A major strength of the current study was the use of a mixed-method research design to explore Thai HCPs' perceptions of their roles and experiences in identifying and responding to IPV during pregnancy. The sequential explanatory design was effective in meeting the research objectives of the study. The first, quantitative phase of the study successfully provided information about the knowledge, attitudes, and practices of Thai HCPs in identifying and responding to IPV during pregnancy. The second, qualitative phase of the study was then able to capture rich insights into participants' perceptions of their roles and experiences including the barriers to and facilitators of IPV identification and response. Finally, the integration of the quantitative and qualitative methods effectively enabled a more comprehensive understanding of Thai HCPs about their identification of and responses to IPV.

With respect to the limitations of the mixed-method design employed in this study, some important issues need to be considered. First, it should be noted that this was a small sample reflecting the knowledge, attitudes, practices, perceptions and experiences of HCPs in one single province of Thailand, which has 77 provinces in total. The knowledge, attitudes, practices, perceptions and experiences of HCPs in other provinces might have been different. For example, Knonkaen province has been selected by the MOPH to be a model for OSCCs, hence HCPs in that province had been trained in the knowledge and practices needed to provide services to victims of IPV and domestic violence. The hospitals in that province have also produced a manual, protocols and guidelines for the staff on violence against women (Grisurapong, 2002). For this reason, HCPs' knowledge, attitudes, practices, perceptions and experiences in these two provinces might be different.

Future research is needed to explore how HCPs' knowledge, attitudes, practices, perceptions and experiences of the province where an OSCC was originally implemented as a model might differ from those in other provinces where OSCCs were established subsequently. So a comparison between these provinces would provide a valuable new perspective, could be used to design an effective programme for IPV training for HCPs in Thailand and could also be used to measure the effectiveness of the model hospital.

Moreover, to add additional interesting variety and to maximise the relevance of research exploring clinical practices in terms of the identification of and responses to IPV, the perceptions of pregnant women on their experience of IPV identification and responses at health services could be investigated. The findings of the current study were that most HCPs had positive attitudes towards and were willing to help pregnant women who might be victims of IPV, but the needs of survivors of IPV and

the choice of appropriate care for them are still being questioned in Thailand. Carrying out research to explore pregnant women's own perspectives on services by HCPs in relation to IPV could provide an understanding of women's needs in relation to the screening and responding interventions which could help HCPs to address IPV during pregnancy in a more comprehensive manner.

8.9 Conclusion

In this chapter, I have discussed the key findings of this study in the light of the existing literature. The results of this study indicate that Thai HCPs had poor knowledge about IPV during pregnancy, especially knowledge regarding the legal requirements. Moreover, most of them had some misconceptions about the factors which are strongly associated with IPV during pregnancy. Most of the participants in this study were not consistent in their clinical practice in terms of IPV management depending on several factors, such as time constraints, lack of knowledge, training and resources and being part of an effective team. The most important barrier affecting this might be related to unclear guidelines and the lack of organisational policy. However, most of the participants had a positive attitude towards the identification of and responses to IPV during pregnancy. The results presented and discussed in the preceding chapters therefore draw attention to the need for ongoing education, training and guidelines and for the establishment of policies which will enable HCPs to deal with the victims of IPV effectively. The conclusion of the study and the implications for healthcare practice will be presented in the next chapter.

CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

This chapter is divided into three sections, starting with the reflections of the researcher and then moving on to an overall summary of the study's findings which offers reflections on the significance of the key findings to emerge from this research. The final section provides recommendations in key four areas.

9.2 Researcher's reflections

As noted earlier, reflexivity is commonly recognised as a significant part of the study process in which the researcher acknowledges her/his position and role in the process of data collection and analysis, and the construction of knowledge (Palaganas *et al.*, 2017). At this point it is important to consider how my own background as a Thai woman, and profession as a Thai nurse, influenced insider/outsider position in relation to my study. I interviewed sixteen nurses who claimed to have had experience of identifying and/or responding to IPV among pregnant women. I considered myself primarily as an insider because both I and each of my interviewees were Thai women and had a background as a nurse, with all of us also being Buddhist. Because of this position, I am fully able to understand and am familiar with the types of issues that affect the participants' experiences and awareness of the pertinent questions to ask which might differ from those devised by an outside, for example when developing an interview guide and during the interview itself. I also believe that my own experiences and knowledge of the Thai health care system and culture, combined with the qualitative date acquired from the questionnaire responses, allowed me to

construct an appropriate interview guide easily and effectively. However, because of my insider status, the participants might have responded to me by making the assumption that a shared experience is intrinsically understood. For me, I also might not adequately have explored an issue with a participant because I assumed commonality in how we view the phenomenon (Hayfield & Huxley, 2015). Therefore, issues may have gone unspoken or not been explore in as much depth as required. During the interviews, I identified myself to the participants as a nursing lecturer and researcher so that positioned me also as an outsider. My outsider position made it easy for me to ask naïve questions in order to gain clarification, whereas the participants might have assumed that I would be knowledgeable. I also found that this technique led to some participants being willing to explain things which I have never heard of and to share more about their experiences. As an outsider, however, I might not be able to understand or accurately represent some of the interviewees' experiences and the participants might understandably feel that I would be able to adequately represent their experiences. It is important to note that I shifted from being an insider to an outsider depending on the context throughout the whole research process (Berger, 2015; Hayfield & Huxley, 2015). And that the knowledge co-constructed in this thesis is a combination of my sense- making of the data as an insider/outsider, and the participants' shared insights.

9.3 Summary of the overall findings

To achieve the aim and the objectives and to answer the research questions, key research priorities for the conduct of this study were developed. These were, first; to assess the Thai HCPs' knowledge, attitudes and practices regarding their identification of and responses to IPV among pregnant women. A survey based on

the PREMIS questionnaire was adapted and translated into the Thai language. The participants' responses have offered new information on Thai HCPs' knowledge, attitudes and practices regarding their identification of and responses to IPV from the large group of questionnaire respondents. A second priority was to select a methodological approach which would enable HCPs' voices to be heard about their perceptions of their role and their clinical experiences, and to explain and clarify the practical implementation barriers to and facilitators of clinical practice which they had encountered. Qualitative interviews were selected as the research method and were employed with a particular focus on HCPs who had completed the questionnaire phase of the study and who had experience of identifying and responding to pregnant women who may be IPV victims. The interviewed participants' narratives have provided new insights into the understanding of how they perceived their role and how they had experienced identifying and responding to IPV during pregnancy. So the perceived barriers to and facilitators of IPV identification and responses among Thai HCPs were identified from the interviews. The key findings from the two phases of this study are presented below.

The findings indicate that Thai HCPs had poor knowledge regarding IPV during pregnancy, doctors had higher scores on perceived and actual knowledge than the nurses, there were misconceptions among the Thai HCPs' knowledge about the leading cause of IPV during pregnancy, they lacked knowledge of law relating to IPV, and the mean score on perceived knowledge of the participants who had been trained was higher than that of those who had never been trained.

Most of the participants reported a positive attitude towards identifying and responding to pregnant women who might be subjected to IPV. Most of them perceived that IPV identification was their responsibility and believed that they had

a duty to protect pregnant women and their unborn babies. They did not feel uncomfortable or afraid of offending the women when asking them questions about IPV. Nevertheless, the reported identification rate was low among both the survey and the interview participants. All of the interviewees reported that they did not routinely ask pregnant women about IPV, they asked only women who showed signs of being abused. The reasons for this clinical practice were identified in the interviews as a series of barriers, for example their personal beliefs, a heavy workload, their lack of knowledge and training and the absence of clear policies regarding the identification of and response to IPV. Interestingly, the findings showed that the interviewees used 2Q as guide for asking about IPV, which had not been reported by any previous studies.

The participants' responses in terms of providing help to victims of IPV varied depending on the woman's situation, her consent and the nurse's competence. The most common nursing interventions provided for victims after IPV disclosure included listening to them, evaluating the situation, making appropriate referrals, and providing information and mental support. The main barriers remained the same as found in the previous studies: unclear policy, poor implementation of guidelines, lack of time, low knowledge and confidence levels of HCPs and the barriers related to the pregnant women themselves. Facilitators for screening and caring for IPV victims included 2Q, IPV training and nurse-patients relationships.

9.4 Recommendations

The recommendations which can now be made as a result of the findings of this study focus on the following key areas:

- Recommendations for HCPs;

- Recommendations for research;
- Recommendations for policy;
- Recommendations for training and/or education,

These recommendations will be discussed separately in the following sections.

9.4.1 Recommendations for HCPs

With the evidence from this current study, there is a clear need for an IPV screening tool during pregnancy to help Thai HCPs to begin discussing IPV with pregnant women. Although some IPV screening tools have been developed and are referred to in the findings found in the existing literature, these tools are for western studies and are not suitable for use in Thailand because of the cultural sensitivity of Thai society. There are several screening tools for IPV against pregnant women which have been recommended for Thai nurses, including the Hurt, Insult, Threaten and Scream (HITS) method, Ongoing Abuse Screen (OAS), the Abuse Assessment Screen (AAS), the Woman Abuse Screening Tool (WAST), and the Partner Violence Screen (PVS). However, none of the interview participants in this current study reported that they had ever used these screening tools to detect IPV. One reason given for this is that the tools use direct questions, which is not appropriate for use in Thailand where IPV is viewed as a private issue and a family matter. The findings from this current study suggested that Thai nurses needed to be familiar with the pregnant women and to use indirect questions which can gently lead to the next questions relating to IPV. They also stated that pregnant women might felt uncomfortable at being asked direct questions. Therefore, based on the results of the current study, the way which was found to be effective for initiating a discussion about IPV between nurses and pregnant women might be suitable for use in the wider Thai context. The suggestion is that start a screening with 2Q, which is routinely used

to screen all patients for depression at all out-patient departments in Thai public hospitals and then using the general questions. The following sample questions and statements, from the 2Q, can be used to develop a strategy to build a rapport with women, to make them feel comfortable and to help nurses to address the issue of the difficulty of starting a conversation about violence.

Opening questions

- During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?
- During the past two weeks, have you been bothered by little interest or pleasure in doing things?

If the answer is 'yes' to either of these questions – continue asking by using general questions about their husbands, for example:

- Are you in a relationship? If 'yes', how does your husband/partner take care you while you are pregnant?
- What does he do specifically while you are pregnant, for example, help around the house, do the shopping?

Even if the result of 2Q is negative, the general questions about their husband/partner can still be used as a trigger for IPV disclosure or can lead to IPV screening. Moreover, at the beginning of questions of this kind, a private and safe setting with the woman alone with the HCP should be considered, confidentiality should be ensured and a system for referral should be available. Based on the findings from both the survey and the interviews of the current study, IPV during pregnancy can happen to all women, regardless of age, relationship status and ethnicity, and, importantly, it can also occur in the absence of alcohol use. Therefore, screening all newly presented pregnant

women for IPV victimisation is strongly suggested.

9.4.2 Recommendations for research

Because this current study is the first attempt to explore HCPs' perceptions and experiences of identifying and responding to IPV during pregnancy, it formulates the basis of developing care in this field of practice in Thailand. This thesis clearly depicts the knowledge, attitudes, practices and experiences of nurses and doctors in regard to IPV during pregnancy. It is therefore recommended that further research should be carried out to explore the perceptions and experiences among other HCPs and/or other service providers who have responsibilities for dealing with IPV victims. This suggestion could include such topics as attitudes towards IPV, their role in responding to IPV victims, and the barriers to and facilitators of dealing with these victims. It would be interesting to include the perspective of HCPs who had never screened patients for IPV to identify the barriers to IPV screening on their practices. In addition, further research should be carried out to compare the findings with other provinces in Thailand, especially the provinces where OSCCs are well-established. Further research could also shed light on Thai pregnant women's experiences of being screening and/or receiving assistance for IPV from HCPs.

9.4.3 Recommendations for policy

The absence of a system support was perceived as a barrier to identifying and responding to IPV by most of the participants in the current study, especially the lack of interventions and clear care referral pathways for women who disclose IPV. The findings from this study can have considerable implications for establishing a guideline and protocol for HCPs to work with this particular client group. It became clear during the study that working with pregnant women who are being subjected to

IPV is something which is not easy to deal with. Any guidelines and protocols developed must therefore be targeted at assisting HCPs to provide appropriate care, for example, by facilitating disclosure, offering support and referral, providing the appropriate medical services and follow-up care, and/or gathering forensic evidence. For HCPs to be knowledgeable about the resources available to refer women to when IPV has been identified is essential. Some participants in the interviews of the current study admitted that they lacked confidence in responding to IPV mainly due to their limited knowledge of the resources available for victims and of the referral system. It is therefore suggested that guidelines for dealing with cases of IPV during pregnancy should provide available resources for victims of IPV which meet the specific needs for each local area and should provide practical guidance in relation to the referral process.

9.4.4 Recommendations for IPV training and education

The results of the current study highlight the need for the improvement of HCPs' knowledge and skills in identifying and responding to IPV during pregnancy. As the findings have clearly demonstrated, the Thai HCPs who participated in the two phases of this study had a positive attitude but lacked the necessary knowledge and skill in terms of how to ask about IPV and how to facilitate the appropriate responses, and most of them reported not having had previous training in IPV, especially in the previous twelve months. Therefore, adequate education and training need to be provided to Thai HCPs. The participants in the current study who had been trained about IPV stated that IPV training provided them with several benefits, for example increasing their IPV knowledge, attitudes and practices, and increasing their self-confidence and self-efficacy related to working with IPV victims. The findings suggest that a standard IPV training programme is required and should be organised annually.

This programme should enhance HCPs' knowledge and skills development in line with the clinical handbook for HCPs to improve their ability to identify and to respond to pregnant women's exposure to IPV.

The results of the questionnaire survey in this current study showed that there was a lack of undergraduate IPV education for Thai HCPs. The majority of the participants had received no IPV training and only a few of them had received some IPV training during their medical/nursing school years, but that training may not be robust enough to translate to their clinical practice. Therefore including IPV training in the formal medical/nursing curriculum is highly recommended. The curriculum should cover all aspects of IPV and can be applied to future clinical practices.

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Appendices

Appendix 1.1

Classifying Form: Criteria for classifying women for the basic component of the new antenatal care model (WHO, 2002)

Name of patient: _____ **Clinic record number:** ☐☐☐☐☐☐

Address: _____ **Telephone:** _____

INSTRUCTIONS: Answer all of the following questions by placing a cross mark in the corresponding box.

OBSTETRIC HISTORY		**No**	**Yes**
1.	Previous stillbirth or neonatal loss?	☐	☒
2.	History of 3 or more consecutive spontaneous abortions?	☐	☒
3.	Birthweight of last baby < 2500g?	☐	☒
4.	Birthweight of last baby > 4500g?	☐	☒
5.	Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	☐	☒
6.	Previous surgery on reproductive tract? (Myomectomy, removal of septum, cone biopsy, classical CS, cervical cerclage)	☐	☒

CURRENT PREGNANCY		**No**	**Yes**
7.	Diagnosed or suspected multiple pregnancy?	☐	☒
8.	Age less than 16 years?	☐	☒
9.	Age more than 40 years?	☐	☒
10.	Isoimmunization Rh (-) in current or in previous pregnancy?	☐	☒
11.	Vaginal bleeding?	☐	☒
12.	Pelvic mass?	☐	☒
13.	Diastolic blood pressure 90mm Hg or more at booking?	☐	☒

GENERAL MEDICAL		**No**	**Yes**
14.	Insulin-dependent diabetes mellitus?	☐	☒
15.	Renal disease?	☐	☒
16.	Cardiac disease?	☐	☒
17.	Known 'substance' abuse (including heavy alcohol drinking)?	☐	☒
18.	Any other severe medical disease or condition?	☐	☒

Please specify _____

_____

A "Yes" answer to any ONE of the above questions (i.e. ONE shaded box marked with a cross) means that the woman is not eligible for the basic component of the new antenatal care model.

Is the woman eligible? (circle) **NO** **YES**

If NO, she is referred to _____

Date _____ Name _____ Signature _____

(staff responsible for ANC)

Appendix 2.1

Key components, synonyms and related terms of research question based on the PEO structure

Research question: What are HCPs' perceptions of their roles and experiences of responding to and identifying IPV among pregnant women?				
PEO format	**Keywords**			
	MeSH term in PubMed	**Subject heading in CINAHL**	**PsycINFO**	**Free text terms**
Population/Healthcare professional	Health personnel Allied health personnel	Healthcare professional	Healthcare professional	Healthcare provider Healthcare worker Nurse Midwife Physician Doctor Obstetrician Gynaecologist

Research question: What are HCPs' perceptions of their roles and experiences of responding to and identifying IPV among pregnant women?				
PEO format	**Keywords**			
	MeSH term in PubMed	**Subject heading in CINAHL**	**PsycINFO**	**Free text terms**
Exposure/ Intimate partner violence during pregnancy	Intimate partner violence Spouse abuse	Intimate partner violence	Intimate partner violence	Domestic violence Spousal violence Spousal abuse Partner violence Partner abuse Wife abuse
	Pregnancy Pregnant women	Pregnant women	Pregnant women	Pregnancies Prenatal care Antenatal care
Outcome/ Perception/Role/Experience	Perception Role Experience	Perception Role Experience	Perception Role Experience	Perception Attitude View Opinion Role Responsibility Experience

Appendix 2.2

Search strategy and results for primary studies in the review and the results

Search history			
Population/Healthcare professionals	**Exposure/Intimate partner violence during pregnancy**		**Outcomes/Perception/Role/Experience**
#1 Healthcare professional	#13 Intimate partner violence	#21 Pregnan* ($)	#26 Perception
#2 Health personnel	#14 Spous*($) abuse	#22 Pregnant wom*($)	#27 Attitude
#3 Allied health personnel	#15 Domestic violence	#23 Prenatal care	#28 View
#4 Healthcare provider	#16 Spous*($) violence	#24 Antenatal care	#29 Opinion
#5 Healthcare worker	#17 Partner abuse	#21 OR #22 OR #23 OR #24 >>>> #25	#30 Role
#6 Nurs*($)	#18 Partner violence		#31 Responsibilit*($)
#7 Midwi*($)	#19 Wife abuse		#32 Experienece
#8 Physician	#13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 >>>> #20		#26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 >>>> #33
#9 Doctor			
#10 Obstetrician			
#11 Gynaecologist			
#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 >>>> #12			
#12 AND #20 AND #25 AND #33			

Results

Database	Limits/Date covered	Date searched	Hits
CINAHL	01/2001-11/2016 Peer review	23/11/2016	34
	12/2016-04/2019 Peer review	26/04/2019	29

Database	Limits/Date covered	Date searched	Hits
PubMed	2001/01/01-2016/11/26	26/11/2016	150
	2016/12/01-2019/04/26	26/04/2019	28

Database	Limits/Date covered	Date searched	Hits
PsycINFO via Ovid	2001-2016 Peer review journal	29/11/2016	976
	2017-2019	26/04/2019	69

Appendix 2.3

Data extraction form

General information

Date of data extraction *8/12/16*

Identification features of the study:

Record number (to uniquely identify study) *No. 8*

Authors *Kathleen Furniss, Mary McCaffrey, Vereene Parnell and Susan Rovi*

Articles title *Nurses and Barriers to Screening for Intimate Partner Violence*

Citation Furniss, K. *et al.* (2007) 'Nurses and Barriers to Screening for Intimate Partner Violence', *The American Journal of Maternal/Child Nursing* , 32(4), pp. 238–243.

Country of original *United States of America*

Source of funding -

Study characteristics

Aims/objectives of the study *To explore nurses' perceived about barriers to screening for IPV*

Study design *Survey study*

Study inclusion and exclusion criteria Inclusion *Nurses in two maternity centres in New Jersey and one maternity centre in Maryland and a national perinatal listserv*

No exclusion criteria

Recruitment procedures used (e.g. details of randomization, blinding)

Convenience sampling

Unit of allocation *Maternity centre in New Jersey and Maryland and national perinatal listserv*

Participant Characteristics

Characteristics of participants at the beginning of the study

Nearly 50% worked in labour and delivery department and other 50% were emergency department, antepartum testing, perinatal, pediatrics, ob/gyn clinics, and nursery and with 16.4% were worked on multiple units. The average of year working in nursing was 13.

Intervention and setting

Setting in which the intervention is delivered -

Description of the intervention(s) and control(s) (e.g. dose, route of administration, number of cycles, duration of cycle, care provider, how the intervention was developed, theoretical basis (where relevant)) -

Description of co-interventions -

Outcome data/results

Unit of assessment/analysis *Using SPSS programme and using content analysis techniques for brief text.*

Statistical technique used *Descriptive statistics*

For each pre-specified outcome: -

Number of participants enrolled

Number of participants included in analysis *The final sample was 385 nurses,* 85 *from maternity centres and 300 from perianal listserv.*

Number of withdrawals, exclusions, lost to follow-up -

Summary outcome data e.g.

Dichotomous: number of events, number of participants

Continuous: mean and standard deviation

Type of analysis used in the study *Descriptive statistics and Content analysis*

Results of study analysis *Percentage, Average, Mean, Standard deviation*

Record details of any additional relevant outcomes reported

- *20.2% reported that they were not comfortable in asking patients about IPV.*
- *Years of working was correlated to comfort levels of nurses in IPV screening.*
- *76% of nurses had never been asked about their own IPV experience.*
- *91.7% reported the ability to ask question in private as a barrier, followed by 56.4% stated did not know how to do if patients disclose and 55.1% reported no time to ask as a barriers.*
- *Nurses from California and Maryland reported language differences as significant barrier for IPV detecting.*
- *Most participants need more training on IPV.*

Appendix 2.4

Critical Appraisal Skill Tool (CASP) Qualitative Research checklist

Screen Questions		**ID No of included research**								
		1	2	3	5	6	7	9	13	14
1. Was there a clear statement of the aims of the research? Hint: Consider - What was the goal of the research? - Why it was thought important? - Its relevance	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate? Hint: Consider - If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants - Is qualitative research the right methodology for addressing the research goal?	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is it worth continuing? <u>Detail Questions</u>										
3. Was the research design appropriate to address the aims of the research? Hint: Consider - If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?	Yes Can't tell No	N	N	N	N	Y	Y	N	N	Y

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
4. Was the recruitment strategy appropriate to the aims of the research?										
Hint: Consider	Yes									
- If the researcher has explained how the participants were selected	Can't tell	N	Y	Y	Y	Y	Y	Y	Y	Y
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study	No	N	Y	Y	N	Y	Y	N	Y	N
- If there are any discussions around recruitment (e.g. why some people chose not to take part)		N	N	Y	N	N	Y	N	N	Y

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
5. Was the data collected in a way that addressed the research issue?										
Hint: Consider	Yes									
- If the setting for data collection was justified	Can't tell	N	N	N	N	Y	N	Y	N	N
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)	No	Y	Y	Y	Y	Y	Y	Y	Y	Y
- If the researcher has justified the methods chosen		N	Y	Y	N	N	N	N	N	N
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?		Y	Y	Y	Y	Y	Y	Y	Y	Y
- If methods were modified during the study. If so, has the researcher explained how and why?		Y	N	N	N	N	N	N	N	Y
- If the form of data is clear (e.g. tape recordings, video material, notes etc)		Y	Y	Y	Y	Y	Y	Y	N	Y
- If the researcher has discussed saturation of data		N	N	N	Y	N	Y	N	N	N

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
6. Has the relationship between researcher and participants been adequately considered? HINT: Consider - If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions	Yes Can't tell No	N	Y	Y	N	N	N	Y	Y	N
(b) Data collection, including sample recruitment and choice of location - How the researcher responded to events during the study and whether they considered the implications of any changes in the research design		N N	N N	Y Y	N N	N N	Y Y	N N	N N	Y N

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
7. Have ethical issues been taken into consideration? HINT: Consider - If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained - If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) - If approval has been sought from the ethics committee	Yes Can't tell No	N N Y	Y Y Y	N N Y	Y Y Y	Y Y Y	Y Y Y	Y Y Y	N N Y	Y Y Y

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
8. Was the data analysis sufficiently rigorous?										
HINT: Consider	Yes									
- If there is an in-depth description of the analysis process	Can't tell	N	Y	Y	Y	N	Y	Y	N	N
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?	No	Y	Y	Y	Y	N	Y	Y	N	N
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process		Y	Y	Y	Y	N	Y	Y	N	Y
- If sufficient data are presented to support the findings										
- To what extent contradictory data are taken into account		Y	Y	Y	Y	Y	Y	Y	Y	Y
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation		Y N	Y Y	Y Y	Y Y	Y N	Y N	Y N	Y N	Y N

Screen Questions		ID No of included research								
		1	2	3	5	6	7	9	13	14
9. Is there a clear statement of findings?										
HINT: Consider	Yes									
- If the findings are explicit	Can't tell	Y	Y	Y	Y	Y	Y	Y	Y	Y
- If there is adequate discussion of the evidence both for and against the researchers arguments	No	Y	Y	Y	Y	Y	Y	Y	Y	N
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)		N	Y	Y	N	N	Y	N	N	N
- If the findings are discussed in relation to the original research question		Y	Y	Y	Y	Y	Y	Y	Y	Y
10. How valuable is the research?										
HINT: Consider										
- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?		Y	Y	N	Y	Y	Y	Y	Y	N
- If they identify new areas where research is necessary										
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used		Y Y	N N	N N	N N	N Y	Y Y	Y N	Y Y	Y Y

Critical Appraisal Skills Programme (CASP) Cohort Study Checklist

(A) Are the results of the study valid? Screening Questions		ID No of included research						
		4	8	10	11	12	16	18
1. Did the study address a clearly focused issue? HINT: A question can be 'focused' In terms of □ The population studied □ The risk factors studied □ Is it clear whether the study tried to detect a beneficial or harmful effect? □ The outcomes considered	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y
2. Was the cohort recruited in an acceptable way? HINT: Look for selection bias which might compromise the generalisibility of the findings: □ Was the cohort representative of a defined population? □ Was there something special about the cohort? □ Was everybody included who should have been included?	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y
Is it worth continuing? <u>Detailed Questions</u>								
3. Was the exposure accurately measured to minimise bias? HINT: Look for measurement or classification bias: □ Did they use subjective or objective measurements?		Y	Y	Y	Y	Y	Y	Y

□ Were all the subjects classified into exposure groups using the same procedure □ Do the measurements truly reflect what you want them to (have they been validated)?	Yes Can't tell No							
4. Was the outcome accurately measured to minimise bias? HINT: Look for measurement or classification bias: □ Did they use subjective or objective measurements? □ Do the measures truly reflect what you want them to (have they been validated)? □ Has a reliable system been established for detecting all the cases (for measuring disease occurrence)? □ Were the measurement methods similar in the different groups? □ Were the subjects and/or the outcome assessor blinded to exposure (does this matter)?	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y
5. (a) have the authors identified all important confounding factors? List the ones you think might be important, that the author missed. (b) have they taken account of the confounding factors in the design and/or analysis? HINT: Look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors	Yes Can't tell No	C	C	C	C	C	C	C
6. (a) Was the follow up of subjects complete enough?	Yes Can't tell No	C	C	C	C	C	C	C

(b) Was the follow up of subjects long enough? HINT: Consider □ The person had effects should have had long enough to reveal themselves are lost to follow-up may have different outcomes than those available for assessment □ In an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort?	Yes Can't tell No							
(B) What are the results?								
7. What are the results of this study? HINT: Consider □ What are the bottom line results? the proportion between the exposed/unexposed, the ratio/the rate difference? □ How strong is the association between exposure and outcome (RR,)? □ What is the absolute risk reduction (ARR)?		Y	Y	Y	Y	Y	Y	Y
8. How precise are the results? HINT: Look for the range of the confidence intervals, if given.								
9. Do you believe the results? HINT: Consider □ Big effect is hard to ignore! □ Can it be due to bias, chance or confounding?	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y

 Are the design and methods of this study sufficiently flawed to make the results unreliable?

 Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

(C) Will the results help locally?								
10. Can the results be applied to the local population? HINT: Consider whether A cohort study was the appropriate method to answer this question The subjects covered in this study could be sufficiently different from your population to cause concern Your local setting is likely to differ much from that of the study You can quantify the local benefits and harms	Yes Can't tell No	C	Y	Y	Y	Y	Y	Y
11. Do the results of this study fit with other available evidence?	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y
12. What are the implications of this study for practice? HINT: Consider One observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making For certain questions observational studies provide the only evidence Recommendations from observational studies are always stronger when supported by other evidence	Yes Can't tell No	Y	Y	Y	Y	Y	Y	Y

MMAT criteria (Pluye *et al.*, 2011)

Types of mixed methods study components or primary studies	**Methodological quality criteria**	**ID No of included research**	
		15	17
Screening questions (for all types)	- Are there clear qualitative and quantitative research question (or objectives*), or a clear mixed methods question (or objectives*)?	Y	Y
	- Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Y	Y
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.		
1. Qualitative	1.1 Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Y	Y
	1.2 Is the process for analyzing qualitative data relevant to address the research question (objective)?	Y	Y
	1.3 Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	N	Y
	1.4 Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	N	Y
2. Quantitative randomized controlled (trials)	2.1 Is there a clear description of the randomization (or an appropriate sequence generation)?	-	-
	2.2 Is there a clear description of the allocation concealment (or blinding when applicable)?	-	-
	2.3 Are there complete outcome data (80% or above)?	-	-
	2.4 Is there low withdrawal/drop-out (below 20%)	-	-
3. Quantitative non-randomized	3.1 Are participants (organizations) recruited in a way that minimizes selection bias?	Y	Y

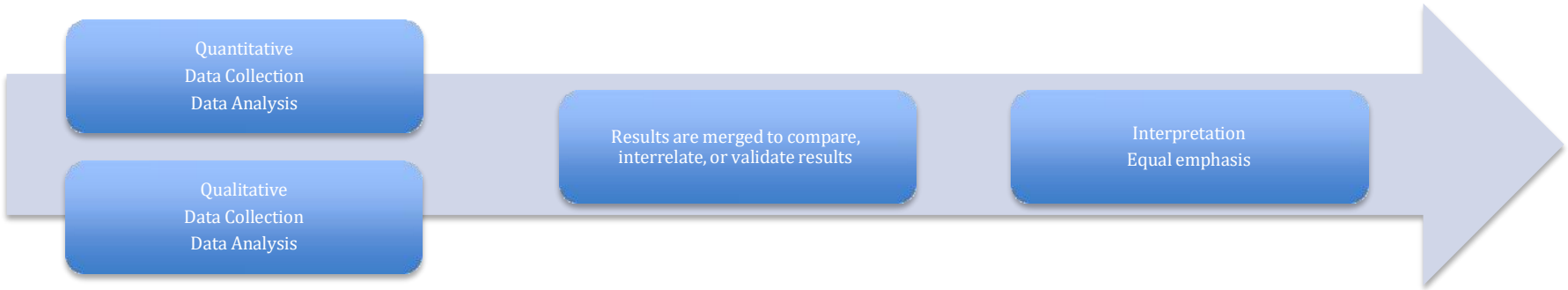
Types of mixed methods study components or primary studies	**Methodological quality criteria**	**ID No of included research**	
		15	17
	3.2 Are measurement appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	Y	Y
	3.3 In the groups being compared (exposed vs. non-exposed; with intervention vs. without; case vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	Y	Y
	3.4 Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	N	Y
4. Qualitative descriptive	4.1 Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	N	Y
	4.2 Is the sample representative of the population understudy?	Y	Y
	4.3 Are measurements appropriate (clear origin, or validity known, or standard instrument)?	Y	Y
	4.4 Is there an acceptable response rate (60% or above)?	C	Y (82%)
5. Mixed methods	5.1 Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	N	Y
	5.2 Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	N	Y
	5.3 Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	N	Y
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.		

Types of mixed methods study components or primary studies	Methodological quality criteria	ID No of included research	
		15	17
	*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated. Responses: Yes (Y), No (N), Can't tell (C)		

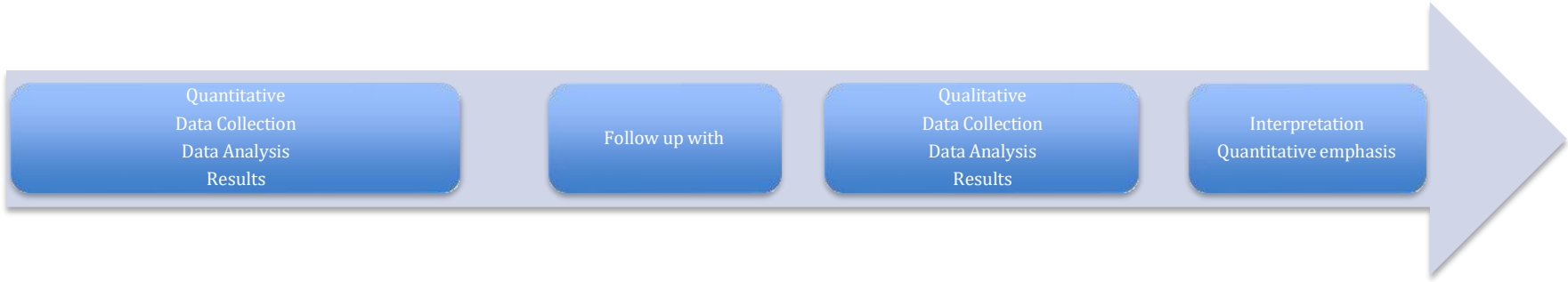
Appendix 3.1

Six major mixed methods research designs, adapted from (Creswell & Plano Clark 2011)

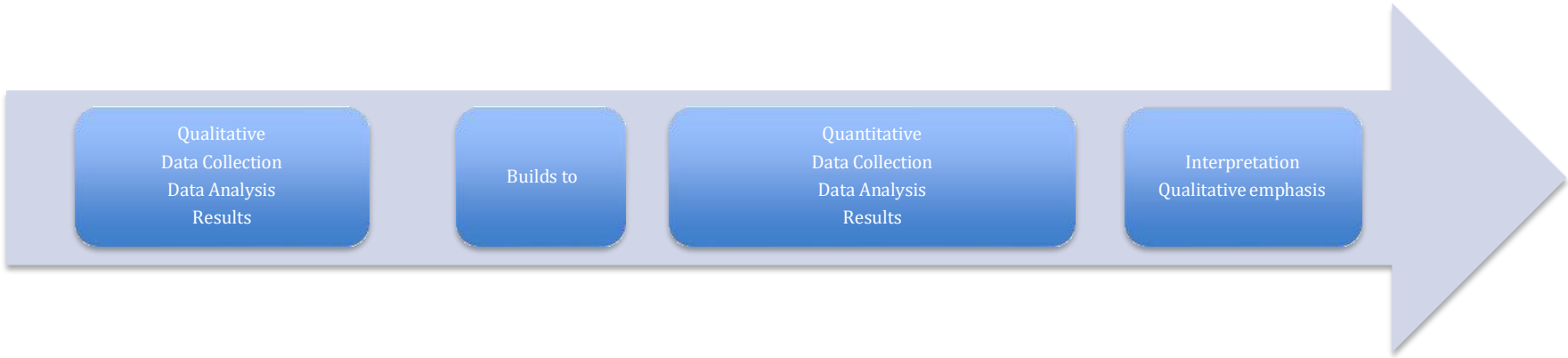
(a) The convergent parallel design/ the convergent design



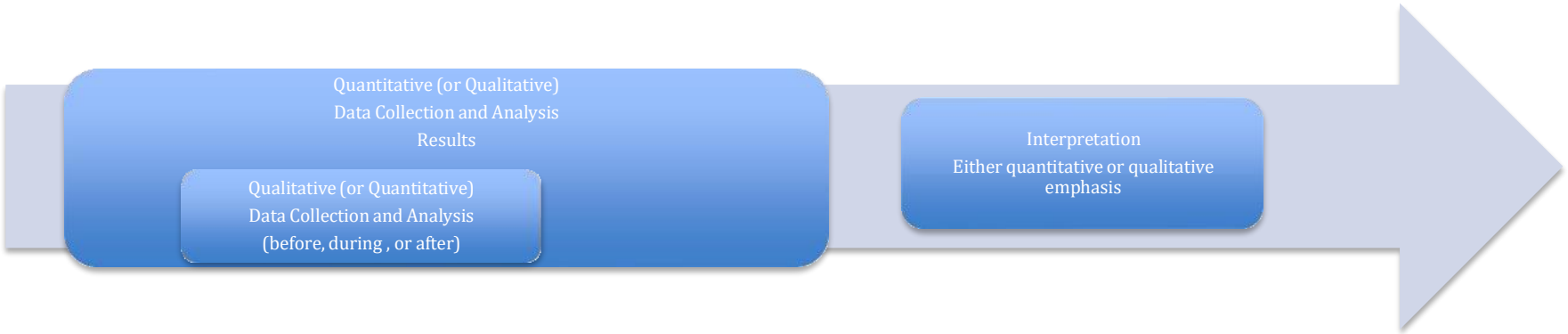
(b) The explanatory sequential design/ explanatory design



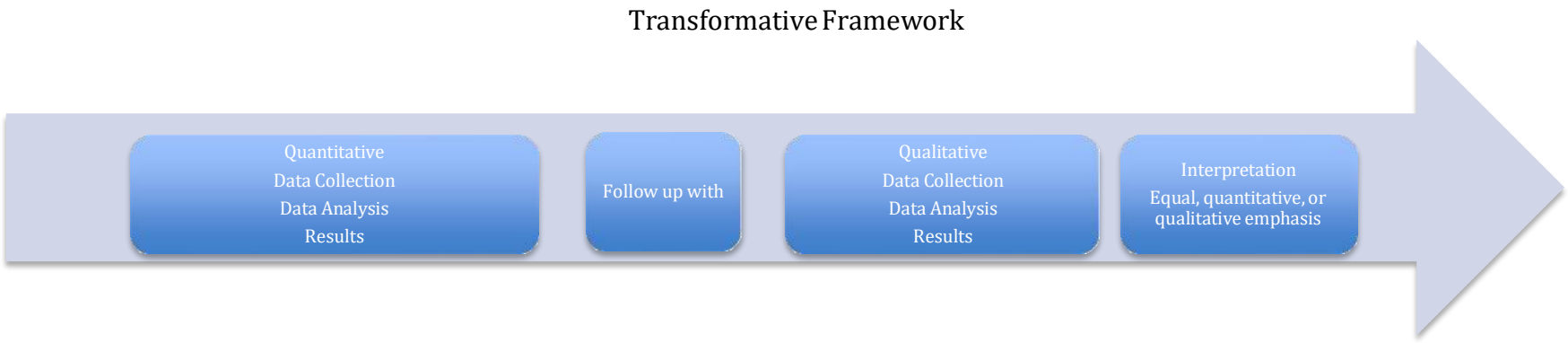
(c) The exploratory sequential design/ exploratory design



(d) The embedded design

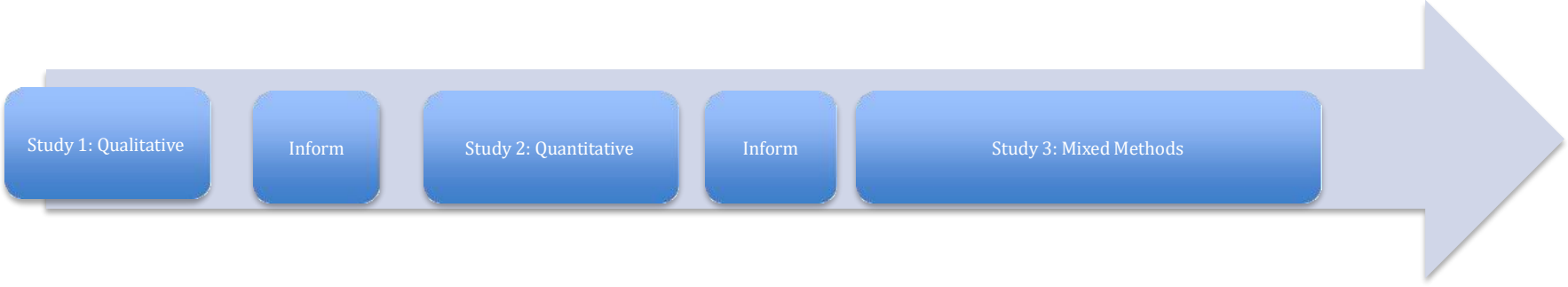


e) The transformative design



(f) The multiphase design

Overall program objective



Appendix 4.1

The modified Physician Readiness to Manage Intimate Partner Violence (PREMIS) questionnaire

Questionnaire

Title: Health Care Professionals' Roles and Experiences of Identifying for and Responding to Intimate Partner Violence among Pregnant Women in Thailand

Researcher: PunyawadeeThongkaew

Thank you for agreeing to take part in a research study that is being undertaken as part of PhD study at the University of Sheffield.

The purpose of this research is to explore health care professionals' knowledge, attitudes and practices regarding intimate partner violence experienced by pregnant women in Thailand.

Your candid responses will greatly assist in attempt to improve health care professionals' recognition and management of intimate partner violence during pregnancy.

Please record your first, instinctive answer, even if you don't think it is politically correct. Don't try to think about what your answers should be. All responses will be coded by an identification number only, kept confidential, and analysed in group form so that no personal information is revealed.

Some questions may seem similar to others. However, I ask that you answer all questions to help ensure the reliability of the assessment. Most of the questions just ask you to tick a box or boxes and so it should not take longer than 25 minutes to complete.

This questionnaire is divided into 5 sections:

Section I Asking about the general information of respondents

Section II Asking about general information on preparing for care of pregnant women who are abused by husband

Section III Asking about the knowledge of intimate partner violence during pregnancy

Section IV Asking about attitudes regarding intimate partner violence during

pregnancy

Section V Asking about practice in identifying and responding to intimate partner violence during pregnancy

In completing and submitting my responses to this questionnaire, and by placing an X mark in the box of my answer, I confirm that I have read and agree to the following:

- I confirm that I have read and understood the information above and I have had the opportunity to ask questions about the project.

- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. I can withdraw from this research right up to the point of publication, by contacting:

PunyawadeeThongkaew, School of Nursing and Midwifery
The University of Sheffield, Barber House, 387 Glossop Road, Sheffield S10 2HQ
Phone: +44 (0) 1142222035 Email: pthongkaew1@sheffield.ac.uk

- I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that results from the research.
- I agree for the data collected from me to be used in future research on the topic.
- I agree to take part in the above research project.

Date _____

Your Ordinal number in staff daily attendance record book_____

Note This information will allow the researcher to identify and trace back to you for the second phase of the research which is interview. Please providing the information, if you wish to participate in interview.

Section I: Respondent Profile

1.1 Your Age: _____

1.2 Gender: [ ] Male [ ] Female

1.3 What is your marital status?

[ ] Single [ ] Married or domestic partnership
[ ] Widow or widower [ ] Divorced or separated

1.4 What is your religion?

[ ] No religion [ ] Buddhist [ ] Christian [ ] Muslim
[ ] Any other religion, please specify _____

1.5 How long have you work in this unit to the recent year?_____Years____Months

1.6 When did you graduate from medical/professional school? _____

1.7 Are you?

[ ] Doctor [ ] Professional nurse [ ] Technical nurse

1.8 What is the highest degree or certificate you have completed?

[ ] Doctor of Medicine [ ] Higher education (specify)_____

[ ] Bachelor of Nursing Science [ ] Higher education (specify)_____

[ ] Certificate in Nursing Science [ ] Higher education (specify)_____

(Technical level)

1.9 Area of work ?

[ ] Antenatal care clinic [ ] Postpartum ward

[ ] OSCC (One Stop Crisis Centre) [ ] Emergency department

[ ] Other, please specify _____

1.10 Average number of pregnant women you care for per week (check one):

[ ] not seeing pregnant women

[ ] less than 20

[ ] 20-39

[ ] 40-59

[ ] 60 or more

1.11 Including yourself, how many practitioners at your unit have participated in an intimate partner violence training course in the past 6 months: _____

This represents: [ ] All

[ ] Most (More than half but not all)

[ ] Some (More than a few but less than a half)

[ ] A few (Not many but more than one)

[ ] Don't know [ ] None

*** Intimate Partner Violence (IPV)** is defined as an actual or threatened physical, sexual, psychological, or emotional abuse carried out by a current or former romantic partner that can be the same or opposite sex.

(Breiding, M.J. et al., 2015. *Intimate Partner Violence Surveillance Uniform Definitions and Reccommended Data Elements*, Available at: http://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf.)

Section II: General information about preparing for responding and taking care of pregnant women who are abused by husband

2.1 How much previous training about intimate partner violence (IPV) issues have you had? (Please check all that apply.)

[ ] None

[ ] Read from the hospital's practice (protocol)

[ ] Watched a TV/video /news

[ ] Attended a lecture or talk

[ ] Attended a skills-based training or workshop
[ ] In the classroom at the medical or nursing school
[ ] In the clinical setting at the medical or nursing school
[ ] Residency/fellowship/other post grad training

[ ] Other in-depth training (more than 4 hours)

[ ] Other (specify)_____

2.2 In the past 1 year, please estimated total number of hours of previous IPV training: _____

2.3 Please put a **mark (X)** by the appropriate number which best describes how prepared you feel to perform the following:

(if Not prepared = 1 Slightly prepared = 2 Moderately prepared = 3

Fairly well prepared = 4 Well prepared = 5 or Quite well prepared = 6)

1. Ask the appropriate questions for pregnant women about violence by husband	1	2	3	4	5	6
2. Appropriate assistance to pregnant women who are abused by the husband	1	2	3	4	5	6
3. Identify a pregnant woman who is abused by husband from the medical history and the physical examination	1	2	3	4	5	6
4. Assess the readiness of pregnant women who have been violent by husband in changing self to solve the problem	1	2	3	4	5	6
5. Help pregnant woman be abused by the husband in assessing the severity of violence that may cause death	1	2	3	4	5	6
6. Assess the safety of children of pregnant women who are abused by husband (In the case that pregnant women have a child and are living together)	1	2	3	4	5	6
7. Help pregnant women who are abused by their husband in planning for their safety	1	2	3	4	5	6
8. Record the history, violence, and physical examination results found in pregnant women's files.	1	2	3	4	5	6
9. Make appropriate referrals for IPV	1	2	3	4	5	6
10. Write a referral report about violence by husband during pregnancy	1	2	3	4	5	6

2.4 Please put a **mark (X)** by the appropriate number which best describes how much do you feel you now know about:

(If Nothing = 1 A little = 2 A moderate amount = 3 A fair amount = 4
Quite a bit = 5 or Very Much = 6)

1. Law about reporting information in the situation of a helping pregnant women be violent by husband	1	2	3	4	5	6
2. Signs or symptoms of being abused during pregnancy	1	2	3	4	5	6
3. How to document IPV in pregnant woman's chart	1	2	3	4	5	6
4. Referral sources for pregnant women who are victims of IPV	1	2	3	4	5	6
5. Specify the characteristic or the nature of the person who may be the perpetrators of IPV during pregnancy	1	2	3	4	5	6
6. The associated factors of IPV among pregnant women	1	2	3	4	5	6
7. Recognising the unborn baby effects of IPV during pregnancy	1	2	3	4	5	6
8. A question used to identify an IPV among pregnant women	1	2	3	4	5	6
9. The reasons that pregnant women are abused by husband do not disclose information to others	1	2	3	4	5	6
10. Your role in detecting IPV during pregnancy	1	2	3	4	5	6
11. What should and should not be said when the abused pregnant woman to be found	1	2	3	4	5	6
12. Identify potential dangers for abused pregnant woman	1	2	3	4	5	6
13. Developing a safety plan to secure a woman who has been abused by husband	1	2	3	4	5	6
14. The sequence processes make abused pregnant women to understand their own situation and are ready to change.	1	2	3	4	5	6

Please add anything you would like to say about this section.

_____

_____

_____

Section III: Knowledge of IPV during pregnancy

Check one answer per item, unless noted otherwise.

3.1 What is the strongest single risk factor for becoming a victim of intimate partner violence during pregnancy?

[ ] Substance and/or alcohol abuse (of partner)

[ ] Unemployed [ ] Unwanted or unintended pregnancy

[ ] Second marriage [ ] Don't know

3.2 Which one of the following is right about the husband who abuse wife?

[ ] They are often problems with emotional control when angry

[ ] They use violence to control their wife

[ ] They are violent when drinking alcohol or substance abuse

[ ] In order to drain their anger

3.3 Which of the following are warning signs that a pregnant woman may have been abused by her partner? (check all that apply)

[ ] Low self-esteem [ ] Unwanted pregnancy

[ ] Obvious physical trauma [ ] Substance abuse

[ ] Frequent injuries [ ] Depression

[ ] History of broken bones/ chronic pain

[ ] Previous history of child abuse

3.4 Which of the following are reasons why victims of violence are not possible to break out the relationship? (check all that apply)

[ ] Afraid of being abused more [ ] Rely on a husband's economy

[ ] Religious/culture beliefs [ ] Children's needs

[ ] Love for one's partner

[ ] Separated from their own family or relatives

3.5 Which of the following are the appropriate questions to be used to identify the pregnant women who are abused by husband? (check all that apply)

[ ] "Have you ever been mentally hurt by your partner?"

[ ] "During pregnancy, has your partner ever hurt or threatened you?"

[ ] "During pregnancy, have you ever been afraid of your partner?"

[ ] "During pregnancy, has your partner ever hit or hurt you?"

3.6 Which of the following is/are generally true? (check all that apply)

[ ] Often there may not be found traces of injuries in pregnant women who are abused by husband

[ ] Some behaviours that partners often show out can indicate the use of violence in the spouse.

[ ] Abdomen is a part of the body being hurt most frequency of women during pregnancy

[ ] The injuries of the bodily injury by partners are usually the usual format

[ ] Those who have a wound with the damage level of different wounds are the indicator of being physically abused

3.7 Do you have any knowledge of The Stages of Change?

[ ] YES, please go to question 3.7.1

[ ] NO, please skip to question 3.8

3.7.1 Please label the following descriptions of the behaviour and feelings of pregnant women with a history of intimate partner violence with the appropriate stage of change.

1 = Pre-contemplation 2 = Contemplation 3 = Preparation

4 = Action 5 = Maintenance 6 = Termination

[ ] Starts planning to leave a relationship with an abusive partner

[ ] Denies a problem or being abused

[ ] Begins thinking the abuse is not their own fault

[ ] Continues changing behaviour

[ ] Accepts help from a variety of help resources

3.8 Please put a **mark (X)** on T for "true", F for "false", or DK if you "don't know" the answer to the following:

1. Alcohol consumption is the one of the strongest correlates of the likelihood of IPV during pregnancy.	T	F	DK
2. There are no reasons for not to leave a husband who is hurting.	T	F	DK
3. There should not be a record about being violent by the husband of pregnant woman in her chart if she does not want to disclose information.	T	F	DK
4. When asking pregnant woman about the violence by husband, physicians/nurses should use the words "abused" or "battered."	T	F	DK
5. Being supportive of a pregnant woman's choice to remain in a violent relationship would deem to promote violent action.	T	F	DK
6. Pregnant women who are abused by husband are able to make appropriate choices and choose the right method solving these issues.	T	F	DK

7. Health care professionals should not pressure pregnant woman to acknowledge that they are the victim of violence by the husband.	T	F	DK
8. Pregnant women who are abused by husband are at greater risk of getting hurt when they are trying to escape the husband.	T	F	DK
9. Strangulation injuries are rare in cases of IPV during pregnancy	T	F	DK
10. Allowing partners or friends to join the history and physical examination of pregnant women is to confirm that pregnant women are safe from violence.	T	F	DK

Please add anything you would like to say about this section.

_____

_____

_____

Section IV: Opinions about IPV during pregnancy

For each of the following statements, please indicate your response and put a mark **x** on the number on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Statements	Strongly Disagree	Disagree	Agree	Strongly Agree
1. If pregnant woman who is abused by husband does not acknowledge the abuse, I cannot help.	1 2	3 4	5 6	7
2. I ask all new pregnant women about abuse in their relationships.	1 2	3 4	5 6	7
3. My workplace supports me to help pregnant woman who is abused.	1 2	3 4	5 6	7
4. I can make referrals to the responsible agencies appropriately within the community for pregnant woman who are being violent.	1 2	3 4	5 6	7
5. I can identify pregnant women who are abused by husband without asking.	1 2	3 4	5 6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
6. I don't get enough training to take care of pregnant woman who is abused by husband.	1	2	3	4	5	6	7
7. Pregnant women using drugs or alcohol are likely to have a history of IPV.	1	2	3	4	5	6	7
8. Pregnant women who are victims of abuse have the right to make their own decisions about whether or not to receive assistance from a medical professional.	1	2	3	4	5	6	7
9. I feel comfortable talking about IPV with my pregnant woman.	1	2	3	4	5	6	7
10. I don't have enough skills to talk about abuse with pregnant women who have been abused by the husband.	1	2	3	4	5	6	7
11. If pregnant women who are victims of abuse remain in the relationship after repeated episodes of violence, they must accept their own choices.	1	2	3	4	5	6	7
12. I am aware of the hospital regulations in reporting of suspected cases of IPV during pregnancy.	1	2	3	4	5	6	7
13. Health care professionals do not have the time to take care of or assist pregnant woman in addressing IPV.	1	2	3	4	5	6	7
14. I have ability to identify pregnant women who are abused by husband from the current illness history such as depression or migraines.	1	2	3	4	5	6	7
15. If a pregnant woman refuses to talk about being abused, medical professionals are only obliged to treat injuries.	1	2	3	4	5	6	7
16. Pregnant woman who are victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
17. Health care professionals have the duty and responsibility to ask all pregnant	1	2	3	4	5	6	7

Statements	Strongly Disagree	Disagree	Agree	Strongly Agree
women about getting abuse during pregnancy.				
18. My workplace gives me the time enough to take care and help pregnant women who are abused by husband.	1 2 3 4 5 6 7			
19. I have contacted services within the community to establish referrals for pregnant women who are IPV victims.	1 2 3 4 5 6 7			
20. Drinking alcohol is a significant cause of violence caused by husband during pregnancy.	1 2 3 4 5 6 7			
21. Pregnant women who are victims of abuse often have many reasons not to be separated from the husband.	1 2 3 4 5 6 7			
22. I am too busy to participate on a multidisciplinary team that manages IPV cases.	1 2 3 4 5 6 7			
23. Screening of violence by a husband in pregnant women is likely to offend those who are screened.	1 2 3 4 5 6 7			
24. In my hospital, there is enough private place to serve and take care of pregnant women who are abused by husband.	1 2 3 4 5 6 7			
25. I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).	1 2 3 4 5 6 7			
26. Pregnant women who choose to step out of traditional roles are often abused by the husband.	1 2 3 4 5 6 7			
27. Health care professionals do not have enough knowledge to take care of pregnant women who are abused by husband in solving issues that occur.	1 2 3 4 5 6 7			

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
28. I am able to take care of pregnant women who are abused by husband and ready to help or fix the problem.	1	2	3	4	5	6	7
29. I understand that why pregnant women who are abused by husband unable to follow the instructions of the medical professionals.	1	2	3	4	5	6	7
30. The use of alcohol or other drugs is associated with IPV victimisation during pregnancy.	1	2	3	4	5	6	7
31. I know that pregnant women are abused by husband from those pregnant women's behaviours.	1	2	3	4	5	6	7

Please add anything you would like to say about this section.

_____

_____

_____

Section V: Practice Issues

Please answer the following questions that match your clinical practice related to identifying and responding of pregnant women who are abused by husband.

5.1 How many new diagnoses/screening (picked up an acute case, uncovered ongoing abuse, or had a pregnant woman disclose a past history) of intimate partner violence (IPV) would you estimate you have made in the past?

[ ] None [ ] 1-5 [ ] 6-10 [ ] 11-20 [ ] 21 or more

5.2 Have you ever screen pregnant women for IPV?

[ ] YES, please go to question 5.2.1

[ ] NO, please skip to answer question 5.4

5.2.1 Check the situations listed below in which you currently screen for IPV (check all that apply)

[ ] I screen all new pregnant women

[ ] I screen all pregnant women with abuse indicators on history or exam

[ ] I screen all pregnant women at specific times of their pregnancy

[ ] I screen certain pregnant women categories only (check below)

[ ] Young adult pregnant women or teenager

[ ] Separated to the husband/ divorced women/single mom

[ ] Married women

[ ] Partner's alcohol or other substance abuse

[ ] Immigrant women

[ ] Depressed/suicidal pregnant women

[ ] Pregnant women who have children with confirmed or suspected child abuse, neglect

[ ] Other. Please specify: _____

5.3 Please put a mark (**X**) by the appropriate number which best describes how often in the past have you asked about the possibility of IPV when seeing pregnant women with the following:

(if Never = 1 Seldom = 2 Sometime = 3 Nearly always = 4 Always = 5 N/A = 6)

1. Unexplained injuries/injuries that cannot tell the cause or injury not in accordance with the notice	1	2	3	4	5	6
2. Chronic pain in the pelvic area	1	2	3	4	5	6
3. Pyelonephritis	1	2	3	4	5	6
4. Sexual Transmitted Infection	1	2	3	4	5	6
5. Depression/Anxiety	1	2	3	4	5	6
6. Hypertension	1	2	3	4	5	6
7. Bleeding per vaginal	1	2	3	4	5	6

5.4 In the past, which of the following actions have you taken when you identified IPV during pregnancy or when pregnant women disclosed IPV? (check all that apply)

[ ] Have not identified IPV during pregnancy

[ ] Provided information (phone numbers, pamphlets, other information) to pregnant women

[ ] Conducted a safety assessment for the pregnant women who are victim of IPV

[ ] Helped pregnant woman who is IPV victim develop a personal safety plan

[ ] Referred pregnant woman to:

[ ] One Stop Crisis Centre

[ ] Foundation

[ ] National DV/IPV Hotline

[ ] Police

[ ] Housing, educational, job or financial assistance

[ ] Other referral (describe): _____

[ ] Other action (describe): _____

5. 5 Is there a protocol for dealing with IPV during pregnancy at your unit? (check one)

[ ] Yes, and widely used

[ ] Yes, and used to some extent

[ ] Yes, but not used

[ ] No

[ ] Unsure

5.6 Do you know the hospital policies regarding the screening and managing of pregnant women who are abused by husband?

[ ] Yes [ ] No [ ] N/A

5.7 Is a camera available at your work site for photographing injuries of pregnant women who are IPV victims?

[ ] Yes - - Type:

[ ] Polaroid or other instant camera,

[ ] Digital, [ ] Other: _____

[ ] No

[ ] Unsure

5.8 Please put a mark (X) to identify that for every pregnant woman who is IPV victim you have identified in the past, how often have you:

(Never = 1 Seldom = 2 Sometime = 3 Nearly always = 4 Always = 5 N/A = 6)

1. Wrote a violent report in pregnant women files.	1	2	3	4	5	6
2. Drew a body-map to report a position of being abused of pregnant women in a file.	1	2	3	4	5	6
3. Photographed injuries of pregnant women who are abused by husband to include in chart	1	2	3	4	5	6
4. Reported to the head of the authorities.	1	2	3	4	5	6
5. Evaluated the potential risks and help to find the way of protecting	1	2	3	4	5	6
6. Conducted a safety assessment for pregnant women who are victim and have children	1	2	3	4	5	6
7. Helped a pregnant women who are IPV victim develop a safety plan	1	2	3	4	5	6
8. Contacted the relevant agency for assistance	1	2	3	4	5	6
9. Offered validating or supportive statements	1	2	3	4	5	6
10. Provided advice and basic information about being abused during pregnancy	1	2	3	4	5	6
11. Provided referral and/or resource information	1	2	3	4	5	6

5.9 Are IPV education or resource materials (posters, brochures, etc.) available at your practice site? (check one)

[ ] Yes, there is enough to be given to all pregnant women who come for service

[ ] Yes, but there is not enough to be provided to all pregnant women who come to service

[ ] Yes, but not to pregnant women who come for service

[ ] No
[ ] Unsure

5.10 Do you distribute leaflets, flyers, or knowledge about IPV during pregnancy to pregnant women who come to service in your organisation? (check one)

[ ] Yes, every time
[ ] Yes, when it is seen as safe

[ ] Yes, only when pregnant women request
[ ] No, due to referral system is not good enough
[ ] No, because I do not feel these materials are useful in general
[ ] No, other reason (specify) _____

5.11 Do you feel you have adequate adult IPV referral resources for pregnant women at your work site (including mental health referral)?

[ ] Yes [ ] No [ ] Unsure

5.12 Do you feel you have adequate knowledge of referral resources in the community (including shelters or support groups) for pregnant women who are IPV victims?

[ ] Yes [ ] No [ ] Unsure

Please add anything you would like to say about this section.

_____
_____
_____

Thank you for completing this questionnaire.

I do not anticipate that there will be any risks associated with undertaking this survey. However, given the nature of the subject area, some participants may find some questions sensitive or distressing. In such instances, you can stop at any point. You can contact counselling for support. There is also some information available for some organisations who you can contact for support.

Thailand National Mental Health and Violence Against Women Helplines

Organisation	**Telephone**	**Website/Other information**
One Stop Crisis Centre	1300	www.osccthailand.go.th 24 hour
Department of Mental Health	1323 1667	http://www.dmh.go.th 24 hour
Foundation For Women	0-2433-5149 0-2435-1246	http://womenthai.org Mon-Fri 8.30 am-5.30 pm
Fowomen.org	0-4261-2232 0-4595-0305	http://www.fowomen.org
Buriram Hospital	0-4461-5002	http://www.brh.go.th Tues & Thurs 8 am – 12 pm

Organisation	Telephone	Website/Other information
Paveena Foundation	1134 0-2521-9231-2	http://www.paveenafoundation.or.th
Emergency Centre for Violence against Women	1507 1578	24 hour
Hotline Center Foundation Thailand	0-2276-2950 0-2277-8811	www.hotline.or.th Mon – Fri 8.30 am – 6.00 pm Sat 9.00 am – 6.00 pm
Samaritans Thailand	0-2713-6791 0-2713-6793	www.samaritansthai.com
SathiraDhammasathan	0-2519-1119 0-2510-6697	http://www.sdsweb.org/

Appendix 4.2

Detail of Experts

Questionnaire - Forward Translation (English to Thai language)			
Name and Institute	Education	Area of Expertise	Contact Details
Dr Gallayanee Yaoyuneyong The University of Southern Mississippi, United States	Ph.D.- The Florida State University M.S. – Eastern Michigan University M.S. – The University of Southern Mississippi, United States B.A. – Thammasat University, Thailand	Technology and Merchandising/Marketing • Consumer Behavior in Technology • Young Consumer Marketing/Merchandising • Online/E-commerce • International Textiles Industry • Color Management and Communication • Technology and Education Design	Phone: 601.266.4630
Questionnaire - Backward Translation (Thai to English language)/Checking Transcripts			
Kingdao Karaket The University of Southern Mississippi	Ph.D. (Candidate) in Nursing - The University of Southern Mississippi M.Sc.- Burapa University, Thailand B.N.S. – Burapa University	Domestic Violence	Email :karakedFBI@gmail.com
Uriawan Sirithammaphan Sirindhorn College of Public Health, Yala, Thailand	Ph.D. in Nursing- University of Hull M.S. – Prince of Songkla University, Thailand B.N.S. – Prince of Songkla University	Occupational health	Email: noree90@hotmail.com

Experts Raters of Content Validity Index			
Name and Institute	Education	Area of Expertise	Contact Details
Expert: 1 Assist. Prof Dr Chokchai Munsawaengsub Mahidol University, Thailand	Dip. Thai Board of Family Medicine- The Royal College of Family Medicine Dip. Thai Board of Paediatrics (Paediatrics)- Mahidol University DTM.&H. (Tropical Medicine and Hygiene)- Mahidol University M.D. (Doctor of Medicine)- RTRMF College of Medicine, Philippines B.Sc. (Microbiology)- Srinakharinwirot University, Thailand	- Child and adolescent health - Health promotion - Reproductive health - Quality of life	Email: chokchai.mun@mahidol.ac.th
Expert 2: Dr Korravarn Yodmai Mahidol University	Ph.D. (Public Health)- Chulalongkorn University M.Sc. (Human Reproductive Health and Population Planning)- Mahidol University B.N.S.- Saint Louise College, Thailand	-Maternal and Child Health -Communicable Disease -The Quality of Life of Aging and the Improvement	Email: Korravarn.yod@mahidol.ac.t h
Expert 3: Dr Ngamnit Ratananukul	Ph.D. in Nursing (Parent &Child) – University of Texas at Austin, USA	Maternal and child health	Email: ngamnit.rat@kbu.ac.th

Kasem Bundit University, Thailand	M.Sc. (Human Reproductive Health and Population Planning)- Mahidol University B.N.S. – Mahidol University		

Experts Raters of Content Validity Index			
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Expert: 4 Assist Prof Sumitra Sittirit St. Theresa International College, Thailand	M.Sc. (Public Health)- Mahidol University M.Ed. (Health Education) - Srinakharinwirot University B.N.S.- Mahidol University	Maternal and Child Health	Phone : +66 3734 9933
Expert: 5 Dr Watcharaporn Huntranee Narong Hospital, Buriram province, Thailand	Ph.D. – Buriram Rajabhat University, Thailand M.Sc. (Human Reproductive Health and Population Planning)- Mahidol University B.N.S –Bromrajonani College of Nursing, Surin, Thailand	-Maternal and Child Health -Violence against child and women	Phone: +66 44 631 374

Experts for initial Thai version questionnaire			
Name and Institute	Education	Area of Expertise	Contact Details
Anantree Smithnaraseth University of Eastern Asia, Thailand	Ph.D. (Candidate) – in Doctoral of Nursing Science, Mahidol University, Thailand M.Sc. (Counselling Psychology) – Assumption University, Thailand B.N.S – Mahidol University, Thailand	Psychiatric and mental health nursing	Phone : +66 2 577 1028

Appendix 4.3

Content Validity Index (CVI) Form

Title: Health Care Professionals' Roles and Experiences of Identifying for and Responding to Intimate Partner Violence among Pregnant Women in Thailand

Thank you for agreeing to review and evaluate the questionnaire I have developed for my study. The questionnaire consisted of five sections: (I) preparation; (II) feeling of knowing; (III) knowledge; (IV) attitude; and (V) practice. Detail is provided below for each section. You were selected for this task because of your expertise in the field of domestic violence and maternal and child heath in Thailand. At this time, I need your assistance in assessing the content validity of the questionnaire to measure Healthcare Professional's (including physicians, professional nurses, and technical nurses) preparation, feeling of knowing, knowledge, attitudes and practices regarding Intimate Partner Violence during pregnancy in Thailand.

Instructions

Please read each item carefully; then rate each item on the four-point scale in terms of how relevant you believe it is in measuring the preparation, feeling of knowing, knowledge, attitudes, and practices of healthcare professional about IPV during pregnancy. Moreover, you can make any suggestions you may have for the addition or deletion of items or for changes in the wording of items on the form itself.

Rating

1 = not relevant

2 = somewhat relevant

3 = quite relevant

4 = highly relevant

Section I: Preparation

This section was designed to measure the HCPs' feeling of their preparation to perform themselves about identifying and responding to IPV among pregnant women. There were 10 questions and accompanied by a six-point Likert scale, where 1 = not prepared, 2 = slightly prepared, 3 = moderately prepared, 4 = fairly well prepared, 5 = well prepared, 6 = quite well prepared.

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	**1**	**2**	**3**	**4**	**Suggestions**
1.1 Ask pregnant woman appropriate questions about IPV					
1.2 Appropriately respond to pregnant woman's disclosures of IPV					
1.3 Identify IPV indicators based on pregnant woman's history, and physical examination					
1.4 Assess readiness to change of pregnant woman who experience IPV					
1.5 Help pregnant woman who experience IPV assess her danger of lethality					
1.6 Conduct a safety assessment for the pregnant woman's children					
1.7 Help a pregnant woman who are victim of IPV create a safety plan					
1.8 Document IPV history and physical examination findings in pregnant woman's chart					

Item	1	2	3	4	Suggestions
1.9 Make appropriate referrals for IPV					
1.10 Fulfil hospital reporting requirement for IPV during pregnancy					

Section II: Feeling of Knowing

This section is designed to find out about the feeling of HCPs of knowing about identifying and responding to IPV during pregnancy. Each item has a Likert response scale of 6 points (1 = nothing, 2 = a little, 3 = a moderate amount, 4 = a fair amount, 5 = quite a bit, 6 = very much) to reflect the degree of their feeling with each statement.

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	1	2	3	4	Suggestions
2.1 Your legal reporting requirements for IPV during pregnancy					
2.2 Signs or symptoms of IPV during pregnancy					
2.3 How to document IPV in pregnant woman's chart					
2.4 Referral sources for pregnant woman who are victims of IPV					
2.5 Perpetrators of IPV during pregnancy					
2.6 Relationship between IPV and pregnancy					
2.7 Recognizing the unborn baby effects of IPV during pregnancy					

Item	1	2	3	4	Suggestions
2.8 What questions to ask to identify IPV during pregnancy					
2.9 Why a pregnant woman who are victim of IPV might not disclose					
2.10 Your role in detecting IPV during pregnancy					
2.11 What to say and not say in IPV situations with a pregnant woman					
2.12 Determining danger for a pregnant woman experiencing					
2.13 Developing a safety plan with pregnant woman who are IPV victim					
2.14 The stages a pregnant woman who are IPV victim experiences in understanding and changing her situation					

Section III: Knowledge

This section is a set of 5 multi-choice questions (item 3.1-3.7) and 10 true/false questions (item 3.6-3.15) to measure the HCPs' knowledge regarding to IPV during pregnancy.

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	1	2	3	4	Suggestions
3.1 What is the strongest single risk factor for becoming a victim of intimate partner violence during pregnancy? (Multiple choice question)					
3.2 Which one of the following is generally true about batterers? (Multiple choice question)					
3.3 Which of the following are warning signs that a pregnant woman may have been abused by her partner? (Multiple choice question)					
3.4 Which of the following are reasons an intimate partner violence victim may not be able to leave a violent relationship? (Multiple choice question)					
3.5 Which of the following are the most appropriate ways to ask about IPV during pregnancy? (Multiple choice question)					
3.6 Which of the following is/are generally true? (Multiple choice question)					
3.7 Label the following descriptions of the behaviours and feelings of pregnant women with a history of intimate partner violence with the appropriate stage of change.					
3.8 Alcohol consumption is the greatest single predictor of the likelihood of IPV during pregnancy. (True/False question)					
3.9 There are no good reasons for not leaving an abusive relationship. (True/False question)					
3.10 Reasons for concern about IPV during pregnancy should not be included in a pregnant woman's chart if she does not disclose the violence. (True/False question)					

Item	1	2	3	4	Suggestions
3.11 When asking pregnant woman about IPV, physicians/nurses should use the words "abused" or "battered." (True/False question)					
3.12 Being supportive of a pregnant woman's choice to remain in a violent relationship would condone the abuse. (True/False question)					
3.13 Pregnant women who are victims of IPV are able to make appropriate choices about how to handle their situation. (True/False question)					
3.14 Health care professionals should not pressure pregnant woman to acknowledge that they are living in an abusive relationship. (True/False question)					
3.15 Pregnant woman who are victims of IPV are at greater risk of injury when they leave the relationship. (True/False question)					
3.16 Strangulation injuries are rare in cases of IPV during pregnancy. (True/False question)					
3.17 Allowing partners or friends to be present during a pregnant woman's history and physical exam ensures safety for an IPV victim. (True/False question)					

Section IV: Opinions

This section contains 31 questions that ask HCPs' views on IPV among pregnant women to rate their level of agreement from "Strongly Disagree" (1) to "Strongly Agree" (7).

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	1	2	3	4	Suggestions
4.1 If a pregnant woman who are IPV victim does not acknowledge the abuse, there is very little that I can do to help.					
4.2 I ask all new pregnant women about abuse in their relationships.					
4.3 My workplace encourages me to respond to IPV during pregnancy.					
4.4 I can make appropriate referrals to services within the community for pregnant woman who are IPV victims.					
4.5 I am capable of identifying IPV without asking pregnant woman about it.					
4.6 I do not have sufficient training to assist individuals in addressing situations of IPV during pregnancy.					
4.7 Pregnant women who abuse alcohol or other drugs are likely to have a history of IPV.					
4.8 Pregnant women who are victims of abuse have the right to make their own decisions about whether hospital staff should intervene.					
4.9 I feel comfortable discussing IPV with my pregnant woman.					
4.10 I don't have the necessary skills to discuss abuse with a pregnant woman who is IPV victim.					

Item	1	2	3	4	Suggestions
4.11 If pregnant women who are victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.					
4.12 I am aware of legal requirements in this hospital regarding reporting of suspected cases of IPV during pregnancy.					
4.13 Health care professionals do not have the time to assist pregnant woman in addressing IPV.					
4.14 I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient illnesses (e.g., depression, migraines).					
4.15 If a pregnant woman refuses to discuss the abuse, staff can only treat their injuries.					
4.16 Pregnant woman who are victims of abuse could leave the relationship if they wanted to.					
4.17 Health care professionals have a responsibility to ask all women about IPV during pregnancy.					
4.18 My practice setting allows me adequate time to respond to pregnant woman who are victims of IPV.					
4.19 I have contacted services within the community to establish referrals for pregnant women who are IPV victims.					
4.20 Alcohol abuse is a leading cause of IPV during pregnancy.					

Item	1	2	3	4	Suggestions
4.21 Pregnant women who are victims of abuse often have valid reasons for remaining in the abusive relationship.					
4.22 I am too busy to participate on a multidisciplinary team that manages IPV cases.					
4.23 Screening for IPV during pregnancy is likely to offend those who are screened.					
4.24 There is adequate private space for me to provide care for pregnant women who are victims of IPV.					
4.25 I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).					
4.26 Pregnant women who choose to step out of traditional roles are a major cause of IPV.					
4.27 Health care professionals do not have the knowledge to assist pregnant women in addressing IPV.					
4.28 I can match therapeutic interventions to a pregnant women who is victim of IPV and readiness to change.					
4.29 I understand why pregnant women who are IPV victims do not always comply with staff recommendations.					
4.30 Use of alcohol or other drugs is related to IPV victimisation during pregnancy.					

Item	1	2	3	4	Suggestions
4.31 I can recognise pregnant women who are victims of IPV by the way they behave.					

Section V: Practices

Part 1

The first part of this section looks into the HCPs' practice regarding to identifying pregnant women who are abused by their partners. The questions are multiple choice (item 5.1, 5.2, 5.4, 5.5, 5.6, and 5.7) and rating scale questions (5.3). For rating scale question, HCPs are asked to estimate the frequency of their identifying in a general practice, using a 6-point Likert-type scale (1= never, 2 = seldom, 3 = sometime, 4 = nearly always, 5= always, and 6 = not applicable).

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	1	2	3	4	Suggestions
5.1 How many new diagnoses/screening (picked up an acute case, uncovered ongoing abuse, or had a pregnant woman disclose a past history) of intimate partner violence (IPV) would you estimate you have made in the last 6 months? (Multiple choice question)					
5.2 What characteristics of pregnant women in which you currently screen for IPV. (Multiple choice question)					

Item	1	2	3	4	Suggestions
5.3 How often in the past six months have you asked about the possibility of IPV when seeing pregnant women with the following. (Rating scale question) a. Unexplained injuries b. Chronic pelvic pain c. Pyelonephritis d. Sexual Transmitted Infection e. Depression/Anxiety f. Hypertension g. Bleeding per vaginal					
5.4 In the past 6 months, which of the following actions have you taken when you identified IPV during pregnancy? (Multiple choice question)					
5.5 Is there a protocol for dealing with IPV during pregnancy at your unit? (Multiple choice question)					
5.6 Are you familiar with your institution's policies regarding screening & management of IPV during pregnancy? (Multiple choice question)					
5.7 Is a camera available at your work site for photographing injuries of pregnant women who are IPV victims? (Multiple choice question)					

Part 2

This part of fifth section is scaled questions measuring the frequency of HCPs' engagement in responding to IPV during pregnancy, using a 6-point Likert-type scale (1= never, 2 = seldom, 3 = sometime, 4 = nearly always, 5= always, and 6 = not applicable).

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	1	2	3	4	Suggestions
5.8 For every pregnant women who are IPV victim you have identified in the past 6 months, how often have you:					
a. Documented pregnant women' statements re. IPV in chart					
b. Used a body-map to document pregnant women injuries					
c. Photographed injuries of pregnant women who are victim of IPV to include in chart					
d. Notified appropriate authorities when mandated					
e. Conducted a safety assessment for pregnant women who are victim					
f. Conducted a safety assessment for pregnant women who are victim and have children					
g. Helped pregnant women who are IPV victim develop a safety plan					
h. Contacted an IPV service provider					
i. Offered validating or supportive statements					
j. Provided basic information about IPV during pregnancy					
k. Provided referral and/or resource information					

Part 3

The last part of this section includes 4 multiple-choice questions that asking HCPs questions about their responding to IPV during pregnant women.

Rating

1 = not relevant 2 = somewhat relevant 3 = quite relevant 4 = highly relevant

Item	**1**	**2**	**3**	**4**	**Suggestions**
5.9 Are IPV education or resource materials (posters, brochures, etc.) available at your practice site?					
5.10 Do you provide pregnant women with IPV education or resource materials?					
5.11 Do you feel you have adequate adult IPV referral resources for pregnant women at your work site (including mental health referral)?					
5.12 Do you feel you have adequate knowledge of referral resources for pregnant women in the community (including shelters or support groups) for pregnant women who are IPV victims?					

Appendix 4.4

Individual and Scale Content Validity Index

Section I: Preparation

Item Number	Question	Number in Agreement	I-CVI
1.1	Ask pregnant woman appropriate questions about IPV	5	1
1.2	Appropriately respond to pregnant woman's disclosures of IPV*	4	0.8
1.3	Identify IPV indicators based on pregnant woman's history, and physical examination*	5	1
1.4	Assess readiness to change of pregnant woman who experience IPV	5	1
1.5	Help pregnant woman who experience IPV assess her danger of lethality*	5	1
1.6	Conduct a safety assessment for the pregnant woman's children	5	1
1.7	Help a pregnant woman who are victim of IPV create a safety plan	5	1
1.8	Document IPV history and physical examination findings in pregnant woman's chart	5	1
1.9	Make appropriate referrals for IPV*	5	1
1.10	Fulfil hospital reporting requirement for IPV during pregnancy*	5	1

Section II: Feeling of Knowing

Item Number	Question	Number in Agreement	I-CVI
2.1	Your legal reporting requirements for IPV during pregnancy	5	1
2.2	Signs or symptoms of IPV during pregnancy	5	1
2.3	How to document IPV in pregnant woman's chart	5	1
2.4	Referral sources for pregnant woman who are victims of IPV*	5	1
2.5	Perpetrators of IPV during pregnancy**	4	0.8
2.6	Relationship between IPV and pregnancy**	4	0.8
2.7	Recognizing the unborn baby effects of IPV during pregnancy**	5	1
2.8	What questions to ask to identify IPV during pregnancy*	5	1
2.9	Why a pregnant woman who are victim of IPV might not disclose	5	1
2.10	Your role in detecting IPV during pregnancy*	5	1
2.11	What to say and not say in IPV situations with a pregnant woman*	4	0.8
2.12	Determining danger for a pregnant woman experiencing**	4	0.8
2.13	Developing a safety plan with pregnant woman who are IPV victim	5	1
2.14	The stages a pregnant woman who are IPV victim experiences in understanding and changing her situation**	5	1

Section III: Knowledge

Item Number	Question	Number in Agreement	I-CVI
3.1	What is the strongest single risk factor for becoming a victim of intimate partner violence during pregnancy? (Multiple choice question)*	5	1
3.2	Which one of the following is generally true about batterers? (Multiple choice question)*	5	1
3.3	Which of the following are warning signs that a pregnant woman may have been abused by her partner? (Multiple choice question)*	5	1
3.4	Which of the following are reasons an intimate partner violence victim may not be able to leave a violent relationship? (Multiple choice question)*	5	1
3.5	Which of the following are the most appropriate ways to ask about IPV during pregnancy? (Multiple choice question)*	5	1
3.6	Which of the following is/are generally true? (Multiple choice question)*	5	1
3.7	Label the following descriptions of the behaviours and feelings of pregnant women with a history of intimate partner violence with the appropriate stage of change.*	5	1
3.8	Alcohol consumption is the greatest single predictor of the likelihood of IPV during pregnancy. (True/False question)*	5	1
3.9	There are no good reasons for not leaving an abusive relationship. (True/False question)*	4	0.8
3.10	Reasons for concern about IPV during pregnancy should not be included in a pregnant woman's chart if she does not disclose the violence. (True/False question)*	5	1
3.11	When asking pregnant woman about IPV, physicians/nurses should use the words "abused" or "battered." (True/False question)*	5	1
3.12	Being supportive of a pregnant woman's choice to remain in a violent relationship would condone the abuse. (True/False question)*	5	1
3.13	Pregnant women who are victims of IPV are able to make appropriate choices about how to handle their situation. (True/False question)	5	1
3.14	Health care professionals should not pressure pregnant woman to acknowledge that they are living in an abusive relationship. (True/False question)	5	1
3.15	Pregnant woman who are victims of IPV are at greater risk of injury when they leave the relationship. (True/False question)**	4	0.8
3.16	Strangulation injuries are rare in cases of IPV during pregnancy. (True/False question)*	3	0.6
3.17	Allowing partners or friends to be present during a pregnant woman's history and physical exam ensures safety for an IPV victim. (True/False question)*	5	1

Section IV: Opinions

Item Number	Question	Number in Agreement	I-CVI
4.1	If a pregnant woman who are IPV victim does not acknowledge the abuse, there is very little that I can do to help.	5	1
4.2	I ask all new pregnant women about abuse in their relationships.	5	1
4.3	My workplace encourages me to respond to IPV during pregnancy.	5	1
4.4	I can make appropriate referrals to services within the community for pregnant woman who are IPV victims.	5	1
4.5	I am capable of identifying IPV without asking pregnant woman about it.	5	1
4.6	I do not have sufficient training to assist individuals in addressing situations of IPV during pregnancy.	5	1
4.7	Pregnant women who abuse alcohol or other drugs are likely to have a history of IPV.	5	1
4.8	Pregnant women who are victims of abuse have the right to make their own decisions about whether hospital staff should intervene.*	5	1
4.9	I feel comfortable discussing IPV with my pregnant woman.*	5	1
4.10	I don't have the necessary skills to discuss abuse with a pregnant woman who is IPV victim.	5	1
4.11	If pregnant women who are victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.*	5	1
4.12	I am aware of legal requirements in this hospital regarding reporting of suspected cases of IPV during pregnancy.*	5	1
4.13	Health care professionals do not have the time to assist pregnant woman in addressing IPV.	5	1
4.14	I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient illnesses (e.g., depression, migraines).*	5	1
4.15	If a pregnant woman refuses to discuss the abuse, staff can only treat their injuries.	5	1
4.16	Pregnant woman who are victims of abuse could leave the relationship if they wanted to.	5	1
4.17	Health care professionals have a responsibility to ask all women about IPV during pregnancy.*	5	1
4.18	My practice setting allows me adequate time to respond to pregnant woman who are victims of IPV.	5	1
4.19	I have contacted services within the community to establish referrals for pregnant women who are IPV victims.**	5	1
4.20	Alcohol abuse is a leading cause of IPV during pregnancy.*	5	1
4.21	Pregnant women who are victims of abuse often have valid reasons for remaining in the abusive relationship.*	5	1
4.22	I am too busy to participate on a multidisciplinary team that manages IPV cases.	5	1
4.23	Screening for IPV during pregnancy is likely to offend those who are screened.*	5	1
4.24	There is adequate private space for me to provide care for pregnant women who are victims of IPV.*	5	1
4.25	I am able to gather the necessary information to identify IPV during pregnancy as the underlying cause of patient injuries (e.g., bruises, fractures, etc.).**	5	1
4.26	Pregnant women who choose to step out of traditional roles are a major cause of IPV.	5	1
4.27	Health care professionals do not have the knowledge to assist pregnant women in addressing IPV.	5	1
4.28	I can match therapeutic interventions to a pregnant women who is victim of IPV and readiness to change.	5	1

4.29	I understand why pregnant women who are IPV victims do not always comply with staff recommendations.	5	1
4.30	Use of alcohol or other drugs is related to IPV victimisation during pregnancy.	5	1
4.31	I can recognise pregnant women who are victims of IPV by the way they behave. *	4	0.8

Section V: Practices

Part 1

Item Number	Question	Number in Agreement	I-CVI
5.1	How many new diagnoses/screening (picked up an acute case, uncovered ongoing abuse, or had a pregnant woman disclose a past history) of intimate partner violence (IPV) would you estimate you have made in the last 6 months? (Multiple choice question)***	5	1
5.2	What characteristics of pregnant women in which you currently screen for IPV. (Multiple choice question)	5	1
5.3	How often in the past six months have you asked about the possibility of IPV when seeing pregnant women with the following. (Rating scale question) a. Unexplained injuries b. Chronic pelvic pain c. Pyelonephritis d. Sexual Transmitted Infection e. Depression/Anxiety f. Hypertension g. Bleeding per vaginal***	5	1
5.4	In the past 6 months, which of the following actions have you taken when you identified IPV during pregnancy? (Multiple choice question)***	5	1
5.5	Is there a protocol for dealing with IPV during pregnancy at your unit? (Multiple choice question)	5	1
5.6	Are you familiar with your institution's policies regarding screening & management of IPV during pregnancy? (Multiple choice question)	5	1
5.7	Is a camera available at your work site for photographing injuries of pregnant women who are IPV victims? (Multiple choice question)	5	1

Part 2

Item Number	Question	Number in Agreement	I-CVI
5.8 **a.**	Please put a mark to identify that for every pregnant woman who is IPV victim you have identified in the past 6 months, how often have you: Documented pregnant women' statements re. IPV in chart***	5	1
b.	Used a body-map to document pregnant women injuries*	5	1
c.	Photographed injuries of pregnant women who are victim of IPV to include in chart	5	1
d.	Notified appropriate authorities when mandated	5	1
e.	Conducted a safety assessment for pregnant women who are victim	5	1
f.	Conducted a safety assessment for pregnant women who are victim and have children*	5	1
g.	Helped pregnant women who are IPV victim develop a safety plan	5	1
h.	Contacted an IPV service provider	5	1

i.	Offered validating or supportive statements	5	1
j.	Provided basic information about IPV during pregnancy	5	1
k.	Provided referral and/or resource information	5	1

Part 3

Item Number	Question	Number in Agreement	I-CVI
5.9	Are IPV education or resource materials (posters, brochures, etc.) available at your practice site?	5	1
5.10	Do you provide pregnant women with IPV education or resource materials?*	5	1
5.11	Do you feel you have adequate adult IPV referral resources for pregnant women at your work site (including mental health referral)?	5	1
5.12	Do you feel you have adequate knowledge of referral resources for pregnant women in the community (including shelters or support groups) for pregnant women who are IPV victims? *	5	1

S-CVI/Ave (all sections) of the questionnaire is 0.98.

I-CVI = Individual Content Validity Index

S-CVI/Ave = Scale Content Validity Index/Average

* This item was revised by one expert.

** This item was revised by two experts.

*** This item was revised by three experts.

Appendix 4.5

The items of modified version after piloting

Item No.	Adapted version	Modified version
1.11	Including yourself, how many practitioners at your unit have participated in an intimate partner violence training course in the past 6 months: _____ This represents: [ ] All [ ] Most [ ] Some [ ] A few [ ] Don't know	Including yourself, how many practitioners at your unit have participated in an intimate partner violence training course in the past 6 months: _____ This represents: [ ] All [ ] Most **(More than half but not all)** [ ] Some **(More than a few but less than a half)** [ ] A few **(Not many but more than one)** [ ] Don't know **[ ] None**
3.7	Please label the following descriptions of the behaviors and feelings of pregnant women with a history of intimate partner violence with the appropriate stage of change.	**3.7 Do you have any knowledge of The Stages of Change** **[ ] YES, please go to question 3.7.1** **[ ] No, please skip to 3.8** **3.7.1** Please label the following descriptions of the behaviors and feelings of pregnant women with a history of intimate partner violence with the appropriate stage of change.
5.2	Check the situations listed below in which you currently screen for IPV (check all that apply) [ ] I screen all new pregnant women [ ] I screen all pregnant women with abuse indicators on history or exam ……	**5.2 Do you screen pregnant women for IPV?** **[ ] YES, please go to question 5.2.1** **[ ] NO, please skip to 5.4** **5.2.1** Check the situations listed below in which you currently screen for IPV (check all that apply) [ ] I screen all new pregnant women [ ] I screen all pregnant women with abuse indicators on history or exam …….
5.4	In the past, which of the following actions have you taken when you identified IPV during pregnancy? (check all that apply)	In the past, which of the following actions have you taken when you identified IPV during pregnancy **or when pregnant women disclosed IPV?** (check all that apply)

Appendix 4.6

Interview schedule

1. Introduction of the researcher
2. Thank participant for choosing to be involved in the study
3. Provide information about the research, looking at the information sheet and considering ethical issues
4. Give participant opportunity to ask questions
5. Explain the interview process
6. Ask participant to sign the consent form
7. Collect demographic data
8. Ask participant open-ended questions regarding the below
9. Terminate the interview and thank the participant.

The following interview schedule will be used as a flexible guide to the interviews with health care professional in Thailand. A qualitative semi-structure approach to the interviews was adopted and therefore the order and wording of the particular question was adapted to suit the interview situation.

Interview Guide

Script

Thank you for your participation today. My name is Punyawadee Thongkaew and I am a PhD student at the University of Sheffield. Thank you for completing the questionnaire, and this follow-up interview will take up to 60 minutes and will include questions regarding your demographic background, your perspective and your experiences about identifying and responding to pregnant women who are abused by their partner.

I would like your permission to audio record this interview, so I may accurately document the information you convey. If at anytime during the interview you wish to discontinue the use of the recorder or the interview itself, please feel free to let me know. All of your responses are confidential. Your response will remain confidential and will be used to develop a better understanding of how you and your peer perspectives and experiences.

At this time I would like to remind you of your written consent to participate in this study. Your personal information will be treated confidentially and remain anonymous at all time.

Your participation in this interview is completely voluntary. If at any time you need to stop, take a break, please let me know. You may also withdraw your participation at any time without consequence. Do you have any questions or concerns before we begin? Then with your permission we will begin the interview.

Introductory question

Interview questions

1. How was your day at work today?
2. Did you have a busy day?
3. Could you please tell me about your daily routine when you are working in the hospital?

I would like to ask you some questions about your professional background, your marital status, your age and your education. So, please tell me about yourself (personal background age, gender, family etc.); How old are you? ; What is your current marital or relationship status? What is the highest level of education you have receive? What religion are you? Do you practice your religion?

- Tell me about our professional role
- How long have you been working as a (doctor, nurse, technical nurse);
- How long have you been working in this clinic?
- How many pregnant women do you care in day?
- Who do they come to clinic with (alone, parent, friend, partner?)

4. Have you received any training on IPV or domestic violence?

If yes, please describe what it was and when you last did it.

Was it useful? For example, has it helped you do your job?

Key questions

1. Now I would like to ask some questions about IPV screening of pregnant women, and how it takes place in your hospital.

- Who is responsible for screening pregnant women who are victim of IPV?
- Why do you think (…….) appropriate to do it?
- Do you have guideline (hospital guideline) for helping you to screen pregnant women for IPV?
- How do you think professional (nurse) respond to these victims of IPV?
- What is the process, whose responsibility is it to respond to victim of IPV?

2. How about responding to these victims in Thailand?

Possible prompts: Refer to the relevant organisations/Protection after IPV disclosure

3. Do you think, IPV against pregnant women is a significant public health problem or not?

- Why? In questionnaire, you answer that you have experience of identifying pregnant women about IPV.

4. Could you tell me about your experiences of identifying pregnant women who are abused by their partner?

- Did you identify all pregnant women for potential IPV?

Possible prompts:

Or screen when suspect, such as women with physical signs of being abuse

Screen only teenagers

5. What was questions that you use to ask these pregnant women about violence?

- Are you able to give me an example?

6. Please describe what are you doing after that?

7. Please describe a difficult experience in your work (identify) with one of these pregnant women.

Probe - Lack of time? Emotional upset? Lack of privacy and confidentiality?

8. What kind of support do you need to perform your identifying effectively?

- Can you give me some examples of the support you need?

Probe – Training?

9. I would like to find out about your experience of responding to pregnant women who were abused by their partner.

- Can you tell me about your experience of responding to these pregnant women?

Probes: Mental support Document Referral

10. What are some of the challenges of responding to these pregnant women?

<u>Closing questions</u>

1. Is there anything that you would like to add?

2. Are there other things that you expect me to ask you about?

3. Is there anything that you like to ask me about this study?

Appendix 4.7

Example of the transcript

Interview transcript B2	Meaning Units	Interpretation of meaning units
It is something about their family and I am a stranger for them and personally I never got into this kind of situation, so I couldn't understand them much why they can accept this situation. On the other hand, I also think this is Thai tradition and culture. It is not too bad to believe in our ancestors' teaching that a husband must be a leader and hold the power in the house. Sometime, I think like because of gender and culture, so it is normal for violence can happen. I think the cause of conflict in marriage are the different of family background, culture and financial	It is difficult because - it's a family matter. - she's a stranger. - she never met this kind of situation. This is Thai tradition and culture. It's normal for violence.	Difficult She thought she's a stranger to them. She thought because she never met violence in her life, so it's difficult for her to help them. Family matter Stranger Never met, Thai traditional and culture She thought it's because of Thai traditional and culture. Traditional Thai attitudes around gender are that men are powerful, especially in the family home. Cultural factors and gender roles: normalised for men to be violent towards partner.

Appendix 4.8

บันทึกข้อความ

ส่วนราชการ กลุ่มงานพัฒนาทรัพยากรบุคคล โรงพยาบาลบุรีรัมย์ โทร. [illegible]

ที่ บร [illegible] **วันที่** [illegible] พฤศจิกายน [illegible]

เรื่อง แจ้งผลการพิจารณาจริยธรรมการวิจัยในมนุษย์โรงพยาบาลบุรีรัมย์

เรียน หัวหน้าโครงการวิจัย นางสาวปัญญาวดี ทองแก้ว

ตามบันทึกข้อความการขออนุญาตทำการวิจัยในมนุษย์ เรื่อง บทบาทและประสบการณ์ของบุคลากรด้านสุขภาพในการดูแลผู้ป่วยหญิงตั้งครรภ์ที่ถูกกระทำรุนแรงโดยคู่สมรส (Health Care Professionals' Roles and Experiences of Responding to and Identifying for Intimate Partner Violence among Pregnant Women in Thailand) คณะกรรมการจริยธรรมการวิจัยในมนุษย์โรงพยาบาลบุรีรัมย์ได้ประชุมเพื่อพิจารณาแล้ว นั้น

ในฐานะตัวแทนของคณะกรรมการจริยธรรมการวิจัย ขอแสดงความชื่นชมต่อท่าน ในความพยายามสร้างงานวิจัยที่จะเป็นประโยชน์ต่อการพัฒนาทางการแพทย์ในประเทศไทยเป็นอย่างยิ่ง คณะกรรมการมีความเห็นต่องานวิจัยของท่านดังนี้

- [√] ๑. เห็นสมควรให้ทำงานวิจัยดังกล่าวในโรงพยาบาลบุรีรัมย์ได้
- [ ] ๒. ไม่สมควรให้ทำงานวิจัยดังกล่าวในโรงพยาบาลบุรีรัมย์ เนื่องจาก..........
- [ ] ๓. ขอให้ปรับปรุง / แก้ไข / ชี้แจง ในเรื่องต่อไปนี้ เพื่อให้งานวิจัยของท่านมีอันตรายต่อผู้ป่วยน้อยที่สุด
....
....

จึงเรียนมาเพื่อโปรดทราบ

(signature)

(นางสาวพัชรี ยิ้มรัตนบวร)

ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์โรงพยาบาลบุรีรัมย์

"[illegible] สวัสดี มีคุณธรรม"

Appendix 4.9

Participants Information Sheet

Study Title: Health Care Professionals' Roles and Experiences of Identifying and Responding to Intimate Partner Violence among Pregnant Women in Thailand

I would like to invite you to take part in a research study that is being undertaken as part of a doctoral programme at the University of Sheffield. Before you decide whether to take part, it is important for you to understand why the research is being done and what it involves. Please take time to read the following information carefully. Talk to others about the study if you wish. You are welcome to ask me (researcher) anything that is unclear or if you would like more information. Please take time to decide whether or not you wish to take part.

This participant information sheet tells you the purpose of the study and what will happen to you if you take part as well as gives you information about the conduct of the study.

1. **What is the purpose of the study?**

The purpose of this research is to gain an in-depth insight into Health Care Professionals' perceptions and experiences of responding to and identifying intimate partner violence during pregnancy.

2. **Why have I been chosen?**

You have been chosen to take part in this study as you have shown an agreed to be contacted for interview. Moreover, you have been chosen because you are a health care professional who has professional experiences of responding to and/or identifying intimate partner violence during pregnancy, as indicated on the questionnaire.

3. Do I have to take part?

No. Your participation in this interview study is completely VOLUNTARY and you have the right to refuse to be in the study. If you agree to participate, I will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw consent at any time during the interview or after the interview without giving a reason.

4. What will happen to me if I take part?

You are invited to participate in an individual face-to-face interview which will be recorded with your permission to ensure that there is an accurate record of what has been said. You will be invited to talk about your clinical experiences regarding to responding to and/or identifying IPV among pregnant women. The record will be typed out after the interview is completed. Your name and any comment that can identify you will be removed to ensure it is completely anonymous. Only the researcher and supervisors will have access to anonymised data during the study. I will be making field notes during interview that will be about problems or ideas arise during the interview. These will not identify you.

The place for the interview will be the meeting room at the hospital or your office, whichever is more comfortable for you. It is anticipated that the interview will be of approximately one to one and half hours in duration.

5. What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without giving a reason. If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions:

Punyawadee Thongkaew, PhD student (Researcher), University of Sheffield Phone: +44

(0) 1142222035 Email: pthongkaew1@sheffield.ac.uk

6. What if I have concern or a complaint?

If you have any concern or complaints about this study, you can contact my supervisors.

Contact details:

Dr Sharron Hinchliff, Supervisor

Senior Lecture & Postgraduate Research Tutor

School of Nursing & Midwifery, University of Sheffield

Barber House Annexe, 3a Clarkehouse Road, Sheffield S10 2LA Tel : +44 (0)114 22 22045 Email: s.hinchliff@shefiield.ac.uk

Dr Parveen Ali, Supervisor Lecturer

School of Nursing & Midwifery, University of Sheffield

Barber House Annexe, 3a Clarkehouse Road, Sheffield S10 2LA Tel : +44 (0)114 22 22046 Email: parveen.ali@sheffield.ac.uk

7. What will happen to the results of the research study?

I will use the information from the interview and also from the questionnaire to analyse and present in my PhD thesis.

The results of the study may be published and may also be presented at conferences. You will not be identifiable in these publications or presentations.

8. What are the possible advantages and disadvantages of taking part?

A benefit of this study is to improve professional practice of responding to and identifying for intimate partner violence during pregnancy and therefore improve health outcomes for

women and their children. During the interview, sometimes, you might be asked questions about certain topics which are sensitive or may upset you. You can refuse to answer any questions which you feel uncomfortable with, or you can stop the interview anytime.

9. Will my taking part in the study be kept confidential?

All information, which is collected about you, will be treated as strictly confidential throughout.

- Paper and other manual files will be stored securely in a locked filing cabinet at Postgraduate Research Student office, School of Nursing & Midwifery, University of Sheffield, which will only be made accessible to researcher and supervisors.
- Your name will not be on the data record as well as digital audio recording of the interview and no individual will be identifiable from any report resulting from this research.
- Computers will be password protected on secure networks.
- All data will be stored securely until the completion of my PhD degree and then destroyed.

10. Further information and contact details

Punyawadee Thongkaew School of Nursing & Midwifery University of Sheffield
Barber House
387 Glossop Road Sheffield S10 2HQ
Phone: +44 (0) 1142222035
Email: pthongkaew1@sheffield.ac.uk

Thank you for reading this information.