A Mixed Methods Study of the Factors that Influence Papua New Guinean Nurses' Identification and Management of Family and Sexual Violence

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Acronyms

FSV	family and sexual violence
IPV	intimate partner violence
HCPs	health care providers
HIV	Human Immunodeficiency Virus
LMIC	low and middle income country
LRC	Law Reform Commission
MMR	mixed methods research
NDoH	National Department of Health
PEP	post exposure prophylaxis
PNG	Papua New Guinea
STI	sexually transmitted infection
VAW	violence against women
WHO	World Health Organization

Summary

Background

Family and sexual violence (FSV) occurs at unacceptably high rates in Papua New Guinea and is a key determinant of women's poor health. Despite the health implications, health care providers (HCPs) often fail to ask about abuse, or recognise FSV as a contributing factor to other health complaints. This has a negative impact on the quality of care and treatment and is a missed opportunity for prevention of further abuse, particularly as health professionals are often the first and only professional from whom survivors seek help. Using critical realism, this study sought to explain the underlying factors that influence nurses' identification and management of cases of FSV in order to provide contextually specific evidence to improve service delivery for survivors in PNG.

Methodology and method

A mixed methods approach was used for data collection. Fifty-four nurses completed the Domestic Violence Healthcare Provider Survey Scales (DVHPSS) which measured their self-perceived knowledge, attitudes, beliefs and practices towards identification of FSV. In-depth interviews with eighteen postgraduate nurses studying midwifery nursing students were used to explore social, cultural and organisational factors that impact on the identification and management of FSV.

Findings

Most participants scored moderately on the survey subscales of self-efficacy, blame, system support, and victim and provider safety, indicating that these constitute barriers for some nurses. Content analyses of qualitative comments revealed four interrelated themes. Together these results indicate that a reasonable number of survivors attend health facilities for treatment and care of injuries. However, the service that survivors receive is largely dependent on how overarching cultural beliefs about gender, biomedical influence of training, location of the facility and resources available to that facility, interact and converge to shape the individual behaviour or practices of nurses.

Conclusion

The findings of this study show that nurses in PNG face similar challenges when dealing with FSV to nurses in other parts of the world, particularly those working lower and middle income countries (LMICs) and with high levels of gender inequality. However, these findings showed nuances in the PNG context that are important for consideration for policy and planning.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed:………………………………………………………… Date:………………………

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Chapter 1: Family and Sexual Violence (FSV) from a Public Health Perspective

"Do not ignore what you see and what you know is wrong"

Rosie Batty, 2015

1.1 Introduction

Family and sexual violence (FSV) occurs in all types of families, in rich and in poor communities, in every country. It is regarded as a serious abuse of human rights and a global public health problem with significant impact on women's health (WHO, 2013a). This is particularly the case in Papua New Guinea (PNG) where FSV against women is reported as affecting up to 56% of all women (Law Reform Commission [LRC] of Papua New Guinea, 1992). The health sector has a central role to play in the prevention, treatment and care of FSV. Health facilities are often the first and only service that survivors go to for help following assault and health care providers (HCPs) are in a unique position to provide treatment, care and support to survivors plus contribute to efforts to prevent violence through referrals, advocacy and awareness (WHO 2013b; Garcia-Moreno, 2002). Despite this, FSV as a health issue is under-serviced and under-researched in PNG. The practices of HCPs are central to the effectiveness of any strategy by the health sector to respond to FSV, yet there is very limited contextually specific evidence available about the current practices of HCPs in PNG towards cases of FSV. There is a small but growing body of PNG research looking at factors that influence health worker practices in PNG (Jayasuriya, Whittaker, Hallim & Matineau, 2012; Razee, Whittaker, Jayasuriya, Yap, & Brentnall, 2012; Tynan et al., 2013; Worth et al., 2012). They all highlight the importance of understanding how socio-cultural as well as individual factors influence health worker behaviour and emphasise that these have implications for the effectiveness of service delivery and the success of programs.

It is imperative that any future policies or procedures introduced to improve health service delivery for survivors of FSV are informed by evidence that is relevant to PNG, otherwise interventions risk being inappropriate, ineffective, and potentially harmful. Nurses represent 27.3% of the PNG health workforce and are a critical cadre of HCP, particularly in rural areas, where they are frequently the most skilled and qualified HCPs available in health facilities (Morris & Somanathan, 2011). Nurses are frequently the first and only clinical HCPs that survivors interact with and as such are an important cadre for study.

The main purpose of this study, was to critically analyse; a) how nurses identify and manage cases of family and sexual violence in health facilities in PNG; and b) what factors influence nurses' identification and management of FSV. The research questions guiding this study were:

1. How and when do nurses ask and talk about FSV with patients?
2. What are the factors that influence how and when they ask about FSV?
3. How do nurses manage or respond to survivors?
4. What are the factors that influence how nurses manage or respond to survivors?
5. How do those factors influence the way nurses ask about and manage or respond to survivors?

This is. a significant study because it is the first of its kind in PNG and this information will help to inform implementation of the *National Health Plan 2011-2020* (National Department of Health [NDoH], 2011) which has a key result area focused on reducing the impact of violence and trauma.

This thesis is divided into seven chapters. Chapter one includes this introduction, then sets out the argument why FSV is a major public health problem. Chapter two reviews the literature specific to this study and Chapter three provides background information about PNG as a research setting. The methodology for the study is described in Chapter four with quantitative findings reported in Chapter five and qualitative findings in Chapter six. Chapter seven is the discussion of the findings and their implications, followed by a brief conclusion

The remainder of this chapter presents a detailed review of available prevalence studies in PNG to establish the magnitude of the problem of FSV, followed by a brief discussion about the definitions used in this study. Drawing on global evidence, the short and long term impacts of family and sexual violence (FSV) on women's health are described. A brief overview of the evolution of the health sector response to FSV, and an explanation of the role that the health sector can play in preventing FSV is presented, including arguments about why identification of FSV by HCPs is important. Reported rates of HCP enquiry from a range of international studies are summarised, noting that no PNG-specific literature exists on this issue. A brief discussion about evidence on the role of screening is included because of the dominant influence this issue has had in public health research on responding to FSV. Thus, this chapter aims to present sufficient evidence to demonstrate that FSV is a serious public health threat, particularly to women in PNG, and to establish that the health sector has a critical role to play in responding to FSV at all levels of prevention.

1.2 Family and Sexual Violence Prevalence

1.2.1 Global prevalence.

In a global report, the WHO (2013a) has confirmed that FSV against women occurs at epidemic rates in every region. According to that report, 30% of women globally experience physical and/or sexual intimate partner violence and 7.2% experience non-partner sexual violence is 7.2% in their lifetime (WHO, 2013a).[1] Thirty-eight per cent of all murdered women are killed by an intimate partner in comparison to six % of all murdered men. The highest reported rate of all murdered women by an intimate partner is 55% in the South East Asia region (WHO, 2013a). Initial estimations showed the highest prevalence for physical partner violence occurring in the African, Eastern Mediterranean and South East Asian regions at approximately 37%. The prevalence of non-partnered sexual violence was highest in the high income regions (Northern Europe, America, Canada, Australia, and New

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[1] The WHO acknowledge that much physical violence is accompanied by psychological violence but because it is very difficult to measure given the subjective nature of psychological violence, it was deliberately excluded from the study.

Zealand) at 13.6% and the African region at 11.9%. It is likely that the estimates for non-partner sexual violence are impacted by underreporting in some regions because of the stigma and repercussions for disclosing. A subsequent study (Fulu et al., 2013) in the Western Pacific Region published after these data were compiled show a much higher prevalence of physical partner violence than initially reported. The revised prevalence of physical partner violence reported in the Western Pacific, where PNG is located, is 60-68%.

It is important to acknowledge the limitations of the WHO methodology for calculating prevalence. Chan (2011) states there are differences in reporting patterns by men and women but the WHO methodology only asks questions of women, meaning that results cannot be triangulated against those of men. Further, prevalence is calculated based on the number of acts of violence. This means that in determining lifetime prevalence, all acts of violence, whether slaps to the leg or recurrent beatings with weapons are counted equally. Researchers like Johnson (2006) and Cook and Goodman (2006) have theorised that the severity and frequency of occurrence are important factors to consider when determining the type of abuse. However, this is the only standardised methodology that has been used in multiple countries, allowing cross-country comparisons.

1.2.2 Prevalence in Papua New Guinea (PNG)

Data on violence against women in PNG is limited to a small number of reliable studies and unpublished reports. The most frequently cited and only national prevalence research is the work by the LRC (1992) conducted in the 1980s, based on a sample of 1,191 men and 1,203 women across 16 provinces. It was found that 67% of women reported having been beaten by their husbands. Differences between provinces was found with 100% of women in two highlands provinces reporting FSV by their male partner, in comparison to 50% of women in coastal provinces reporting FSV. This reflects some of the cultural and social differences that exist between ethnic groups, as well as between people living in rural and urban locations in PNG. In urban areas, 56% of the urban poor and 62% of the urban elite reported having been hit by their husbands. Although PNG, has undergone rapid social and cultural change since this data was collected, more recent studies (discussed below), although smaller in scale and targeted to specific populations, suggest that the rates of FSV against women have remained at similar levels.

Research on sexual violence, which included interviews with 423 men and women, 61 focus group discussions and which represented 82% of the PNG population, found that 55% of women in the study had been forced to have sex against their will, mostly by men known to them. Half of married women reported being beaten or threatened by their partner to force them into sex. Of the men interviewed, 60% reported that they had taken part in gang rape (The National Sex and Reproductive Research Team [NSRRT] & Jenkins, 1994). The research showed that sexual violence is common in relationships and argued that there is a link between sexual violence and male entitlement.

Lewis, Maura, Wills and Walker (2008), sampled 415 women attending antenatal clinics in four provinces, and found that 58% of women reported physical or emotional abuse and 44% reported sexual abuse. The work of Lewis et al. (2008) is one of the only studies conducted in PNG that has measured the prevalence of intimate partner violence (IPV) and HIV status. Although the study found an association between IPV and HIV, it was conducted amongst women attending antenatal clinics in Port Moresby and is not generalisable to the majority rural population because there is a known higher prevalence of HIV in this urban setting.

In a behavioural surveillance survey of 460 workers (m = 299; f = 161) across eight tea and coffee plantations in the Western Highlands Province, 19.2% of men reported having vaginal, anal or oral sex with a woman when she did not want to have sex and 42% of women reported that they had been forced to have sex without their consent (Buchanan-Aruwafu et al., 2010). Of the women who reported rape, 39% reported that it had occurred more than twice. Perpetrators of rape were reported to be mostly men from the local area or male youth from the plantation.

Another surveillance survey of 300 participants attending the Angau Memorial Hospital STI clinic found that 76% of women reported that they had been forced to have sex against their wishes by their husbands and 42.6% of men said they had forced their wives to have sex. Over one third (35%) of female participants reported being forced to have sex by other individuals or groups of men. Fifteen per cent of these participants tested positive for syphilis and 4% tested positive for HIV.

Ganster-Briedler (2010) surveyed 200 women and found that almost two-thirds (65%) reported being physically abused by their partner, with 41% of these reporting it had happened more than five times. Women reported being slapped (56%), punched by a man's fist (55%), pushed or shoved (53%), kicked and dragged (48%), threatened, or hurt with a stick, gun or knife (36%) and burnt (36%). The majority of these women (87%) reported having been pregnant at one time and of these, 86% reported being hit by their partners during pregnancy, with 47% punched or kicked in their abdomen. Similarly the majority of these women (65%) reported being forced to have sexual intercourse or having submitted to sex in fear of violence if they did not.

The joint UN regional program, *Partners for Prevention*, conducted the UN Multi-Country Study on Men and Violence in the Asia- Pacific to assess men's experience of violence and perpetration of violence (Fulu et al., 2013). Bougainville was included as one of nine research sites across six countries and included a sample of 741 men and 792 women. For Bougainville, the proportion of ever-partnered men who reported perpetrating physical and/or sexual violence in their lifetime was 80%, with 41% reporting use of both physical and sexual violence. This is in comparison to a range of between 30-57% for most other sites. Fifty-nine per cent of men reported rape of a partner, 40% reported rape of a non-partner and 14% reported gang rape. Twenty-five per cent of men reported rape in the last year. Among men who had perpetrated a rape, 64% had done so before age twenty and 23% had done so before the age of fifteen. The most common motivation for rape was sexual entitlement (71%), followed by desire for fun or feeling bored (63%). Sixty-seven per cent of men reported experiencing physical abuse as a child. Men's perpetration of rape of other men was also reported at 8%. Factors associated with IPV and sexual violence for Bougainvillean men included food insecurity, childhood emotional abuse or neglect, childhood sexual abuse and involvement in fights with weapons. The study does note that Bougainville is a post-conflict state and that militarised environments have an impact on masculinities. However, Sri Lanka, where conflict has only recently ended, was also included as a study site. The prevalence of men's use of physical and/or sexual violence in Sri Lanka was 32%.

In two service provision sites, 2008-2010, Médecins Sans Frontières (MSF) (2010) reported 5,500 consultations for survivors of FSV, most of whom were women. Ninety-five per cent of these survivors had been attacked in their home by intimate partners or family members, confirming that in PNG, the majority of cases of family violence are against women and by their partners. Of people seeking care, 13% reported being attacked by more than one person and 17% of all rapes were perpetrated by more than one attacker. At one site, 74% of all sexual violence consultations were for children under age 18, with 56% of them for children under the age of 12. MSF (2010) state that this is a reflection of the fact that people are more likely to seek medical help following attacks on children, whereas sexual violence against women by a partner or family member is often condoned. Twenty-eight per cent of women presenting for services required surgical treatment. At both sites, men who had been attacked by women were treated and women who had been attacked by other women were treated. Taken together these figures demonstrate the need for appropriately targeted health care for survivors of violence in PNG.

1.3 Definitions

There is a lack of clear and consistent use of definitions to describe violence occurring within families and/or against women and this can be a major challenge when conducting research. This section reviews how violence is broadly defined, then explains what is meant by the term family and sexual violence and how it is used in this study.

1.3.1 Violence.

The World Health Organization (WHO) defines, violence as:

the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Dahlberg & Krug, 2002, p. 5).

Violence is defined as it relates to health and well-being, so even though some acts of violence, like female genital mutilation, are culturally accepted, they are considered violent because of the health implications for the individual. The definition covers all acts of violence whether occurring in public or private, whether reactive in response to provocation or proactive, and whether they are criminal or not. Included in this definition is the 'intentionality' of the act, to distinguish deliberate acts of violence from accidental occurrences. Power is included as well as force, to broaden the definition to include acts such as intimidation and neglect.

Acts of violence are further differentiated as physical, sexual, or psychological violence and deprivation or neglect. Physical acts involve the intentional use of force, strength or of a weapon to harm or injure a person, for example, hitting, slapping, kicking, burning, cutting with a knife, or beating with a stick. Psychological violence involves humiliating, threatening, intimidating, controlling or isolating acts. For example, locking women in their homes, preventing women from socialising, name calling and issuing threats are all examples of psychological violence inflicted by male partners. Sexual violence includes forced intercourse and any acts of sexual coercion, neglect and deprivation (Dahlberg & Krug, 2002).

The typology of violence, developed by WHO (see Figure 1) categorises violence into self-directed, interpersonal and collective violence. Self-directed violence is violence a person inflicts upon him- or herself, including suicidal behaviour and self-abuse. Interpersonal violence is subdivided into family and intimate partner violence and community violence. Family and intimate partner violence includes violence between intimate partners or family members usually, but not exclusively, occurring within the home. Community violence includes violence between unrelated people, generally outside the home, for example gang violence, rape or sexual assault by strangers. Collective violence is divided into political, social and economic violence. It includes violence instigated by larger groups such as the state, political groups or militia. Collective violence may be used to promote a particular social agenda, such as hate crimes against minority groups, be politically motivated in the case of war or state-sanctioned violence against political protesters. Economic violence includes the disruption of economic activity or denying access to resources or services. The motivations for collective violence can be multiple (Dahlberg & Krug, 2002).

Women in particular can also suffer from harmful traditional practices like genital cutting, honour crimes, dowry-related violence, forced and early marriage, maltreatment of widows, dietary restrictions, denial of rights to marry and sorcery (UN General Assembly, 2006). This type of violence is not explicitly included within the WHO typology, but some of these acts, like genital mutilation, are often committed by family members, hereas others, like sorcery killings, are a form of collective violence.

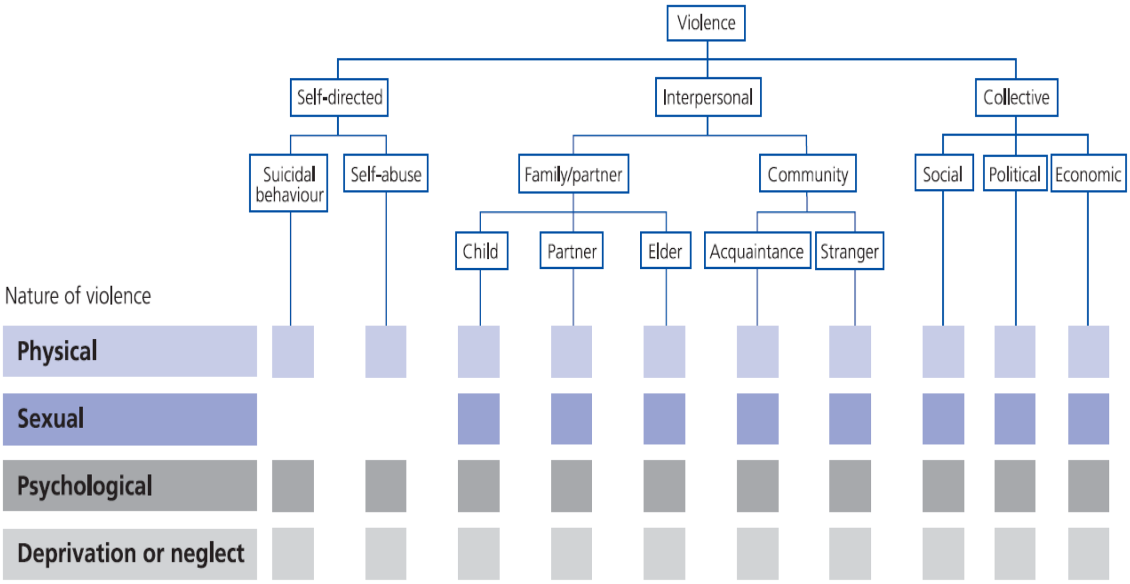

Figure 1: WHO typology of violence (Dahlberg & Krug, 2002)

This study is focused on interpersonal violence occurring within families, in particular violence that is perpetrated against women, and sexual violence by non-partners and strangers against women. This study does not specifically focus on other forms of community violence, like tribal fighting and sorcery-related violence, or collective violence, like violence perpetrated by police against women. However, it is acknowledged that in PNG interpersonal violence can trigger and be reinforced by self-directed, community and collective violence.

1.3.2 Family and sexual violence.

In Papua New Guinea, the term family and sexual violence is commonly used and is accepted as accurately reflecting the nature of interpersonal violence in that country (The World Bank, 2012). The term acknowledges that violence occurs not only between intimate partners but is perpetrated by other family members, including co-wives, uncles, and other relatives within the extended family setting. High rates of non-partner and stranger sexual violence necessitate the inclusion of sexual violence distinctly, and this is common in international literature. However, there is no universally accepted or single definition of family and sexual violence and the term appears less frequently in literature than other terms like ‘gender-based violence’, ‘violence against women’, ‘domestic violence’ and ‘intimate partner violence’ (See Appendix A for a more detailed review of these definitions). It is not evident in the literature that there is agreement about the parameters of any of these interrelated terms and many are used interchangeably as well as distinctly in publications. However, there is a consensus that the overwhelming majority of acts of gender-based violence and domestic violence are targeted towards women and are perpetrated by their male partners (Garcia-Moreno, 2002). This means that, irrespective of whether the terms gender-based violence, violence against women, domestic or family violence are used, the majority of violent acts perpetrated within the scope of each of these definitions is intimate partner violence against women.

Definitions become particularly important in prevalence studies and the Center for Disease Control recommends the use of the term ‘intimate partner violence’ because it is a more precise term and can more accurately capture the extent of that type of violence (Trabold, 2007). Although most cases of family and sexual violence in PNG occur against women by their intimate partner, this research is aimed at understanding and examining how nurses respond to cases of violence. To achieve this, it was decided that a broad and loosely defined term which was familiar to participants, was appropriate and would enable a fuller picture of the experiences of nurses working in health facilities dealing with family and sexual violence. If limited to IPV, there was a risk that discussion about dealing with other types of family violence impacting women would be excluded from participants' responses. This study predominantly uses the term family and sexual violence, except when quoting or referring to literature which uses an alternate term.

The term 'survivor' is regarded as more empowering than the term 'victim' when referring to people who have been abused however both terms appear in research (UN General Assembly, 2006). In PNG the term victim is used more frequently than survivor and thus in this study, both terms are used. I have chosen to use the term survivor except during data collection, when victim was used because it was more familiar to participants. The term perpetrator is used to describe those who use violence against others.

Health care providers (HCPs) include those who work in health care settings providing health services to patients. This includes doctors, nurses, community health workers, medical social workers, dentists, pharmacists, specialists and other forms of allied health workers. It does not refer to administrative staff. Literature specific to nurses and to HCPs more broadly was determined to be relevant for this study.

1.4 Health consequences of family and sexual violence

There is an established link between FSV and a range of adverse health conditions in women. WHO (2013a) estimate that 42% of women experiencing FSV sustain physically injuries from their partner. The reported physical effects of FSV include; minor and major injuries (Carbone-Lopez, Kruttschnitt, & Macmillam, 2006; Ellsberg, Jansen, Heise, Watts & Garcia-Morena, 2008; Plichta, 2004), chronic pain (Campbell et al., 2002; Trabold, 2007; Vives-Cases, Ruiz-Cantero, Escriba-Aguir & Miralles 2011), gynaecological problems (Campbell et al., 2002; Trabold, 2007); gastrointestinal disease and other chronic disease (Campbell et al., 2002; Ruiz-Perez, Plazaola-Castano & Del Rio-Loranzo, 2007; Trabold, 2007; Vives-Cases et al., 2011), and head and traumatic brain injury (Kwako et al., 2011). The head, face and neck are the most frequently injured body parts, followed by musculo-skeletal and genital injuries (WHO, 2013a).

Survivors of FSV are more likely to have a disability that constrains daily activity and as a result of exposure to traumatic stress, suffer poor mental health, particularly depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal behaviour (Carbone-Lopez et al., 2006; Ellsberg et al., 2008; Mechanic, Weaver & Resick, 2008; WHO, 2013a). Based on data collected across nine countries, Devries et al. (2011) reported that intimate partner violence was the most consistent risk factor for suicide attempts among women, after controlling for mental health disorders.

Female survivors have been shown to have greater use of drugs and alcohol (Carbone-Lopez et al., 2006; Escriba-Aguir et al., 2010; Ntaganira, Muula, Siziya, Stoskopf & Rudatsikira, 2009) and hence suffer higher levels of the health problems related to substance abuse. The relationship between alcohol use and violence is bidirectional, in that women who experience violence consume more alcohol and harmful use of alcohol increases likelihood of experiencing FSV (WHO, 2013a).

Studies conducted amongst pregnant women have found that FSV during pregnancy is linked to low birth weight, miscarriage, neonatal death and late entry into prenatal care (Furniss, McCaffrey, Parnell, & Rovi, 2007; Johri et al., 2011; WHO 2013a). Based on analysis of 31 studies, WHO (2013a) reported strong evidence that women with a history of FSV are more likely to have an induced abortion. Chambliss (2008) reported that 10% of hospitalisations due to injury during pregnancy were intentionally inflicted by a male partner. Brownbridge, et al, (2011) found women who report violence during pregnancy are more likely to have experienced multiple types of violence with greater severity with more serious health consequences. FSV during pregnancy has dire consequences for both mother and child, which has particular relevance for PNG because the maternal mortality rate is 733 per 100,000, (National Statistics Office [NSO], 2009), which is the highest in the region.

Research has demonstrated that FSV places women and girls at increased risk of sexually transmitted infections (STIs) including HIV infection (El-Bassell et al., 2007; Laughon, et al., 2007; WHO, 2013a). Women are at increased risk of HIV or other STIs through forced or coerced sex with an infected partner. Fear and the threat of violence limit women's ability to negotiate safer sexual practices and abuse has been shown to increase the probability of sexual risk-taking amongst women in adulthood (El-Bassell et al., 2007). HIV risk factors that are more prevalent in women who experience FSV include engaging in unprotected sex; higher rates of STIs; sex with multiple partners; disclosure of a STI or a positive HIV status; trading sex for money or drugs; having a risky sexual partner (a person who injects drugs, is HIV positive, has had an STI and/or has had sex with multiple partners); and injecting drugs (El-Bassell et al., 2007). Similarly, WHO (2013a) report that male perpetrators are more likely to have higher levels of alcohol use, visit sex workers and have an STI, which increases their own as well as their partner's risk of HIV. The association between FSV and HIV has particular relevance for countries with a high HIV prevalence, including Papua New Guinea. Lewis et al. (2008), found that women in PNG who were in abusive relationships were more likely to have a positive HIV status and that there was a significant association between HIV status and history of sexual abuse.

Figure 2 from the WHO (2013a) shows the likely causal pathways between exposure to intimate partner violence (the most common form of FSV) and morbidity and mortality, noting that the relationship between violence and health is complex with both direct and indirect links.

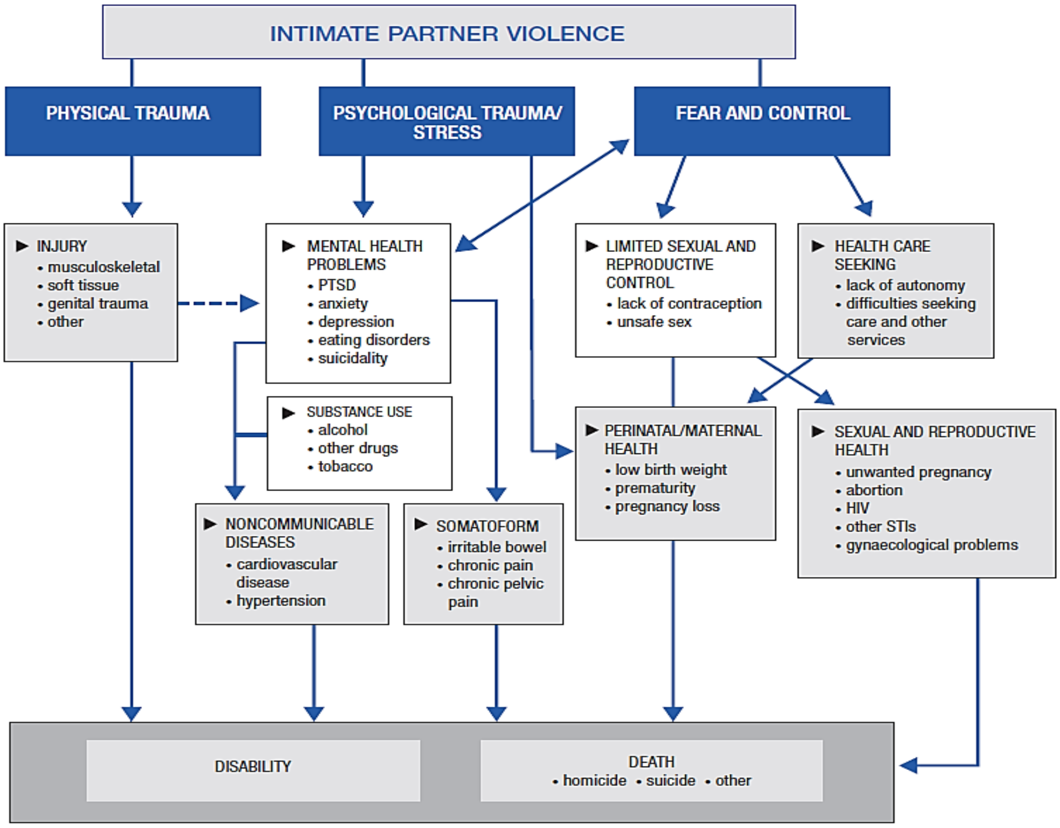

Figure 2: Pathways between IPV and morbidity and mortality (WHO, 2013a)

The wide range of health problems caused by FSV has clear implications for service delivery across multiple specialist and general health services. In PNG, Ganster-Briedler (2010) found that survivors reported physical injuries including bruises, cuts, ear and eye injuries, broken bones, sprains, internal injuries, burns, broken teeth and deep cuts. In the same study, the majority of women reported a range of psychological symptoms such as difficulty enjoying life, feeling nervous and tense, feeling unhappy, having difficulty making decisions and a loss of interest in activities previously enjoyed. These all point to poorer mental health amongst this population. MSF (2010) report that they provided surgical treatment for injuries, STI testing and treatment, post-exposure prophylaxis and emergency contraception to large numbers of survivors in PNG. Given the prevalence of FSV and the consequences for the health of women, it is hard to imagine that any health care provider in PNG could have a career untouched by a case of FSV. This is why the involvement of the health sector in responding to FSV is crucial. The next section will explain the role that the health sector can play in preventing and treating FSV.

1.5 Health Sector Response to FSV

Public health is concerned with preventing health problems and extending care and safety to entire populations (Dahlberg & Krug, 2002). The health consequences of FSV, combined with the rate at which it occurs, clearly demonstrates that FSV is a public health issue of concern. However, whilst the public health significance of FSV has increased over the last two decades, amidst growing acknowledgement of the social and economic more broadly, FSV continues to be perceived as a social issue rather than a health issue by many HCPs. The following section provides a brief overview of the growing momentum within the health sector to respond to FSV, followed by a summary of the reasons which compel the involvement of health care workers in the identification, treatment and prevention of FSV.

1.5.1 History of the response to violence against women in the health sector.

The issue of violence against women came to the fore during the United Nations Decade for Women (1975-1985) (UN General Assembly, 2006). The 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defined discrimination against women and set an agenda to end such discrimination. The Committee on the Elimination of Discrimination against Women, set up in 1982 to implement and monitor CEDAW, made it clear that, under the Convention, gender-based violence is an act of discrimination and that states are responsible for protecting women from any forms of such violence (UN General Assembly, 2006). In 1980, the Second World Conference of the United Nations Decade for Women called for health care programs to support the elimination of violence and provide protection from physical and mental abuse. Women's activism increased throughout the 1980s and by the early 1990s recognition of violence against women as a human rights issue had intensified. At the World Conference on Human Rights in Vienna, 1993, women's groups presented close to half a million signatures from 128 countries, demanding that violence against women be recognised as a violation of human rights. The Beijing Declaration and Platform for Action, adopted by 189 countries at the Fourth World Conference on Women in Beijing in 1995, consolidated the gains already made and shifted focus onto the state's accountability to prevent and eliminate violence against women (UN General Assembly, 2006).

Efforts to address violence against women within the health sector have lagged behind international efforts to have the issue recognised as a human rights violation. In 1996, the 49th World Health Assembly declared violence a major public health problem, drawing attention to the consequences for individuals, communities and families. The WHO as the lead health agency, responded with the first *World Report of Violence and Health*, in 2002 (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). The report sets out the role of public health in responding to violence more broadly and separates out violence by intimate partners and sexual violence as distinct chapters in the report.

In 2005, the WHO Multicountry study on women's health and domestic violence against women used a consistent methodology to report the prevalence of intimate partner and sexual violence across ten countries (Garcia-Moreno, Jansen, Ellsberg, M., Heise, & Watts, 2005). Based on interviews with 24,000 women, the study found that 13-61% of ever-partnered women reported physical violence by a partner at some point during their lives. This work was significant because it developed a standard methodology to measure prevalence that could be used across countries.

Throughout the late 1990s and 2000s, publications about FSV increasingly appeared in health journals and in international reports, building up an evidence base to shape health sector policy and practice. Key focuses of health research have included measurement and surveillance of FSV (e.g. Cook & Goodman, 2006; Johnson, 2006; Kilpatrick, 2004;); the health impacts of FSV (e.g. Campbell et al., 2002; Ellsberg et al., 2008; Heise, Pitanguy, & Germain, 1994); health sector policy (e.g. Garcia-Moreno, 2002), the use of screening for FSV (e.g. Feder et al., 2009; Nelson, Bougatos, & Blazina , 2012; Taft et al., 2013; Wathen & MacMillan, 2003); interventions (e.g. Bair-Merritt et al., 2014; Spangaro, Zwi, Poulos, & Man, 2010; Thompson et al., 2000); health care worker issues when providing treatment and care (e.g. Colarossi, Breirbart, & Betancourt, 2010; Sprague et al., 2012); and to a lesser extent, survivors' needs and issues (e.g. Bacchus, Mezey, & Bewley, 2003;

Pratt-Eriksson, Bergbom, & Lyckhage, 2014; Usta, Antoun, Ambuel, & Khawaja, 2012). As with most research, there is significantly more evidence from high income countries than from low and middle income countries (LMICs) like PNG.

In 2013 the WHO released a report (WHO, 2013a) on the global prevalence of FSV presenting clear evidence of both the magnitude and the nature of the problem. This included data from 77 studies covering 56 countries. Drawing on previous research, the report demonstrates the substantial health consequences of IPV and non-partners' sexual violence for women (WHO, 2013a). Following this, the WHO released for the first time their policy and clinical guidelines for health workers (WHO, 2013b). These are aimed at supporting HCPs to assume their roles and responsibilities in mitigating the effects of violence (WHO, 2013b) and take account of the constraints faced by health care workers in LMICs. In the following year (2014), the *Lancet* also released a five paper series 'Violence against Women and Girls' (Vol 385, No. 9977). The dedication of a series to this issue in a premier health publication cannot be understated and signifies the transition of FSV into mainstream public health. The challenge is now for this work to be translated into country level action.

1.5.2 The role of the health sector

Women are the both main users of health services, and make up the majority of the survivors of family and sexual violence (Malpass, Sales, Johnson, Howell, Agnew-Davies, & Feder, 2014). Further, women who experience FSV are more likely than non-abused women to seek health care for the treatment of the immediate and long-term effects of violence, even if they do not disclose abuse. Often health care providers are the first and sometimes only contact survivors have with a professional who can help them (Feder et al., 2009; Malpass et al., 2014). In PNG, 55% of survivors reported that they will first turn to health services for help, whereas only 39.5% turn to police and local leaders (Ganster-Breidler, 2010). Health care settings can provide safe and confidential environments for disclosure and can act as a point of referral to other specialist services, such as legal aid and welfare services. This places HCPs in a unique position to identify and help women at risk by providing appropriate treatment and care, documenting injuries, providing referrals, and thereby potentially preventing health problems (Feder et al., 2009; WHO 2013b).

Health care providers must be able to ask their patients about FSV to be able to play a role in prevention. Asking about FSV in health settings creates an opportunity for primary and secondary prevention of violence-related health problems, and can lead to referral to other services that can assist women. In the case of FSV, work in shelters, emergency departments or crisis support centres are examples of tertiary prevention because the violence has already happened and the focus is to treat the consequences by preventing death, disability, or further harm. Secondary prevention in the health sector can include asking about violence for early identification and implementation of intervention, like safety planning, counselling, and to stop further incidents and negative health effects from happening (Coker, 2004). Early identification of FSV can reduce health consequences and decrease risk of further attacks (Garcia-Moreno, 2002). Asking about violence, regardless of whether FSV is identified, plays a role in primary prevention because it reinforces the message that FSV is not acceptable among the broader community and provides an opportunity to educate survivors and non-abused women. HCPs, because of the status they often hold within their communities, can be effective in raising general awareness and providing education (Thurston & Eisener, 2006; Wong & Mellor, 2008).

Even though injury is a common result of FSV, only a minority of survivors seek medical assistance and voluntarily disclose abuse (Todahl & Walters, 2011). For example, Morse, Lafleur, Fogarty, Mittal & Cerulli, (2012) reported that only one third of women sought medical help following an assault and Plichta (2007) reported that 41% of victims of partner-related femicide had accessed health care in the year before their murder, but only a third of these women had accessed care for FSV related injuries. Identification of FSV by HCPs, followed with an appropriate response, could have potentially saved the lives of some of these women.

Survivors of FSV attend health facilities frequently but often for reasons other than those related to injury from physical assault. A failure to identify FSV means that survivors are less likely to have the cause of their poor health identified and therefore less likely to receive the treatment and care they need. This leads to an overuse of services and a poor relationship between the patient and health care provider. Low identification of FSV leads to missed opportunities to refer survivors to appropriate services as well as misdiagnosis of health problems (Spangaro, 2007). The WHO (2013b) now stipulates that the health sector should play a critical role in the identification, assessment, treatment, crisis intervention, documentation, referral and follow up of family violence, and recommends that all health workers need to be trained to understand the relationship between violence and women's health and to respond appropriately. However, this is rarely reflected in national policies and training curricula, if at all (WHO, 2013b).

1.6 Why identification of violence is important

Research in Anglo-European countries suggests that the majority of women find it acceptable for HCPs to ask about FSV and would disclose abuse if asked. For example, 92% of women in maternity wards found routine enquiry about partner violence acceptable (Stockl et al., 2013) and 86% of women surveyed in GP clinics also agreed that routine enquiry was acceptable (Boyle & Jones, 2006. However, in the same study, Boyle and Jones (2006) found that women who had experienced abuse in the last year were less accepting of enquiry than those who had not (Boyle & Jones, 2006. Similarly, Wendt, Lidell, Westerstahl, Marklund and Hildingh (2011) reported lower acceptance of routine enquiry amongst survivors of sexual abuse. Supporting this, studies of voluntary disclosure rates indicate that some survivors do not readily disclose abuse to HCPs. Martins, Assunção, Caldas and Magalhães (2014) reported that 18.8% of survivors who sought out health care following abuse chose not to disclose this to service providers. Likewise, Spangaro et al. (2010) reported that 14% of women who screened negative for abuse had in fact experienced abuse but did not reveal this during screening. Morse et al. (2012) reported slightly different results. They found that only 31% in a sample of survivors had disclosed their experiences of abuse to HCPs, but 63% of these said they would have disclosed if asked. Wendt et al. (2011) suggest that survivors may find it difficult to raise issues of abuse themselves, and believe it is easier for HCPs to initiate such discussions. This points to the need for HCPs to actually ask about abuse during healthcare consultations however it is important to note that, for survivors, non-disclosure can be a very intentional decision.

Women may choose not to disclose FSV for a number of reasons, including being afraid for their safety if the perpetrator finds out, fearing involvement of social services, inadequate support services or believing the abuse is not serious enough to raise as an issue (Bhandari, Bullock, Anderson, Danis, & Sharps, 2011; Prosman, Lo Fo Wong, & Lagro-Janssen, 2014; Rose et al., 2011; Schuler, Trang, Ha, & Anh, 2011; Shamu, Abrahams, Temmerman, & Zarowsky, 2013; Spangaro et al., 2010). For example, Schuler et al. (2011) discussed the risks Vietnamese women face in the light of insufficient support systems. When a woman perceives FSV to be non-life threatening, and she feels there is inadequate support, disclosing may be more harmful than not disclosing, if the perpetrator finds out. A lack of trust in midwives to maintain confidentiality in small community settings was reported by Zimbabwean women. This generated fear that their partners would find out they had sought help and told HCPs about the violence (Shamu et al., 2013). None of these reasons suggest that survivors do not want help, rather that there are opportunity-costs to disclosure which survivors tend to take into account.

Further, many females survivors have had negative experiences with HCPs, leaving them feeling ignored or ashamed, and this reduces the likelihood of disclosure and effective treatment and care (Pratt-Eriksson et al., 2014; Prosman et al., 2014; Tiwari et al., 2005; Tower, 2006). Negative experiences with HCPs can be traumatic and intensify survivors' suffering. Being treated with care, respect and in a non-judgemental manner by HCPs and being given information about the reasons for the enquiry have been identified by women as critical when asking about FSV (Mork, Andersen & Taket et al., 2014; Pratt-Eriksson et al., 2014; Usta et al., 2012). Stigma surrounding FSV and the negative attitudes of HCPs contributes to reluctance by survivors to talk about violence (Roush, 2011). These issues point to the necessity for HCPs to be properly trained to ask about violence and provide care and treatment to survivors in an appropriately sensitive way.

However, survivors may find enquiry about FSV beneficial even if they are not ready to disclose abuse and for many it may be the first time they have had an opportunity to talk to someone about violence. In a meta-analysis of qualitative literature, Feder et al. (2009) reported that female survivors value support and education, whether or not they are ready to talk about their experience of abuse. Spangaro et al. (2010) found that 23% of women in an Australian sample who reported abuse in the preceding six months, responded that this was the first time they had ever told another person. Enquiry in itself can act as a brief intervention, especially when HCPs explain why they are asking and demonstrate a willingness to discuss the issues seriously, in a non-judgemental way (Spangaro et al. 2010; Taket, 2012). Therefore, disclosure and intervention may not be the only positive outcome from enquiring about abuse and non-disclosure rates should not be seen as a reason not to enquire about FSV, although this may be challenging for solution-focused HCPs who see the purpose of asking about violence as obtaining a disclosure to enable appropriate care (Feder et al., 2009). Regardless, women who are not asked about FSV are denied an opportunity to disclose, to receive support and information, and may not get the most appropriate medical care (Janssen, 2006; Morse et al., 2012).

1.6.1 Health care provider rates of enquiry

Although there is sufficient evidence to suggest that there are benefits to asking about violence, research has shown that HCPs often fail to ask about abuse, or even recognise violence as a contributing factor to other health complaints (Beccaria et al. 2012). This has a negative impact on the quality of care and treatment and is a missed opportunity for prevention of further abuse.

Studies across several countries have shown that rates of enquiry about FSV by HCPs are low. Kothari and Rhodes (2006) found that 72% of women who attended a US emergency department after a police-recorded partner assault were not identified as survivors by health care staff. In a review of earlier evidence from 32 descriptive studies between 1992 and 2002, Stayton and Duncan (2005) reported rates of routine enquiry ranged from 3 – 41% for physicians and 0 – 70% for nurses. In Canadian samples, Gutmanis, Beynon, Tutty, Wathen and MacMillan (2007) reported that 32% of nurses and 42% of physicians routinely discussed IPV and Guillery, Benzies, Mannion and Evans (2012) found that only 33% of postpartum nurses often or always asked about physical abuse and 11.5 % asked about sexual abuse. In non-Western samples, John, Lawoko and Svanström (2011) found that 74% of HCPs in a Nigerian hospital did not ask about FSV during the preceding three months and Al-Natour, Gillespie, Felblinger and Wang (2014) reported that 25% of nurses in health facilities in Jordan did not ask about violence when women presented with physical injuries. Although each study used different methods to determine rates of enquiry and were conducted in different types of facilities, all demonstrate that a proportion of HCPs do not routinely ask about FSV.

The problem is that physical injury is only one manifestation of abuse and the patterns of abuse are not consistent, therefore relying on presentation of symptoms may lead to under-identification. Further, given women's hesitation for self-disclosure, much FSV is likely to go undetected unless HCPs actively ask about the issue (Phelan, 2007). Even where there are signs of abuse, HCPs may not enquire, as demonstrated by Martins et al. (2014), who reported that in 52.3% of cases where survivors believed there was evidence of abuse or did not conceal it, their physicians did not discuss the abuse or its implications. Management of FSV has not become well integrated into health care settings (Stayton & Duncan, 2005; Thurston & Eisner, 2006) and health care providers have been ranked lowest of all groups, including social services, clergy, community services, law enforcement and legal services, in providing assistance (Davis & Harsh, 2001). This is of concern given the frequency of use of health services by survivors and the immense need for appropriate services.

Low rates of enquiry and reluctance of HCPs to discuss FSV, combined with the consequences of misdiagnosing abuse as the cause of poor health, has prompted researchers to examine how to increase identification of FSV by health care workers. This has led to a significant investment in research on screening for FSV which has been the dominant response proposed for health sector interventions.

1.7 Screening for FSV

Screening is a public health process that involves asking specific questions to a target population in order to identify a health issue and offer treatment. The United

States Preventative Services Task Force (USPSTF), who have been influential in establishing FSV health care practices, define screening as "*a preventative health care service in which specific tests, standardised questions or exam procedures are routinely used to identify people who require specific interventions to improve health*" (Phelan, 2007). The underlying premise of screening is that it is beneficial to detect risk factors and early signs of disease so that treatment can be applied early which will prevent disease. Availability of assessment tools and treatment are conditions of effective screening (Feder et al., 2009). Wilson and Jugner (1968), who were early proponents of public health screening, cautioned that while the idea of screening may seem straightforward, successful implementation to treat those undetected and at the same time to avoid harm to those not requiring treatment is far from simple. In the FSV literature, screening is a contested term because some argue that asking about abuse cannot be compared to public health screening for other conditions because there is no accepted "treatment" within the remit of the health sector that can cure or reduce the occurrence of FSV.

Of note, screening, universal screening, routine enquiry, selective screening, and case finding are all used in the literature to describe processes of asking about violence. Universal or routine screening involves asking all women a standardised set of questions using a valid tool, regardless of whether they show signs or symptoms of abuse or their reasons for seeking medical attention (Feder et al., 2009; Taft et al., 2013). Routine enquiry is a process whereby all women are routinely asked about FSV but the types of questioning may vary depending on the setting and are not necessarily standardised (Feder et al., 2009; Phelan 2007). Taft et al. (2013) define selective screening as asking questions only to women in high-risk groups, such as pregnant women or women with substance abuse issues. However, others define selective screening as asking questions only to those women who present with symptoms that the health care worker suspects are consistent with abuse (Garcia- Moreno, 2002; Phelan, 2007), which some authors refer to as 'case-finding' (Taft et al., 2013). The prevalence of FSV amongst men is not high enough to warrant inclusion of men in any type of screening.

Over the last decade, several leading health and medical associations have adopted policies promoting universal or routine screening by health care providers. In 1992, the American Medical Association published guidelines on routine screening of women in emergency, paediatric, antenatal and mental health settings (Spangaro, 2007). Many professional health associations in the United States of America (US) and other high-income countries followed suit, including the American College of Obstetricians and Gynaecologists, the American Academy for Family Physicians, the American Academy for Nurse Practitioners, National Association of Social Workers and American Psychological Association. In Australia, the New South Wales Department of Health developed a policy of routine screening in 2004 (Spangaro, 2007). In 2013, the USPSTF revised a previous recommendation against universal screening to endorse a recommendation that clinicians screen all women of child bearing age for IPV and refer survivors to intervention services (Moyer, 2013). This was based on a review by Nelson, Bougatos and Blazina (2012) of existing evidence of availability and validity of screening tools, and an assessment of the benefits and harms of screening. Assumptions underpinning these guidelines are that screening or asking routinely about FSV increases the identification of women experiencing violence, leads to appropriate interventions and support, which then leads to a reduction in violence and improved health (Taft et al., 2013). It is this last point that has been greatly debated in the literature.

Many studies use the term screening as a broad term to describe any process where HCPs ask about FSV, regardless of whether a standardised protocol is used and without reference to whether the screening took place with availability of interventions (treatment), both of which are necessary conditions (by definition) for public health screening (e.g., Al-Natour et al., 2014; Baig, Ryan, & Rodriguez, 2012; De Boer Kothari, Kothari, Koestner, & Rohs, 2013; Sormanti & Smith, 2010). As this research is not specifically focused on testing the efficacy of public health screening for FSV, the multiple uses of terms is less problematic. The importance of the ‘screening’ literature for this research is what these studies have revealed about the challenges of identifying and providing an effective ‘treatment’ or intervention for cases of FSV in health facilities.

1.7.1 Screening & intervention research.

There is broad consensus that screening increases identification of survivors (Feder et al., 2009; O'Reilly, Beale, & Gillies, 2010; Taft et al., 2013) but the issue as to whether screening leads to improved health and reduced violence has been more difficult to determine. This has led to a significant number of studies investigating the effectiveness of interventions following positive identification. Results of these studies have been inconclusive.

In an Australian cross-sectional study, Spangaro et al. (2010) reported that 35% of women who were identified as survivors through screening and offered a referral, accessed further services. In most cases, this was the hospital social work service, which led the authors to conclude that immediate, onsite referral options may be an important feature of referral uptake. This finding is supported by Ramachandran, Covarrubias, Watson and Decker (2013), who interviewed American HCPs and concluded that increased screening and disclosure occurs where there are on-site services such as danger assessments, safety plans, mental health services, and compassionate referrals. These results point to the importance of the availability of referral services.

Kiely, El-Mohandes, El-Khorazaty, Blake and Gantz (2010) conducted a randomised control trial (RCT) in the US to test a psycho–behavioural intervention to reduce IPV recurrence during pregnancy and the postpartum period. They found that the intervention, which included individually tailored counselling sessions, reduced victimisation and improved pregnancy outcomes. However 25% did not attend any counselling and only half received all of the intervention. Whilst these results are encouraging, the uptake rates of counselling demonstrate the challenges of integrating counselling into practice and this intervention is also dependent on the availability of trained counsellors. Tiwari et al. (2005) conducted an RCT of a 30 minute empowerment training intervention provided to pregnant Chinese women with a history of abuse. Women who were provided with empowerment training had significantly higher physical functioning and lower emotional problems. These women also reported lower psychological abuse, lower minor physical violence and lower postnatal depression scores. Similarly, this intervention was dependent on the ability of HCPs and their facility to fund and staff 30 minutes of training, which would be unlikely in resource-constrained settings like PNG.

McFarlane, Geoff, O'Brien and Watson (2006) tested two interventions with US samples: a wallet-sized referral card and a 20 minute nurse case management protocol. They found that there was a significant reduction in violence over time for all women, regardless of type of intervention. They concluded that abuse assessment and referral is sufficient to influence levels of future violence. These results need to be replicated in other settings because they indicate that there are more efficient and cheaper types of interventions than provision of counselling within the health setting. Two important factors to consider in PNG would be the literacy rates of survivors which impact on their ability to read and understand referral cards, as well as the availability of services outside the health system.

In another US trial, Rhodes et al. (2014) tested a multifaceted intervention in which a self-completed questionnaire was used to increase identification, and provider training and awareness were combined with the availability of on-site IPV advocators. This did result in an increase in identification and intervention during the pilot period but was not sustained without the advocate on-site. After six months, the intervention became difficult to maintain and there was no significant difference in detection rates between the intervention and the control group.

In a systematic review of 17 intervention studies, including some of those mentioned here, Bair-Merritt (2014) concluded that eleven studies reported a reduction in IPV, 12 reported improvements in some aspect of health and five reported increased safety behaviours. They concluded that successful interventions have a focus on increasing self-efficacy and empowerment, increasing access to IPV-related resources and use of brief, non-physician models of intervention delivery. O'Campo, Kirst, Tsamis, Chambers and Ahmad (2011), who took a realist approach to reviewing evidence for screening, concluded that programs which use standard protocols, have institutional support and immediate access to referrals had significantly increased rates of IPV screening, disclosure and identification. These reviews indicate that additional resources, in particular access to referrals or counselling, are required to make screening successful.

Although O’Campo et al. (2011) argue that consideration of context is essential to determine what works, the authors do not comment on the implications of working in resource-constrained settings. Nor do they comment on the role of professional and cultural beliefs in determining the effectiveness of screening, which are critical in low and middle income countries and in countries with high levels of gender inequality. Shamu et al. (2013), who explored the opportunities and obstacles for interventions aimed at reducing IPV in antenatal care clinics in Zimbabwe, highlighted that most African health care settings have weak health systems with poor infrastructure and limited human resources, meaning comprehensive programs, as suggested by O’Campo et al. (2011), would be unachievable.

Likewise, each of these interventions, whilst producing positive results, would not be transferrable to PNG because of the resources required for implementation. On-site services, like those available in the Spangaro et al. (2010) trial, require additional staff with appropriate skills, funding, infrastructure and for the service to be integrated into the existing organisational processes. Providing tailored counselling sessions or resourcing a 30 minute intervention in busy health care settings are also unfeasible where health systems are underfunded, staff poorly trained and referral services limited.

Further, there are a number of studies which conclude that screening and subsequent interventions have not improved health or reduced FSV. In one of the first RCTs to examine the effectiveness of screening and communication of positive results to clinicians, MacMillan et al. (2009) did not find evidence that asking about violence led to improved health. In their results, 44% of screened and 8% of non-screened women discussed IPV with their clinician during their first visit. Although positive screening promoted more discussion of IPV between patients and clinicians, it is concerning that less than half of the clinicians raised IPV with their patients, especially given that clinicians were notified of all positive screens. Further, screened women showed improvements in quality of life, mental health and reduced IPV exposure, but the differences from the non-screened group were not significant. However, the trial was criticised because all women in the trial were screened and all abused women were given a referral, meaning that the control group did not constitute a usual control group and there was a likelihood that the screening and referral in itself could be considered as an intervention (Rhodes, 2012; Nelson et al., 2012).

Two other trials which did not confirm the effectiveness of subsequent interventions include Hegarty et al. (2013) and Koziol-MacLain et al. (2010). Twelve months after a brief counselling intervention in Australia, Hegarty et al. (2013) did not find any improvement in quality of life, safety planning and behaviour and mental health. Koziol-MacLain et al. (2010) tested a three minute brief intervention in New Zealand and did not find a significant reduction in exposure to IPV in the short term (after a three month follow-up). A systematic review by Taft et al. (2013) reviewed 11 studies conducted in health care settings that assessed the effectiveness of universal screening for intimate partner violence on identification, referral and health outcomes for women. The review concluded that in high-income countries with well-developed referral services, screening increases the likelihood of identification of IPV, but does not increase referrals to specialist help, reduce the level of violence experienced by women or improve women's health and wellbeing 3-18 months after screening. Taft et al. (2013) do acknowledge that the review only targets screening, not interventions, unlike Bair-Merritt et al. (2014), who reviewed the effectiveness of interventions. However, MacMillan and Feder (2012) argue in an editorial letter that most of the interventions used in the RCTs which were found to be effective, do not require the implementation of universal screening. This is a point that Bair-Merritt et al. (2014) do not discuss in their conclusions on support for policies of universal screening.

Whilst these RCTs and systematic reviews have progressed the debate on whether screening does or does not work, the question of how health services should manage this complex social problem remains unclear (Taket, 2012). The overemphasis on finding evidence to support or discount policies of screening has diverted attention and resources away from determining how the health system can respond appropriately to women's disclosures (MacMillan & Feder, 2012; Taft et al., 2013). RCTs, in addition to being costly to run, focus on proving or disproving the effectiveness of an intervention. The nature of such studies does not leave room to examine other factors which are critical to success in non-clinical service delivery, like the availability and willingness of organisations to commit resources to FSV, the attitudes and beliefs of health care providers, the training and competencies of staff implementing the intervention and institutional support. As O'Campo et al. (2011) point out, many of the factors which contribute to reductions in FSV are outside the remit of the health system and as FSV is a complex social phenomenon, not a disease, obtaining conclusive evidence may be impossible.

1.8 Conclusion

There is clear evidence that FSV occurs at epidemic rates with significant consequences for the health of women. In PNG, the reported rates of FSV from the limited research that has been conducted show that unacceptably high numbers of women and girls are affected by physical and sexual violence. As HCPs are often the first and only professionals that survivors turn to for help, they play a central role in all levels of prevention. However, given women's hesitation for self-disclosure, much FSV is likely to go undetected unless HCPs actively ask about the issue (Phelan, 2007). Despite this, HCPs fail to routinely ask women about FSV, even where there are signs of abuse. Asking about violence has not become well integrated into health care, which is of concern given the frequency of use of health services by survivors. Understanding the factors which influence why, when and how HCPs ask about FSV and what HCPs do following disclosure are important questions for research. This is even more the case for countries like PNG where there is limited evidence about health service delivery in general and there is poor understanding about contextual influences on HCP practice. Hence the need for this study to examine and explore what factors influence nurses' identification and management of FSV in PNG.

Chapter 2: Literature Review

2.1 Review Methodology

The purpose of this study was to critically analyse; a) how nurses identify and manage cases of FAV; and b) what factors influence nurses' identification and management of FSV. Using the research questions as the overarching guide, a review of the literature was undertaken to determine what has been shown to influence the identification and management of FSV by HCPs and to identify methodological issues.

Context was an important consideration for this literature review. In PNG, there is scant research about health service delivery and little documented research about HCP behaviour towards survivors of FSV. What is known from other areas of health research, particularly HIV studies (see Hammar, 2007; Lepani, 2007; Wardlow, 2007), is that it is essential to understand socio-cultural constructions of health and illness when considering prevention, and that interventions which work elsewhere do not easily fit the PNG context. Unfortunately no published PNG or broader Melanesian studies could be found on the role of HCPs in responding to FSV, on the factors influencing HCPs' practice or that have tested interventions in response to FSV. Therefore during the literature search considerable attention was paid to the setting in which the research was conducted, with greater weighting placed on those studies in LMIC settings with similar social and cultural structures.

A traditional systematic review and meta-analysis of the literature was not appropriate for this review because the topic under investigation was not clinical treatment outcomes but non-clinical service delivery. Instead, drawing on realist methods to explore context specific issues, and using a qualitative approach, literature was reviewed to determine the evidence already in existence and the lessons which can be drawn. The intent of a realist approach is to provide explanations rather than judgements about what works. The key difference between a traditional systematic review and a realist review is that systematic reviews set out to ascertain from evidence "what works" , whereas realist reviews go beyond this to answer questions about "what works, for whom, under what circumstances and why?” (Pawson et al, 2004). In this way realist reviews take account of the influence of context when assessing the effectiveness of interventions.

A systematic process was used to search and select relevant publications. To begin, an informal search of the researcher’s existing personal reference library was conducted to get a sense of the issues and establish provisional scope. The reference library held 327 pieces of reference material including academic and grey literature relevant to the topic of family violence and health service delivery. These references had been collected prior to and during the research period, through database searches, professional networks and opportunistic searching of the internet. ’Intimate partner violence’, ’abuse’ and ’domestic violence’ were used as search terms and 131 articles were identified. The titles of these were reviewed and 67 articles which referred to identification or screening of violence, barriers to identifying or managing violence interventions, and methods used by HCPs to respond to violence, were extracted. Thirty-one articles were selected based on abstracts as the most relevant to the research questions for this initial stage of browsing.

Personal reference library 327

Search with ‘intimate partner violence’, ‘domestic violence, ‘abuse’

131 extracts

Titles were reviewed for references to: ‘screening’ , ‘identification’, ‘asking about violence’, ‘barriers’, ‘health care providers‘, ‘survivors’ experiences’

67 kept

Abstracts reviewed and articles which provided information about identification of FSV and/or managing or treating survivors successfully were kept.

31 kept

Table 1: Results of informal search

The purpose at this stage was to get a sense of the key issues emerging from the literature, to help determine what further material would be needed, to refine the scope of the research, and to inform the 'search proper' (Pawson, Greenhalgh, Harvey, & Walshe, 2004). Appendix B includes sample pages of the matrix used to record articles and the key themes. After this process, as the scope for the review became clearer, broad inclusion/exclusion criteria were developed.

Inclusion Criteria	Exclusion
Studies with analysis of factors influencing HCPs' identification or management of FSV, including HCPs' perceptions, experiences, knowledge, practices, attitudes, barriers, and enablers.	Studies which tested a protocol, screening tool or intervention.
Studies from perspectives of survivors if they commented on HCP practice, behaviour, and attitudes.	Studies with samples of non-clinical or social service workers
Studies in all countries considered but bias towards LMIC settings. This means some studies included from LMIC settings were of poorer quality but were kept because they provided information context.	Studies not in the English language
	Opinion pieces

Table 2: Inclusion and exclusion criteria

Three databases (PubMed, CINAHL, Scopus) were then searched using main search terms and within the date range of 2000 – present, with last systematic search on 16 May 2015. Search terms included: ' screening', 'domestic violence', 'intimate partner violence', 'abuse', 'health personnel', and 'nurses'. A total of 293 articles published after 2000 were retrieved and reviewed from PubMed, 95 were kept; 782 from Scopus with 45 kept; 109 retrieved from CINAHL with 44 kept. This gave a total of 184 relevant articles retrieved, at which point systematic database searching was ceased.

Search terms: ‘domestic violence’ ‘intimate partner violence’, ‘abuse’, ‘health personnel,

Date range: 2000 – present (2015)

PubMed: 293 articles retrieved, 95 kept

Scopus: 782 articles retrieved, 45 kept

CINAHL: 109 articles retrieved, 44 kept

Total articles kept: 184

Table 3: Articles retrieved from systematic searching

Snowball sampling of the reference lists of the selected articles and the researcher’s own knowledge of key studies added a further 53 titles to the list (including some of those from the initial informal search) bringing the total to 228 articles. The abstracts of these 228 articles were read. The inclusion and exclusion criteria were applied and 68 articles kept.

Notes were made on emerging concepts and themes repeated in the literature. As the review was an iterative process, the themes and concepts were refined, reworded and regrouped throughout the process to help determine the final interpretation of themes discussed in the review. The relevance and quality of each study was assessed by applying a weighting to the relevance of findings, of the study characteristics and the rigour of the study’s methodology. Appendix C displays a sample of the matrix used to capture this assessment.

As mentioned, context was considered important and one of the main criteria to assess relevance was the study setting. Those in LMICs were considered particularly relevant because of the insights they provided about contextual influences, such as poverty and cultural attitudes towards gender, and how this influenced health worker behaviour. These themes were less prominent in studies from developed countries which were often of higher quality.

The aim of this review was to identify underlying themes emerging from the literature, rather than to complete an exhaustive search and analysis of all published material. Following a systematic approach to the initial and main search as described above, the process became more organic as articles were reviewed and writing began, generating intermittent returns to the databases, to find evidence to further support conclusions, over time. This added several more pieces of literature to the review. The relevance and quality of these studies were assessed in the same way as those found through more systematic searching. Throughout all stages of the review, key concepts and themes were recorded, grouped and regrouped to help determine the final set of themes.

2.2 Results of Literature Review

There are a considerable number of good quality studies from the US, Canada, United Kingdom (UK), Scandinavia and Australia that have examined factors which influence HCPs' decisions to ask about violence and how they respond once FSV is identified. There are a smaller number of studies that have been conducted in LMICs, pointing to some important considerations for settings that are culturally, economically and socially different to Anglo-European countries. Some studies focus exclusively on specific target populations, such as physicians or nurses, whilst others have mixed samples of HCPs that include social workers and psychologists, in addition to physicians and nurses. Research has been conducted in a range of health settings, including hospitals, in particular emergency departments, specialist services like STI and reproductive health clinics, as well as primary care facilities.

The evidence has been grouped into four broad themes covering clinician factors, resource factors, patient factors and enablers with sub-themes within each, as shown in Table 4. Clinician factors are more prominent in this review because the literature search focused on studies with HCPs, rather than survivors or policy makers, and most of the studies use cross-sectional surveys and interviews with samples of HCPs. Additionally, although evidence is presented in discrete categories, many factors are interrelated, and the presentation of evidence here is one of many possible ways to interpret the literature, but is the way which made most sense for this study.

Theme	Subtheme
Clinician Factors	Competency • Knowledge and skills • Training • Confidence, experience Legal Issues Personal safety Role of clinician Fear of offending patients HCP characteristics Personal experience of FSV Attitudes and belief • Stereotypes • Victim-blaming • Acceptance of violence
Patient Factors	Non-disclosure Non-compliance
Resource factors	Time Privacy Lack of interventions, follow-up • Culturally appropriate interventions Policy
Enablers	

Table 4: Factors influencing identification and management of FSV

2.2.1 Health care provider factors.

2.2.1.1 Competency.

Competency is about the ability to perform a task well and is a combination of the ability to apply knowledge and skills and to draw on experience to achieve outcomes (Kak, Burkhalter & Cooper, 2001). Knowledge, skills, training, confidence, experience, preparedness, which are all related to competence, have been examined in research, giving insights into issues surrounding HCPs' competence to identify and manage FSV.

Knowledge & skills.

Lack of knowledge, skills and insufficient training is widely reported in the literature as a barrier to responding to FSV across settings (Al-Natour et al., 2014; Garcia-Moreno 2002; Kaye, Mirembe, & Bantebya, 2005; Sprague et al., 2012), yet, Feder et al. (2009) identified that women have an expectation that HCPs have undergone training and are therefore knowledgeable and competent before they ask about abuse.

Where HCPs lack knowledge, they do not always understand the connection between FSV and health outcomes, which can make it hard for them to explain to patients why they want to ask about the issue (Baig et al., 2012). HCPs often underestimate the prevalence of FSV amongst their patient populations, meaning that they may be unaware of the extent to which FSV is contributing to poor health amongst their patients (Becarria et al., 2012; Krantz, Phuong, Larsson, Thuan & Ringsberg, 2005; Vieira, Dos Santos & Ford, 2012). For example, Sprague et al. (2013) found that American orthopaedic surgeons estimated the prevalence of FSV to be 5%, even though 17% of fractures among female patients are a result of abuse. Lack of knowledge and skills can also mean HCPs do not know how to ask or respond to women after they disclose, which reduces their confidence in dealing with FSV (Efe & Taşkin, 2012; Husso et al., 2012; Laisser, Nystrom, Lindmark, Lugina, & Emmelin, 2011; Maina, 2009; Moreira Sda, Galvao, Melo & de Azevedo , 2008). In LMICs, access to knowledge can be particularly challenging. Al-Natour et al. (2014) reported that 72% of Jordanian nurses did not have access to information and Kaye et al. (2005) found that for nurses in Uganda, the lack of knowledge is compounded by scarcity of information about FSV in standard medical textbooks which are key references. Having knowledge and skills is related to feelings of preparedness and self-efficacy, which have been shown to be factors in determining whether HCPs ask about violence. Further, having good knowledge about FSV has been linked to more positive attitudes towards survivors (Vieira et al., 2012).

Training.

Linked to a lack of knowledge is that HCPs generally have had no or inadequate training on FSV (Becarria et al., 2012; Colarossi et al., 2010; Gutmanis et al., 2007; Kaye et al., 2005; Natan & Rais, 2010). Gutmanis et al. (2007) reported that 60% of Canadian physicians had not received any specific training on FSV. In an Israeli study, Natan and Rais (2010) reported that 44% of nurses had not had any training on abuse. Further, although nurses were aware of the significance of FSV, this did not translate into practice because they perceived they lacked skills. In Zimbabwe, Shamu et al. (2013) reported that midwives had no specific training or skills to identify abused women. This meant that midwives relied on women's willingness to disclose violence, even though midwives acknowledged that very few do. Training is the main mechanism used to increase knowledge and skills, therefore, without adequate training, HCPs are unlikely to feel confident or prepared to ask about FSV or respond to disclosures.

However, studies on the effectiveness of training have produced mixed results. Jayatilleke et al. (2015) found that a four day training of public health midwives in Sri Lanka improved knowledge of FSV and the identification of survivors. They proposed that the culturally sensitive style and content of the training program was a key factor in its success. Lo Fo Wong, Wester, Mol and Largo-Janssen (2007) found improved awareness amongst doctors in a Netherlands study, reporting that the length of training (1.5 days) was the most significant factor in achieving this. Gutmanis et al. (2007) reported an association between training, professional experience and increased feelings of preparedness and self-confidence to ask about IPV. However, these and other studies (e.g.; Chapin, Coleman, & Varner, 2011; Jina, Jewkes, Christofides, & Loots, 2014; Roark et al., 2010) rely on self-reported measures of confidence and competency and did not examine if the training changed practice or increased rates of enquiry over time. As Jina et al. (2014) note, this requires long term follow-up and finding ideal indicators to measure change in HCP behaviour is difficult, particularly as there are many other factors that influence practice.

In a review of the influences on screening, Stayton and Duncan (2005) found that provider training was the most commonly investigated factor and cited three studies in their article (Carbone et al., 1995; Elliott et al., 2002; Parsons et al., 1995) which found that the HCPs who had FSV training were significantly more likely to ask about violence than those who had not received training. However, they concluded that training alone seldom brings about change and adjuncts to training are essential. Other studies, including Papadakaki, Petridou, Kogevinas and Lionis (2013), Ramsay et al. (2012), Ritchie, Nelson, Wills and Jones (2013), all failed to establish that training improved practice around responding to FSV. Schuler et al. (2011) concluded in their study in Vietnam, that even when HCPs were given training, serious under-resourcing influenced motivation and requesting HCPs to take on additional tasks in this environment without monetary compensation could not be achieved. This highlights the challenge of transferring knowledge into practice and the complex interaction of influences on practice behaviour, including resources, organisational support, policy and socio-cultural norms. Training alone is unlikely to be sufficient to change practice on its own.

Confidence, experience, comfort and preparedness.

The complexity of factors influencing practice is demonstrated in the interaction between competency and HCP confidence, experience, comfort, and preparedness. These factors have been considered differently in relation to each other across studies, which makes it difficult to draw conclusions about their respective roles and impact in HCP behaviour. However, they all have been reported to influence HCPs' behaviour toward survivors of FSV.

Confidence or self-efficacy has been found to be a determinant of HCP practice (Chapin et al., 2011). Al-Natour et al. (2014) reported that 61.6% of Jordanian nurses were not confident to refer survivors of FSV, which was related to a lack of access to IPV information. Gerber, Leiter, Hermann and Bo (2005) found that 82% of physicians in a US sample thought it was their role to screen for IPV, but only 68% felt confident to do so. Factors significantly associated with confidence in that study were training and experience. Gutmanis et al. (2007) concluded that professional experience in dealing with disclosure was the key factor contributing to preparedness and Sundborg, Saleh-Stattin, Wändell and Törnkvist (2012) found that being prepared was the only significant variable related to asking about violence.

Preparedness, a concept that appears frequently in the literature (e.g. Krantz et al., 2005; John et al., 2011; Ramsay et al., 2012; Sundborg et al., 2012) is poorly defined, but measured most frequently through questions about knowledge, skills, confidence, attitudes, beliefs, access to resources and experience. As such, preparedness appears to be a more comprehensive measure of the combination of attributes that HCPs need to have to ask about violence and/or provide care and support to survivors. In a UK study, Ramsay et al. (2012) reported that most clinicians had a positive attitude towards survivors and had a basic knowledge of risk factors and clinical issues, but they had low confidence in dealing with abuse with, only 29% of physicians reporting feeling prepared to ask questions about IPV and 24% reporting that they felt prepared to make referrals.

Other studies have discussed the issue of HCPs' discomfort (Colarossi et al., 2010; Sprague et al., 2012, Williston & Lafreniere, 2013). Feeling discomfort is related to lack of knowledge and skills, and lack of confidence, but also to fear of offending patients or perceptions that asking about FSV is not a clinician's role or is not culturally appropriate. For example, Yeung, Chowdhury, Malpass and Feder (2012) found that UK nurses expressed discomfort with asking about violence because of a lack of experience, even though they were satisfied with their training. Williston and Lafreniere (2013) found that Canadian HCPs expressed discomfort around their perceived ability to competently handle disclosure and respond in a fashion that is appropriate and helpful, whereas, Sohani et al. (2013) reported that Indian HCPs' concerns with asking questions on FSV was because they perceived them to be too personal and not compliant with Indian culture.

In sum, training does increases skills and knowledge but may have limited impact on changing practice behaviour because of other factors which intervene. Confidence, comfort, experience and feeling prepared are all important in determining if and how HCPs ask about and respond to FSV.

2.2.1.2 Legal issues.

Another issue for HCPs is fear over the legal implications of working with cases of FSV (Baig et al., 2012; Shamu et al., 2013; Spangaro et al., 2011). Depending on the setting, mandatory reporting requirements can interfere with building relationships of trust, particularly if HCPs are required to report child abuse (Spangaro et al., 2010). This is a barrier for HCPs because it creates a conflict between their need to respect women's decisions, maintain confidentiality and legal reporting requirements. It is also a barrier for survivors, who fear losing their children if authorities get involved (Shamu et al., 2013). HCPs may be required to provide evidence for legal proceedings or testify in court cases, which can be time consuming and can raise safety concerns in situations where HCPs fear repercussions from perpetrators (Baig et al., 2012). For example, Sohani et al. (2013) reported that Indian physicians believed being called to court to testify went beyond what they found acceptable in terms of their role. Further, physicians feared litigation and complaints if they offended women by asking about FSV or reached incorrect conclusions and this would damage their professional reputations. Zakar, Zakar and Kraemer (2011) reported similar perceptions from Pakistani physicians who felt involvement in cases would only lead to embarrassment because FSV is considered a matter to be resolved within the family and outside intervention is discouraged. This points to how cultural beliefs and social norms may not align with the methods of dealing with FSV recommended in Anglo-European laws and policies.

2.2.1.3 Personal safety.

Personal safety is a serious issue for HCPs. In a Turkish study, nurses reported the possibility of being physically attacked by perpetrators or their families. The lack of safety was related to feeling unsafe to work with FSV cases in the hospital environment (Efe & Taskin, 2012). In a South African study, some nurses who lived in the local community were afraid of being criticised for spreading stories if they asked about violence and were worried that they would be targeted by the perpetrators (Joyner & Mash, 2012). Maina and Majeke (2008) described how abusive partners in Tanzania accompany survivors to health facilities and interfere with the consultation. Safety in health facilities is dependent on whether the right infrastructure is in place to provide privacy and security, whether there are protocols that assist nurses to deal with partners and family members, whether there is access to effective security and police and whether there is community acceptance to allow HCPs to deal with cases, which in itself is related to broader cultural beliefs about gender norms of the society. Although not identified as frequently as other barriers, Sprague et al. (2012) found that four out of 22 studies reviewed reported HCP fear of the partner's reaction, however only two out of the 22 studies reviewed were in LMIC and there is limited discussion about the implications of that finding.

From the literature reviewed here, personal safety concerns were reported more frequently in studies conducted in LMIC settings than those in higher income settings. This is not surprising as many LMICs struggle with greater resource constraints, which in turn impact security. Further several of these studies were conducted in countries where men's use of violence against women, especially against their intimate partners, is accepted and considered a private matter. HCP involvement in FSV under these conditions is more likely to meet unfavourable reactions from the men involved. It is important to note however, FSV is not the only health issue which presents safety concerns for HCPs. Working with substance abuse and mental illness can also present dangerous situations. Although beyond the scope of this study, it would be worthwhile to review how safety and security issues interact with HCPs' practices when dealing with those health issues and if there are effective strategies to overcome this.

2.2.1.4 Role of health care provider.

Another frequently discussed barrier is the perception amongst HCPs that it is not their role to ask about FSV or provide assistance beyond clinical care. This has been reported in studies from high income countries (e.g. Colarossi et al., 2010; Husso et al., 2012; Sprague, 2013) as well as LMICs (Al-Natour et al., 2014; Efe & Taskin, 2012; Krantz et al., 2005; Joyner & Mash, 2012). This is largely because many HCPs identify FSV as a social problem and not a health problem, and therefore, believe that the health system has a limited role in helping survivors (Kaye et al., 2005; Joyner & Mash, 2012; Rees, Zweigenthal & Joyner, 2014; Robinson, 2010). In the US, orthopaedic surgeons felt that dealing with FSV was outside the scope of their role, despite the prevalence of IPV and its contribution to fractures amongst their patient population (Sprague et al., 2013). Ramchandaran et al. (2013) similarly reported a lack of awareness about the relationship between FSV and sexual and reproductive health by HCPs in US reproductive health clinics. In their study, although HCPs generally recognised the importance of asking about violence, there was a reluctance to own responsibility for this task. In Angola, HCPs saw their role as providing treatment for physical injuries and did not feel responsible for providing any care beyond this, in particular, psychosocial care. For them, not dealing with FSV was unproblematic because their role was clearly restricted to biomedical care (Nascimento, Ribeiro & Souza, 2014).

Linked to this is fact that HCPs' training is based on a biomedical model of health, which 'fixes' clinical problems, therefore, dealing with health issues which are driven by social phenomena can create tension (Sormanti & Smith, 2010; Williston et al., 2013). Baig et al. (2012) found that Colombian respondents in their study noted that the role of the physician was to stabilise the patient physically and to attend to medical problems, not psychosocial problems. Rees et al. (2014) point out that health care in rural South Africa is focused on acute, episodic care which does not fit the model of service provision for dealing with FSV. This is reiterated by Joyner and Mash (2012) who reported that South African health care practitioners were concerned about having to deal with complex psychosocial issues, which could not easily be treated or fixed, when there were so many obvious biomedical problems. In a Finnish study, Husso et al. (2012) concluded that HCPs intervene and take responsibility for violence when it is medicalised and reduced to an issue of diagnosis and cure. In this way, HCPs restrict themselves to taking practical actions to deal with specific injuries and in doing so distance themselves from engaging in 'messy interventions' required for social problems. The biomedical training of HCPs, does not position or prepare HCPs to deal with complex psychosocial issues, and influences HCPs' attitudes toward dealing with health issues like FSV which have social drivers.

Several studies note HCPs' experiences of frustration when dealing with what is often seen as a time consuming, chronic problem that they are not able to quickly fix (Robinson 2010; Sormanti & Smith, 2010; Vieira et al. 2012). There is no immediate resolution to FSV, unlike other diseases and conditions which HCPs treat. Efe and Taskin (2012) discussed how the idea that FSV was a problem without a solution led to a sense of learned hopelessness amongst HCPs. Such experiences are compounded when HCPs lack skills to deal with FSV or resources to support survivors following disclosures. Further, dealing with FSV can be seen to take time away from what HCPs consider to be more important health issues (Colarossi et al., 2010; Joyner & Mash, 2012; Sprague et al., 2012). For example, in a Zimbabwean study, midwives differentiated FSV from clinical work and saw it as a burden added to their already demanding workload (Shamu et al., 2013). This can act to discourage HCPs from wanting to actively ask about FSV and provide anything beyond treatment for presenting injuries.

Two studies highlighted how role perception is linked to broader social and cultural norms about FSV. Zakar et al. (2011) reported that all physicians interviewed considered screening unnecessary and unfeasible in Pakistan and a waste of time and resources because FSV is seen largely as a private matter in which HCPs should not get involved. Further, these physicians noted that the health care system was not set up to deal with FSV and there were too many structural limitations, such as profit-oriented practice, the existing medico-legal system, the biomedical approach to health care and the lack of availability of mental health and social services, for them to be able to handle FSV. Thus it appears that FSV in Pakistan is not considered an issue to be dealt with by the health sector. Sohani et al. (2013) reported that Indian doctors felt patients would perceive it as not a doctor's role, particularly in private-sector facilities, to ask about private issues like abuse, and by doing so, they risk offending patients who will decide not to come back to their practice. Analysis of the influence of culture norms on professional identity and how this interacts with the ways HCPs respond to FSV was not prominent in the literature but would be worthy of further exploration, particularly in contexts such as Pakistan and PNG, where cultural norms accept the use of male violence against their female partners.

However, it should be noted that other studies have found more positive responses from HCPs about their role in responding to FSV, including acceptance of FSV as a public health issue and acknowledgement of the responsibility of HCPs to ask about abuse (De Boer et al., 2013; Maina, 2009; Sprague, Hatcher, Wollett, & Black, 2015; Vieira et al., 2012). Laisser, Lugina, Lindmark, Nystrom & Emmelin, (2009) reported that Tanzanian HCPs perceived their roles to extend beyond clinical care and to include anti-violence advertising within women's associations, conducting awareness during mobile clinics and providing education during home visits. HCPs in a Kenyan study identified several roles they fulfil, including being experts in addressing medical consequences, counsellors, health educators to inform about preventive health needs and community educators with a duty to raise awareness (Maina & Majeke, 2008). These studies illustrate that many HCPs provide services beyond clinical care.

Further, studies like Al-Natour et al. (2014), which reported that almost half (49%) of the participants agreed it was not their role to ask about IPV, by default demonstrate that half agreed that it was their role, but the researchers chose not to highlight this. Similarly, Kaye et al. (2005) reported that 24% of Ugandan health workers in a hospital did not perceive domestic violence as a public health issue, but in that study 71% agreed that it was a public health issue and 10% (included in the 24%) were actually undecided. This is perhaps because the literature is overwhelmingly focused on barriers to working with FSV rather than on enablers. So whilst perceptions of the clinician's role may be a barrier, it is not insurmountable and not shared by all HCPs.

2.2.1.5 Fear of offending women.

Several studies raised the issue of HCPs' fear of offending women if they ask about FSV (Al- Natour et al., 2014; Robinson, 2010; Somanti & Smith, 2010). Al–Natour et al. (2014) reported that up to 60% of nurses believe that asking about violence would offend patients and Sprague et al. (2013) reported that 21% of surgeons feared offending patients. Sormanti and Smith (2010) reported that HCPs believe that patients would be offended because asking about FSV is a judgement that they are a survivor and this would damage their relationship with the patient. This is contrary to evidence from women who report acceptance of enquiry about violence.

2.2.1.6 Health care provider characteristics: Age, profession and gender.

A few studies have looked at the influence of age and profession on the likelihood of HCPs asking about FSV, with inconclusive results. Firstly, being older seems to be related to more negative responses to FSV. Jaffee, Epling, Grant, Ghandour and Callendar (2005) found that older physicians reported more barriers to asking patients about FSV. Likewise John et al. (2011) reported an association between increasing age and being male with the likelihood to blame the victim and Mitchell, Parekh, Russ, Forget and Wright (2013) found that older participants were more likely to accept justification of violence, as did Haj-Yahia, Sousa, Alnabilsy and Elias (2015). Vieira et al. (2012) found that younger women had more sympathetic and helpful attitudes towards women living in violent situations. This could be related to type of education and training, assuming that older HCPs have had less exposure to newer paradigms in health, such as social determinants. It could also be that older HCPs are more likely to hold traditional gender norms which influence their attitudes to FSV. The causes of these findings were not explored in any depth in these studies, as age was not a central feature of the designs.

Differences between professional groups have been examined but only as a relatively minor issue. Jaffee et al. (2005) found that knowledge barriers were reported less amongst obstetricians than among other HCP groups. This is understandable given the nature of obstetric work. Beynon, Gutmanis, Tutty, Wathen & MacMillan, (2012) reported that nurses more frequently described language, partner presence and lack of privacy as barriers than physicians, which was thought to be related to role expectations, and Ramsay et al. (2012) reported that GPs had more positive attitudes towards women experiencing abuse, were more knowledgeable and more proactive, in comparison to practice nurses, which they suggested could be related to level of experience (Ramsay et al., 2012). Differences between professional groups are important given that HCPs play different roles in different countries. In Colombia, emphasis is placed on physicians to detect and treat IPV, rather than nurses (Baig et al., 2012). In Tanzania, public health nurses, not midwives, attend antenatal consultations (Shamu et al., 2013). So it is important to acknowledge that in certain settings, some HCP groups may hold more positive attitudes to FSV than others and that different health systems delineate different responsibilities to their health personnel. This has implications for understanding evidence and then applying that evidence to designing interventions.

Studies which commented specifically on gender included John et al. (2011), who reported that female care givers (along with doctors more broadly) were less likely to blame victims. Jaffee et al. (2005) found that males reported more barriers than females and that patients reported a higher level of comfort talking to females. However there was no difference in patient satisfaction with care between male and female providers. One of the reasons why the gender of provider may not appear more frequently as a variable is because many studies have either a majority male or majority female sample, which reduces the ability to analyse for the impact of gender amongst HCPs. For example, Haj-Yahia et al. (2015), who commented on the relevance of age of HCP, had a majority male sample and Beynon et al. (2012), who commented on professional groups, had a majority female sample.

2.2.1.7 Personal experience.

Given the prevalence of FSV in the general population of women, reported by WHO as 33%, it can be assumed that a similar rate of prevalence exists among female HCPs. For example, in Guyana, Mitcheli et al. (2013) reported that 50% of HCPs surveyed had experienced FSV and 21% had perpetrated FSV. The impact of personal experience of violence on HCPs' responses to survivors has been examined, with mixed results. Beynon et al. (2012) found that nurses and physicians who disclosed their personal experience of abuse said that their experience helped them to deal with survivors. Christofides and Silo (2005) identified that personal experience of violence was related to higher quality of care amongst South African nurses. They suggest that nurses who have experienced IPV were more empathetic, but did not explore this in their research. However, in another South African study, Joyner and Mash (2012) concluded that because many HCPs have experienced IPV, they may find it difficult to deal with this in their professional role, leading to reluctance to ask about IPV. In a Swedish study, Stenson and Heimer (2008) specifically examined the relationship between personal experience and caregiving and found that experience of FSV was not associated with increased practice and knowledge. They postulate that some HCPs may be preoccupied with their own situation and do not want to be reminded of their experience. In general the influence of personal experience is under-reported in studies looking at barriers but potentially has significant implications, particularly in countries where there is higher gender inequality and higher prevalence of IPV.

2.2.1.8 Attitudes and beliefs.

Stereotypes

Globally, attitudes and beliefs influence practices towards survivors. HCPs can hold stereotypical beliefs about what survivors look like, their social backgrounds and their behaviour, and these beliefs influence what HCPs do in practice. Frequently reported stereotypes include the notions that FSV occurs amongst people who are poor, have lower education and have problems with drug and alcohol use. In the US, Tower (2006) found that some nurses believed survivors exaggerated or lied about facts to get revenge or obtain additional support, and categorised them as likely to have problems with alcohol and drug use. This meant that nurses frequently questioned the credibility of survivors' stories. Beccaria et al. (2012) found that Australian student nurses held stereotypes including that perpetrators were domineering males who were abused themselves as children and were drug or alcohol dependent and were more likely to be from an ethnic minority. Having preconceived ideas about who is impacted by FSV and under what circumstances, is a missed opportunity to adequately identify FSV and provide care.

There is also evidence that stereotypical beliefs influence how empathetic HCPs feel towards survivors. Nicolaidis, Curry and Gerrity (2005) reported that American HCPs had diminished empathy for survivors who were described as healthy, educated, and middle class with financial stability but found it easy to empathise with survivors who were poor, uneducated, depressed or physically disabled. The authors concluded this was because HCPs lack education and understanding about abuse. Koistinen and Holma (2015) found that Finnish HCPs believed patients experiencing FSV are easily recognisable because they present with "classic characteristics", such as being damaged or disturbed, emotional, had visible and recurrent injuries, and reported being in troublesome relationships. These characteristics differentiated these patients from ‘normal’ patients. This study also confirmed that HCPs rely on their ‘intuition’ to identify abuse, which is troubling given the degree to which they held stereotypes about survivors.

Similarly, Zakar et al. (2011) found Pakistani physicians differentiated between ‘real victims’ and ‘pseudo victims’ based on social status, education and profession of husband. Where women did not fit stereotypes of being poor, lowly educated, with criminal or alcoholic husbands, physicians questioned why they should intervene. In circumstances where the survivors do not fit stereotypes, HCPs do not accept the FSV as genuine because there are no extenuating social circumstances to explain the violence. This is related to socio-cultural beliefs about gender roles in marriage and the degree to which violence against female partners is accepted in Pakistan, and is discussed below. However in India, Chibber et al. (2011) found that physicians were less sympathetic to women from lower socio-economic backgrounds, believing that their lifestyles were the cause of their problems, whereas the physicians could relate to wealthier, middle-class survivors. These studies point to the influence of different interpretations of socio-economic status by HCPs on their treatment of survivors

Victim blaming.

Blaming female survivors for causing or contributing to violence is common amongst HCPs. For example, Sprague et al. (2013) reported that American orthopaedic surgeons believed women get something out of abusive relationships and that their personalities contribute to violence. In Angola, there were HCPs who believed that women who stay in relationships enjoy beatings (Nascimento et al., 2014).

Al-Natour et al. (2014) reported that 72% of Jordanian nurses agreed that victims’ personalities contribute to IPV and 52% agreed that people choose to be victims. HCPs position survivors as responsible for causing violence and see the decision to stay in a relationship as an individual choice, despite cultural norms that accept male use of violence against their partners. Koisten and Holma (2015) reported that Finnish HCPs believed survivors could not be helped unless they left their violent partner. These attitudes place responsibility on the survivor to make changes to their circumstances and when they fail to do this, they become a lower priority to help. In Uganda, Kaye et al. (2005) reported that it is normal to discipline wives and thus when FSV occurs against women, it is accepted that she must have done something to cause it. In Zimbabwe, some male HCPs blamed women for failing to comply with marriage norms and therefore sanctioned the violence perpetrated against such women and because of these attitudes, they felt screening for IPV was a waste of time and resources (Shamu et al., 2013).

These studies highlight how beliefs about gender roles hold women responsible for the violence perpetrated against them and because of this, survivors become less deserving of assistance. This in turn affects HCPs' decisions about how much resources, time and energy they are willing to allocate to treat and care for survivors. Victim blaming attitudes demonstrate a lack of knowledge amongst HCPs about the nature of violence and are underpinned by a broader societal acceptance of violence and beliefs about gender roles.

Acceptance of violence.

In this review, the link between societal acceptance of violence and HCP behaviour is highlighted, particularly in studies from LMICs. This reflects the higher levels of gender inequality and socio-cultural beliefs about gender roles and marriage in these countries and possibly recognition by researchers from these countries that such attitudes and beliefs are important to acknowledge in public health research.

Nascimento et al. (2014) found that HCPs' perceptions of survivors were heavily marked by cultural constructions of male and female roles that justified and reinforced male domination in the household and in particular the notion that abuse is a private problem between couples where clinicians should avoid intervention because this would invade privacy. Haj-Yahia et al. (2015) reported that a substantial percentage of Palestinian physicians justified 'wife beating', believing that battered women benefit from beatings, but at the same time they reported a tendency to help women. Seventy-three per cent agreed or strongly agreed that wives deserve to be beaten in certain marital circumstances, which included making fun of manhood (47%) and reminding husbands of weak points (35%). This study found that patriarchal beliefs played a larger explanatory role in explaining wife beating than social learning (as measured by witnessing FSV as a child). The more physicians maintained sex-role stereotypes and non-egalitarian expectations of marriage, the greater their tendency to justify wife beating (Haj-Yahia et al., 2015). This is one of the few studies that have attempted to test theoretical explanations for the beliefs of HCPs and it shows that socio-cultural belief structures play a role in determining practice behaviour.

In a Turkish sample, Efe and Taskan (2012) reported that 69% of females and 84.7% of males accepted at least one reason to justify physical violence. The most frequently accepted reason for using violence was 'deceiving the husband', which is considered taboo in Turkish society and is a frequent reason for honour killings. This highlights that what is valued or emphasised as important in partner relationships in one cultural setting will be different from another and it is important to understand the role and place of such beliefs and values when considering service delivery because they will influence whether or not HCPs believe they should provide support to the survivor. If HCPs believe that the cause of a woman's injuries is from committing a culturally prohibited act, they will be less sympathetic in providing care and treatment. This also has implications for how HCPs are perceived by the rest of their peers and the community. HCPs may be stigmatised or ostracised for intervening in what the general population has sanctioned as appropriate behaviour.

This issue was reported by Zakar et al. (2011), who found that physicians felt screening was unnecessary and unfeasible in Pakistan and a waste of time and resources. This was in part because physicians were pragmatic about the acceptance of FSV more broadly and felt that if they went against this, there would be ramifications for their reputations and patient relationships. HCPs provide services that align with the dominant social ideology as expressed in the saying '*family privacy is sacred, obedience to the husband is essential, to be silent is a virtue and to be faithful is highly valued*', therefore any acts to support women's autonomy and empowerment are discouraged (Zakar et al., 2011). However in an

Indian study, Chibber et al. (2011) found that some female physicians were acting as 'champions' and were more likely to promote human rights and equality between men and women. This was reflected in their practices towards survivors. The other physicians in the study were more likely to hold traditional norms, including accepting women's subordinate position and confinement to domestic chores and child rearing. Those who held such attitudes were found to not refer FSV patients and to be ambivalent about asking about violence. In contrast the champion physicians did refer patients and were proactive about being informed of resources and where in contact with a range of support networks.

A few other researchers (Al-Natour et al., 2014; Laisser et al., 2009; Rees et al., 2014; Shamu et al., 2013) commented on the fact that HCPs' behaviour is influenced by broader socio-cultural belief systems. Male dominance and a lack of autonomy amongst women are noted as additional barriers to identifying and responding to FSV. Where FSV is seen as a shameful and private matter, it can be difficult to engage women who remain silent. At the same time, as Laisser et al. (2009) point out, it can also be challenging to access support from communities. HCPs are members of the societies in which they live and work and are embedded in the cultural belief systems. Where traditional gender norms hold and FSV is normalised, identifying FSV is often a low priority for HCPs. Further, these beliefs are replicated, both explicitly and non-explicitly, in the ethos of that society's institutions, including those providing health care. Rees et al. (2014) evaluated a comprehensive intervention for IPV in rural South Africa but found numerous barriers. They concluded that for the intervention to be effective there would need to be transformational change to the values and attitudes amongst service providers and community members. The intervention was given a low priority because of the normalisation of IPV in the community and the perception that the health system has a limited role to play.

The importance of the role of cultural beliefs and societal norms around marriage and the use of violence in informing health care practice, particularly in relation to FSV, cannot be underestimated. However, it is poorly discussed in the Anglo-European literature, which informs the lion's share of the evidence base about practice and interventions. For example, Beynon et al. (2012) reported from qualitative comments that some HCPs in their Canadian sample recognised the link between cultural norms, acceptance of violence and disclosure, however in the same study, only 18% of nurses and 8.8% of physicians cited language and cultural practices as barrier. Whilst the article does not describe the patient populations of the participants, the sample size was 931, and we can assume that a number of the participants would be working with multiple ethnic groups. The issue was not discussed in the discussion section by the authors.

Attitudes towards helping survivors are complex to unpack. Not all findings on attitudes towards survivors are negative. For example, Ramsay et al. (2012) found that most clinicians reported a positive attitude towards responding to women. Beccaria et al. (2012) found that Australian student nurses believed their role should include building trust and acting as advocates and they identified that they needed skills to be empathetic, compassionate, improve their communication and have non-judgemental attitudes. Several studies, including some of those mentioned above, despite reporting a number of negative attitudes of HCPs towards survivors, also show that HCPs see that they have a responsibility to do more to assist survivors, (Nicolaidis et al., 2005), show willingness to help survivors (Haj-Yahia, et al., 2015), and are willing to improve their support to FSV patients (Laisser et al., 2009). The point is that HCPs can hold multiple and conflicting beliefs. The desire to help and care as a health professional can come into conflict with the broader beliefs they may hold about FSV. Even where HCPs may want to help, they may hold back because of perceived consequences from their communities.

2.2.2 Patient factors.

Two key issues emerged from the literature about patients' behaviour that influence the way HCPs respond towards to them. It is likely that there are many other factors that influence patients' experience of service delivery, but this was not a focus of the literature included in this review.

2.2.2.1 Non-disclosure.

Patient non-disclosure is cited as a barrier to HCP identification of and responses to FSV, in both high income and LMI countries (Baig et al., 2012; Husso et al., 2012; Laisser et al., 2009; Maina, 2009; Robinson, 2010). Non-disclosure is often a deliberate choice by a survivor but influences HCPs' practice in a number of ways. If survivors do not disclose abuse, it can be difficult for HCPs to provide appropriate treatment and intervention, especially where they lack skills and knowledge in working with survivors. Additionally, HCPs express frustration when they perceive patients are trying to conceal abuse because it stands in the way of care (Maina, 2009). Evidence suggests that HCPs hold stereotypical views about survivors, like that they don't tell the truth, but assume that survivors will volunteer information about their personal lives. At the same time, many HCPs lack understanding about the reasons why survivors may choose not to disclose (Maina, 2009; Robinson, 2010; Sormanti & Smith, 2010). This leads to frustration because patients are seen as deliberately withholding information. This in turn acts as a disincentive for HCPs ask about FSV or to take time to provide appropriate care. Yet regardless of whether survivors disclose, talking about FSV can validate survivor's experiences, be an opportunity to provide information about sources of support and break isolation. Beynon et al. (2012) connects the frustration felt by HCPs over non-disclosure to the 'results-orientated' paradigm of medicine, which is linked to earlier discussion about frustrations over not being able to 'fix' the problem of FSV. Where HCPs lack knowledge about the nature of FSV, believing that survivors will not disclose, which is often reaffirmed by survivors behaviour, works to prevent them from investing time and energy into what many see as a complex issue and outside the scope of their clinical work (Beynon et al., 2012).

2.2.2.2 Non-compliance.

Another source of frustration for HCPs, reported in US and European studies, is the perception of patient non-compliance. When women return to abusive situations or do not take up referrals, some HCPs perceive this as non-compliance with the recommended 'treatment' or pathway to stop the abuse (Gutmanis et al., 2007; Husso et al., 2012; Robinson, 2010; Spangaro et al., 2011). Recurring encounters with the same women can be frustrating for HCPs, particular where they feel they have invested time and energy in offering assistance to help women make changes to circumstances that significantly impact upon their health (Husso et al., 2012; Robinson, 2010; Spangaro et al., 2011). This leads HCPs to hold survivors responsible for repeat cases because they believe the survivor has chosen to stay with their violent partner and under such circumstances they cannot be helped (Husso et al., 2012; Koistinen & Holma, 2015). This reflects a lack of knowledge amongst HCPs about the reasons why survivors decline help or stay with an abusive partner and reiterates the challenges for health workers who are trained in a biomedical model of care in responding to a socially derived health issue.

2.2.3 Resource factors.

The reality for many health care facilities is that they frequently operate with serious time and resource constraints, a scenario that is significantly more pronounced in LMICs (Husso et al., 2012; John et al., 2011; Laisser et al., 2009; Schuler et al., 2011). A lack of resources is one of the most frequently cited barriers, regardless of facility type, country and HCP group. In many LMICs, the health sectors are characterised by poor and deteriorating physical infrastructure, limited supplies, low salaries for HCPs, inadequate leadership and supervision, few opportunities for quality training and continued professional development and a small number of properly qualified personnel to service large and growing populations (Kulkarni, Bell, & Rhodes, 2012; John et al., 2011; Laisser et al., 2009; Schuler et al., 2011). These conditions inhibit the capacity of HCPs and health systems more broadly to respond appropriately and effectively to complex health issues like FSV. Further, as D'Avolio (2011) points out, struggling to deliver care in under-resourced environments with a lack of organisational support can lead to inadequate and even harmful responses.

2.2.3.1 Time.

A lack of time was perhaps the most frequently cited barrier to enquiry reported by clinicians. Studies in hospital and clinic settings with physicians (Sormati & Smith, 2010; Zakar et al., 2011), nurses (Efe & Taskin, 2012 , Guillery et al., 2012, Joyner &

Mash, 2012; Sprague et al., 2013), as well as with HCPs more broadly (Baig et al., 2012; Colarossi et al., 2010; D'Avolio, 2011; Ramchandaran et al., 2013; Vieira et al., 2012; Yeung et al., 2012) all report time as a barrier. A lack of time is cited as a challenge to both asking about FSV, as well as providing any additional support or dealing with the issue once a disclosure takes place. Further, in settings where HCPs manage high volumes of patients or which are busy and hectic by nature, such as emergency departments, FSV can be perceived as creating extra workload on already stretched resources (D'Avolio, 2011; Joyner & Mash, 2012; Laisser et al., 2009; Sormanti &Smith, 2010). Perception of lack of time is also linked to lack of experience because HCPs who are unsure about what to do, perceive they cannot efficiently manage the case if disclosure takes place (Vieira et al., 2012; Yeung et al., 2012). For example, Beynon et al. (2012) reported that 27% of nurses and 46% of physicians in a Canadian sample reported time as barrier which was linked to the complexity of dealing with FSV. HCPs felt unable to provide emotional support, to develop a relationship and make time to listen because of the environment and workload. Without skills or appropriate interventions, including referrals, HCPs may perceive that they are wasting time asking about FSV when they could be attending to other important priorities. Time is reported as a barrier for HCPs across countries, however, in LMICs the issue of time is compounded by the fact that there are more significant resource constraints, in particular, lower numbers of suitably qualified staff. This conclusion raises questions about the efficacy of screening policies. Screening is time intensive and time is one of the most frequently cited reasons for not asking about violence, which highlights the fact that interventions cannot be developed in isolation from the context in which they will be implemented.

2.2.3.2 Privacy.

A lack of private spaces and an inability to see patients alone is an obstacle for many HCPs (Garcia-Moreno, 2002; Sprague et al., 2012). Particularly in LIMC countries, health infrastructure often does not have private rooms or spaces that HCPs can use to talk with women alone (Kaye et al., 2005; Laisser et al., 2009; Rees et al., 2014; Schuler et al., 2011). In Tanzania, Laisser et al. (2009) identified that the open ward settings makes it is difficult for HCPs to create trust and ask about FSV. HCPs felt that the poor physical environment contributed to “maintaining the silence”. In Turkey, where sociocultural beliefs dictate that FSV should be resolved within the family and that the family union needs to be maintained, nurses questioning women about FSV can invite attacks from relatives attending the hospital with the survivor, yet 30% of nurses in a survey said there was no suitable place to be alone with survivors (Efe & Taskin, 2012). The lack of privacy heightens safety risks for both survivors and HCPs. If HCPs do not feel safe to ask about violence, they do not ask (Efe & Taskin, 2012). This is a particular challenge in LMIC settings because the low levels of funding for infrastructure mean that facilities are often designed with large, open wards and outpatient spaces, with limited private and enclosed rooms.

Even in settings where there may be private rooms available, the type of service may prevent an opportunity to be alone with patients. Sprague et al. (2013) reported that orthopaedic surgeons are often accompanied by surgical interns and other specialists and that fracture clinics are open rooms with only curtains used to separate patients, so having a conversation about FSV is not appropriate, even though 17% of female patients with musculo-skeletal injuries in the US are survivors of FSV. Furniss et al. (2007) found that 91.7% of participants in a US sample of perinatal services reported the inability to ask questions in private settings as a barrier, and 74% of those ranked it as their number one barrier. In maternal health settings, partners are often encouraged to attend appointments as part of inclusive care which can provide a challenge for midwives to ask women about FSV (Furniss et al., 2007; Spangaro et al., 2011), although Spangaro et al. (2011) found that most midwives had strategies to get time with women alone.

Being able to create privacy to discuss FSV means there must be both appropriate infrastructure and processes or procedures that allow HCPs to be alone with patients. This is essential for HCPs to develop a relationship of trust and maintain a level of confidentiality which will enable safe disclosure.

2.2.3.3 Lack of interventions, follow-up, referrals.

A lack of effective interventions is a deterrent for HCPs to ask about violence (Colarossi et al., 2010; Gutmanis et al., 2007; Laisser et al., 2011; Sprague et al., 2012). As discussed in Chapter 1 screening, and associated interventions can be resource-intensive to implement and rely on the availability of referral sources, trained HCPs and institutional support. Even then, as Hegarty et al. (2013), Kozoi-Maclain et al. (2010) and MacMillan et al. (2009), have demonstrated, interventions may not have an impact on health outcomes or result in the reduction of violence. Where HCPs have inadequate options to refer patients or lack skills to deal with the situation themselves, they can end up feeling frustrated and powerless to help. Robinson (2010) found that emergency department (ED) nurses felt frustrated when they were unable to help survivors which led them to question whether asking about violence was beneficial or necessary because they were unable to resolve the problem. D'Avolio (2011) reported that nurses worried about discovering that the referral source, in this case an IPV advocate, was not available after making a positive identification. The importance of available, on-site support, in increasing identification rates was shown by Ramchandaran et al. (2013) and Spangaro et al. (2010). These studies were conducted in Australia and Canada where the feasibility of on-site services and access to appropriate support services is more likely. Availability of support services in LMICs is more challenging.

In a Jordanian sample, Al-Natour et al. (2014) reported that 78% of nurses did not have access to social workers and 73% did not have access to mental health services. Further, only 50% of nurses thought that a social worker would be able to provide help. This led the authors to conclude that even if Jordanian nurses were educated about community services, it is unlikely they would make any referrals because of a lack of availability. Similarly, the lack of psychosocial services was noted by Nascimento et al. (2014) where HCPs report treating physical injuries only, without referring to psychological or social follow–up, partly because there are few such services in Angola. In Kenya, a lack of resources and shelters for survivors was noted (Maina, 2009). Support from police has also been reported as problematic in LMICs, as women are likely to receive unfavourable treatment or no help at all (Laisser et al., 2009; Sprague et al., 2015). This limits options for protection from perpetrators for survivors who disclose and HCPs who try to help. Lack of appropriate support services is a critical barrier for responding to FSV in LMICs and a deterrent to asking about FSV.

Cultural appropriateness of interventions.

Further, approaches to FSV that have been trialled in Anglo-European countries many not be effective in other settings. In Tanzania, nurse s viewed routine screening to be unfair because it biased partner violence against women, neglected other types of violence, and did not include men and children. This is in a context where 22% of women screened had experienced violence at the hands of a relative, indicating that family violence more broadly is an issue in Tanzania (Laisser et al., 2011). Chibber et al. (2011) noted that even when they lacked training, Indian female physicians were using culturally appropriate ways of asking about FSV, building trust and working with families to resolve issues. In India, a woman's marital family often instigates violence, whereas the natal family can be a source of support. Involving families does not contravene laws or ethics involving privacy in India and may thus provide a more effective approach to prevention. These two examples highlight the need for research to consider the cultural context for implementation of interventions.

2.2.3.4 Policy.

Some researcher haves noted the absence of FSV policies or protocols as a barrier, however this has featured less than other health system constraints (Guillery et al., 2012; Thurston & Eisener, 2006; Sprague et al., 2013). For example, Thurston and Eisener (2006) reported that the failure to implement screening protocols in health in the US & Canada was not because of a lack of interest on the part of HCPs, but an absence of policy, lack of resources in the community or lack of guidelines. However, beyond noting an absence of policy, research does not explore how policy enables better practice in relation to FSV. The availability of protocols and guidelines has been noted as enabling identification and some of the screening o/[[[[[[[[[[[[[[[[- +studies which test protocols have confirmed that the availability of a protocol has i21|*///////ncreased identification rates (Spangaro et al., 2010) but, as discussed, evidence on whether this leads to better health outcomes is inconclusive. Ty62\1

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2.2.4 Enablers.

Several studies identify factors which facilitate or enable HCPs to work with survivors. These include adequately trained and confident HCPs, having structured procedures such as scripted questions, having protocols for referrals, having institutional policies on how to respond post-disclosure, and having access to referrals, particularly on-site services (Kirst et al., 2012; Sprague et al., 2013; Sundborg et al., 2012).

2.2.4.1 Use of protocols and tools

Laisser et al. (2009) noted that protocols and tools provided a mechanism for HCPs to obtain adequate information to make a proper diagnosis and in this way, made the HCPs' job easier. In addition, for these Tanzanian HCPs, a screening tool provided an opportunity to talk to women. However, conclusions about what works are rarely considered alongside other issues raised as barriers, such as time. As discussed previously, having HCPs who are trained, confident and feel prepared has also been shown as an important factor. The availability of referrals is also crucial because this is the main intervention that HCPs can offer to survivors. Without referrals, HCPs can feel that their time and energy is not well used because they cannot offer women the support or care that they need.

2.2.4.2 Commitment to help people and provide care

Another important enabler is the positive attitudes of HCPs to provide help and care. Although problematic attitudes of HCPs have been identified as a barrier, there is also sufficient evidence that shows that many HCPs understand the relevance of FSV as a health issue, are sympathetic to survivors and are motivated to provide care (Husso et al., 2012; Laisser et al., 2009; 2011; Nicolaidis et al., 2005; Sprague et al., 2015; Tower, 2006; Vieira et al., 2012). Further, HCPS can and do play multiple roles in responding to FSV which extend beyond provision of clinical treatment for injuries to providing health education, raising community awareness and working as advocates (Maina & Majeke, 2008; Sprague et al., 2015).

Other studies have also shown that HCPs are often already using their own strategies to respond to and support survivors. Spangaro et al. (2011) showed that midwives use their own techniques, such as inventing urine tests to make sure they get time alone with women to ask them about FSV without raising the suspicion of attending partners. Laisser et al. (2009) reported similar actions by Tanzanian midwives who detect family problems from subtle cues. For example, a mother attending a facility without family or supplies, which is unusual in Tanzania, may be held in hospital until the midwives are able confirm support for her on returning home. In this same study, midwives acknowledged their own ability to guide and counsel patients.

Sprague et al. (2015) pointed to the innovation and responsiveness of the South African health care system in a time of reform and change. They concluded that despite a lack of support, nurses were already attending to the needs of female patients and did not need to wait to be told through policy to do so. This was in reference to the HIV response, where South African nurses and health care personnel began to treat and care for HIV patients long before the advent of government policy recommendations. In India, Chibber et al. (2011) found that there were ‘physician champions’ who regularly informed survivors of their rights and helped them to access support services. These physicians exhibited attributes of self-reflection, self-commitment and motivation linked to attributes of physician leaders. These champions saw it as their duty to advocate against the injustice that women experience and inform them of their rights and choices. They went out of their way to be informed about support services and develop networks amongst these providers. Laisser et al. (2009) found a strong will amongst HCPs to improve their support to IPV clients. The HCPs acknowledged their own ability to guide and counsel clients and their responsibility to change attitudes in the community.

These examples speak to the commitment and motivation of HCPs to provide care and healing to their patients. This should not be understated and perhaps provides the greatest opportunity for bringing about more positive health outcomes for survivors in the health system.

2.3 Conclusion

This review took a thematic approach to analysing the literature and identified four groups of factors that influence how nurses ask about and manage cases of FSV. These included clinician factors, patient factors, resourcing issues as well as factors which work as enablers. There was considerable more focus on barriers or factors which prevent HCPs from asking about FSV or providing treatment and care than on factors which enable better treatment and care of survivors. A key issue arising from this review was the lack of attention to how these factors operate differentially across contexts. Whilst it is evident that many issues are shared across health cadres and countries, it is less clear how these issues influence nurses in different settings. In particular, how the availability of resources and the broader cultural beliefs that influence HCP behaviour are not often explored research, a point but acknowledged by Sprague et al. (2015) who call for more research in LMICs to understand the “how” and “why” of nurses actions. There were no PNG studies available to inform this review, yet the effectiveness of future interventions in PNG depends on having nuanced evidence. Hence this study will begin to fill an important research gap by exploring not only what influences the practices nurses towards survivors of FSV of HCPs in PNG but how and why.

Chapter 3: The Research Setting - Papua New Guinea

This section will provide background information about Papua New Guinea, starting with a description of its geography and social demographics, followed by a short synopsis of the major constraints to the health system, along with current health policies and services targeting survivors. It is important to note that the quality of data on PNG is poor and statistics are often out-dated. Equally important to this study is consideration of the cultural norms and beliefs about gender in PNG and the role they play in creating gender inequality and enabling family and sexual violence. This is done with full acknowledgement that interpretations of culture and belief systems and what they mean are complex and contested, especially when presented by people living outside of those systems. This chapter does not purport to be a detailed description of the health system, or causes of or nature of FSV in PNG, but rather an insight into the research setting which is important to understand because of the implications for health service delivery.

3.1 PNG Population Demographics

Papua New Guinea is a Pacific nation with immense geographic, cultural and linguistic diversity. The landscape is characterised by tropical rainforests, mountains, savannah, grass plains, wide rivers, swamps, lagoons, and islands, with an array of ecosystems. PNG is comprised of over 600 islands and has the largest number of active volcanoes in Melanesia. The highest peak rises to 4500 metres (Cammack, 2009). The rugged terrain has prevented the establishment and maintenance of infrastructure and services in remote areas and is the underlying factor in the continued isolation of many rural communities (Cammack, 2009; Jayasuriya et al., 2012). The country's population is just over seven million, with 35% estimated to be under the age of fifteen (National Statistics Office [NSO], 2015). There are over 800 distinct languages spoken and much of the population is organised in small ethnic groups with strong identities and traditions. This contributes to a weak sense of nationhood (Cammack, 2009). Internal migration from rural to urban areas is increasing, although around 85% of the population still live in rural areas and rely on subsistence farming for their livelihood (NSO, 2015). The structure, traditions and cultures across communities in urban settlements, rural villages, and resource (mining and logging) enclaves are highly variable, meaning that there are great differences in lifestyles amongst Papua New Guineans (Amnesty, 2006).

Few people are employed in the formal economy and there are limited employment opportunities for the burgeoning population of young people. Only 6.6% of the population have completed Grade 12 and only 4% of females have a qualification beyond Grade 12 (NSO, 2015). The nationally reported adult literacy rate is 67.6%, however a recent study of amongst Grade 6 students in five provinces found that functional literacy rates ranged from 4-25% and was less than 15% in four of the surveyed provinces (Australia South Pacific Association for Basic and Adult Education and PNG Advocacy Network, 2011).

PNG is classified as a Lower Middle Income Country but increased revenue from mineral income and steady economic growth in recent years, has not translated into improved health and social well-being (Assante & Hall, 2011; The World Bank, 2015). It is estimated that 40% of citizens live in poverty on less than US$1 per day and improving government spending so that it is equitable and inclusive remains a challenge (NSO, 2015). PNG is one of the few countries that did not meet any of the Millennium Development Goals (MDGs) (Howes, Mako, Sawn, Walton, Webster, & Wiltshire, 2014) and is ranked 158th out of 185 countries on the human development index meaning it is classified as a country with low human development (United Nations Development Program, 2015).

Amnesty (2006) claim that PNG suffers from an epidemic of violent crime, including robbery, assault, murder, armed hold ups, gang rape, tribal fighting and election-related violence. Homicide rates in Lae and Port Moresby are 66 and 33 per 100,000 respectively, three times the global average and amongst the highest in the world[2] (Lakhani & Willman, 2014). Robbery and assault are the most commonly reported types of crime with other major crimes in PNG including pervasive corruption,

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[2] Data on homicide is problematic in PNG. Royal PNG Constabulary data fluctuates considerably from year to year and the differences between victimisation surveys and official crime data are usually large (Lakhani & Willman, 2014)

violence against women, transnational crime, and tribal and other localised conflicts often over land or resources (Lakhani & Willman, 2014).

Crime and violence are driven by the inability of the traditional and formal institutions in PNG to manage the stresses of social, economic and political transition. Crime in PNG fosters fear and insecurity, erodes trust, limits mobility and reinforces stigmatisation of some groups, like young males (Lakhani & Willman, 2014). This in turn is a constraint to growth, with 81% of businesses reporting that they need to pay for security at a cost of 5% of their annual operating costs. Agencies responsible for law and order, including the Royal PNG Constabulary (RPNGC), have experienced weak leadership, under-resourcing and low capacity, hampering their ability to be effective, meaning that community-based systems of governance frequently take precedence. These systems, a morphed hybrid of traditional governance mechanisms, frequently perpetuate gender and power inequities and fail to adequately deal with complex cases of crime, including violence (Lakhani & Willman, 2014).

Life expectancy at 62 years is below the average for LMICs (NSO, 2015). The maternal mortality ratio for PNG is estimated to be 700 per 100,000 live births (NSO, 2009) meaning that a woman in PNG is 200 more times more likely to die in childbirth than a woman in Australia (Hinton & Earnest, 2011). Contributing to this is the low number of women (44% in 2014) who choose to have their babies delivered in health centres and lack of awareness about and access to family planning (National Department of Health [NDoH], 2015a). Child mortality is 58 per 1000 with children commonly dying of preventable diseases like pneumonia, diarrhoeal disease and malaria (NSO, 2009). Contributing to poor health are high levels of malnutrition, low access to water and sanitation and poor hygiene practices. In 2012, 40 % of people had access to an improved water source and 19% had access to improved sanitation, with wide variation between urban and rural areas (NSO, 2011).

Communicable diseases are the major cause of morbidity and mortality amongst PNG adults, with tuberculosis (TB), diarrheal diseases and acute respiratory infections at the top of the list. Estimates of TB in the national capital are over 1,550 per 100,000 (NDoH, 2015b,) and primary transmission of drug resistant TB is occurring as are cases of extremely drug resistant (XDR) TB. The HIV prevalence rate is 0.65% in the general population, but is reported to be as high as 20% amongst key populations, including men who have sex with men, transgender people and female sex workers (NDoH, 2015c). The high rates of maternal mortality and communicable disease point to a breakdown in the delivery of basic and routine primary health care services.

3.2 Health Care Services

Health care is delivered through a decentralised, government-funded system of hospitals, sub-national health centres and aid posts. Church-run health clinics are integral to the health system and provide almost half of all health services, and are located in some of the most remote areas of the country (Howes et al., 2014). There are a small number of private providers operating in in large urban centres.

The PNG health system remains one of the most under-performing health systems in the region, with deteriorating performance over the last decade (Assante & Hall, 2011; Howes et al., 2014). Key constraints to improving health service delivery exist across the health system and include a lack of funding combined with ineffective spending, inequitably distributed workforce, deteriorating infrastructure and regular stock outs of drugs and essential medical equipment. (Assante & Hall, 2011; Razee, Whitaker, Jayasuriya, Yap, & Brentnall, 2012). Davy and Patrickson (2012) reported that 90% of health workers were coping with inadequate or outdated infrastructure, insufficient resources and lack of the medication required to treat patients according to the standard treatment manuals. In the context of such poorly performing clinics, indigenous health practices are still preferred by many as legitimate alternatives for diagnosing and treating patients.

In a survey of rural primary care facilities, Howes et al. (2014) found that over the last decade, the population’s use of health services is declining, suggesting a loss of confidence in the primary health care system. According to Howes et al. (2014), in some provinces, just over half of all staff positions were filled and of the facilities surveyed, only 40% had access to electricity, 41% to refrigeration and 51% had enough toilets. The most common type of toilet was a pit latrine with no separate facilities for males and females. Only 55% of clinics had a regular water supply all year long, with less than half (47%) reporting a water supply connected to the delivery rooms. Two-thirds of clinic rooms needed either rebuilding or maintenance. In the same report, it was demonstrated that there was little investment in the health sector by government, which has contributed to the decline. Seventy-five per cent of health workers use their own pay to fund facilities. The decline in rural primary health services has resulted in people bypassing primary care facilities and presenting at district and provincial hospitals. In addition to pressure on hospitals to deal with large caseloads, people tend to wait until their health problem is serious before seeking help, leading to complications, particularly given the additional time and distance taken to reach larger hospitals.

Funding to the health sector increased up until 2012, but allocations have since declined. In 2013, PNG spent around $94 USD per person (down from $97 in 2012) on health, this is in comparison to $6114 per person spend in Australia that same year (The World Bank, 2015). Further, analysis suggests that PNG's indicators are lower than expected, even for this level of health spend, pointing to chronic financial mismanagement, inadequate oversight and monitoring of expenditure, and corruption (The World Bank, 2014). In short, there are insufficient funds going into the health sector and the funds that are received are poorly managed or leak out.

It is estimated that over 12,000 people work in the health sector, most of these are community health workers, who complete a two year training course to provide basic primary care services. The number of registered nurses reduced by 34% from 1998 to 2009, with the majority of those remaining due to reach retirement age in the current decade, leaving PNG with a serious health workforce crisis (Morris & Somanathan, 2011). The ratio of HCPs (doctors, nurses, midwives) to population is 0.58 per 1000, which is significantly below the 2.28 which the WHO set as the standard to reach the MDGs (Jayasuriya et al., 2012). There are insufficient numbers of health care providers and they are not equally dispersed across remote, rural and urban locations. The majority of doctors reside in the capital city, which limits access to equitable care in rural and remote areas (Howes et al., 2014).

3.2.1 Health care services for survivors.

The low healthcare worker ratios, combined with poor infrastructure, and difficult, inaccessible terrain mean that few women have access to trained health care workers and generally only seek treatment in serious cases (Hinton & Earnest, 2010). Lewis et al. (2008) reported that 76% of women in their sample had not accessed support services following assault. Despite the government's free health care policy, many health facilities continue to charge user fees, including 'fight fees', or fees to treat cases of violence (including FSV), because of a lack of funds to operate (Howes et al., 2014). This is a barrier to treatment and care for survivors. Social workers, usually based in larger urban hospitals, have limited training and experience in counselling and gender issues and referral of survivors who attend hospitals as outpatients to social workers is rare. Most women go to the hospital, get treatment for their injuries and go home. Women do not discuss their health or family issues with staff and staff do not have time to ask (Hinton & Earnest, 2010). In some cases, nurses may act informally as a contact point, particularly if they have had additional training or an interest in the area (Hinton & Earnest, 2010).

Prevention of trauma and violence is an objective of the *National Health Plan: 2011-2020*, and the key strategy to reduce the impact of violence is the roll-out of and access to family support centres, where survivors can access medical treatment for injuries, psychosocial support and referral to social and legal services. In several provincial hospitals and at the national referral hospital (Port Moresby General Hospital) these centres have been set up, but operate as standalone services. They exhibit varying functionality and have not been successful without donor support (Butcher, Kaybryn, & Lepani, 2016). For example, the most successful centre was funded, managed and staffed by Medicine Sans Frontieres, at the provincial hospital in Lae between 2007 and 2013, who were able to train staff and develop systems (MSF, 2010). Other centres do not have the same capacity and are not backed by the political will of the hospital administration responsible for funding and staffing them. However, the NDOH has recently developed operational guidelines for the management of these centres which clearly sets out the expectations for delivery of services to survivors and is a signal that the health sector is beginning to take ownership of this initiative (NDoH, 2012). Another positive step towards improving services for survivors has been the development of draft training modules by the

NDoH in gender sensitisation but there is no funding to roll out the training and little discussion with relevant sections within the NDoH about how to institutionalise the training in the curriculum (Butcher et al., 2016).

In general, there is no systematic or standardised provision of services to survivors, and health workers lack training and institutional support to deal with cases. Whilst the policies and guidelines established by the NDoH are a step in the right direction, the challenge, as mentioned above, is that policies developed centrally are not always implemented by sub-national services.

3.3 Cultural Norms and Beliefs about Gender

It is important to discuss gender issues in PNG and how cultural norms and beliefs interact to promote high levels of gender inequality. PNG has a Melanesian culture that is characterised by traditional obligation and rewards systems and clan allegiances (Kavanamur, Okole, Manning, & Levantis, 2004). Christianity has been adopted into the PNG Constitution and 96% of Papua New Guineans identify themselves as Christian (NSO, 2015). Although gender equality is enshrined in the PNG constitution and is an expressed goal in the national development strategies of the Government of PNG, women struggle for equitable status and power within society (The World Bank, 2012). Part of the reason for the high level of gender inequality is because of the deeply embedded beliefs about male and female roles, which are informed by traditional culture, the evolution of that culture amidst rapid social transition, and Christianity.

3.3.1 Traditional gender norms and customs.

Traditional societies in PNG have unequally valued spheres of gendered activity and gender relations are characterised by inequality and the subordination of women (The World Bank, 2012). Women are responsible for household and domestic chores such as gathering food, fishing, caring for domestic animals, producing and raising children. Men clear land for cultivation, hunt, build houses and defend the family and village during war. Men are responsible for religious and political activities and need to benefit from women's production to support their political activities. Underpinning the formal and informal rules governing day-to-day life are deeply entrenched patriarchal systems. Some regions in PNG, like the New Guinea Islands, have matrilineal systems governing the inheritance of land, however, noting that these are matrilineal but not matriarchal systems, decision-making and power remain firmly within the realm of men, even within these cultures (MacIntyre, 2012; The World Bank, 2012).

3.3.2 Customs.

Customary practices deeply influence gender relationships and reproduce gender inequality in PNG. Traditionally, payment in the form of food and ceremonial goods was made by the male's kin to the female's kin when brides were exchanged. This payment is known as a bride price and signifies the transfer of the woman (and her productive capacity) from one group to another. Women have great economic value and the payment of bride price is compensation to a women's kin group for losing her (The World Bank 2012).[3] Polygamy, another customary practice, is linked to male leadership and status. Having more than one wife brings prestige because a man can father more children and harvest more produce, but this requires wealth and political skills to negotiate the marriages (The World Bank, 2012). Traditionally, only wealthy and powerful men had more than one wife. In 2006, 10% of women in coastal region and 28% of women in Highlands region reported living in polygamous marriages (NSO, 2009).

Traditional practices like bride price and polygamy have evolved in response to the modern cash economy (The World Bank, 2012). Bride price has become a commercial transaction, often involving large sums of money, while the traditional meaning has often been eroded and forgotten (Eves, 2006). Instead of an exchange creating a relationship between two kin groups, it has become simply a property transaction (Eves, 2006). Further, bride price reinforces the belief that men 'own' women and entitles the husband to a woman's labour, sexual services and full obedience (Eves,

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[3] Note that there are different interpretations of the meaning of bride price. Others have explained that bride price was paid by the prospective husband's family to demonstrate that they had sufficient wealth to look after the incumbent bride. As PNG is ethnically diverse and has an oral culture, there is no established and agreed explanation of bride price and its precise meaning varies from group to group.

2006; Oxfam, 2010). Families can be lured by large bride prices to enter their daughters into polygamous marriages and once the bride price has been paid, families are reluctant to assist abused women or allow them to return to the family home, because they will be required to repay the bride price (Oxfam, 2010).

Polygamy, in its modern form, permits men to be promiscuous without accruing any longer term obligations to provide for women and the children of these relationships, as young men increasingly 'marry' second and third wives (Amnesty, 2006; Jolly, 2012). This can be a trigger for further violence within families as men seek to settle disputes and complaints with violence and co-wives fight over resources and attention. Amnesty (2006) reported that one third of the female prison population are incarcerated for crimes they have committed against another woman with whom they share a partner. This is because a woman's survival and her children's survival is contingent on the husband's ongoing support. Additional partners are viewed as competition for resources, which is perceived as a greater threat to survival than abuse.

Instead of facilitating equal access to economic opportunities, education and political activities, modern social practices have increased certain forms of gender inequality and marginalisation for PNG women. Traditional mechanisms of dispute resolution and social control are weakened and subverted and customs, often distorted by changed circumstances, justify discrimination and subordination (Amnesty, 2006).

3.3.3 Christianity.

According to the national census (NSO, 2015), 96% of Papua New Guinean's are Christian and the churches play a large role in society, including the delivery of health and education services. Christianity also has a strong role in consolidating male power (Jolly, 2012). Christian doctrines reinforce patriarchal authority through promotion of the ideal wife as good, submissive, and a home-maker. Women who do not comply to this ideal are considered wayward. The Bible is used to justify male power and reiterate the power of the husband and father as head of the household. This in turn legitimises men's use of violence to maintain that power and to discipline members of his household. In PNG, Christianity combined with indigenous Melanesian world views results in a "*powerful doctrine of submission*" (Hermkens, 2012, p. 150).

3.3.4 Intersection between cultural attitudes and FSV.

Cultural attitudes about the role of women in marriage have long been identified as a barrier to preventing FSV. In early research on FSV in PNG, common attitudes shared by men and women, (including those in official positions who have a responsibility to help survivors) included that bride price gives a man the right to beat his wife; men are superior to women and women must obey them; no one can interfere between husband and wife; as wifebeating is customary in many parts of PNG it must be legal; a man can do whatever he likes inside his own home; if a woman is beaten, she must have done something to deserve it; and if a woman really minded being beaten, she would leave the man and prosecute him (Toft & Bonnell, 1985). More than thirty years on, these attitudes persist. For example, Ganster-Briedler (2010) reported that 78% of surveyed women believed that a good wife obeys her husband and 66% believed that the man must show that he is the boss in a relationship. In this same study, the majority of women believed that a man's use of violence against his wife is justified if she has been unfaithful (77%) or if he suspects that she has been unfaithful (61%), if she has disobeyed her male partner (77%), and if the woman does not complete the housework to the satisfaction of the man (51%). Both women and men accept these cultural concepts of gender and women's subordinate position in society, which makes it difficult to tackle the drivers of FSV (Jolly, 2012).

Women are frequently blamed for inciting rape, particularly if the assault occurred whilst the woman was intoxicated or engaged in socially unacceptable activities, such as going to a dance or to a boyfriend's house (Amnesty, 2006). It is a common belief that female sex workers cannot be raped and police often refuse to help them until they receive sexual favours, meaning that these women are exceptionally vulnerable to sexual assault. This is all the more alarming given the increase in informal sex work due to rising poverty and limited employment opportunities for women. For example, in one survey, two out of three women aged 15-24 and two in five older women accept cash or gifts in exchange for sex (Amnesty, 2006).

Intimate partner violence (IPV) is the most common form of family violence in PNG and in some regions it is accepted as an inevitable part of family life and a valid way to correct women's behaviour for minor transgressions that are perceived as challenging to male authority or to norms of feminine conduct (Amnesty, 2006; Chattier & Tararia, 2014). In addition to verbal abuse, kicking, punching, burning and cutting with bush knives, women are also locked in homes to prevent them returning to their families or accessing help (Amnesty, 2006; Ganster-Briedler, 2010). Triggers of FSV have been reported as including failure of the wife to carry out her duties, not having food ready, not caring for children, gossiping, not paying due respect to relatives, refusing sex, or secretly using contraception (Eves, 2006; McPherson, 2012). Sexual jealousy is also a frequently cited reason for FSV and usually incited when a woman spends time with or talks to a non-relative male (Ganster-Briedler, 2010; Fulu et al., 2013). As Eves (2006) explains, the reasons given for violence are often trivial and if taken at face value would lead to the assumption that "*the men of PNG are extremely delicately balanced, easily upset and unable to follow a path of reason*" (p. 25). However, the underlying causes of violence are driven by men's desire and need to maintain their power over women and their power in the world. Violence is an execution of power which keeps women in their place and subservient (Eves, 2006).

Adding to the problem are the weakened traditional mechanisms for conflict resolution and lack of confidence in the formal justice system, which fosters tolerance for violence in the community and legitimisation of the use of violence to resolve disputes, including those within the home (Lakhani & William, 2014). Corruption at all levels undermines the ability of state institutions to address the country's crime issues. It is well documented that police are perpetrators of violence against women in PNG and act with impunity (Amnesty, 2006). Gang rapes, particularly of sex workers, in police stations and barracks are common.

Several researchers (Chattier & Tararia, 2014; Eves, 2006; Jolly, 2012) have begun looking at FSV in PNG through a masculinity lens. These researchers note the challenges faced by PNG men as they negotiate their role in the context of modernity and evolving customs, leading to insecurities and loss of status, particularly as women's agency and empowerment rises. This sparks a need to reassert and maintain their dominance amidst mass social transformation. In a study with convicted rapists, Hukula (2012) concluded that many young men face a lack of control over the resources they need in order to live up to ideals of masculine power. Rape becomes an expression of their frustration, retribution against women and an assertion of their masculinity. The importance of the work on masculinity in PNG highlights the changing context of male power and the emergence of new challenges to that power, and hence, the layers of complexity underpinning the drivers of FSV.

3.4 Conclusion

National income and budget priorities, education levels, levels of crime, roads and transport systems are all important for public health research as they determine how the social determinants of health play out in particular settings. This chapter sought to provide background information about the demographics and culture of Papua New Guinea, the setting for this research. PNG as a nation faces significant development challenges which impact the performance of the health sector. In particular, low numbers of health workers, poor quality training, low spending on health care, and deteriorating infrastructure, combined with large diversity of culture and terrain, constrain health service delivery. In terms of FSV, there are additional contextual and cultural influences that shape both the nature of violence and the rate at which it occurs. These factors intersect with service delivery for survivors, which is a crucial consideration for this research.

Chapter 4: Methodology

This chapter introduces the research methodology used for this study and how it has guided data collection, analysis and development of theory. Firstly, the research questions and objectives are revisited, followed by a brief overview of the research approach. Then, the appropriateness of the mixed method design for this research is explained, followed by a discussion about critical realism as an appropriate paradigm to guide mixed method design and its application to this study. The subsequent sections describe the research setting, population and sampling, tools for data collection, procedures for the data collection and processes for data analysis. The chapter concludes with a discussion about the limitations of this study.

4.1 Research Questions, Objectives and Approach

The main purpose of this study was to critically analyse a) how nurses identify and manage cases of family and sexual violence in health facilities in PNG; and b) what factors influence nurses' identification and management of FSV. The research questions guiding this study were:

6. How and when do nurses ask and talk about FSV with patients?
7. What are the factors that influence how and when they ask about FSV?
8. How do nurses manage or respond to survivors?
9. What are the factors that influence how nurses manage or respond to survivors?
10. How do those factors influence the way nurses ask about and manage or respond to survivors?

The review of the literature helped to indicate which factors may be important to explore through data collection. The literature helped to refine the final research objectives which were:

1. To describe the attitudes, beliefs and self-reported behaviours nurses have regarding the identification and management of family and sexual violence.
2. To measure how frequently nurses ask about family and sexual violence.
3. To identify what nurses do when survivors present at health facilities.
4. To identify how and in what circumstances nurses ask about FSV.
5. To critically analyse what factors influence nurses' identification and management of survivors.
6. To critically analyse how those factors influence nurses' treatment of survivors.

A mixed methods design framed by critical realism was used to address the research objectives. Qualitative in-depth interviews and quantitative descriptive survey data helped to confirm overall findings about what factors influence how nurses identify and manage cases of FSV. This enabled conclusions to be drawn about why nurses respond in the way they do towards survivors of FSV. Grounded theory was used to guide analyses, in which quantitative data strengthened components of the qualitative findings and added credibility to the overall conclusions. The qualitative data was essential to understand and account for context-specific factors. The research was conducted in two phases. Phase one involved the usability testing of the survey and phase two incorporated the survey and interview data collection.

4.2 Mixed Methods

Mixed methods research (MMR) has been referred to as the third methodological paradigm because it is an alternative to the purely qualitative or quantitative methodologies traditionally used in research (Johnson & Onwuegbuzie, 2004). In MMR, the strengths of both approaches are intentionally brought together to gain deeper insights into social phenomena (Tashakkori & Teddie, 2010). The definition of MMR is debated. Within the *Handbook of Mixed Methods in Social and Behavioural Research* (Tashakkori & Teddie, 2010), a key text for MMR, contributing authors present different interpretations and definitions of MMR. Morse (2010) differentiates multiple methods design, which consists of two or more studies using different methods to address the same or different parts of the same research question, from mixed methods, which includes a core project and supplementary project that is unable to stand alone from the core project. Leech (2010) takes a broader approach, defining MMR as any research that involves both qualitative and quantitative data, whereas Creswell (2010) avoids a methodological definition and highlights the importance of the connection, integration or linking of independent data strands. The most consistently referenced and adapted definition is that of Johnson, Onwuegbuzie and Turner (2007) who reviewed 19 definitions to conclude that MMR "*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*". This is the definition of MMR applied to this study.

Greene, Caracelli and Graham (1989) proposed five rationales for using mixed methods. These continue to be relevant and cited in MMR texts. MMR can be used to triangulate findings through different methods, to illuminate and clarify findings gained from one method with another, to assist in the development of methods used in later phases of research, to uncover contradictions and find new ways of looking at research questions and to expand the breadth and scope of enquiry. In this study, the purpose for using MMR was triangulation whereby the survey data sought to triangulate (confirm or discount) aspects of the qualitative findings and the qualitative interviews sought to uncover processes and contexts not captured by the survey.

A key part of developing an MMR design is to decide what methods are used, the status accorded to those methods and at what point in the study they are mixed. Taking Tashakkori and Teddie's (2010) recommendation to visually address these questions in a diagram and using the common MMR notation and design typologies (Creswell, 2010; 2014; Nastasi, Hitchcock, & Brown, 2010). Figure 3 displays this study's mixed method design.

As per Figure 3, this research is best described as a partially mixed, concurrent design with dominant status given to the qualitative component. This means that data collection for the qualitative and quantitative components occurred at the same time (i.e. there was no sequencing), and that data was collected and analysed independently (i.e. the findings from one study were not needed to inform the design of the other). The qualitative component has dominant status in this research because those data are central to the research questions. The point at which mixing occurs is in the interpretation of the findings. As per Nastasi et al. (2010), this is denoted as QUAL + quan = convergence. Linking back to Green et al. (1989), this is how the mixing of methods enables triangulation.

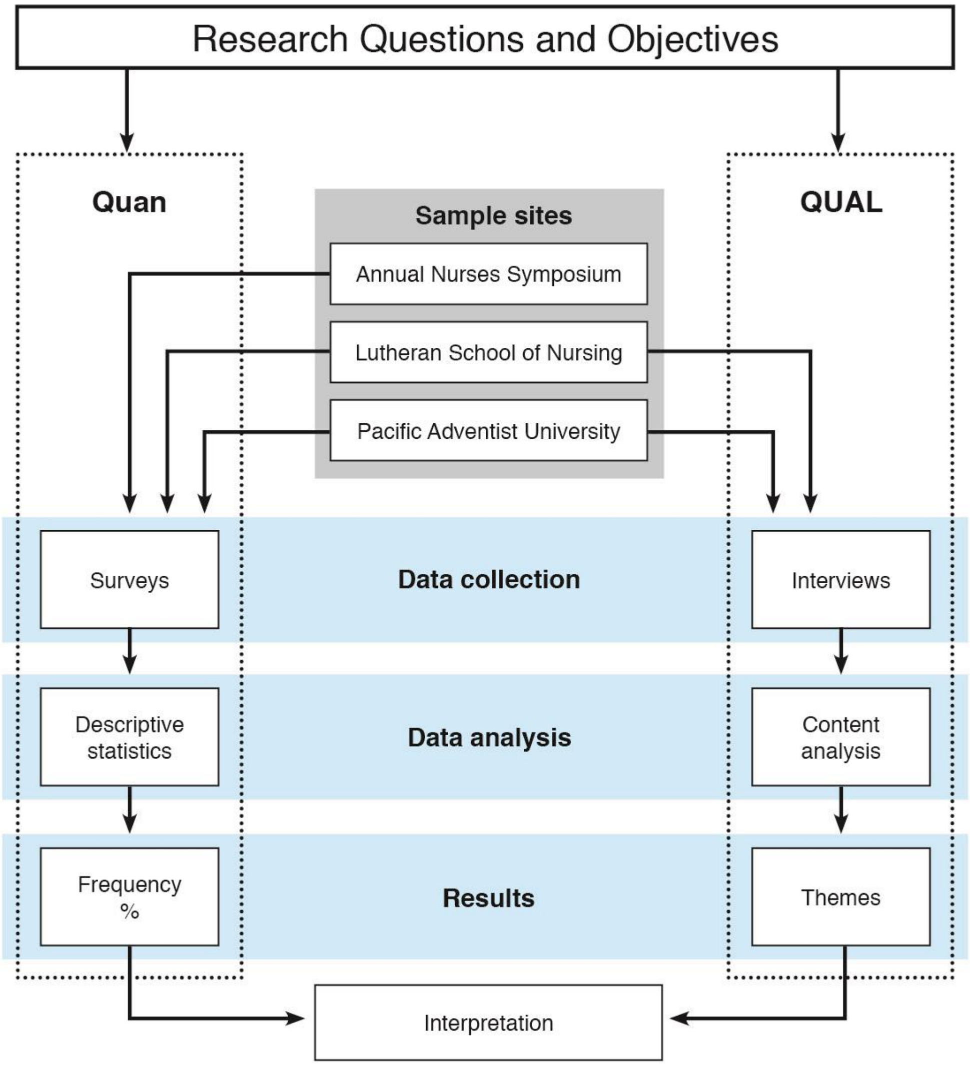

Figure 3. Partially mixed, concurrent design, QUAL + quan = convergence

MMR is contested by those researchers who propose that the philosophical assumptions (ontology, epistemology and axiology) of positivism and post-positivism associated with quantitative research and the constructivist paradigm associated with qualitative research cannot be reconciled and therefore mixing methods is not possible. MMR researchers acknowledge the difference between philosophical paradigms but argue that they are not incompatible (Tashakkori & Teddie, 2010). They argue a ’compatibility thesis’, stating that qualitative and quantitative methods can complement each other and be used effectively together in a single study. Central to MMR is the idea that methodological and conceptual assumptions are separate from other philosophical assumptions (Tashakkori & Teddie, 2010). This allows for theoretical eclecticism, meaning multiple theories can be used to interpret findings, which is particularly useful when trying to understand complex social phenomena such as family and sexual violence.

4.3 Theoretical Orientation

4.3.1 Pragmatism.

Pragmatism is frequently identified as the appropriate philosophical paradigm for mixed method research because pragmatists argue that research methods are not intrinsically linked to philosophical positions and that methods can be combined based on their practical utility (Biesta, 2010). For pragmatists, the validity of research lies in the results being tested in practice (Creswell, 2010). However, there is debate over the multiple interpretations of what the pragmatic paradigm includes and it is an eclectic use in practice (Christ, 2013). In particular, pragmatism is criticised for conflating the influence of ontological assumptions about the nature of the ’real’ world and epistemological assumptions about how we come to ’know’ that world (Christ, 2013).

Other MMR researchers maintain that epistemological and ontological concerns are central to the work of research (Greene, 2006; Maxwell & Mittapali, 2010; Scott, 2007) and note the inadequacies of pragmatism as a paradigm, particularly because of the lack of attention to ontological, epistemological and axiological assumptions. They suggest critical realism as an alternative theory which can resolve tensions in mixed methods research by providing a philosophical position that is compatible with both qualitative and quantitative methods.

4.3.2 Critical realism.

Critical realism emerged as a theory in the 1980s and is largely attributed to the work of British philosopher Roy Bhaskar, but has been advanced by other key writers, including William Outhwaite, Margaret Archer, and Andrew Collier (Bergin, Wells, & Owen, 2010; Connelly, 2007). There are a growing number of researchers (e.g. Angus & Clarke, 2012; Bergin et al., 2010; Connelly, 2007; McEvoy & Richards, 2006) who advocate for the adoption of critical realism as a paradigm to understand public health phenomena because it attempts to account for the complexity of human nature.

While positivists claim there is a single, observable reality, and constructivists assert there are multiple realities, critical realists propose that there are multiple interpretations of a single, independent reality (Niglas, 2010). Critical realism has a realist ontology (there is a real world that exists independent of our perceptions, theories and interpretations) and a constructivist epistemology (our understanding of the world is inevitably a construction from our own perspectives and positions) (Bergin et al., 2010; Maxwell & Mittapali, 2010). Critical realists accept that individuals know and experience the world differently but reject the constructivist position that there are 'multiple and incommensurate realities' (Maxwell & Mittapali, 2010). Instead, they propose that a single, real world exists, regardless of whether we perceive it or not, but maintain that this world can never be objectively known. Critical realists distinguish between the world and our experience of it (Sayer, 2000). Critical realists are concerned primarily with ontology (what exists) and then with epistemology (how we come to know what exists) and warn against conflating the two (Bergin et al., 2010; Connelly, 2007). A criticism of constructivists is that often they conflate the actual social phenomenon with what is or can be known about that phenomenon, which Bhaskar has termed the 'epistemic fallacy' (Deforge & Shaw, 2012)

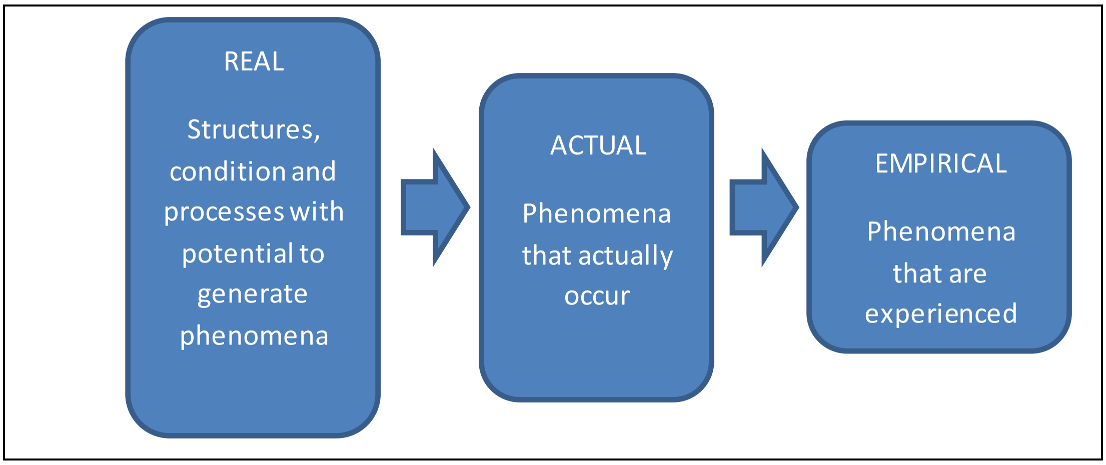

Figure 4: Ontological domains of reality adapted from McEvoy & Richards, 2006

Importantly, critical realism distinguishes between three ontological domains of reality (see Figure 4). The real domain is all that exists in the natural and social world, whether we know about those existences or not. It is "*the realm of objects, their structures and powers*" (Sayer, 2000, p. 11). Physical and social objects have causal structures and powers that give them the capacity to behave in a particular way and make them susceptible to change (Sayer, 2000). The actual domain is the events and experiences that happen when structures in the real domain are activated, noting that not all events are experienced. The empirical domain is what we experience (directly or indirectly). Individuals may not be aware of all the conditions and events that culminate to shape their experience (De Forge & Shaw, 2012).

Although individual experiences of phenomena are contingent on context-specific conditions, regularities and patterns in how phenomena occur across space and time can be observed (De Forge & Shaw, 2012). This leads to the role of causation in critical realism, which is identified through exploration of underlying causal mechanisms. Causal mechanisms are the structures, conditions and processes that drive and shape the events that lead to experience (Sayer, 2000). As Sayer (2000) explains, "*what causes something to happen has nothing to do with the number of times we have observed it happening*" (p. 14). Instead explanations for what happens in the social world come from understanding how causal mechanisms work and under what conditions (Christ, 2013). The relationship between causal mechanisms and their effects is contingent on the context within which they operate. Therefore, the patterns and events we observe are the result of causal mechanisms which come from the structure of objects that are located within social, political, cultural and historical contexts (Maxwell & Mittapali, 2010). In this sense, critical realism aims to understand the processes by which observed events or conditions come about, rather than a simple comparison of situations.

4.3.3 Structure and agency.

The axiological aim of critical realist research is emancipation, which is achieved by revealing the ways that structures interact with context through causal mechanisms to shape experience and constrain health and wellbeing. Critical realism's position on structure and agency is central to understanding this. Social events cannot be explained by either structures or agency alone (De Forge & Shaw, 2012; Harwood & Clark, 2012). For example, social structures do not determine an individual's health but create the conditions that foster or limit health. Agency refers to an individual's capacity to make free choices and act independently. Structure is the social patterns, institutions and conventions that influence the choices that individuals make (Elder-Vaas, 2010). Within sociology, there has been great debate over which has more influence in shaping human behaviour (Elder-Vaas, 2010), but critical realism does not take an either /or stance. For critical realists, although separate, structure and agency are inherently interrelated. Individuals deliberately and unconsciously interact with and thereby reproduce or change the structures that facilitate or constrain their actions. Structures are therefore the outcomes of human agency. By exposing causal mechanisms and how they operate, we learn about the ways that social structures impinge on our freedom to act, which in turn creates opportunity for consciousness raising and transformation (De Forge & Shaw, 2012). For critical realists, emancipation comes from the transformation of structures (De Forge & Shaw, 2012). The focus on emancipatory goals achieved through transformation of the social and economic conditions that impact individual wellbeing is where critical realism aligns with critical theory (De Forge & Shaw, 2012; Walsh & Evans, 2014).

4.3.4 Application of critical realism to the mixed methods design.

Critical realists accept that social phenomena can never be fully understood and that there can be a number of plausible interpretations of data. What critical realists aim for is the *’best plausible representations of participants’ experiences’*, which are derived from observed evidence and the application of theoretical concepts (Christ, 2013, p. 115).

By exploring what happens in the real, actual and empirical domains we can describe mechanisms, events and experiences that are foundations of causal, yet tentative, theoretical models that emerge from research (Christ, 2013). Two analytical processes are described to help researchers. *Retroduction* is the process used to move from description of phenomena to description of causal mechanisms. *Abduction* involves a re-description and re-contextualisation of data to gain knowledge about the complex workings of social phenomena (Christ, 2013). Through these processes, objective findings obtained from surveys and tests, can be merged with subjective findings obtained from co-constructed participant perspectives which allow researchers to develop explanations (Christ, 2013). Hence, the mixed method designs are seen to be an appropriate methodology for critical realism (Christ, 2013; Scott, 2007).

To demonstrate how critical realism is applied to this study, it is useful to revisit the study’s purpose. Part of this study is concerned with describing ’what’ the attitudes, beliefs and behaviours of nurses are towards survivors of FSV. This corresponds to describing the common and regular patterns of what happens in the ‘empirical’ domain. However, this study seeks to go further and understand why nurses do what they do. To achieve this, underlying factors that shape behaviour, attitudes and beliefs related to identification and management of FSV were explored. Moving from describing ’what’ nurses do in health facilities to an explanation of why equates to the process of *retroduction* described above. Through *abduction*, attention to contextual factors help to unpack the context specific conditions shaping how and why nurses identify and manage cases of FSV in PNG. By describing regularities and patterns and exploring context specific conditions to answer the research questions, the study has applied a critical realist lens. With this in mind, the use of a mixed method approach becomes particularly relevant.

This study was designed so that there was overlap between the content of the survey and the interviews, meaning that both ask questions about similar issues but in different ways, an important feature of MMR (Creswell, 2014). The survey was used as an objective measure of self-reported knowledge, attitudes and beliefs and frequency of enquiry about FSV. This study accepts that knowledge, attitudes and beliefs, as well as behaviours, are constructs that can be measured. As such, the survey findings were used to describe the regular and common patterns of knowledge, attitudes and beliefs, and frequency of enquiry among nurses. The context in which these operate and how they operate was further explored through the in-depth interviews. Survey data complemented interview data by confirming and discounting the existence of particular knowledge, attitudes, and beliefs about, and behaviours towards, working with survivors, then went further by exploring how these (and other factors) work to trigger positive and negative actions or behaviours from nurses. Because the interview data captured the perspectives of nurses, it helped shaped an understanding of the specific contextual factors that could not be captured through survey data alone. This understanding of context is crucial from a critical realist perspective because it allows for development of theory not only about what is happening, but why. Findings from specific items on the survey helped triangulate or confirm findings from the interviews which openly explored similar issues, such as nurses' perceptions of their role in responding to FSV and access to referral sources. The qualitative data became the core data which study findings were built around with the survey triangulating particular components.

Table 5 displays the data type that addressed the objectives. Both qualitative and quantitative data addressed research objective one, which is aimed at gaining an understanding of 'what' nurses do in health facilities and 'what' attitudes and beliefs they hold about identification and management of FSV. Survey data alone addressed research objectives two and three which measured the frequency of asking about FSV in health facilities and how this relates to the specific knowledge, attitudes and beliefs captured in the survey. Interview data was used to address research objectives three, four, five and six, which answered questions about 'for whom' and 'in what circumstances. In this way, the two data sets address the realist questions of 'what, for whom and in what circumstances' (Pawson et al, 2004).

Research Objective	Quantitative Data	Qualitative Data
1. To describe the attitudes, beliefs and self-reported behaviours nurses have regarding the identification and management of family and sexual violence.	X	X
2. To measure how frequently nurses ask about family and sexual violence	X	
3. To identify what nurses do when survivors present at health facilities		X
4. To explore how and in what circumstances nurses ask about FSV		X
5. To explore what factors influence nurses' identification and management of survivors	X	X
6. To explore how those factors influence nurses' treatment of survivors		X

Table 5: Research objectives & data type

4.4 Methods

This research was conducted in two phases. The first phase involved testing the suitability of the survey and the second phase involved the data collection for the analyses. The logistical challenges of conducting research in PNG, compounded by the actual events which occurred during field work, played a significant role in determining how this study was executed and are described in detail in Appendix B. This appendix highlights that it is hard to conduct quality research in certain settings, which has the unfortunate effect of limiting production of a much-needed evidence base.

4.5 Phase 1 – Survey Suitability Testing

4.5.1 Data collection site.

Data collection for phase one of the project occurred through email, although all participants were based in Port Moresby, Papua New Guinea.

4.5.2 Participant population and sample.

4.5.2.1 Sampling method.

A sample is smaller subset of a population. This study used convenience sampling, meaning that participants for phase one were recruited from a pool of known and available experts who were available at the time of recruitment and consented to participate.

4.5.2.2 Population & sample.

A population is defined as all the elements (objects, events or people) that meet the criteria for the research study (Christensen, Johnson & Turner, 2011). The inclusion criteria for phase one were: 1) health professionals working in the PNG health sector; and 2) has knowledge of and experience with FSV.

4.5.2.3 Sample size.

The number of participants recruited to phase one was based on the small pool of publically available and known email addresses of health professionals working on family and sexual violence or related programs in PNG. Ten experts were invited to participate in reviewing the survey to test its suitability for use in PNG. A total of five experts responded, three before the deadline and two after.

4.5.2.4 Data collection instrument.

Four open-ended questions were attached to the end of the Domestic Violence Healthcare Provider Survey Scales (DVHPSS) (Maiuro et al., 2000) to collect feedback from experts on the survey's suitability for use.

4.5.3 Procedure.

Fowler (2009) recommends pretesting self-administered questionnaires in person with a group of potential respondents to assess the usability of the survey, both in terms of questions and layout. The intention was to pretest the suitability of the survey for use in PNG using a focus group with PNG nurses before administering it more broadly. However delays in finalising ethics approvals reduced the time available for data collection in PNG. A decision was made to email participants to test the suitability of the survey instead. This was necessary to ensure that any changes to the survey could be reviewed and approved by the Flinders University Social and Behavioural Research Ethics Committee (SBREC) before the scheduled travel to PNG for data collection.

Publically available emails of health professionals working in areas related to health and family and sexual violence were sourced through the National Department of Health and the Family and Sexual Violence Action Committee. Ten health professionals were contacted and invited to read and comment on the survey's suitability for use in PNG. Each person received an email introduction, information sheet and the original survey.

Participants were asked to read the survey and respond by email to questions about the suitability of the survey for use in PNG. Three participants responded before the set deadline, two responded after, one declined to participate and no responses were received from four professionals. Due to the printing deadlines to meet field work requirements, the comments which came in late were not used to adjust the survey. Although this feedback did not influence the final revised survey, it has helped to highlight issues with the potential validity of the survey for use in PNG. A summary including the pretest questions, comments from participants and researcher action/response is included in Appendix C.

4.5.4 Data Analysis.

Responses from the three experts on the suitability of the survey for use in PNG were reviewed, resulting in minor changes to language and the terms used.

4.6 Phase 2 – Interviews and Surveys

4.6.1 Data collection site.

Nurse training institutions running postgraduate courses were selected as settings to recruit participants because they were easy sites from which to access large numbers of nurses. Postgraduate students are already qualified nurses with practical experience, and therefore met the selection criteria. The initial intention had been to recruit from all four institutions offering postgraduate nurse training, but agreement to recruit participants was only finalised with two institutions.

The Lutheran School of Nursing (LSoN), located in the coastal town of Madang, is run by the Lutheran church and has a student population of around 350 and teaching staff of 25. The LSoN offers Bachelor degrees in general nursing and postgraduate midwifery. The Pacific Adventist University (PAU), Central Province, is a Christian institution located 22 kilometres outside of Port Moresby, the capital city. The university offers Bachelor level and postgraduate courses in business, teaching, theology, science and nursing. All nurses recruited to the study from these institutions were midwifery students, because this is the only postgraduate training offered.

The Nursing Symposium in 2013 was a three day conference for PNG nurses held in Mendi, Enga Province. It was an appropriate research setting because over 300 nurses had registered to attend, supplying an additional pool of potential participants for the survey. The timing of the conference coincided with the dates scheduled for field work and permission was negotiated with the PNG Nursing Council to attend the symposium for the purposes of recruiting nurses to participate in the study.

4.6.2 Participant population and sample.

4.6.2.1 Sampling method.

Phase two of the study also used convenience sampling, meaning participants were recruited nurses who were available at the time of recruitment and consented to participate.

4.6.2.2 Population & sample.

The criteria for inclusion in this phase of the project were: 1) PNG nurse, and 2) recent (within last six months) clinical practice. Nurses were selected as the main target population because they represent almost one third (27.7%) of the health workforce (3,618 out of 13,063 including administrative staff), (Morris & Somanathan, 2011); work across urban, rural and remote facilities; and are often the first point of care with whom survivors come into contact.

Two accessible populations of PNG nurses included:

1) Nurses enrolled as students in postgraduate midwifery training recruited to participate in both interviews and surveys.

2) Nurses attending the PNG Nursing Association Annual Conference recruited to participate in surveys only.

All postgraduate students were assumed to have met the selection criteria because the course entry requires that all students are registered nurses who are currently practising and all students complete practicums throughout the year. It was possible that non-practising nurses and other health professionals attended the conference, but the survey information sheet specified the selection criteria for the study. The survey also asked participants for their current job/position and number of years worked, which helped to verify that participants had met the selection criteria.

4.6.2.3 Sample Size.

Survey.

The number of nurses enrolled in postgraduate midwifery courses and available at the time of recruitment was 37. Based on advice from the conference organisers, the estimated number of nurses who attended the 2013 Nurses Symposium and were available for recruitment was 300. The total accessible population for recruitment to the quantitative study was 337.

Using a sample size calculator (http://www.raosoft.com/samplesize.html) with 95% confidence and 5% margin of error, the recommended sample size for the accessible population of 337 was 180.

Fifty-four nurses completed the survey. Twelve respondents were from the Lutheran School of Nursing, 18 were recruited from Pacific Adventist University and 26 were recruited from the 2013 Annual Nurses Symposium.

	No. nurses available at time of recruitment	No. nurses who consented to participate
Lutheran School of Nursing	15	12
Pacific Adventist University	22	18
Nurses Symposium	300	26
Total	337	54

Table 6: Survey population and sample numbers

As such, the sample size for the quantitative study was too small to enable multivariate analysis. Analysis was therefore restricted to descriptive statistics only and research objectives changed to reflect this.

Fifty-four participants returned the survey but one survey was not completed and was removed from the data set, leaving a total of 53 valid surveys. Of these, at least

44 (86.3%) were female and 7 (13.7%) were male. Two participants did not disclose their sex. Participant's age ranged from 20 to over 55 years, with 34.7% reporting to be 30-34 years and another 26.4% in the age bracket 40-44 years. Four participants did not provide their age.

Participants worked in facilities across 19 (out of 22) provinces of PNG. The Southern Highlands Province had the greatest representation with 17% of participants reporting to work there, followed by the National Capital District (13.2%) and East New Britain (11.3%). Smaller numbers of participants worked in the other provinces. The high number of participants working in the Southern Highlands is due to one of the sample sites (the Conference) being held in that location. The two provinces not represented were Western and Manus Island, both of which have small populations and low numbers of health workers.

The majority of participants worked in hospitals (58.5%), with 34% working in sub-health centres and 5.7% working in other facility types (teaching schools). However it should be noted that many district hospitals are in fact health centres but, as the largest and only facility in a district, are often referred to as hospitals, even though they are small facilities in rural areas offering limited services. Most participants had between 1-5 or 6 - 10 years' experience, which is reflective of the students in the sample. At least six participants (11.3%) had more than 25 years' experience with one participant who reported 42 years' experience. Participants included general and specialist nurses such as STI, HIV and infection control nurses. Thirteen nurses were senior nurses, with seven of these holding positions as Officers in Charge in their respective facilities, eight noted a specialisation, while the majority of participants stated that they were general nurses.

Only 19% of these participants had ever completed any training in gender or FSV.

Interviews.

A total of 37 nurses were approached to participate in interviews. Thirteen nurses consented from an accessible pool of fifteen at the Lutheran School of Nursing and five were recruited from Pacific Adventist University, out of an accessible pool of22. All participants were aged 25 - 42 years.

	No. nurses available at time of recruitment	No. nurses who consented to participate
Lutheran School of Nursing	15	13
Pacific Adventist University	22	5
Total	37	18

Table 7: Interview population and sample numbers

Sample size in qualitative research is often determined when saturation of themes has occurred (Corbin & Strauss, 2008). Saturation is the point when the researcher judges that new data will only confirm existing categories and themes rather than contribute to the development of new themes (Corbin & Strauss, 2008). The idea of saturation comes from grounded theory and requires ‘theoretical sampling’, where the researcher engages in a continuous and cyclical process of data collection and analysis until no new data emerges, although true saturation is probably never achieved (Corbin & Strauss, 2008). There are situations, for example, when researchers need to travel to collect data, where theoretical sampling is not possible and researchers have to ’make do’ with the sample size. This does not mean that the research lacks significance or is superficial because high quality analysis can still be conducted (Corbin & Strauss, 2008).

The logistical requirements of this field work prevented an ongoing process of data collection and analysis. Instead, previous studies and guides from the literature were used to make estimations about the necessary quantity of data to be collected during field work. For example, in similar studies, Baig et al. (2012) interviewed 16 participants, Cattaneo and Chapman (2011) interviewed 13 participants, Laisser et al. (2009) interviewed 16 participants, Vieira et al. (2012) interviewed 14 participants and Zakar et al. (2011) interviewed 24 participants. In a review of qualitative research, Creswell (2010) found that phenomenological studies typically included 3 – 10 participants, whereas grounded theory included 20-30 participants. The approach to this research was phenomenological with techniques borrowed from grounded theory in the analysis of data. Therefore the target number of interviews was between 16 and 24. A total of 18 participants consented to participate, which was within this target. Following analyses, 18 interviews were sufficient to answer these research questions with saturation achieved, as evidenced by the volume of data to support themes.

Final participants included 16 female and 2 male students completing a postgraduate diploma in midwifery at two Papua New Guinean nurse training institutions. The number of years' experience working as a nurse ranged from 4 – 21 years. Participants worked across urban, rural and remote facilities. The most remote facility reported was one and half days travel to the nearest district centre. Participants worked at small health centres (e.g. one nurse and three community health workers), larger health centres (32 staff, three wards), as well as in hospitals. Participants worked in government and church run facilities with one participant reporting to have worked in a private hospital. All participants were general nurses but worked in a range of roles, including facility managers, labour wards, maternal and child health, primary health care services, surgical wards, outpatient services, and emergency care. Some participants had undergone specialist training in HIV and TB DOTS. Two participants had worked as nurse educators.

4.6.3 Data collection instrument.

4.6.3.1 Survey.

A revised version of the Domestic Violence Healthcare Provider Survey Scales (DVHPSS) developed by Maiuro et al. (2000) was used to measure nurses' domestic violence-related knowledge, attitudes and beliefs, a as well as frequency of enquiry about FSV (Appendix D). The survey captures six theoretically derived subscales relevant to practice including:

Self-efficacy, which assesses nurses' confidence in their ability to take actions in response to FSV (7 items).

System support, which assesses nurses' access to support networks and referral services for survivors (4 items).

Blame victim assesses nurses' attitudes toward survivors (7 items).

Professional roles resistance/fear of offending clients, which assesses whether nurses perceive that asking about FSV conflicts with their beliefs about their role as a health care provider (7 items).

Victim/provider safety assesses whether nurses perceive that discussing FSV with patients puts the survivor or care provider at risk (10 items).

Frequency of FSV enquiry (7 items).

Respondents used a Likert scale to rate their position against statements ranging from 1 (strongly disagree) to 5 (strongly agree). Sample item statements are shown in Table 8. The survey was brief to administer, taking approximately ten minutes, which according to Maiuro et al. (2000) increases the response rate

Subscales	**Sample Items**
Self-efficacy	I don't have the time to ask about FSV in my practice.
System support	I have ready access to mental health services should our patients need referrals
Blame victim	The victim has often done something to bring about violence in the relationship
Professional role resistance/fear of offending	I am afraid of offending the patient if I ask about FSV It is not my place to interfere with how a couple choose to resolve conflict
Victim/provider safety	When challenged, perpetrators frequently direct their anger toward health professionals I feel it is best to avoid dealing with the perpetrator out of fear and concern for the victim's safety
Frequency of FSV enquiry	In the past three months, when seeing patients with injuries how often have you asked about the possibility of family and sexual violence.

Table 8: Sample survey items

This instrument was chosen for two reasons. Firstly, this instrument measures knowledge, attitudes and beliefs, as well as frequency of asking about FSV, all of which are directly relevant to the research questions. Findings from specific items on the survey helped triangulate or confirm findings from the interviews which openly explored similar issues, such as nurses' roles in responding to violence and factors that influence nurses' responses to FSV.

Secondly, using a pre-existing survey with published reliability and validity was an appropriate choice for this research because it was too difficult to access a sufficiently large population to develop and test a new questionnaire or to confirm the validity of another existing questionnaire. Maiuro et al. (2000), who developed the questionnaire, established the content and criterion validity and internal consistency reliability of the instrument with a Cronbach alpha ranging from 0.73 to 0.9. The instrument has since been used with US populations (Mairuo et al., 2000; Thompson et al., 2000) and validated with non-US populations in Sweden (Lawoko, Sanz, Helstron & Castren, 2010), Nigeria (John & Lawako, 2010), Uganda (Lawoko, Mutto & Guwattude, 2012) and Jordan (Al-Natour et al., 2014). Good internal consistency and concurrent validity of a shortened version was confirmed in a Swedish sample (Lawoko et al., 2010), noting that the survey was shortened to exclude items which probed about FSV because the purpose of that study was to assess suitability for screening exclusively amongst survivors, and not because of any issues related to the survey per se. John and Lawoko (2010) confirmed the factorial structure and internal reliability, following minor refinements to the instrument. Validation of the survey with Nigerian and Ugandan populations was considered particularly relevant because, like PNG, these countries are culturally distinct from Anglo-European countries where most research takes place, and as low income countries, share similar economic, social and development issues. This adds to the credibility of the survey for use outside Anglo-European settings, like PNG.

Other similar instruments that appear in the literature were considered. In most cases, researchers developed their own survey based on the literature and consultation with domestic violence experts, (e.g. Furniss et al., 2007) or developed from other surveys used in previous research (Colarossi et al., 2010; De Boer et al., 2013). This meant that the final instruments were not publically available for use and/or the psychometric properties were untested. Short, Alpert, Harris and

Suprenant (2006) developed the more contemporary *Physicians Readiness to Manage Intimate Partner Violence* which has good published reliability and validity. However, the instrument targets physicians (rather than nurses or health care providers generally), is longer and more complex to complete and to my knowledge has not been applied outside an Anglo-European context. For these reasons, it was considered less appropriate for this study.

4.6.3.2 In-depth interviews.

In-depth interviews were chosen because they allow researchers to collect data about complexity that would not be possible from standard responses in a survey (Bannister, Burman, Parker, Taylor & Tindall, 1994). Other qualitative data collection methods, such as observations and document analysis, would not yield data to answer these research questions and although focus groups are a quick way to gain in-depth insight, it has been shown that participants may not discuss culturally sensitive material in front of other participants (Caspar & Peytcheva, 2011).

Semi-structured, in-depth interviews use open, pre-determined questions to explore areas of interest but retain flexibility to allow for other questions to emerge from dialogue (Harvey-Jordan & Long, 2001). A semi-structured interview schedule (Appendix E) was used to guide participants through topics and at the same time allowed for follow-up on responses and validation of meaning along the way (Bannister et al., 1994; Harvey-Jordan & Long, 2001). This created the opportunity for new and unanticipated themes to be brought out.

As recommended by Jacobsen (2012), the schedule included a set of open-ended questions and prompts that would elicit data to answer the research questions that were grounded in core themes from the literature. Prompts are used when participants provide minimal responses or need help to unpack the intent behind the question. Refer to Appendix F for a sample of the transcript showing the use of open-ended questions and prompts to draw out information and verify meaning.

Scott (2007) recommends that similar questions be asked from each set of participants in a mixed method design to enable the results from one study to elaborate on the other. The interview schedule deliberately sought to do this by asking broad questions like, "*From your experience, can you tell me what problems or challenges nurses face when treating women with injuries or after a rape?*" Whereas survey statements reflected specific problems or barriers faced by nurses identified in the literature, such as:

Item 20. Asking patients about family and sexual violence is an invasion of their privacy.

Item 26. I am reluctant to ask people who use violence about their abusive behaviour out of concern for my personal safety.

Item 27. There is not enough security at my work place to safely permit discussion of family and sexual violence with people who use violence.

The time taken to complete interviews ranged from 30 to 75 minutes.

4.6.4 Procedure.

Field work took place during a two week period in November 2013. Following approval to recruit participants from the Lutheran School of Nursing and the Pacific Adventist University, the respective heads of schools were contacted and dates to conduct field work arranged to coincide with the Annual Nurses Symposium. Recruitment of postgraduate students to complete surveys and interviews took place at the same time, however recruitment processes at each institution differed. Recruitment of nurses to the survey from the Annual Nurses Symposium occurred separately but during the period of field work.

4.6.4.1 Site 1 – Lutheran School of Nursing.

Two teaching staff used the information sheet and voluntarily advertised the study amongst students who were attending practicums at the adjacent hospital. Potential participants nominated times when they were available to be interviewed. The interviews took place in a private meeting room on campus. Participants came to the meeting room at the agreed time for interview. One student did not attend at the scheduled time for interview.

At the end of the interview each participant was invited to complete the survey. They were provided with the survey, instructions and a sealable envelope. Participants were advised that they could return the survey in person to the researcher at the school on any of the following three days. If they did not wish to participate, they did not need to return the survey. Twelve participants returned completed surveys; one participant declined and returned the incomplete survey.

4.6.4.2 Site 2 – Pacific Adventist University.

A time was agreed with the Dean of the school to meet with students in their classroom. The purposes of the study were explained and students were invited to participate in both the survey and interviews. All students were given information sheets, a copy of the survey, a sealable envelope and a contact form to complete their contact details if they wanted to participate in the interview. Participants were instructed to return the surveys in the sealed envelopes to a secure box which was located in the classroom, which was collected three days later.

Those students interested in participating in interviews were asked to inform the researcher or complete the contact details form so they could be contacted at a later time to arrange the interview. Five people advised they would like to participate in an interview. Mutually agreeable times were arranged. All interviews took place in the staff meeting room at the school.

All interviews commenced with an introduction that included the background to the study and a description of the procedure, including advice that participation is voluntary, anonymous and confidential. Participants had an opportunity to ask questions before signing the consent form. Each participant was made aware of the contact details of support services for survivors of violence should they become distressed during the interview or need these services at a later date. Participants were told they could stop the interview at any time and that the alternate topic of menstruation would be immediately referred to if the interview was interrupted by a third party. All participants were given PGK10 prior to commencement of interview. All interviews were audio-taped.

Interviews commenced with questions about the participant's current job and workplace to build rapport and interviews concluded by asking participants what they most liked about being a nurse to end interviews on a positive note. A script was used to guide interviews, however questions were adapted to fit the flow of responses from participants. After several interviews, it became obvious that some questions were redundant (i.e. Are you aware of protocols or policies that require specific actions by health service providers with regard to violence against women?) and others needed to be reworded (i.e.' What would you like to see happen within the health sector to reduce the health consequences of family and sexual violence?' reworded to,' What do you think would help health workers better manage family and sexual violence?'). During interviews, close attention was paid to the impact of the discussion on the participants, particularly because of the sensitive nature of the topic. During three interviews, the participant became visibly upset. On each of these occasions, the audio recording was stopped and participants given time to express and recompose themselves. Participants were asked if they would like to discontinue the interview. Each one agreed to continue.

4.6.4.3 Site 3 – PNG Annual Nurses Symposium.

Permission was granted by the PNG Nurses Council to use the Annual Nurses Symposium to recruit participants to the survey. Arrangements were made for the survey to be introduced and disseminated during a conference session. For security reasons I was not able to travel to the symposium to recruit participants as intended. Instead, with the assistance of colleagues, I arranged for the survey packs (information sheet, survey, letter of invitation, envelope) to be transported to the symposium. The Chair of the PNG Nurses Symposium agreed to distribute the packs to participants on my behalf and return collected completed surveys to me after the symposium. After discussing this with my thesis supervisor, we agreed that the ethical risks were minimal because information sheets were provided to explain the purposes of the study, the survey was anonymous and I had provided envelopes for their return. Twenty-six completed surveys were returned to me in Australia via secure mail in sealed envelopes eight weeks later.

4.6.5 Data analyses

In approaching the data analysis, underlying principles and methods from grounded theory were borrowed. This study adopts the generic definition of grounded theory offered by Corbin and Strauss (2008) as a methodology for generating theoretical constructs from qualitative data analysis, noting that this approach to grounded theory has evolved from the methodology originally posited by Glassner and Strauss in 1967. A theory is an explanation of how and why something happens. Grounded theory's emphasis on the role of social circumstances in explaining interactions, behaviours and experiences of phenomena (Oliver, 2012) is congruent with critical realism's aim to identify structures and causal mechanisms that underpin experience. Critical realism shares with grounded theory a focus on "*evidence and meaning, individual agency and social structure, theory-building and the pursuit of practical emancipatory goals*" (Oliver, 2012, p371). The methods of grounded theory, in particular open coding, constant comparison and questioning data, help critical realists move beyond description of phenomena to explore the underlying causal mechanisms and answer what Pawson et al.'s (2004) realist questions about what works, for whom, in what circumstances.

The use of grounded theory does not exclude the use of quantitative data (Oliver, 2012; Scott, 2007), which in this study is used as supporting evidence for the theories that emerged from the qualitative data. Therefore critical realist grounded theory is entirely compatible with mixed methods design which is often necessary to answer questions about patterns and regularities in empirical phenomena and to generate rich and deep explanations about the circumstances and forces that shape those patterns and regularities.

This study diverts from traditional grounded theory research in the process of theory development. A key methodological technique in grounded theory is theoretical sampling which is an iterative approach to data collection and refinement of core categories leading to theory development (Creswell et al., 2011). Theoretical sampling is an open and flexible approach to data collection and analysis where the researcher commences analysis after the first data is collected. Concepts that emerge from this analysis determine the source for the next set of data collection. The data collection process becomes more and more refined until saturation of themes is achieved (Corbin & Strauss, 2008). In this study, data collection and analyses were not approached in this way, due to logistical considerations. Therefore, data collection was not driven by the search for evidence of emerging concepts and theories. However, Corbin and Strauss (2008) acknowledge that most research happens in a practical way and that sampling often occurs on the basis of convenience meaning that data is regularly collected in one batch. In such cases, researchers must accept the data they have, but this does not preclude concept-directed analysis or the use of open, axial and selective coding, constant comparison and questioning data, which are the main techniques of grounded theory. Following is a description of how the techniques of grounded theory were applied to an iterative process of data analysis.

4.6.5.1 Survey data analyses.

Survey data was analysed using IBM SPSS Statistics (SPSS). Each survey was allocated a unique code and entered into SPSS. Data was cleaned and examined for missing items. If a participant answered more items, any that were missed were coded as a missing result and reported accordingly. Only one participant completed demographic information only, which was omitted from the final sample. Following this, scores for each of the subscales were calculated and entered.

Demographic information (age, sex, location of work, years, experience) was analysed first to describe the sample characteristics.

Due to the small sample size and the limitations to data quality, only frequencies and percentages were calculated. It was decided that this would still help to triangulate qualitative data and would provide a sense of the trends that exist amongst nurses with regards to survey questions.

The frequency and percentage of each individual item was calculated. The cumulative percentage was reported, meaning that the results were reported based on the number of people who answered that item, with missing items not included in the calculation. Following this, scores were calculated for each of the subscales. These are reported in Chapter five.

No further statistical analyses were undertaken.

4.6.5.2 Interview data analyses.

Qualitative data analysis was performed manually and samples of different procedures described in this section and used in the analyses are included in Appendix G. Summaries of each interview were made during field work. These captured immediate impressions, issues and ideas. All 18 interviews were transcribed verbatim by the researcher into Word files. Grounded theory uses three-stages of data analysis, commencing with open coding, moving to axial coding, then to selective coding as the analysis becomes more and more refined (Jacobsen, 2012). Four transcripts were read to get a sense of the data, before one was selected to commence open coding whereby words describing the pieces of text were noted in the margins of print outs of each transcript. Using suggestions from Miles, Huberman and Saldana (2014), initial codes included descriptive codes, emotion codes and value codes. After each transcript was read and coded, new codes were recorded in a master code list. Word files were transferred to Excel to better manage data and coding. Each transcript was allocated to a worksheet with codes and later categories, noted in columns adjacent to the text. This enabled the process of 'constant comparison' (Corbin & Strauss, 2008) by making it easier to move between transcripts, sort and search for codes and view codes and categories together.

Moving to axial coding, where concepts are prioritised and ordered so that their interconnectedness can be revealed, as a first step all initial codes were clustered manually using sticky labels on large pieces of card, to produce a large, schematic map of emerging categories. As a large number of codes were initially generated, mapping them visually made it easier to see how they related to each other. Where text was coded with similar words or phrases, it was re-examined to ensure that the same meaning could be applied to each code, then the code which best represented the meaning attributed to the text was retained or a new code assigned. In some cases, text was reassigned a third code if it did not fit with the initial cluster. The list of codes was reduced and refined, clusters of similar and related codes became categories and were renamed. For example, 'PNG culture' became a category with related codes including “its normal", “male control” and “customs”. Through the analyses, many of these were collapsed, others reassigned, and some expanded to get to the final model.

Throughout the coding process, transcripts and text were continuously re-read and interrogated with questions like; ‘What is happening here? Who is involved? What are the underlying factors at play? What and who is this not about? What does this mean for identifying FSV? What does this mean for managing FSV?’ This helped to search for deeper meaning and focus the analyses back to the research questions which were aimed at identifying underlying factors involved in explaining nurses’ behaviour towards survivors of FSV

Guided by Corbin and Strauss (2008), analytical memos and diagrams were recorded. Analytical memos about pieces of text were used to probe data for deeper interpretations and assisted in making comparative analyses. These were recorded alongside key pieces of text in Excel. A second set of analytical memos was collected in a separate document as ‘analytical insights’ emerged throughout the process. Mind maps and flow diagrams were used to help tease out how categories linked together. Combined, these processes were critical to the third phase of data analysis referred to as selective coding or development of the main ’storyline’ (Corbin & Strauss, 2008)

The writing process itself became part of the analysis because greater clarity about categories emerged as data were integrated into interpretations. Analytical diagrams became further refined and more focused as the integration of categories into overarching explanations of theories came about. This was the final stage of analysis as described by Corbin and Strauss (2008), where “*all threads of the research were pulled together in a plausible explanatory framework*.”

Note that although the process has been described as linear, it was in fact iterative and with all phases of data analysis happening together and the techniques of coding, comparing and questioning continuing throughout.

4.7 Research Rigour

Research needs to be defensible (Onwuegbuzie & Johnson, 2006). This means that the researchers need to provide sufficient information to make clear the decisions that have been made throughout the process to allow readers to judge that the appropriate methods and tools were used to meet the stated objectives and that the interpretations arrived at are logical, substantiated, give insight and are grounded in data (Corbin & Strauss, 2008).

The criteria of validity, reliability, and generalisability are used to assess the quality of quantitative research (Loh, 2013; O'Cathain, 2010). Agreement on criteria to assess the quality of qualitative studies is more contentious. It is generally accepted that qualitative research should establish trustworthiness. Multiple terms with overlapping meanings appear throughout the literature and have been proposed as criteria for assessing trustworthiness. The most well-known criteria are those proposed by Lincoln and Guba, which include credibility, confirmability, transferability, dependability and authenticity (Loh, 2013; O'Cathain, 2010). These criteria should be used as a map, rather than as a complete list of all standards that a study must meet (Loh, 2013). The combination of methods in MMR makes quality assessment trickier than that of a single study. O'Cathain (2010) proposes a set of eight domains, each with numerous criteria to asses MMR. As noted by the author, the use of so many criteria may be difficult to apply in real life.

To demonstrate that this research is defensible, an account of the decisions that were made and strategies used to design and implement this study have been included throughout this report, particularly in this chapter. In addition, the quality criteria to assess the quantitative, qualitative and MMR, as proposed by previous researchers, has been responded to below.

4.7.1 Quantitative study.

In quantitative research, issues of reliability, validity and generalisability focus on the data collection and sample. Reliability is the extent to which people in comparable situations will answer questions in similar ways (Fowler, 2009). Validity is the extent to which the answer is a true measure and means what the researcher wants it to mean (Fowler, 2009). Generalisability is the extent to which the results can be generalised to the broader population

As discussed this study did not test the validity and reliability of the survey with a PNG sample. This was because of the constraints of conducting field work in PNG within the scope of a doctoral thesis. Instead, the particular instrument used (DVHPSS) was chosen because its reliability and validity had been tested in several other LMIC settings. This added confidence that the tool was appropriate to use with non-Anglo populations. However, a pretest of the survey helped to establish its usability with PNG nurses.

The sample size was smaller than anticipated, which limits the generalisability of the survey. Further, almost half the sample for the survey was made up of nurses studying midwifery which mean that the results are less applicable to a general population of PNG nurses, who for the most part, do not have postgraduate qualifications. These issues are further discussed under limitations. However, the survey results art a valuable source of triangulation for some of the qualitative findings because they strengthen some conclusions and provide a point of contestation to other conclusions. The survey findings are used in this study as an indication of the patterns of knowledge, beliefs and practices of nurses in relation to FSV and have been used with appropriate caution.

4.7.2 Qualitative study.

Trustworthiness is an alternative term used in qualitative research to replace validity, reliability and generalisability. Trustworthiness is particularly important for inductive content analysis because theory is created from raw data, not tested against pre-developed theoretical conceptual maps (Elo et al., 2014). Lincoln and Guba’s (1985) criteria (cited in Loh, 2013; O’Cathain, 2010) for assessing trustworthiness includes credibility, confirmability, transferability, dependability and authenticity. Multiple, overlapping strategies are suggested to improve the trustworthiness of data, many of which involve providing details about the research methodology, including decisions about the sample, data collection and analysis and thus are addressed throughout this chapter (Elo et al., 2014).

Credibility of the qualitative findings was enhanced by triangulation of the data with survey data, peer validation and negative case finding. Triangulation with findings from the survey helped to verify and discount conclusions made through content analyses of interview data. Comparing the findings with international literature was another source of triangulation which helped to establish the degree to which the findings were transferable. This study did not use ‘member checking’, which is frequently proposed as the main method to test the validity of qualitative data. This was because it was not possible to complete data analysis and return to PNG to follow up with participants before they finished their courses at the end of the year and returned to their homes. Further, member checking relies on the assumption that people are privileged commentators on their own actions or have insights into the attitudes and experiences of others even though people may deny or misreport accounts of themselves (Loh, 2013).

To validate the findings, particularly amongst the PNG audience, peer validation was used instead. This process involves discussing emerging findings with knowledgeable colleagues and is aimed at preventing premature closure of analyses (Loh, 2013). Throughout, the preliminary findings were discussed with PNG colleagues to test and interpret. Examples of notes following discussions with peers are included in the section on reflexivity below.

To support interpretations of the meaning, words and phrases from participants have been integrated into the findings, sometimes referred to as the use of low inference descriptors, to demonstrate points (Christensen et al., 2011). An audit trail of decisions made during analyses, including how data was coded, has been provided in the report and appendices to increase transparency of interpretation.

Transferability is enhanced through provision of sufficient detail or ’thick description’ about the setting in which field work took place, to allow judgement about the extent to which the findings would be applicable to other settings. In addition to providing an explicit account in this chapter about how the research was conducted and with whom, two additional sections provide further contextual information, including broader background information about Papua New Guinea as a setting (discussed in Chapter four) and a description of the actual events during field work (Appendix B). Given the nature of this study, it should not be expected that the findings are transferable to many other contexts, however, as argued in the final chapter, there are lessons which can be applied to PNG nurses more broadly and conclusions which strengthen the points made in the international literature, particularly about health responses to FSV in LMICs.

Dependability in qualitative research is similar to reliability in quantitative research. It is recommended that details about how a study was planned, how field work evolved, and how data was collected and analysed, are reported to enable the reader to judge if appropriate research practices have been followed and if another researcher could repeat the research (Loh, 2013). Although the amount of detail in this chapter and throughout the appendices would allow another researcher to replicate the study, in reality this is actually impossible. However an 'honest' account of the planning and execution of this study and the processes of analyses are provided.

To enhance confirmability, steps must be taken to help ensure that interpretations are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. Negative case finding, a technique where researchers actively seek out examples to disconfirm early explanations, helps to enhance not only confirmability but credibility. An 'audit trail' of the research process and decisions made along the way also help to improve the transparency of the researcher's interpretations. Field notes, interview summaries, conceptual maps of data analyses and samples of coding, all form part of the audit trail for this study, some of which have been integrated into the body of the report and others in the appendices.

The final criterion is reflexivity, which strengthens all other criteria. It is a cornerstone of qualitative research and integral to mixed methods research (Finlay & Gough, 2003). The premise of reflexivity is acceptance that the researcher engages in subjective decisions throughout data collection, selection and interpretation and that this is a part of the research process (Bannister et al., 1994; Finlay & Gough, 2003). Charmaz (2006) defines reflexivity as:

the researchers scrutiny of his or her research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interest, position and assumptions influenced inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants and represents them in written reports (pp. 188-189).

Our interpretation of the world is influenced by our cultural, social and historical backgrounds and the research experience is not immune to this. Even with quantitative research, the decisions about the focus of research questions, choice of instrument, selection of sample and use of analyses are all subjectively made by the researcher. Reflexivity accepts that another researcher approaching the same research would tell a different story, therefore reflexivity is about being explicit about the story behind the story (Nagata, 2006). The process of laying bare how one's own actions, values and opinions impact choices throughout the research process, including topic choice, design, data collection and analysis, can transform the problem of research bias into an opportunity to create deeper meaning (Finlay & Gough, 2003; Lambert, Jomeen, & McSherry, 2010). There is agreement about the necessity of reflexivity but the extent to which it is carried out varies depending on the researcher, their orientations and relevance.

Much could be written about my personal reflection on how and why I made each decision throughout the entire process, commencing with choice of topic, through to the final conclusions. Noting Finlay and Gough's (2003) warning that reflexivity is not an opportunity for self- wallowing and emoting, what is presented here is not an exhaustive account of all my reflections of the research experience but a summary of the key points about the impact of my "position, perspective and presence" (Finlay & Gough, 2003) which I believe were particularly influential on this study. In this study, reflexivity is used to help provide what Lambert et al. (2010) promotes as an "an honest interpretation of data" (p. 325).

To begin, this research was part of a Doctoral thesis which influenced the scope, timing and funds available to complete the project which in turn influenced the methodology. As discussed throughout this chapter, the logistical constraints of conducting research in PNG significantly influenced the methodology. Selection of the research topic was based on my personal and professional interest. At the time of selecting a topic, I had been living in PNG, working for an organisation on analysis of service delivery for survivors. I knew more about the PNG health sector than I did about the Australian health sector, therefore it made sense for me to extend this work and conduct research in PNG that filled the evidence gap about health care workers and FSV in the hope of better informing program delivery.

Feminist researchers have urged researchers to be explicit about their position of power in terms of gender, race and class (Finlay, 2002). I am a Scottish-born Australian conducting research in PNG with PNG health workers. I have been privileged to gain a tertiary education and live a life free from poverty and violence. The participants in this study were educated but some have faced significant poverty and many live with types of stress and fear that I have never experienced. Further, there is a unique relationship between PNG and Australia. PNG is a former colony and now the largest beneficiary of Australian aid. White Australians are still referred to as “masta” (master) by some PNGs who believe that white Australians and their ways of living are superior to their own. However many others are acutely aware that this is left-over baggage from colonisation and actively resist white superiority. This is rarely played out in individual interactions, however, I am very aware of the complexities of the broader PNG-Australian relationship and how this influences the way that PNGs see me. In PNG, my race and class positions me as a powerful outsider who at times may be resented.

Interacting with my outsider status is the fact that I have lived in PNG for over eight years and am married to a Papua New Guinean. Work colleagues often refer to me as ’one of us’ because they recognise that I have closer ties to PNGs than other expatriates. Further, through my personal relationships, particularly with family, I have witnessed the effects of poverty, illiteracy and dysfunctional government services. Adding to this, professionally, I have worked for the Australian government delivering their aid program in PNG. Whilst this experience has helped to inform my understanding of life in PNG, as an aid worker of the Australian government, I am seen to be in the powerful position of 'giving' funds or making decisions about aid which affect people's lives, including the participants in this study some of whom were recipients of Australian Government scholarships.

These personal and situational circumstances interacted with data collection and analysis. For example, during data collection, because I was a white Australian and they were PNG students, there were power differentials between us. This meant that participants may have felt uncomfortable sharing their true experiences and felt obliged to tell me what they believed I wanted to hear and what they perceived to be the correct answer. There were occasions when participants did make comments like "*I'm not sure if I'm answering correctly*". This could have been both a result of their identifying as students, feeling that the process was like a test, as well as a reaction to me, an Australian, who they felt knew what the correct answer was. I picked this up during field work when writing an interview, when writing a summary, and also later during data analysis.

> *At times I was unsure if the participant was telling me what she does do or what she thinks should be done. Could be influence of her feeling the need to project a particular view of herself to me, Australian* (Interview Summary, Participant 9)

> It's *not always clear if participant telling what they do or what they think they should do or trying to say correct answer. What are participants understandings of interview, do some treat like an exam or test of their knowledge*?(Analytical Notes, April 2014).

I kept an awareness of this when analysing data. Other comments made during interviews about the research, validated the relevance of the study for participants. For example, "*I think for the research that you are doing it gives me an opportunity to speak up for and address the things, just one out of how many nurses in PNG, we* *are facing this kind of things*" and "*I'm really happy that there is research conducted and I hope that the results If you university or faculty allows you to publish that it would be good for upcoming nurses and midwives and other professionals who deal with this very thing*". Further, at least five participants personally shared their experience of FSV which signalled that there was a degree of trust built during the interview.

The second major influence on the project is how my position as well as my intimate relationship with PNG, provided both insight but also bias when interpreting data. For example, I had visited some of the facilities where participants worked and knew the extent of constraints. I knew what local words and phrases meant, including those in Tok Pisin. At the same time, I had preconceived ideas about life and the health sector in PNG. I already believed I knew the weaknesses in the health system, I knew that there were high levels of FSV and that for most women, this was a usual experience and was related to complex social and cultural issues. This placed a risk that I would 'go native' by over-identifying with my participants and thus blurring my role as a researcher with that of a longer term resident working in the sector. To assist in retaining an 'honest interpretation of data' I used a number of strategies. I wrote a summary at the end of each interview, I kept notes on my thoughts, feelings and reactions as they arose during field work and data analyses and frequently discussed my research and findings with PNG colleagues to check that I was on the right track. Here are some examples which helped me to recognise how I was interacting with the data:

> *A note about the translation of words like 'shy' from PNG English to Australian English. Shy often used to describe feeling embarrassed. Ask at work what people think shy means*. (Analytical Notes, April 2014)

> *I see that my thinking is much more closely aligned to thinking about health systems and health policy. In the process of my research journey I have changed jobs, moved country twice and now work on health systems strengthening in PNG. I wonder how much I can attribute to arrive at this*

> *point to my journey as a health professional as much as to theory merging from the data*. (Analytical Notes, May, 2015)
>
> *Spoke to C and D today about using the term "It's normal" and what it means. It's a translation of Tok Pisin "em normal yah", meaning it happens all the time, that's just the way it is. But I'm reminded of M's point that just because people say "it's normal" doesn't mean they agree with FSV, it's more likely that feel powerless to make change, and therefore accept its part of life*. (Analytical Notes, Dec 2014)

Remaining sensitive to the fact my worldview is coloured by my beliefs and values and is not necessarily shared with my participants, I was acutely aware not to judge and react to data. For example, there were numerous times when participants told me that the counselling they provide is for survivors and their husbands. This is counter-intuitive to my feminist, person-centred counselling orientation but I had to put that aside to understand why this was important to these people. This was necessary to enhance reflexivity and therefore trustworthiness but also to enable meaning and context to be unpacked to answer the critical realist questions, "what, for whom and in what circumstances".

4.8 Limitations of the Design

The main limitations to this study are related to the logistics of implementing a research project in Papua New Guinea, when based in Australia, as a part-time student. The real and actual challenges faced in attempting to carry out this research are included in Appendix B and provide a detailed background to the limitations of this design.

4.8.1 Interviews.

Due to poor infrastructure, limited services and security issues, the logistical requirements to collect data from a range of health care facilities in Papua New Guinea were beyond the resources available to complete this study. This limited options for the design of the study, resulting in a decision to recruit participants from postgraduate training courses. There are two main limitations with the sample selected for interviews, both of which impact the representativeness of the findings. Firstly, a convenience sample cannot be assumed to be representative of the broader population and therefore the results may not be generalizable (Etikan, Musa & Alksassim, 2016). Secondly, as evidenced by their enrolment in postgraduate training courses, the nurses who participated in this study have a commitment to professional development, thus have a higher level of knowledge and skills than the general population of nurses. This brings a particular bias to the qualitative results which need to be interpreted with this in mind. Further, these participants were studying midwifery, which means that their responses would be biased by their knowledge of maternal health.

The interviews were conducted in English which is one of three national languages in PNG and is the language used by government, including in the education system. Because participants were postgraduate university students, all of participants were able to converse in English. However, for many English is not their first language and this may have impacted participant's understanding of questions and my interpretation of their responses. Further, PNG English, like all versions of English has nuances in the way it is spoken and it is often intermixed with Tok Pisin words and phrases. I used my knowledge of PNG to help unpack meaning in transcripts and also referred to friends and colleagues for advice. However, the interpretation of meaning may have been limited by my comprehension of participant's language.

4.8.2 Survey.

4.8.2.1 Field work.

Two field trips were planned for data collection, the first coincided with a work trip to reduce costs and the second was scheduled according to the training institutions' preferences for visiting their campuses. Delayed ethics approval on the PNG side reduced time for data collection overall and meant that the pretest focus group was not able to proceed during the first field trip, which was instead used to personally follow up ethical clearances. This led to a decision to pretest the survey using a group of experts via email. Ten experts were invited, through convenience sampling, to participate in reviewing the survey to test its suitability for use in PNG. A total of five responded, three before the deadline for amending and printing and two after the deadline. Issues identified in expert feedback, particularly relating to the language and phrasing of questions, could have been better addressed if a focus group has been used. With hindsight and review of the late feedback, there are several questions which may have been inappropriate for a PNG audience. The use of convenience sampling in this case, means the comments may not be representative of experts more broadly on the use of survey in PNG. Caution has been exercised in interpreting the survey results which have been used to supplement qualitative conclusions rather than providing decisive evidence in their own right.

4.8.2.2 Sampling strategy.

The delays caused by the slow turnaround and non-response from the relevant ethical review boards in PNG impacted the sampling strategy for phases one and two of the quantitative component of the study. This has resulted in reduced validity of the survey data.

The study was initially designed to collect data from students at three universities (University of Goroka, University of PNG, Pacific Adventist University) and one training school (the Lutheran School of Nursing). Although ethics applications were submitted to each of the universities, the Pacific Adventist University was the only institution to provide a formal reply. The Lutheran School of Nursing did not require formal ethics review but did provide a permission letter.

Due to time restrictions, a decision was made to proceed with only two training institutions, reducing the potential pool of participants, particularly as the University of PNG has the largest postgraduate student intake. This led to the late decision to include the PNG Annual Nurses Symposium as a second setting to collect survey data.

During fieldwork, it became apparent that it would not be possible to personally travel to the venue of the PNG Annual Nurses Symposium as planned because of significant security issues (tribal fights). Instead, using personal networks, the survey packs (information sheets, survey and envelopes) were collected and transported to the conference separately and later returned to me in Australia. Of the 260 sent to the conference, only 26 were completed.

The sample size was not large enough to conduct multivariate analyses, meaning that the results are limited to descriptive analyses. As the number of participants recruited from the symposium was small, approximately half of the entire survey sample is now made up of postgraduate students. Therefore the survey results must be treated with caution because they are not generalisable to either postgraduate students or to nurses more broadly.

Further the surveys were not administered as per original design. Instead the Chair of the Nurses Association distributed these on my behalf. The intention was for me to introduce the research, explain the purposes of the study and provide instructions on how to complete the survey. I do not know how the research was introduced or surveys distributed at the conference and the Chair is now deceased. Although details about the study and instructions on how to complete the survey were included in packs, the inability to provide this information verbally may have affected participation rates.

A further limitation of the survey is that the label 'not sure' was used for a neutral response. In some cases, it is not clear whether some participants have marked their response as 'not sure' because they did not understand the question or because they neither agreed nor disagreed, and this impacts interpretation of the findings. To deal with this, other information was considered when making a judgement about the response rate. For example 35.8% of participants responded 'not sure' to Item 14 – '*When it comes to family and sexual violence, it usually "takes two to tango*". It is likely, particularly in the context of additional late comments from a reviewer of the survey, that many participants may not have understood the phrase, "it takes two to tango". Item 4 had 27.5% of people respond 'not sure' to the statement "*I am confident that I can make appropriate referrals for people who use violence*", which probably meant that participants did not know how, where or to whom to refer these people. In this case, responses to other items in the same subscale, i.e. Item 5, *"I feel confident I can make* *appropriate referrals for abused patients"*, against which only 18.5% responded 'not sure', suggests that the high response rate for 'not sure' may be related to uncertainty about making referrals (which is what the question is asking) rather than a lack of understanding about the question. However, caution was used when interpreting high frequencies of neutral responses.

4.9 Ethics Approvals

The WHO (2001) recommendations for research on domestic violence against women were considered in the design of the study. As such, emphasis was placed on a study design that maintained safety, protected identity, and minimised distress and that, as a researcher, I was sufficiently prepared to undertake research on a sensitive subject.

Ethics approval was granted from the Social and Behavioural Research Ethics Committee, Flinders University, and as such complies with the National Statement on Ethical Conduct in Human Research, (2007). In PNG, ethics approval was granted from the Medical and Research Advisory Council, National Department of Health, PNG, and the Institutional Review Board of Pacific Adventist University and a letter of permission was granted from the Lutheran School of Nursing. Ethics approval from the MRAC was required to conducted health related research in PNG. Ethics approval from the Pacific Adventist University was required to recruit students from that university. A letter of permission was required from the Lutheran School of Nursing to recruit students from that school, noting that as a small health training institution they do not have a formal research ethics review board. Copies of the approval letters can be found in Appendix H.

Ethics applications were also submitted to the University of Papua New Guinea and the University of Goroka. No response was received from these review boards.

Chapter 5: Quantitative Findings

This chapter reports the results from the Domestic Violence Healthcare Provider Survey Scales (DVHPSS), developed by Maiuro et al. (2000), which was used to measure nurses' domestic violence-related knowledge, attitudes, and beliefs, because the literature identified these as key factors influencing FSV enquiry. The self-reported frequency of enquiry about FSV was also measured to gauge an indication of practice. The survey sample was small and therefore these findings are used to provide descriptive information only and by doing so provide an indication of possible trends amongst a group of PNG nurses with respect to FSV enquiry.

5.1 Subscale Responses

The subscales were scored according to the scoring key (Mauiro et al., 2000). The range of scores was equally divided into low, moderate and high categories to get a sense of the proportions of participants who scored across the subscale. Where the range could not be equally divided, the larger range was accorded to moderate scores. The spread of low, moderate and high scores for each subscale is displayed in Chart 1, which demonstrates the indicative trends in how PNG nurses self-report against these factors.

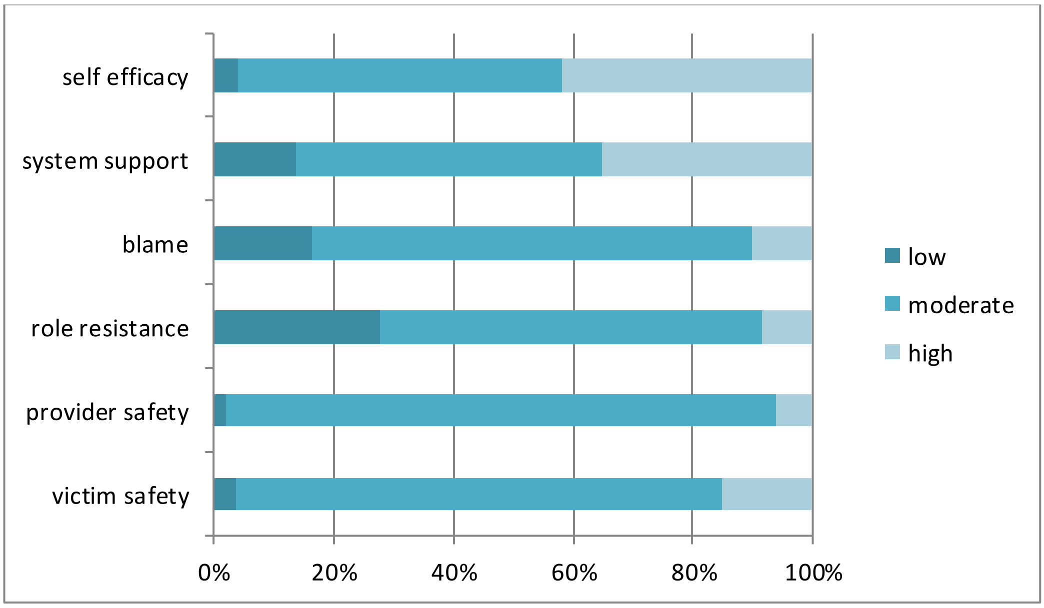

Chart 1: Percentages of scores for the DVHPS subscales

The mean, mode and percentages for low, moderate and high scores for each separate subscale are reported here. Responses for individual items 1 – 35 are in Appendix I.

5.1.1 Self-efficacy subscale.

No. of Respondents	Mean Score	Mode	% of scores 7-16 (low)	% of scores 17-26 (moderate)	% of scores 27-35 (high)
50	25	29	4	54	42

Table 9: Self-efficacy subscale

Perceived self-efficacy is the degree to which participants feel confident to work with FSV cases and is measured by items 1 – 7. The subscale scores show that the majority of nurses (54%) scored moderately on perceived self-efficacy, with slightly less (42%) scoring highly and only a small proportion (4%) with a low score. This is because of the high number of participants who strongly agreed or agreed with items 2, 5 and 5, which indicates high levels of self-confidence by participants in their own skills to help survivors. The items which scored lowest (items 1 and 7) related to time and access to information. Both of these are reflective of organisational factors rather than attributes of the individual HCP.

The highest frequencies in the self-efficacy scale indicate that the majority of participants either agreed of strongly agreed with item 2 *"There are strategies I can use to encourage perpetrators to seek help"*(79.2%); item 3, *"There are ways I can help victims of family and sexual violence change their situation."* (71.9%); item 4, *"I feel confident that I can make appropriate referrals for people who use violence"* (56.9%); and item 5,*"I feel confident that I can make referrals for abused patients"* (67.9%). However, 50% strongly agreed or agreed with the statement *"I don't have time to ask about FSV in my work"* (item 1) and only 35% strongly agreed or agreed with the statement *"I have ready access to information about how to manage family and sexual violence"* (item 6). On item 7, the spread of frequencies across responses was similar, with 43.4% strongly agreeing or agreeing to *"There are ways*

I can ask people who use violence about their behaviour that will minimise risk to the potential survivor". However, 35.8% responded 'not sure', which could indicate uncertainty about their ability to reduce risk for survivors.

5.1.2 System support subscale.

No. of Respondents	Mean Score	Mode	% of scores 4-8 (low)	% of scores 9-15 (moderate)	% of scores 16-20 (high)
51	13.5	19	13.7	51	35.3

Table 10: System support subscale

System Support measures nurses' access to support networks and referral services for survivors, and was measured by items 8 – 11. The overall subscale scores revealed that most participants scored moderately (51%) with just over one third (35.3%) with high perceived system support and 13.7% with low system support. Social work and mental health services, if available at all, would be available in hospitals, so these results are consistent given that 58% of the participants reported working in a hospital setting.

The majority of participants strongly agreed or agreed with item 8, "*I have easy access to social workers or community groups to assist in the management of cases of family and sexual violence*" (52.8%); and item 9, "*I feel that hospital social work personnel can help manage family and sexual violence patients*" (73.1%). In fact, item 9, had the highest reported frequency for all strongly agreed statements at 42%. Conversely, 41.5% of participants disagreed or strongly disagreed with item 8, which is perhaps a reflection that access to social workers in the health sector is contingent on facility type and location. Similarly, only 41.5% of participants agreed or strongly agreed that they have ready access to mental health services (item 10) and 42.3% that mental health services were able to meet the needs of survivors (item 11). This may be related to low numbers of mental health professionals and the fact that most work exclusively with psychiatric patients or in the private sector.

5.1.3 Blame subscale.

No. of Respondents	Mean Score	Mode	% of scores 7-15 (low)	% of scores 16-26 (moderate)	% of scores 27-35 (high)
49	19.8	18	16.3	73.5	10.2

Table 11: Blame subscale

The Blame subscale is made up of items 12-18 and measures nurses' attitudes toward survivors. A larger majority of participants (73.5%) scored a moderate score on this subscale, with only 10% scoring highly, meaning that they are more likely to blame survivors for FSV, and 16.3% with low scores. There were some curious inconsistencies in responses to items on the Blame subscale, with a high number of people responding 'not sure' to item 12 (30.8%), item 14 (35.8%) and item 17 (27.5%), which may be linked to ambivalent attitudes about FSV.

Items which had a larger proportion of strongly agreed or agreed responses, indicating higher levels of victim blaming, included item 12, "*A victim must be getting something out of the abusive relationship or else he/she would leave*" (36.5%); item 14, "*When it comes to family and sexual violence it usually "takes two to tango*" (41.5%); and item 16, "*Women who choose to step out of traditional roles are a major cause of family and sexual violence* " (37.7%). This reveals that at least one third of participants hold victim blaming attitudes.

In contrast, three quarters of participants (75%) disagreed or strongly disagreed with item 13, "*People are only victims if they choose to be*". In fact, 48% of participants strongly disagreed with this statement. Further, 49% strongly disagreed or disagreed with item 17, "*The victim's emotionally dependent personality often leads to abuse"* and 45.3% with item 18*, "The victim has often done something to bring about the violence in the relationship*". These results show a mix of attitudes towards survivors which is consistent with the way in which beliefs about gender roles interact with men's power and control over women and the use of violence.

5.1.4 Role resistance subscale

No. of Respondents	Mean Score	Mode	% of scores 7-15 (low)	% of scores 16-26 (moderate)	% of scores 27-35 (high)
47	18.5	16	27.7	63.8	8.5

Table 12: Role resistance subscale

Role resistance is about whether nurses perceive that asking about FSV conflicts with their beliefs about their role as a health care provider and was measured by items 19-25 on the survey. Overall, the total subscale scores balanced out with 63.8% scoring moderately, 27.7% with a low level of role resistance and a small proportion 9.5%, with a high level of role resistance.

Items 20, 22, and 25 on the role resistance subscale had similar proportions of frequencies spread between those who strongly agreed or agreed and those who disagreed or strongly disagreed. Forty-two per cent reported that they strongly agreed or agreed with item 20, "*Asking patients about family and sexual violence is an invasion of their privacy*"; whereas 46.5% disagreed or strongly disagreed with the same statement and 11.5% were 'not sure'. For item 22, 37.5% reported that they strongly agreed or agreed with the statement, "*If I ask non-abused patients about FSV they will get very angry*". The same percentage (37.5%) disagreed or strongly disagreed with the statement and a further 25.5% reported that they were unsure. For item 25, 38.5% agreed or strongly agree that "*If patients do not reveal abuse to me, then they must feel it's none of my business*", whereas 40.4% disagreed or strongly disagreed and 21.2% were unsure. If role resistance is a barrier, then the responses to these items signals that for just over one third of participants, issues of privacy and offending patients remain a concern when asking about FSV.

The other items on the scale provide more insight into how nurses in PNG perceive their role in relation to FSV. For items 19, 21, 23 and 24, the majority of participants responded that they disagreed or strongly disagreed with the respective statements. In particular, 81.1% of participants either disagreed or strongly disagreed with item 24, "*I think investigating underlying cases of a patient's injury is* *not part of medical care*". In fact, half the participants (50.9%) strongly disagreed with this statement. This is important because the belief that FSV is not a medical issue has been identified in the international literature as a key barrier to identifying and appropriately managing cases. For these participants, the overwhelming majority believe that investigating FSV is part of their job. In addition, only 6.5% of participants disagreed or strongly disagreed with item 21, "*It is not my place to interfere with how a couple resolve conflict*". This is contradictory to other beliefs that FSV in PNG is a private matter and perhaps is a sign that nurses perceive their role and responsibilities as a health professional differently to their role as a family and community member. This has implications for the development of interventions, which could be designed to capitalise on the perceived role and status of health care providers.

5.1.5 Victim and provider safety.

The ten items on the victim and provider safety subscale assesses whether nurses perceive that discussing FSV with patients puts survivors or care providers at risk. Items 26-31 measure perceptions of provider safety and items 31-35 measure perceptions of victim safety.

No. of Respondents	Mean Score	Mode	% of scores 6-13 (low)	% of scores Moderate (14-22)	% of scores High (23-30)
53	19.1	18	2	92	6

Table 13: Provider safety

No. of Respondents	Mean Score	Mode	% of scores 4-8 (low)	% of scores 9-15 (Moderate)	% of scores 16-20 (high)
53	12.8	12	3.8	81.1	15.1

Table 14: Victim Safety

Overall, participants responded with higher levels of agreement about issues concerning the victim's safety than provider's safety. However, as with other subscales, the majority of participants on both scales (92% on provider safety and 81.1% on victim safety) scored moderately.

In response to item 26, "*I am reluctant to ask people who use violence about their abusive behaviour out of concern for my personal safety*", 41.5% strongly agreed or agreed, with another 30.2% reporting 'not sure'. The high number of participants reporting 'not sure' could be because talking about FSV with perpetrators in health settings would be uncommon and many participants may have never been in a position to do this, therefore are unsure about the safety risks.

Almost half (49.1%) of participants agreed or strongly agreed with item 27, "*There is not enough security at my work place to safely permit discussion of FSV with people who use violence*", which is a serious concern for the safety of health care staff, especially given that 59.7% of nurses strongly agreed or agreed with item 29, *"When challenged, people who use violence frequently direct their anger towards me"*. More than half the nurses in this sample report that they perceive a safety risk when asking about FSV and that they do not have security to protect them. However, 87.4% strongly agreed or agreed with item 30, "*I feel there are ways of asking about violence behaviour without placing myself at risk*", and 56.6% strongly agreed or agreed with item 31, "*I feel I can effectively discuss issues of violence and abuse with people who use violence without further endangering the victim*". These results are in line with the high levels of self-efficacy reported in items 1 – 7, which reflected a level of confidence in nurses' skills and abilities to work with survivors and cases of FSV. It also indicates that despite the personal risk, nurses have strategies to talk about violent behaviour safely.

Similar levels of confidence in being able to talk about FSV without endangering victims were reflected in item 32, with 56.6% strongly agreeing or agreeing with the statement, "*I feel I can discuss issues of violence and abuse with people who use violence without further endangering the victim.",* and 54.7% strongly disagreeing or disagreeing with item 34, "*There is no way to ask people who use violence about their behaviours without putting the victims in more danger*". Although it should be noted that 28.3% of participants responded 'not sure' to item 32 and 20.8%

responded ‘not sure’ to item 34. Responses to items 33 and 35 were more evenly spread.

5.2 Frequency of Enquiry.

Items 36- 41 measured nurses’ frequency of enquiry about FSV when seeing patients with health complaints that may be caused by abuse. These are reported in Table 15.

Frequency of enquiry about FSV in past three months when seeing patients with the following health complaints	**Never %**	**Rarely %**	**Sometimes %**	**Often %**	**Always %**	**N = 53**
Injuries	15.7	17.6	39.2	13.7	13.7	51
Chronic pelvic pain	35.2	15.1	26.4	5.7	15.1	51
Irritable bowel syndrome	49.0	19.6	17	7.5	5.7	51
Headaches	36	20	26	8	10	50
Depression and/or anxiety	15.4	17.3	34.6	17.3	13.5	52
Hypertension and/or coronary heart disease	29.4	21.6	21.6	11.8	15.7	51
Pregnancy or OB/GYN care	26.0	6.0	28.	20.0	20.0	50

Table 15: Frequency of enquiry about FSV

The results show that rates of enquiry about FSV when seeing patients for related health complaints are not high and that asking about FSV is not happening regularly. On every item, the majority of participants either never ask about violence or do so rarely or on occasions. Of particular note is that only 17.4% of these participants either often or always ask about FSV when seeing patients with injuries. This is worrying as survivors are most likely to seek out treatment for physical injuries which are often the most visible sign of FSV. On a slightly more positive note, 40% of these participants do ask about violence always (20%) or often (20%) when seeing patients seeking maternal health or reproductive care. This is possibly because of the large number of students studying midwifery in the sample and a greater awareness amongst them about the causes of poor maternal health.

Despite this, there were still 28% of participants who only ask about FSV sometimes and 26% who never ask patients seeking pregnancy or OB/GYN care about FSV. These results suggest that asking about FSV is not happening as part of standard practice.

5.3 Conclusion

Although the sample size for this survey was small, the results have indicated important trends. On all subscales, the majority of participants scored moderately, however a higher proportion of participants scored highly on self-efficacy and system support, and only a small proportion had low scores on perceived safety. The individual items provide a better context to provide explanations behind subscale scores and are a useful complement to the qualitative data. Further interpretations of what these findings mean in the context of the whole study are discussed in Chapter seven.

Chapter 6: Qualitative Findings

The current study sought to explore how Papua New Guinean nurses identify and manage cases of family and sexual violence. Taking an inductive approach, interviews with 18 nurses were conducted to find out what nurses do when survivors of violence come to health facilities for services and what factors influence and drive their practice. Past research was explored prior to interpretation and this research framed points of enquiry covering perceptions about FSV as an issue in PNG, procedures and processes when dealing with survivors in health facilities, and barriers and enablers for nurses when responding to survivors. Rich and deep information was collected providing a comprehensive set of data for analysis. The analyses focused on finding the underlying factors that explained why nurses do or do not take certain actions and in what circumstances. Four overarching themes and one minor theme emerged, as shown in Table 16.

Importantly these themes are deeply interconnected and this was evident in the participants' narratives which revealed a combination of a multitude of complex factors that interact to drive what nurses say and do and ultimately shape the current health sector response to survivors in PNG.

The next section presents the themes and subthemes through a detailed analysis of data. A selection of quotes is used throughout to illuminate the interpretation and substantiate conclusions. There is a brief introduction to each theme but the bulk of discussion about what these findings mean is presented in the chapter seven, where these findings are brought together with the results from the cross-sectional survey and synthesised with the international literature to draw broader conclusions about what works, for whom and in what circumstances.

Theme	Subtheme
Views and experience of Family and Sexual Violence	Views on the problem of FSV Experience of FSV in the workplace Personal experience of FSV
Cultural beliefs, attitudes and practices	Cultural acceptance of violence Male control of women's access to health Customary practices that influence FSV services • Bride price • Polygamy • Interactions with relatives Fear of Perpetrators • Nurses' fear of perpetrators • Disclosure is risky: Patients fear of further abuse
The operating environment	Medical supplies Physical environment Staff shortages Knowledge and skills • Pre and in-service training Fees
Professional practice	Identifying FSV • History taking • How to ask about violence • Third party disclosure Management of cases • Treating physical symptoms • Medical reports Further Help: Counselling & referrals • In facilities • Police • Churches • Village leaders • Social workers • Effectiveness of referrals Negative attitudes of nurses • Frustration because of repeat cases A biomedical response The role of nurses in responding to FSV

Table 16: Qualitative themes and subthemes

6.1 Views and Experience of Family and Sexual Violence

This theme is about nurses' own perceptions and experiences of FSV. It is drawn from the thoughts and feelings participants shared about FSV as an issue in PNG, as well as their descriptions of FSV cases that they have dealt with in their work and in their personal lives. The evidence demonstrates a need for nurses to be able to respond to survivors in health facilities and acknowledgement by nurses that it is important for them to do so. What is striking from the comments is that every single participant shared at least one story of a survivor they had encountered in their workplace. Many of the experiences shared were brutal and disturbing.

All participants worked in general health care facilities and all participants were able to describe some of the health consequences of family and sexual violence, although there was an emphasis on external physical injuries and sexual and reproductive health issues. Participants were of the view that survivors only come to health care facilities following severe attacks, which suggests that much FSV goes untreated and unnoticed. Despite this, participants explained that family and sexual violence is not considered an important issue and remains largely unaddressed both within the health sector and across PNG more broadly.

6.1.1 Views about the problem.

Interviews confirmed that most incidents of FSV occur between "*married couples*" and are perpetrated against females by their male partners, for example, "*mostly it was the women who have been victimised by husbands*," (P11), noting that people living in de facto relationships are considered husband and wife in PNG. One participant acknowledged that men can also be survivors of violence but "*a very low portion compared to females*" (P2). Several participants also commented on sexual violence against children, "*especially little girls*", within families. For example, "*underage [children] being sexually abused by their father or step-fathers or their close relatives*" (P5). A number of cases involving girls, some "*as young as 2 years*" (P4), were described. P18 said, "*I only seen one, I think 10 or 9 years old, small girl. Yeah but its rape by one of the eighteen years old boy in the villag*e". Violence against children is particularly "*sensitive*" and not well understood in PNG. However, most of the discussion by participants in this study focused on male intimate partner violence.

On one hand, most participants stated that FSV was a "*big issue*" in PNG. There was a general sense that it is a "*serious proble*m" and is widespread, with one participant claiming that "*90% of families go through it*". Additionally, participants thought that FSV is "*rising*", becoming more frequent, with the problem getting "*worse*". The term *'priority*' was used by several participants when describing what they thought about FSV as a health issue. For example, "*Personally, I see it is a priority health issue*" (P16), and "*in relation to sexual violence it should become a priority or a must that every nurse must know how to deal with these issues*." (P7). This is not really surprising given the number and severity of FSV cases that nurses are dealing with in their routine work.

However other comments suggest that FSV is not seen as an "*important issue*" and that, for nurses more broadly, it is not their "*concern*". In PNG, FSV is "*not talked about, especially in health settings*" (P13). As P4 explained:

> *Family and sexual violence in PNG is like, it's an issue to me but I think most of the time it's never been raised as a topic…by most health workers especially. Maybe due to cultural issue or something so like most of the time they try to avoid that. Like it's not commonly discussed, but otherwise it's an issue that is being faced by most of our women especially and girls. ..But I think its important thing we should consider. (P4)*

These participants clearly identified FSV as a serious issue for the health sector but at the same time explained it was generally not considered important or prioritised by health workers, that "*only a few of us see this as a problem*" (P16). Throughout participants described and discussed what "*they*" do and by doing so, distanced themselves from the behaviour of others. What is important is that individuals can see an issue as important but work in a system that does not. This can contribute to nurses feeling disempowered. As alluded to in the text above, culture is one of the factors which contributes to the low prioritisation of FSV within the health system and this is discussed in detail, as are the other factors that influence if and how nurses respond to survivors. Examination of these underlying factors that influence how nurses behave helps to explain why such a serious issue is not prioritised.

6.1.2 Experience of FSV in the workplace.

All participants were able to describe some of the health consequences of family and sexual violence, with an emphasis on external physical injuries and sexual and reproductive health. Participants described dealing with "*physical injuries*", "*fractures*", "*wounds and swollen faces*", "*deep lacerations*" and "*bruises on the skin*". P14 described a woman who "*had her jaw dislocated and 4 -5 teeth just removed.*" This was one example of several descriptions of severe cases of abuse against women. P17 explained that "*sometimes they can't walk because they are badly beaten*". Longer-term effects of violence, including "*disfigurement*" and "*disabilities of the limbs*", and "*living with pain*" were also identified. The chronic effects of violence were acknowledged, "*for some of them it's a lifelong thing*" (P7).

The psychological effects of violence, were also discussed, particularly "*depression*", "*being mentally disturbed*" and "*mentally traumatised*". P12 explained, "*it's like affecting them psychologically. I see problems, emotional problems especially. Like the wounds and all this they go but I still see them as being depressed.*" This is particularly worrying because of the limited availability of counselling and mental health services in PNG.

The impact of violence on women's sexual and reproductive health was highlighted. Participants described "*birth complications*", "*vaginal bleeding*", "*chronic STIs*", and miscarriage. The amount of violence-related health issues that these participants are dealing with is considerable given that none of these participants work in trauma or other specialist areas and that very few have had any training on dealing with FSV. Below are examples of cases which demonstrate the severity of the types of cases nurses regularly deal with in PNG:

> *There was one I can remember with sexual violence, the husband I don't know what he was using and she got her cervix torn really bad*. (P15)
>
> *One mother, who's 38 weeks of pregnancy and it's almost her time for delivery so her husband was always drinking and try to fight with this female, wife. So one time they fight and then he got the pocket knife, just, he tried to kill the wife. Yeah stab all the tummy, goes down and almost injured the foetus inside*. (P18)

> *I can remember a case, this student, she's a student grade 11 student, and she was sexually assaulted on the way back to school … and when she came, her face was really swollen, as well as that, she has vaginal bleeding and vaginal trauma so that's one of the very case. She was maybe about 16 or 17. That I just couldn't forget. She was severely traumatised and she was in our care for so long, for treatment*. (P4)

> *There was a girl, 10 year old girl, she was raped and then she was brought in. I think she was mentally traumatised so she came in, she didn't even eat anything, she just sat down. Just put a drip on her, tried to talk to her but she didn't even respond, even the parents she doesn't want to talk to her parents.* (P10)

6.1.3 Personal experience.

Given that nursing is a female-dominated profession, it was not surprising to learn that many nurses experience FSV. A number of participants disclosed their own experiences and those of colleagues. For example, "*Nurses, caregivers are victims ourselve*s" (P7) and "*some of my colleagues…they are still violated by their husbands*" (P3) and "*Yes we do have a lot of nurses with this domestic violence"* (P14). However, it was identified that many nurses "*do not talk*" (P13) about their personal experience of violence with colleagues, "*they keep it to themselves*" (P15). Additionally, nurses themselves are reluctant to provide support to colleagues. They said, "*we don't really support each other*" (12), "*We don't go near him or her*" (P1). The reasons given were fear "*the husband is so violent we fear for us*" (P3) and because "*it's their own problem*" (P14) which is linked to broader cultural beliefs about FSV. These issues then limit nurses' ability to help and even if nurses want to help their colleagues they feel they cannot. As P3 said, "*we cannot help her*".

Further, it was noted that there is a lack of support for nurses from workplace supervisors. It was said the supervisors "*don't have time for the staff*" (P15), are "*not doing anything*" (P8) and "*I don't see that they take it seriously"* (P?), meaning that nurses, like other survivors, are given little assistance to deal with FSV.

Importantly for the health sector, this has an impact on the productivity of nurses and hence on the quantity and quality of services.

Absenteeism was the most commonly cited consequence - "*they skip work*" (P10) and "*She gets injured she cannot come to work*," (P18). Absenteeism then creates higher workload for others "*that workload is there for others*". This adds to the challenge of delivering services where there are already low numbers of health workers. This creates feelings of resentment towards survivors as P8 explained, "*it's very hard to come and work with people who are victims*". The impact of trauma on nurses' ability to carry out their normal duties was also raised. P15 observed that because of their "*problems at home*", for some survivors "*frustration builds up and they throw it on the patients*" suggesting that when people are living with FSV, they are less empathetic to patients. P5 raised a similar issue saying, "*when she is traumatised, she doesn't perform to the standard*". Although not explored in depth in this study, from these comments, personal experience of violence is a barrier for nurses in being able to support other survivors or provide general patients with appropriate care, affecting the quality of care.

6.2 Cultural Beliefs and Practices

This theme is about how cultural beliefs about gender and gender practices influence how nurses identify and manage cases of FSV and is discussed through four related sub-themes. In particular, the normalisation of violence and the acceptance of male control over women's health has a significant impact on how care and treatment for survivors is delivered. In particular, cultural beliefs can generate negative attitudes towards survivors and, as a result, nurses deny or limit the quality of care. Bride price and polygamy emerged as customary practices which reaffirm cultural norms about FSV and influence the attitude of nurses. Customary rules about interacting with in-laws were identified as impacting nurses' ability to treat and care for survivors. The acceptance of male violence also contributes to heightened safety and security issues for nurses who assist survivors.

6.2.1 Cultural acceptance of male violence against female intimate partners.

The word "*normal*" was repeatedly used by multiple participants when describing male violence against women and the normality of it was linked to PNG culture. For example, "*in PNG culture, they find it's normal for wife beating*" (P12) and "*it's normal for a woman to be belted*" (P7). Normal implies that FSV is routine, regular, part of daily life and what usually happens, therefore not out of the ordinary. This helps explain why FSV is not seen as a priority, it is a social and cultural norm rather than behaviour that is regarded as unacceptable.

References to "*our culture*" recurred as an explanation for FSV, for example, *"So they think that because of the culture, I have to be beaten up, I have to accept it"* (P 11). Going further, it is the cultural beliefs held about men and women's roles and relative positions of power that maintain and underpin the use of violence against women. This was clear when participants explained why there is so much FSV. For example, P3 said: "*We are to submit under them. Everything*." and "*They are up there, they are bosses and they control everything and we are just like nobody to them*". In this statement P3 was referring to the unequal status between men and women which gives men power over women and places them in control, leaving women disempowered with little control over their own lives. Her use of the phrase "*we are just like nobody*" encapsulates the low status of and regard for women by men. This was reiterated in other comments that describe women as "*inferior*" to men, "*are not valid as man*" and where men "*control everything*", men are "*the boss*" in families and they "*can do anything*" to women. The belief that in PNG men have authority over their female partners and have the right to beat them emerged persistently in comments.

Although PNG is culturally diverse and has matrilineal societies there were no comments that indicated that the acceptance of violence against women is specific to any particular group or region. This emphasises the extent to which male authority and their control over women is the accepted norm. To maintain that authority, men can and do use violence to control women, for example, "*the man is still the boss so when the woman wants to talk, … the man won't listen to the woman, so it's the man who always starts domestic violence.*" (P6). In this sense, men are seen as a cause of FSV because they need to use violence to control female partners. Female partners must submit to their male partner's demands and, if not, they will be corrected or punished.

Leading on, within society, men are accepted as the head of the family, "*men used to make the decisions*" (P9). People do not challenge this established power structure, even if they think the man's behaviour toward his wife is wrong, "*It's PNG attitude, culture, like men are always the boss in the family. They want the ladies to follow them and so like if the man do anything wrong to his wife, no one will step in to help*." (P16). This is a challenge for prevention because the need or desire to comply with norms may override individual feelings about violence, particularly in a collectivist culture like PNG. Further, many people, particularly women, are afraid and disempowered to intervene in FSV because they will be challenging male authority, which can have personal consequences. One participant very neatly sums up the relationship between the cultural acceptance of violence and lack of willingness to address the issue:

> *Culturally, like I said, it's taken as a normal way of behaving between men and women. So they see that is what the husband and wife they used to do, fight and all this, so they don't take serious. Culturally that has been practising, so they don't mind them. Culture, it prevents them from taking further action.* (P9)

Although participants describe FSV as "*normal*", there were many comments that infer that for this group, FSV is not acceptable. As mentioned, participants differentiated their personal opinions and views from those of others, for example, "*Like in PNG wife beating is seen as normal. It's normal to most of them. If they see a man beating the wife and all this, then they don't do anything about it.*" (P10). Other participants stated that violence is "*not right*" and "*this thing is not normal"* and referenced the lack of awareness about gender equality policy and legislation, for example, "*women are not aware of this, the laws*", which also contributes to the acceptance of abuse within their relationships. Acceptance that violence is normal does not mean that people agree with the use of violence, but rather that they are unable to do much to shift or change the larger systems of beliefs that inform PNG culture and sanction the use of violence.

6.2.2 Male control of women's access to health care

The cultural beliefs about the roles and status of men and women described above interact with health care in a number of ways. Men's control over their female partners means they make decisions for them and this extends to decisions about access to and use of health services. This means that if a man does not permit his female partner to go to the health facility, then she will not receive services. For example, "*…because of the status and all this, ladies are not accessing the services available*" (P11). Denying access to services is particularly prominent when it comes to family planning, "*most women because the man becoming their boss, if the husband said no for family planning, then no family planning, they can bear as much children as the husband want." (*P16). Not only do men deny their partner access to family planning so they can father more children but it also is used as a way for men to make sure that their female partners do not have other sexual partners because they will become pregnant and found out. Family planning has become associated with promiscuity. This is highly problematic given that post-partum haemorrhage is one of the leading causes of maternal death which is linked to having large numbers of children. However women, including nurses, are either unable or unwilling to act without the male's permission. This point is further demonstrated in another example:

> *There was a lady who came in for family planning, that IUD, without husband knowing it…then maybe sometimes later he found out so he came with the wife to the hospital, he came and he got on those nurses "why did you help her to do this without my consent?"…The husband came scolding and the nurses got up and got the lady inside and they removed that thing again.* (P10)

In this example the woman decided to use family planning without her husband's permission but was forced to reverse her decision when he found out. In this case, the nurses acquiesced with the husband's demand to remove the IUD even though, by law, there was no requirement for them to do so. The husband demanded to know why the nurses had acted without his "*consent*", demonstrating the expectation that health workers should have a husband's permission before providing family planning. Even though policies and information about family planning emphasise the right of women to choose how many children they have and that consent from husbands is not a legal requirement, nurses will follow cultural norms. This is in contrast to the views of another participant who said it was "*her right*" if a woman chose family planning. Many nurses may recognise this but they are hesitant to act without male permission because they too are part of the system which accepts male authority and decision-making over the affairs of women, including family planning. Related to this is the fear of personal repercussions that nurses have, if and when they decide to help women, especially in cases of FSV. The following example shows how these issues play out in the provision of care for survivors

> *I had a case, a mother who came in, came to the health centre with bruises all over and several punctures and dislocated jaw and she lost four of her teeth …. He got this stick and pushed it into her vagina and parts of that stick got onto her vagina wall and I cannot remove that. And I was scared because that guy is a very famous guy and he usually get on people, so I need to get permission before I refer the wife to hospital…Because he might come and hit me too because he had some bad reputation. I don't want to get that…I send (for the) chairman of the health centre to get that man and bring him to the health centre. I said "no, you don't need to do that so I need to transfer her so I want to get your permission is it ok?" "If you refer to the hospital" he said, "I'm going to come and get your life". I told him "you didn't do the right thing, you see, look at your wife, she nearly going to die now, so I need to refer, so please can you give your permission*". (P14)

The participant was fearful to act without the husband's permission, even though the woman had life-threatening injuries. Having witnessed the effects of his brutality toward his wife, she was afraid that the woman's husband would also attack her for helping. The participant was willing to stand up to the perpetrator but was afraid that if she did not get his permission to transfer the woman from her rural clinic to a hospital where her injuries could be treated, the husband would retaliate against her. Legally, the participant did not actually need the man's permission to transfer the patient, but the cultural norm of seeking the male partner’s permission took precedence.

The inability of women to access health services is exacerbated when there is violence in the relationship because men are less likely to support women or give their “*permission*” for women to seek treatment and care. Accessing treatment and care may lead to further abuse, for example, “*Some they usually come but some of them they used to feel scared or shy otherwise the husband used to tell them, “If you go the health centre for treatment I’ll take your life”. So they used to feel afraid to come because of the words their husband used to tell them*” (P 14). If a woman has been beaten as punishment for displeasing or angering her husband, then he is unlikely to consent for her to have treatment and may threaten her with further violence if she does. Denying access to health services can have devastating consequences, for example:

> *Like in most cases in PNG, the men used to make the decisions, so when the man is in fight with the woman, he doesn’t respond to her. There was a woman who came in but she was not taken in early as possible, so her baby was dead, while the mother had problems. She was delayed to move into the hospital because he didn’t come in to make that decision. This is how the effect of this.* (P9)

In this case, the male partner did not give his permission for his wife to attend hospital within sufficient time to get treatment for injuries from violence he inflicted upon her and she was not able to seek assistance without his permission. This led to a miscarriage late in pregnancy. The acceptance of male control over women permits men to abuse their female partners then enables them to prevent their partners from seeking treatment for the injuries they inflict.

6.2.3 Customary practices that influence care: bride price, polygamy and interaction with relatives.

The customary practices of paying “*bride price*” and “*polygamy*” were frequently mentioned as causing and contributing to FSV because of the way these practices reinforce male authority and disempower women at the same time.

6.2.3.1 Bride Price.

According a number of participants, payment of bride price to a woman's family to seal a marriage, as per customary practice, is taken to mean that husbands have bought their wives and own them like "*property*". For example, "*Men think they own ladies because of this bride price thing*" (P12). This contributes to the perception that women are commodities for men to use. Once bride price has been paid, women have reduced power to negotiate within marriage and are expected to comply with their husband's demands. Men will use violence to ensure compliance or to punish her when she does not comply. Payment of bride price provides men with the justification to do this. For example, "*the husband will say, "you are my property, I paid for you already so you do whatever I want". And if she doesn't do anything that the husband expects, then there she goes*." (P15). Here is another example:

> *Bride price is the main, the big barrier. Especially guys when they pay for bride price, then they think that they own that lady and they can do anything. They took that lady as a property or something. They can do anything they want. So like, the ladies, they just submit to whatever the husband talk to them and listen. If they don't listen to them they tend to beat them up.* (P10)

Bride price is used to reinforce and validate male power and authority over his female partner. Further, because bride price confirms men's status in relation to their female partners, it becomes a mechanism that sanctions a man's abuse of his wife. Payment of bride price is an accepted and even respected customary practice, which validates male control of their female "*property*". When bride price is paid, the broader community accepts a husband's actions towards his wife, including abuse:

> *…and because we practise this bride price system where the husband pay off the wives from the tribes, and they take them as their property, which put the woman towards the submission of the man, where they feel that this is part of their property. So they abuse them and do whatever they want with the woman, which is really not good. So that's why, where the husband and*

> *wives have problems in their lives and the woman is beaten up, it's always taken as normal so like we don't have to interfere with them because we like feel that that's part of their normal life*. (P8)

Again, this comment reiterates that FSV is seen to be "*normal*" and that this is the reason why people don't "*interfere*". Importantly this participant acknowledges the practice is "*not good*", which demonstrates that there are people in PNG who are aware of the impact of these customs and how they foster violence. Another problem that can arise with bride price is that the woman's family can become reluctant to help her or provide support if she experiences abuse within her marriage. P1 explained, "*After they paid bride price, they can hit women, they can do anything to women. They, when they do that, your family will not talk. Give them big money, you are our part now, of all this*". Bride price is paid to the woman's family and if she leaves her husband, her family can be asked to repay the bride price, so often survivors' families will not help and will discourage women from leaving their husbands. The woman belongs to her husband and his family so he "*can do anything*".

Some participants noted the practice of bride price "*differs between cultures*" and that in the Highlands in particular "*bride price is a big thing to them*". However for the most part, there was consensus that "*Men who pay a lot of bride price tend to be the superiors, so they tend to be more violence to their wives than others*" (P2). Bride price is not the sole driver of high levels of violence against female intimate partners in PNG. It is one custom that reinforces underlying beliefs about gender norms.

6.2.3.2 Polygamy.

The practice of men marrying more than one wife is common and legal in PNG. There is a perception that "*those kind of marriages used to have problems*" (P1) and that "*the wives are being subject to violence*" (P2). This was verified by other data, "*In my case, in working experience I've seen mothers who have been severely abused because of polygamy in the families*" (P11). Violence occurs when women speak out to their husbands about other wives, for example, "*So now most of the men they want to have 1 -3 wives. When they go like that, first wife talks, (he) comes, bash her up*." (P 1) Additionally, violence between co-wives is common, "*one will butcher with knife, stone or bottle like this…Yes two wives fight*". (1) Polygamy in PNG today has evolved. It is frequently used as a way for men to have multiple female partners but without the formal processes to make them responsible for these relationships. There are increasing cases of "*wives*" being abandoned without economic means of support for her and her children, in favour of other female partners. Further, because of their low status, women are powerless to prevent their husbands from marrying second wives, as participants explain, "*it's like part of our culture where we cannot say anything about it even we take it to the law there is nothing to be done about it*."(P 8) and "*Husbands they want to have so many wives and the first wife doesn't want but there is no choice but she has to live with the decision that the husband make in the family"* (P11). This leads to increased violence between female partners because disempowered women who have no way to influence their male partner, will turn to fight the other woman over the scarce resources to ensure survival of their children.

One participant explained her reluctance to ask women about their polygamous relationships:

> *…when they come for treatment for physical violence because of this case, you know, we don't really tend to ask them about their relationship with their wives, or the other ladies who are living with them and we cannot give them the right kind of advice to them because this is not our culture. This is their culture*. (P2)

This highlights the importance of recognising diversity of both culture and settings across PNG. Overall this is potentially a barrier not just with regards to polygamy but also language, acceptance and status within the community and the ability to influence local justice. Cultural practices are not only different across regions but have also evolved in response to social change at different paces and in different ways. Migration, job placement and inter-cultural marriages can mean health workers may or may not be from that local community. While this is less problematic in large urban centres, it can be a barrier in small rural areas. Where nurses are working in regions, particularly rural areas where traditional cultural beliefs are strong, they may not feel confident to get involved with cases of FSV because they are unfamiliar with the role of local customs and structures in governing community behaviour.

One participant spoke of the negative attitudes nurses can hold towards second wives. In the example given, the nurses blame the second wife for the violence inflicted upon her because they believe she should not have involved herself with a man who she knew was already married. This highlights the complexity of how polygamy is practised in PNG today and that people differ in what they accept as a valid relationship. The comment from P8 below shows how this can influence nurses' attitudes:

> *We nurses don't help women who are in polygamy relationships. We tend to ignore them because we say although that the lady she didn't do well and she went with that guy, so why should we help her". Sometimes keep away from her, most times nurses' keep away from this.*
>
> [Interviewer: why?]
>
> *If she's the second wife then like she knows that she is going around with a married man so why should she go. She is ended up with a married man so she's having all these injuries so this is common here*
>
> [Interviewer: who usually injures the second wife?]
>
> *Usually it's the first wife and her people. Sometimes the husband but mostly it's the first wife and her people.*

The other issue of note here is that violence perpetrated against women in is often by the first wife and her family as discussed, because the second female partner is a threat to resources. Again, consistent with most other data, the woman is seen to cause the violence and there are few sanctions against the male partner.

It is important to understand how these beliefs and attitudes play out in the practice of nurses. Nurses are part of PNG society and their beliefs and attitudes are also informed by PNG culture. If FSV is generally accepted as "normal", then nurses will also accept FSV as normal. Similarly, if the prevailing attitude is for people not to get involved in domestic disputes or not to try to prevent them, this attitude will extend into health facilities and will influence health care worker behaviour towards survivors of violence. This is a critical point in understanding how and why nurses manage cases of FSV in the way they do.

6.2.3.3 Interactions with Relatives.

A number of participants spoke of cultural norms that guide interactions with relatives and extended family, particularly in-laws. Culturally a woman may not be permitted to discuss sex or marital problems with her in-laws, for example, "*if this, this, person is married to the nurse's brother then this nurse can't really help her… it's a cultural belief that she cannot discuss this issue with her*" (P5). As one participant explains, this is problematic because "*most of the nurses we are locals*," and in many rural health facilities, people live amongst large extended families and there may only be one nurse. Participants explained that people who are in-laws "*won't come and talk to me*" (P17) or "*if that woman is my sister-in-law, I won't attend to her*" (P6). Customs dictate that nurses are "*not allowed to listen*" to the personal problems of in-laws. This limits nurses' ability to correctly identify the causes of health issues and discuss these with patients. This is particularly problematic with FSV because the causes are social and involve family. In such situations, the FSV will go unspoken of, with implications for the treatment and care given to the survivor.

Another participant recognised that this means "*I don't tend to ask the right sort of question*" when her relative or in-law comes to the facility. Cultural beliefs about interacting with relatives make her feel "*ashamed*" and "*reluctant to speak up*", even when "*I see bruises on her face and I know for sure that she has a violent husband*". She identified that it is her "*cultural thoughts*" that prevent her from speaking about abuse with her relatives. Participants suggested that in cases where they are not "*open to speak*", they "*refer to somebody else to ask*" and "*other people will attend to them*". However, there may not always be another health worker available to attend to that person in facilities where there are few staff, which is often the case in rural communities. This clearly has implications for identifying FSV and providing treatment and care.

6.2.4 Fear of perpetrators.

6.2.4.1 Nurses' fear of perpetrators.

Most participants reported fear of perpetrators as a major barrier to assisting survivors of FSV. Perpetrators attack and threaten nurses because male partners who have punished or disciplined their wives, do not want them to receive help, "*they don't want us to treat them*" (P18). Male partners can feel ashamed and do not want others to find out or fear being taken to court. Participants spoke about being afraid of threats and acts of retaliation targeted toward them from perpetrators and their relatives. For example, perpetrators will "*come on you for trying to help*", they say "*nasty things*", "*talk harsh*" and threaten to "*belt*" nurses and become "*very violent*". Comments also reflected nurses' concerns about the potential for escalating wider community violence and for the safety of survivors if it becomes known that they have sought help for their injuries. Threats generate fear about personal safety and security, and seriously inhibit nurses' willingness to discuss and correctly identify violence and to provide support to survivors. Further, fear of further violence from perpetrators is one of the reasons why women choose not to disclose the nature and extent of injuries.

Retaliation from perpetrators or their relatives includes physical attacks on facilities, verbal abuse and threats to health workers or their families. For example:

> *in some remote places where that health centre or hospital is surrounded by the surrounding community of the rapist or that man's tribe, they normally like try to burn down the hospital or they try to take revenge on them for exposing the wrong that they did, like at the person who help the woman and all this. The man will try to attack that health worker again. So with that it kind of becoming a barrier where they (health workers) don't speak up for the woman by thinking about their own security the nurses they keep silent and all this so like. Where there is no proper security they don't speak most for the women.* (P9)

The lack of "*proper security*" is also noted in the above quote. Some health facilities are located in remote locations where there are no police or security guards to protect health workers and clients. Further, as demonstrated, when health workers in PNG talk about retaliation, they are talking about the possibility of very serious incidents occurring, such as "*burn down the hospital*", which has implications for the health and safety of the whole community. This is why understanding context and the systems for formal and informal governance is critical when planning and delivering health services for survivors. The other issue raised is that when health worker's assist survivors, wrongdoing is exposed or brought out in the open and the survivor or her kin can seek retribution through payback attacks and compensation. Acts of payback attacks and compensation are mechanisms for traditional dispute resolution. Nurses assisting survivors risk being dragged into complex and often dangerous processes of retribution that can quickly escalate, as shown in other quoted statements.

P18 explained that nurses will try to talk with perpetrators but "*they try to fight with us*". He gave an example of one man who "*chopped his wife leg off and he get the bows and arrows and try to fight with us*". P3 stated that "*they can attack you, your family member*." The threat of retaliation impacts on whether or not nurses decide to treat survivors and the extent of that treatment. Participants expressed that they are placing their own self at risk when they help survivors and experience deep feelings of fear. "*If you are trying to help or put yourself into trying to help the victim you are putting yourself at risk, you know your security, your safety*." (P3). Nurses may want to help, but "*think twice*" and hold back from helping survivors out of fear of personal attacks.

The retaliation of male partners against nurses is linked to the cultural and social acceptance of male authority. Nurses' assistance to survivors is seen as interfering in a matter which is not their "*business*" because only husbands have the right to determine if a woman should get medical help, as discussed earlier. This makes nurses feel afraid to help women. Here are two examples:

> *If the person doing this to the victim finds out that the victim told the nurse about something, maybe outside of work, when, in town or something you*

> *might meet up with this person and he might come on you for trying to help this victim. "Why did you do this?, Is it your business to come in?". That's what nurses fear as well.* (P13)

and

> *men are thinking that ladies are their properties so they can do whatever they want to do and if I'm stepping in to help, they will say "what you want?", or "what are you trying to do, it's none of your business" because of this mentality it's kind of scaring us to really step in and help.* (P16).

Linking back to the issue of gender and gender roles, nurses are fearful to assist because they will be seen to be interfering and going against the authority of men, which is not culturally acceptable. Nurses, who are mostly female, are seen as inferior to men who use violence and have little control or influence over their partner's behaviour, even in health facilities. Nurses will not risk their personal safety or the safety of their family to help survivors and from the examples given, in PNG that risk is high.

Participants spoke of experiences where male partners bring women to clinics for treatment but want to control the treatment she receives. Nurses feel this creates another type of risk to their personal safety because the male partner will retaliate against them if they do not treat the survivor as he demands, for example, "*When that person comes with the woman and he commands the nurse to do this and that. There is also a risk in the nurse in attending to this patient*" (P5). Offering additional assistance, which may in fact be the appropriate care, is a risk to the nurse if the male partner perceives she is going beyond his instructions. Further, nurses feel powerless to protect women in health facilities against violent partners and security systems are not always effective as this case demonstrates: "*There was a time when there was this lady on the bed and the husband came in with a knife to stab her. That was really frightening but then as a nurse what will I do. We were ringing for security and they didn't come*" (P8). As a result of threats from men, nurses may refrain from assisting survivors when their male partners are present *"…the man belted his wife and the wife comes for medical treatment and he comes "don't give medicine to that lady" or "don't treat her". And for me I want to help her, help the* *client and if he says that, I'll get scared and such attitude causes me not to attend to the patient*" (P17). The authority of a male partner is greater than that of a nurse, even in a health setting, and the threat of the use of violence creates fear which prevents nurses from providing care.

6.2.4.2 Disclosure is risky: Patients' fear of husbands.

Fear of further violence from male partners was raised as a barrier for women seeking help or disclosing violence as the cause of their injuries. Participants explained that women feel "*scared of their partners*", "*worried"* and have fear of "*what the husband will do to her*" when they seek help following abuse and because of this they *"suffer silently"*. This is partly because seeking help may mean that women disclose the abuse and this exposes the male partner, for example, "*they are afraid of their husband bashing them up again later when they make it known to some other professionals. They beat them up so that's why they try to keep it secret*" (P9). This relates to broader issues about FSV being considered a family matter or private business. When survivors seek help, the matter is taken out of the realm of the family and as discussed can lead to compensation claims which male partners do not want to pay. Also FSV is often triggered when the female partner is perceived to have not complied with her male partner's instructions or when she has not performed her nominated duties and is an act of male control and discipline. Seeking help, can be perceived as a challenge to that authority and be met with further violence.

Patients' fear of violence limits nurses' ability to provide adequate treatment or further support. For example, "*And sometimes when they come we can't admit them because they, fear that they might be in the hospital and the husband will come after her. So we just help them, give them medicine and tell them, go and hide somewhere*"(P?). There is no reference to using a safe house or calling police and it is unlikely that the facility has any security systems to allow the staff to keep patients safe. The best advice and intervention is to tell women to "*go and hide somewhere*".

There were, however, other examples of how nurses strategize to help a woman, without risking her safety. For example, P10 said "*nurses used to find ways like call* *that particular client to come over to them when the husband is not around so they can talk to her privately*" and P17 explained "*If it's not safe for her to go home, then we have to find a way, talk to her relatives so that she can go we don't want them to go back and visit that same treatment*". This indicates that nurses make assessments about safety and find ways to help women that reduces risk for them personally and for the survivor.

Another issue raised was patients' fear that nurses will not maintain confidentiality. This will lead to their partners finding out they have sought treatment, which will lead to further violence and is another reason which inhibits survivors' disclosure. For example, "*No when they don't trust the nurse…They think, they tell us the truth, the person who has been victimising them will find out and maybe do some further violence or something*" (P5). P14 confirmed that "*nurses might tell my husband*" or "*tell other people*". A lack of trust in nurses is a serious challenge, however, for the most part, these participants recognised the need to maintain confidentiality and provide privacy and discussed the limitations of the facilities they work in to enable this.

6.3 Operating Environment

Comments confirmed that nurses in PNG work in a resource constrained environment and that this hinders their ability to provide adequate care for patients, including survivors of FSV. Several barriers were reported, including a lack of medical supplies, staff shortages, limited time and busy workloads, lack of privacy in health facilities, and charging user fees. These are systemic issues, largely beyond the control of individual nurses and indicative of the general state of the health care system in PNG. This section describes how these factors affect the capacity of nurses to provide survivors with adequate services.

6.3.1 Medical supplies.

Participants noted stock outs of medical supplies as a barrier to treating survivors. Participants spoke of irregular supplies of emergency contraception, HIV post exposure prophylaxis (PEP), syphilis strips and vaginal swabs, which are necessary for medical treatment following sexual assault.

For example, for detection and treatment of STIs, participant P17 explained "*we run short of strips, so we are not doing it regularly*". Similarly, participant P1 said "*it's a big challenge, doing vaginal swabs*" because they are not always available. She also advised that they do administer PEP at their facility but "*not at the moment*" because the "*staff didn't follow up*" with the order. The same issues were identified with emergency pills with P18 and P11 saying "*we are supposed to give but at the moment we don't have this*" and that "*we didn't have emergency pills available*". Procurement and distribution of medical supplies is managed through a centralised system and lack of availability is due to broader issues with the supply chain. Administration of emergency contraception, PEP and testing for STIs is part of the standard treatment for survivors of sexual assault. Without these drugs, women are at risk of unwanted pregnancies, STIs and HIV but, as explained, "*We can treat but if these things are not available we can't help the patient*" (P16). Shortages of drugs and other medical supplies severely hinder nurses' ability to provide even basic treatment to survivors and places women at risk of suffering lifelong consequences of FSV.

6.3.2 Physical environment and privacy.

Participants reported that "*privacy is an issue*" for nurses when helping survivors of FSV and that this influences disclosure. However, availability of private spaces for talking with survivors varies depending on the facility. Most participants agreed that the physical "*set up*" of health facilities is not conducive for providing patient "*confidentiality*". The "*health centres or hospital environment itself doesn't provide confidentiality*" (P7) and most are without "*proper place for counselling such victims*" (P10). The need for quiet and private rooms to interview or talk with survivors was connected to the likelihood of disclosure, "*If it's a facility that provides more rooms and you can have a quiet place to interview, then he or she will tell*." (P11). The lack of privacy is a barrier for nurses because they are hesitant to ask about FSV in front of other patients and survivors may be unwilling to openly talk about their problems.

It was stated that most people, including survivors, access health facilities through outpatient services but, "*the outpatient is just an open place*" (P11) and "*outpatient* *is not the right place to see because you have to take time and talk to and get to know what's happening and all these things*."(P3). Typically outpatient services are busy areas where patients and families wait. Consultations happen in the open spaces so it can be difficult for nurses to create the privacy needed to discuss sensitive issues.

The design of hospital wards was also identified as barrier, for example, "*it is a barrier because of the ward setting, it's not in a cubicle, it's an open space…if you talk to a patient about these kind of issues then the other patient next to the bed can hear*" (P8). P10 commented that doctors talk to patients in wards without "*considering their privacy*". She concluded that this means "*patients they don't feel open to talk"* because other patients next to them will hear and this is "*because of the setting*". Wards can be overcrowded with people, beds are rarely segregated by curtains and frequently family members often stay to feed, wash and care for patients, meaning that there is little privacy. Stigma, shame and fear of further abuse if disclosure is overheard by other people, will prevent survivors from talking about their issues.

Some participants said they are able to take patients to "*small rooms or small cubicles*", "*take her out of the crowd*" or to a "*private room*" where they can "*do counselling*" or "*talk*" to women, recognising the importance of confidentiality. P17 reported, "*We always take such cases because we don't want other people to hear it and go and say something else about it and add some more words and make things go big so we used to take the patient to an area we can talk to her*." In small communities, other people at the facility are likely to know the survivor and may "*add more words*" if they overhear the discussion. Discussing sensitive issues in front of these people could invite them to interfere or escalate the problem, creating additional complications for survivors and nurses who are treating them. This links to fear over personal security and risk that nurses feel they place themselves at when treating survivors. By not providing privacy, the physical environment does not provide security, another issue raised by participants.

Most participants raised the physical environment as a problem, claiming it was not "*good enough"* and that women leave "*unsatisfied*" because they cannot discuss their health issues with privacy. There is recognition amongst all participants that privacy is necessary for health workers to be able to ask sensitive questions and for the woman to feel comfortable and safe to disclose the nature of her complaints. Without this, disclosure about family violence is unlikely.

6.3.3. Staff shortages

Participants reported that there are insufficient numbers of health care workers to meet patient demands in facilities across PNG. "*You know human resources are a problem. Not only in the facility I come from, but in the country as a whole*." (P3). Most participants reported a shortage of health workers, for example, "*Within the workforce, we have downfall*" (P2) and "*We have low manpower in most of our facilities, and workload is very high*" (P13). With regards to patient numbers in facilities, participants explained "*everyone is coming*" (P4) and that "*you are seeing a queue of patients waiting*" (P11). The impact of limited human resources and high patient numbers interacts with the treatment and care of survivors in several ways.

Where there is a limited number of health workers, staff do not have time to "*sit with the client*" and "*cannot spend at least 10 minutes with one patient*" (P3). The pressure of time and workload was raised by several participants. For example, P13 said, "*Maybe some are willing to talk about their problems but we nurse due to time and workload do not have enough time to spend with patients.*" and P8 said, "*It's not that we want to ignore them, it's just that for myself personally I don't find time for my patients*." These comments reflect that finding additional time to spend with patients is a real challenge.

For survivors, this means limited care. P13 explained that "*We don't really check them because of our workload. We don't really lift her chest up or do a head to toe or rough examination, we don't really do that because of the busyness and workload*", meaning nurses do not have time to check for internal injuries or injuries hidden underneath clothing which are thus unlikely to be detected. This was reiterated in other comments, for example, "*when there is not enough manpower they don't tend to do thorough examination*" (P15). Another participant explained "*because of low manpower…we tend to forget some history taking, we just look at the patient, treat the patient, get the medical history, treat the main complaint and* *send her away*."(P16). This participant advises that "*history taking*" is forgotten or perhaps disregarded in the interest of being able to serve other patients. As discussed later, "*history taking*" is part of standard medical procedure when seeing patients and is an opportunity for nurses to ask about FSV. A lack of staff clearly impacts on nurses' ability to do this because it restricts the time they have available to appropriately treat and care for patients.

P2 explained, "*So a woman comes in with violence we can treat her symptomatically but we cannot really counsel her, we cannot really attend to her holistically…because we need to attend to the other patients who need our care*." The participant acknowledged that women are treated "s*ymptomatically*" rather than "*holistically*" indicating that important aspects of survivors' social, psychological, and spiritual needs are deprioritised. These participants are aware that they are underserving survivors of violence when it comes to their treatment and care but, as P1 said, "*we just do what we can do*". Therefore, lack of time brought about by heavy workloads and low health worker numbers is one reason why nurses do not provide more comprehensive care to survivors.

There was a sense from other comments that nurses feel overwhelmed by the high demands of their work. P3 expressed, "*it's too much*" and that nurses, "*rush and see another one and another one and another one*", and P8 said "*I have no time. There is always complaint from patients that we need to attend. There is so many of them"*. Several participants spoke about being "*stressed out*" and related this to the "*workload and manpower*". This is important because of the link between workplace stress and low levels of empathy for survivors or not being prepared to provide counselling, for example, "*when somebody is stressed out you wouldn't be in a right mind to do counselling to a patient*" (P13). When workload is high, nurses are less likely to respond positively to survivors and this becomes a barrier for nurses providing care and survivors accessing care. This was reiterated by P6 who explained that:

> *When we have time and we don't have many patients, and that person come when we are not busy we talk to them nicely but when they come in a busy time like we have many patients to see … what will I say, instead of us*

> *talking to her nicely we talk to her in a different way. We put her off. She won't open to say what she has come in for*. (P6)

The effect of high workload impacts attitude and motivation, as P12 said "*The attitude is not good because of the workload.*" This leads to nurses feeling "*frustrated*" and "*irritated*" who then "*talk back*" or "*get cross*" or "*Just shut the patient up*", which deters patients from opening up and talking about their problems.

There were several participants who reported that lack of time is not an issue. These participants worked in "*small rural areas*" that they described as "*not as busy as other places*"(P17). In these facilities, participants said, "*there's always enough time* (P17) or "*all the time in the world to talk with the clients*" (P10). P14 said "*Little patients are there so we can at least talk to them and really counsel them on what's really happening*", however it was less clear whether this translated to higher quality of care for survivors or if nurses in these facilities did in fact spend more time talking with survivors. It is important to note that time may not be as large a barrier in rural facilities but other issues, like lack of supplies, access to referrals and supervision from specialists will be more prominent. Health facilities operate across variable environments and face different resource issues and what may be a barrier for nurses in one facility may not be in another.

6.3.4 Knowledge and skills.

Comments confirmed that, in general, nurses lack knowledge and skills to deal with FSV, for example, "*I don't think many of the nurse have the skills and the knowledge to deal with the family and sexual violence*." (P5) and "*most nurses, they are not aware of this, how to deal with those type of patient*, *I don't think they have any idea how to handle it*."(P8). Other comments suggest that there are some nurses who have skills to respond to FSV but these are few, "*So there are some nurses who have the skills to counsel these types of patients. The majority, they do not have skills*." (P13). In particular, nurses lack skills to "*talk with*" and "*counsel*" survivors, for example, and "*we don't have the skills on how to talk or how to approach and make people satisfied."(P*6). Training was identified as necessary for nurses to "*get more knowledge*" to "*help the people*" (P10). Participants recommended "*What* *would better help nurses is to train them. They just need to train them*" (P7). Lack of skills and knowledge about FSV and how to "*approach those people*" is a key barrier for nurses.

Although participants flagged that nurses needed to learn a different "a*pproac*h" to work with survivors, P7 emphasised that there are nurses who are sensitive and competent to deal with FSV: "*if they are very sensitive and very competent, they can already pick up and then get to the specific issues, area to be interrogated.*" Being sensitive and competent does not require additional specialist training but requires an empathetic attitude, quality pre-service training and continuing professional development. Therefore the issue about "a*pproach*" feeds into broader issues about training, supervision and models of care, which not only impact how nurses respond to FSV but a range of other health issues as well.

Importantly, HIV training was highlighted as one of the areas where nurses get exposure to counselling skills and knowledge about sexual assault, which they adapt to other issues in their workplace, "*There's nothing different about the skills that I've learned in (HIV) counselling*. (P2) and "*In PNG any topics related to HIV/AIDs, a lot of them have some form of sexual violence counselling in them. That's where we have acquired our knowledge from.*"(P7). PNG has made significant investment in HIV training over the last decade (Commonwealth of Australia, 2012) meaning that there is a cadre of health care workers trained in basic counselling and also in working with sensitive issues. This issue was not explored in this study but it would useful to understand further what skills these workers have and how they are using and adapting them more broadly in the workplace.

6.3.4.1 Pre- and in-service training.

Counselling and family and sexual violence are not included as topics in the pre-service nursing curriculum. *"I've never had counselling skills in my pre-service training"* (P7). For health issues like FSV, as P17 explained, "*most of us, even we graduated from colleges and go back and work we still lack this knowledge about it because it was not involved, in our curriculum*". P13 explained, *"Gynie problems and this may also be associated with this but I never knew that"*. Despite the prevalence and significant health consequences of FSV, it is not incorporated into mainstream health training, reflecting its lower prominence as a health issue in PNG. The lack of training in counselling skills is linked to the focus on biomedical training of nurses in PNG.

In-service training is the main way for nurses already in the workplace to continue professional development and get "*updates of the new skills and knowledge to deal with such patients*" (P11). In-service training was seen as one avenue to strengthen nurses' ability to care for survivors of violence. "*We need in-service to really know about these cases, so that we can deal at our end, appropriately. At the moment we lack knowledge about this*" (P1). A lack of knowledge was given as one reason why nurses do not respond appropriately and these participants indicate that training would help to resolve this, will make nurses "*skilful to do it*" and know "*how to treat them*". P14 believed that if nurses accessed in-service training they "*can really help these people with domestic violence*". However, although participants propose "*training*" as the solution to improving service delivery for survivors, these comments were disconnected from the other barriers raised, such as cultural beliefs and practices and limited resources.

There are limited opportunities for in-service training in FSV or in any health issues more generally. None of the participants spoke of structured or regular in-service training, for example '*Sometime they used to run in-house training*" (P5) and "*it depends on which hospital*" and "*it's once a while*" (P10). For FSV, training is even more limited, "*In-service training to do with this counselling and family sexual violence is not mostly done …I think most of the nurses are being left out so they don't get more information on that*"(P9). The comment that "*nurses are being left out*" reflects the lack of engagement of the health sector in efforts to respond to FSV more broadly. Of the training that is provided, it is usually targeted at social workers, advocates and women's groups, rather than at health care providers, which is a problem because of the role they play in front line service delivery for survivors.

6.3.5 Fees.

Data confirmed that "*fight fees*" are charged in some facilities. These are service fees charged to patients seeking treatment for injuries caused by family violence, for example, “*for domestic violence they have to pay certain fee*” (P12). These fees are “*a bit higher than normal fees*” (P9) or “*quite high*” (P18), with reports of PGK50 -100 being charged (AUD$25-50). Charging high user fees is perceived by some participants to be a preventative measure, “*the intention is to stop them from going into fighting*” (P9). Accordingly, high fees will stop family violence because people will not want to pay the high costs for treatment of injuries. P9 explained, “*they think if they put this fine they will stop people from being involved in domestic violence*”, because “*it will prevent them by thinking about the fees they might lose*”. P17 also explained that people are “*afraid of paying this kind of amount*”. The fee is supposed to act as a financial disincentive to engage in FSV.

Details about who is required to pay the fee are inconsistent. In some facilities it is the perpetrator, “*the husband will pay for it, the person who causes the fight has to pay*” (P17). This aligns with the idea that charging fees are preventative, because the fee becomes a form of financial punishment. The ironic issue is that in all cases it is the survivor who attends the facility for treatment, “*the poor one who is victimised*” (P11), and is it unlikely (but not always the case) that the perpetrator accompanies her. Other comments suggest that the fee is charged before admission or treatment and therefore it is the person presenting with injuries, the survivor, who will pay. For example, “*They have to pay it before we attend to them*” (P12), and “*any family violence are to be charged on the admission during the visit at the health facilities*.” (P11). If survivors are unable to pay the fee, in some situations they will be turned away: “*If they don’t have enough money then sometimes we send back*” (P12), and “*If they can’t find the fight fee they are told to wait until they have paid and then they’ll be served*.” (P9). This means that charging fees prevents survivors from accessing potentially lifesaving health care.

Most participants recognised that fees do not stop family violence, for example, “*I don’t think it works*” (P9), and “*the actual problem, you are not solving the problem, the problem is still there*” (P4). Participants identified that it is unlikely that people consider the fees they might incur if they inflict injuries on their partners immediately prior to and during escalations of violence. “*They (perpetrators of violence) don’t take this into consideration, the consequence of paying a high fee.*” (P9). Instead, charging of high user fees prevents survivors accessing treatment, "*But to me I think that when you put up the fine it's just like you are preventing them from coming in for treatment.*" (P4). Additionally, when the survivor is fleeing assault, she is unlikely to have money, as P11 said, "*she can't afford to pay for that fee*", which prevents her from accessing care, "*some people do not have money so sometimes because the fees for violence are high, they do not come.*"(P13).

Further, because women may be unable to pay the higher fee, they may be unwilling to disclose the cause of their injuries "*if they come, they lie that they sustain injury from something else so they pay the normal fee*" (P13), and "*because of this payment, user fee pay for domestic violence they will scared of saying I was beaten by my husband*" (P16). When survivors do not reveal the source of their injuries, they risk unseen injuries and consequences going undetected and miss out on HIV and STI tests, prevention of unwanted pregnancies and permanent disabilities.

Charging user fees to survivors of violence is contrary to administrative instructions from the PNG National Department of Health, which most participants were aware of: "*Yes there is a policy that says those who are being victimised can receive free service, they cannot be charged from the health service*" (P5), and "*I think there is something that says that you don't have to put, fees for such people*" (P4). However, management of some facilities clearly ignore this: "*the health board of the facility, they made policies that any family violence are to be charged on the admission during the visit at the health facilities. So that was what we have done to the victims' part*" (P11). Some participants were critical of the continued practice, "*I don't know why the management are still charging people with hefty fines to receive care just because of domestic violence*" (P4). Another participant similarly expressed her criticism of facilities charging user fees, "*And worst of all is our Department of Health has given a memo saying that we should not charge fees, or impose fees for that but a lot of the time we seem to be very negative about it.*" (P7). However, responsibility for rural service delivery is decentralised and the NDoH has limited power and capacity to regulate the functioning of health facilities.

The charging of user fees in general and higher fees for FSV cases was linked to chronic underfunding of health facilities. "*Like the user fees are not supposed to be* *charged but then it depends on the facility where we are working and the equipment and other resources that are used. If the government funds doesn't come on time and all this to manage the facility, then they use this user fees to manage that's the problem*" (P11). P5 reiterated this saying "*there is no clear instructions that the health department is going to fund the services for these people*." Charging user fees is related to broader issues about how health is financed and governed at sub-national levels.

Other participants revealed that nurses often exercise flexibility in charging fees, "*we are not strict on the amount*" (P18), because the majority of patients are poor. It was noted that survivors "*can't afford to pay for that fee*" and when they attend facilities they often have "*nothing*". Nurses will treat her anyway, "*regardless of that, we still treat*" (P11). Another participant expressed "*I took the heart for the sick people and most of them visit free treatment we don't always ask for K50 because most of them are poor*" (P17). These are examples of nurses using their own agency to get around barriers and of the commitment of nurses to deliver services under difficult conditions.

6.4 Professional Practice

This theme focuses on what nurses do in health facilities or how they practice with regards to FSV. It begins with a discussion on how nurses identify FSV in health facilities. The next subtheme is about how nurses manage cases, and includes descriptions of clinical management of cases, the role of medical reports, provision of counselling and referrals,. The negative attitude of nurses is included as subtheme here because attitudes are acted out in nurses' behaviour towards survivors and were raised as an issue by participants. This theme also includes discussion about the limitations of the biomedical model of care which dominates nurses' practice and the role of nurses in responding to FSV.

6.4.1 Identifying FSV.

6.4.1.1 History taking.

When asked about how nurses identify violence, most participants mentioned the procedure of '*history taking*'. This involves asking questions about "*the personal information, details, social history and medication history*" (P5). It is asked of "*every patient who comes for health service*" (P16). Participants noted that this is part of "*routine management*" and that asking about the patient's background happens "*from the beginning, from the first they come in*" (P14) and "*before we proceed onto managing the case*" (P5). P2 advised that it is the role of "*the first person to attend to her"* to ask questions and document the patient's history. In particular, taking the patient's "*social history*" is the point at which health care workers can ask about FSV, for example "*social history is one of the question we used to ask them if they are ok or if there is something wrong in the family, within the family they need to discuss with us*" (P10). Taking a record of a patient's history was described as "*very important*" by one participant and "*a must*" by another. It is a standard procedure that is described as "*part of our responsibility*". It is during the process of '*history taking'* that nurses should ask about FSV.

However several participants clarified that "*although the procedures are there that we should ask…it doesn't happen*" (P7). It was explained that nurses "*never do social history as a routine most of the time… they skip that part and go straight to physical assessment*" (P10). P15 said, even though it is "*a routine thing…it depends on whoever is doing the assessment…sometimes when they are very busy, just treat and send them away*". Comments about time also confirm that the process of taking patients' histories is often not completed.

Other comments suggest that asking about violence usually happens when people present with injuries consistent with abuse, for example, "*From the experiences I had with that, if there is physical injuries, then it will stir them to say were you abused or were you hurt, then it will stand to ask that question, otherwise it's not always a routine thing to do*" (P7). Relying on observation of physical injuries to act as a cue to ask about violence was reported by other participants, "*I think they usually ask when they see something like this … some signs of being beaten or something*." (P 4), and "*maybe by looking at her I'll know that something is wrong and I'll ask her "is there anything wrong?" but I won't just present that question "does your husband beat you or no?"*(P17). This points to a gap between what is reported as standard procedure and what happens in practice. It is also consistent with comments that survivors are treated symptomatically, meaning that there is little need to ask about social issues.

Therefore, in many circumstances, without the presence of physical injuries, FSV is not being identified, "*Otherwise if I don't see any bruises or whatever I cannot diagnose this domestic violence so* (P14)." This is important because so many of the health problems caused by FSV are not immediately observable. This point was made by one participant who explained, "*So it can also be hidden, under maybe the trousers, inside the shirt and they just present with the top part so it's our job to go thoroughly though the patients and check the hidden things that are not being spoken of*" (P2). Relying on observing physical signs of abuse to ask about FSV means that health problems go undetected.

Other comments suggest that nurses "*can tell*" when women are suffering "*just by looking at the patient*". P17 said "*I can sense it, I can, by just looking at the patient her expression you can tell that she is psychologically impacted*." P6 described patients who "*will be very quiet, they won't want to talk too much*". P5 explained that with a survivor, "*she doesn't look active, she looks worried …you know she doesn't look normal*". If a patient looks psychologically or emotionally distressed, nurses will "*recognise them*" or identify that they are a survivor. However, similar to relying on physical symptoms of violence as a prompt to ask about violence, using one's '*sense*' or intuition to identify violence is problematic, because many survivors are adept at disguising abuse. The following excerpt demonstrates this:

> *And these two girls, my colleagues, when they just said that they were you know being abused and I couldn't believe it, I just stared them in the face and I just said 'I can't really believe it' and they say 'why can't you believe it', I say 'because every time you are just smiling and talking and telling stories and you never mentioned it'. Yeah and they say … 'we don't want to show that we are like this'.* (P3)

These survivors were "*smiling and talking and telling stories*" which is why this participant "*couldn't believe*" her colleagues were living in abusive relationships. Their behaviour was inconsistent with her idea or stereotype of how survivors look and act. Nurses have established ideas about survivors and use this as a way to detect when their patients are living with FSV and whilst this may work in some cases, when survivors don't "*look normal*", nurses are unlikely to ask them about FSV. In the data above, the participants colleagues' responded that they "*don't want to show that we are like this*", which reiterates that survivors will consciously hide their experiences of FSV. The crux of the problem is that nurses rely on seeing physical injuries or sensing that something is wrong as prompts to ask about violence, whilst survivors may actively try to hide that they have been beaten.

6.4.1.2 How to ask about violence.

Participants described the ways nurses ask about violence, including during history taking. Most do not ask about violence directly, but ask questions to women about their "*relationship with their husband*", or "*life at home*", or ask, "*How she is going with her domestic chores*" and whether she is *"ok".* A few examples of the types of questions given include: "*how long have you been with this problem, since your marriage or since last year*?", "*has your husband been good to you in the beginning?*, "*are you ok? Ok with your family? Has you, your husband been having an affair with another women*", and "*does your husband have another wife?"*. One participant explained that nurses will ask questions about "*this kind of things that will lead to this problem*" (P16) that is, questions about the types of issues known to trigger violence. There seemed to be an assumption that survivors will disclose their experiences of FSV if they are asked these questions, despite other comments about patients' fear, safety and confidentiality. Further, asking broad questions about family or wellbeing means survivors can answer without disclosing violence. Survivors may not even realise that it is an opportunity to discuss such issues with the nurse, particularly if the survivors themselves does not see FSV as a health issue. So although nurses ask questions about the patients' "*social history*", they may miss identifying that the patient is a survivor of FSV. The comment below demonstrates this:

> *Ah about that, I haven't asked a patient about that, only when they come and tell me that I have been beaten. When I get the history, "why have you come to the hospital?", "can you tell me why you came?", and then she'll*

> *start. …and if she did not tell me then I'll not know, cause I will think she came for another reason.* (P17)

Here the participant acknowledges that she only is aware of FSV when the patient herself reveals that violence was the cause of her injuries. The onus is on the patient to reveal violence and if she does not, the nurse will think "*she came for another reaso*n". This indicates that nurse do not probe for more information beyond what is provided. This is further emphasised by another participant who reported, "*They do treat them but they don't go in detail by asking them how did you do that or try to bring information together to solve the problems*"(P9). There are a number of factors which contribute to this, including a lack of skills and knowledge on how to talk with survivors, limited time, privacy and of course, the cultural barriers which are all discussed in other sections.

Other examples given demonstrate that some nurses may ask more direct questions, for example, "*Usually we ask them direct questions like "Did your husband hit you or did someone hit you?*" (P12). Another said she would ask "*do you have any domestic violence? Or do you fight?*" (P14). A few others showed that they ask for details about the violence, asking, "*how often she has been victimised, has she ever been victimised before?*" (P2), or asking about "*where it occurs, who did it and what were you doing during that period when this happened?*" (P4). There was also acknowledgement that the approach to talking to survivors, making them comfortable and being empathetic is important, "*So when we kindly ask them and they feel easy to talk to us, they just pour out everything*" (P15). So whilst most nurses lack skills and knowledge to ask about FSV, some nurses have acquired these skills and are more sensitive to identifying abuse as a cause of injury.

Of note, in relation to identifying sexual violence, there are the cultural norms that prevent discussions of sex, "*especially our sacred body parts*" (P15) and sexual matters. Culturally, discussing sex, is "*a sensitive thing*" and "*against some of the customs and beliefs*", and for "*most they don't feel open to make mention about their private parts*" (P1). P15 said *"It's a great shame for us in our culture to talk about it openly*", and another confirmed "*we don't really talk about it*." This means that some nurses may feel unable or uncomfortable to ask about sexual abuse.

Further, there are language barriers for nurses when talking about sexual health. P12 explained that it is hard for nurses "*to say the exact words to patients…. To communicate words about sex*", instead, "*we use some other words*" when talking about sex. So in addition to sex being a sensitive issue that is difficult and shameful to talk about, nurses may not have appropriate language to ask, explain or describe sexual health. These cultural issues become barriers and, "*that's why nurse they don't ask about sex*" (P11), and sexual violence is not "*being exposed*", meaning nurses are refraining from discussing sexual health. Further, some participants report that "*mothers won't even answer those questions*" (P14), or "*they don't come and talk to us about this*" (P16), therefore there is no point in asking. Only P17 remarked that the situation has now changed and nurses are no longer *"afraid"* to talk about sexual issues. "*In the past yes, but at the moment we can talk to them freel*y", meaning some nurses may be becoming more comfortable with sexual health which is a reflection of the modern education system, migration and the evolution of traditional lifestyles. This is important because changing nurses' behaviour may be the first step in enabling discussion about sexual health and sexual abuse in health facilities.

6.4.1.3 Third party disclosure.

A number of participants reported that information about FSV can come from third parties, usually relatives who accompany the survivor to the health facility: "*If she doesn't tell, her guardians usually come and tell us*" (P1). Relatives can be helpful because they will provide staff with information about the case, "*Because if we ask directly they won't tell us, so the information we are getting is the relatives or the people who are close to her* "(P6). Relatives often instigate the requests for medical examinations and reports, for example, "*It's usually by the people who are referring the victim to the hospital and they explain to us that this and this happened and we want medical examination*" (P4), and therefore the relatives have an incentive to tell health care workers. However this can be problematic because the incentive for medical reports is complicated by compensation. Other comments show that the involvement of relatives can be a source of frustration for nurses because they can make "*demands*" and "*force them*" to attend to the survivor ahead of other patients. The involvement of third parties also raises questions about confidentiality but this was not identified as an issue by any participants.

6.4.2 Management of cases.

6.4.2.1 Treating physical symptoms.

Participants described how they manage cases of FSV when they present at health facilities for treatment. They explained that nurses will "*treat her symptomatically*" P2), "*take all vital signs*" (P5), and in some cases, get a "*doctor to come and assess or examine the patient*" (P5). Participants were better able to describe specific procedures to follow when dealing with sexual assault. This is partly because "*when people know its sexual assault or rape, then they treat it as a very serious issue…then she is treated according to standard procedures*" (P7). Cases of sexual assault are more likely to be prosecuted and are taken more seriously than other forms of abuse. Additionally, there are "*standard procedures*" or clinical guidelines for nurses to follow in response. These do not exist for other types of abuse.

Following sexual assault, part of that "*procedure*" is to "*confirm if it's rape*" (P10). For children, doctors need to "*check that the hymen is intact*" (P13), for adults, they "*check if sperm is present*" (P13). This information is then written in a "*medical report*" which is used in court. Some participants noted that they must "*offer her STI treatment* and *counsel her for HIV*" (P5), and if the woman agrees, "*do blood tests for HIV*" (P13). Not all participants had been trained in HIV counselling and testing. Those who had been trained, were more likely to recognise the link between abuse and HIV, "*she is being abused then there is always a tendency for being infected*" (P2), and identify the need for HIV testing and counselling, "*when she comes in with bruises I know she has been abused and one of the things that I must always do is to counsel her for HIV*" (P2).

Responses show variability in the type of services a survivor will receive. In some facilities, more comprehensive care is provided than in others. For example, P17 said, "*we have to check her in case she has some bruises or something he put it inside, we have to check her. We have to make sure she is not bleeding. We have to reassure her and test her for HIV, syphilis and other*." In this facility, internal injuries are checked, clinical tests for HIV and STIs provided, and the survivor given reassurance or some level of emotional support. This is in contrast to P8, who responded that they provide *"Just pain relief and advise them if they see any STIs, they can come back to us. If they need antibiotics, they can give them otherwise we leave for time being."* At this facility, the survivor is given medication for pain and, if she is able to recognise symptoms of STIs, and is able to return, these may be treated at a later date, otherwise, she is left alone. It is very likely that survivors attending facilities like the one described here will leave with undiagnosed and untreated conditions with increased risk of contracting STIs because there is no investigation of additional problems.

Where available, survivors will be put on "*post exposure prophylaxis*" (PEP) and given "*emergency contraception*", but this "*depends on the facility*". Where no health workers have undergone HIV training, PEP is unlikely to be given, for example, *"That (PEP) we don' t but I don' t know this year I hear some of my friends at the hospital they have learnt about this prophylaxis, HIV prophylaxis and maybe they are going to give now*"(P16). This shows that previously, because there were no health workers who were trained to administer PEP, it was not offered at that hospital. Therefore, a survivor of sexual assault will only be given PEP if the facility has the drug available and there are health workers who have been trained to give it. This is not always the case. P6 said, "*In my health centre we don't have this PEP but we do offer them emergency contraception.*" Similarly, P17 explained, "*We only know that when someone comes in being sexually assault we have to give emergency pills to prevent pregnancy*", but doesn't mention PEP. P3 said, "*you know I did not know that I should give PEP and these services when victims come in. I just knew when I took up this midwifery course then I knew that I should treat my patients like this*." PEP is not routinely administered to survivors of sexual assault because of a lack of trained health care workers and because not all facilities have the drugs available. This has significant implications for transmission of HIV.

Provision of emergency contraception also varies between health facilities. This is due to family planning policies in church-run health facilities. P9 said, "*we do offer STI treatment but contraceptive and family planning method we do not*". Here the issue is not lack of knowledge about appropriate treatment but church policy about family planning. P2, who also works in a church-run facility, was critical of the facility policy which prohibits provision of emergency contraception to survivors of rape but does permit provision of PEP following potential HIV exposure:

> *Yes that's what I'm saying, so if the organisation says that you can give PEP and you cannot give emergency [pil]l), it's very controversial, it doesn't make sense. The organisation says PEP, it can be used. So what is the difference when a girl gets raped and she is not given the emergency pill …* (P2)

For her, this is "*controversial*" because the survivor of rape is assisted to prevent HIV but not an unwanted pregnancy because of church policy towards family planning. As P2 says, "*it doesn't make sense*". P2 said:

> *despite the organisation doctrines or policies in terms of the use of contraceptives, my aim, the challenge for me in there, when a women comes in being violated for this kind of sexual act and she has a lot of children I still have to step in and give the right information".*

This participant contests her facility policy and in practice works around it to make sure that she is able to provide women with emergency contraception following assault to limit the adverse consequences.

Overall participants demonstrated more knowledge about dealing with sexual assault and outlined specific actions they would take in the case of sexual assault, including examinations, testing and writing reports. For nurses, clinical standards make clear what actions they should take, what role they play, and where they fit into a medical response. Further, a decade of donor investment in HIV prevention has also raised the profile of the need to respond to sexual assault.

6.4.2.2 Medical reports.

The preparation of medical reports emerged as a central feature of service provision for survivors at health facilities and was mentioned by all but one participant. For example, "*We examine her, treat her and we do write report for her if she wants to take it to court*" (P16), and "*When they come in we just treat them as a patient, usual, then we take them in for the doctors to examine them and then* *after that doctor write a report and hand it back over to them*" (P4). P11 shared the details of her experience when she assisted in preparing a report for a case of sexual assault against a child: "*we had to write everything we see visually from the child and we have to note it down, this is what we're going to treat and we know for sure that they are going to take it before the law so these are the evidence we have to take note of*" (P11). She emphasises that she knew that the information recorded would be used by the child's family in court because medical reports become key pieces of evidence.

There were discrepancies in participants' reports about the circumstances in which medical reports are provided. P3 stated, "*that one is a different one…for sexual assault we get medical reports done for them*" making a distinction between medical reports for sexual assault, and other forms of abuse. P1 advised, "*Yeah we treat them then we offer them the book and we say this is important. If you want to go further like police and all this, you can come back to us we've got our boss there and she can do the medical report*", meaning that the nurses record information about the case in a notebook and if the survivor wants a report, she will need to return to the health facility when a senior officer is present who can prepare it for her.

Medical reports are prepared by the most senior member of staff because "*this has to do with legal issues*" and medical reports become legal documents. In some cases, this is "*always a doctor*", for others, it would be the "*officer-in-charge*" or "*health extension officer*", particularly if it is an "*outside facility*" where there are no doctors. In P8's facility, a person will be referred to another facility "*to a setting where there is a health extension officer or a doctor there so they can deal with it.*" P12 explained that survivors who come "*in the night*" are asked to "*come back the next day*" so the doctor can complete the report. Travelling to another facility or returning back at a later time can be incredibly difficult for survivors, meaning that they may give up and not get the medical evidence they need to take the issue to court. So although there is awareness about the need to provide medical reports, there is no consistency in how health facilities approach preparing them. This relates back to the lack of clear and current policy on treating survivors of violence.

Another issue that emerged in the interviews is the extent to which the need or desire to obtain a medical report overshadows care for survivors. P4 explained, "*Most of the time clients come in to take medical reports and they just want the doctors to examine them*" which is reiterated by P12 who also said, "*And most of them, they come for report, medical report.*" A medical report can be used by the survivor and her family to take action against perpetrators and seek compensation. The report is an essential piece of evidence which allows police to charge perpetrators. For most survivors, the justice system they access will be local, village level courts which use traditional systems for resolving disputes, which almost always involves a payment of compensation. In the case of assault, compensation is often demanded by the survivor and/or her relatives. In fact, P17 emphasised that "*relatives always ask for us to write a medical certificate.*" Relatives are important stakeholders who want to influence outcomes for survivors in health facilities. P6 explained, "*They will expect us to report exactly what they are saying but the health centre will only put medical examinations… Sometimes they won't be satisfied with what we are writing. So they will go to other people and tell them to write*." This indicates that survivors and their families can exert pressure on nurses to sway evidence. However, the emphasis is on the health facility to prepare the medical report for evidence rather than to treat and care for the survivor, which raises issues about the role of medical reports.

Because medical reports are used as evidence against perpetrators, health workers fear potential legal implications and retribution from perpetrators and their relatives. This leaves health workers feeling reluctant to prepare reports, for example, "*when they want medical report…, we just don't want to deal with it.*" (P12), and "*Well for me it's my obligation to do but for me it's kind of a fear…when I did a case and the person was arrested, … It was like obvious that rumours were going around. That's this perpetrators relatives were not quite happy with me. It's like they are trying to get revenge on me*" (P2). Being involved in the preparation of evidence can put nurses' safety at risk, which is a significant challenge.

P14 explained, "*Because nowadays a lot of these people are educated and they normally take the nurses to court and all this so they [health facility management] don't want us to get involved*". The threat of legal complications for staff, as well as violence, is too great which, in this case, has resulted in facility management declining to offer the service, meaning that survivors have no ability to get medical evidence of their injuries which they need in order to pursue the matter in court, including to obtain restraining orders.

The role of medical reports in service provision to survivors is complex. As indicated, medical reports may be a driver for seeking health care assistance. This in itself is not a problem unless the report becomes the focus of the services, rather than treatment and psychosocial support. The lack of standard procedure for providing reports increases the burden for survivors, who may have to travel several times to get a report. Because medical reports are often used as evidence in court, this becomes a barrier for health workers providing care, because they fear retribution from perpetrators for writing reports or have to deal with unsatisfied survivors and their relatives.

6.4.3 Further help: counselling & referrals.

6.4.3.1 In facilities.

All participants acknowledged that referral to additional support services is needed when caring for survivors of FSV. "*I know, although I meet with her, her physical abuse but mentally and socially she is still, she is still being affected so she needs support so I need to refer*" (P7). Some nurses provide counselling themselves, as is the case with P14, "*I'm the only nursing officer so they used to refer to me and I do counselling*". Several other participants reported access to skilled people to refer to within their facilities, "*we have nurses who are counsellors*" (P6), and "*At our setting, back at Vunapope, there was a nurse who was into sexual violence, where we tried to refer patients to her for sexual counselling*" (P13), and "*Normally we used to refer them to counsellor I mean hospital violence worker*" (P10). P5 reported that her facility has "*committees in place, like this, for domestic violence and child protection*" (P5). Larger hospitals do have social workers but these participants had very little knowledge about their work in the hospital: "*Yep Port Moresby General Hospital we have social people there but so far I've worked there for years I have not seen any of them come to the ward*" (P8), and "*it depends on the hospital* *themselves. In some hospital they do have that and they have welfare system in place where the welfare team are based in the hospital, like big hospital"* (P18).

Although comments indicate some access to counselling and support services, it was difficult to determine the quality of counselling and the actual usage of such services.

P16 said, *"Hospital management must try to link the hospital with other service people. We cannot handle it ourselves"*. One participant did provide a detailed explanation of the approach he would take to counselling a survivor, which gives some insight into quality and how it is impacted by context. This stood out because the focus in his counselling is to encourage the survivor to accept her situation, which sits uncomfortably with many feminist and human rights approaches to FSV counselling. As explained:

> *In the most cases in the Highlands, man want to get another woman or something. This is the causes of the violence so when the man want to get another woman and the first woman, wife, she don't like the second wife so she want to you know go against with the husband and the husband get up and fight with the wife. So that's the biggest problem, so we need to get the story and we try to give counselling to the mother... So like we normally counsel the mother and say if you do that you'll get injured , and if you get belted when you died or something, all these kids, who going to look after them. So don't think big on this area and then you get any harm to your body and all these things can happen so we counsel the mother*. (P18)
>
> [Interviewer: *why would you counsel her to accept the situation*?]
>
> *Well it's a common problem. We cannot change the man's mindset. The husband's mind set is he wants to get another a second wife so the only advice we give to the mother, the first wife is to like, we tell her not to fully involve with this problem or sometimes she can like get injury and then bleed to death or something and nobody going to look after the kids. So we need to tell the mother so she can forget*. (P18)

The participant explains that they counsel women to accept their husband's decision to take a second wife because if she does not and continues to argue with her husband, she will continue to be beaten and get *"injured"*. The abuse is inevitable because women cannot challenge their husband's wishes. The participant notes that this will have longer term consequences for the woman's children, who will have no one to look after them if she is injured or dead. The competition amongst women for resources and support from male partners means it is unlikely that the children would be cared for by additional wives. P18 recognises the limitations of what he is able to do to support the woman. He is cognisant of the fact that "*we cannot change the man's mindset*". So his approach, which reiterates acceptance of male decision-making, may be all he can do to prevent further injury whilst working within the existing cultural framework.

Details about P17's environment further help to understand this situation. He works in a Highlands province, which have some of the highest levels of reported violence against women in PNG. He describes it as "*very remote place with a lot of mountains and big rivers*" where "*the villages are all scattered on the big mountains*". The "*road condition is not really good*", meaning that people have to drive "*8-9 hours*" to the nearest district centre, which itself is a lower-level administrative centre for government. The health centre where he works has "*no doctor*" and "*no midwives*". There are low literacy levels because "*we don't have more schools*" and often "*women they don't know how to speak pidgin*" meaning that they cannot communicate with health workers. There is a "*lack of law and order*" and "*no police*" and problems within households and communities can escalate quickly to "*tribal fighting*", as explained:

> *Particularly in the Highlands when small things, when husband and wife, they fight, we need to go and stop them fighting but if you don't go and stop them, things will go into the bigger problem. Whole family involved, whole community involved, other community involved and then the problems are even worse. Sometimes men, they can lose their life so when things start small we just go in and we stop them*. (P17)

The consequences of tribal fighting can continue for generations, so there is an imperative on the part of the nurses to prevent "*small things*" like FSV, evolving to widespread community violence. So although P17's approach seems at odds with a survivor-centred approach, does not promote her human rights and reinforces her inferiority, it may also be the only strategy the health worker has to keep her safe. Understanding the context in which health workers operate and the constraints within their settings is essential to understand why health workers behave the way they do towards survivors of FSV.

Here is another example to demonstrate why it is important to understand context when looking at practice. P9 reported that in his facility, when they provide counselling, they only do so when the "*husband is around*". When the husband is not around, "*then they just do prayer with the chaplain.*" When asked why counselling would not be offered to a woman without her husband present, he replied, "*Ahm, that's because in most cases the husband is the one who cause all this that's what they assume and also when we try to counsel it there will be no change because he is the one who get angry and do a lot of this so that's why there will be no effect.*" Practically, returning to live with their intimate partner is the reality for most survivors in PNG. There are limited safe houses and these are all in town centres, there is no welfare system to support survivors, and cultural beliefs and customs mean that her family may not be willing to allow her to return to her family home. Therefore, *"counselling"* the male partner to stop him from inflicting the abuse is seen as the solution. In both cases for P17 and P9, providing the survivor with emotional support was not presented as the purpose for counselling. This raises a second issue about the quality of counselling. At least 50% of health care facilities are run by churches. In some cases, faith-based trained counsellors will have an explicit agenda to promote the reconciliation of marital relations.

6.4.3.2 Police.

The police were cited as the most common external service that nurses refer survivors to. In many cases, survivors are advised to "*go to the police and seek help*", or "*take this case to the police*", particularly if "*it's a serious problem*". At the same time, it was stated that many survivors and their families "*go to the police* *themselves*". In rural and remote parts of PNG, police may be the only service available. However the limitations of the police were mentioned in interviews. Survivors may not have access to travel to police and they may also fear further violence from perpetrators if they involve police. P6 explained, "*sometimes they're not, they don't feel free to go to the police to report and they just stay in the village*". P9 pointed out that " *If there is a police station nearby it is effective but when it is in some remote places, faraway places in the bush I don' t think its most effective*" because it is unlikely that a survivor would be able to travel far on her own to a police station.

The quality of service from police was raised. P8 explained, "*everything is dealt at the police station and then many times it is not being assessed properly and then they end up at the hospital*", she went on to say, "*but most people have problem they don't want to go to police. Because they see they're not helping, police are dealing with big things not just minor sexual things in the family*." Police fail to intervene, which prevents more serious violence form occurring and this is because sexual violence with in the family is viewed as a "*minor*" issue, reinforcing the acceptance of FSV in PNG.

6.4.3.3 Churches.

Church personnel were also noted as a common referral point, predominantly due to the fact that churches are more available and accessible than other social services. Some participants mentioned using priests or pastors as referral sources, "*we can refer the mother to the church elders in the community to counsel her*" (P11), and "*we tell them you go to this certain church group*" (P1). P9 reported that in her facility it is "*protocol*" to "*report it immediately to the chaplain to come in and pray*".

Limitations of religious leaders and organisations as referrals were pointed out. Pastors, or priests "*come in and pray*" or "*pray and reconcile*", but it was noted that there was a need for "*professionals who are capable of dealing with this*" (P7), and who go "*through the right channels*" (P13) to help the survivor and deal with the issue in an "*appropriate way apart from praying over the problem*" (P13). But as with police, church personnel may be the only source of support available in remote areas: "*in remote areas, I don't have a trained social worker, then the only avenue is a pastor or priest*" (P7).

6.4.3.4 Village leaders.

Village leaders were also identified as referral sources, especially in remote health facilities. *"In some remote places where there is no doctors they always refer to the counsellors, the ward counsellors*" (P9). A ward counsellor is a locally elected village leader. A few participants reported that they themselves would approach village leaders to assist with cases. P1, who "*comes from the local community*" and works in "*a very remote area*" said, "*Sometimes I go straight to the leader of the village to make mention so if they want us to go present that time they have their meeting I go there and sit there are talk too on behalf of the woman or just a neutral person*.". Here she is talking about acting as an "*advocate*" at village level meetings, where leaders "*help us to make decision*" and "*do an agreement*". These are common forums for resolving conflict, including violence within families, particularly in remote areas. P6, who also lives in a remote community, advised, "*after treating them we get the chiefs or the chiefs come and interview us on what we have seen with the patient*" P17, who comes from the same area, describes how cases of family and sexual violence are resolved:

> *When we see that we can't handle this case … then we involve the chief, … then they'll sit on a certain day and talk about that problem. .. During that, they usually come to a peace ceremony because these problems will be forgiven. But if her are same problems that continue, if the, if the violence is getting worse then we involve the police, there's district police to report it to the police so the police can deal with the man*.

The village chiefs play a key role in resolving conflict and dealing with social issues within their communities. What is not clear is how effective they are at providing support to survivors, as their objective may be to maintain community harmony and ensure that problems "*are forgiven*".

6.4.3.5 Social workers.

Social workers or welfare officers were mentioned by only a few participants: "*there used to be welfare officer in the district level so where his kind of cases we do refer them'* (P9), and "*if they want to go for police or welfare and all these, social workers*"(P1). But these government services are mostly available at the "district level or in "town". P7 states "*it's not easy for women to come all the way to town to get such services"* and P1 explained that women from remote areas "*don't have money for travel*". Government social workers are supposed to play a key role in facilitating access to justice and supporting survivors in mediation over children and property but if they are inaccessible to most women, then they cannot fulfil this role.

6.3.4.6 Effectiveness of referrals.

Participants identified a need for services where they can easily "*refer women*" or to contact and get "*help from them to some advice*". They want "*those people who have caring for women*" to "*work alongside*" them (P16), in other words, specialist services, where staff understand women's issues and can work with nurses to support women. However, making referrals was described as a "*challenge*", "*very hard*", a "*barrier*" and a "*fear*". Participants noted that there are a lack of "*effective social places"* or referral services for health care workers, "*especially in remote areas*" because there aren't "*places that people can go and just sit and talk about their problems*" (P8).

Another issue raised in interviews was the lack of knowledge about appropriate places to refer survivors. P10 said, "*I don't know those referral places and I think most of my colleagues too would say the same thing*", and P12 said, "*We didn't have a good referral system, so I didn't know where to send them to ...we know we should be referring them but we don't even tell them*". P13 linked the lack of knowledge about referrals to nurse training, she said "*mostly general nursing, this sexual violence is not taught. We cannot learn on that, that's why sometimes we are not sure how to refer victim*". P8 also said "c*ause we were not taught how to refer*", identifying deficiencies in current pre-service training. When nurses do not know where to refer survivors or have a lack of options to refer to, survivors suffer and nurses can be left feeling disempowered and helpless. This can be a barrier for nurses' willingness to work with survivors. The following case is an example of what can happen when nurses do not know how to make referrals:

> *There was a time last year when I was in the clinic and there came this little girl around 10 or 11 years old. She came in and said, "my mother died and I was living with my father and my uncle". She told me straight, "my uncle raped me and I got on the PMV and I came all the way here". You see we found it hard to know where to refer to this little girl. And then we just gave her bus fare and explained the Catholic one for counselling and testing for HIV. You see we don't know exactly where to refer her. That's what we did you see, there is no clear picture here of where to refer*. (P15)

This example demonstrates several issues. Firstly, the nurses did not know how to respond to the child. Alarmingly the child was not offered any health services or checks at the facility for ongoing trauma or injuries as a result of the sexual assault. The child was referred to an HIV counselling and testing centre which was the only service the nurses knew of. Even though she was a minor disclosing sexual assault, the nurses sent her to another health service rather than contacting the police or child welfare officers and did not escort her to the next centre nor follow up to see if she arrived. It also shows that for the child, the health facility was the first place she went to for help, reiterating the role of health facilities in responding to FSV. Sadly, in this case, the facility offered little assistance. However, if the nurses had skills to treat and care for the child and had greater knowledge about the support she might need, as well more information about services available in their area, their response to the child may have been different.

6.4.4 Negative attitudes of nurses

Cultural beliefs about gender, along with professional beliefs about the role of nurses, are reproduced through the negative attitudes of health workers towards female survivors of FSV and were identified by most participants as a barrier for nurses caring for survivors of intimate partner violence. For example, "*there are a lot of negative attitudes being displayed by the nurse and I think that is one of the things that is causing barriers in patients accessing the right sort of care*" (P2). These attitudes are displayed in the way nurses talk to and behave towards survivors. In fact, P3 went as far as saying "*sometimes they abuse women too, the nurse abuse too*".

Negative attitudes shown by nurses include blaming women for causing the violence, for example, "*like sometimes they like "Oh it's your fault because you did this and that, you yourself you asked for this*" (P10). Women are blamed for causing violence when they step out of their expected role as a wife and question their husband's authority, for example, "*Like for sexual violence some nurse will think that maybe because of the woman must have said something that was not appropriate for the man or they must have come to an argument so he turned to abuse her physically*" (P11). As explained, the woman must have done something that was deemed wrong or "*not appropriate*" and this is why her husband abused her. The implication is that, had she behaved as expected, then he would not have abused her. There is no acknowledgement that it is against the law for the man to abuse his wife or that the husband could have reacted differently.

Other comments indicate that some nurses believe FSV is "*not our business*". This is confirmed by participants who explained that people "*don't interfere*" when there are domestic disputes and returns to the issue that FSV is "*normal*" behaviour between intimate partners and is a private matter. For example, "*I think, we nurses are thinking maybe it's not our business or something so we just let them go when we think it's maybe something to do with herself and maybe the husband or the family or something*"(P4). The source of FSV is often disputes between intimate partners, unlike malaria, STIs or pneumonia, which are caused by viruses and bacteria. Nurses are trained to treat and cure biological causes of illness, which are readily accepted as health issues. FSV is far more challenging.

Another participant explained, "*Because they are married and we cannot solve it …so what we usually do is just tell them that, "you have made a wrong choice of choosing him as your husband*" (P16). This comment reiterates that nurses "*cannot solve*" FSV, and the reason given is because the people involved are "*married*". It is easier to blame an individual's choice than to help them resolve their domestic disputes and by locating the problem with the individual, nurses distance themselves from feeling responsible for ‘solving’ the issue. This was identified by another participant who explains:

> *Sometimes nurses won’t want to know them, cause this is not a disease but you know wife beating is like it’s not even an accidental, you just create it yourself and at the same time you are giving hard time to us to talk to you” … We have that most often I see that, “larim wori belong em”. Sorry “let her, it’s her problem, she deserves it” or things like that. (*P15)

For some nurses, FSV is “*not a disease*” that can be diagnosed and cured with drugs or procedures. FSV is a complex cultural and social phenomenon with serious implications for people’s health. Again this comment reiterates that nurses believe the survivor causes or *“creates”* the problem, which gives nurses a *“hard time”* to deal with what is an unnecessary problem in a resource constrained environment. Therefore, if you cause violence yourself, then your injuries are your own fault, and you are less deserving of help. This generates attitudes of blame and the sentiment that survivors do not deserve help. A shift in the way nurses understand violence would be required before the ways in which they deal with survivors of violence could be improved.

Nurses can treat the physical injuries from violence but this does not fix the problem, which can be frustrating and disempowering. The reference to disease also indicates the prominence of biomedical understandings of health, which take little account of the social determinants of health. This makes it difficult to understand family and sexual violence as a health problem. So nurses may see FSV as an issue beyond their ability to deal with and outside the scope of their duties: “*they feel that’s not their problem to talk about*”. (P9)

Other comments suggest that nurses do not approach survivors of violence with empathy and treat them poorly. In the following example, nurses’ questioning of the survivor about the time of her presentation demonstrates a lack of understanding about the challenges survivors may face in trying to reach health care facilities. It also reflects an unwillingness to want to deal with survivors, with the issue of time being used as an excuse not to treat the survivor. In effect, survivors are punished with denial of treatment:

> *Yes, we scold patients. "Where have you been all day?" if she comes in the afternoon, very late in the afternoon, they will say, "where have you been all this day and you are coming at this time and we are hungry, we want to go. Its time already and you are coming and no one will see you." So they will just stay like that in the health centre and that poor person will wait for the evening staff to come and see her. So it happens*. (P6)

Although this participant acknowledges "*scolding*" survivors, she was empathetic to the "*poor person*" who has to wait for treatment because of the negative nurses' behaviour. There is recognition that this is negative behaviour on the part of nurses. Other participants were cognisant of the damage that negative attitudes can have on survivors and how this becomes a barrier for survivors to access treatment and care: "*So that's what I mean. They'll never come back to get the service from here. They won't come back. It's very shameful for them, it's very hurting for them to come for help and then you are told that you are the fault of* it"(P7), and "*if women do come across such instances already and they do have this mentality that maybe these nurse didn't, or never treat us properly, then maybe they don't keep our issues confidential then yeah maybe they wouldn't come for treatment*"(P4). These comments reaffirm that nurses' attitudes are a significant barrier for women accessing care. Women who have been traumatised by violence potentially face further trauma and risk their safety with breaches of confidentiality when seeking care and treatment.

All of these examples, in addition to demonstrating the types of attitudes nurses hold towards survivors, suggest an unwillingness to help and even a degree of disdain which creates stigma amongst survivors. These attitudes are informed by the broader belief systems and cultural frameworks which nurses live with and transfer into their work practices. The following comment articulates how cultural beliefs inform nurses' practices:

> *I think yes maybe yes, culture is also a very important factor in there because culturally woman are regarded as what will I say like not that important, inferiors and that. If we do have this values in our culture then if they, we believe in that value and you work in our health care setting and we don't*

> *change our mindset at the community level then where we go to work, especially as nurse maybe we wouldn't treat them as well as we should because of that culture we have. If we change the mindset and maybe change people's attitudes and customs and all this then we will be able to treat people fairly*. (P4)

As explained, nurses do not leave their beliefs and values at the door of the facility when they enter their workplaces. Nurses are part of the cultural system that accepts male authority over women and their use of violence as normal. These beliefs and values inform nurses' attitudes and behaviours and are played out in the way they treat female survivors of violence. In many of the examples given, the strength of cultural beliefs and need to adhere to them overrides nurses' personal views and opinions about what is right or their professional values about caregiving. All participants demonstrated empathy for survivors of violence and acknowledged the magnitude of the issue. What is clear is how difficult it is for health care workers to operate outside cultural frameworks, especially where there is limited support and nurses have had little exposure to education or information which informs them otherwise. Even where nurses want to assist or intervene to prevent violence, this is not always possible.

6.4.4.1 Frustration because of repeat cases.

Participants described feeling frustrated when dealing with repeat cases, which leads to negative attitudes. The examples provided reveal the extent of poor treatment of survivors. When nurses are under pressure or "*busy*", they may be less tolerant, as P1 explained, "*we are busy and these things just pop up, for us. Frustrated, we can just scold back we tell the wives "you, every time you have this, so you and your husband go back and solve it"*. Survivors cause additional workload unnecessarily because they have the means to "*go back and solve it*" and this is a source of frustration in busy settings. This is exemplified when nurses feel they have already tried to assist survivors as was explained by P9 who said:

> *Sometimes they (nurses) feel like the work they have (done) is useless and they get frustrated and talk to them aggressively. Basically like "do you ever listen to us? We are wasting our time talking to you and you go*

> *and you get this issue again and all over again you come, so we don't want to see you with the same face again" and like that*.

Nurses blame survivors for repeat episodes of violence because they have not followed advice or taken suggested actions to resolve the issues. Clearly, underpinning this frustration is the lack of knowledge that nurses have about disclosure and a lack of understanding or acknowledgement of the ability of women to actually change their circumstances. FSV is seen as a result of the woman's actions or inaction and there is an assumption that women have an ability to control outcomes in their lives. This is interesting because other comments about the status of women and access to resources demonstrate that many nurses, who are mostly female, do have an acute understanding of the limited ability of women to control outcomes in their personal lives.

P16 shared her experience dealing with a repeat case and the poor treatment survivors may receive at the hands of health workers. She openly admits that the way she responded and spoke to the survivor caused the woman to leave without treatment. Under circumstances like these, it is not hard to imagine why survivors do not come to health facilities. This is a serious impediment to service delivery:

> T*here was a case where that woman came to me 5 times, 4 times. During the 1st time I talked to her she just told me about her family problem. She tend to come to me now because all the staff, they just give up, they don't want to work with her. She came (again), I scolded her. Like I told her "we always tell you to go and seek help not to go and live with this pain for so long". And she didn't talk, she just sit there. I told her "wait, I'll attend to the patient first and later I'll see you and we'll talk." But because I already scolded her she left without treatment and I was regretting at the end of the day I was thinking "lord forgive me for that". But I was just fed up. I already told her, there is a solution, there is a way that you can solve this problem. But she didn't tend to follow our instruction and all the staff already fed up with her. Maybe she is her own reason, maybe she's scared of the husband or yeah*. (P16)

In the discussion about frustration over seeing repeat cases, most participants recognised the damage of such attitudes or referred to them as "*negative*". In P16's case, she realises that the survivor may have reasons for not dealing with the problem, including fear, however, that did not translate to empathy for her situation at that time. P16 assumed that the survivor was able to get help and that this *"solution",* given through advice from nurses, would work. This is in contrast to all the other evidence which these participants gave about lack of police, limited referral sources and the cultural beliefs relating to women's status. The survivor may have sought help, but if she is dependent on her partner for shelter, food and the survival of her children, she may have limited choice but to stay in the relationship. What is problematic about the types of attitudes and behaviour shown by nurses is that although they understand the issues facing survivors, they do always show empathy to survivors in practice. P11 gave an honest reflection, saying, "It's *challenging to be a nurse to deal with these people. We can be judgemental but that's not we're supposed to*". This reiterates how hard and complex dealing with FSV can be.

6.4.5 A biomedical response

Although these participants recognise the special needs of survivors, treatment and care for survivors is often approached in the same way as for any other patients and is focused on attending to the immediate and short term physical needs. A recurring sentiment was that health workers "*treat them and let them go*", that they "*see women with violence and everybody the same*", "*I don't look beyond the bruises*". Comments like "*just treat them, then that's it, they just go back home*" (P4), and "*anybody attend to that person, treats their injuries and then they are gone*" (P7), indicate the inadequacy of current services. P3 commented, "*they used to think that, our job is just to see them, treat them physically, give drugs and all these things, and they go but actually it's like we have to see a patient as a whole human being physically, emotionally and socially, wholly."* This comment not only demonstrates that psychosocial needs are often neglected but emphasises the biomedical training of health workers who think it is their job to "*treat them physically*".

There was a sense that the current approach is a missed opportunity to truly help survivors, who often return home to experience repeated episodes of violence. P4 expressed, "*Because most of the time after this, some just go on the same problem over and over again and ah, I think it's not right, just sending them away like that and they continue to have that abuse at home*". The lack of action on the part of nurses to prevent further violence is seen as problematic and "*not right*". P8 expressed the sense of helplessness that nurses feel because they are unable to do more for survivors, "*They come, they're there, we treat them but how can we help them, we don't know*". By distinguishing between treating and helping survivors, she highlights the limitations of medical treatment in assisting survivors. She later explained, "*We only deal with the curative kind of measures and with the social issue of a patient, we don't*." There is recognition that the needs of survivors go beyond medical care but this is beyond the role or capacity of nurses to provide. This highlights the challenge for nurses when dealing with FSV as a health issue because its causes are social and nurses are not trained to deal with social issues. This speaks to two broader issues. Firstly the limitations on the role that nurses can realistically play in responding to FSV, and secondly, the effectiveness of biomedical training paradigms in preparing nurses to deal with complex health issues driven by social phenomena. For nurses at the front line of dealing with the effects of FSV, being unable to stop or "*cure*" it leads to frustration and helplessness. This leads to negative attitudes which drive poor behaviour and practices towards the care of survivors.

6.4.6 The role of nurses in responding to FSV

Participants described what they see as their role in responding to FSV. Some comments reiterated that the issue of FSV is not seen as important and is outside the role of nurses, whereas other comments highlighted that nurses feel that they have a greater part to play in preventing FSV and supporting survivors. Advocacy and education were key responsibilities identified by participants.

Linked to comments that showed that nurses in general do not consider FSV as important, P3 said, "*we just don't see the important of, women coming with that and our role as nurses to help them*". This helps to explain other comments which say FSV is not a "*priority*" within health facilities. It also fits in with the proposition that nurses trained under a biomedical paradigm of health care struggle to assist FSV survivors because they are not taught the skills and knowledge to provide the care or treatment required. However this is in contrast to other participants who emphasised the role of nurses in preventing violence. Others recognised that nurses have "*a big part to play*". So on one hand, participants acknowledge the limitations of existing health services in being unable to treat beyond physical injuries, but at the same time, recognise the role that nurses can play in primary and secondary prevention: "*preventative measure is part of our job*". (P12)

When discussing the role of nurses, several participants emphasised the responsibility to "*educate our people*", and "*do awareness*" and "*be advocators*". Awareness, prevention and health education were mentioned as being the "*job of nurses*". P4 referred to nurses as *"educated elites"* in their communities and this positions them to be able to "*do something to stop domestic violence in communities*". A point raised was that nurses "*are always there for them*" (P11) and often the only service providers in "*very remote areas where other people are not*", meaning that they are in a position to provide education and awareness. P11 talked about nurse's responsibility as "*educated people*" to "*stand together and advocate*" for "*poor ones*" and *"work in partnership"* with social workers and the community. This alludes to the status that nurses and other health care workers often hold in communities. P18 confirms this by suggesting that nurses and teachers are respected members of communities and as such, can influence community behaviour, "*Because they have respect on us so when we try to stop them, they listen to us and they stop fighting*". Nurses see themselves as educated people with positions of respect within communities which they can use to educate others about preventing FSV.

However, it should be noted that providing education and awareness to a community is different from providing health services to a survivor. Providing awareness may be seen as less threatening or challenging to male authority and may be a more accepted role for nurses, which will help to break down cultural barriers. Participants expressed the importance of "*doing awareness*" or "*information*" to the community so they understand the "*value of women*". P9 said, "*but I feel that the best thing we can do now is to get down to the basic level to letting people know what is right and what is wrong and do more of the awareness as to the rights of the women and the man so they will follow they right track*". The reference to the "*basic level*" refers to primary care level, moving from treatment of physical problems to prevention, which is an indication of the value of public health for these participants. There was an assumption that providing people with information or talking to people about rights will actually change behaviour, although P18 acknowledged that change takes time and "*So we really try our best to educate them, we give them information about the importance of what will their wife be facing or what consequences we are trying our best to teach them but you know they will, it takes time*". What is positive is that these participants see a role for themselves in prevention and do not resist the idea that responding to social issues is outside the scope of their work. It is less clear how nurses would be able to execute that role given other resource constraints, like training and staff.

6.5 Conclusion

This chapter presented the analyses of qualitative data. Quotes were used to illustrate four overarching themes and a range of interconnected subthemes. The data is dense, detailed and complex, demonstrating the challenge of unpacking the factors that drive nurses' behaviour in response to FSV. Chapter 7 will synthesise these findings with those from the survey, where relevant, and with the international literature to make broader interpretations about the identification and management of FSV in PNG by nurses.

Chapter 7: Discussion

This study aimed to critically analyse the influences on nurses' identification and management of FSV in PNG. This was achieved using a mixed methods design incorporating a survey and interviews with nurses. This chapter will bring together interpretations of the qualitative and quantitative results by discussing where findings converge and where there are inconsistencies. Pawson et al.'s (2004) questions, "*what, for whom and in what circumstances*" drove interpretations and this is how the critical realist lens was applied. The findings are discussed in relation to the relevant scholarly literature, along with policy and practice implications, and pointers for future research, where relevant. This will help to embed the implications alongside the interpretations, rather than separating them into distinct sections, disconnected from the heart of the discussion. The policy and practice implications are tangible and are confined to actions that the PNG health sector could conceivably manage to implement. This is because, keeping in line with the critical realist orientation of the study, it is fully acknowledged that real change to outcomes for survivors will come from generational shifts that affect social processes and structures and this cannot be practically or reasonably influenced by health interventions or policies alone. Reference back to the ways in which these interpretations fit with a critical realist orientation are made throughout.

7.1 Summary of Results

The findings of this study show that, when dealing with FSV, nurses in PNG face similar challenges to nurses in other parts of the world, particularly those working in LMICs and with high levels of gender inequality. However, the findings here show nuances in the PNG context that are important for consideration.

The results from the survey found that most participants scored moderately on the self-efficacy, blame, system support, victim and provider safety subscales of the DVHPSS. This is similar to John et al. (2011) who used the same questionnaire on a Nigerian sample of HCPs and found that they also scored moderately on these subscales. They concluded that these factors constitute a barrier to asking about violence. More interesting were the response patterns to specific items where larger proportions of participants responded affirmatively or negatively. These items, when considered alongside qualitative themes, help to fill out the picture of the experiences of nurses when it comes to identifying and managing FSV in PNG.

The content analyses of qualitative comments revealed distinct interrelated themes. The first theme captured participants' views and experiences of FSV, including their interpretation of the importance of FSV, the extent of FSV in their communities and in PNG more broadly, as well as their professional and personal experiences of FSV. The second theme was about the way in which cultural beliefs around gender roles, and in particular the acceptance of male violence against women, influence their practices with survivors in health facilities. The third theme centred on challenges in the operating environment, covering issues relating to inadequate resourcing of medical supplies, infrastructure, human resources, as well as the role of facility fees. The final theme describes the practices of nurses, including how they ask about FSV and how they manage cases of FSV, how they make referrals, and issues relating to the role of nurses in responding to FSV.

From a critical realist perspective, what this study tells us is that cases of FSV are occurring and a reasonable number of survivors attend health facilities for treatment and care of their injuries. This is what is happening in the 'actual' domain. However, the experience or treatment that survivors receive at health facilities is largely dependent on how a range of factors, including overarching cultural beliefs about gender, biomedical influence of training, location of the facility and resources available to that facility, interact and converge to shape the individual behaviour and practices of nurses. These factors exist in the 'real' domain and are the underlying social structures, processes and conditions that influence nurses' behaviour, but they are context dependent and activate differently across settings and in individual cases. It is this individual and context-specific response to FSV that is experienced in the 'empirical' domain. The three ontological domains of nurses' identification and management of FSV are shown in Figure 5.

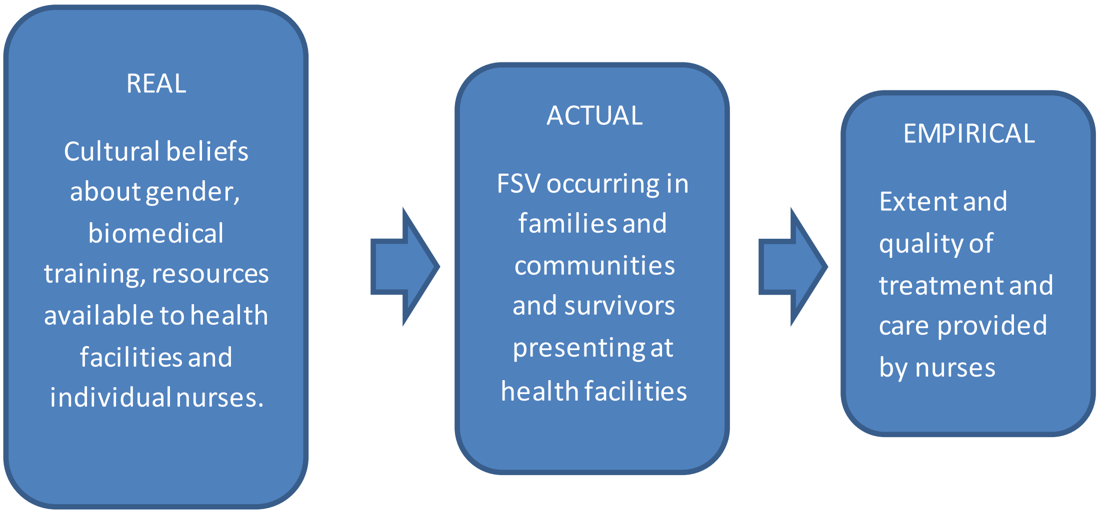

Figure 5: Three ontological domains of nurses' identification and management of FSV

7.2 FSV is and isn't an important health issue

FSV is considered a serious problem by nurses who deal with the consequences in the health facilities where they work. Survivors, predominantly women and girls, come to seek care for injuries caused by violence inflicted upon them by male partners, family members and sometimes strangers. These findings reported severe and brutal cases of violence against women. Other accounts by Eves (2006), Amnesty Intentional (2006), McPherson (2012) and Oxfam (2010) also describe similarly severe cases of FSV amongst the women interviewed and consulted.

Not surprisingly, many nurses have had personal experiences of violence or have worked with colleagues who are suffering abuse. This contributes to absenteeism in the workplace, generating additional pressure in already constrained settings. It also impacts the quality of care that nurses who are living with abuse are able to provide to patients. FSV has an impact on the capacity of the health workforce, however this is not recognised in health or public service workforce policies and support to those impacted by FSV is not forthcoming.

The qualitative comments suggest that violence is pervasive and affects the majority of women. This is consistent with the Law Reform Commission report (1992) that found that on average, 67% of married women in PNG are abused by their husbands; Lewis et al. (2008), who found that 58% of women in her study had experienced FSV and Ganster-Briedler (2010) who found 65% of women reported

FSV. The data published by Fulu et al. (2013), which reported that 80% of surveyed men had perpetrated physical and/or sexual violence in their lifetime, with 59% reporting rape of a partner and 40% reporting rape of a non-partner, supports the view that FSV happens in most families, noting however that, Bougainville, being a post-conflict setting is not necessarily representative of other parts of PNG. It was perceived that FSV is increasing, but so too has awareness and reporting on the issue.

Eves (2006) notes that some commentators report that FSV is increasing, whereas Jolly (2012) cautions that the traditional practices involving restorative violence should not be underestimated, and without recent national prevalence data it is not possible to determine whether FSV is actually more prevalent than in the past. This clearly points to the need for a national prevalence study to determine the extent of FSV.

Despite widespread occurrence, FSV is not considered an important issue and participants felt it remains largely unaddressed, both within the health sector and in PNG more broadly. There are a range of complex factors or social structures, processes and conditions, which underpin this non-engagement with FSV. In this sense, PNG is not all that different from most countries. Globally, FSV as a health issue is poorly understood or accepted amongst HCPs, who tend to view FSV as a criminal justice issue or a welfare issue (WHO, 2013b). This is further compounded by the dominance of the biomedical approach to health in medical and nurse education, which omits FSV as a health issue, meaning that many HCPs complete training without the appropriate skills and knowledge to respond effectively to cases. In Uganda, HCPs did not know that FSV was a problem of public health importance and their knowledge was limited to physical trauma because that was what appeared in medical texts, their key source of learning (Kaye et al., 2005). Uganda, like PNG, struggles to adequately fund basic health care, including professional development of staff and this further limits HCPs' ability to effectively respond to the non-medical aspects of health issues. Further, in countries where there are strong patriarchal norms that accept male use of violence against women, there are cultural barriers to HCP involvement (Laisser et al., 2009; Shamu et al., 2013 Sohani et al., 2013; Usta et al., 2012). For example, Chibber et al. (2011) and Haj-ya et al. (2015), whose studies were conducted in India and Palestine respectively, both found that the health workers in their studies did not believe that they should get involved or intervene in cases of FSV because it is a private matter for families to resolve. The findings from this study, as discussed subsequently, provide strong evidence that in PNG, cultural beliefs about gender roles play a large part in determining health worker behaviour towards survivors of FSV.

7.3 Identification and Management of FSV in PNG

7.3.1 Inconsistent enquiry

With regard to the specific procedures nurses use to ask about and manage cases of FSV in their facilities, patient assessments or "*history taking*" can enable the identification of FSV and clinical guidelines which describe how cases of sexual assault should be managed do exist. The problem is that these procedures are applied inconsistently or not all. Although the assessment form for taking a patient history prompts nurses to ask about social issues, there are no specific questions relating to FSV or protocols on how to ask about FSV, including ensuring confidentiality. Further, a number of participants admitted that it is often skipped because of time constraints or deemed not to be important. Whilst a few nurses reported asking directly about FSV, a larger number either ask using indirect questions or ask only when they suspect abuse. Patients who have physical injuries or a distressed and quiet demeanour are more likely to be asked about FSV. Few participants were familiar with the content of the clinical guidelines and as they are limited to sexual violence, they do not help nurses manage other types of violence. In addition, facilities do not always have qualified staff, medical supplies and referral services to be able to implement them anyway.

That enquiry is more likely to happen when nurses see visible signs of abuse is also common in other settings. Sundborg et al. (2012) found that only half of the nurses in their Swedish sample stated that they always asked about IPV and only when women showed visible injuries. This was because nurses felt uncomfortable and were unsure on how to ask direct questions. Baig et al. (2012) similarly reported that Colombian health workers ask most often when they suspect victimisation, even when specific protocols were in place and Maina (2009) reported that Kenyan HCPs stated that they could not identify abuse unless there were injuries present. These all point to the fact that survivors who do not have observable signs of abuse miss opportunities to have the source of their health conditions properly assessed.

The survey in this study found that there is a low percentage of nurses who frequently ask patients about FSV following common related health complaints. Between 32% and 68.6% of participants responded that they never or rarely ask patients about FSV when seeing patients for any of the health complaints listed in the survey (injuries, chronic pelvic pain, irritable bowel, headaches, reproductive care, depression and anxiety, hypertension). On all survey items, there were more participants who **never** asked about FSV than who **always** asked about FSV. Of particular concern was that only 27.4% of participants often or always ask about FSV when seeing patients for injuries. Survivors are more likely to seek medical care for physical injuries and, as discussed above, nurses are more likely to ask about FSV if they observe physical injuries. These findings indicate however that even when there are observable signs of FSV, like injuries, many nurses in PNG do not ask about FSV.

The reluctance to ask about FSV, even when there is evidence that it has occurred, has been reported elsewhere. Shamu et al. (2013) reported that Tanzanian midwives relied on mothers disclosing abuse, meaning that they do ask about it, even though they acknowledged that disclosure rarely occurs. In a clinical trial in Canada, MacMillan et al. (2009) found that only half the number of physicians who had been informed that their patient had screened positive for IPV actually raised IPV as an issue during consultation. This reiterates that there are other factors beyond seeing visible signs and the availability of protocols that influence whether HCPs decide to ask about abuse.

In comparison to other studies which assessed rates of identification, based on these results, the proportions of PNG nurses asking about violence are similar to rates of identification by HCPs reported elsewhere. John et al. (2011), who used the same survey as that used in this study, reported that the majority (76%) of Nigerian HCPs had not enquired about FSV for any health conditions in the previous three months. Al-Natour et al. (2014), who used an adapted version with Jordanian nurses, reported that only 25% asked about FSV when treating patients for injuries. Low rates of enquiry is not just a problem in LMICs. For example, Gutmanis et al. (2007) reported that 32% of Canadian nurses and 42% of physicians routinely discussed IPV. However rates of enquiry alone, particularly as measured by surveys, cannot be used to judge how effective HCPs are at dealing with survivors. In India, Chibber et al. (2011) reported that physicians ask indirect questions unless they see clear visible signs of FSV, which indicates a lack of routine enquiry. However they also suggested that the use of indirect questions may be culturally more appropriate in India because of cultural perceptions of FSV. Indirect questioning allowed physicians to employ a ‘personalised’ approach to screen through questions about broader family and this fostered a trusting relationship which enabled disclosure. This points to the limitations of surveys in determining how nurses do or do not ask about violence in particular settings.

One finding particular to this study was that patients are more likely to be asked about FSV when seeking reproductive or maternal care than other health issues. Forty per cent of participants responded that they often or always ask about FSV when seeing patients for pregnancy or reproductive care. Similar comparisons can be made against Al-Natour et al. (2014), who reported that 10.8% of Jordanian nurses asked about FSV when providing obstetric and gynaecological care and Guillery et al. (2012), who found that only 33% of Canadian postpartum nurses often or always asked about physical abuse and 11.5 % asked about sexual abuse. On one hand it is encouraging that there are greater numbers of nurses asking about FSV with regard to this health issue. Reproductive care targets women and male partners are rarely involved, meaning that this may be a safe time to ask about FSV. Further, PNG has high numbers of women who die or suffer complications during childbirth and FSV is known to contribute to poor outcomes in pregnancy (Devries et al., 2011). However, these findings should not be overstated, because it is still a minority of nurses who are regularly asking about FSV. This finding also needs to be interpreted with caution because there was a large representation of midwifery students in the sample, which biases these results. Regardless, asking about FSV is not common practice for the majority of HCPs and PNG is no different. Taking a critical realist view, it can be concluded that underpinning the low rate of enquiry, which is an example of an event in the ‘empirical’ domain, are issues relating to perceptions of professional role, cultural and resource barriers, which are tied to social structures, process and conditions that predispose the likelihood of enquiry.

7.3.2 Medically oriented treatment of survivors

The treatment and care of survivors of FSV in PNG health facilities is variable depending on the number of staff, their skills and knowledge, as well as their beliefs and attitudes about FSV. The most common description was that survivors are treated for presenting physical injuries and then “*let go*”. There was acknowledgement that nurses do not look beyond superficial injuries but at the same time there was recognition that survivors often need additional care and assistance. Survivors of sexual assault may receive more targeted care because of the existence of clinical guidelines but also because many survivors and their families require medical reports to be used as evidence in court cases. Participants could describe more specific actions to take following sexual assault, like administering PEP, testing for STIs, providing emergency contraception, and carrying out internal examinations. It should be noted that these are specific treatment tasks that nurses are trained to carry out, unlike psychosocial care which is not part of the current biomedical-oriented training curricula in PNG.

A similar situation was reported by Vieira et al. (2012), who found that in Brazil sexual violence was more medicalised and had a clear protocol which made it easier for nurses to treat and care for sexual assault survivors. Leppakoski, Flink and Paavilanen et al. (2014) also concluded that HCPs who had clear procedural guidelines were more likely to have helped survivors than those who did not. Clinical guidelines reduce the response to a set of practical tasks focused on diagnosis and cure. This is what HCPs are trained to do and therefore, these types of procedures give them a sense of control over obtaining a tangible outcome, which is perhaps why HCPs are more likely to use them. This tension for HCPs who are trained to deal with medical, not social, problems has been discussed in other studies (Baig et al., 2012; Beynon et al., 2012; Husso et al. , 2012; Maina & Majeke, 2008; Nascimento et al., 2014; Rees et al., 2014). The unpredictability that comes with disclosure can leave HCPs feeling frustrated, particularly if they lack interpersonal skills and the knowledge to deal with and obtain the right diagnosis. Further, there is no clear treatment for FSV and interventions like counselling may not improve outcomes for survivors and this can leave HCPs feeling like they are wasting time which could be spent on other priorities such as medical conditions which they can cure (Beynon et al., 2012). This relates to broader issues about the limitations of the biomedical paradigm of training when it comes to dealing with health issues which have social, not biological, origins. The critical realist conclusion from this study is that the biomedical paradigm is a social structure which exists in the 'real' world and interacts with other pre-conditions, in particular how nurses are trained and their conceptualisation of health, to influence whether or not they have the skills to deal with socially-derived health conditions and whether they even perceive these conditions as a health issue in the first place. This contributes to shaping how nurses actually respond to survivors in the 'empirical' domain.

Interestingly, Davy and Patrickson (2012) presented another view of influences on health care delivery in PNG. They concluded that HCPs lived and worked in a context where multiple belief systems contributed to everyday life and to the diagnosis and treatment of illness. Despite initial biomedical training and access to standard treatment manuals, many HCPs were comfortable using other belief systems when diagnosing and treating. They concluded that PNG health workers do not appear as constrained by the biomedical model as their Western counterparts and can expand their belief systems to incorporate approaches more aligned to that of the community. As discussed, there were many participants from this study who recognised the need to attend holistically to patients' health and voiced a strong commitment to preventative care. Further, investigation of indigenous and other alternate paradigms for understanding health and the opportunities that they present to improve the quality of care in PNG would be a useful topic for further research and may help to provide locally-derived solutions to the seemingly insurmountable task of improving health outcomes.

The role of compensation following sexual assault is an issue particular to PNG and needs to be viewed in the context of traditional mechanisms for dispute resolution in PNG. Compensation is paid to the survivor, but more often to her family, and is often a negotiated outcome of mediation between families or in the village courts (Oxfam, 2010). Exploring to what extent financial incentives derived from compensation payments drive survivors to seek care and whether this compromises quality or is an opportunity for resourcing to an under-prioritised issue would be worthy of further investigation, alongside approaches to reconcile the need for obtaining evidence for court with the need for care and treatment of individual survivors.

7.3.3 Limited skills and knowledge

Results from the interviews showed that a lack of knowledge and skills was a barrier for nurses, in particular, the skills to talk with and approach patients in a sensitive way. In contrast, 79.3% of participants strongly agreed or agreed that they have ways of working with perpetrators and 71.7% of participants strongly agreed or agreed that they had ways to encourage survivors to seek help. This indicates that the nurses surveyed believe they have skills and knowledge to work with cases of FSV. Throughout the qualitative data there were numerous examples of nurses treating, counselling and referring patients. Further, participants described processes to deal with survivors, including asking about violence when taking patient histories, procedures for medical examination, tests and specific treatment, particularly for unwanted pregnancy and STIs, and preparing medical reports. This was more the case for sexual assault than for other forms of FSV and these procedures are not consistently followed or known by all staff, as already discussed.

However, reports of the omission of FSV from pre-service training, limited in-service training, irregular clinical supervision and a lack of guidelines for dealing with FSV beyond sexual assault, mean that nurses are not taught practical skills to manage

FSV and are not exposed to information about the prevalence, causes and consequences of FSV. This leaves a gap in knowledge and skills among nurses on issues about the nature of FSV, basic counselling skills and appropriate types of referral services for survivors. These stem from a lack of investment in the training and ongoing professional development of nurses, particularly in FSV. So whilst some nurses do have skills and ways of working with survivors, in general they are lacking specific skills to talk with or counsel survivors, make referrals and lack knowledge of the broader issues causing and contributing to FSV.

The issue about skills and knowledge is both a resourcing issue, in that there is insufficient funding for training in general, but also an issue about the conceptual understanding of health and health service delivery. The biomedical model or paradigm is predominant in health care around the world and PNG is not an exception. So even if there was further investment in training, it is not guaranteed that nurses would be better prepared to deal with FSV because the biomedical model does not train nurses to deal with the psychological and social causes of illness. From a policy perspective, revising curriculum to teach a public health approach and incorporation of basic counselling skills would help to address this gap.

Lack of skills and knowledge are commonly cited barriers to dealing with FSV and provision of appropriate training is a commonly cited solution (De Boer et al., 2013; Sprague et al., 2012). Although training alone cannot improve performance, there is some evidence that training does improve HCPs' treatment and care of survivors. Chibber et al. (2011) found that the subset of physicians who had a higher level of engagement with survivors, routinely enquired about FSV, informed women of their rights and made referrals, had greater exposure to training, which was attributed as a source of their deep commitment. Shamu et al. (2013) found that midwives who were exposed to intervention programs were more empathetic to patients and realised that listening to patients was critical. This connects with a central theme which emerged from participants' discussions about the 'approach' to survivors or the lack of patient-centred care.

Low empathy and poor quality care were reflected in comments about nurses' attitudes to survivors of FSV. Not all survivors or patients, for that matter, are treated equally and some nurses do not help women, particularly if the woman is in a polygamous marriage, when bride price has been paid, when she is unable to pay fees or when she comes to the health centre repeatedly. These are deliberate decisions by nurses not to treat or to limit the care they provide to the survivor. This is different from not knowing how to treat beyond the physical complaints of survivors. Although nurses report that they are dealing with survivors on a regular basis, and that they have strategies to manage FSV, this highlights that nurses make choices about how they want to deal with FSV cases and sadly, this is not always in a way that puts the survivor at the centre of care.

The role of empathy and models of care is not much discussed in the literature on FSV, which tends to focus on issues like, skills and knowledge, or interventions. Whilst it is critical to understand these issues, more scrutiny of how core professional values of care and empathy can enable or prohibit nurses' behaviour towards survivors is needed. Doyle, Hungerford and Cruikshank (2014) discussed the relationship between poor patient outcomes and a lack of empathy by nurses in the UK and Australia, highlighting that complaints against nurses are often generated from "*callousness and a lack of empathy*". They quote the UK's Francis Inquiry and the Keogh Report, which call for an increase in caring and compassion from health care workers and emphasise that nurse education needs to foster the attributes of caring and empathy among students. This is also a concern for nurses in PNG. An evaluation of a PNG reproductive health training program found that teaching respectful midwifery care was critical to improving maternal health outcomes (Thiessen, Rumsey & Homer, 2014). The report cited examples of the poor, and at times abusive, treatment of pregnant mothers by nurses, an issue that was also raised by participants in this study. Being respectful and having an empathetic and caring attitude is not necessarily intrinsic to current nursing practice, but when nurses were taught these as professional values, they changed their midwifery practice.

In contexts where there is poor social support, survivors can benefit from feeling supported, validated and listened to (Rees et al., 2014). Given the complexity of the cultural frameworks that PNG nurses are working within, combined with the chronic underfunding of health services, perhaps as a first point, emphasising empathy, care and compassion as professional values in pre-service and in-service training, may make more difference to the care and treatment survivors receive than complex interventions which are doomed to fail because of the resources required to effectively implement and sustain them. Referring back to critical realism, professional values and health training programmes, as social structures, may be more easily changed than the other factors in the “real” domain, such as cultural beliefs, which require generational change and interventions that go far beyond the scope of the health system to influence.

7.3.4 The quality and appropriateness of referral services.

The need for appropriate referral services emerged because in general these services are few and far between, meaning most facilities do not have any specialist services to where they can refer survivors. However, nurses do use other support mechanisms, such as police, church and community leaders, and to a lesser extent, government social workers, where they exist. Sometimes nurses only provide advice or information to survivors to contact these groups. In other circumstances, nurses actively involve themselves in broader dispute resolution, particularly in rural settings. In these instances, nurses may act as advocates for survivors in community meetings or work with community leaders to prevent FSV.

The majority of participants either strongly agreed (29.4% and 30.2%) or agreed (29.4% and 37.7%) that they could make referrals for perpetrators and survivors (items 4 and 5). Whilst referrals were acknowledged as key to helping survivors, the inadequacy of existing referral services was highlighted in interviews, as was a lack of knowledge about where to send survivors. The interview data showed that counselling and support services may be available in larger hospitals or town-based facilities. Most of the survey participants (58.5%) reported that they worked in hospitals, meaning there may have been a larger number of survey participants who did actually have access to counselling or social work services in their facilities or towns. Another explanation may be that nurses commonly refer survivors to police, churches and community leaders. With this in mind, it is not surprising that most participants reported that they could make referrals, as these types of services would be available in most settings. What is less clear is the quality and appropriateness of these services to respond to survivors' needs. The child who was referred to the HIV testing clinic following sexual assault is one example of an inappropriate referral. Options for shelters, counselling or social support are limited and it may be these types of specialist referral services that nurses lack knowledge about, partly because they do not exist.

Consistent with interview data which indicates that nurses understand the relevance of such services but struggle with access, the majority of participants reported that they strongly agreed (15.1%) and agreed (26.4%) that they had easy access to such services. For mental health services, 17.6% strongly agreed and 26.4% agreed they have access and similar proportions strongly agreed (15.4%) or agreed (26.9%) that these services could meet the needs of survivors. This is a curious result because a report on skilled counsellors indicated that there are only eight suitably qualified professionals in the entire country (Edwards & Sanderson, 2015). The issue may be about what is perceived to constitute a mental health service, because churches are frequently used to provide counselling and pastoral care and would be readily available, and thus may be considered to be a form of mental health service. It can be concluded that nurses perceive the importance of support services and are able to make referrals, but availability of and knowledge about appropriate services, whether mental health, social work or other, and the quality of those services, is more problematic.

The availability of support services and cooperation to work with these services has been identified as an important component of effective comprehensive care and is more likely to facilitate interventions (Leppakoski et al., 2014; O'Campo et al., 2011. However, access to support services is a more difficult challenge in LMIC settings. For example Al-Natour et al. (2014) found that a lack of mental health and social services in Jordan was a significant barrier to asking about violence; Maina and

Majeke (2008) reported that Kenyan HCPs do not make referrals because there are few psychologists and social workers available and there is no guarantee that referrals will be followed up. Nascimento et al. (2014) reported that HCPs in Angola, as in PNG, most commonly use the police to help with cases. Therefore, interventions which rely on the availability of referral services, such as those reported by Spangaro et al. (2010) and Ramachandran et al. (2013), have limited applicability in PNG. The challenge is to find ways for HCPs to be able to maximise help for survivors when adequate support services do not exist.

The effectiveness of referral services to provide additional support to survivors and form part of their overall 'treatment' is not simply about teaching nurses to provide referrals. The effectiveness of referrals depends on whether the nurse attending to the survivor understands the need to provide broader support, which is linked to their training and knowledge about FSV. It is also dependent on what types of services are available and whether the nurse attending to the survivor is aware that those services can support survivors and to what extent. For example, police, the most frequently cited referral point, can provide some assistance in pursuing justice but cannot provide any psychosocial support. In fact, police are commonly reported as perpetrating violence against women who seek their assistance (Amnesty, 2006; Eves, 2006). Here the critical realist lens has helped to unpack the complexity behind what is perceived to be effective support for survivors.

7.3.5 Motivation and commitment

These results suggest that, in general, nurses see a role for themselves in prevention and resist the idea that responding to FSV is outside the scope of their work. However, this is not uniformly accepted and, as reiterated throughout interview data, there is great diversity in how nurses articulate that role. From the survey, 30.8% disagreed and 15.4% strongly disagreed that asking patients about FSV is an invasion of privacy and 11.5% strongly disagreed and 44.2% disagreed that asking about FSV is demeaning for patients (items 20 & 21). Even more participants disagreed (44.2%) and strongly disagreed (19.2%) that they were afraid of offending patients by asking about FSV. These items are part of the role resistance subscale and measure whether nurses perceive that asking about FSV conflicts with their beliefs about their role as a health care provider. The high frequency of disagreement with item 23 (19.2% strongly disagree and 46.2% disagree) that it is not the place of nurses to interfere with resolving conflict indicates acceptance by a majority that to intervene in FSV is part of their role. The survey results suggest less role resistance than would have been expected based on the barriers identified in the literature (Chibber et al., 2011; John et al., 2010; Sohani et al., 2013; Sprague et al., 2012) and is also seemingly inconsistent with the qualitative findings.

In interviews, participants reported that nurses do not get involved in cases of FSV and their role is confined to the treatment of physical injuries. The low rates of enquiry reported in the survey support this. As stated, nurses "*treat them and let them go*". However there was other evidence that, in some cases, nurses do take action to prevent or help resolve cases of FSV. Participants spoke about their role as advocates at community meetings, or working with community leaders to try to prevent FSV from escalating into broader community violence and many expressed the need for health care to be delivered from a public health model. There was a strong awareness about the link between health and FSV, as shown by the knowledge participants had about the health consequences of abuse. Most participants spoke about their responsibility to promote prevention and to provide awareness and education to bring about changes in health outcomes. It was recognised that, as nurses, they have status within their communities and are often the only professional available to assist. However this is dependent on the relationship the nurse has with the community. In smaller rural communities, health workers carry status and influence which they can use to influence traditional dispute resolution mechanisms. This is supported by Howes et al. (2014), who reported that the officer-in-charge in PNG health facilities (43% of whom are female) carry influence in their village or community. In terms of critical realism, this is another example of how the outcome or experience, in this case nurses positively advocating for survivors in communities, is dependent on the community mechanisms for dispute resolution in the geographical location where they work and the status they hold within that community. What is positive from these results is that some nurses are clearly willing to use their status to influence outcomes for survivors and recognise a broader role for themselves in advocacy.

Although participants recognised a broader lack of prioritisation of FSV, as individuals, many expressed that attending to the health needs of survivors is and should be an important part of their role. In fact, the strongest response to any item on the survey was for item 24, where overwhelmingly, participants strongly disagreed (50.9%) and disagreed (30.2%) with the statement that investigating underlying causes of injury is not part of medical care, meaning that asking about FSV is accepted as part of health care. Interestingly, Al-Natour et al. (2014), who asked the same question of Jordanian nurses, also found that the majority of nurses (83.2%) disagreed that IPV investigation is a non-medical role. From this perspective, in the role of a nurse, asking about FSV seems neither problematic nor offensive and PNG nurses accept this as part of their job.

It is important to note however, that the frequency with which nurses ask about FSV when treating related health complaints indicates that the majority do not investigate FSV as part of regular practice and this was reiterated in qualitative comments. This suggests that there is a difference between what nurses do in practice and what they believe they should do or would like to do if better supported, trained or had more resources. Guillery et al. (2012) found similar inconsistences between Canadian nurses' reports that it was within their role to screen and their actual screening practices. Nevertheless, the positive message is that there is a cohort of nurses who agree that identifying abuse and assisting survivors is part of their job and that is a good starting point to change practice.

International literature on the acceptance of HCPs' roles in responding to FSV is mixed. Shamu et al. (2013) reported that midwives in Zimbabwe did not see it as their role to ask about violence. Furniss et al. (2007) found that one fourth of American nurses thought IPV was not a nursing problem and Nascimento et al. (2014) found that Angolan HCWs did not feel responsible for providing care beyond clinical procedures for treating physical injuries, because FSV is a matter for police, psychologists and social workers to deal with. Even amongst patients there can be perceptions that doctors only deal with diseases and a preference for social work personnel to ask about FSV (Usta et al., 2012).

Other studies have shown that some HCPs have strong motivation to support survivors (Chibber et al., 2011; Maina, 2009, 210; Sprague et al., 2015). Much like the nurses who participated in this study, Laisser et al. (2009) found that HCPs recognised their own ability to guide and counsel people on health issues like FSV and acknowledged that they had a responsibility to change community attitudes through awareness and education. Beccaria et al. (2012) found that Australian nursing students believed they had a role in building trust, acting as an advocate and referring to support services. Even in Shamu et al.'s (2013) study, midwives worked around the system to keep women in hospital if they suspected abuse, despite their resistance to accepting FSV as part of their role.

Highly motivated individuals can often overcome obstacles such as poor working conditions, personal safety concerns and inadequate equipment (Luoma, 2006). Further, individual 'champions' have been found to go out their way to provide better support for survivors (Chibber et al., 2011). Tapping into the commitment of HCPs to improve health outcomes and capitalising on the motivation of individuals who want to see change is an important opportunity to improve services for survivors in PNG. Hence, a practical implication of this research is for such individuals to be identified and supported within their facilities. Supporting a core group of nurses committed to FSV is much more feasible than rolling out training and attempting to change the behaviour of the entire health workforce. These nurses than can provide a foundation from which to grow not only the skills and knowledge of the workforce but improved practices to better service survivors' needs.

7.4 The broader influences on service delivery

In addition to the influence of the biomedical paradigm of health on the practice of nurses, the two other most prominent influences on nurses' treatment and care of survivors in PNG that emerged from this study were cultural beliefs and the constraints of the operating environment. This is similar to conclusions drawn by Shamu et al. (2013), who found that the combination of health system issues and nurses' embeddedness in a patriarchal culture which normalises FSV made it difficult for Zimbabwean midwives to help survivors. This is significant because systemic and social factors driving HCP behaviour are largely absent from public health studies, which tend to focus on individual and organisational factors (Allen, Lehrner, Mattison, Miles & Russell, 2007; Razee et al., 2012; Thurston & Eisener, 2006). The importance of these contextual factors in influencing HCP behaviour in PNG cannot be understated.

7.4.1 Inadequate resourcing of the whole system

The findings demonstrate that the availability and quality of care for survivors is impacted by inadequate resourcing of the PNG health system more generally. Participants described problems with infrastructure, supply of drugs and basic commodities, staffing, both in terms numbers of health workers and quality of training, as well as unavailability of appropriate support services. Similar issues were reported by Hinton and Earnest (2011), who found that lack of resources, staff training and time constraints restricted PNG HCPs' capacity to respond to the psychosocial needs of their patients. However, the impact of a lack of resources affects facilities differently and is highly dependent on the location and on the management of the facility. In some cases, remote facilities are less impacted by staff shortages because they see fewer patients but are more likely to have limited supplies, less access to training, no doctors and fewer options for referral services. Larger urban centres and hospitals may have referral and support services but do not have the human resources to deal with the number of patients. In terms of critical realism, the location and the management of the facility are considered contextual conditions that affect the experience of service delivery. As shown by the example of time below, these conditions affect service delivery differently depending on the setting.

A lack of time is one of the most frequently cited barriers reported by HCPs and has been demonstrated to be a valid factor in both quantitative and qualitative studies conducted in high income countries, including the US (Colarossi et al., 2010; Sormati & Smith, 2010); Canada (Guillery et al., 2012); and the UK (Yeung et al., 2012); as well as LMICs, including Colombia (Baig et al., 2012); Brazil (Vieira et al., 2012); Turkey (Efe & Taskin, 2012); Pakistan (Zakar et al., 2011); South Africa (Joyner & Mash, 2012); and Tanzania (Laisser et al., 2011). Time available to spend with patients is linked to the number of staff and the workload in a facility and is particularly acute in facilities in LMICs, where there are generally lower health worker to patient ratios.

In interviews, time was reported as a barrier for most, but not all, nurses. In particular, a few nurses working in remote areas said that time was not an issue for them because their facilities were not busy. Item 1 on the survey asked specifically about time available to treat FSV, to which 42.3% agreed and 50% disagreed with a few (7.7%) taking a neutral position. There were similar numbers of participants who agreed and disagreed that time was an issue in responding to FSV, and this adds weight to the conclusion that the time available for patients depends on the workload at each facility, noting that in PNG, remote facilities generally provide basic primary care and a lower spectrum of services. Underlying the problem of time are issues to do with staffing, which most participants agreed was a huge challenge for the health sector, both in terms of insufficient numbers as well as level of skills and knowledge. These findings showed a link between time, workload and nurses' attitudes. When nurses feel stressed or pressured, they are less likely to be empathetic to survivors who are seen to be creating unnecessary workload. Feeding into this are beliefs about the nature of FSV, including gender norms which accept male violence against women and blame victims for resisting subordination. From a critical realist perspective, the convergence of resourcing issues with cultural beliefs (social process and conditions) interacts in health facilities to shape nurses' attitudes, which in turn influences how they behave and how the experience of delivering services to survivors is shaped.

Time, like other resource issues, cannot be treated as a barrier in isolation and it is important to understand the other issues that limit HCPs' time to spend caring for survivors. For example, both Shamu et al. (2013) and Nascimento et al. (2014) report that staff shortages, heavy workloads and a focus on medical problems means that HCPs resist the additional task of asking about FSV because it is seen as using up time to deal with a non-biological problem. Resourcing of priorities in these cases is linked to perceptions about what constitutes health care. Beynon et al. (2012) suggest that an overemphasis on the lack of time by Canadian physicians may mask other barriers that are more challenging to address, like feeling helpless about how best to help survivors. This indicates that for those physicians, time is entwined with competence and ability to provide adequate services. Laisser et al. (2009) found that Tanzanian midwives face being accused of bribery if they spend too much time with patients, which hinders their ability to spend time talking with women. This is in the context of acute staff shortages, where three midwives have responsibility for meeting the demands of up to 90 patients. In this instance, time is linked to under-resourcing and a complex system of patient demand for health care. Whereas in Pakistan, where a large proportion of care is delivered through private providers who are paid per occasion of service, physicians are reluctant to allocate more time to patients because it comes at a cost to their personal income (Zakar et al., 2011). These examples demonstrate that time is an issue for many health workers, but for different reasons.

To take this point further, in their review of barriers to screening for IPV, Sprague et al. (2012) found that lack of resources was the most commonly cited barrier across studies. Although lack of resourcing is a shared concern in the global response to FSV, it is important to contextualise what this means in PNG. In this study, the inappropriateness of infrastructure, lack of medical supplies, insufficient training and the need to charge fees were identified as issues in the operating environment that impact the availability and quality of care. To put these in context, Howes et al. (2014), reporting on rural primary care facilities in PNG, found that only 40% had access to electricity, 51% had enough toilets (most of these pit latrines), 55% had water supply throughout the year, and 20% had beds with mattresses. They also reported a declining supply of essential drugs over the last decade. This confirms comments from the nurses interviewed that drug shortages are common, particularly for those not included on essential drug lists, such as PEP and emergency contraception, leaving nurses feeling helpless. Further, the ability to access PEP, emergency contraception, and be tested for STIs, is not only dependent on the actual availability of drugs but on the availability of staff who have the skills to administer them and conduct appropriate tests. In some cases, where there are no doctors at a facility, survivors of sexual assault are told go to other facilities if they want to obtain a medical report for legal purposes, otherwise they will not be provided with this service. When researchers in high income countries report a lack of resources as a barrier from studies conducted in Australia, Canada and the US, they are not referring to the same kinds of resourcing issues that HCPs in PNG experience.

The interaction between resource constraints and the ability to provide comprehensive services in LMICs has been highlighted in a few studies (Joyner & Mash, 2012; Laisser et al., 2009; Shamu et al., 2011), leading authors to call into question the relevance for these countries of interventions designed in high income countries. For example, Beynon et al. (2012) concluded that practitioners require specific personal skills and knowledge, access to community resources and work environments that encourage the development and sustainability of their skills, to work with survivors. They note that mentoring, coaching and opportunities for debriefing are important support mechanisms for HCPs to deal effectively with survivors. O’Campo et al. (2011) conclude that thorough and ongoing mandatory training, protocols, immediate access to onsite support services and institutional support to improve self-efficacy are necessary for comprehensive screening programs. The problem with both these suggested approaches is that they are entirely unfeasible in places like PNG. The danger, however, is that researchers and policy makers, who do not pay attention to the specific dynamics of operating environments, will misapply approaches, leading to failed interventions which use precious resources and detract attention from actions that could make a difference in the types of settings where the majority of women in the world live. By adopting a critical realist approach, studies like this one, fill an important lacuna by explicitly bringing to the forefront the contextually specific different social structures, processes and conditions which affect HCP behaviour and practice.

7.4.2 It's cultural

In this study, participants readily identified that PNG's patriarchal culture, whereby men have a naturally dominant position over women who are subordinate to them, perpetuates FSV and shapes the attitudes of men and women, including HCPs. Patriarchy is the social structure, situated in the domain of the 'real', which in PNG dictates the relationship between men and women and is reinforced through cultural practices like bride price and polygamous marriage. Other PNG researchers and commentators (e.g. Amnesty, 2006; Eves, 2006; Jolly, 2012) have written extensively about how violence against women is accepted and legitimised through culture and the impact this has on women in PNG today. What is particularly relevant about these findings is the analysis of how these beliefs influence health service delivery for survivors.

Culture plays a significant role in the outcomes of interventions and needs further investigation, but is not particularly prominent in the Anglo-European public health literature (O'Reilly et al., 2011). Research conducted in other settings (Haj-Yahia et al., 2015; Laisser et al., 2009; Nascimento et al., 2014; Shamu et al., 2013; Zakar et al., 2011) has identified cultural attitudes and beliefs as preventing HCPs from responding effectively to survivors. These researchers highlight that HCPs do not sit outside the cultural belief systems of the societies and communities they work in. The cultural constructions of female and male roles interact with how HCPs perceive FSV, and this influences the treatment and care they give, particularly when those constructions are patriarchal.

Using critical realism in this study, three ways that patriarchal beliefs and norms, expressed as cultural beliefs, interact with nurses' behaviour emerged. Firstly, patriarchal beliefs contribute to the levels of violence occurring in the 'actual' domain, because men feel entitled to use violence against women and this contributes to the number and severity of cases that nurses have to treat. Secondly, these beliefs contribute to situations where male perpetrators threaten and attack nurses who attempt to assist survivors because men believe that they have the unquestionable right to control their female partners, including their right to seek care. Nurses become reluctant to provide treatment and care when their own personal safety is at risk, which influences the experience of delivering services in the ‘empirical’ domain. Thirdly, nurses live in the same society and communities as their patients, and share these beliefs, leading them to blame victims and limit care because they perceive that the woman has caused the violence unnecessarily by not complying with the norms set out for her role and her partner’s demands. This also influences the experience of service delivery (or lack of it) for survivors in the ‘empirical’ domain

7.4.2.1 Fear & concern for safety

The findings around nurses’ fear and safety concerns were mixed. Fear of perpetrators was a major issue identified by interviewed participants and prevents nurses from providing assistance to survivors, yet the survey indicated that the majority of nurses are confident in talking with and referring people who use violence (items 2, 4 and 7). This is better understood by reviewing items on the safety subscale and interpreting them alongside other data from the interviews.

Item 26 asked about concern for personal safety. There were 7.5% who strongly agreed and 34% who agreed that they are reluctant to ask people who use violence about their behaviour out of fear for their personal safety. A further 30.2% were not sure and just over one quarter disagreed (22.6%) or strongly disagreed (5.7%). This is consistent with comments that fear of perpetrators is a real threat and prohibits nurses from providing care. The large proportion of uncertain or neutral responses may be because male use of violence against female partners is a cultural norm and perpetrators do not generally come to health facilities for help, so nurses may not have considered the risk of doing this. Consistent with high levels of fear of perpetrators reported in interviews, was the responses to item 29, to which 21.2% of participants strongly agreed and 38.5% agreed that people who use violence frequently direct their anger toward nurses when challenged. The examples given in interviews of verbal and physical threats by male partners corroborate that this is a real problem.

At the same time, responses to items 2, 4, and 7 showed that nurses are confident to talk with perpetrators, as discussed above. Interview data did reveal that on many occasions counselling is directed at both men and women, with one participant going as far to explain that there was no point offering counselling unless the male partner was participated. This suggests that there are nurses who are confident to talk with perpetrators and that counselling men is part of the way some nurses in PNG respond to cases of FSV. In fact, 34% of participants disagreed and 17% strongly disagreed that it is best to avoid dealing with people who use violence out of fear or concern for the victim's safety (item 33), and 35.8% disagreed and 18.9% strongly disagreed that there is no way to ask perpetrators about their behaviours without endangering survivors, meaning that they believe that there are ways to achieve this. This is an indication that some nurses may use strategies to deal with people who use violence, without placing themselves at risk. This could involve referring them to police, involving other influential people, like community leaders, pastors or senior male health workers, and requesting to see the male partner at a later time. All of these strategies were referred to in the qualitative data, which is supported by responses to item 30, where 18.9% strongly agreed and 58.5% agreed that there are ways of asking about FSV without risking personal safety. Therefore, nurses have ways of assessing the level of risk involved and use judgement about who can talk to perpetrators, when and under what circumstances and this may or may not be when providing care and treatment to survivors. Just because nurses have concerns about their personal safety, does not mean that they will not take action.

Results from Al-Natour et al. (2014) demonstrate that 73.6% of nurses were afraid that perpetrators would direct their anger towards them if challenged and 62.4% were fearful for the survivor's safety. However, as in the current study, the majority of Jordanian nurses (75.2%) in that sample agreed that there were ways to talk about FSV without endangering themselves and 61.6% disagreed that they avoid dealing with perpetrators because of safety. So whilst nurses have real concerns about safety, this does not necessarily prevent them from feeling able to talk about FSV. Unfortunately Al-Natour et al. (2014) do not explore why nurses feel able to ask about FSV despite feelings of fear, but they do point to the lack of security in

Jordanian health services. This is also an issue for PNG facilities, so perhaps with appropriate security, nurses may perceive that they can overcome such a barrier.

Safety concerns and fear of reprisals from perpetrators have been reported as pertinent factors in other studies (Efe & Taskin, 2012; Maina, 2009; Usta et al., 2012). What can be concluded from these studies is that the drivers of male attacks and aggression towards HCPs differ across countries. For example, in Kenya, perpetrators attend facilities with their partners and interfere with care to prevent their partners from reporting them and instigating legal action (Maina, 2009), whereas in Lebanon, men’s violent reactions directed towards HCPs and to their partners following enquiry were related to strong cultural obligations for families to remain intact and avoid the shame and scandal that public revelations of abuse would bring upon a family (Efe & Taskin, 2012). In this study, participants explained that perpetrators threaten nurses for intervening because it can be seen as a challenge to male authority, brings shame and fear on the perpetrator who is exposed and can enable legal (formal and traditional) repercussions. Nurses, who are mostly female, have limited ability to protect themselves, and their clients, even in health facilities, from aggressive male partners.

This issue of safety and security for PNG HCPs was raised by Razee et al. (2012) who found that it affected the motivation of rural health workers in PNG. They identified a range of additional issues that heighten HCPs’ risk of danger, including being young, a single woman, being new to a community, living without family, and working with male security officers and managers. They described situations where nurses are sexually harassed by male staff, have been threatened by families for disciplining poorly performing staff, have been attacked and raped travelling to and from their workplace, and have been shot at by armed tribesman who blamed the HCP for the death of a baby born with abnormalities. The study highlighted the inability of some facilities to provide security to allow female HCPs to work in safety. For PNG HCPs who perceive that they are already working in risky environments, getting involved in cases of FSV only heightens this risk, particularly where there is a lack of security. Razee et al. (2012) suggest that generating a culture of respect for the health facility and its services would be more appropriate than policy changes. Given that nurses identify that they have skills to ask about FSV and believe that they have strategies to work with survivors, it is important for future research to examine the interventions aimed at increasing security and safety in health facilities to see if this enables nurses to provide better quality care and treatment. Investigating how to improve security in health facilities, particularly in settings where there is no police presence, is an important area for future research with clear practical implications.

7.4.2.2 Mixed and complex attitudes.

Taken together, the interview and survey data emphasise that attitudes towards survivors are complex. There is awareness that cultural beliefs about gender position women as subordinate to men and justify male use of violence against women, in particular their female partners. This leads to acceptance of FSV within communities. Nurses and, by extension, other HCPs who are part of those communities, interpret those attitudes and beliefs into their work practice which results in survivors being blamed for the violence inflicted upon them. Other research in PNG has described how both men and women accept the use of violence (Ganster-Briedler et al., 2010; McPherson, 2012). FSV is socially legitimised by both men and women and this perpetuates a culture of silence and impunity. When measuring gender attitudes, Fulu et al. (2013) found that women held more conservative views about gender than their male counterparts and concluded that gender norms, including those that contribute to inequality and support men’s use of violence, are reinforced by women as well as men. In health facilities this translates into inappropriate care, denial of services and even mistreatment by nurses who often perceive that the survivor is at fault for causing the violence.

The items on the survey which measure the degree to which nurses blame survivors for the abuse reveal mixed results and were broadly consistent with the qualitative data. At least 10% of participants had a high score on the blame subscale, with 73.5% scoring moderately. On all items except item 13, 25 – 45 % of participants agreed or strongly agreed with victim blaming statements, with 45.1% affirming that women stepping out of traditional roles is a major cause of FSV. This was reiterated in interviews where participants explained that men treat their wives as property over whom they have complete control. Real or perceived non-compliance with male demands is a reason for men to use violence to both discipline women and to reassert control. That FSV is driven by cultural beliefs about gender roles was well understood by participants and hence why the survey data found so many agreeing that women stepping outside of their traditional roles causes FSV. This is supported by MacPherson (2012), who wrote "*Women are enculturated as much as men and most (not all) accept cultural concepts of their gender and sexuality, their subordinate position in social structure and physical abuse they all suffer because they are female, woman, wife and daughter*." (p68) Women accept the violence inflicted upon them. Al-Natour et al. (2014) also reported similar results in that half of the nurses in their sample held beliefs that blamed women for IPV, with 60% believing that women who step out of traditional gender roles cause IPV. Women, as much as men, are part of the system which maintains gender inequality.

Consistent with qualitative comments which showed that beliefs about gender roles and FSV are complex and multi-layered, there were high levels of disagreement with other items on the blame subscale. In particular, 48.1% of participants strongly disagreed and 26.9% disagreed with the statement that people choose to be victims. Qualitative comments reiterated acceptance of violence as a normal part of life over which women have little control because of their low status and that FSV is caused by PNG culture. Therefore, nurses may perceive that it is because survivors are women, and women are subordinate to men, that they suffer high levels of FSV, rather than any individual decision that they make. This may also be the reason that almost half (49% and 45.3%) disagreed or strongly disagreed that the survivor's personality causes abuse and that the survivor has often done something to cause the violence in the relationship.

Bearing in mind that 86.3% of survey participants were female, and going on estimations of prevalence in PNG, at least 50% of these are likely to have experienced FSV. It is unlikely that they would have agreed their individual personality or choices caused the FSV, even though this seems contradictory to other findings about the degree to which many nurses continue to blame survivors for FSV. Fulu et al. (2013) found that 85% of men and 72.3% of women agreed that women should obey their husbands, but only 29% of men and 14% of women agreed that a woman should tolerate violence in order to keep her family together. This suggests that women living in PNG accept their subordinate status but do not accept that the violence inflicted upon them to maintain their low status is justified. They simply may be unable to do much to change it.

A finding of contradictory beliefs reinforces the fact that culture is not homogenous and it does encompass competing and contradictory values (UN General Assembly, 2006). From a critical realist perspective, this illuminates further how culture and belief systems operate differently amongst individuals. PNG cultural or ethnic beliefs are not the only set of beliefs that influence nurses. Nurses are also influenced by their professional beliefs and values which may come into conflict with cultural beliefs, particularly with regard to the right of all people to have access to health care. Culture is a shifting set of discourses and the beliefs and values that take the foreground in any particular situation will vary depending on a range of factors. Recognising the fluidity of belief systems and the multitude of interactions that beliefs have with other factors (like the operating environment) to influence behaviour is important to avoid overly simplistic interpretations of HCP behaviour. Further investigation into the different ways that professional and cultural beliefs interact to inform HCP behaviour and to identify in what set of circumstances one or the other set of beliefs takes precedence would be worthy of investigation and would be a platform on which to build interventions.

These findings have provided a glimpse at the complexity of the numerous factors that influence nurses' identification and management of FSV in PNG. Whilst issues like cultural beliefs, resource constraints, and biomedical training can be identified as influencing nurses' identification and management of survivors, drawing definitive conclusions about how these issues influence nurses is not straightforward because they operate differently depending on the circumstances.

Conclusion

This research was a critical analysis of factors that influence nurses' identification and management of cases of FSV in health facilities in PNG. In particular, keeping in line with its critical realist orientation, this study examined the contextual circumstances that trigger how and when the underlying factors (social processes, conditions and structures) influence nurse behaviour. The research questions had a dual focus. Firstly, the research identified what happens in health facilities when survivors present, how nurses ask about FSV, and what treatment and care they provide to survivors. The second aspect of this research was focused on understanding what factors influenced or interacted with how nurses identified and managed cases of FSV in health facilities.

The literature reviewed in this study demonstrated that there are range of clinician, patient and resourcing factors and enablers that influence HCP practice and these operate differentially across contexts. What was less clear was how these factors interact with HCP behaviour to shape the delivery of services for survivors of FSV, even though it is clear that the effectiveness of interventions and service delivery is dependent on understanding such issues. Given that there were no known published studies on HCP identification and management of FSV in PNG, this study sought to fill an important evidence gap.

The study used a mixed methods design by combining interpretations of interview and survey data. The findings revealed that the factors influencing how nurses' identify and manage FSV in PNG are similar to those experienced elsewhere, particularly those working in LMICs and with high levels of gender inequality. The use of critical realism helped to unpack the underlying and context-dependent processes, conditions and structures that shape experiences in health facilities and by doing so revealed a complex mix of factors which drive and shape nurses' behaviour towards survivors. In particular, what stood out was that overarching cultural beliefs, the influence of biomedical training, the location of the facility and resources available to that facility, all interact and converge to influence how nurses ask about FSV and provide treatment and care to survivors but they do so differently for individual nurses.

These findings are important because they highlight that any interventions designed to respond to FSV in PNG must take account of the complexity of cultural beliefs and how they influence nurses' behaviour, the diversity between communities and health facility settings, as well as the capabilities of staff and the resources available to the health sector. Despite the challenges faced in their work environments, nurses are committed to improving outcomes for their patients, including those who are survivors of FSV and this commitment is a source of great opportunity. However, interventions and recommendations need to be feasible and possible for nurses to implement. Improving safety and security for HCPs, investing in pre-service training which promotes caring and compassion as core professional values and increasing the knowledge of nurses and other HCPs so that they better understand the nature of FSV may be the best option to improve service delivery for survivors in PNG at this stage. This is because the underlying factors affecting service delivery, like cultural attitudes towards women and men, functionality of the health system, and financing for health care requires action beyond the health sector and is a longer term agenda. Focusing on what is achievable for nurses to implement within the scope of their role is likely to bring greater returns for the care and treatment of survivors.

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Appendix A - Definitions of Family Violence against Women

Gender Based Violence and Violence against Women

Gender-based violence and violence against women are two terms which are favoured, particularly in international forums. One of the first official uses of the term gender-based violence appears in the *Convention on the Elimination of Discrimination against Women* (1992), which described violence against women as "*violence that is directed against a woman because she is a woman, or violence that affects women disproportionately*." In 1993, the Declaration on the Elimination of Violence Against Women confirmed this definition declaring that violence against women is "*any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*." Violence against women was further delineated by physical, sexual and psychological violence occurring within the family, within the general community and perpetrated or condoned by the State. Given their international status, these gendered definitions of family violence against women are prominent within international literature and reports.

These definitions arose out of decades of campaigning by activists to improve gender equality and have violence against women recognised as a serious human rights abuse. What is important about these definitions is the centrality of gender which has theoretical and practical implications for research, in particular, the necessity to examine the cultural, societal and relational contexts in which violence against women and girls occurs. These definitions position research on violence against women within a human rights and feminist framework, emphasising the historical and unequal relations between men and women as the source of violence (UN General Assembly, 2006). One problem is that neither specifically defines gender-based violence. Instead both provide a definition of violence against women. This has led to gender-based violence being used synonymously with the term violence against women. Gender-based violence frames violence through a gendered lens, which is not necessarily the same as violence against women (Jolly, 2012). Not all acts of violence against women are gender-based, not all perpetrators of violence against women are men and not all victims of gender-based violence are women (Eves, 2006; Jolly, 2012). Gay men and transgender people are frequently harassed, beaten and sometimes killed because they do not conform to socially determined roles, and dominant views of masculinity. Female relatives, including mothers, aunts, in-laws use violence against other women and children to discipline and punish. For example, in PNG young women with pre-marital pregnancies are often abused by both their male and female relatives (Jolly, 2012)

Domestic and Family Violence

The term domestic violence incorporates all forms of violence that may occur within a family unit against women and men, including child abuse, intimate partner abuse and elder abuse. An accepted definition of domestic violence "*refers to violence that occurs within the private sphere, generally between individuals who are related by blood or intimacy*" (United National Economic and Social Council, 1996). Domestic violence is a more commonly used term in the health literature than family violence. Both are broad terms that cross over with definitions of violence against women because the majority of family or domestic violence is perpetrated against women and by an intimate partner. Family violence is used in a similar way and is defined as "*people who have been physically, sexually or emotionally harmed by another member or members of the family, regardless of ages or sex of victim or perpetrator*" (Ellsberg & Heise, 2005). There is little difference between the two terms, although domestic violence could include violence between people in a domestic unit who are not related, for example, flat mates, whereas family violence infers violence between relatives. Both terms exclude sexual violence against women by strangers outside the home. In this study, family violence included people who live within same household, village or compound, including blood and non-blood relatives, co-wives and members of the extended family.

Violence against children and the elderly are important areas of research that require further investigation but have specific methodological and safety concerns and are not a focus of this study. Further, there is a consensus that the overwhelming majority of acts of gender-based violence and domestic violence are targeted towards women and girls and most gender-based violence against women is perpetrated by their male partners (Garcia-Moreno et al., 2005). This means, irrespective of whether using the term gender-based violence, violence against women, domestic or family violence, the majority of violent acts perpetrated within the scope of each of these definitions is intimate partner violence against women.

Intimate partner violence

More recently, intimate partner violence has been used in preference to domestic violence. The World Health Organisation defines intimate partner violence as "*acts of physical, sexual or emotional abuse by a partner or former partner (same or opposite sex) whether cohabiting or not*" (Garcia-Moreno et al., 2005). This is different from domestic violence, which is not specific to partner relationships. Terms such as wife abuse, wife beating, and battering were previously common, but appear less frequently in recognition that survivors are not always married to the perpetrator, that abuse has other forms beyond physical abuse, males and females can be both survivors and perpetrators, and all forms of intimate partner violence can occur in same sex partnerships.

Sexual Violence

Definitions of sexual violence are less contested. WHO defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Jewekes et al., 2002). Definitions of domestic violence, family violence, and intimate partner violence incorporate sexual violence, but only within familial or intimate relationships, not when perpetrated by a stranger. For this reason, sexual violence is often included as a distinct term to cover acts of sexual violence perpetrated by strangers.

Appendix B - Record of Themes from Literature

Author	Setting	Study Design	Results & Conclusions	Key words	Concepts
Chapin et al (2011)	USA	320 nurses & medical students Post test surveys measuring self-efficacy, usefulness of screening, accessibility of services, obstacles for victims Multiple regression analysis	• Range of self-efficacy in screening; IPV training linked to better knowledge of services and victim obstacles. • Partnerships with women's centres valuable resources for training and care	Intimate partner violence, emergency department, self efficacy	HCW motivation Self-efficacy HCW empowerment Referral systems/networks Cross-organisational links
Gutmanis et al (2012)	Canada	769 physicians & nurses Analysis of 2 open-ended questions attached to 43 item mail survey Inductive content analysis	• Prevalence rates dependent on setting • Barriers include time, behaviour of women, lack of training, language/culture, partner presence • Facilitators include training, community professional resources, protocols and tools • Difference between nurses and physicians in role expectations • Inability to control situation professionally frustrating • Greater need for understanding of complex dynamics and factors for women denying abuse or returning to partners	Intimate partner violence inquiry, barriers and facilitators	Organisational resources Competence, training Outcomes for patients (negative) Organisational policy, protocols, practices Professional roles

Sprague eta al (2013)	Canada	3 focus groups (20 part) with orthopaedic surgeons, surgical & junior surgical trainees 2 in-depth interviews of opinion leaders Qualitative content analysis	• 4 categories of barriers: surgeon perception; perceived patient barriers; fracture clinic barriers; orthopaedic health care barriers. • Facilitators identified: availability of crisis team; screening form; IPV posters; policy & govt. support. • Need for increased awareness on IPV among health professions, local and national champions. • Increased resources for setting required.	Intimate partner violence, musculoskeletal injuries, barriers, screening	Health facility environment Role of HCW Professional roles Patient-provider relationship Outcomes for patients (negative) Organisational policy, protocols, practices Organisational priorities
Sundborg et al (2012)	Sweden	27 item questionnaire on nurses preparedness to care for women with IPV organisation (conditions & attitudes) 277 nurses across 39 PHCC Multivariate logistical regression	• Nurses unprepared to act • Individual and organisational level 'shortcomings'. • Poor knowledge • Shared attitudes with those in community • Unsure how to ask, feeling uncomfortable • Preference to refer to physician • Lack of mandate to deal with issue • Lack of guidelines on care or cooperation with authorities		Competence Motivation Self-efficacy Social & Cultural beliefs Organisational policy, protocols, practices Cross-organisational links
Thurston & Eisener (2006)		Research review/discussion (non-systematic)	• Research focused on individual-level characteristics of HCP to explain effectiveness of screening • Social context and organisational factors play critical role in IPV policy implementation • Framing of DV, practice of intersectoral collaboration, gender, culture, organisational	Domestic violence, screening, prevention, health sector	Cross-organisational links Health facility environment Organisational policy, protocols, practices Organisational priorities Gender norms Social & Cultural beliefs

			structure and system complexity have implications for DV screening in health facility		Role of HCW IPV as public health issue
Zakar et al (2011)	Pakistan	24 in-depth interviews with physicians	• Rigid patriarchal structure • Physicians and system confers to dominant ideology – patriarchy in system • No incentive for victims to go to hospital • IPV not an issue to be dealt with by health sector – social not medical issue. Biomedial model of health • Time & resource constraints, lack of knowledge, stereotyping of victims, blaming victims • Considered unnecessary and unfeasible to treat IPV • No incentive for physicians to provide complex care – 'wastes time' • Women in rural areas doubly disadvantaged		Competence, training Motivation Professional role beliefs Model of health Gender norms Social & Cultural beliefs Organisational priorities Organisational resources
Colarossi et al (2010)	(NYC) USA	Focus groups with 75 health care staff (licensed and unlicensed) family planning organisation, 64 completed brief survey, multiple analysis of variance.	• Barriers include lack of time, training and referral sources • Lack understanding of connection between IPV and RSH • Overall positive about screening for IPV, but licensed more than unlicensed • Frustration with patient response, taking time away from other health matters • More appropriate for licensed practitioners to conduct screening		Organisational resources IPV as public health issue Professional roles Competence, training Motivation Organisational policy, protocols, practices Organisational priorities

Appendix C –Assessment Matrix with a Sample of Studies

Assessment of relevance	**Weighting**
1. **Study characteristics** **Country setting – emphasis on non-Anlgo social and/or cultural environments** LMIC or country with high gender inequality Developed or LMIC but with non- Anglo, Western European but lower SES group or migrants Anglo, Western-European **Facility setting** Health and clinical settings Non-health settings, other setting **Population sample** Clinical health staff (nurses, doctors) Other HCPs, including allied health (dentists, social workers)	Highly Relevant Partially Relevant Less Relevant Relevant Less Relevant Relevant Less Relevant
2. **Relevance of findings** Part of the study findings relevant to theory and concepts looking for (HCW motivation, self-efficacy, referral systems/networks, policy, roles and responsibilities, cultural beliefs, gender norms etc) Results related to theory are minor focus	Highly relevant Partially relevant Less relevant
Assessment of Rigour	
Clear explanation of methodology, including validity and reliability testing explained and appropriate sample size, participant mix & design	High, medium or low quality

Author	Setting	Participants	Design	Relevance of Results	Relevance of Study Characteristics	Rigour	Themes
Al – Natour	Jordan	125 nurses from 3 hospitals, 10 clinics	Cross-sectional, descriptive survey DVHPSS,	HR	HR	Medium	**Knowledge/competency/self efficacy**- Half nurses feel confident or report knowledge or strategies to deal with IPV but only 28% agree they have access to information **System support** - System support reported as most significant barrier to asking about violence but not discussed in relation to identification **Access to referrals** - More than half nurses in the study disagreed they had access to mental health and social services and that these services work. .* 90% and 98% of nurses in the study disagreed they had access to mental health and social services and 99% and 62% disagreed that these services help. * Suggested because of lack of mental health services in Jordan health facilities. **Safety** - One third and more, report safety concerns for victim but also that they have ways to deal with this. **Gender norms** Approximately half of nurses hold beliefs that blame victims for IPV with strongest being that women who step out of traditional gender roles cause IPV (60%). * Reporting about beliefs reflective of Jordanian cultural beliefs. Roles - majority of nurses (83.2%) disagree that IPV investigation is non-medical role

Bacchus et al , 2012	England	32 women using antenatal services	Interviews of users following training intervention of midwives	PR	R	medium	**Knowledge/competency/self efficacy** Women reported that routine enquiry facilitated disclosure; Midwives who seemed comfortable and confident to enquire about DV produced most results (concluded but not tested) **Gender and cultural norms -** Non-judgemental response and not pressure into 223asking decisions was important for women; Concludes that enquiry acceptable when empathic, non-judgemental and shows interest in health and well being.
Feder et al 2011	England	48 practices	Intervention Control trial using records	LR	R	High	**Competency/skills** - Training and support intervention has s substantial effect on recorded referrals to specialist domestic violence agencies and on recorded identification of women experiences abuse. **Access to referral** * Unique feature of intervention was that advocator who trained clinicians was also the referral advocate .; Close partnership with third-sector specialist agencies; Limited access to referrals in resource poor settings may be limiting factor for success o intervention.
Sundborg et al (2012)	Sweden	192 nurses	survey	PR	R	Medium	**Knowledge/confidence** - Participants generally unsure how to ask direct questions ; Feeling prepared means having obtained knowledge; Lack of knowledge about cycle of violence; Nurses suspect violence when physical injuries; **Role** - Nurses referred identified victims to a physician as the preferred intervention method. **Referrals/process -** Lack of mandate to deal with issue reflected in lack of guidelines on nursing care. **Organisational support** - Organisational support important to improve care.; Results on guidelines to implement screen are inconclusive

Laisser et al (2009)	Tanzania	16 nurses	In-depth interviews	HR	HR	Medium	**Knowledge** - Have little to offer women if they choose to seek help. Leads to frustration; Difficulties in encouraging women to disclose their problem and this was primarily due to unfavourable gender structures. Legal procedures discourage them from attending the health services; **Legal** - Legal procedures discourage them from attending the health services; Women discouraged from accessing referrals because of unfavourable structures and legal procedures. **Organisation/work environment** Current working conditions play role in maintaining silence. Under pressure to deliver on daily responsibilities; Inadequate leadership, lack of resources and poor physical environment; Can create extended workload – attitudes of frustration or unwillingness to help; Lack of tools to support clients do not discourage them from meeting their roles as HCW; Lack of privacy and support tools limit ability to help clients which leads to dissatisfaction. Avoidance becomes a coping mechanism **Referrals** - HCWs identify need to involve others in management of IPV but lack knowledge and skills to do so when no resources to respond, **Gender Norms** - Problem of abuse linked to inequality, cultural influences and poverty; Male dominance, acceptance of violence for doing something wrong; IPV a taboo subject which prohibits disclosure; Lack of support from community and women to intervene because of protection of perpetrator; Despite barriers, HCWs have strong will to support IPV clients. **Roles & responsibilities** - HCWs recognise their ability to guide people and responsibility to change attitudes toward IPV and to reduce

							problem in communities; Confidence in preventative measures and role in creating awareness
Leppakoski et al (2013)	Finland	480 ED professionals	Descriptive, cross-sectional convenience sample	PR	R	medium	**Knowledge/training** - The more professional have training on IPV, the more often they have used various intervention methods and drafted procedures for how to help women. **Referrals/systems and processes** - Written protocols for IPV intervention and the availability of support and referral are important ways in which ED staff can provide women and their family members help. Otherwise care can be haphazard and unplanned depending on caregiver skills; Professionals reported having helped women dn their perpetrators more often than the professionals without procedures. **Referral/intercollaboration** - Professionals with good cooperation with different help providers reported having made a further care plan with women, told women abet shelters, helped perpetrators and assessed safety. Good cooperation facilitates intervention. Requires high resources
O'Campo et al (2010)	Mixed	23 articles	Realist review	PR	R	high	**Organisational support** - All comprehensive screening programs had institutions support – institutionalising program and making likes with community resources; Created a culture of IPV awareness and health care based solutions. **Referrals** Availability of support services enable victim to address needs an important component of comprehensive care. Providers wanted to know that subsequent actions would make difference to patients well being. Did not discuss social or cultural context.

Appendix D – Notes on field work

As a part-time student, working full-time in Canberra, organising field work to collect data in PNG was a major challenge and this impacted the design of the study and quality of data. Outlined below is a personal account of processes and obstacles overcome to complete the research. It is included as additional support to the research design and to highlight how difficult it is to conduct research in places like PNG.

Ethics

As the project was conducted in PNG, ethical clearance was required from the PNG Medical Research Advisory Council (MRAC) before I could submit an ethics application to the Flinders SBREC. However there are no formally published guidelines on the PNG process or official application forms. Within six weeks I received a vague approval letter requesting a number of changes but stating that the MRAC saw no obstacles to the research. I spent five months contacting the Chair (via email, phone and in person) to determine the process for submitting a revised application. In the end, I used a personal contact to take a drafted approval letter to the Chair to sign. The final approval from the PNG Medical Research Advisory Council took seven months.

The study initially intended to collect data from three universities, (University of Goroka, University of PNG, Pacific Adventist University) and one training school (Lutheran School of Nursing). Each university requested a separate ethics application to be submitted to their respective ethical review boards. This was done, along with numerous telephone and email conversations with the respective Deans and staff confirming permission to recruit their students to the study. I personally spoke to and emailed the Head of Nursing at UOG who assured me that he would make it his priority to get the application submitted to the board prior to his leave. He confirmed that he did this over the phone but I never received a response.

I had spoken with the University of PNG's Chair of Ethics, who is also the head of the School of Medicine, about the research. He gave his approval in principle and asked for the ethics application via email. I sent the application but he was unable to open the PDF documents so he did not include the application to be reviewed at the ethics meeting. I asked if it would be possible to have an out-of-session approval as UPNG ethics meetings were only held 3 times per year. He referred me to the Head of School of Nursing and instructed her to assist me. I called her office 3 times and sent multiple emails, but she never responded to any of my requests.

The Pacific Adventist University was the only institution to provide a formal reply. The Lutheran School of Nursing did not require a formal ethics review but did provide a permission letter, which I drafted.

Field trips

Two field trips were scheduled for data collection, the first coincided with a work trip to reduce costs and the second was scheduled according to the training institutions' preferences for visiting their campuses. The intention was to complete the pretesting during the first field trip so that the survey could be amended, cleared by the respective ethics boards and printed before the second field trip. Delayed ethics approval on the PNG side reduced time for data collection overall and meant that the pretest focus group was not able to proceed during the first field trip, which was then used to personally follow up ethical clearances. Conducting a focus group to pretest the survey, making relevant changes, then clearing through ethics during the time I had allocated to the second field trip, was not feasible. As I needed to conduct field trips during periods of annual leave, adding a third field trip was not possible and it was also beyond my financial resources.

I confirmed with the Head of School in both institutions via email dates during a two week period in November when students would be available and it would be suitable for me to spend a few days at the institutions. When I arrived in Port Moresby, the Principal of the Lutheran School then informed me that the students were on clinical placements and asked if I could come in December instead. After explaining that I had travelled from Canberra and could not return in December he agreed to put the posters advertising the research in the study rooms, as most of students were on placement at the hospital adjacent from the campus and still slept in the campus dorms. I travelled to the school unsure if there would be any students available to interview. When I arrived I was advised that only one student had agreed to participate. Fortunately I was then introduced to international midwifery educators who worked at the school. They voluntarily promoted the research and encouraged students to participate. Through their efforts 14 students agreed to be interviewed. They then allocated me a private room and organised times in two- hourly slots for each student to meet with me over the next three days.

When I contacted the Head of School of Nursing from PAU, she then advised that the students were having exams that week and asked if I could come the following week. I explained my limited timeframe and she agreed to ask the students to meet with me during one their study periods. Five agreed to participate and 18 completed surveys.

Although I was able to visit both institutions I was dismayed because neither seemed to recognise the efforts that it took to arrange the field work. I was also puzzled because both institutions had agreed to the dates and I was unsure as to why they did not inform me that students would be unavailable at the time. On reflection, I was probably a bit naïve to assume that the institutions would prioritise my research in the way that I expected and, knowing that business is conducted in a very fluid way in the Pacific, it is unlikely that either institution thought returning at a later time would be a problem.

To increase the sample size for the survey, I had arranged with the PNG Nurses Association to use their annual conference to disseminate and collect surveys. Initially, I had planned to travel with two PNG colleagues to the conference located in the town of Mendi, Southern Highlands. In the lead up to the conference, their employer tried continuously to secure accommodation but as there were only three guesthouses in the town and approximately 300 conference participants, there no accommodation was available. Further, all fights to Mendi were cancelled because of tribal fighting in the area. There was an option for us to travel to Mt Hagen, a neighbouring town, and go by road, but my colleagues were not permitted to travel because of security issues. However, I was still able to travel by myself. This would mean organising my own flights, transport and accommodation. By this stage I had already commenced the first stage of my qualitative field work in the provincial town of Madang. It was Thursday and the conference began on Monday. I had no internet connection and only mobile phone to communicate and was in the middle of intense field work. I should also note that I was eight weeks pregnant, and having had complications in the past, was feeling a little anxious. I recall making a mobile call to my colleague whilst in a motel room in between interviews, feeling as though my research was slipping through my fingers and I had no ability to control it.

Fortunately, my two colleagues took it upon themselves to work out an alternate solution. One asked her sister, who happened to be a doctor at the Mendi Hospital and was in Port Moresby, travelling to Mendi the very next day, to take my surveys with her on the plane. The other colleague contacted his associate who was attending the conference and asked him to collect the surveys from the hospital and deliver them to the conference. The head of the PNG Nurses Association agreed to distribute them. I was in Madang, two hours flight from Port Moresby, where I had left the survey packs for the conference. I contacted my father-in-law's business in Port Moresby and asked if the driver could collect the surveys from my friend's house and deliver them to my colleague's office. I had prepared all the survey packs prior to leaving for Madang and put them in a bag. Miraculously, this plan worked and the surveys were delivered to the conference. I am forever indebted to my two colleagues who helped me in this moment of crisis and if it were not for their generosity I would not have collected survey data.

The Head of the PNG Nurses Association brought the surveys back to Port Moresby with her. By this stage, I had already returned to Australia but my colleague sent them back to me in Australia. I did not receive the completed surveys until two months after completing field work. Ironically, only 26 out of 150 were complete.

Reflecting back, from a personal level, given that I already knew the constraints of the operating environment, I should perhaps have made different decisions about the scope of the research and the sample. People individually were willing to help support the research but accessing these people required using personal networks which is very much the Melanesian way because systems and processes are not set up to facilitate research. For example, to access a population of health workers, I physically needed to be present to negotiate that access because there is limited internet and phone networks which restricts communication, people do not have mail boxes, the postal system is unreliably and the professional associations and registration bodies are under resourced and poorly organised. For researchers, my experience highlights that there are additional considerations for conducting research in PNG because many of the systems and processes we take for grant in Australia, do not exist in developing countries.

The irony is that this research has shown how important it is for health service delivery to be based on contextualised evidence and at the same time shown how hard it is to collect quality data in the countries where there is most need for such evidence.

Appendix E – Pre-test questions and participant responses

Questions about the survey

1. What thoughts come into your mind when reading the survey?
2. What do you think about the language and words used in the survey? What would you suggest as alternatives?
3. Do the questions make sense to you? Are there any questions that do not make sense? What would you recommend as an alternative?
4. Are all of the questions relevant for asking PNG nurses?
5. Do you have any additional comments, concerns or suggestions?

Comment	**Response/action**
Participant 1 This is going to be fascinating research. I guess the acronyms will all be written out in a full a few times - FSV, for example. Well done, it will highlight the massive gaps we have in the current health system response.	Agree – will spell out acronyms
Q 25 - typo.	Corrected
Q 31 - not sure what you mean here - the perpetrator or the survivor? I guess you mean the survivor, but it is not clear on the first read.	Change to make sure clear that it's the perpetrator
Q 32 - also. Hmmm - maybe it is the word "battering" that i am stumbling on. Not sure how much this word is understood in PNG.	Change to family and sexual violence and/or abuse
There is nothing there specific to PNG in that there is evidence of violence in relationships being bi-directional. In addition, i guess the terminology used in PNG was deliberate - Family & Sexual violence to include the co-wives / jealousy and violence perpetrated against girlfriends, 2nd, 3rd, etc. wives by the other wives who are competing for resources.	Agree. Use term family and sexual violence to better reflect reality of violence in PNG
Also, I think nurses and community health workers are often victims themselves and while we do not want to ask them outright, maybe a question on how they support their colleagues who may be in an IPV situation. Sexual Dysfunction, painful intercourse is a real concern of PNG women - I'm glad you have included the Pelvic Pain, but a question on pain	Agree. Will include question about violence amongst nurses in interviews. Will not add question

Comment	**Response/action**
with sex, low sexual desire and if nurses feel they have the skills to deal with that is also a question i would add. Just presenting a paper next week on sexual dysfunction in the context of IPV.	on sexual desire as because doesn't fit with questionnaire but will probe for this in interviews
Participant 2	
1. What thoughts come into your mind when reading the survey? I thought the questions were intensive & focused ie: 42 questions, some of which would really get the nurses to think some through. As some of it will test any biases they have. Do you think it may be good to have a sentence in the survey that you want their honest answers and NOT what they think you as the researcher want to read? Or answer with, if you'll be personally asking the nurses?	Noted and will include emphasis on honesty in introduction and instructions on survey completion. Large sample size should help to adjust for those who answer to please researcher.
2. What do you think about the language and words used in the survey? What would you suggest as alternatives? The questions make sense and are clear, though some of the language could possibly be simpler in case some nurses may not have a high level of education. For example for the word 'strategies' you could say 'ways'. Also maybe to give it a PNG context you may need to put down on the survey (if you're not personally asking the questions) the meaning of some of the words. Like medical social worker and community advocate ie: what these words mean.	Agree. Will amend survey with suggestions, although limited with alternatives for medical social worker.
3. Do the questions make sense to you? Are there any questions that do not make sense? What would you recommend as an alternative? *Same as above. But in addition the word passive-dependent personality will need explaining ie: if someone else is asking the questions on your behalf. As that's quite a technical term. And Im not sure what I would suggest. Also the word demeaning may not be easily understood and you could replace with the following: "Would you think the patient would feel bad about themselves if you questioned them about abuse?".* Maybe the word battery and perpetrator could be changed with simpler words, especially for nurses who may not be advanced in English. (Synonym for battery could be violence and for perpetrator, MAYBE you ll need a longer sentence saying 'the person carrying out the violence' or maybe culprit).	Noted. Reluctant to make too many changes to questions because reliability and validity tested on these statements. Batterer changed but perpetrator kept as seems to be used in other reporting in PNG. Not many alternatives.
4. Are all of the questions relevant for asking PNG nurses? *They look relevant to me. And can't comment too much as not a health Professional. But I think the questions are framed in a way that nurses in PNG will understand and be able to answer comfortably.*	Agree.
5. Do you have any additional comments, concerns or suggestions? Completing the survey itself will be an education itself.	
Participant 3 The survey looks fine to use with PNG nurses.	Noted
Comment	**Response/action**
Participant 4	

Comment	**Response/action**
Introduction on what FSV means? Definition - Qtn 14 – reword again - Qtn 16 – Women who step out of traditional roles in PNG are main victims of FSV - Qtn 17- too complex may be reword again - Qtn 36 – 42 are medical, suggest lump as psychosomatic refer to my suggestion in the attached	Comments noted
1. What thoughts come into your mind when reading the survey? It is too long(42 questions) if we can break them into thematic areas and focus on key qtns too detailed maybe consider target audience – community health care workers will find this process cumbersome	Survey should take around 10 mins to complete which is actually quite brief but this reconfirms use of this instrument over a longer one. Also target audience nurses not CHWs. Nurses should have higher literacy. Amendments were made to some technical words. Will keep in mind when analysing to and review if some questions have unexpected results of too many non-responses to see if relates to comments made about language of particular items noted
2. What do you think about the language and words used in the survey? What would you suggest as alternatives? The language at times is technical and believe not culturally appropriate maybe reword eg it takes two to tango , some respondents will not know what Tango is – can reword?	Noted but not sure agree with psychosomatic complaints or that other nurses would even pick this up and treatment very symptomatically. Will review in literature for further evidence.
3. Do the questions make sense to you? Are there any questions that do not make sense? What would you recommend as an alternative? Some questions make sense others are somewhat repetitive and slightly different I suggest instead of all illnesses addressed here maybe just medical illness an eg given would help – I also suggest that a very important presentation in PNG for FSV is psychosomatic complaints I suggest we reword this to say eg Do you know of patients who present to your clinic numerous times for multiple complaints like headache, stomach ache, dizziness, fainting spells, epileptic seizures and when investigated are repeatedly found to be well. Another sub question is if yes do you ask for FSV? Also FSV by default means women here are we also going to highlight only this?? Need to be clear.	This is in contrast to comment that violence bi-directional. Deliberately not highlighting gender in survey but interviews will give opportunity to explore nurses' perceptions of gendered dimensions of FSV.
4. Are all of the questions relevant for asking PNG nurses? Depends on the category community health care workers or CHWs may find this exercise too much and nurses may find the 42 qtns are bit too much – narrow it down to core qtns covering all areas you want covered for FSV. Then a short introductory paragraph on what FSV means.	Study not targeting CHWs and although 42 items, it takes 10-15 minutes to complete. Removing items will impact subscales.

Comment	**Response/action**
5. Do you have any additional comments, concerns or suggestions? Otherwise I can see the south American flavor coming out of this survey☺ but wish for it when read by a nurse feels it has a PNG context to it – simple easy few questions say 20 items.	Agree on point about FSV. Will have opportunity to explore this in interview
Comment	**Response/action**
Participant 5 ***1. What thoughts come into your mind when reading the survey?*** Overall, good. Addresses a lot of the issues. Needs some wordsmithing.	Agree on wordsmithing as per other comments.
2. What do you think about the language and words used in the survey? What would you suggest as alternatives? Speaking as an American in PNG, the questions are very American English. I suggest working with a Papua New Guinean to translate the text into Tok Pisin and then translate it back. This may improve the appropriateness of the language. Terms I think they'll have trouble with—"ready access", "strategies", "appropriate referrals", "takes two to tango", "passive-dependent personality", "perpetrators", and "demeaning". There seems to be two different terms used almost interchangeably. I suggest asking a health worker in PNG what term they use (either FSV or domestic violence) to include both physical and sexual violence and stick with that. From what I've see, domestic violence means physical only to a wife, while Family and Sexual violence means physical and sexual violence (other forms of violence are lesser known/understood) of wives and children. Do the nurses call them "victims"? Could they be called survivors or something else instead? #4 referrals where? To FSCs?	Good idea but lack recourses to do this. However useful feedback for analyses This similar to another participants comment. Will take note of this during analysis of this item Used only FSV as term used by Department of Health and research not exclusive to IPV Survivors politically correct but victims still commonly use term in PNG Good point. I would expect response indicates that they don't refer because limited options
3. Do the questions make sense to you? Are there any questions that do not make sense? What would you recommend as an alternative? Per the attached, I suggest reformatting your Likert scale so it is easier to read and go through. While the personnel you'll be working with speak English, in many of the cases Tok Pisin is the language they are reason in. It may be good to, in addition to the English, add the Tok Pisin. Strongly Disagree becomes No Wanbel Stret, Disagree- No Wanbel, etc. This may make it easier for the respondents to focus on rating the content of the statements. Using color shading also makes it easier to mark it correctly. For Part 2, the never-always questions may be hard (or not, hard to know). You may want to test to see if they would be more comfortable estimating the number of times and how often they did X than using never-always. Pre-testing would help here.	Agree but lack resources. Also targeting nurses not CHWs who have university degrees. Agree and intention was to pre-test but timing issues interfered

Comment	**Response/action**
4. Are all of the questions relevant for asking PNG nurses? Yes, I recommend also including something that refers to the high number of clients, short staff/time. Something like “I’m too busy at work to deal with FSV survivor problems” or “I do not get enough training or support to deal…”. If possible (ethics boards), it would be good to also ask the respondents about their own, personal experience with violence. They may feel that since they deal with it, these women can too. This is a global issue where women who face FSV are sometimes complicit in the FSV of others (ex. aunties telling their nieces to stay with their abusive husband). PNG nurses primarily deal with women and children, they rarely deal with men and therefore their experience with treating perpetrators may be limited. You may want to cut those questions. Perhaps PNG nurses feel that the survivors should not bring their FSV issues to them- but address them with village magistrates, the police, religious leaders, or deal with it through their family. Because dealing with FSV cases is so political and emotionally charged (the use of medical certificates in compensation cases), nurses may feel that they can’t confidently deal with FSV cases properly (just bare basic first aid, blind eye approach). It would be good to ask questions to address that issue. The questions talk about fear or reprisals, but not about if the nurses feel women should come to them (and not someone else) with those issues.	Noted will explore in interviews
5. Do you have any additional comments, concerns or suggestions? No	Will explore in interviews.

Table 17: Matrix of comments from participants during survey pre-test.

Appendix F – Revised Domestic Violence Health Care Provider Survey

PART 1: PARTICIPANT DETAILS
Please complete the following questions about yourself.

1. Age (*circle*): 20-24 25-29 30-34 35-39 40-44 45-49 50-54 over 55

2. Sex (*circle*): Female Male

3. Which province are you from?__________________________________

4. In which province do you usually live? : ______________________________

5. How many years have you worked as a nurse? __________________________

6. What is your current position/job? _______ ___________________________

7. Which health facility do you currently work in? ____ ________________________

8. Have you ever completed any training on family and sexual violence? Yes No

9. If yes, how long was the training and who provided it? ______________________________

10. Have you ever completed any gender specific training? Yes No

11. If yes, how long was the training and who provided it? __________________________

---**_PART 2: DOMESTIC VIOENCE HEALTH CARE PROVIDER SURVEY_**

In answering the following questions, circle the appropriate number:

1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree, 5 = strongly agree

1.	I don’t have the time to ask about domestic violence in my practice.	**1**	**2**	**3**	**4**	**5**
2.	There are strategies I can use to encourage perpetrators to seek help.	**1**	**2**	**3**	**4**	**5**
3.	There are strategies I can use to help victims of domestic violence change their situation.	**1**	**2**	**3**	**4**	**5**
4.	I feel confident that I can make appropriate referrals for perpetrators.	**1**	**2**	**3**	**4**	**5**
5.	I feel confident that I can make the appropriate referrals for abused patients.	**1**	**2**	**3**	**4**	**5**
6.	I have ready access to information about how to manage domestic violence	**1**	**2**	**3**	**4**	**5**
7.	There are ways I can ask perpetrators about their behaviour that will minimize risk to the potential victim.	**1**	**2**	**3**	**4**	**5**

8.	I have ready access to medical social workers or community advocates to assist in the management of family and sexual violence	**1**	**2**	**3**	**4**	**5**
9.	I feel that medical social work personnel can help manage domestic violence patients.	**1**	**2**	**3**	**4**	**5**
10.	I have ready access to mental health services should our patients need referrals.	**1**	**2**	**3**	**4**	**5**
11.	I feel that the mental health services at my clinic or agency can meet the needs of domestic violence victims in cases where they are needed.	**1**	**2**	**3**	**4**	**5**
12.	A victim must be getting something out of the abusive relationship, or else he/she would leave.	**1**	**2**	**3**	**4**	**5**
13.	People are only victims if they choose to be.	**1**	**2**	**3**	**4**	**5**
14.	When it comes to domestic violence victimization, it usually "takes two to tango."	**1**	**2**	**3**	**4**	**5**
15.	I have patients whose personalities cause them to be abused.	**1**	**2**	**3**	**4**	**5**
16.	Women who choose to step out of traditional roles are a major cause of domestic violence	**1**	**2**	**3**	**4**	**5**
17.	The victim's passive-dependent personality often leads to abuse.	**1**	**2**	**3**	**4**	**5**
18.	The victim has often done something to bring about violence in the relationship.	**1**	**2**	**3**	**4**	**5**
19.	I am afraid of offending the patient if I ask about .	**1**	**2**	**3**	**4**	**5**
20.	Asking patients about domestic violence is an invasion of their privacy.	**1**	**2**	**3**	**4**	**5**
21.	It is demeaning to patients to question them about abuse.	**1**	**2**	**3**	**4**	**5**
22.	If I ask non-abused patients about domestic violence, they will get very angry.	**1**	**2**	**3**	**4**	**5**
23.	It is not my place to interfere with how a couple chooses to resolve conflicts.	**1**	**2**	**3**	**4**	**5**
24.	I think that investigating the underlying cause of a patient's injury is not part of medical care.	**1**	**2**	**3**	**4**	**5**
25.	If patients do no reveal abuse to me, then they feel it is none of my business.	**1**	**2**	**3**	**4**	**5**
26.	I am reluctant to ask perpetrators about their abusive behaviour out of concern for my personal safety.	**1**	**2**	**3**	**4**	**5**
27.	There is not enough security at my work place to safely permit discussion of domestic violence with perpetrators.	**1**	**2**	**3**	**4**	**5**
28.	I am afraid of offending patients if I ask about their abusive behaviour.	**1**	**2**	**3**	**4**	**5**
29.	When challenged, perpetrators frequently direct their anger toward health care providers.	**1**	**2**	**3**	**4**	**5**
30.	I feel there are ways of asking about abusive behaviour without placing myself at risk.	**1**	**2**	**3**	**4**	**5**
31.	I feel I can effectively discuss issues of domestic violence and abuse with patients who are perpetrators.	**1**	**2**	**3**	**4**	**5**
32.	I feel I can discuss issues of domestic violence and abuse with a a patients who is perpetrator without further endangering the victim.	**1**	**2**	**3**	**4**	**5**
33.	I feel it is best to avoid dealing with the perpetrator out of fear and concern for the victim's safety.	**1**	**2**	**3**	**4**	**5**

34.	There is no way to ask perpetrators about their behaviours without putting the victims in more danger.	**1**	**2**	**3**	**4**	**5**
35.	I am afraid if I talk to the perpetrator, I will increase risk for the victim.	**1**	**2**	**3**	**4**	**5**

Frequency of Enquiry

1.	In the past three months, when seeing patients with injuries, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
2.	In the past three months, when seeing patients with chronic pelvic pain, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
3.	In the past three months, when seeing patients with irritable bowel syndrome, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
4.	In the past three months, when seeing patients with headaches, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
5.	In the past three months, when seeing patients with depression and/or anxiety, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
6.	In the past three months, when seeing patients with hypertension and/or coronary artery disease, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**
7.	In the past three months, when seeing patients requiring pregnancy or OB/GYN care, how often have you asked about the possibility of domestic violence?	**1**	**2**	**3**	**4**	**5**

Adapted from: Maiuro RD, Vitaliano PP, Sugg NK, Thompson DC, Rivara F, and Thompson RS. Development of a Healthcare Provider Survey for Domestic Violence: Psychometric Properties. ***American Journal of Preventive Medicine***, 19 (4), 245-252

Please place completed surveys into the envelopes provided, seal them and return either to the researcher or to the box provided.

Appendix G - Interview questions and prompts

Warm-up questions

Can you tell me about your job as a nurse? What type of place do you usually work in? What type of patients do you usually deal with? How long have you been a nurse? How are you enjoying your studies?

Role of nurses in responding to family and sexual violence

1. Can you tell me in your words what is family and sexual violence? Is it a problem nurses deal with in health facilities?
   Prompt - What does it include? Who's involved in family and sexual violence? Scale of problem PNG? Is it a big problem for nurses? Why/why not?

2. From your point of view, what do you think is the role/job of nurses in responding to family and sexual violence? At what point in a case do nurses usually get involved in FSV?
   prompt– is it a priority issue for nurses?

3. Can you tell me what nurses would usually do if they had a patient who they suspected was a victim of violence?

4. How would you know if a patient was a victim/survivor of family and sexual violence? How might nurses ask or talk to patients about family and sexual violence
   Prompt – what about women who don't have visible signs?

Nurses' treatment of victims/survivors of violence

5. Can you describe what usually happens when a woman comes into a health facility with injuries? Who would help her? What kind of services would she find?

6. Can you tell what usually happens when a woman comes into a health facility following rape or sexual assault?
   Prompt – treatment, care, referrals

7. From your experience, can you tell me what problems or challenges nurses face when treating women with injuries or after a rape? Can you tell me some of the things nurses might do to overcome these challenges?

Factors influencing identification and management of family and sexual violence

8. What are some of the things you think might influence a nurse to ask or not ask about family and sexual violence?
   Prompt – cultural considerations, setting/environmental factors, comfort

9. What sort of support do nurses receive to help them support victims of family and sexual violence and to treat patients?
   Prompt – training, specialist training for discussing sexual issues

10. What about supporting colleagues who live with violence? Is that an issue that nurses need to deal with? How do they manage that?

Enabling environment

11. What sorts of things might managers do in a health facility to help victims or survivors of violence?
12. Are you aware of national policies or laws that exist to prevent violence against women? Which

ones?

13. Are you aware of protocols or policies that require specific actions by health service providers with regard to violence against women?
14. What would you like to see happen within the health sector to reduce the health consequences of family and sexual violence?

Close

What do you enjoy most about being a nurse? Is there anything else you would like to add?

Appendix H – Sample transcript with use of prompting questions

I: And so what do you think are some of the barriers or some of the challenges for some of the nurses trying to work with cases of FSV?

P: I think some of the barriers is maybe we are not taking this issue seriously and that's why we don't think about them as important. And next is maybe due to staff uhm, staff these staff shortage, maybe.

I: And how does that affect people's work? Staff shortages?

P: If there is no plenty of nurse available at that shift then they won't have time to sit with the client and go through the process step by step. It's like due to shortage of nurses, everyone is coming and we just see the as usual.

I: So they don't have time?

P: Yeah they don't have time. And also one of the main barriers is that we don't have appropriate referral pathways or something there that we can refer them to.

I: Hmm. So what does that mean for nurses if there aren't referral pathways?

P: Most of the time we don't know where to refer these client so we just treat them as usual. If, may if we do know where to refer them or maybe if there is any social services available in our areas then we can be able to refer them to where they can but ahm at XXXXXX we have this counselling HIV centre so especially for sexually abused clients we advise them to go to that ah what HIV counselling centre and yeah they usually go there when they come in after treating them and all that there is, we advise them to go there and also ahm we notify the counsellors there and they come in and they talk with them and then they do what testing and provide PEP.

I: What, you said, the first thing you said was that we are not taking the issue seriously – why do you think that is? Why don't nurses think it's a serious issue?

P: Uhm, I think because the way we treat domestic clients, we may empathise with them but then the next moment we forget all about them and too I think people, we nurses are thinking maybe it's not our business or something so we just let them go when we think its maybe something to do with herself and maybe the husband or the family or something.

I: So nurses think it's not their business to get involved?

P: Yeah maybe

Appendix I – Samples of Qualitative Analytical Procedures

Interview Summary

7 November 2013
Memo – Interview A3
Several strong issues emerged. Disempowerment of women and their lack of value in PNG society was voiced. Status of women and the issues of literacy and knowledge of "poor ones" in the rural areas. There was a note of sympathy for these "mothers" who do not know their rights. The participant distinguished herself from these women without verbally stating so. The lack of power of women and their lack of knowledge of their rights was the reason given for not speaking out about violence.

Overall the participant indicates that violence happens to many if not most women. The participant was not clear about distinguishing between physical and sexual violence and frequently referred to sexual violence in the interview. I'm not sure if she specifically meant sexual violence or any form of violence. The participant stated that she had not come across injuries from sexual violence but later in the interview spoke of giving emergency pills to a girl who came to the centre claiming she was raped. The participant did state that unless a woman has physical injuries then she will not be asked about violence. Attitudes of nurses was discussed as a key barrier. The participant explained that nurses often judge victims and believe that either she deserved it or did something to cause it. This is both a barrier to nurses providing care and for women coming forward for treatment. The participant also spoke of issue between women outside the workplace that may interfere with whether or not nurses provide care. This highlights that nurses often live and are part of the communities they work in and as a result have multiple roles and identities. This may be more the case in rural areas than large hospitals. Also highlights that FSV can be a community issue with many parties involved. This will pose a risk for nurses.

However the participant also spoke of the history taking process whereby health workers ask about social backgrounds. I think the inconsistencies illuminate what the participant knows to be good practice and what she may do herself and what happens in reality in most cases. It was difficult to tell if the participant was talking about what she does and what happens or what she thinks or knows to be the relevant course of action. The description of the processes, whether followed or not does reveal that there are some processes in place that would help health workers identify and support victims of family and sexual violence.

The comment that the participant had only seen cases involving children who had been sexually abused was alarming. It seems sexual abuse of children is treated differently. Perhaps because parents bring the child forward or because there is less judgement about a child who has been abused than a woman. A key driver to bring a child to the health centre is to gain a medical report to take to court.

This participant spoke of the need for partnerships with police, social workers and NGOs, indicating knowledge that victims need support and services beyond what can be provided *in the health centre and that there needs to be coordination. How this coordination works or doesn't work was not explored in the interview but note that XXXX town is 1 ½ days away so availability of services in this area likely to be minimal. Cost of travelling to town to access welfare was noted as a barrier for women. The participant spoke of social workers, church leaders and police who can assist in the village. It's not clear whether the social workers are trained workers or play volunteer roles.*

Another issue raised was charging of fees, which is a practice of the health facility this participant works in. This was noted as a barrier to discussing abuse and to coming in for treatment as women cannot afford the fee. The participant said the reason for charging fees was prevention. Management believe that charging a fee will discourage violence but she thought this was ineffective. However, she did say that they will treat women regardless and take payment in kind. So her empathy for women means she will override policy. The health facility is church run and they do have different fee schedules from government run clinics.

The participant said that polygamy is one of the main causes of violence. Women in polygamous relationships are disempowered, can't speak out. Toward the end of the interview, the participant said that she had been in a polygamous relationship which has now ended. She commented it was too much trouble and now prefers to be left alone. This would influence her experience of violence and polygamy. I expect she suffered violence whilst in her marriage although not disclosed directly.

At times I was unsure if the participant was telling me what she does do or what she thinks should be done. This participant clearly understood about approaching victims in a sensitive way, taking time to talk etc.

Key words: remoteness, lack of value, status and power, blurred boundaries

Coding text (extracted from Excel)

When you say they don't talk properly, what do you mean? Can you give an example?				
They used to be harsh and this type of attitude will scare the patient. Like they don't feel open to talk with us.	"being harsh"	Nurses' attitudes	Patient fear	Barrier for disclosure
So what sorts of things would they say? How would they behave?				
You mean the patients?				
The nurses				
Oh the nurses. Oh like sometimes they like "Oh it's you fault because you did this and that, you yourself you asked for this". Some direct comment they use dot say where I think it's not right. Nurses attitude. And for example in labour ward we have experience a lot of midwives especially because nurses working there, those old ones, been in the ward for a long time. They way where they used to slap patients and the mothers especially when the mother don't, when they didn't cooperate during delivering and labour that's the time when the scold at them, slap them. That's one thing I think the patients don't feel open to talk to us, especially with those ones who act that way.	blaming	scolding and slapping	Attitudes and practices, patient abuse	Patient barriers
Yeah. Not sure I'd feel open either. What are some of the things that might influence what a nurse might do at work? Like with FSV clients, who have this FSV problem? Are there any, you mentioned cultural issues?				
Yes. Like in PNG they got this bride price issue. Bride price is the main, the big barrier especially guys when they pay for bride price, then they think that they own that lady and they can do anything. They took that lady as a property or something. They can do anything they want. So like, the ladies they just submit to whatever the husband talk to them and listen. If they don't listen to them they tend to beat them up.	Bride price, customs	Male control and ownership, women's submission	gender roles,	PNG culture

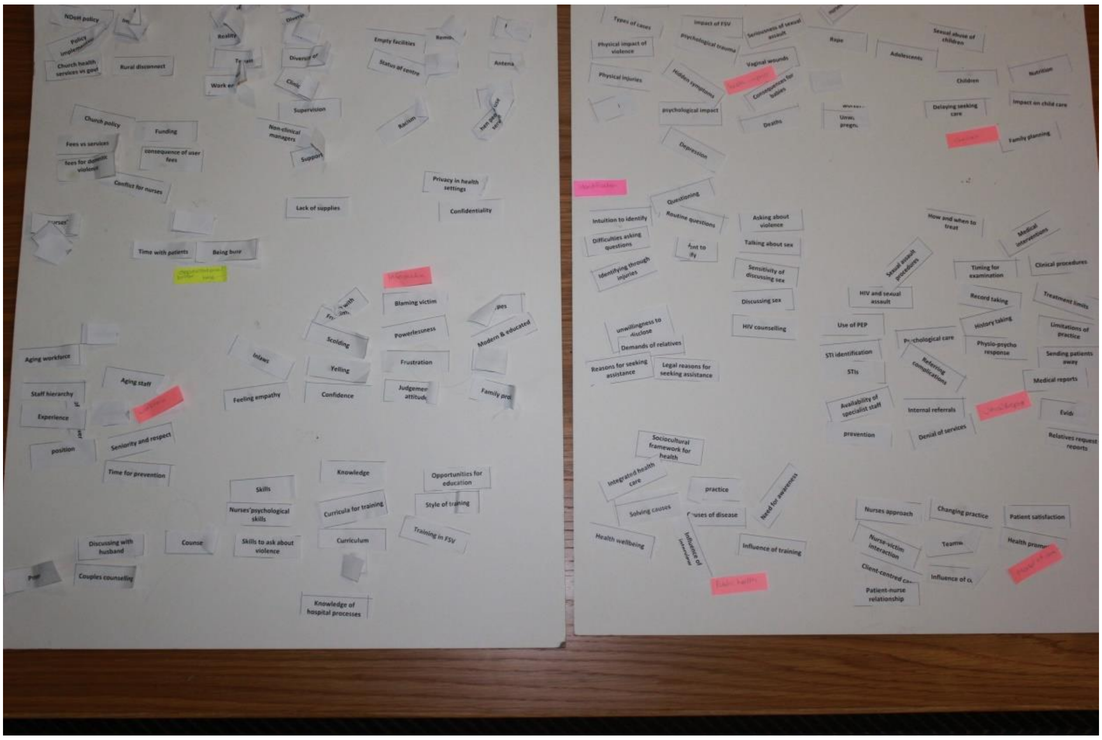
Master code list

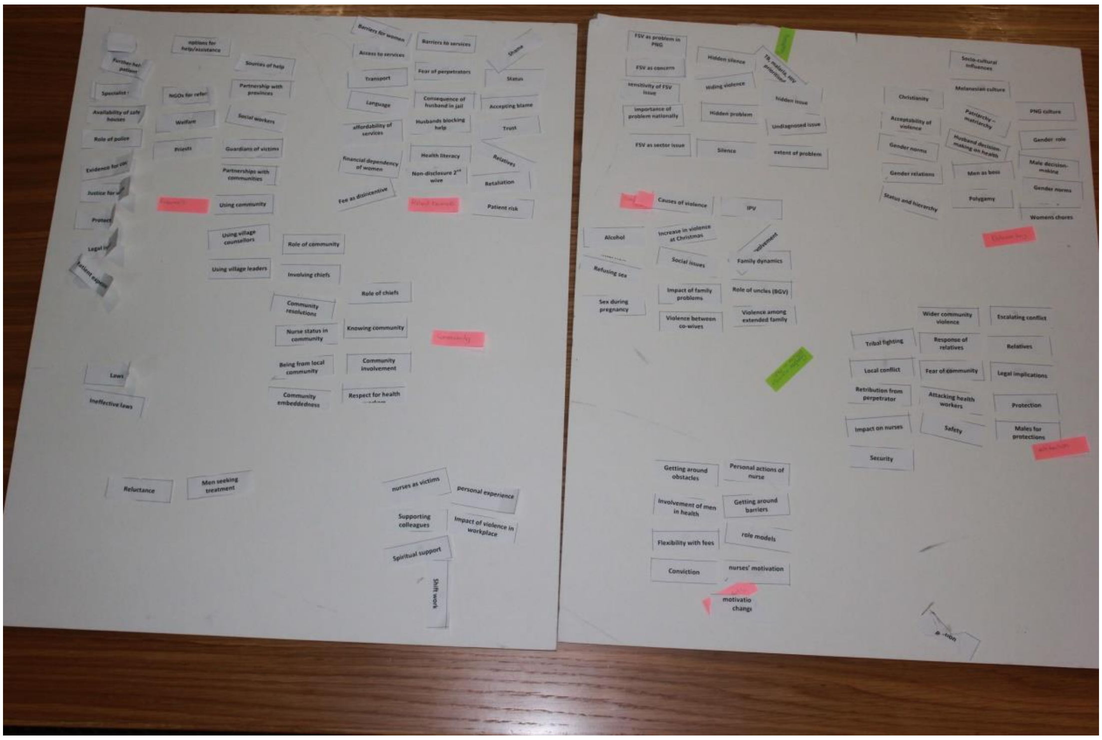
role of nurses
nurses' job
position
Big issue in PNG
importance of problem nationally
consequences of user fees
health impact on women
unwillingness to disclose
nurses as advocates
role models
confidentiality
skills
nurses psychological skills
church health services vs government
clinical procedures
social workers
remote areas
sociocultural influences
language
shame
safety
access to services
asking about violence
medical reports
HIV and sexual assault
In-laws
role of community
types of cases
availability of specialist staff

FSV as sector issue
nurses' motivation
motivation to change
nurses as victims
fees for domestic violence
health impact of violence
hidden issue
options for help/assistance
implementation of policy
sociocultural framework for health
causes of violence
privacy in health settings
knowledge
physical injuries
HIV counselling
human resources
integrated health care
status and hierarchy
blaming victim
gender roles
nurses' approach
treatment limits
time with patients
curricula for training
use of PEP
patient risk
patient-nurse relationship
sexual assault procedures
legal issues
security

sensitivity of issue
impact of FSV
extent of problem
psychological trauma
affordability of services
psychological impact
personal experience
financial dependency of women
prevention
PNG culture
physical impact of violence
lack of manpower
counselling
skills to ask about violence
training in FSV
seriousness of sexual assault
reality of setting
barriers to services
acceptability of violence
gender norms
fear of perpetrators
networks & referrals
support for staff
reason for seeking assistance
violence among extended family
retribution from perpetrator
trust
justice for victims
sources for help
role of police

Sample of initial schematic clustering on card





Transcript with analytical memo (extracted from Excel)

Can you tell what you think about the issue of FSV in PNG?

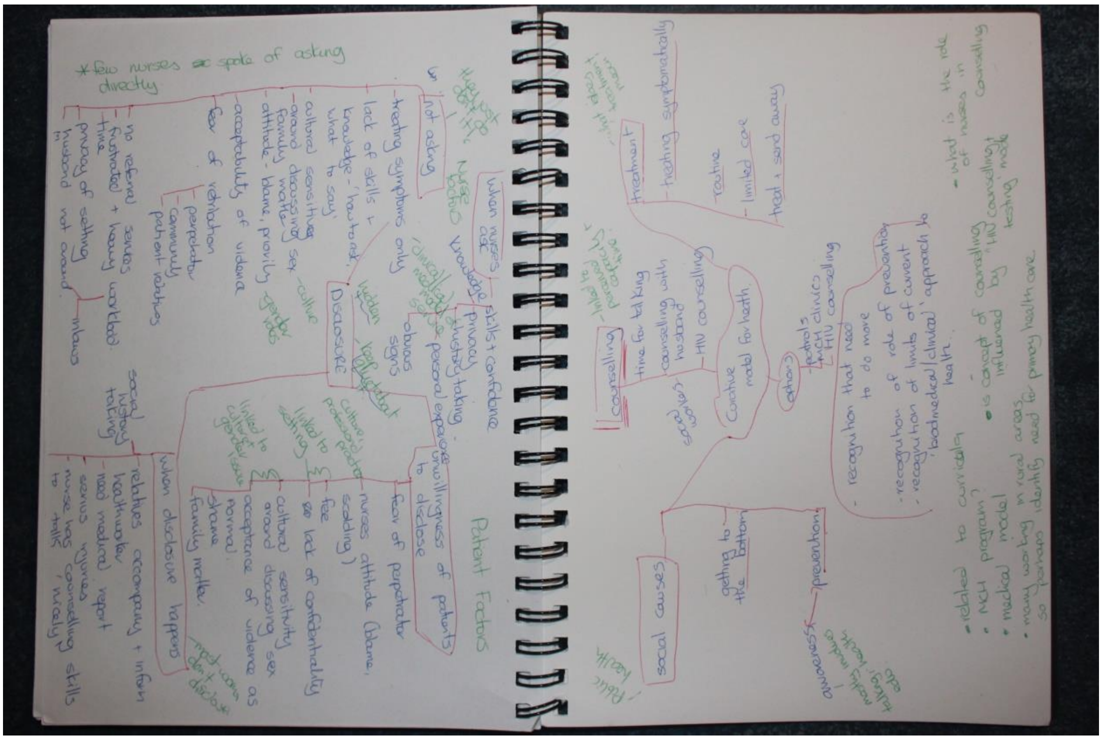
"Yes being violent. Women are more prone to this domestic violence than men and people are, women still continue to suffer silently in terms of this violence. They did not actually come out to speak up for how they feel about it. Like I said in the first place in fear of being beaten by their husbands or their spouses. We have all these cultural aspects that also prevents us from expressing how we feel. I don' think but I believe it's one of the biggest issues for PNG. In the workplace that I have been working for the last years, I haven't really come across so much of violence. Although I may have noticed some form of violence, like bruises being sustained. Not only females but males too being involved but a very low portion compared to female. And even though there are people who come and present themselves with this I don't actually look beyond this bruises. I only treat this physical. Yeah because most of the time I am not in a better position to really express or to talk about these things, because I'm not really an experienced person where I can just step in. One of the things that is in me, I'm so what will I sat seem to sympathise a lot on people, when I try to talk about peoples issues and I try to talk openly and they try to shed tears, and I also shed tears and this is not a good, doesn't give me the right position to stand in and talk with them. But physically, with the physical appearance and how they present , yes I do, I see that there is violence, existing in families.

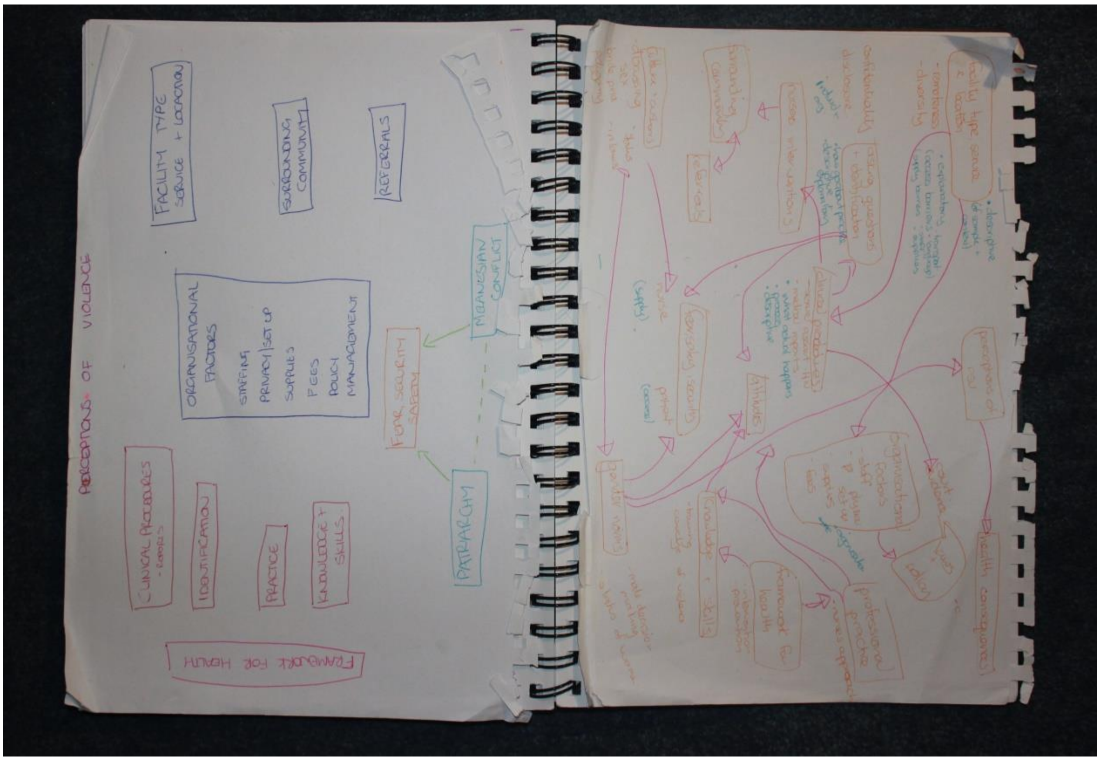
Analytical Note -Suffer silently stands out is this because of culture and fear. It's the biggest issue in PNG but not expressed. She says "Don't look beyond the bruises". Acknowledgement that there is something beyond bruises but does not have experience to discuss "not in a better position, not experienced". What does experienced include - personal experience or professional training. What qualifies as experience in PNG? What is accepted as "experience" in PNG? Think about formality of training and status and structure of professionals. Lay experience probably not accepted. Emphasis on physical indicating that there may be more than just physical. **Actions:** talking to people, being open, sympathising, crying. **Emotions/thoughts:** overwhelming, sadness, concerned about role, lacks confidence to discuss with patients, not qualified, not her position. **Interaction -** possibly limits her involvement with cases, reluctant to provide support.

Notes and Insights

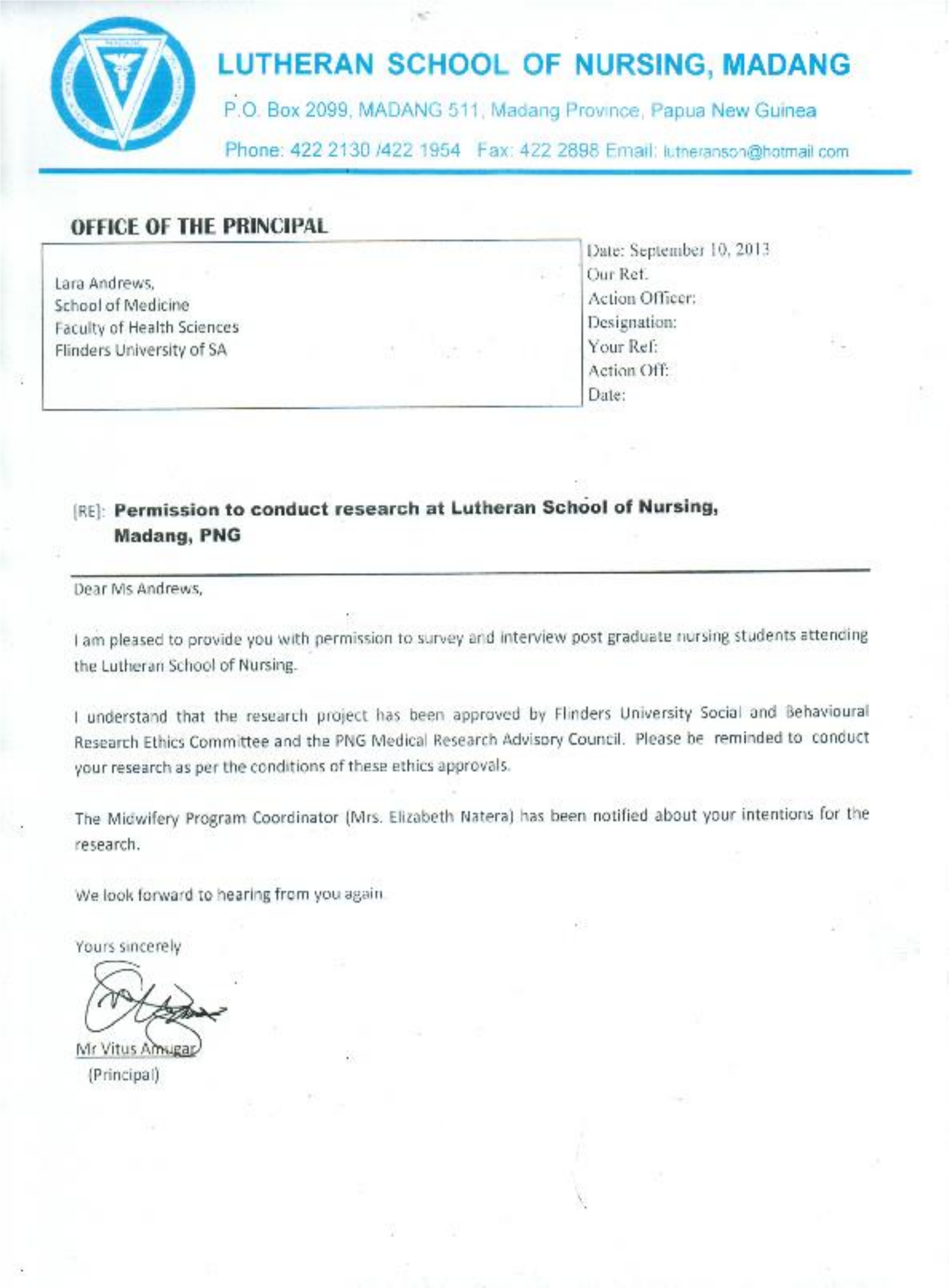
Notes	**Relates to:**	**Examples**
Relatives' demand for medical reports driven by need for evidence to demonstrate crime in courts. Possibly linked to culture of compensation and retribution because most likely outcome at lower level courts (village) is payment (cash or goods) by perpetrator to victim or her family. Less about victims' compensation. Related to communal problem-solving. The offence is against the family who the woman belonged to. Families goods have been damaged therefore need to be compensated. Also related to distortion of use of compensation in contemporary PNG. Tension between individual rights, victim centred response, introduced and pushed by international stakeholders (i.e. UN) and Melanesian cultural practices which emphasise community cohesion over individual needs. Reason for seeking assistance is for evidence to take to court (medical report) rather than restoration of health. So does this then mean health workers focus on documenting injuries and examination rather than client care? Women presenting at police then coming for treatment and to get medical report. Does this mean first response is legal	PNG culture of compensation Displaced traditional cultural processes Retribution	Case example: interview 14 12
Context is important for reader. Will need to explain context in terms of actual settings and terrain but also severity of the cases and circumstances in which they occur of violence and diverse ways in which respond. Remote areas have limited services, including police which impacts ability to respond to violence. More remote areas live more traditionally – with customs and culture playing larger role.	Putting findings in context Extent of gender inequality	**Interview** **9 and 18**

Mind maps & conceptual diagrams





Appendix J – Ethics Approval letters



LUTHERAN SCHOOL OF NURSING, MADANG
P.O. Box 2099, MADANG 511, Madang Province, Papua New Guinea
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OFFICE OF THE PRINCIPAL

Lara Andrews,
School of Medicine
Faculty of Health Sciences
Flinders University of SA

Date: September 10, 2013
Our Ref.
Action Officer:
Designation:
Your Ref:
Action Off:
Date:

[RE]: **Permission to conduct research at Lutheran School of Nursing, Madang, PNG**

Dear Ms Andrews,

I am pleased to provide you with permission to survey and interview post graduate nursing students attending the Lutheran School of Nursing.

I understand that the research project has been approved by Flinders University Social and Behavioural Research Ethics Committee and the PNG Medical Research Advisory Council. Please be reminded to conduct your research as per the conditions of these ethics approvals.

The Midwifery Program Coordinator (Mrs. Elizabeth Natera) has been notified about your intentions for the research.

We look forward to hearing from you again.

Yours sincerely

Mr Vitus Amugar
(Principal)

Pacific Adventist University
EDUCATE TO SERVE

Office of the Director of Research & Postgraduate Studies

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15 August 2013

Ms Lara Andrews
Flinders University Student
School of Medicine/Discipline of Public Health
Flinders University
GPO Box 2100
Adelaide, SA. 5001
Australia

Dear Lara,

Re: Ethics approval for PhD research "An exploration of the factors that influence the identification and management of cases of family and sexual violence by nurses in Papua New Guinea."

The Pacific Adventist University Research and Ethics Committee (PAUREC) considered application to undertake Research on our Nursing students here at PAU with the accompanying documentation. Including confirmation of approval by the Flinders University Social and Behavioural Research Ethics Committee for the above project.

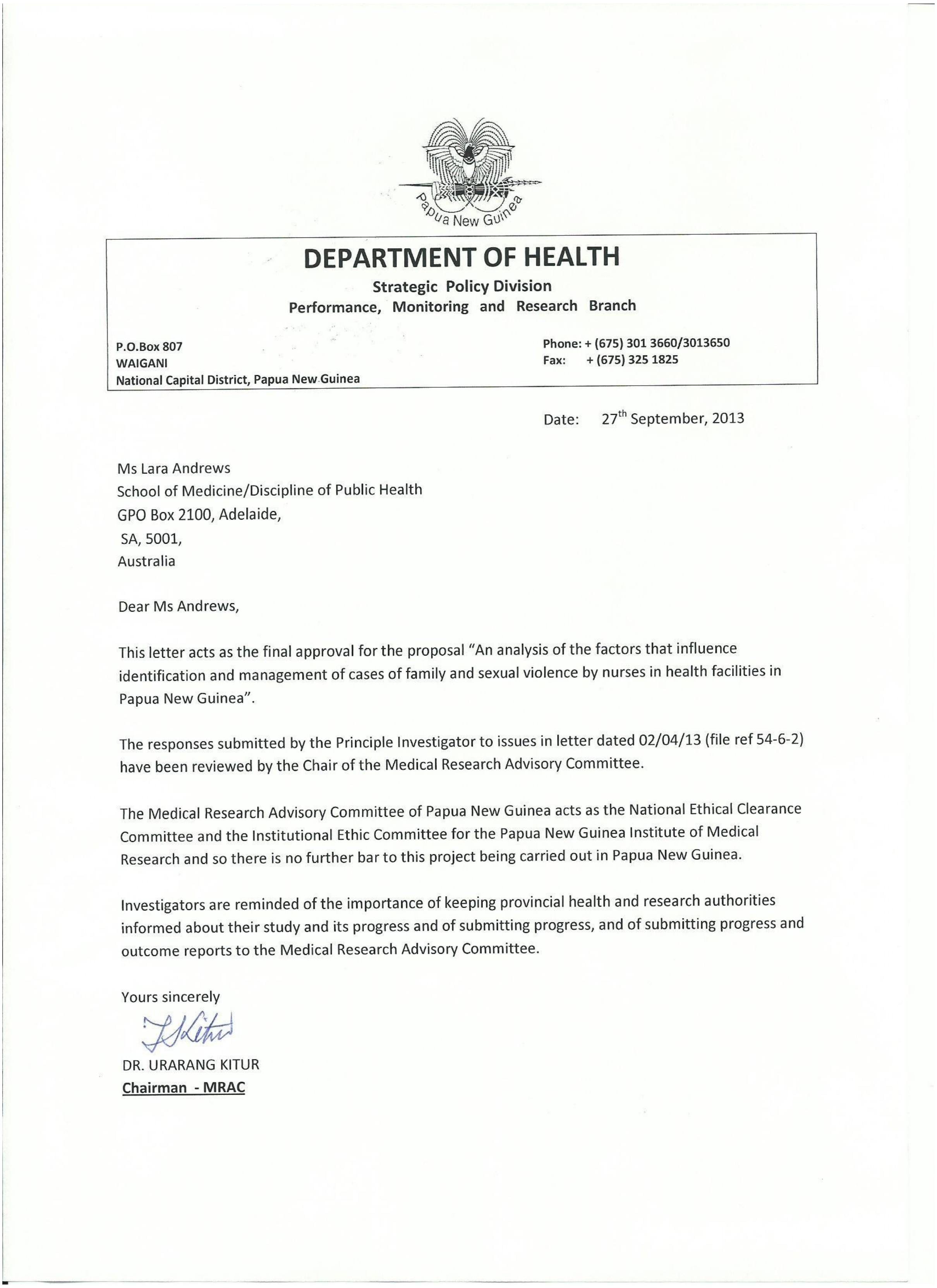
I am pleased to confirm that PAUREC approves your application and endorses you to proceed with the study on the understanding that you are familiar with the University operations.

We wish you all the best in this study.

Yours Faithfully,

Dr Lalen Simeon
Chair – Research and Ethics Committee

[illegible]



DEPARTMENT OF HEALTH
Strategic Policy Division
Performance, Monitoring and Research Branch

P.O.Box 807
WAIGANI
National Capital District, Papua New Guinea

Phone: + (675) 301 3660/3013650
Fax: + (675) 325 1825

Date: 27th September, 2013

Ms Lara Andrews
School of Medicine/Discipline of Public Health
GPO Box 2100, Adelaide,
SA, 5001,
Australia

Dear Ms Andrews,

This letter acts as the final approval for the proposal "An analysis of the factors that influence identification and management of cases of family and sexual violence by nurses in health facilities in Papua New Guinea".

The responses submitted by the Principle Investigator to issues in letter dated 02/04/13 (file ref 54-6-2) have been reviewed by the Chair of the Medical Research Advisory Committee.

The Medical Research Advisory Committee of Papua New Guinea acts as the National Ethical Clearance Committee and the Institutional Ethic Committee for the Papua New Guinea Institute of Medical Research and so there is no further bar to this project being carried out in Papua New Guinea.

Investigators are reminded of the importance of keeping provincial health and research authorities informed about their study and its progress and of submitting progress, and of submitting progress and outcome reports to the Medical Research Advisory Committee.

Yours sincerely

DR. URARANG KITUR
Chairman - MRAC

6042 SBREC - Final approval (13 June 2013)

Dear Lara,

The Deputy Chair of the Social and Behavioural Research Ethics Committee (SBREC) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.: **6042**

Project Title: An exploration of the factors that influence the identification and management of cases and family and sexual violence by nurses in Papua New Guinea

Principal Researcher: Ms Lara Andrews

Email: andr0183@flinders.edu.au

Address: Public Health

Approval Date: 13 June 2013

Ethics Approval Expiry Date: **30 June 2014**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment:

Additional information required following commencement of research:

1. Please ensure that copies of the correspondence requesting and granting permission to conduct the research from the Deans / Heads of Schools of Nursing to be involved are submitted to the Committee *on receipt*. Please ensure that the SBREC project number is included in the subject line of any permission emails forwarded to the Committee. Please note that data collection should not commence until the researcher has received the relevant permissions (item D8 and Conditional approval response – number 6).

Andrea Fiegert
Executive Officer
Social and Behavioural Research Ethics Committee

c.c Dr Mariastella Pulvirenti
Prof Paul Ward

Appendix K – Survey response

	Item	**Frequency of responses as per cent (%)**					**Total responses (N)**
	Scale: Perceived Self-Efficacy	**Strongly agree**	**Agree**	**Not sure**	**Disagree**	**Strongly Disagree**	
1	I don't have the time to ask about FSV in my work	13.5	28.8	7.7	36.5	13.5	52
2	There are ways I can encourage people who use violence to seek help.	34	45.3	17	0	3.8	53
3	There are ways I can help victims of family and sexual violence change their situation.	28.3	43.4	20.8	5.7	1.9	53
4	I feel confident that I can make appropriate referrals for people who use violence.	29.4	29.4	27.5	11.8	2.0	51
5	I feel confident I can make appropriate referrals for abused patients	30.2	37.7	18.9	7.5	5.7	53
6	I have ready access to information about how to manage family and sexual violence.	11.3	24.5	22.6	32.1	9.4	53
7	There are ways I can ask people who use violence about their behaviour that will minimize risk to the potential survivor.	7.	35.8	35.8	13.2	7.5	53
	Scale: System Support Items						
8	I have easy access to hospital social workers or community groups to assist in the management of case of family and sexual violence.	15.1	26.4	7.5	24.5	26.4	53
9	I feel that hospital social work personnel can help manage family and sexual violence patients.	42.3	30.8	11.5	7.7	7.7	52
10	I have ready access to mental health services should our patients need referrals	17.0	26.4	18.9	18.9	18.9	53
11	I feel that the mental health services at my clinic or agency can meet the needs of family and sexual violence victims in cases where they are needed.	15.4	26.9	28.8	17.3	11.5	52
	Scale: Blame Victim Items						

12	A victim must be getting something out of the abusive relationship, or else he/she would leave.	7.7	28.8	30.8	17.3	15.4	52
13	People are only victims if they choose to be.	9.6	7.7	7.7	26.9	48.1	52
14	When it comes to family and sexual violence victimization, it usually “takes two to tango.”	9.4	32.1	35.8	9.4	13.2	3
15	I have patients whose personalities cause them to be abused.	11.3	34	20.8	20.8	13.2	53
16	Women who choose to step out of traditional roles are a major cause of family and sexual violence.	17	20.8	11.3	28.3	22.6	53
17	The victim’s emotionally dependent personality often leads to abuse.	7.8	17.6	27.5	25.5	21.6	51
18	The victim has often done something to bring about violence in the relationship	5.7	28.3	20.8	24.5	20.8	53
	Scale: Professional Role Resistance/Fear of Offending the patient						
19	I am afraid of offending the patient if I ask about family and sexual violence	1.9	26	7.7	44.2	19.2	52
20	Asking patients about family and sexual violence is an invasion of their privacy.	15.4	26.9	11.5	30.8	15.4	52
21	It is demeaning to patients to question them about abuse.	5.8	21.2	17.3	44.2	11.5	52
22	If I ask non-abused patients about family and sexual violence they will get very angry.	5.9	31.4	25.5	31.4	5.9	51
23	It is not my place to interfere with how a couple resolve conflict	7.7	17.3	9.6	46.2	19.2	52
24	I think investigating underlying causes of a patient’s injury is not part of medical care	5.7	3.8	9.4	30.2	50.9	53
25	If patients do not reveal abuse to me, then they must feel it’s none of my business	9.6	28.8	21.2	32.7	7.7	52
	Scale: Victim/Provider Safety						
26	I am reluctant to ask people who use violence about their abusive behaviour out of concern for my personal safety	7.5	34.0	30.2	22.6	5.7	53

27	There is not enough security at my work place to safely permit discussion of family and sexual violence with people who use violence.	15.1	34	11.3	37.7	1.9	53
28	I am afraid of offending patients if I ask about their abusive behaviour.	5.9	33.3	13.7	33.3	13.7	51
29	When challenged, people who use violence frequently direct their anger toward health care providers.	21.2	38.5	9.6	26.9	3.8	52
30	I feel there are ways of asking about violent behaviour without placing myself at risk.	18.9	58.5	13.2	5.7	3.8	53
31	I feel I can effectively discuss issues of family and sexual violence with a patient who uses violence.	20.8	35.8	26.4	13.2	3.8	53
32	I feel I can discuss issues of violence and abuse with a people who use violence without further endangering the victim.	13.2	43.4	28.3	9.4	5.7	53
33	I feel it is best to avoid dealing with the people who use violence out of fear and concern for the victim's safety.	11.3	24.5	13.2	34	17	53
34	There is no way to ask people who use violence about their behaviours without putting the victims in more danger	5.7	18.9	20.8	35.8	18.9	53
35	I am afraid if I talk to the people who use violence, I will increase risk for the victim.	13.2	26.4	17	30.2	13.2	53

References

Allen, N. E., Lehrner, A., Mattison, E., Miles, T. & Russell A. (2007). Promoting systems change in the health care response to domestic violence. *Journal of Community Psychology, 35*(1),103-120. doi: 10.1002/jcop.20137

Al-Natour, A., Gillespie, G. L., Felblinger, D., & Wang, L. L. (2014). Jordanian nurses' barriers to screening for intimate partner violence. *Violence Against Women, 20*(12), 1473-1488. doi: 10.1177/1077801214559057

Amnesty International (2006). *Papua New Guinea: Violence Against Women: Not Inevitable, Never Acceptable!,* Port Moresby, Papua New Guinea.

Angus, J. E., & Clark, A. M. (2012). Using critical realism in nursing and health research: promise and challenges. *Nursing Inquiry, 19*(1),1-3. doi:10,1111/j.1440-1800.2011.00580x

Assante, A., & Hall, J. (2011). *A Review of Health Leadership and Management Capacity in Papua New Guinea.* Human Resources for Health Knowledge Hub, Sydney, University of New South Wales, Sydney.

Australian South Pacific Assocition for Basic and Adult Education and PNG Education Advocacy Network (2011). *PNG Education Experience Survey and Literacy Assessment: A Report on 5 Provinces: New Ireland, NCD, Chimbu, Sandaun & Gulf*. ASPBAE Autralia Ltd. Canberra, Australia.

Bacchus, L., Mezey, G., & Bewley, S. (2003). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health & Social Care in the Community, 11*(1), 10-18.

Baig, A. A., Ryan, G. W., & Rodriguez, M. A. (2012). Provider barriers and facilitators to screening for intimate partner violence in Bogota, Colombia. *Health Care for Women Inernational, 33*(3), 250-261. doi: 10.1080/07399332.2011.646368

Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., . . . Cronholm, P. (2014). Primary care-based interventions for intimate partner violence: A systematic review. *American Journal of Preventative Medecine, 46*(2), 188-194. doi: 10.1016/j.amepre.2013.10.001

Bannister,P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative Methods in Psyhcology: A Research Guide*. Buckingham, Open Press University, Buckinghamshire.

Beccaria, G., Beccaria, L., Dawson, R., Gorman, D., Harris, J. A., & Hossain, D. (2012). Nursing student's perceptions and understanding of intimate partner violence. *Nurse Education Today*. doi: 10.1016/j.nedt.2012.08.004

Bergin, M., Wells, J. G., & Owen, S. (2010). Relating realist methodology to issue of gener and mental health. *Journal of Psychiatric and Mental Health Nursing*, 17, 442-451. doi: 10.1111/j.1.365-2850.2010.01539x

Beynon, C. E., Gutmanis, I. A., Tutty, L.M., Wathen, N. & MacMillan, H. (2012). Why phsycians and nurses as (or don't) about partner violence: A qualitative analysis. *BMC Public Health, 12*, 473. doi: 10.1186/1471-2458-12-473

Bhandari, S., Bullock, L. F., Anderson, K. M., Danis, F. S., & Sharps, P. W. (2011). Pregnancy and intimate partner violence: how do rural, low-income women cope? *Health Care for Women International, 32*(9), 833-854. doi: 10.1080/07399332.2011.585532

Biesta, G. (2010) Pragmatism and the philosophical foudnations of mixed methods research. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp. 1-41). Thousand Oaks, Sage Publications.

Boyle, A., & Jones, P. B. (2006). The acceptibility of routine inquiry about domestic violence towards women: a survey in three healthcare settings. *British Journal of General Practice, April*.

Brownbridge, D. A., Taillieu, T. L., Tyker, K. A., Tiwari, A., Chan, K. L., & Santos, S. C. (2011). Pregnancy and intiamte partner violence: Risk factors, severity and health effects. *Violence Against Women, 17*(7), 858-881. doi: 10.1177/1077801211412547

Buchanan,-Aruwafu, H., Akuani, F., Kupe, F., Kawage, T., Sapak, K., Amos, A, ... Couch, M. (2010) *Behavioural Surveillance Research in Rural Development Enclaves in Papua New Guinea: A Sutdy with WR Carpenters Workforce*. National Research Institute,Special Publication No. 59. Boroko, National Research Institute.

Butcher, K., Kaybryn, J., & Lepani, K. (2016). Independent Formative Evaluation of Family Support Centres in Papua New Guinea. Victoris, IOD PARC.

Cammack, D. (2009). *Chronic Poverty in Papua New Guinea* Chronic Poverty Research Centre: Working Paper No. 2008-09. doi.org/10.2139/ssrn.1755079

Campbell, J., Jones, A. S., Dienerman, J., Kun, J., Schollenberger, J., O'Campo, P., … Wynne, C. (2002). Intimate partner violence and physical health consequences. *Arch Intern Med, 162*, 1157-1163.

Carbone-Lopez, K., Kruttschnitt, C., & Macmillan, R. (2006). Patterns of intimate partner violence and their associations with physical health, psycholgoical distress, and substance use. *Public Health Reports, 121*(July-August), 11.

Caspar, R. & Peytcheva, E. (2011), XI Prestesting. In *Cross-Cultural Survey Guidelines*. Retrieved from http://ccsg.isr.umich.edu/pretesting.cfm [3 September 2013].

Cattaneo, L. B., & Chapman, A. R. (2011). Risk assessment with victims of intimate partner violence: investigating the gap between research and practice. *Violence Against Women, 17*(10), 1286-1298. doi: 10.1177/1077801211424477

Chambliss, L. R. (2008). Intimate partner violence and its implication for pregnancy. *Clinical Obstetrics and Gynecology, 51*(2), 385-397.

Chan, K. L. (2011) . Gender differences in self-reports of initimate partner violence. A review. *Aggression & Violent Behaviour, 16*(2), 167-165. doi.org/10.1016/j.avb.2011.02.008

Chapin, J. R., Coleman, G., & Varner, E. (2011). Yes we can! Improving medical screening for intimate partner violence through self-efficacy. *Journal of Injury & Violence Research, 3*(1), 19-23. doi: 10.5249/jivr.v3i1.62

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London, Sage publications.

Chattier, P., & Tararia, A. (2014). A woman should be beaten if she deserves punishment: conversations with men and women in Fiji and PNG. *ANU In Breif SSGN*, 2. Canberra, Australian National Univesity.

Chibber, K. S., Krishnan, S. & Minkler, M. (2011). Physician practices in response to intimate partner violence in Southern India: Insights from a qualitative study. *Women & Health, 51*(2), 168-185.

Christ, T. W. (2013). The worldview martix as a strategy when designing mixed methods research. *International Journal of Multiple Research Approaches, 7*(1), 9.

Christensen, L., Johnson, R., & Turner, L. A. (2011). *Research Methods, Design and Analysis.* (11th ed.). Boston ,Allyn & Bacon.

Christofides, N. J., & Silo, Z. (2005). How nurses' experiences of domestic violence influence service provision: Study conducted in North-West province, South Africa. *Nursing and Health Sciences, 7*(1), 9-14. doi: 10.1111/j.1442-2018.2005.00222.x

Coker, A. L. (2004). Primary prevention of intimate partner violence for women's health: a response to Plichta. *Jounral of Interpersonal Violence, 19*(11), 1324-1334. doi: 10.1177/0886260504269686

Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to screening for intimate partner violence: a mixed-methods study of providers in family planning clinics. *Perspective on Sexual and Reprouctive Health, 42*(4), 236-243. doi: 10.1363/4223610

Commonwealth of Australia (2012). *Responding to Crisis: Evaluation of the Australian Aid Program's Contribution to the National HIV Response in Papua New Guinea, 2006-2010.* Canberra, Australian Agency for International Development.

Connelly, J. (2007). Evaluating complex public health interventions: theory, methods and scope of realist enquiry. *Journal of Evaluation and Clinical Practice, 13*, 935-941

Cook, S. L., & Goodman, L. A. (2006). Beyond frequency and severity: development and validation of the brief coercion and conflict scales. *Violence Against Women, 12*(11), 1050-1072. doi: 10.1177/1077801206293333

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Rsearch 3e: Techniques and Procdures for Develping Grounded Theory*. Sage Publications Thousand Oaks, Sage Publications.

Creswell, J. W. (2010). Mapping the Deceloping Landscape of Mixed Methods Research. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp. 1-41). Sage Publications, Thousand Oaks.

Creswell, J. W., Klassen, A. C., PLano Clark, V. L, & Clegg Smith, K. (2011). *Best Practices for Mixed Methods Research in the Health Sciences*. Bethesda, Office of Behavioural and Social Sciences Research: National Institute of Health.

Creswell, J. W. (2014). *Research Design: International Student Edition: Qualitative, Quantitative and Mixed Methods Approaches* (4th ed). Thousand Oaks, Sage Publciations.

Dalhberg, L. L., & Krug, E. G. (2002). Violence – a gloabal public health problem. In Krug, E., G., Dahlberg, L. L. Mercy, J, A, Zwi, A. B. & Lozano, R. (2002). *The World Report on Violence and Health*. World Health Organization, Geneva.

Davis, R. E., & Harsh, K. E. (2001). Confronting barriers to universal screening for domestic violence. *Journal of Professional Nursing, 17*(6), 313-320. doi: 10.1053/jpnu.2001.28181

D'Avolio, D. A. (2011). System issues: challenges to intimate partner violence screening and intervention. *Clinical Nursing Research, 20*(1), 64-80. doi: 10.1177/1054773810387923

Davy, C. P., & Patrickson, M. (2012). Implementation of evidence-based healthcare in Papua New Guinea. *International Journal of Evidence Based Healthcare, 10*(4), 361-368. doi: 10.1111/j.1744-1609.2012.00294.x

DeBoer, M. I., Kothari, R., Kothari, C., Koestner, A. L., & Rohs, T., Jr. (2013). What are barriers to nurses screening for intimate partner violence? *Journal of Trauma Nursing, 20*(3), 155-160; quiz 161-152. Doi: 10.1097/JTN.0b013e3182a171b1

De Forge, R., & Shaw, J. (2012). Back- and fore-grounding ontology: exploring the linkages between critical realism, pragmatism and methodologies in health and rehabilitation science. *Nursing Inquiry, 19*(1), 13.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., . . . Garcia-Moreno, C. (2011). Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine 73*(1), 79-86. doi: 10.1016/j.socscimed.2011.05.006

Doyle, K. Hungerford, C. & Cruikshank, M. (2014). Reviewing tribunal cases and nurses behaviour: putting empathy back into nurse education with Bloom’s taxonomy. *Nurse Education Today, 37*(7). doi: 10.1016/j.nedt.2014.02.004

Edwards, J., & Sanderson G. (2015*). Feasibility study for private sector counselling service in PNG*. Prepared for the World Bank Group, International Finance Corporation and the Papua New Guinea Business Coalition for Women, Port Moresby.

Efe, S. Y., & Taşkin, L. (2012). Emergency nurses' barriers to intervention of domestic violence in Turkey: A qualitative study. *Sexuality and Disability, 30*(4), 441-451. doi: 10.1007/s11195-012-9269-1

El-Bassel, N., Gilbert, L., Wu, E., Chang, M., Gomes, C., Vinocur, D., & Spevack, T. (2007). Intimate partner violence prevalence and HIV risks among women receiving care in emergency departments: implications for IPV and HIV screening. *Emergency Medicine Journal, 24*(4), 255-259. doi: 10.1136/emj.2006.041541

Elder Vass, D. (2010). *The Causal Power of Social Structures: Emergence, Structure and Agency*. Cambridge, Univesity Press.

Elo, S., Kaarlainen, M., Kanste, O., Polkki, T., Utriainen, K., &Kyngas, H. (2014) *Qualitative content analysis: a focus on trustworthiness*. SAGE Open, Jan-Mar, 1-10. doi:1011747/2158244014522633

Ellsberg, M. & Heise, L. (2005). *Researching Violence against Women: A Practical Guide for Researchers and Activists*, Washington DC, World Health Organization, PATH.

Ellsberg, M., Jansen, H,. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women’s physical and mentalhealth in the WHO multi-country study on women’s health and domestic violence: an observational study. *The Lancet, 371*(5), 1165-72.

Escriba-Aguir, V., Ruiz-Perez, I., Montero-Pinar, M. I., Vives-Cases, C., Plazaola-Castano, J., & Martin-Baena, D. (2010). Partner violence and psychological well-being: Buffer of indrect effect of social support. *Psychological Medicine, 72*, 383-389. doi:0033-3174/10/7204-0383

Etikan, I, Msa, S.A., &Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics,* 5,1, pp1-4. Doi: 10.11648/j.ajtas.20160501.11

Eves, R. (2006). *Exploring the Role of Men and Masculinities in Papua New Guinea in the 21st century. How to address violence in ways that generate empowerment for both men and women*. Sydney, Caritas Australia.

Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., … Taket, A. (2009). How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment, 13*(16). doi: 10.3310/hta13160

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflxivity in research practice. *Qualitative Research, 2*(2), 209-230.

Finlay, L., & Gough., B. (2003). *Reflexivity: a Practical Guide for Researchers in Health and Social Sciences*. Oxford, Blackwell Science.

Fowler, F. J. (2009). *Survey Research Methods. Fourth Edition*. Sage Publications, Thousand Oaks.

Fulu, E., Warner, X., Miedema, S. Jewkes, R., Roselli, T., & Lang, J. (2013). *Why Some Men Use Violence Against Women and How Can We Prevent It? Quantitative Findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific*. Bangkok: UNDP, UNFPA, UN Women and UNV;.

Furniss, K., McCaffrey, M., Parnell, V., & Rovi, S. (2007). Nurses and Barriers to Screening for Intimate Partner Violence. *Journal of Maternal Child Nursing, 4*(1), 238-243.

Ganster-Briedler, M. (2010). Gender-based violence and the impact on women's health and well-being in Papua New Guinea. *Contemporary PNG Studies: DWU Research Journal, 13*.

García-Moreno, C. (2002). Dilemmas and opportunities for an appropriate health-service response to violence against women. *The Lancet, 359* (9316), 1509-1514. doi: 10.1016/s0140-6736(02)08417-9

Garcia-Moreno, C., Jansen, H., A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Vioelnce against Women*: *Initial Results on Prevalence, Health Outcomes and Womens Responses*. Geneva, World Health Organization.

Gerber, M. R., Leiter, K. S., Hermann, R. C., & Bor, D. H. (2005). How and why community hospital clinicians document a positive screen for intimate partner violence: a cross-sectional study. *BMC Family Practice, 6*, 48. doi: 10.1186/1471-2296-6-48

Greene, J. C. (2006). Toward a methodology of mixed methods social inquiry. *Research in the Schools, 13*(1), 93-99.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a coceptual framework for mixed-method evaluation designs. *Education Evaluation and Policy Analysis, 11*(3), 255-274

Guillery, M. E., Benzies, K. M., Mannion, C., & Evans, S. (2012). Postpartum nurses' perceptions of barriers to screening for intimate partner violence: a cross-sectional survey. *BMC Nursing, 11*(2). doi: 10.1186/1472-6955-11-2

Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health, 7*(12). doi: 10.1186/1471-2458-7-12

Haj-Yahia, M., Sousa, C., Alnabilsy, R., & Elias, H. (2015). The influence of Palestinian physicians' patriarchal ideology and exposure to family violence on their beliefs about wife beating. *Journal of Family Violence, 30*(3), 263-276. doi: 10.1007/s10896-015-9671-4

Hammar, L. (2007). Epilogue: Homegrown in PNG - Rural response to HIV and AIDS. *Oceania, 77*(1), 72.

Harvey-Jordan, S., & Long, S. (2001). The process and the pitfalls of semi-structured interviews. *Community Practitioner, 74*(6), 219.

Harwood, L., & Clark A. M. (2012). Understanding health decisions using critical reaslism: Home -dialysis decision-making during chronic kidney disease. *Nursing Inquiry, 19*(1) doi: 10.1111/j.1440-1800.2011.00575.x

Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., . . . Gunn, J. (2013). Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. *The Lancet*. (April) doi: 10.1016/s0140-6736(13)60052-5

Heise, L., Pitanguy, J. & Germain, A.. (1994). *Violence Against Women: The Hidden Health Burden.* World Bank Discussion Papers 255. The World Bank, Washington DC.

Hermekns, A-K. (2012). Becoming Mary: Marian devotion as a solution to gender-based violence in urban PNG. In Jolly, M., Steward, C & Brewer, C. (eds). *Engendering Violence in Papua New Guinea*. (pp. 137-162) Canberra, ANU E Press.

Hinton, R., & Earnest, J. (2010). The right to health: Overcoming inequalities and barriers to women's health in Papua New Guinea. *Women's Studies International Forum, 33*(3), 180-187. doi: 10.1016/j.wsif.2009.12.006

Hinton, R., & Earnest, J. (2011). Assessing women's understandings of health in rural Papua New Guinea: Implications for health policy and practice. *Asia Pacific Viewpoint, 52*(2), 178-193. doi: 10.1111/j.1467-8373.2011.01449.x

Howes, S., Mako, A. A, Swan, A., Walton, G., Webster, T., & Wiltshire, C. (2014). *A Lost Decade? Service Delivery and Reforms in Papua New Guinea 2002 – 2012*, Canberra, The National Research Institute and the Development Policy Centre.

Hukula, F. (2012). Conversations with convicted rapists. In Jolly, M., Steward, C & Brewer, C. (eds). *Engendering Violence in Papua New Guinea* (pp. 197-212). Canberra, ANU E Press.

Husso, M., Virkki, T., Notko, M., Holma, J., Laitila, A., & Mantysaari, M. (2012). Making sense of domestic violence intervention in professional health care. *Health & Social Care in the Community, 20*(4), 347-355. doi: 10.1111/j.1365-2524.2011.01034.x

Jacobsen, K. H. (2012). *Introduction to Health Research Methods: A Practical Guide*. Sudbury, Jones & Bartlett Learning.

Jaffee, K. D., Epling, J. W., Grant, W., Ghandour, R. M., & Callendar, E. (2005). Physician-identified barriers to intimate partner violence screening. *Journal of Womens Health, 14*(8), 713-720. doi: 10.1089/jwh.2005.14.713

Janssen, P. (2006). Assessment for intimate partner violence: Where do we stand? *Journal of the American Board of Family Practice*, 413-415.

Jayasuriya, R., Whittaker, M., Halim, G. & Matineau, T. (2012). Rural health workers and their work environment: the role of inter-personal factors on job satisfaction of nurses in rural Papua New Guinea. *Health Services Research, 12*, 12.

Jayatilleke, A. C., Yoshikawa, K., Yasuoka, J., Poudel, K. C., Fernando, N., Jayatilleke, A. U., & Jimba, M. (2015). Training Sri Lankan public health midwives on intimate partner violence: a pre- and post-intervention study. *BMC Public Health, 15*, 331. doi: 10.1186/s12889-015-1674-9

Jina, R., Jewkes, R., Christofides, N., & Loots, L. (2014). A cross-sectional study on the effect of post-rape training on knowledge and confidence of health professionals in South Africa. *International Jounral of Gynaecology and Obstetrics, 126*(2), 187-192. doi: 10.1016/j.ijgo.2014.02.011

Jeweks, R. Sen, P., & Garcia-Moreno, C. (2002) Sexual Violence. In Krug, E.G., Dahlberg,L.L., Mercy, A.J. Zwi, A.B. & Lozano, R. (Eds) *The World Report on Violence and Health*. Geneva, World Health Organization.

John, I. A. & Lawoko, S. (2010). Assessment of the structural validty of the Domestic Violence Healthcare Provider's Survey questionnaire using a Nigerian sample. *Journal of Injury & Violence Research, 2*,2,75-83. doi: 10.5249/jivr.v2i2.41

John, I. A., Lawoko, S., & Svanström, L. (2011). Screening for intimate partner violence in healthcare in Kano, Nigeria: Extent and determinants. *Journal of Family Violence, 26*(2), 109-116. doi: 10.1007/s10896-010-9348-y

Johnson, M. P. (2006). Conflict and control: Gender symmetry and asymmetry in domestic violence. *Violence Against Women, 12*(11), 1003-1018. doi: 10.1177/1077801206293328

Johnson, R. B., & Onwuegbuzie, A. J. (2004) Mixed methods research: A research paradigm whose time has come. *Education Researchers, 33* (7) 14-26.

Johnson, M., P., Onwuegbuzie, A. J., & Turner, L. (2007) Toward a defintion of mixed methods research. *Journal of Mixed Methods Research, 1*,112-133.

Johri, M., Morales, R. E., Boivin, J. F., Samayoa, B. E., Hoch, J. S., Grazioso, C. F., … Arathoon, E. G. (2011). Increased risk of miscarriage among women experiencing physical or sexual intimate partner violence during pregnancy in Guatemala City, Guatemala: cross-sectional study. *BMC Pregnancy Childbirth, 11*, 49. doi: 10.1186/1471-2393-11-49

Jolly, M. (2012). Introduction – Engendering Violence in Papua New Guinea: Persons, Power and Perilous Transformations. In Jolly, M., Steward, C & Brewer, C. (eds). *Engendering Violence in Papua New Guinea* (pp. 1-46). Canberra, ANU E Press.

Joyner, K., & Mash, B. (2012). A comprehensive model for intimate partner violence in South African primary care: action research. *BMC Health Services Research, 12*, 399. doi: 10.1186/1472-6963-12-399

Kak, N., Burkhalter, B., & Cooper, M. (2001). *Measuring the Competence of Healthcare Providers. Operations Research Issue Paper, 2*(1), Bethesda, Quality Assuranace Project, US Agency for International Development.

Kavanamur, D., Okole, H., Manning, M., & Levantis, T. (2004). *Understanding Reform in Papua New Guinea: An Analytical Evaluation,* Port Moresby, Global Development Network.

Kaye, D. K., Mirembe, F., & Bantebya, G. (2005). Perceptions of health care providers in Mulago hospital on prevention and management of domestic violence. *African Health Sciences, 5*(4), 315-318.

Kiely, M., El-Mohandes, A. A., El-Khorazaty, M. N., Blake, S. M., & Gantz, M. G. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. *Obstet Gynecol, 115*(2 Pt 1), 273-283. doi: 10.1097/AOG.0b013e3181cbd482

Kilpatrick, D. G. (2004). What is violence against women: defining and measuring the problem. *Journal of Interpersonal Violence, 19*(11), 1209-1234. doi: 10.1177/0886260504269679

Kirst, M., Zhang, Y. J., Young, A., Marshall, A., O'Campo, P., & Ahmad, F. (2012). Referral to health and social services for intimate partner violence in health care settings: a realist scoping review. *Trauma Violence Abuse, 13*(4), 198-208. doi: 10.1177/1524838012454942

Kothari, C. L., & Rhodes, K. V. (2006). Missed opportunities: Emergency department visits by police-identified victims of intimate partner violence. *Annals of Emergency Medicine, 47*(2), 190-199. doi: 10.1016/j.annemergmed.2005.10.016

Koistinen, I. & Holma, J. (2015). Finish health care professionals' views of patients who experience family violence. *SAGE Open, Jan –Mar*, 1-10. doi: 10.1177/2158244015570392

Koziol-McLain, J., Garrett, N., Fanslow, J., Hassall, I., Dobbs, T., Henare-Toka, T. A., & Lovell, V. (2010). A randomized controlled trial of a brief emergency department intimate partner violence screening intervention. *Annals of Emergency Medicine, 56*(4), 413-423 e411. doi: 10.1016/j.annemergmed.2010.05.001

Krantz, G., Phuong, T. V., Larsson, V., Thuan, N. T. B., & Ringsberg, K. C. (2005). Intimate partner violence: Forms, consequences and preparedness to act as perceived by healthcare staff and district and community leaders in a rural district in northern Vietnam. *Public Health, 119*(11), 1048-1055. doi: 10.1016/j.puhe.2005.03.015

Krug, E., G., Dahlberg, L. L. Mercy, J, A, Zwi, A. B. & Lozano, R. (2002). *The World Report on Violence and Health*. World Health Organization*, Geneva*.

Kulkarni, S. J., Bell, H., & Rhodes, D. M. (2012). Back to basics: Essential qualities of services for survivors of intimate partner violence. *Violence Against Women, 18*(1), 85-101. doi: 10.1177/1077801212437137

Kwako, L. E., Glass, N., Campbell, J., Melvin, K. C., Barr, T., & Gill, J. M. (2011). Traumatic brain injury in intimate partner violence: a critical review of outcomes and mechanisms. *Trauma Violence Abuse, 12*(3), 115-126. doi: 10.1177/1524838011404251

Laisser, R.M., Lugina, H. I., Lindmark, G., Nystrom, L., & Emmelin, M. (2009). Striving to make a difference: Health care worker experiences with intimate partner violence clients in Tanzania. *Health Care for Women International, 30*,1-2, 64-78.

Laisser, R. M., Nystrom, L., Lindmark, G., Lugina, H. I., & Emmelin, M. (2011). Screening of women for intimate partner violence: a pilot intervention at an outpatient department in Tanzania. *Global Health Action, 4*, 7288. doi: 10.3402/gha.v4i0.7288

Lakhani, S., & Willman, A. M. (2014). *Trends in crime and violence in Papua New Guinea*. World Bank, Washington, DC.

Lambert, C., Jomeen, J., & McSherry, W. (2010). Reflexivity: a review of the literature in the context of midwifery research. *British Jounral of Midwifery Education, 18*(5), 321-326.

Law Reform Commission of Papua New Guinea. (1992) *Final Report on Domestic Violence: Report No. 14*. Boroko: Papua New Guinea.

Laughon, K., Gielen, A. C., Campbell, J. C., Burke, J., McDonnell, K. & O'Campo, P. (2007). The relationship among sexually transmitted infection, depression and lifetime violence in a sample of predominantly African American women. *Research in Nursing & Health, 30*(4), 413-428 doi: 10.1002/nur.20226

Lawoko, S., Sanz, S., Helstron, L. & Castren, M. (2012). Assessing the structural and concurrent validity of a shortened version of the Domestic Violence Healthcare Providers' Survey Questionnaire for use in Sweden. *Psychology, 3*(2), 183-191. doi: 10.4236/psych.2012.32027.

Lawoko, S., Mutto, M. & Guwattude, D. (2012). Piloting the Domestiv Violence Healthcare Providers' Survey for use in Uganda: Testing factorial structure and reliability. *Psychology, 3*(11), 947-952

Leech, N. L., (2010). Interviews with the early developers of mixed methods research. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp 1-41). Thousand Oaks, Sage Publications.

Lepani, K. (2007). Sovasova and the Problem of Sameness: Convergin Interpretive Frameworks fo Making Sense of HIV and AIDs in the Trobriand Islands. *Oceania, 77*(1), 17.

Leppakoski,T., Flinck, A., & Paavilainen, E. (2014). Assessing and enhancing health care providers' response to domestic violence. *Nurse Research Practice*, *2014*. doi: 10.1155/2014/759682

Lewis, I., Maruia, B., Mills, D., & Walker, S. (2008). *Final Report on Links Beween Violence Against Women and the Transmission of HIV in 4 Provinces of PNG*. Port Moresby, University of Canberra, Australia and National HIV/AIDs Support Program.

Lo Fo Wong, S., Wester, F., Mol, S., & Lagro-Janssen, T. (2007). "I am not frustrated anymore". Family doctors' evaluation of a comprehensive training on partner abuse. *Patient Educationand Counselling, 66*(2), 129-137. doi: 10.1016/j.pec.2006.12.013

Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: a persepctive. *The Qualitative Report, 18*(65), 1-5.

Luoma, M. (2006). *Increasing the Motivation of Health Care Workers. Capacity Project Knowledge Sharing. Technical Brief* 7, Chapel Hill ,The Capacity Project Intrahealth International.

MacIntyre, M, (2012). Gender violence in Melanesia and the problem of the millennium development goal No. 3. In Jolly, M., Steward, C & Brewer, C. (eds). *Engendering Violence in Papua New Guinea*. (pp. 239-266). Canberra, ANU E Press.

MacMillan, H. L., & Feder, G. (2012). Screening women for intimate partner violence: Comments and Responses. *Annals of Internal Medicine, 159*(9), 676-7.

MacMIllan, H. L., Wathen, C. N., Jamieson, E., Boyle, M., Shannon, H. S., Ford-Gilboe, M., Worster, A., Lent, B., Coben, J.H., Campbell, J. C., & McNutt, L-A. (2009). Screening for Intimate Partner Violence in Health Care Settings: A Randomised Trial. *Journal of American Medical Association, 302*(5), 493-501.

Maina, G., & Majeke, S. (2008). Intimate partner violence in Kenya: expanding healthcare roles. *Nursing Standard, 22*(35), 35-39. doi: 10.7748/ns2008.05.22.35.35.c6533

Maina, G. M. (2009). Emergency medical response to intimate partner violence in Kenya. *Nursing Standard, 23*(21), 35-39. doi: 10.7748/ns2009.01.23.21.35.c6766

Maiuro, R. D., Vitaliano, P. P., Snugg, N. K., Thompson, D. C., Rivara, F. P., & Thompson, R., S. (2000). Development of a health care provider survey for domestic violence: Psychometric properties. *American Journal of Preventative Medicine, 19*(4), 8.

Malpass, A., Sales, K., Johnson, M., Howell, A., Agnew-Davies, R., & Feder, G. (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. *British Journal of General Practice, 64*(620), e151-158. doi: 10.3399/bjgp14X677527

Martins, H., Assunção, L., Caldas, I., & Magalhães, T. (2014). Victims of Intimate Partner Violence. The Physician's Intervention in the Portuguese National Health Service. *Journal of Family Violence, 29*(3), 315-322. doi: 10.1007/s10896-014-9586-5

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp. 1-41). Thousand Oaks, California, Sage Publications.

McEvoy, P. & Richards, D. (2006). A cricital realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, 11, 66. doi:10.1177/1744987106060192

McFarlane, J., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006). Secondary Prevention of Intimate Partner Violence: A Randomised Controlled Trial. *Nursing Research, 55*(1), 52-61.

McPherson, N. (2012). Black and blue: Shades of violence in West New Britain, PNG. In Jolly, M., Steward, C & Brewer, C. (eds). *Engendering Violence in Papua New Guinea* (pp. 47-72), ANU E Press, Canberra.

Mechanic, M. B., Weaver, T. L., & Resick, P. A. (2008). Mental health consequences of intimate partner abuse: a multidimensional assessment of four different forms of abuse. *Violence Against Women, 14*(6), 634-654. doi: 10.1177/1077801208319283

Medecins sans Frontieres (2010). *Hidden and Neglected: the Medical and Emotional Needs of Surivors of Family and Sexual Violence in Papua New Guinea*. MSF, Port Moresby.

Miles, M. B., Huberman, A. M., & Saldana J. (2014). *Qualitative Data Analysis: A Methods Sourcebook, 3rd Edition*. Thousand Oaks, Sage Publications.

Mitchell, V., Parekh, K. P., Russ, S., Forget, N. P., & Wright, S. W. (2013). Personal experiences and attitudes towards intimate partner violence in healthcare providers in Guyana. *International Health, 505*(4), 273-279. doi: 10.1093/inthealth/iht030

Moreira Sda, N., Galvao, L. L., Melo, C. O., & de Azevedo, G. D. (2008). Physical violence against women from the perspective of health professionals. *Rev Saude Publica, 42*(6), 1053-1059.

Mork, T., Andersen, P. T., & Taket, A. (2014). Barriers among Danish women and general practitioners to raising the issue of intimate partner violence in general practice: A qualitative study. *BMC Womens Health, 14*, 74. doi: 10.1186/1472-6874-14-74

Morris, I. P., & Somanathan A. (2011.) *Papua New Guinea (PNG) health workforce crisis : A call to action*. The World Bank: Washington D.C.

Morse, D. S., Lafleur, R., Fogarty, C. T., Mittal, M., & Cerulli, C. (2012). "They told me to leave": how health care providers address intimate partner violence. *Journal of the American Board of Famiyl Medicine*, *25*(3), 333-342. doi: 10.3122/jabfm.2012.03.110193

Morse, J. M. (2010). Procedures and practice of mixed method design: Maintaing control, rigour and complexity. In Tashakori, A. & C. Teddlie (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp 1-41). Thousand Oaks, Sage Publications.

Moyer, V. A. (2013). Screening for intimate partner violence and abuse of elderly and vulnerbale adults: US Preventative Services Task Force Recommendation Statement. *Annals of Internal Medicine, 158*, 10.

Nagata, A. L. (2006). Cultivating researcher self-reflexivity and voice using mindful inquiry in intercultural eduction. *Journal of International Communication, 9*, 135-154.

Nascimento, E. F. G. A., Ribeiro, A. P., & Souza, E. R. (2014). Perceptions and practices of Angolan health care professionals concerning intimate partner violence against women. *Cadernos de Saúde Pública, 30*(6), 1229-1238. doi: 10.1590/0102-311x00103613

Nastasi, B. K., Hitchcock, J.H., & Brown, L.M. (2010). An inclusive framework for conceptualising mixed methods design typologies: Moving toward fully integrated synergistic research models. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp 1-41). Thousand Oaks, Sage Publications.

Natan, M. B., & Rais, I. (2010). Knowledge and attitudes of nurses regarding domestic violence and their effect on the identification of battered women. *Jounral of Trauma Nursing, 17*(2), 112-117. doi: 10.1097/JTN.0b013e3181e736db

National Department of Health. (2011). *National Health Plan 2011-2020: Back to Basics*. Port Moresby, Government of Papua New Guinea.

National Department of Health. (2012). *Guidelines for Establishing Family Support Centres*. Port Moresby, Papua New Guinea.

National Department of Health. (2015a). *Sector Performance Annual Review*. Port Moresby, Government of Papua New Ginea.

National Department of Health. (2015b). *Country Progress Report on HIV. January 1, 2014- December 31, 2014*. Port Moresby, Government of Papua New Guinea.

National Department of Health. (2015c). *Tuberculosis Control Program. Annual Report 2014*. Port Moresby, Government of Papua New Guinea.

National Statistical Office. (2009.) *Papua New Guinea Demographic and Health Survey 2006. National Report*. Port Moresby: Government of Papua New Guinea.

National Statistical Office. (2011). *2009-2010 Household and Income Expenditure Surey Summary Tables*. Port Moresby: Government of Papua New Guinea.

National Statistical Office. (2015). *National Population & Housing Census 2011. Final Figures*. Port Moresby: Government of Papua New Guinea.

Nelson, H. D., Bougatos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force Recommendation. *Annals of Internal Medicine, 156*, 17.

Nicolaidis, C., Curry, M., & Gerrity, M. (2005). Health care workers' expectations and empathy toward patients in abusive relationships. *Journal of the Aerican Board of Family Practice, 18*(3), 159-165.

Niglas, K. (2010). The multidimensional model of research methodology: An integrated set of continua. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp 1-41). Thousand Oaks, California, Sage Publications.

Ntaganira, J., Muula, A. S., Siziya, S., Stoskopf, C., & Rudatsikira, E. (2009). Factors associated with intimate partner violence among pregnant rural women in Rwanda. *Rural Remote Health, 9*(3), 1153.

O'Cathain, A. (2010). Assessing the quality of mixed methods reseach: toward a comprehensive framework. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp 1-41). Thousand Oaks, Sage Publications.

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review. *Social Science and Medicine, 72*(6), 855-866. doi: 10.1016/j.socscimed.2010.12.019

Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work, 42*(2), 371-387. doi: 10.1093/bjsw/bcr064

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validty issue in mixed research. *Research in the Schools*, (*13*)1, 48-63.

O'Reilly, R., Beale, B., & Gillies, D. (2010). Screening and intervention for domestic violence during pregnancy care: A systematic review. *Trauma Violence Abuse, 11*(4), 190-201. doi: 10.1177/1524838010378298

Oxfam. (2010). *Violence Aagainst Women: A Review of Service Provision for Surivors of Family and Sexual Violence in National Capital District of Papua New Giunea*. Boroko, Papua New Guinea.

Papadakaki, M., Petridou, E., Kogevinas, M., & Lionis, C. (2013). Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. *BMC Medical Education, 13*(1). doi: 10.1186/1472-6920-13-46

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2004). *Realist Synthesis: an introduction. RMP Methods Paper 2/2004*, ESRC Research Methods Programme, University of Manchester.

Phelan, M. B. (2007). Screening for intimate partner violence in medical settings. *Trauma Violence Abuse, 8*(2), 199-213. doi: 10.1177/1524838007301221

Plichta, S. B. (2004). Intimate partner violence and physical health consequences: policy and practice implications. *Journal of Interpersonal Violence, 19*(11), 1296-1323. doi: 10.1177/0886260504269685

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice iImplications. *Trauma Violence Abuse, 8* (226). doi: 10.1177/1524838007301220

Pratt-Eriksson, D., Bergbom, I., & Lyckhage, E. D. (2014). Don't ask don't tell: Battered women living in Sweden encounter with healthcare personnel and their experience of the care given. *International Journal of Qualitative Studies Health Well-being, 9*, 23166. doi: 10.3402/qhw.v9.23166

Prosman, G.-J., Lo Fo Wong, S. H., & Lagro-Janssen, A. L. M. (2014). Why abused women do not seek professional help: a qualitative study. *Scandinavian Journal Caring Sciences, 28*(1), 3-11. doi: 10.1111/scs.12025

Ramachandran, D. V., Covarrubias, L., Watson, C., & Decker, M. R. (2013). How you screen is as important as whether you screen: A qualitative analysis of violence screening practices in reproductive health clinics. *Journal of Community Health*. doi: 10.1007/s10900-013-9690-0

Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G. (2012). Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *British Journal of General Practice, 62*(602), e647-655. doi: 10.3399/bjgp12X654623

Razee, H., Whittaker, M., Jayasuriya, R., Yap, L., & Brentnall, L. (2012). Listening to the rural health workers in Papua New Guinea – The social factors that influence their motivation to work. *Social Science & Medicine, 75*(5), 828-835. doi: http://dx.doi.org/10.1016/j.socscimed.2012.04.013.

Rees, K., Zweigenthal, V., & Joyner, K. (2014). Implementing intimate partner violence care in a rural sub-district of South Africa: a qualitative evaluation. *Global Health Action, 7*, 24588. doi: 10.3402/gha.v7.24588

Rhodes, K. V. (2012). Taking a fresh look at routine screening for intimate partner violene: What can we do about what we know? *Mayo Clinic Proccedings, 87*(5), 419-423. doi: 10.1016/j.mayocp,2012.02.06

Rhodes, K. V., Grisso, J. A., Rodgers, M., Gohel, M., Witherspoon, M., Davis, M., . . . Crits-Christoph, P. (2014). The anatomy of a community health center system-level intervention for intimate partner violence. *Journal of Urban Health, 91*(1), 107-121. doi: 10.1007/s11524-013-9816-9

Ritchie, M., Nelson, K., Wills, R., & Jones, L. (2013). Does training and documentation improve emergency department assessments ofdomestic violence victims? *Journal of Family Violence, 28*(5), 471-477. doi: 10.1007/s10896-013-9514-0

Roark, S. V. (2010). Intimate partner violence: screening and intervention in the health care setting. *Journal of Continuing Education in Nursing, 41*(11), 490-495; quiz 496-497. doi: 10.3928/00220124-20100601-02

Robinson, R. (2010). Myths and stereotypes: How registered nurses screen for intimate partner violence. *Jounral of Emergency Nursing, 36*, 572-576. doi: 0099-1767

Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry, 198*(3), 189-194. doi: 10.1192/bjp.bp.109.072389.

Rousch, K. (2011). Domestic violence screening: when will we get it right? *International Nursing Review, 59*, 115-116.

Ruiz-Perez, I., Plazaola-Castano, J., & Del Rio-Lozano, M. (2007). Physical health consequences of intimate partner violence in Spanish women. *European Journal of Public Health, 17*(5), 437-443. doi: 10.1093/eurpub/ckl280.

Sayer, A. (2000). *Realism and Social Science*. London: Sage Publications.

Schuler, S. R., Trang, Q. T., Ha, V. S., & Anh, H., T. (2011). Qualitative study of an operations research project to engage abused women, health providers, and communities in responding to gender-based violence in Vietnam. *Violence Against Women, 17*(11), 1421-1441. doi: 10.1177/1077801211433990

Scott, D. (2007). Resolving the quantitative–qualitative dilemma: a critical realist approach. *International Journal of Research & Method in Education, 30*(1), 3-17. doi: 10.1080/17437270701207694

Shamu, S., Abrahams, N., Temmerman, M., & Zarowsky, C. (2013). Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe. *Culture, Health & Sexuality:An International Journal for Research Intervention and Care*. doi: 10.1080/13691058.2012.759393

Short, L. M., Alpert, E., Harris, J. M., & Suprenant, Z. J. (2006). A tool for measuring physician readiness to manage intimate partner violence. *American Journal of Preventative Medicine, 30*(2). doi: 10.1016/j.amepre.2005.10.009

Sohani, Z., Shannon, H., Busse, J. W., Tikacz, D., Sancheti, P., Shende, M., & Bhandari, M. (2013). Feasibility of screening for intimate partner violence at orthopedic trauma hospitals in India. *Journal of Interpersonal Violence, 28*(7), 1455-1475. doi: 10.1177/0886260512468244

Sormanti, M., & Smith, E. (2010). Intimate partner violence screening in the emergency department: U.S. medical residents' perspectives. *International Quarterly of Community Health Education, 30*(1), 21-40. doi: 10.2190/IQ.30.1.c

Spangaro, J. M. (2007). The NSW Health routing screening for domestic violence program. *NSW Public Health Bulletin, 18*(5-6), 4.

Spangaro, J. M., Zwi, A. B., Poulos, R. G., & Man, W. Y. (2010). Who tells and what happens: disclosure and health service responses to screening for intimate partner violence. *Health and Social Care in the Community, 18*(6), 671-680. doi: 10.1111/j.1365-2524.2010.00943.x

Spangaro, J. B., Poulos, R. G., Zwi, A. B. (2011). Pandora doesn't live here anymore: Normalization of screening for intimate partner violence in Australian antenatal, mental health and substance abuse services. *Violence & Victims, 26*(1). doi: 10.1891/0886-6708.26.1.130

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., & Goslings, J. C. (2012). Barriers to screening for intimate partner violence. *Women Health, 52*(6), 587-605. doi: 10.1080/03630242.2012.690840

Sprague S., S., M., Madden, K., Swaleh, R., Goslings J., Petrisor, B. & Bhandari, M. (2013). Barriers to and facilitoars for screening women for intimate partner violence in surgical fracture clinics: a qualitative description approach. *BMC Musculoskeletal, 14*(122), 10.

Sprague, C., Hatcher, A. M., Woollett, N., & Black, V. (2015). How Nurses in Johannesburg address intimate partner violence in female patients:

Understanding IPV responses in low- and middle-income country health systems. *Journal of Interpersonal Violence*. doi: 10.1177/0886260515589929

Stayton, C. D., & Duncan, M. M. (2005). Mutable influences on intimate partner abuse screening in health care settings: a synthesis of the literature. *Trauma Violence Abuse, 6*(4), 271-285. doi: 10.1177/1524838005277439

Stenson, K. & Heinmer, G. (2008). Prevalence of experinces of partner violence among female health staff: Relevance to awareness and action when meeting abused women patients. *Women's Health Issues, 18*, 141-149. doi: 10.1016/j.whi.2007.12.003

Stockl, H., Hertlein, L., Himsl, I., Ditsch, N., Blume, C., Hasbargen, U., … Stockl, D. (2013). Acceptance of routine or case-based inquiry for intimate partner violence: a mixed method study. *BMC Pregnancy Childbirth, 13*, 77. doi: 10.1186/1471-2393-13-77

Sundborg, E. M., Saleh-Stattin, N., Wändell, P., & Törnkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence: A quantitative study in primary health care. *BMC Nursing, 11*(1), 1-11. doi: 10.1186/1472-6955-11-1

Taft, A. O'Doherty, L, Hegarty K, Ramsay, J., Davison, L., & Feder G. (2013). Screening women for intimate partner violence in healthcare settings (Review). *The Cochrane Library Issue 4*, The Cochrane Collaboration, John Wiley & Sons.

Taket, A. (2012). Responding to domestic violence in primary care. *British Medical Journal, 344*, e757-e757. doi: 10.1136/bmj.e757

Tashakori, A. & Teddlie, C. (2010). Overview of Contemporary Issues in Mixed Methods Research. In Tashakori, A. & Teddlie, C. (Eds.) *Sage Handbook of Mixed Methods In Social and Behavioral Research* (2nd Ed). (pp. 1-41). Thousand Oaks, Sage Publications.

The National Sex and Reproduction Research Team (1994). *National Study of Sexual and Reproductive Knowledge and Behaviour in Papua New Guinea, Monograph no. 10*. Goroka: Institute of Medical Research.

The World Bank. (2012). *Papua New Guinea - Country Gender Assessment for the Period 2011-2012*. Washington DC: World Bank.

The World Bank. (2014) . *Below the Glass Floor: The Analytical Review of Expenditure by Provincial Administrations on Front Line Rural Health* (Vol. 2). Washington DC: World Bank.

The World Bank (2015). *Data: Health Expenditure per Capita (current $USD)*. Available at: http://data.worldbank.org/indicator/SH.XPD.PCAP [accessed on 15 October 2015].

Theissen, J., Rumsey, M., & Homer, C. (2014) *Reproductive Health Training Unit Monitoring and Evaluation (M&E) Report*, World Health Organization Collaborating Centre for Nursing, Midwifery and Health, Sydney , University of Technology Sydney.

Thompson, R. S., Rivara, F. P., Thompson, D. C., Barlow, W. E, Snugg, N. K., Maiuro, R. D., & Rubanowice, D.M. (2000). Identification and management of domestic violence: A randomised trial. *American Journal of Preventative Medicine, 19*(4), 11.

Thurston, W. E., & Eisener, A. C. (2006). Successful integration and maintenance of screening for domestic violence in the health sector: moving beyond individual responsibility. *Trauma Violence Abuse, 7*(2), 83-92. doi: 10.1177/1524838005285915

Tiwari, A., Leung, W. C., Leung, T. W., Humphreys, J., Parker, B., & Ho, P. C. (2005). A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: an International Jounral of Obstetrics and Gynaecology, 112*(9), 1249-1256. doi: 10.1111/j.1471-0528.2005.00709.x.

Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: a systematic review. *Journal of Marital and Family Therapy, 37*(3), 355-369. doi: 10.1111/j.1752-0606.2009.00179.x

Toft, S., & Bonnell, S. (1985). *Marriage and domestic violence in rural Papua New Guinea. Occasional Paper, No. 18.,* Boroko, Law Reform Commission of Papua New Guinea.

Tower, L. E. (2006). Barriers in screening women for domestic violence: A survey of social workers, family practitioners, and obstetrician-gynecologists. *Journal of Family Violence, 21*(4), 245-257. doi: 10.1007/s10896-006-9024-4

Trabold, N. (2007). Screening for intimate partner violence within a health care setting:a systematic review of the literature. *Social Work in Health Care, 45*(1), 1-18. doi: 10.1300/J010v45n01_01

Tynan, A., Vallely, A., Kelly, A., Kupul, M., Neo, J., Naketrumb, R., … Hill, P. S. (2013). Sociocultural and individual determinants for motivation of sexual and reproductive health workers in Papua New Guinea and their implications for male circumcision as an HIV prevention strategy. *Huanm Resources for Health, 11*(1), 7. doi: 10.1186/1478-4491-11-7

UN General Assembly (2006). *In-depth study on all forms of violence against women: report of the Secretary-General*, 6 July 2006, A/61/123/Add.1.

United Nations Development Program (2015). *Human Development Report 2015*: *Work for Human Development*. New York.

United National Economic and Social Council. (1996) *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 1995/85*. Commission on Human Rights, Fifty-second session, Item 9 (a) of the provisional agenda, Geneva.

Usta, J., Antoun, J., Ambuel, B., & Khawaja, M. (2012). Involving the health care system in domestic violence: What women want. *Annals of Family Medicine, 10*(3), 213-220. doi: 10.1370/afm.1336

Vieira, E. M., Dos Santos, M. A., & Ford, N. J. (2012). Seizing an opportunity to help-knowledge and attitudes of doctors and nurses toward women victimized by intimate partner violence in Brazil. *Health Care for Women International, 33*(3), 228-249. doi: 10.1080/07399332.2011.646365

Vives-Cases, C., Ruiz-Cantero, M. T., Escriba-Aguir, V., & Miralles, J. J. (2011). The effect of intimate partner violence and other forms of violence against women on health. *Journal of Public Health, 33*(1), 15-21. doi: 10.1093/pubmed/fdq101

Walsh, D., & Evans, K. (2014). Critical realism: An important theoretical perspective for midwifery research. *Midwifery, 30*(1), e1-e6. doi: http://dx.doi.org/10.1016/j.midw.2013.09.002

Wardlow, H. (2007). Men's extramarital sexuality in rural Papua New Guinea. *American Jounral of Public Health, 97*(6), 1006-1014. doi: 10.2105/AJPH.2006.088559

Wathen, C. N., & MacMillan, H. L. (2003). Prevention of violence against women. *Canadian Medical Association. Journal, 169*(6), 582-584.

Wendt, E. K., Lidell, E. A., Westerstahl, A. K., Marklund, B. R., & Hildingh, C. I. (2011). Young women's perceptions of being asked questions about sexuality and sexual abuse: a content analysis. *Midwifery, 27*(2), 250-256. doi: 10.1016/j.midw.2009.06.008

Williston, C. J., & Lafreniere, K. D. (2013). "Holy cow, does that ever open up a can of worms": health care providers' experiences of inquiring about intimate partner violence. *Health Care for Women International, 34*(9), 814-831. doi: 10.1080/07399332.2013.794460

Wilson, J. M. G., & Jugner, G. (1968). Principles and practice of screening for disease. *Public Health Papers*, 34, Geneva, World Health Organization.

Wong, J. M., & Mellor, D. (2014). Initmate partner violence and womens health and wellbeing: Impacts, risks factors and resonse. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 46,* 2, 170-179.

World Health Organization. (2001). *Putting women First: Ethical and Safety Recommendationsfor Research on Domestic Violence against Women*. Department of Gender and Women’s Health, Family and Communtiy Health. World Health Organization, Geneva, Switzerland.

World Health Organization (2013a). *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner and Non-partner Sexual Violence*. Geneva.

World Health Organization (2013b). *Responding to Intimate Partner Vioelnce and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. Geneva.

Worth. H., R., J., Buchanan, H., Kelly, A., Amos, A., Kaitani, M., Browne, K.,… Taylor. (2012). *HIV and Human Resources Challenges in Papua New Guinea: An overview*. Human Resources for Health Knowledge Hub, Sydney, University of New South Wales.

Yeung, H., Chowdhury, N., Malpass, A., & Feder, G. S. (2012). Responding to domestic violence in general practice: a qualitative study on perceptions and experiences. *International Journal of Family Medincine, 2012*, 960523. doi: 10.1155/2012/960523

Zakar, R., Zakar, M. Z., & Kraemer, A. (2011). Primary health care physicians' response to the victims of spousal violence against women in Pakistan. *Health Care for Women International, 32*(9), 811-832. doi: 10.1080/07399332.2011.569042