ADAPTATION OF THE ABUSE ASSESSMENT SCREENING TOOL FOR MIDWIVES IN NORTHERN NIGERIA

BY

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STUDENT NUMBER: MSMAYI001

A THESIS SUBMITTED TO THE UNIVERSITY OF CAPE TOWN
In accordance with the requirements of

DOCTOR OF PHILOSOPHY IN NURSING

Department of Health and Rehabilitation Sciences,
Faculty of Health Sciences

UNIVERSITY OF CAPE TOWN

SUPERVISOR: PROFESSOR SINEGUGU DUMA

December 2018

DECLARATION

I, Ayishetu Uduoye Musa-Maliki, hereby declare that the work on which this thesis is based is my original work and that I have acknowledged through references all materials used in this thesis. I declare that neither the whole work, nor any part has been, is being, or is to be submitted for another degree in this or any other university.

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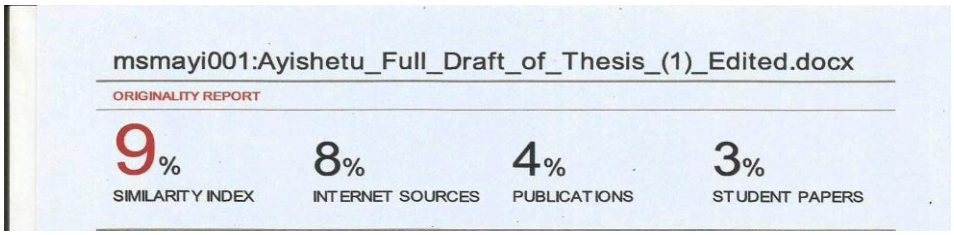

DEDICATION

I dedicate this thesis to my family for their massive support, love and patience during my PhD journey. Especially for caring for my six-month-old baby who I left behind in Nigeria in order to pursue my degree in South Africa. I pray that the Almighty Allah reward them abundantly.

ACKNOWLEDGEMENTS

I thank Almighty Allah for His blessings, protection, and for granting me good health throughout my PhD studies at the University of Cape Town, South Africa.

To Professor Sinegugu Duma, I say thank you for your advice, mentorship and guidance in the course of this research. Your prompt reading of work submitted and your constructive criticism helped me in accomplishing this study. I cannot thank you enough for securing accommodation for me in Durban and dedicating your energy and time to pick me up and drop me at the residence, for a period of two weeks. You are such a wonderful person and a rare gem. Know that you have a special place in my heart.

To Mrs Salega Tape of the Faculty of Health Sciences, thank you for your support and encouragement. Thank you especially for assisting me to get a refund of my money from an off-campus accommodation agent, when I no longer wanted the accommodation because of its unsafe location, and also in facilitating my acquiring an accommodation in a safe place in Cape Town.

My gratitude also goes to the management of Ahmadu Bello University, Zaria, for giving me TETFUND sponsorship and the opportunity to have an international experience for my PhD programme at the University of Cape Town, South Africa.

I want to appreciate the Department of Nursing Sciences, Ahmadu Bello University, Zaria, for believing in me and nominating me for the scholarship to study at the University of Cape Town. In particular, thank you Dr Saleh N Garba, my confidante and my Head of Department for the role played in actualising the TETFUND scholarship.

To my research participants, I say thank you for participating in this study, especially for screening pregnant women for IPV despite your tight schedules.

I thank the good friends that I made during this journey, who were always ready to pick me up and drop me at the airport and provided accommodation for the first few days before I settled down. I particularly thank Dr Khadijah Dauda, and Mrs Fawziya Fiji. Thank you Cape Town Muslim Prayer Group for your prayers and support in actualising this dream. Thank you Mr Eke Okechukwu for bringing up the idea of my studying in South Africa and your continuous encouragement.

To my brothers, Adam Musa, Ibrahim Musa, Abdulkareem Musa, Zakariya Musa and my sisters Hauwa Dauda, Rabiat Abdulmalik, Mariam Musa-Ajah, and Rahmat Musa, I say thank you and may Allah reward you all for your prayers, support and encouragement during this journey. I also want to appreciate my in-laws, the Afegbuas, Thank you.

To my loving mother Mrs Habiba Musa, thank you so much for your prayers, encouragement and taking care of my children in Nigeria, especially while I was away in South Africa. You were always there. Words cannot express the depth of my gratitude.

To my darling husband Dr Ahmadu Maliki, thank you for encouraging me to take up the programme in South Africa, despite knowing the inconveniences that my being away would cause you and our family. Also for always being there to provide constructive arguments and advice in refining my work. Thank you also for playing the role of mother to our children while I was away in Cape Town. Thank you very much, may Allah reward you.

To my loving children Fawziya Maliki, Humaida Maliki, Suad Maliki and Abdallah Maliki, thank you for being there and acting as a motivation for me to conclude my work whenever I became tired and felt like giving up. The sacrifices you endured in not being with your mother for so long encouraged me to go on.

LIST OF ACRONYMS AND ABBREVIATIONS

AAS	Abuse Assessment Screen
ABU	Ahmadu Bello University
ABUTH	Ahmadu Bello University Teaching Hospital
ACOG	American College of Obstetricians and Gynaecologists
ANC	Antenatal clinic
DVHSPSS	Domestic Violence Healthcare Provider Survey Scale
FGD	Focus group discussion
HITS	Hurts, Insults, Threatens and Screams at her
HIV	Human immunodeficiency virus
HPT	Human performance technology
IPV	Intimate partner violence
IPVAS	IPV Assessment Screen
NHREC	National Health Research Ethics Council
NMCN	Nursing and Midwifery Council of Nigeria
SDG	Sustainable Development Goal
UK	United Kingdom
US	United States
USA	United States of America
WHO	World Health Organization

ABSTRACT

The term ‘intimate partner violence’ (IPV) is employed in this study to denote the physical, sexual, economic, and psychological or other harm directed against a pregnant woman by her partner or spouse. It affects both pregnant women and their unborn children, as both may suffer serious health consequences. The purpose of this study is to investigate midwives’ current screening practice for IPV among pregnant women in a northern Nigerian hospital and to adapt the Abuse Assessment Screen (AAS) tool to aid midwives’ screening practice. Qualitative data were collected from midwives in the antenatal clinic of Ahmadu Bello University Teaching Hospital, Zaria, Nigeria, in four phases using a panel longitudinal design as a guide. In the first phase non-participant observation and individual face-to-face semi-structured interviews were conducted with ten participants using an interview guide. In phase two non-participant observation of the same participants took place as pregnant women were screened with the original AAS tool for two months, then a focus group discussion was conducted in phase three. Thematic data analysis was carried out in all phases using Yin’s five stages of analytical cycle and also guided by the conceptual framework of Wile’s human technology model. In phase four the original AAS tool was modified based on the findings of phases two and three. Five themes emerged in phase one and four in phase three after triangulation of data from phase two. It was found that routine screening for IPV is not practiced by midwives in the research setting as a result of various factors, some internal and others external to them. The midwives also faced several challenges that discourage screening of pregnant women for IPV. Their suggested solutions to these challenges were also incorporated into a modified version of the original AAS tool after analysing the data. Thereafter the modified tool was given to the same participants to use and to confirm its suitability for IPV screening in phase four, and a theme emerged. With adequate education and training the internal factors hindering midwives’ screening practice can be eliminated, while the external factors will need the intervention of hospital authorities to eliminate or mitigate their effects on screening.

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CHAPTER ONE: INTRODUCTION

1.1. Background to the study

Intimate partner violence (IPV) is a serious public health issue as well as a women's rights issue because it is a violation of women's fundamental rights (World Health Organization (WHO), 2013a). It has been identified as a major cause of mortality and disability globally (Ellsberg, 2006; O'Doherty *et al*., 2014). Yet IPV can be prevented and mitigated. The Centers for Disease Control and Prevention defines IPV as physical violence, sexual violence, stalking and psychological aggression or other coercive tactics by a current or former intimate partner to his or her spouse or partner (Breiding, Basile, Smith, Black, & Mahendra, 2015). Similarly, the World Health Organization defines IPV as any behaviour that causes physical, sexual or psychological harm, including aggressive, sexual, coercive and controlling behaviours to an intimate partner (either current or former spouse or partner) (WHO, 2013b), regardless of their marital status, nature of their sexual union, or whether they even engage in sexual intimacy (Saltzman, Fanslow, McMahon, & Shelley, 2002). The phrase 'intimate partner violence', although often used interchangeably with domestic violence by some authors, actually refers to a form of domestic violence. Domestic violence is broader because it is violence that occurs in the home or family, irrespective of whether those concerned share an intimate relationship or not (Gill, 2004). IPV can also be referred to as spousal abuse or women battering or partner violence (Feder et al., 2009; WHO, 2013b).

The different forms of violence mentioned in the above definitions can be broadly categorised as follows:

- Physical violence, which is the deliberate use of physical force to cause harm, injury, disability or death. This physical force may include pushing, grabbing, choking, punching, hitting, slapping, burning, use of a weapon or body strength against the victim.
- Sexual violence, which is the sexual act perpetrated or attempted by a person without consent from the victim. This includes forcefully engaging a victim in the sexual act or the use of alcohol or other drugs to achieve sexual submission.
- Psychological aggression, which is the use of verbal or non-verbal communication to dominate, humiliate or threaten a person, or harm the person emotionally. This could also include limited access to finances in the home.

- Stalking, which is a deliberate and repeated contact with a person that imposes fear in the victim and undermines her safety (Breiding et al., 2015, pp. 11-12). Although it is another form of IPV, stalking is not included in the operational definition of IPV in this study.

The prevalence of IPV in women globally is put at 30%. That is, one in every three women is likely a victim of IPV. The highest prevalences of IPV that contribute to the global 30% are in developing countries, particularly in Africa (O'Doherty et al., 2015; WHO, 2013a). It is noteworthy that the WHO measured only physical and sexual violence in their study, excluding other forms of violence. Furthermore, this prevalence figure includes both pregnant and non-pregnant women. The prevalence of IPV in non-pregnant women in Africa as at 2013 were 42% in western Africa, 27% in southern Africa, 39% in eastern Africa and 66% in central Africa countries (Devries et al., 2013). In Nigeria, IPV prevalence among non-pregnant women is 52% to 37% in the South and 31% to 7% in the north geo-political zones (National Population Commission and ICF International, 2014). The high prevalence indicate that there is a high risk of both physical and mental health of women in Africa particularly Nigeria, This called for prompt interventions to mitigate IPV and its effect.

The literature on the prevalence of IPV specific to pregnant women in developed and developing countries is presented below.

1.2. Prevalence of IPV among pregnant women internationally

The prevalence of IPV among pregnant women ranges from 1% to 20% in the developed countries. The wide range may be attributed to the diversity of data collection methods, settings and sample sizes (Bailey, 2010; Jasinski, 2004). A study conducted in 2007 by the National Institute of Statistics in Italy found that 11.5% of pregnant women in that country were victims of IPV. Similar rates were found in Turkey, India, and England (Bailey, 2010; Mauri, Nespoli, Persico, & Zobbi, 2015). The prevalence study conducted by Devries et al. (2010) used secondary data from Demographic and Health Surveys in five countries in Asia and four in the Americas, and the International Violence Against Women Surveys in two European countries and Australia. They found that from 2003-2005, 2% of pregnant women were victims of IPV in Australia and Demark. In Columbia it was 8%, 4% in Haiti, and in Jordan 5% of pregnant women were victims of IPV. The prevalence in these countries was

not high, probably because only the physical aspect of IPV in pregnant women was measured.

In Iran the current prevalence of IPV among pregnant women is 14%, while it is 15% in Thailand (Abdollahi, Abhari, Delavar, & Charati, 2015; Thananowan & Heidrich, 2008). In Mexico Romero-Gutiérrez, Cruz-Arvizu, Regalado-Cedillo, and Ponce-Ponce de León (2011) found that the prevalence of IPV among pregnant women is 44%. This rate is quite high when compared to other rates in developing countries internationally. This could be due to the instrument of measurement used, which is a modified index of spouse scale and severity of violence against women scale, and the indices measured, which are physical, sexual and psychological violence against pregnant women (Romero-Gutiérrez et al., 2011).

The literature has shown that IPV exists in different countries, irrespective of ethnicity or culture, but the rate of occurrence differs, and also that pregnancy does not hinder the occurrence of IPV (Stöckl, Watts, & Mbwambo, 2010).

1.3. Prevalence of IPV among pregnant women in African countries

In Africa the prevalence of IPV against pregnant women is similar to rates reported internationally, although it is expected to be higher than in the developed countries when poor or non-reporting, poor or non-screening by hospitals, low or non-recording when disclosed and low publication of IPV studies are taken into consideration (Hatcher et al., 2013; Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011).

IPV prevalence ranges from about 8% in Zimbabwe to 27% in Uganda and 28% in Kenya (Hatcher et al., 2013; Shamu et al., 2011). In Tanzania the prevalence of IPV in pregnant women is 19%, while in South Africa it is 41% (Modiba, Baliki, Mmalasa, Reineke, & Nsiki, 2011; Stöckl et al., 2010). The prevalence rate in South Africa was high, probably due to the small sample size and the broader measurement indices employed, which included physical, psychological and sexual violence (Modiba et al., 2011). By way of comparison, in Tanzania only physical violence was measured.

In Nigeria, the country where this study was conducted, the Demographic and Health Survey of 2013 showed that IPV prevalence among pregnant women differed among the geo-political zones, with the highest rate reported in the South at 9% and the lowest in the North at 2% (National Population Commission and ICF International, 2014). In addition, state by

state prevalence of IPV among pregnant women revealed that the prevalence of IPV in Ogun State and Lagos State in the South West geopolitical zone of Nigeria are 2% and 8% respectively (Fawole, Hunyinbo, & Fawole, 2008; Okenwa, Lawoko, & Jansson, 2009). The prevalence of IPV is 7% in Kano State and 8% in Kaduna State in the North West geopolitical zone of Nigeria (Iliyasu, Abubakar, Galadanci, Hayatu, & Aliyu, 2013; National Population Commission and ICF International, 2014).

These relatively low statistics of IPV in Nigeria are presumably due to the deeply entrenched culture of secrecy, family values, fear of further victimisation, and shame to disclose abuse by husbands or partners (Hatcher et al., 2013; Mauri et al., 2015; Shamu et al., 2013). It is presumed that when IPV screening becomes part of routine hospital practices in Nigeria as a contribution of this study, more accurate records of IPV will be available, thus improving the reliability and accuracy of the statistics for IPV in pregnant women. IPV also has an adverse effect on the maternal and perinatal mortality rate in Nigeria, which may indirectly affect the achievement of Goal Number Three of the Sustainable Development Goals (SDGs) on good health and wellbeing. According to the African Population and Health Research Centre one woman dies every 13 minutes from pregnancy- and childbirth-related problems (Wekesah Frederick, 2017, pp. 1-2). About 30 women will experience life-long disabilities. Among the most common causes of death in pregnancy is unsafe abortion due to the huge number of unintended pregnancies. This may be because of the inability of women to negotiate contraceptive use with their spouse due to IPV, leading to unintended pregnancy and unsafe abortions. Pregnant women from northern Nigeria have a higher maternal mortality rate than those from the southern part of the country (Wekesah & Izgbara, 2017, pp. 1-2). Overall, the maternal mortality as at 2015 is 814 deaths per 100,000 live births in Nigeria (WHO, 2015).

1.4. Consequences of IPV on pregnant women and their babies

IPV against pregnant women not only jeopardises the health of pregnant women, but also the health of their children. Both mother and child suffer serious health consequences or outcomes that may range from mild to severe, physical to psychological, and short- to long-term effects (Romero-Gutiérrez et al., 2011). For the women the specific consequences may include delayed entry for antenatal care, poor nutrition, alcohol use, smoking, sexually transmitted diseases, injuries, weight gain, post-traumatic stress disorder, hypertension, threatened abortion, premature labour, miscarriage, homicide and suicide (Alhusen, Ray,

Sharps, & Bullock, 2015; Romero-Gutiérrez et al., 2011; WHO, 2013a). Tiwari et al. (2008) found that pregnant women who were abused psychologically suffered more postpartum depression and are at higher risk of committing suicide, thereby affecting the unborn child. The effects of IPV on the child are low birth weight, respiratory distress syndrome, and perinatal death (Alhusen et al., 2015; Romero-Gutiérrez et al., 2011). Misch and Yount (2014) found that IPV also affects the early initiation of babies to breastfeeding, and this delay and irregular breastfeeding can also affect the baby's mental and physical development.

The study of Stöckl et al. (2010) on IPV during pregnancy found that IPV did not decrease during pregnancy in women with previous experience of IPV before becoming pregnant. Also, violence experienced during pregnancy may continue after delivery of the baby, except the pregnant women seek for help and safety to end the violence (Bianchi et al., 2014). Therefore screening of pregnant women for IPV is being advocated by several commentators and organisations in order to curtail the menace to both mother and child (Boinville, 2013).

1.5. IPV screening

The United Kingdom National Screening Committee defines screening as a public health service where members of a defined population who do not necessarily perceive that they are at risk of or are already affected by a disease or its complications, are asked questions to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications. The term 'screening' may also refer to the application of standardised questions according to a procedure that does not vary from place to place (Feder et al., 2009). O'Doherty et al. (2015) explained that the rationale behind screening is to help women who might be experiencing or have experienced IPV through interventions that will be useful to the pregnant women.

The different forms of screening identified in the literature include the following:

- Case finding, which is the process of identifying abused women through the midwives' knowledge of the factors or risk factors associated with abuse, such as physical injuries, mental health symptoms and relationship issues such as over-controlling attitudes shown to be related to current abuse (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). Case finding can also be defined as asking questions

about abuse to women if certain indicators of abuse (such as bruises or scars) are present (O'Doherty et al., 2015).

- Selective screening, which is screening that involves a high-risk group such as pregnant women (O'Doherty et al., 2015).
- Universal or routine screening, which entails the application of standardised questions to all symptom-free women according to a procedure that does not vary from place to place (O'Doherty et al., 2015; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).
- Routine enquiring is when all women are asked about abuse but the method or questions vary according to the healthcare professional or the woman's situation (O'Doherty et al., 2015).

Various organisations encourage routine screening of all women presenting either in ANCs, emergency departments, orthopaedic departments or family clinics for IPV (Nelson, Bougatsos, & Blazina, 2012). Midwives have unique opportunities to screen these women for IPV because of their midwife-patient relationship and frequent contact with the women during their ANC, family planning, and any other visits (American College of Obstetricians and Gynecologists (ACOG), 2012). The America college of Nurse-Midwives advocates for proper assessment, intervention and referral of violence victims to be integrated into the health care services provided to women. As such, universal screening of all women presenting to the health care settings is important to reduce the effects of violence in the women's lives (American College of Nurse-Midwives, 2013).

The United States (US) Department of Health and Human Services has endorsed the Institute of Medicine's recommendation that screening for IPV and counselling be included in routine women's health care (Institute of Medicine, 2011). The Institute of Medicine did not specify the number of times that the screening for IPV should be done, and what needs to be in place before screening in their recommendations. The ACOG (2012) explained that screening for IPV should be conducted at the first antenatal visit of pregnant women and subsequently once every trimester and again once postpartum, making a total of four times in one pregnancy. Furthermore, the screening should be conducted in a private and safe place, alone with the pregnant woman. The midwife is to avoid stereotyping words such as "abuse" or "rape" and to explain to the women that the procedure is done routinely. In addition, she is to develop and maintain a relationship with the women. The midwives should also be trained before being involved in screening for IPV. Other organisations that endorsed routine and universal screening of women for IPV are the American Academy of Paediatrics, American Nurses

Association, American Medical Association and US Preventive Services Task Force (Boinville, 2013; Nelson et al., 2012; Thackeray et al., 2010).

However, the WHO 2013 guidelines are against routine or universal screening because there is not enough evidence that routine screening reduces IPV or improves the health outcomes and quality of life of affected women generally (Klevens et al., 2012; MacMillan et al., 2009). Instead the WHO recommends case-finding screening; that is, clinicians should discuss IPV exposure when assessing conditions resembling those of IPV patients or their complications (WHO, 2013b). O'Campo et al. (2011) disagree with this view, which amounts to measuring the effectiveness of screening by how well it reduces IPV in women. They argued that intervention for IPV involves complex, multi-step processes which are not under the control of the hospitals and health providers. Other actors in the process who may affect the outcomes include the social health workers, counsellors, psychiatrists, legal office and police force.

It is noteworthy that due to the health implications of IPV for pregnant women and their children, the WHO has since reviewed and modified its position on routine screening among women. It now states that routine screening can be initiated in pregnant women during their antenatal visit, provided that the midwives are well trained to screen for IPV, can ensure confidentiality, screen in a private place and use IPV protocol. Referral channels should also be available before screening can be conducted (WHO, 2013b).

Routine screening for IPV has the advantages of early identification of victims of IPV, thereby ensuring prompt management and referral to prevent future reoccurrence. It raises awareness of IPV and reduces the stigma that is associated with IPV in society. It is cost-effective and not harmful to women (Feder et al., 2009; O'Doherty et al., 2015; WHO, 2013b). Screening of pregnant women for IPV during their antenatal visit may be conducted through the use of a standardised screening tool.

1.6. General screening tools

A screening tool is a set of standardised questions asked to all symptom-free women to identify those who might be experiencing or have experienced IPV and are more likely to be helped than harmed (Feder et al., 2009; O'Doherty et al., 2015). There are several types of screening tools used in assessing IPV in the developed world. These include the Women's

Experience with Battering tool, Ongoing Violence Assessment Tool, Ongoing Abuse Screen, Abuse Assessment Screen (AAS), Woman Abuse Screen Tool, the Hurts, Insults, Threatens and Scream at her (HITS) scale, Danger Assessment, Partner Violence Screen and Slapped, Threatened or Thrown scale (Basile, Hertz, & Back, 2007). It is noteworthy that none of these tools were developed in developing countries, especially when cognizance is taken of the peculiarities of the developing countries and the alleged preponderance of IPV in them.

A study by Feder et al. (2009) of the United Kingdom (UK) assessed 18 tools in 15 validation studies; of these studies, 11 were carried out in the United States of America (USA), two in Canada, two in France and one in Brazil – none in Africa. They found that there are reliable and valid screening tools that can be used in hospitals, although the validation and reliability of any one of the tools is not enough to meet the criteria of the National Screening Committee, except the HITS tool. However, even the HITS tool suffers from the limitation that it fails to address sexual violence (Feder et al., 2009).

1.6.1. Abuse Assessment Screen (AAS) tool

The Abuse Assessment Screen (AAS) tool was first published in 1987 as Helton's protocol for caring for battered women with nine questions. Its emphasis was on physical violence, access to resources, a body map and question on pregnancy (Helton, McFarlane, & Anderson, 1987). In 1992, McFarlane, Parker, Soeken, and Bullock (1992) used a shorten version of the AAS tool with conflict tactics scale and index of spouse abuse to assess for abuse during pregnancy, the severity and frequency of injuries. Three questions out of the five questions on the AAS were able to identified abused women and gave a similar result with other validated instrument when compared. In 2008 it was further modified to include questions on choking (Laughon, Renker, Glass, & Parker, 2008). The AAS tool has five items which are questions on physical, emotional and sexual abuse in pregnancy. It also addresses issues of the frequency, severity, and perpetrator of the abuse (Laughon et al., 2008; Rabin, Jennings, Campbell, & Bair-Merritt, 2009). (Appendix A.)

The AAS tool has been modified several times by different researchers in different studies to meet the particular needs of their studies. One modification for an African study was the reduction of the five item questions to three questions on abuse, leaving out the ranking questions and body map, as seen in the pilot intervention study in an outpatient department in Tanzania (Laisser, Nyström, Lindmark, Lugina, & Emmelin, 2011). The AAS tool was also

modified to two questions and pilot tested in a study conducted in Australia, to become the New South Wales Health Screening Questions. The New South Wales Health Screening Questions contained a brief introductory statement, two questions from the AAS tool on abuse and two other questions not specifically related to abuse, and was developed in 2002 by Ramsden and Bonner (Basile et al., 2007; Spangaro, Poulos, & Zwi, 2011).

Laughon et al. (2008) confirmed that the AAS has been tested and yielded good validity and internal reliability results, consistent with other screening tools such as the Conflict Tactics Scale, the Index of Spouse Scale, and the Danger Assessment. The AAS has also been semantically and transculturally validated with translations into Portuguese, Spanish and Chinese (Laughon et al., 2008; Tiwari et al., 2007). The AAS asked questions specifically about abuse in pregnancy, and consequently it is an important screening tool in obstetrics (Rabin et al., 2009). The AAS also has short questions that are easy to understand and time effective in screening (Laughon et al., 2008).

Feder et al. (2009), however, argued that the reliability and validity of the AAS tool was not conclusive since it has low sensitivity for minor abuse rather than severe abuse. It therefore has an inability to detect relatively minor abuses. Since this is a minor limitation the AAS tool was still preferred for adaptation for the current study, because of its short questions, which make it easier to administer timeously, and the fact that it has questions related to pregnancy, which makes it relevant in obstetric care (Rabin et al., 2009).

Midwives screening practice in Nigeria

Midwives are in a unique position to screen pregnant women for IPV because of pregnant women's regular contact with midwives in the antenatal clinics (ACOG, 2012). In Nigeria, there is a dearth of literature on the midwives screening practice. The only study that described the screening practices of IPV in Nigeria, was conducted with other health professionals on their readiness to screen for IPV and their actual screening activities. Using the Domestic Violence Healthcare Provider Survey scale in Kano, northern Nigeria. They found that majority of the health professionals not enquire from patients about the possibility of IPV. They also found that there are certain factors that hindered their screening practices such as lack of self-efficacy in screening for IPV, fear of offending patients, fear for victim safety fear for health care provider safety, patriarchy bias of blaming the victim for abused and lack of access to support system to refer victims (John, Lawoko, & Svanström, 2011).

Their study was conducted with doctors, social workers, nurses, midwives, laboratory scientists and opticians, therefore the findings cannot be generalize to midwives. This is because midwives have unique routine duties and unit they work in which differs from other health professionals. Other studies in Africa highlighted huge workload, lack of resources, lack of policies on IPV, and lack of skills to screen for IPV (Ehrenberg et al. 2014; Hatcher et al., 2016; Shamu et al., 2013). The factors influencing midwives screening practice of IPV in Nigeria is unknown, this study shall provide the current screening practice of midwives in northern Nigeria and factors that influence their practice.

1.7. Problem statement of the study

The adverse health consequences of IPV indirectly contribute to sustaining the high maternal and perinatal morbidity and mortality in Nigeria and negatively impact on the country's efforts to attain SDG 3. Although the prevalence of IPV in pregnant women in Nigeria is officially put at between 2% and 9%, such statistics reflect gross under-reporting due to the well-known virtual absence of screening tools and routine IPV screening practices in Nigeria. The consequence is that relevant health policies on the issue, where they exist, are largely arbitrary. This makes it difficult to provide the necessary services or to improve midwives' screening practices. The AAS tool has been adopted by this study with a view to adapting it to become effective for usage in northern Nigeria. This study is important because it will underscore the need for a standardised screening tool to improve midwives' screening practices, which can then facilitate the early diagnosis, referral and treatment of IPV victims. The study will contribute new knowledge in the area of screening for IPV.

1.8. Purpose of the study

The purpose of the study was to adapt the AAS tool to aid midwives' screening practice for IPV among pregnant women in northern Nigeria using current screening practices for IPV in that context as baseline.

1.8.1. Objectives of the study

The objectives of the study were:

I. To describe midwives' current screening practices for IPV among pregnant women in a hospital in northern Nigeria.
II. To determine and describe the factors that influence midwives' screening of pregnant women for IPV in a northern Nigerian hospital.
III. To determine the challenges encountered by midwives in using the AAS tool among pregnant women in a northern Nigerian hospital.
IV. To adapt the AAS tool for screening pregnant women for IPV in northern Nigeria.
V. To develop and confirm the IPV assessment screening tool for pregnant women in Nigeria as a modification of the AAS tool.

1.8.2. Research questions

The research questions were as follows:

I. What is the current screening practice for IPV among pregnant women by midwives in northern Nigeria?
II. What are the factors that influence midwives' screening practices against IPV?
III. What are the challenges of using the AAS tool?
IV. How can the AAS tool be adapted for screening pregnant women against IPV in northern Nigeria?
V. How suitable is the modified screening tool for pregnant women used by the midwives?

1.8.3. Significance of the study

The study provided insights into current screening practices of midwives among pregnant women in ANCs, which may be used in the development of policies for IPV screening by the midwives. A new IPV screening tool was developed, which will improve the screening for IPV in pregnancy and contribute to new knowledge about IPV in Nigeria, which will form a baseline for further studies.

1.9. Theoretical framework guiding the study

This study was guided by practice-based research and Wile's human performance technology (HPT) framework (Wile, 1996). The theoretical framework was selected because it helps to identify performance problems as well as providing ways of solving these problems in an organisation. Practice-based research could bridge the gap between research and practice and the findings can be used to update midwifery screening practice (Crooke & Olswang, 2015; Wilmoth, Prigmore, & Bray, 2002).

1.9.1. Practice-based research

Practice-based research is an inclusive approach that utilises clinicians in gathering information from their patients within their existing practices, in order to answer the research question in a manner that will improve their practice. This approach brings the researchers and clinicians together in a study in order to bridge the gap between research and practice (Austin & Isokuortti, 2016; Crooke & Olswang, 2015; Vasilopoulos, 2017).

The clinicians may act in collaboration with the researcher or may act as participants in the research. The information generated represents multiple voices from the study without preference to any. This leads to development of knowledge directly from their practices that is important to the practice (Austin & Isokuortti, 2016). Clinicians are closer to their patients due to their unique position in the hospital; as such it is easier for their patients to trust them more than they trust researchers in divulging information. Clinicians' knowledge and expertise in their field of practice also gives them an edge with patients over researchers. The findings from PBR can be used to update practice, and to assist in planning and implementing an intervention (Crooke & Olswang, 2015).

Using the practice-based research theoretical framework as a guide, this study utilised the midwives to conduct the screening of pregnant women for IPV during their antenatal clinic (ANC) visits. The rationale was that the midwives are closer to pregnant women than the researcher because of their unique position in the clinic, and they have knowledge and expertise in communicating with pregnant women. Practice-based research was used because it could help the researcher and midwives in improving the midwifery practice of IPV screening. Also, in adapting the AAS tool the researcher needed the voices of midwives in actual practice. The fact that the modified IPV screening tool will be used by midwives to improve their practice also made the need to have their input in its development more compelling.

1.9.2. Wile's human performance technology model

Wile's human performance technology (HPT) model is a synthesis of five different models by authors including Thomas F. Gilbert, Allison Rossett, Joe Harless, Dean Spitzer and Robert F. Mager. These authors have produced authoritative studies in the field of HPT (Schwen, Kalman, Hara, & Kisling, 1998; Wile, 1996; Wilmoth et al., 2002).

Wile's HPT model was employed by the study as a guide to identify and describe factors that influence midwives' screening practices for IPV. According to Wilmoth et al. (2002, p. 19) Wile's HPT model is unique in that it offers real solutions to varying performance problems and differentiates between solutions that are training inclined from those that are not. This model is made up of two main domains, namely the domain external to the performer and the domain internal to the performer.

Factors external to the performer: The external domain is further subdivided into tangible and intangible factors. Tangible factors are resources needed by performers (in this case midwives) to execute their daily routine duties, such as cognitive support, tools, and physical environment. Cognitive support includes job aids such as the antenatal booking card, and documentation. Tools are instruments that are not cognitive in nature, such as computers, calculators and software. The physical environment is different from the performers' environment, it is made up of other resources needed for normal operation in an organisation, such as lights, normal temperature, lack of noise, and good physical layout to provide privacy (Wile, 1996).

The intangible factors are components of the performers' environment that are external to them but cannot be touched. These intangible factors are very important and necessary for smooth running of their duties, and take the form of organisational systems and incentives. The organisational systems include factors that may influence practices and often have solutions embedded within them. Examples here include clear organisation goals, clear job design and descriptions, implementable policies, and adequate workload and staff. Incentives, on the other hand, are compensation to workers, interesting tasks, and a proper feedback system, and are meant to encourage and motivate workers to increase performance in their job (Wile, 1996).

Factors internal to performers: The factors internal to performers are skills/knowledge and inherent ability. Skills and knowledge are important for a job to be properly executed in any

organisation, and may be acquired through adequate training, in-service training or on the job training and self-study. Inherent abilities are abilities that are innate within an individual; a person possesses them naturally or is born with them. It is necessary for managers to recognise these abilities so that tasks can be allocated to the appropriate individuals. Each individual has his/her own strengths and weaknesses in the possession of particular abilities, such as resilience, emotional ability and intelligence, which determine proper execution of tasks in an organisation (Wile, 1996).

Wile (1996) reported that in rating the external categories such as organisational system, incentives, cognitive support, tools and physical environment the organisational system is the most important factor, as it is known to affect performance of workers most frequently, as seen in Figure 1.

In the current study Wile's HPT model was used as a guide to identify and describe factors that influence midwives' screening practice for IPV, which were external and internal to the midwives. This model was used because it helps to identify factors that may affect midwives' screening practice for IPV as well as helping to identify solutions to problems.

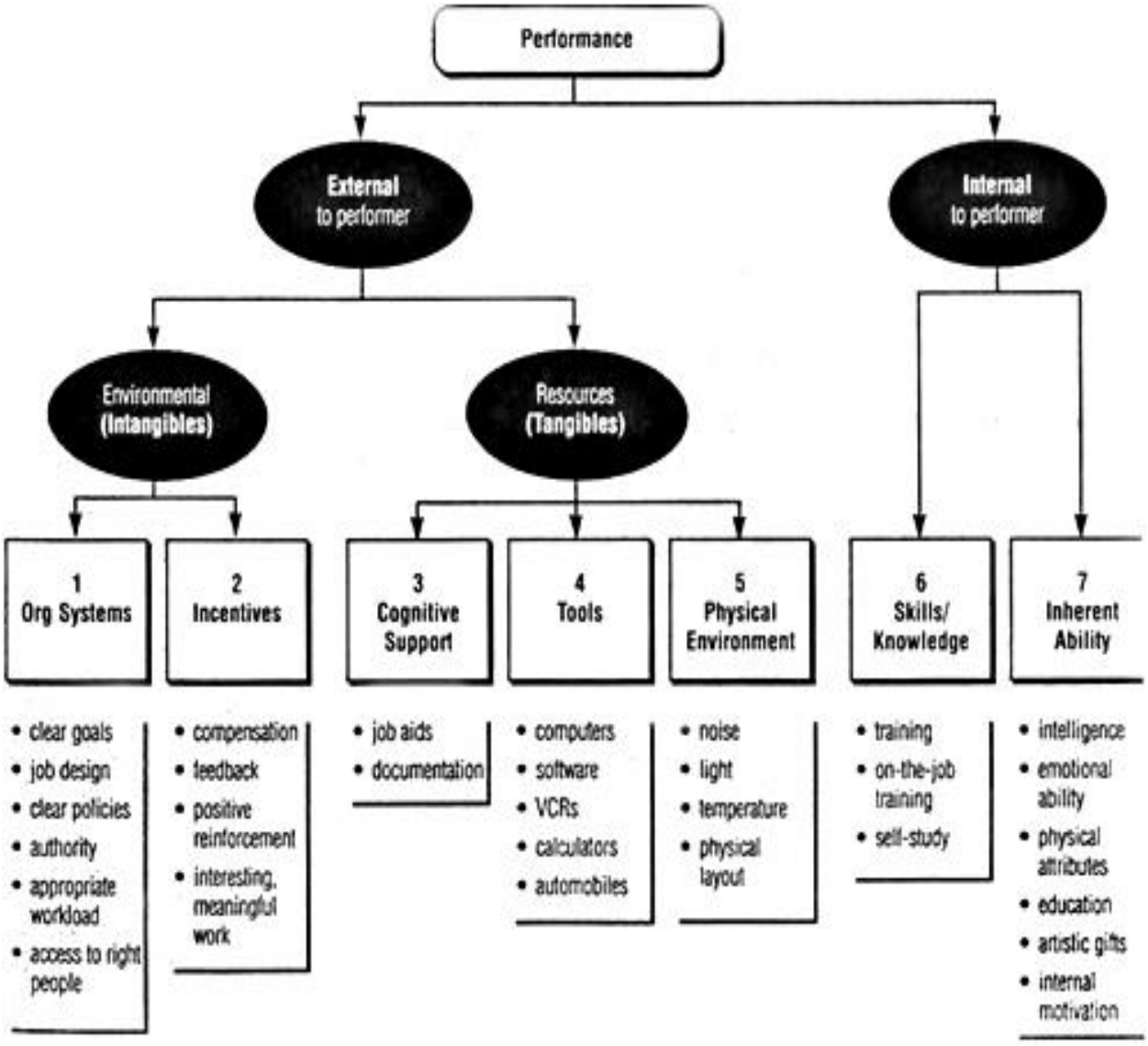


Figure 1: Wile's human performance model. Source: *Wile (1996).*

Personal values and beliefs are assumptions which a researcher holds, which they unknowingly bring into research. Acknowledging these values and beliefs upfront serves as bracketing to check the researcher's biases in the conduct of the study. Bracketing is the suspension of the researcher's belief and prior assumptions about a phenomenon before conducting the study (Holloway & Wheeler, 2010, p. 216).

The researcher in this study holds the following beliefs:

- That midwives should be friendly to pregnant women so that the pregnant women will be at ease to discuss their affairs and things happening at home with the midwives.

- That midwives should screen pregnant women for IPV even when there are no obvious signs of abuse. This will allow them to know about or see any danger signs that will prompt immediate treatment to save the life of both mother and child.
- That midwives should be at the forefront of care for pregnant women because of the unique opportunity they have in attending to pregnant women about 6 to 10 times in the ANC in an index pregnancy. This care should be in totality, such as checking and knowing the physical health of both mother and child, the mental health of mothers, the obstetric history and medical health as well as social history.
- That midwives should be advocates for pregnant women against IPV and should collaborate with other agencies with the responsibility of managing and preventing IPV in society, such as mental health providers, non-governmental organisations in communities, lawyers, and police.

1.10. Operational definition of terms

In this study the following definitions were used:

Abuse Assessment Screen (AAS) tool: A screening tool with five items which are questions on physical, emotional and sexual abuse in pregnancy. It also addresses issues to do with the frequency and severity of the abuse, as well as the perpetrator of the abuse.

Adaptation: The process of making something suitable for use in a new or different environment.

Intimate partner violence: Physical violence, sexual violence, stalking and psychological aggression or other coercive tactics by a current or former intimate partner to his or her spouse or partner.

Midwife: An individual who has undergone a midwifery programme and is registered as a midwife and qualified to practice in caring for pregnant women till after delivery.

Screening: A public health service by which members of a defined population, who do not necessarily perceive that they are at risk of or are already affected by a disease or its complications, are asked questions to identify those who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.

Screening tool: A set of standardised questions asked of all symptom-free women, to identify those who might be experiencing or have experienced IPV and are more likely to be helped than harmed.

1.11. Outline of chapters in the study

This thesis has Eight chapters in all. An outline of the chapters is presented below.

Chapter One: Introduction

This chapter presents the background on IPV and screening and screening tools. It also describes the problem statement, purpose, research objectives, research questions, significance and theoretical framework of the study.

Chapter Two: Literature Review

This chapter discusses the literature in relation to the midwives' screening practice for IPV in both developed and developing countries. In addition, the literature on the factors that influence IPV screening practice by midwives in developed and developing countries are scrutinised and reviewed in line with the objectives and theoretical framework of reference.

Chapter Three: Methodology

Chapter three discusses the research design, setting and study population, sampling method, sample size, inclusion and exclusion criteria, and recruitment of participants. The pilot study, methods of data collection at the different phases of the study and ethical considerations abided by in this research are all addressed.

Chapter Four: Data Analysis

In chapter four the methods of data management used in organising the data obtained from the fieldwork are presented and justified. The chapter also describes the analysis of the data using Yin's five stages of the analytical cycle as well as steps taken to ensure that the study meets the required degree of scientific rigour in attaining credibility and research quality.

Chapter Five: Findings of All the Phases of the Study

This chapter is subdivided into three sections: the first section presents a description of the participants in the study, while the second and third sections provides thick descriptions of the findings in phase one, two and three of the study.

Chapter Six: Adaptation of the AAS Tool

This chapter provides a detailed description of the adaptation process. The findings inform the modifications, the new IPV Assessment Screen tool, and provide letters from participants confirming the suitability of the new IPV Assessment Screen tool

Chapter Seven: Discussion

The chapter discusses the findings of all the phases of the study by comparing them with findings from previous studies. The strengths and limitations of the study design are also presented.

Chapter Eight: Recommendations and Conclusion

The recommendations that emerged from this study as well as the general conclusions in relation to the theme, aim and theoretical framework of the study are presented in the last chapter of the study.

1.12. Conclusion

This chapter described the background to the study and the prevalence of IPV globally and in Nigeria. It also looked at the screening tools available for use in screening for IPV. The purpose, research objectives, research questions, significance and theoretical framework that guided the study were also presented.

A critical review of the literature on midwives' screening practice and various hindrances to such practices, with reference to Wile's HPT model, are discussed in the next chapter.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter presents a review of relevant literature which was reviewed earlier in the study during proposal development, during data analysis and towards the end of the study. The purpose of conducting the literature review was to arm the researcher with the necessary knowledge on IPV, midwives' screening practice of IPV and factors that influence screening for IPV in developed and developing countries. The literature review was guided by Wile's HPT model which explains the external and internal factors that affect performance in an organisation and informed the study.

The following databases were searched: EbscoHost, CINAHL, MEDLINE, Health Source: nursing/academic edition, PsycINFO, PsycTESTS, PsycARTICLES, Africa wide information, Academic search premier, Science Direct, Google, Google Scholar, and Scopus. The purpose of this wide frame was not just to enhance an extensive search of the literature but also to follow the trends in the conception, regulation and practice of midwives' screening for IPV worldwide, as well as the factors that influence these. In Scopus and Science Direct suggested articles and their references were checked to select those articles deemed relevant to the research. The search terms were midwives screening practice, intimate partner violence/domestic violence/abuse, screening tools, pregnant women, and factors/barriers that hinder/enhance intimate partner/domestic violence screening practice among pregnant women. Publications that met the inclusion criteria – which were essentially published in English by reputable publishing outfits, and articles in peer-reviewed journals that met the aim and objectives of the study and fell within the time period 2003 to 2018 were reviewed.

The literature review discusses the literature on midwives' screening practice for IPV in developed and developing countries, and the external and internal factors that influence midwives' screening practice for IPV in developed countries, and concluded with external and internal factors influencing midwives' screening practice in developing countries.

2.2. Midwives' screening practices for IPV in developed countries

Midwives have been identified as having a unique opportunity to screen pregnant women for IPV because of their frequent contact with the pregnant women during their ANCs (ACOG, 2012; McCloskey et al., 2005). However, midwives' screening practice for IPV in relation to pregnant women has been reported by some studies, such as Hindin (2006) study on IPV screening practices of certified nurse midwives, to fall short of the recommendations of ACOG. ACOG recommends four screenings in ANCs, one in each of the three trimesters and one in the postpartum period (ACOG, 2012).

In Australia midwives routinely screen pregnant women for IPV in ANCs on booking days. The midwives explained that it was easier to screen on this day because it gave them the opportunity to become acquainted with their patients (Eustace, Baird, Saito, & Creedy, 2016; Spangaro et al., 2011). However, Spangaro and colleagues found that midwives repeatedly screened pregnant women during their subsequent visits since they are aware that the pregnant women may not divulge abuse to them at the first contact. This repeated screening gives pregnant women more time to develop trust and become at ease with the midwives during screening (Spangaro et al., 2011). The study did not, however, specify the number of times the screening was executed in an index pregnancy of women or whether it met the ACOG recommendations. Baird, Salmon, and White (2013) reported similar screening practices by midwives in the UK. They found that screening was mostly conducted at the first booking visit of pregnant women, although this may be too early for developing a relationship of trust with the pregnant women. They therefore recommended a repeated screening at six months so as to give sufficient time to establish a relationship between the midwives and the pregnant women.

In New Zealand Lauti and Miller (2008) found that midwives complained about screening for IPV at the initial booking, arguing that it might not be the appropriate day to screen. This is because pregnant women may not disclose abuse since at the time they will not have established a relationship with the midwives yet. The midwives therefore suggested a subsequent visit to screen pregnant women against IPV.

In the USA routine screening for IPV among women is usually carried out at their first visit to the clinic. However, Williams and colleagues did not report in their study of IPV screening

in the USA whether screening was repeated or should be repeated (Williams, Halstead, Salani, & Koermer, 2017). Similarly, Hindin (2006) reported that routine screening for IPV by midwives at the initial visit of pregnant women was being executed, but at subsequent visits of these pregnant women the midwives used the case-finding approach, which entails asking pregnant women about abuse when they have a gut feeling that the pregnant woman might be experiencing abuse. This does not comply with the ACOG recommendation of screening four times.

Renker and Tonkin (2006) reported that screening of pregnant women for IPV was initiated by midwives in the USA, but the IPV disclosure rate by pregnant women to their midwives was low when compared to their disclosures in the computer self-interview. Renker and Tonkin therefore supported the need for screening of pregnant women being repeated several times, to allow time for the women to feel comfortable to discuss IPV with their midwives.

In other countries, such as Sweden, Italy and Israel, midwives do not routinely screen pregnant women for IPV, although they use the case-finding approach, asking pregnant women about abuse when there are obvious signs of it.

2.3. Midwives' screening practices for IPV in developing countries (Africa)

In Africa Shamu et al. (2013) found that midwives in Zimbabwe do not routinely screen pregnant women for IPV in the ANC, but rely on observation for obvious signs of abuse as well as history-taking. The midwives also expect victims of IPV to bring up the issue of IPV for discussion. When this is not done, the midwives will not screen, even when there are obvious signs of abuse. In South Africa similar practices were reported in the study of Hatcher et al. (2016), who found that routine screening for IPV is not being carried out by midwives. The midwives' attention is only drawn to those pregnant women with serious forms of bodily injuries, while those with slight forms of abuse are missed. They suggested that routine screening for IPV should be conducted alongside other antenatal routines on booking day to maximise the time spent attending to the pregnant women. They also suggested that pregnant women should be screened several times to gain the trust of the women, but did not specify the number of times that screening should be done in an index pregnancy.

The study by Maina (2009) in Kenya was conducted in an emergency department with six nurses, four clinical officials and one doctor. He found that deliberate routine screening is not practiced, and rather, the medical personnel depend on history-taking and physical examination for confirming IPV (Maina, 2009). In Tanzania routine screening for IPV is also not practiced, although the screening intervention study by Laisser et al. (2011) shows that there is a feasibility that routine screening will be practiced by the midwives in the near future.

In Nigeria John et al. (2011) conducted a cross-sectional study on the extent and determinants of health professionals screening for IPV using the Domestic Violence Healthcare Provider Survey scale in Kano, northern Nigeria. The health professionals included 156 doctors, 29 social workers, 61 nurses, 12 midwives, and 11 laboratory scientists and opticians, and they found that more than 74% of their respondents do not screen for IPV. The findings of their study are not generalizable and cannot be conclusive when cognizance is taken of the poor representation of midwives compared to the doctors in the study. Although their study is quantitative and cross-sectional and included all health care providers, midwives were not well represented; only 4% of the respondents were midwives compared to 58% that were medical doctors. Moreover, the time and frequency of screening were not specified in the study, and this may serve as a gap in possible implementation of screening practice. Nevertheless the study highlighted the need to adapt a screening tool to reflect the peculiarity of the Nigerian context in order to guide midwives on their screening practice for IPV among pregnant women. Other studies in Nigeria have also recommended adaptation of screening tools for IPV to aid in early detection of IPV so that prompt treatment can be initiated (Ezeanochie, Olagbuji, Ande, Kubeyinje, & Okonofua, 2011; Fawole et al., 2008).

On the whole, the literature revealed the absence of routine screening practices of midwives for IPV in Nigeria and other African countries. This shows that midwives depend on the case-finding approach despite their limited knowledge on IPV issues and its identification. Only the physical forms of abuse that the midwives are able to identify through their obvious signs attract probing, while other forms of abuse are being missed. The literature also revealed the absence of screening tools for midwifery practice in Nigeria. Where such tools and practices exist, they are rudimentary, unorganised, inconsistent, and therefore not very useful.

The current study, which was a qualitative panel longitudinal study with only midwives as its participants, described their screening practice and identified the factors that serve as a

hindrance to/influence their practice. The study therefore filled the identified need for adaptation of a screening tool to fit the northern Nigerian context. The current study can therefore be considered a pioneer study on this aspect in northern Nigeria.

2.4. Factors influencing midwives' screening practice for IPV

The literature review revealed many factors that may influence midwives' screening practice, and these can be categorised as either external to the midwives or internal to them. Wile's model in Figure 1 provides a good starting point for describing these factors.

2.4.1. External factors influencing midwives' screening practices for IPV in developed countries

Lack of time due to huge workload has been cited in various studies as a major factor that affects midwives' screening practice, especially in the developed countries where initiation of screening for IPV is being performed (Bacchus et al., 2010; Hooker, Small, Humphreys, Hegarty, & Taft, 2015; Lauti & Miller, 2008). Although screening is not regular and the rate is low, midwives still screened. For example, in the study by the Bristol Pregnancy And Domestic Violence Programme in the UK by Price, Baird, and Salmon (2007), several of the midwives complained about the huge amount of time it took them to screen pregnant women for IPV. They claimed they spent about one to two hours to screen a patient, and they still have to continue the normal antenatal routine practices in the clinic. Baird et al. (2013) also reported that the midwives showed anxiety at possible disclosure of IPV by pregnant women during screening, as they are apprehensive of the workload and time it will take to respond to this and manage them effectively. The indications are that even in the course of screening the midwives are unconsciously preoccupied by other work routines in the clinic. This negatively affect their concentration in screening the pregnant women and their screening practice too.

Eustace et al. (2016) and Guillery, Benzies, Mannion, and Evans (2012) found that midwives lack of adequate time in the ANC was due to their huge workload, and that adversely affects their capacity to establish a trusting relationship with their patients. Lack of time further affects their screening practice, which indirectly leads to non-disclosure of IPV by their patients. Lack of time has been found to be a consistent factor hindering midwives' screening practice for IPV for decades (Sprague et al., 2012).

The literature reviewed also revealed that lack of privacy due to the presence of pregnant women's partners or family members during the antenatal visit served as another hindrance to screening for IPV by midwives (Finnbogadóttir & Dykes, 2012; Hooker et al., 2015). Mezey, Bacchus, Haworth, and Bewley (2003) found that despite confidential time granted to midwives to see pregnant women alone without the presence of their partners, midwives find it hard to ask pregnant women's partners to leave the consulting room to gain privacy with the pregnant women. The partner may decline to leave the pregnant woman alone with the midwives and be responding to questions put to the pregnant woman by the midwives. The answers given by the partner may not correspond with the injuries presented by the pregnant woman (Duma & Ogunbanjo, 2004). This hinders midwives' screening practice for IPV.

This view on hovering partners is further supported by the evaluation study reported by Bacchus et al. (2010), which found that in the UK 43 midwives out of 56 reported the presence of the pregnant women's partners as a problem for privacy during pregnant women's ANC visitation. The 'Pandora doesn't live here anymore' study in Australia by Spangaro et al. (2011) further reported that the presence of pregnant women's partners posed a challenge for midwives in creating privacy for effective screening of pregnant women for IPV. These partners may also be the perpetrators of violence in their homes, and therefore getting privacy was difficult. The midwives devised means of going around this by requesting more urine tests from the women to avoid suspicion from their partners in gaining privacy with the women. Baird et al. (2013) also reported similar situations encountered by midwives during screening for IPV. Their strategy of overcoming the presence of pregnant women's partners was to request a urine test and inform the pregnant women to paste a blue sticker on the urine bottle if they wished to speak with the midwives in private. This would them draw the attention of the particular midwife to carry out screening on such women.

Bermele, Andresen, and Urbanski (2018) in the USA also reported the problem of the presence of pregnant women's partners or family members during the course of screening. When the partners were asked to leave the room they either refused to leave or the pregnant women themselves would ask their partner to stay in the room, and then screening would not be done. As a result of this, policy revision is in progress in the USA to allow midwives to have a private time alone with their patients when antenatal assessment and screening for IPV is on-going.

Lack of privacy due to inadequate space in the clinic is not a problem in ANCs, but healthcare providers working in emergency departments, fracture clinics and outpatient departments expressed lack of privacy due to space as a hindrance to their screening practice for IPV (Feder et al., 2009; Williams et al., 2017). A study in an orthopaedic clinic in Canada conducted by Conn, Young, Rotstein, and Schemitsch (2014) found that lack of space for privacy to conduct screening due to the close proximity of stretchers for patients prevented them from screening for IPV. Sprague et al. (2013) reported that the physical layout of the fracture clinic did not provide privacy for sensitive discussions such as that about IPV to be held with patients. This served as a hindrance to screening for IPV.

A study conducted in an accident and emergency department in The Netherlands by Zijlstra, van de Laar, Moors, Lo Fo Wong, and Lagro-Janssen (2017) found that one of the facilitating factors that influenced screening was having private consultation rooms that were newly fixed to provide privacy for effective discussions of private issues like IPV with their patients, without others being able to listen to the discussion.

Although the literature did not point out a lack of space for privacy as a hindrance to screening by midwives in ANCs in developed countries, it was identified as a challenge for screening practices of other health providers in emergency departments, fracture clinics and paediatric clinics. The trend of the argument in the literature is that physical design in any clinic involved in screening for IPV should be structured in a way that it provides privacy. This would allow sensitive matters such as IPV to be effectively discussed comfortably for both healthcare providers and pregnant women (Williams et al., 2017).

The literature reviewed reveals a lack of resources for effective interventions to support victims of IPV, such as 24-hour on-site counsellors, an effective referral system, IPV hotlines, and mental and child protective services, influence midwives' screening practice for IPV (Gutmanis et al., 2007; O'Campo et al., 2011; Price et al., 2007; Williams et al., 2017). In a study of midwives' experience of routine screening for IPV in Australia, Eustace et al. (2016) found that midwives felt discouraged from screening pregnant women for IPV largely due to a lack of resources available to support victims who may disclose IPV.

Lack of awareness on the available resources in the hospital and community as well as access to these resources posed a further problem for midwives' screening practice for IPV (Clark, Renner, & Logeais, 2017; Prust, Mellor-Crummey, Sullivan, Lang, & Hansen, 2017;

Williams et al., 2017). Lauti and Miller (2008) study in New Zealand found that lack of knowledge of referral services available in the hospital, as well as how to gain access to them in case of possible disclosure of IPV by pregnant women, proved to be a major concern of midwives in their practice of screening for IPV. Ellsberg (2006) expressed lack of support and proper referral services for IPV victims as a hindrance, arguing that it is unethical to even initiate screening for IPV without having these services available for victims. Hooker et al. (2015) stated in their implementation study that the most frequent complaint of midwives for not screening in practice is the lack of referral services. Even where these resources are available, some midwives are not aware of how to gain access to them, especially those located in the community.

O'Doherty et al. (2015) argued that midwives will be encouraged to screen pregnant women for IPV when they realise that they will not be the ones to administer continuous counselling and advocacy for IPV victims. It is therefore necessary to let midwives know that they form part of a wider body of individuals involved in the care of IPV victims, and that these other advocates have the time and specialised training to handle IPV victims properly. This calls for referral and effective collaboration with other agencies involved in the management of IPV victims in the hospital and communities for effective intervention and support for these women (Alvarez, Fedock, Grace, & Campbell, 2017; O'Campo et al., 2011). Spangaro et al. (2011) study in Australia found that one of the facilitating factors that influenced screening by midwives was the access to referral services such as an on-site social welfare officer and the availability of other resources to support victims of IPV. The plea for availability of resources for IPV victims in the literature cannot be over-emphasised, especially when it is necessary for the effective screening practice of midwives for IPV in the clinical setting.

The virtual absence of implementable policies, protocols and guidelines for effective intervention of midwives' screening practice for IPV has also been identified as part of the external factors which hinder such practices (Guillery et al., 2012; O'Doherty et al., 2014). For instance, the study of Eustace et al. (2016) reported that absence of clear guidelines for midwives' screening practice and what to do in the case of possible disclosure made the midwives anxious, and this prevented them from screening pregnant women for IPV. Sprague et al. (2012) argued that the absence of policy on screening for IPV deterred their participants from screening since they did not know what to do after possible disclosure of IPV. This is

unlike the screening for child abuse, where they have full guidelines to follow after discovering abuse.

The study of Price et al. (2007) revealed that institutional support, in terms of clear policies in place to support midwives and to provide advice and guidelines to them on how to handle difficult situations that they may encounter in screening pregnant women for IPV, has been shown to increase the screening practice of midwives.

A systematic review of existing studies on IPV screening programmes across various electronic databases by O'Campo et al. (2011) revealed that the programmes that have been successful to date had institutional support. This includes approval of the programme, institutionalising it at upper levels and availability of effective screening protocols. The institutional support is crucial in formalising, implementing and maintaining the screening process. Spangaro and colleagues (2011) argued that such support should form part of a nationwide policy, which may be evaluated annually.

2.4.2. Internal factors influencing midwives' screening practices for IPV in developed countries

The literature revealed the lack of trust in the relationship between pregnant women and midwives as a hindrance to midwives' screening practices for IPV (Stenson, Sidenvall, & Heimer, 2005). The phenomenological-hermeneutical study on the midwives' experience by Mauri, Nespoli, Persico, and Zobbi (2015) found that there is need to build a relationship of trust before initiation of screening with women. This is because without establishing this relationship the women will not disclose abuse, thereby wasting the midwives' limited time during which they could carry out other routine duties. Hindin (2006) reported similar findings, noting that the presence of trust enables pregnant women to develop rapport and discuss various sensitive matters with the midwives. This has a tendency to ease the task of screening pregnant women for IPV.

Another qualitative study on exploration of screening protocols for IPV was conducted by Williams et al. (2017) among 115 healthcare providers including nurses, from 16 health facilities which were previously involved in a surveillance study and have organisational screening policies. They found that one of the facilitators of screening is to ensure the comfort of the women through developing a relationship of trust with them. This tends to ease anxiety and raise the women's comfort level for screening to take place.

A multi-method approach in a five-year follow-up study of the Bristol Pregnancy Domestic Violence Programme, conducted by Baird et al. (2013) with 58 midwives in the UK, also reported that due to the relationship already built with the pregnant women in their previous visits, pregnant women were able to disclose abuse which they experienced to the midwives.

Bacchus et al. (2016) explained the steps in building a trusting relationship, which include being honest, friendly and caring with the patient, displaying knowledge on the subject matter, showing confidence, assurance of confidentiality and listening attentively to the patient without being judgemental. Furthermore, Spangaro et al. (2016) noted that being caring includes explaining the screening process to the patients without rushing it and the use of body language. In addition, giving patients enough time to express themselves when screening them in private and the use of eye contact when asking questions in a face-to-face manner have been shown to increase the level of comfort and care that patients felt from their health provider in the course of screening (Williams et al., 2017).

The literature also indicated that the culture of pregnant women played a significant role in the midwives' decision to screen or not (Hindin, 2006; Mauri et al., 2015). In some studies screening for IPV was seen as a cultural taboo not to be violated by healthcare providers. IPV was perceived as a culturally sensitive issue for women. Within such cultures it is regarded as something that has happened within the family and therefore as a private affair within the home, which midwives have no right to probe into. As such, midwives desist from screening women for IPV (Mauri et al., 2015; Zijlstra et al., 2017). Hindin (2006) reported that a midwife expressed fear at screening pregnant women from other culture for IPV, even when she sees obvious signs of abuse. Williams et al. (2017) reported that the culture of Hispanic women tends to prevent them from willingly disclosing abuse to their healthcare provider, even when there are obvious signs of abuse, compared to American women. This may affect midwives' willingness to screen the pregnant women for IPV.

The literature revealed that although lack of knowledge on IPV screening and related issues is not a major problem hindering midwives' screening in countries like Australia, the UK and USA, they still want additional and ongoing education to keep them motivated and up to date on practices in the area of IPV (Baird et al., 2013; Hooker et al., 2015; Williams et al., 2017). It should also be pointed out that lack of knowledge is still an issue affecting screening practice of doctors and other healthcare providers, apart from midwives, in countries like the USA. This is more noticeable with those working in emergency departments, fracture clinics,

HIV clinics and primary care (Clark et al., 2017; Prust et al., 2017). Even now countries like Italy, Sweden and Canada are facing the problem of lack of knowledge on IPV screening and related issues among virtually all healthcare providers (Guillery et al., 2012; Mauri et al., 2015; Sprague et al., 2013).

In Sweden Stenson et al. (2005) found that the midwives emphasised that their deficiency in IPV screening is a result of lack of knowledge on screening, and that they need such knowledge in order to be well equipped to take up IPV screening and know the available referral options for victims of IPV. Another study in Sweden reported that the midwives expressed apprehension over lack of knowledge in screening and managing possible positive responses of pregnant women to IPV (Finnbogadóttir & Dykes, 2012). In Italy Mauri et al. (2015) found in their study of midwives' experience with domestic violence that midwives refrained from screening pregnant women for IPV due to their lack of knowledge on how to identify IPV among pregnant women as well as the signs and symptoms of IPV in case they use the case- finding approach. They also have fear of mismanagement of possible disclosure of IPV by the pregnant women.

Ellsberg (2006) reported that some midwives find it difficult to screen pregnant women for IPV because they do not want to open a Pandora's box of problems that they will not have the skills and knowledge to manage. As such they refrained from screening for IPV. Other studies that also identified lack of knowledge and skills on management of IPV identification and related issues as hindrances to healthcare providers' screening practice for IPV among their patients include Clark et al. (2017), Sprague et al. (2013), and Zijlstra et al. (2017).

In Australia the trial study of Hooker et al. (2015) reported that the midwives expressed concern about the one-off training they received from the government on family violence. They conveyed the need for continuous education on gender-based violence in order to continue improving their knowledge and skills in handling issues relating to violence in the home. Also, in Australia Eustace et al. (2016) revealed that while midwives received training for IPV and its related issues, the education they received as registered midwives was little when compared to what gender-based violence entails. They called for additional training for IPV to equip them in proper management of IPV.

Spangaro et al. (2011) reported that the training that midwives received facilitated their routine screening of pregnant women for IPV. Therefore training is important for achieving

routine screening practice of midwives for IPV, improving their confidence level, and creating awareness among them about the dangers of IPV and the resources available to manage it (O'Campo et al., 2011; Price et al., 2007). Baird et al. (2013) found that there was considerable improvement in midwives' attitudes towards screening pregnant women for IPV after training. The initial attitudes that hindered screening were concern about maintaining a relationship with the pregnant women, perceived lack of organisational support and personal experience of IPV. These attitudes were no longer hindrances to their screening practice after the midwives received training on IPV.

O'Campo et al. (2011) observed that continuous and compulsory education to increase midwives' knowledge of IPV not only increased the screening rate of IPV but also increased the midwives' comfort in initiating screening as well as the efficacy of the process. Bacchus et al. (2010) advise that a one-off training of midwives will not achieve routine screening of pregnant women, but ongoing training and continuous education and support are needed for effective and routine screening of pregnant women. Training for IPV should also be channelled towards screening skills, managing difficult situations and referral options in the hospital and communities, and any practical intervention available for prompt management of IPV should be incorporated into any existing nursing programme (Baird et al., 2013; Natan, Ari, Bader, & Hallak, 2012; O'Campo et al., 2011).

Other internal factors identified in the literature that constitute hindrances to midwives' screening practice are lack of communication skills, language barriers and midwives' fear for their safety (Price et al., 2007; Stenson et al., 2005). Midwives may also be apprehensive of offending their patients, be impatient with patient attitudes, have personal discomfort in initiating IPV discussions, consider IPV a social rather than a medical problem, and have an attitude or mind-set that displays patriarchal biases towards women experiencing IPV (Gutmanis et al., 2007; Natan et al., 2012; Sprague et al., 2012).

2.4.3. External factors influencing midwives' screening practices for IPV in developing countries (Africa)

In Africa external factors influencing midwives' screening practices appear not to be much different from those affecting midwives in the developed countries. Huge workload due to too many pregnant women to attend to, shortage of staff and lack of time have all been

identified as hindrances to midwives' screening practice (Hatcher et al., 2016; Laisser et al., 2011).

Shamu et al. (2013) study in Zimbabwe revealed that midwives do not have enough time to complete their normal, routine daily duties in the ANC, let alone conducting screening for IPV that seems more of a family issue than a medical problem. They perceived lack of time as the major factor hindering their screening practice. In South Africa Hatcher et al. (2016) reported that due to insufficient staff and rotation of the few that are available there is enormous pressure of workload to be attended to the scant staff, and hence the staff always appear to be exhausted. Screening for IPV further adds to the burden of overwork that is already affecting the quality of care that pregnant women are receiving from midwives. Therefore workload hinders the midwives' screening practice. Based on their pilot intervention study in Tanzania, Laisser et al. (2011) suggested that a screening intervention should be executed only when the hospital authorities are prepared to hire more staff. In doing so the problem of lack of time and too many patients to attend to would be addressed and pregnant women would get quality care from their midwives.

Lack of space for privacy is a serious constraint which negatively affects midwives' screening practice in Africa (Laisser et al., 2011), although it is not much of a problem for midwives in ANCs in developed countries. For example, Shamu et al. (2013) observed that inadequate infrastructure such as private space for screening for IPV in the six clinics covered by their study served as a major hindrance to midwives' screening practice. They reported that discussions with pregnant women about their medical history and other activities were carried out in close proximity to other pregnant women waiting to be attended to by the midwives in a hall that is also used by other visitors and staff in the clinic. This poses a big challenge for midwives initiating screening practice in Africa, especially for IPV which is a sensitive matter for pregnant women to discuss with midwives. This has the effect of further reducing the disclosure rate of IPV by pregnant women.

The literature reviewed did not identify the presence of pregnant women's husbands or partners in the course of screening or consultations with the pregnant women in the ANCs as a privacy problem in Africa. There is no explicit policy on whether husbands or partners of pregnant women can be present during consultation with the midwives.

The literature revealed that research conducted in African settings were sometimes referred to as taking place in 'resource-poor settings'. This means there is generally a low level or

absence of resources to care for the needs of patients in hospitals. Lack of resources to help and support pregnant women who are experiencing or have experienced IPV emerged as an external factor that further discourages midwives from screening for IPV (Maina, 2009; Shamu et al., 2013). In their pilot intervention study Laisser et al. (2011) found that there are no resources to manage and ensure proper referral of victims of IPV to enable them to get appropriate care and support. This led the midwives to feel discouraged from screening for IPV. They concluded that it is an ethical dilemma to screen when appropriate resources are not available to support these women. In Kenya Maina (2009) found that lack of shelter and needed resources in the management of victims of IPV discouraged the midwives' screening practice. In Uganda Ehrenberg et al. (2014) found that the majority of the midwives in their cross-sectional study were concerned about the lack of resources for support and appropriate referral for continuity of care of victims of IPV, and this constituted a dilemma after identification of abuse in patients.

Hatcher et al. (2016) suggested that in order to motivate midwives to take up screening for IPV there have to be the resources to manage the victims of IPV. This should also include a good referral system that will have a direct link with the hospital. This will enable the midwives to get feedback from the referral site on the progress of the case.

The literature reviewed revealed that a dearth of policies, protocols and guidelines on screening for IPV also hinders midwives' screening practice (Ehrenberg et al., 2014; Shamu et al., 2013). Maina (2009) found that the participants in his study do not have or know of any policy on IPV that will serve as a guide on how to screen or manage victims of abuse. Hatcher et al. (2016) revealed that the midwives in South Africa do not have policies to guide their screening practice, despite the presence of pre-set questions on the antenatal card that they are supposed to ask pregnant women visiting the ANC. There are no questions on IPV in the pre-set questions on the antenatal card. It will be difficult to venture into a field that little is known about or to handle the situation if pregnant women were to disclose abuse, in the absence of prescribed guidelines on the subject.

2.4.4. Internal factors influencing midwives' screening practices for IPV in developing countries (Africa)

The internal factors influencing midwives' screening practice are those that are closely related to or internal to the midwives. These include midwives' lack of adequate knowledge, deficient communication skills, perceived cultural inhibitive factors and lack of trust (Laisser et al., 2011).

Shamu et al. (2013) found that the midwives in their study had not received training on IPV to equip them with the knowledge and skills required for managing IPV victims. This also made it difficult for them to identify victims of IPV without seeing obvious signs or being told of abuse. Hatcher et al. (2016) opined that if appropriate training is given to midwives they will at least be able to identify or persuade victims of IPV who may have the obvious signs, but are reluctant to disclose abuse to the midwives. Training for IPV is important to boost the confidence and improve the skills needed for midwives to undertake the screening practice.

Lack of trust in midwives by pregnant women has been shown to be another internal factor of hindrance. In the Zimbabwean study by Shamu et al. (2013) it was reported that pregnant women do not disclose IPV to their midwives due to lack of trust about the confidentiality of their disclosures and fear that their partners may get to know of it; such a breach of trust may lead to loss of economic support from their partners. This in turn hindered the midwives, who did not want to waste their limited time to screen for IPV knowing that the pregnant women would not disclose IPV, regardless of obvious signs they may display and reassurance from the midwives. The midwives called this "the culture of silence". Similar findings were made by the South African study of Hatcher et al. (2016), who reported that midwives perceived that pregnant women will not disclose abuse due to the fear of reprisal and the loss of economic support from their partner if he gets to know of such disclosure in the clinic. To overcome such reluctance, midwives may devote more time to establishing rapport and attending to pregnant women on repeated occasions, so as to develop trust and confidence in them on any issue discussed.

In Nigeria, the northern people have a culture of shame called "kunya" which means the shameful act of a husband is the shame of the family and the wife. As a daughter inlaw of the

family she is to protect the family honor by conceding the husband's shamful act. The shamful act of the husband may include physical, sexual or emotional abuse to the wife. In conceding the husband shameful act the women see the midwives as an outsider as such they may not disclose their problem/ abuse to her. Knowing this, may discourage the midwives from screning.

Yet another internal hindrance to IPV screening identified by the literature is the perception of IPV as a family or private matter which should be discussed only within the home and not with outsiders (Shamu et al., 2013). Hatcher et al. (2013) study in Kenya found that mothers-in-law encouraged IPV against pregnant women by urging such women to keep mute about abuse in their homes and by rationalising IPV as a normal occurrence in any relationship. With this mind-set pregnant women will not disclose abuse to midwives, since they are not seen as part of their family members. The overall effect is that midwives are discouraged from screening for IPV.

In Nigeria John, Lawoko, Svanström, and Mohammed (2010) conducted a cross-sectional study on the readiness to screen for IPV of healthcare providers using the Domestic Violence Healthcare Provider Survey Scale (DVHSPSS) in Kano, northern Nigeria. The DVHSPSS measures perceived self-efficacy in screening for IPV, professional roles resistance/fear of offending patients, fear for victim/provider safety, blaming the victim for being abused and access to system support to refer victims as indicators for readiness to screen. They found that their participants scored average on all the readiness indicators of screening, which shows they might not be ready to screen. Therefore these factors may serve as a hindrance to their routine screening practice. They also found other factors that influenced readiness to screen and actual screening, such as age, gender and ethnicity of healthcare providers. Healthcare providers in their mid-thirties, males and those from the southern part of the country were more likely to screen than those aged below the mid-thirties, females and those from the northern part of the country.

John et al. (2010) carried out a cross-sectional quantitative study which utilised questionnaires to acquire data. The questionnaire was, however, a pre-set group of questions on the researcher's view on what may hinder screening practice, and may not cover some of the participants' views. As such it cannot exhaust all the factors that may influence midwives' screening practice. This shortfall in the quantitative study cannot be overlooked in

view of the significant role that midwives play in the care of pregnant women and their unborn children.

This further exposed the need for a more vigorous qualitative study to be conducted on midwives' screening practice for IPV, in order to gain in-depth knowledge about the actual factors that may influence their practice from their own emic view (participants) and not the etic view of the researcher.

On the whole the external and internal factors influencing effective midwives' screening practice in Nigeria are still largely unknown, since there are no comprehensive or nationwide studies on the subject. This study shall, to an appreciable extent, fill that gap.

2.5. Conclusion

This chapter presents a review of the relevant literature on IPV screening at a global, regional and country-specific level. In the course of the review the various midwives' screening practices in developed and developing countries as well as factors that influence their screening practice were explained. With particular reference to northern Nigeria, which is the geographical focus of this study, the literature review established that the AAS tool has not been used there before. Therefore it cannot be established whether it will be suitable for use by midwives in northern Nigeria. The dearth of literature on the screening practice of midwives for IPV in Nigeria also posed a challenge in determining factors that may influence their screening practice. These are part of the gaps in the literature which this study is designed to plug.

The next chapter discusses the methodology used in investigating the midwives' screening practice and factors that influence such practices in northern Nigeria.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter discusses the research design that served as a blueprint for the study. It explains and justifies the methodology components including the research setting, study population, sampling method employed, gaining access to the setting, recruitment of participants and the pilot study. The chapter further explains the methods of data collection employed in the various phases of the study as well as the ethical principles that guided and were adhered to during the course of the study.

Overall the research methodology is tailored to suit the purpose of this study, which is to investigate and describe current midwives' screening practice for IPV and to adapt the Abuse Assessment Screen tool to aid midwives' screening practice for IPV among pregnant women in a hospital in northern Nigeria.

3.2. Research design

A panel longitudinal qualitative research design was employed for this study to obtain information from the midwives on their screening practice for IPV among pregnant women in northern Nigeria. It was also designed to unravel factors that influence midwives' screening practice, and challenges they face in using the AAS tool, and to confirm the suitability and efficacy of the new IPV screening tool.

Qualitative research is a form of social inquiry that focuses on the way people make sense of their experiences and the world in which they live (Holloway & Wheeler, 2010, p. 3). A longitudinal research design could be in the form of a trend, panel, or cohort study. A panel longitudinal study is the collection of data or information from the same sample population, group and organisation at two or more contacts over a period of time. It has a major strength that lies in the high reliability of results obtained at the end of the study (Neuman, 2011).

The panel longitudinal design was selected because it allowed the researcher to have four sequential contacts with the same midwives as study participants, in order to collect adequate data over time on their screening practices for IPV prior to and after the adaptation of the AAS to suit the Nigerian context. In sum, it allowed the researcher to achieve all the research objectives.

Panel studies are difficult to conduct because of the challenges of accessing and retaining all the sample population for months or even years for the same study. The need to track and

keep the participants for the study also makes it expensive (Neuman, 2011; Polit & Beck, 2012). However, this was not a serious problem in the present study because the researcher was employed in the same research setting and therefore had unlimited access to the research setting to trace, track and access the ANC personnel as study participants, while being guided by the ethical standards of respecting and protecting research participants. The researcher's familiarity with the midwives combined with other retention strategies employed in this study, such as compensation for the time taken for research purposes, assisted in the retention of the participants until the completion of the study.

3.3. Research setting

The study was conducted in the ANC of the Department of Obstetrics and Gynaecology at Ahmadu Bello University Teaching Hospital (ABUTH), Zaria. Zaria is located in Kaduna State, which is part of the seven states in the North West geopolitical zone of Nigeria. A map of Nigeria with Kaduna State highlighted is shown in Figure 2.

***Figure 2*: Map of Nigeria showing Kaduna State.** Source: https://www.africaprimenews.com/wp-content/uploads/2016/10/image-2.png

Zaria is a big city within Kaduna State that has a population of about 9,725,200 (National Population Commission, 2014). The major language spoken is Hausa.

ABUTH is a tertiary hospital with equipment and practices comparable to basic standards in other parts of the modern world. It enjoys high patient patronage and is a referral centre for patients from other hospitals from all over Nigeria, particularly northern Nigeria. ABUTH is located within the first university in northern Nigeria, which is Ahmadu Bello University, in the central northern town of Zaria, Kaduna State. ABUTH was established in 1967, and is the first and largest teaching hospital in northern Nigeria to date. It has trained, and continues to train, medical personnel including nurses and midwives to service the whole 19 States of northern Nigeria, notwithstanding that other teaching hospitals have since been established in these other states (Ahmadu Bello University, 2017). The fact that ABUTH trains midwives is important for this study, because it has midwives whose training is of international standard and who may have the expertise needed for screening pregnant women for IPV. Furthermore, when screening for IPV becomes established it will spread to other parts of the northern states since it trains nurses and midwives from other states.

ABUTH's strategic location in Zaria makes it easily accessible to patients from urban and rural communities across the whole region. The ANC, which was the main data collection site, is combined with the family planning unit and fertility unit. The ANC has an extension in the HIV centre called Nasara Clinic or PEPFAR (President's Emergency Plan for Aids Relief) where pregnant women with HIV attend on Tuesdays and Fridays. This clinic is being managed by the midwives.

The ANC sees an average of 38 new pregnant women for booking, that is pregnant women attending the ANC for the first time, and has an average attendance of 230 pregnant women per week. The clinic runs from Mondays to Fridays under different teams of obstetricians. For example, Mondays are for team C, Tuesdays for team A, Wednesdays for team B, Thursdays for team D and Fridays for team E. Wednesdays are for the booking of new pregnant women attending the ANC for the first time. On that day the pregnant woman is allocated to a specific team of obstetricians and given specific days to visit the ANC throughout her pregnancy. The midwives, however, are not grouped into teams. They attend to patients every day in the ANC. The midwives are also responsible for managing the gynaecology clinic and postnatal clinic every day. In addition, they attend to new pregnant women for their booking in the ANC on Wednesdays.

3.4. Study population

The study population consists of a group of individuals who have the particular knowledge or experience of the phenomenon which is being researched and from which the sample will be picked (Babbie, 2015; Holloway & Wheeler, 2010). The population for this study comprised 11 midwives working in the ANC of ABUTH, Zaria, Nigeria. These midwives render care to pregnant women and their unborn children, and have completed the General Nursing and Post Basic Midwifery programme, which qualifies them to be Registered Nurses and Registered Midwives at the same time.

3.5. Sampling method

Purposive sampling is a non-probability sampling technique whereby individuals are selected for a specific reason, based on the researcher's judgement of those that have the knowledge or experience of the phenomenon that is being researched (Babbie, 2015; Holloway & Wheeler, 2010). This technique was employed by the study to select participants from the ANC for individual face-to-face semi-structured interviews, non-participant observation and FGD. The major consideration for selection was knowledge of midwives' screening experience of IPV or any screening of pregnant women, which is based on their length of service in the ANC, availability for the duration of the data collection in the ANC, willingness to participate for the full length of the study, and ability to communicate effectively.

3.5.1. Inclusion criteria

The inclusion criteria for the study was midwives working in the ANC, who had experience of screening pregnant women for IPV or any other phenomenon, who had spent a minimum of three years as staff and were currently a staff member in the ANC. They also had to be available for the duration of the study and willing to participate in the study. This was in order to be able to tap from their experience in assessment procedures and effective communication with pregnant women and for continuity.

3.5.2. Exclusion criteria

The exclusion criteria for the study were midwives working in the ANC who were on study leave. This is because they would not be available for screening pregnant women for IPV and for the full length of the study.

3.5.3. Sample size

Sample size is simply the total number of participants who participate in a given research study (Polit & Beck, 2012). Creswell (2013) suggests that the sample size in qualitative research is not about large numbers, but is about quality and extensive rich details about the phenomenon being studied. Dukes (1984), as cited in Creswell (2013), recommends that three to ten participants are enough to obtain rich detailed data in a qualitative study. Also, in determining the sample size of qualitative research Patton (2002) advised that it should be guided by the rationale of the study, what will be suitable for the study to achieve credibility, and the time and resources available to the researcher. All of these were taken into consideration in selecting participants for the study.

The sample size of ten participants in this study was reached through data saturation in the individual face-to-face interviews, so as to obtain an in-depth understanding about their screening practices and factors influencing this practice. Data saturation is the point at which no new information can be obtained from participants, leading to redundancy (Holloway & Wheeler, 2010). This number was considered adequate for the longitudinal qualitative study that was to be conducted in multiple phases. The sample size enabled the researcher to undertake an in-depth investigation of the phenomenon and participants' views, knowledge attitudes and practice. The sample size also afforded the researcher adequate time to conduct non-participant observations during the first and second phases of the study.

3.6. Gaining access to the study site

The researcher first obtained ethical clearance from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (Appendix B). She then proceeded to obtain permission from relevant authorities hosting the research setting to conduct the research. The researcher approached the Head of Department of Obstetrics and Gynaecology

in the research setting (since the ANC is under this department) to present her request. Then the Research Proposal coupled with the Ethical Form from the research setting were submitted for approval to the Health Research Ethics Committee of ABUTH, Zaria, Nigeria, in April 2016. Before receiving the approval the researcher was invited to present the Research Proposal to the hospital board of the Department of Obstetrics and Gynaecology overseeing the ANC which is the study site, where the researcher responded to specific research questions about issues such as the duration of the study and the screening process.

The researcher also seized the opportunity to familiarise herself with the midwife in charge of the ANC and to tell her about the purpose of the study and ask for her permission to conduct the study. Her positive response was that the researcher was free to start data collection once she had ethical approval from the ABUTH Health Research Ethics Committee. The research was approved on 30 June 2016 (see Appendix C).

3.7. Recruitment of research participants

Recruitment of study participants started in July 2016 after receiving ethical clearance from the Health Research Ethics Committee of ABUTH (Appendix C). The researcher scheduled a meeting with the midwife in charge of the ANC to seek permission to conduct the study in the ANC, where she presented her with the ethical approval and the study information sheet. The midwife in charge of the ANC granted permission for the study. The researcher then discussed the inclusion and exclusion criteria with the midwife in charge and requested a list of the staff that met the criteria for inclusion. This was provided and it also contained the midwives' office contact numbers which eased the task of locating and recruiting the midwives for the study.

The researcher approached the midwives who met the inclusion criteria in their respective offices for the purpose of recruiting them for the study. In the case of each of these potential participants the researcher explained the purpose of the study, what is expected from the participants during the study (such as screening of pregnant women in the second phase of the study), the duration of the study and the number of contacts the researcher would have with the participants. Emphasis was put on the voluntary participation and that participants were free to withdraw from the study at any time if need be. Hard copies of the study information sheet (Appendix D) and consent form (Appendix E) were given to the midwives to study in their free time to help them decide if they would participate in the study. The goal

was to ensure that participation was voluntary and that the potential participants did not feel coerced to participate in the research.

The midwives were all given 48 hours to read the information sheet before consenting to participate in the study. On the scheduled date of the first data collection meeting the researcher again went through the information sheet and consent with the participants before obtaining the signed consent, to ensure that the participants understood everything.

The above recruitment process continued until ten participants had been recruited for the study

3.7.1. Recruitment of research assistant

In preparation for phase two of the study a nurse educator with a Bachelor degree in Nursing Science was recruited and trained to provide assistance to the researcher. A meeting was scheduled with the research assistant in November 2016, during which her remuneration and responsibilities were discussed. The study's design, the activities involved and mode of operation were explained to her. The researcher emphasised the need for confidentiality on what may be discussed during the FGD and clarification was provided on questions asked by the research assistant. The research assistant was trained on how to operate the audio-recorder and the taking of notes in the FGD, which were to be her major responsibility during the research. She also received instruction on her responsibility for organising refreshments, the venue and tidying of the venue after the FGD, as well as on how to go about all of these under the direction of the researcher.

3.8. Pilot study

A pilot study is a minor version of the main study, designed to identify potential practical problems or ethical issues, uncover local politics, and provide insight into logistical issues in the course of the research, and also to help the novice researcher in perfecting her interviewing skills (Duma, Khanyile, & Daniels, 2009; Polit & Beck, 2012; Van Teijlingen & Hundley, 2002). The pilot study for this research was conducted to identify the potential practical problems that may arise in using the interview guide in the study of the midwives' screening practices for IPV among pregnant women, test the researcher's interviewing skills, and determine the feasibility of the interviewing time.

The data collection for the pilot study started in August 2016 with three participants in the ANC of the research setting. Incidentally, the appointed date for the first pilot study interview was scheduled for Wednesday, which coincided with a booking day for the intake of new pregnant women into the ANC. This proved to be an inconvenient day, because Wednesdays are the busiest days at the ANC. The interview session had to be cancelled and rescheduled for Tuesday of the following week. This indicated the need to select an appropriate day to conduct interviews in the main study.

The general office which was selected to hold the rescheduled interview sessions with the pilot study participants in proved to be a challenge. There were constant interruptions by both patients and other staff who kept coming in, looking for one thing or another. In order to continue with the first pilot study interview session the venue of the interview was changed to a cubicle which was now empty because the doctor occupying it had left. This further highlighted the need for another venue for the main study. The clarity and length of the interview were ascertained with the participants, and they confirmed that the questions were clear and not rushed and that the length of the interview was fine. This view was also confirmed from the preliminary data analysis.

The transcribed raw data from the pilot study were shared with the researcher's supervisor to determine any practical problems with the interview guide and the researcher's skills in conducting interviews. The research supervisor agreed that the data generated from the interviews were fine, but expressed the need for more probing questions from the researcher to yield more responses from the participants. In addition, some questions were restructured when it was observed that routine screening was not being undertaken by the midwives. For example, the question 'How often do you screen pregnant women for IPV?' was no longer relevant and was removed from the interview guide.

3.8.1. Lessons learnt from the pilot study

The following lessons were learnt during the pilot study:

1. Venue: The researcher encountered problems with venue for conducting interviews. The general office used for the interview was not suitable because of constant interruptions by both patients and other staff, disrupting the interview session. The researcher resolved the venue problem by shifting the venues for the interview from

the general office to a cubicle or private offices of the senior midwives, which could also be used for interviews in the main study.

2. Days for interviews: The researcher encountered a practical problem of which days to carry out the interviews on. She found that Mondays, which are for departmental board meetings with staff of the ANC, Wednesdays, which are for booking new patients, and Fridays, which are short days as the clinic closes at 13h00 instead of 16h00 because of Muslim prayers were not convenient for the interview sessions with midwives. This was resolved by leaving out Mondays, Wednesdays and Fridays for the interviews, and it was decided that the best days for interviews were Tuesdays and Thursdays.

The findings from the data analysis of the pilot study were included in the main study since the method of data collection and data analysis was the same as in the main study. This is allowed in qualitative studies where there is no fear of data contamination (Duma et al., 2009; van Teijlingen & Hundley, 2002).

3.9. Data collection process

The data collection was conducted in phases according to the research objectives of the study, and these are phase one, two, three and four, as shown in Table 1. In phase one the data collection involved non-participant observation and individual face-to-face semi-structured interviews. Phase two involved non-participant observation during the process of screening of pregnant women by participants, while phase three involved an FGD with the same participants. Phase four involved letters of attestation from the same participants as a confirmation of the adapted screening tool. These were the four major methods of data collection that were utilised to generate data for this study. For the interviews and FGD the semi-structured interview guides, developed by the researcher according to the phases of the study objectives, were used. A checklist was used for non-participant observation (Appendix F). Data from all of these sources were triangulated and informed the adaptation of the AAS tool.

The English language was used for the interviews and FGD because English is both the official language and the language of instruction during midwives' training and documentation in health care in Nigeria.

Table 1: Summary of the phases and activities in the study

PHASES IN THE STUDY	SPECIFIC OBJECTIVES	METHOD OF DATA COLLECTION
Phase One: Investigating the current midwives' screening practice for IPV	• To describe midwives' current screening practices for IPV among pregnant women in a northern Nigerian hospital. • To determine and describe the factors that influence the midwives' screening of pregnant women for IPV in a northern Nigerian hospital.	• Non-participant observation using observation checklist. • Individual face-to-face interview using a semi-structured interview guide.
Phase Two: Midwives' used of the AAS tool to screen pregnant women for IPV	• To determine the challenges encountered by midwives in using the AAS tool among pregnant women in a northern Nigerian hospital.	• Non-participant observation using observation checklist.
Phase Three: Affirming the challenges observed and adapting the AAS tool through an FGD	• To adapt the AAS tool for screening pregnant women for IPV in northern Nigeria.	• FGD held after two months of the midwives screening pregnant women for IPV with the AAS tool.
Phase Four: Adaptation of the AAS tool (based on findings from phases two and three of the study to use and confirm it) for suitability in the context of Nigeria	• To develop and confirm the IPV Screen tool for pregnant women in Nigeria as a modification of the AAS tool.	• Letter of attestation from midwives to confirm the suitability of the new IPV screening tool.

3.9.1. Data collection in phase one

The data collection in phase one involved non-participant observation of the daily activities of participants in the ANC and individual face-to-face semi-structured interviews with the ten participants. An observation checklist and semi-structured interview guide were the research instruments used to generate data for this phase in the study. The objectives of this phase included to describe midwives' current screening practices for IPV among pregnant women

in a northern Nigerian hospital and to determine and describe the factors that influence midwives' screening practice of pregnant women for IPV in a northern Nigerian hospital. The data from this phase would form a baseline to know if the midwives screen for IPV and the tool use, which would informed the adaptation of a screening tool.

3.9.1.1. Non-participant observation

This is the act of taking into cognizance a phenomenon being studied in the research setting through listening, watching, asking casual questions and taking field notes as events are unfolding. It may also entail using a checklist designed according to the research objectives. The researcher is seen and known as an outsider to the group under study because he/she does not participate in the daily routines of the organisation (Creswell, 2013).

In the present study data collection started with the non-participant observations, which were conducted by the researcher from 1 September to the end of October 2016. The researcher visited the ANC from Monday to Friday every week from 08h00 to 14h00 to observe the participants when they were attending to pregnant women as data collection. Consent was obtained from the midwives to participate in the study during the recruitment of study participants. The consent of the pregnant women were obtained prior to the observation each day to different pregnant women that the midwives were interacting with. The researcher observed all the activities of the participants during their interactions with pregnant women in the ANC using a checklist (Appendix F) and took field notes. The commonly observed activities included checking of blood pressure, weight, urine testing and health education. The researcher observed each of the ten participants at different times and days within a period of two months. The notes that were taken were later developed and elaborated as field notes. Field notes are detailed accounts of occurrences in the research setting observed by a researcher that contains a descriptions of events as they unfold and the reflective thoughts of the researcher (Polit & Beck, 2012). These notes also form part of the data that are analysed, as suggested by Polit and Beck (2012).

The non-participant observation was conducted to inform the individual face-to-face interviews with each participant to determine and describe the factors that influence midwives' screening practice of pregnant women for IPV in a northern Nigerian hospital.

3.9.1.2. Individual face-to-face interviews

The individual face-to-face interviews were conducted with ten participants using a semi-structured interview guide developed by the researcher from the findings obtained from the

non-participant observations and in line with the study objectives (Appendix G). The data collection and preliminary data analyses for individual face-to-face interviews started in November and ended in December 2016.

Each of the interviews lasted for one hour. They were all audio-recorded after seeking the permission of the participants. The interviews took place in either a private cubicle or the private offices of senior midwives in the ANC. Only one participant was interviewed per day due to the tight working schedule of the participants. This also gave the researcher adequate time for transcribing and conducting preliminary data analysis, which helped towards saturation and determination of sample size.

The interviews were conducted around midday when the participants had finished attending to pregnant women. A socio-demographics form was presented to each participant to fill in before the commencement of each interview. For the interview one opening question was read out to each participant for their response: 'To screen for IPV is therefore to apply a standardised tool to a pregnant woman with a view to determine if she has been victim of IPV. In the context of what I have just explained to you about screening, after two months of observing you, I notice you people have not been screening, why?' The researcher also asked probing questions as per the interview guide as well as for further clarification on how they practice IPV screening.

The first two objectives of the study were covered by the interview method, i.e. to describe midwives' current screening practices for IPV among pregnant women in a northern Nigerian hospital and to determine and describe the factors that influence midwives' practice of screening pregnant women for IPV in a northern Nigerian hospital.

The data were transcribed immediately after the interview session was over and preliminary data analysis was conducted; this helped towards saturation and determination of sample size. Each participant's transcript was stored in a file according to the date of the interview and a number allocated to each participant for identification. These were all saved in the researcher's computer with a password. These transcripts were stored and saved on an external hard drive as a back-up, in case of any accident or damage to the researcher's computer. The hard copy of the transcribed data was stored in a cupboard under lock and key.

At the end of phase 1 the researcher gave each participant a copy of the original AAS tool and explained its contents to them. The participants were asked to familiarise themselves with

the AAS tool for two weeks before they commenced the screening of pregnant women using the AAS tool.

3.9.2. Data collection in phase two

During this phase participants were given the AAS tool and asked to use it to screen pregnant women for IPV for two months, from January to February 2017. The method of data collection was non-participant observation with study participants. The data collection instrument used was an observation checklist (Appendix H).

The objective covered by this phase was to determine the challenges encountered by midwives in using the AAS tool among pregnant women in a northern Nigerian hospital in order to adapt this tool for screening pregnant women for IPV in northern Nigeria. The data obtained from this phase would help to identify those questions on the screening tool that will need to be adjusted.

3.9.2.1. Non-participant observation

Non-participant observation for phase two started in the first week of January 2017 and last until the end of February 2017, following the completion of phase 1. Only nine out of the initial ten participants were observed during the non-participant observation because one participant withdrew from the study because she had to undergo emergency eye surgery.

The researcher explained the screening procedure to the pregnant women who were coming for antenatal care. This was done during the midwives' health education talk together with the midwife responsible for the health talk. This was because the hospital has a policy of no entrance of pregnant women's partners and relations to the antenatal clinic. Therefore, there was privacy to discuss IPV during the health education talk. The pregnant women were informed about the AAS tool and its purpose as well as the purpose of the study. They were assured of the confidentiality of their discussions with the midwives during the screening. Their cooperation was requested as they were informed of the usefulness of the information that would be elicited during the screening. Thereafter voluntary participation was asked for and obtained individually and privately. The study information sheet (Appendix I) was provided to the pregnant women for them to take time to study it and further clarification was given when asked for. Thereafter informed consent (Appendix J) was obtained privately from the pregnant women that indicated interest before commencement of the screening. About 90 pregnant women were approached but only 86 pregnant women agreed to be screened. The

excuse two gave was that they have to report back to office after seeing the doctor and the others were not interested to be screened.

The pregnant women who were interested in being screened were asked to see a particular midwife designated for documenting such. During the actual screening the researcher observed the participants as they used the AAS tool to screen the pregnant women in the ANC for IPV. This observation was not haphazard but structured by the use of an observation checklist (Appendix H). The observation checklist was developed by the researcher based on the objectives of the study; hence the main category to be observed as well as descriptive and reflective notes were indicated in the checklist, as suggested by Creswell (2013). The researcher sat at the tail end of the same cubicle with the participant and pregnant woman and observed the screening process. After the screening process the researcher thanked the participants and left the cubicle when it was time to start discussing other matters not related to screening for IPV with the patient. The researcher observed one or two participants in a day, each screening about four to five pregnant women a day, for a period of two months. Some of the participants repeated the screening in other days until the researcher observed saturation.

At the end of each screening session the researcher collected the used screening tool from participants as part of data analysis, as well as to remove the data from the hospital records. This was done to protect the information in the used screening tool. At the end of each day the researcher elaborated on the field notes made during the observation of the screening process, as advised by Creswell (2013).

The non-participant observation conducted during screening of pregnant women for IPV in phase 2 was to inform the FGD with the same participants in order to adapt the AAS tool for screening pregnant women for IPV in northern Nigeria.

3.9.3. Data collection in phase three

The data collection in this phase involved an FGD with the same participants who screened pregnant women for IPV in phase 2 of the study.

The objective covered in this phase was to adapt the AAS tool for screening pregnant women for IPV in northern Nigeria, based on the challenges encountered by midwives in using the AAS tool among pregnant women in a northern Nigerian hospital.

3.9.3.1. FGD

An FGD is usually a small group of people made up of about 6-10 individuals with peculiar characteristics or shared experiences, being interviewed by a researcher in order to stimulate ideas, thoughts and perceptions in a discussion about a phenomenon being studied (Holloway & Wheeler, 2010, p. 125; Liamputtong, 2013). This small group of people with similar experiences should be able to discuss the matter in an in-depth manner within and among themselves, comfortably for about one to two hours without problem and with the researcher serving as a moderator (Liamputtong, 2013). The FGD is used to generate data from the group, based on their opinion, knowledge, feelings and thoughts on a particular topic of interest because of their shared experience. The findings from the FGD can be used to make decisions and develop tools or products that are crucial to the group because they have their direct input (Krueger & Casey, 2009).

In the current study the FGD was conducted in March 2017. However, only seven out of ten participants who had originally participated in the first phase and in the screening of pregnant women for IPV using the AAS tool were available for the FGD. One participant withdrew from the study in phase 2 due to emergency eye surgery, which prevented her from screening pregnant women for IPV. Of the nine participants who used the AAS tool to screen pregnant women for IPV, two were not available for the FGD. One of them was out of the country for her annual leave, while the second participant could not be reached although she was aware of the date and time for the FGD. A date, time and venue suitable for all participants was identified and agreed upon by all of the participants and the researcher.

The FGD was conducted in the office of the midwife in charge of ANC due to the need for privacy and a large enough space to accommodate all the participants in the study. The researcher welcomed the participants as they arrived at the venue for the discussion. The venue had been arranged, and the recorder tested and ready for use. The researcher welcomed the participants once more as they were seated, explained the confidentiality of the discussion. The research assistant helped the participants to sign the confidentiality form (Appendix K). The rules of the discussion were explained, a brief introduction of the study and activities of participants in the past months were summarised, and the opening question was read out by the researcher using the FGD guide (Appendix L): ‘What were your experiences of using the Abuse Assessment Screen tool to screen pregnant women for IPV?’.

The researcher served as the moderator of the FGD so was the questioner and listener, and directed the flow of the discussion (Krueger & Casey, 2009). Probing was done to elicit more responses from participants. The silent participants were also encouraged to participate by asking them directly for their opinion to enrich the discussions. At the end of the FGD the participants were thanked for taking part, and a token of appreciation in monetary form (3000 naira) was given as compensation for their time, inconvenience and sharing of their expertise, as supported by (Department of Health, 2015). Assurance was also given that participants will be trained further on IPV and IPV screening by the researcher at the end of the research. The rationale for the training was to reciprocate or give something back to the research participants and not to bias the findings of the research.

3.9.4. Data collection in phase four of the study

This phase was conducted after data analysis of the other three phases, and the findings were used to adapt the AAS tool by the researcher (for the adaptation process, see chapter six).

The same participants who participated in the FGD were met individually with the adapted screening tool to use and confirm its suitability for detecting IPV among pregnant women in the research setting. The adapted tool was used for a week. Thereafter participants were asked to comment on their experiences in using the adapted AAS tool and, where possible, to comment on how the adapted tool met their expectations or differed from the original AAS tool. Each participant had to provide their views in writing, attesting to the suitability of the adapted AAS tool in identifying IPV within their context. This was done to avoid midwives from influencing each other and also to use these as an additional set of data.

The letters were coded, scanned and saved as a soft copy in the researcher's computer with a password. They were also stored in an external hard drive as a back-up copy. The hard copies of the letter were stored in a file in a cupboard under lock and key to protect the information.

3.10. Reciprocity

This is the principle of giving back to participants for their time and effort in participating in a study; in other words, giving back or exchanging information with participants for mutual benefits (Creswell, 2013; Soanes & Stevenson, 2004). Reciprocity was actualised in February 2018 when the researcher presented a seminar on IPV to all midwives who participated in the

study and colleagues using a PowerPoint presentation. Questions were asked and answers provided in an interactive discussion. Twelve midwives attended the seminar (see Appendix M for attendance list). The seminar on IPV was presented at the end of the study to avoid bias of the findings of the study and contamination of data. This served as a mutual benefit for the participants and researcher from the information obtained during the data collection phases, as suggested by Duma (2006). The training was conducted because all of the participants echoed lack of training as a hindrance to their screening practice for IPV in the ANC. The seminar marked the end of the study, although the copy of the thesis will still be shared with the hospital management as part of the dissemination of findings.

3.11. Ethical considerations

This study adhered to all the ethical principles in the Declaration of Helsinki of the 64th World Medical Association General Assembly (World Medical Association, 2013), as indicated below.

3.11.1. Ethical clearance

This includes obtaining ethical approval of the research protocol from the Human Research Ethics Committee before the study can be conducted (World Medical Association, 2013). Ethical clearance was obtained from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (Appendix B) and from the Health Research Ethics Committee of ABUTH, Zaria, Nigeria (Appendix C) before commencement of the study. The initial ethical clearance lapsed before the completion of the study, and therefore renewal of the clearances was acquired from both bodies to allow the continuation and completion of the study (see Appendix N and Appendix O).

3.11.2. Autonomy

This is respect of a participant's decision to participate or not to participate in a study. It entails allowing participants the right to make an informed decision, free from pressure or compulsion to participate in a given study (Holloway & Wheeler, 2010). In accordance with the principle of respect for a participant's autonomy, informed consent is also a means of achieving this (Liamputtong, 2013). In the current study participants were invited to take part in the study and clearly informed that their participation was voluntarily and that they were free to withdraw at any point during the study. The researcher explained the research purpose,

potential risks, benefits, and discomfort that the study may have on them if they participated. Thereafter the information sheet and consent forms were given to participants to study independently in their free time. Participants' questions were answered and further clarification was made that they were free to withdraw at any time during the study and that this would not jeopardise their jobs. This was done even while appreciating and impressing upon them the importance of their participation for the full duration of the study so as to meet all the objectives of the study. After a few days some consented to participate and the consent form was signed by both participants and researcher and a copy kept by both. The researcher allowed participants to pick pseudonyms that they wished to be identified by in the course of the interview for anonymity. Several of them declined and left this to the discretion of the researcher.

Informed consent was also obtained from the pregnant women at the first and second phase, although they were not directly involved in the study. A participant introduced the researcher to pregnant women during their group health education talk with midwives. The researcher explained the purpose of the study, potential risks, benefits and discomfort they may have during the study. Voluntary participation was emphasised and that refusal to be screened by the participants would not affect the quality of care that they would receive from the midwives. They asked questions about the study and the researcher answered and clarified any worries. Thereafter the information sheet (Appendix I) was given to pregnant women to study in the waiting hall while waiting to be seen by their respective doctors. Those that indicated interest were shown to a room for IPV screening, where they also signed the consent form (Appendix J). The pregnant women were told to drop the information sheet off with a midwife in the ANC after studying it, the rationale being to prevent their partners from knowing that they were interested in IPV screening.

3.11.3. Confidentiality and privacy

According to the World Medical Association (2013), as expressed in the Declaration of Helsinki, the privacy of participants in any study should be secured and information obtained from them, especially personal information, should be kept confidential. This can be achieved by disguising the real identity of participants, refraining from discussing information obtained from participants with third parties without the participants' consent, and conducting interviews in a secluded area (Holloway & Wheeler, 2010; Liamputtong, 2013).

The research participants' names or addresses were not required in the interviews or FGD. The consent forms that required participants to sign and insert their name were not shared with anyone, not even the researcher's supervisor, and were kept under lock and key. In order to identify participants' transcripts, numbers were assigned to each participant, such as 'participant 1' or 'participant 2'. The same numbers were used to refer to participants during the FGD. The interviews were conducted in cubicles or personal offices of midwives, while the FGD was conducted in the office of the midwife in charge of ANC. This was to provide privacy to the participants and protect the confidentiality of the information obtained from them. Participants signed the confidentiality forms during the FGD and confidentiality was explained and emphasised before commencement of the FGD. The interviews and FGD were transcribed by the researcher only and shared with the researcher's supervisor for supervision purposes only. The researcher used a password that was known to her only to lock her computer.

Confidentiality was also explained and ensured with the pregnant women. After the pregnant women were screened by participants using the AAS tool, the filled AAS tools were collected from participants by the researcher at the end of each day of screening, sealed and kept under lock and key. The IPV screenings were conducted in cubicles for privacy and confidentiality of pregnant women's disclosure. Where cubicles could not be acquired due to large numbers of pregnant women attending the ANC and occupying the cubicles with their doctors, the screening was carried out in a small parlour, although with lowered voices to prevent other pregnant women from listening to the discussions.

3.11.4. Non-maleficence and beneficence

Non-maleficence is the prevention or mitigation of potential harm to participants in a study. Only a qualified researcher that is competent and knowledgeable to handle such potential harm should conduct such studies (Polit & Beck, 2012). It is the responsibility of the researcher to ensure the physical, emotional and social well-being of the study participants and that there should not be adverse effects on these participants from the study (Liamputtong, 2013, p. 42).

In the current study the researcher is a qualified Registered Nurse and Midwife, a trained qualitative researcher, holds a Master's degree and is currently a lecturer at Ahmadu Bello University, Zaria, Nigeria. The researcher has studied and passed qualitative research

methods at MSc level. Furthermore, the research was conducted under the supervision of a qualitative researcher experienced in gender-based violence research. Although there was no potential harm to participants involved in this study, they were interviewed only after they had studied the information sheet and their informed consent had been obtained. Information obtained was not linked to participants directly. Emphasis was placed on the confidentiality of information disclosed in the FGD, and participants were told to try as much as possible not to disclose information discussed during the FGD. Each participant also signed the confidentiality form on confidentiality of the information discussed during the FGD. The interviews and FGD took place on a day and time and at venues agreed upon by both participants and the researcher, to ensure convenience and not erode work schedules.

Beneficence is the principle that requires that there should be more benefits than harm to the participants in a study and the general public. Research should not be executed when there is no benefit to the greater society (Flick, 2009). The benefits of this study to participants included increased levels of awareness of IPV screening and related issues. Both midwives and pregnant women gained more awareness and knowledge due to the explanations made by the researcher during recruitment of participants, in the course of the observation and in the post-research training. IPV and its screening were also explained to pregnant women during their health talk and in the course of recruiting them to be screened by midwives. The potential benefit for midwives in this study, in addition to knowledge gained, is that it will improve their screening practice for IPV. The findings of the study may also positively influence policy, and the new IPV screening tool will aid midwives in identifying pregnant women involved in abusive relationships. All these may probably lead to administration of prompt treatment and referral for further management by hospital and government authorities, thereby improving the quality of life of pregnant women and the nation in general.

3.11.5. Justice

This is the principle of fair treatment of participants by the researcher during execution of a study. Participants have the right to equal selection to participate in a study so long as they meet the inclusion criteria. Explanations and reasons should be provided to those that are excluded from participation. Those that may withdraw from the study should not be suffer in terms of respect and honouring agreements made prior to the commencement of the study

compared to those that complete participation in the study. The benefit of participation should be equally distributed as well as the risks (Holloway & Wheeler, 2010; Polit & Beck, 2012).

This principle was adhered to in this study. All eligible participants that met the inclusion criteria were recruited to take part in the study after explaining the research purpose. All participants were compensated, including those that participated in IPV screening during phase two of the study but could not make it to the FGD. They were all compensated for their time and inconvenience in screening pregnant women for IPV and reimbursed for transportation costs incurred for getting to the FGD.

The counselling service provided by the researcher was made available to all participants and pregnant women that needed it. The pregnant women were not discriminated against on grounds of culture and their beliefs when being recruited to be screened for IPV by midwives. Those pregnant women that declined to be screened were not denied care and their choice was respected. Likewise, those that were screened were not exploited.

3.11.6. Benefits and risks

The literature supports compensation of participants for participating in research, especially for their time, inconvenience and expertise, although the monetary value should not be so much as to influence their participation (Duma et al., 2009; National Health Research Ethics Council, 2012). Participants benefitted from taking part in this study. They were compensated with the sum of 3000 naira, equivalent to 150 South Africa rand (ZAR150.00) each for screening pregnant women at the end of phase two, and another #3000.00 (ZAR150.00) each for their time and expertise used in this study at the end of the FGD, making a total of #6000. (ZAR300.00). Also a training session was conducted with participants at the end of the study as a means to reciprocate for their participation in the study, as advised by Creswell (2013). There were also indirect benefits to participants, such as increased knowledge on IPV screening and ways of handling disclosure. The midwives also contributed in identifying factors that served as hindrances to screening for IPV, and adaptation of the original AAS tool into a new IPV screening tool based on their suggestions, which are also an indirect benefit.

There may be potential risk involved in this study as IPV is a very sensitive issue. In recognition of such risks, counselling services were made available to midwives and pregnant women who might have been involved in such abusive relations and need to seek counselling. Two experienced female psychologists from ABUTH were engaged in this study

for participants and pregnant women. One of the psychologists was present during the screening process for a week and interchanged with the second psychologist the following week. The psychologists' phone numbers were made available to participants and pregnant women, and it was ensured that the psychologist and researcher were both easily accessible when not on site. No participants sought counselling sessions with the psychologist, but three of the 86 pregnant women screened sought the services of the psychologist. Such services were free and this had been communicated to them before commencement of the screening.

3.11.7. At the end of study

The study participants will have access to the findings at the end of the research. This access will be facilitated by disseminating the findings through presentations at conferences, publications in reputable journals, and publication in books. In addition, the final PhD thesis shall be available online and in the libraries of Ahmadu Bello University and the University of Cape Town. The researcher shall also present recommendations derived directly from the findings, to the Board of ABUTH for consideration as input to its policy on IPV.

3.12. Conclusion

In this chapter the research design and research process that guided the collection of data in each of the phases of this study were discussed, along with the ethical considerations adhered to in this study. The detailed description of the data collection process serves as an audit trail through which major decisions can be traced to the reasons behind them. The methods of data management and analysis will be discussed in the next chapter.

CHAPTER FOUR: DATA ANALYSIS

4.1. Introduction

This chapter discusses the procedures used in data management and data analysis from all phases of the study. The four critical attributes of scientific rigour which were adopted during the study include credibility, transferability, dependability and confirmability are also discussed.

4.2 Data management

Data management is a system of organising, cataloguing and indexing data to make them easy to retrieve when needed (Schwandt, 2007, p. 62). It is very important to manage qualitative data well because data produced during research can be very voluminous (Creswell, 2013). A good data management system should ensure that data are well organised, easily retrievable, stored, protected and backed up against loss. It should also ensure confidentiality of the participants' identity (Guest, Namey, & Mitchell, 2013). In this study the sets of data were generated from individual face-to-face interviews and an FGD as well as from non-participant observation from all phases of data collection. It was therefore important to manage these data accurately to avoid mixing them up or losing any of it, as suggested by Guest et al. (2013) and Holloway and Wheeler (2010).

To manage data the researcher personally followed established best practices and systematic procedures for organising, storing and protecting the data generated from all phases of this research. Hence the voices of the participants that were recorded, the transcripts from the interviews and the FGD, and data from the checklists from observation of the various phases of the research were preserved in both soft and hard copies and were marked and appropriately labelled.

4.2.1. Management of data from non-participant observation

Data from checklists from the non-participant observation were collected in phases one and two of the study. These observed midwives' current screening practice for IPV among pregnant women in phase one and the challenges that midwives may encounter when screening pregnant women for IPV with the AAS tool in phase two. The data from non-participant observation were documented in the checklists, coded, stored and saved in a file in Microsoft Word according to the date when the observation was carried out. These were saved in a file on the researcher's computer and protected by a password known only to the

researcher. The data were also password protected and stored on an external hard drive and the hard copies stored in a file in a locked cupboard. This was to protect the information obtained from the field as well as the confidentiality of participants in the study. However, the transcripts were password protected and shared electronically with the researcher's supervisor for supervision purposes.

4.2.2. Management of data from individual face-to-face interviews and FGD

The individual face-to-face interviews were recorded with a voice recorder and saved in it. The recorded voices were also transferred to and saved in the researcher's computer, according to the date and number of the interview. The interviews were then transcribed verbatim, coded, interpreted and saved according to the participants' pseudonyms (which were numbers) in the researcher's computer. The pseudonyms were used to ensure anonymity and confidentiality. The transcripts of the interviews were password protected and saved on an external hard drive and also printed out to be filed and saved in hard copies which were stored in a cupboard under lock and key. This was to back up the documents in the event of unforeseen accident with the computer and to maintain confidentiality. The computer was password-protected for security, with the password known only to the researcher. However, the transcripts were password protected and shared electronically with the researcher's supervisor for supervision purposes.

The data from the FGD were recorded with a voice recorder and saved in it. The recorded voices were also transferred to the researcher's computer and saved. The proceedings of the FGD were transcribed verbatim within the second day of the FGD using Microsoft Word, as suggested by Yin (2016). The transcript was coded, stored and saved in a folder in the researcher's computer using a password, and also password protected and stored on an external hard drive and as a hard copy in order to back up the data for any eventuality with the computer, whether accident or theft.

4.2.3. Management of letters of attestation from midwives

The letter of attestation from midwives as a confirmation of the effectiveness of the new screening assessment tool for screening pregnant women for IPV were obtained in participants' handwriting. These letters were scanned and saved as soft copies in the researcher's computer, as well as being password protected and saved on an external hard drive to prevent loss. Hard copies were stored in a file and saved in a cupboard under lock and key under pseudonym to ensure confidentiality. The data collected were password

protected and shared with the researcher's supervisor for verification of the data and for supervision purposes.

4.3. Data analysis

Data analysis is the process of bringing order, structure and interpretation to a mass of data that is ambiguous, and is usually a time-consuming process (Marshall & Rossman, 2016, p. 214). Data analysis is not a linear process but a systematic, backward and forward action which transforms the data into a comprehensible and reasonable form (Holloway & Wheeler, 2010; Liamputtong, 2013).

Miles, Huberman, and Jonny (2014) recommend that data collection and analysis should be carried out simultaneously to give the researcher time to reflect on the data already collected and strategies to obtain better data. It also shortens the time involved in the analysis process. The data collection and analysis were conducted simultaneously but were written up separately for technical purposes in the study.

In the current study thematic analysis and Yin's five stages of data analysis were used in processing and analysing the data generated in all the phases of the research. Thematic analysis is the systematic method of detecting, analysing and writing out themes from a database (Braun & Clark, 2013). The strength of thematic analysis is its flexibility to answer any type of research questions and analyse different types of data. The results generated by thematic analysis can be viewed by wider educated group for verification. The weakness of this method of analysis is that it does not offer the logic of continuity and contradictions within research participants' accounts, due to its attention to patterns driven across various datasets (Braun & Clark, 2013). This was curtailed in the data analysis of this study. Quotes from the participants were presented in full sentences in a logical manner and labelled by a number assigned to each participant for identification.

The researcher also incorporated thematic analysis in Yin's stages of the analytical cycle, which is the process of breaking down of data, identification of patterns across the dataset and naming of themes and subthemes generated in the research.

The five stages of Yin's analytical cycle of qualitative data analysis are compiling, disassembling, reassembling (and arraying), interpreting, and concluding.

The methods of data analysis were conducted in all phases of the research, but for technicality and to avoid repetition the analysis process is described only once.

4.3.1. Compiling the database

The compiling stage entails putting the data into a database in an orderly/organised manner. The database consists of all the data collected in the field, organised in a systematic way. Yin (2016) recommends re-familiarising oneself with the data at this stage, by reading and rereading the transcripts and listening to the audio-recording of the interview. By doing this the researcher gets to know the transcripts well and is able to underscore data and themes of importance to the research problem.

The researcher transcribed data collected from the interviews and FGD verbatim. The researcher reread the transcripts again and again and listened to the audio-recordings several times to ensure that she had captured all that was said in the interview and FGD. This also enabled familiarisation with the contents of the transcripts and noting of ideas and patterns of importance to the research objectives. The transcripts were also edited to clarify what the participants said and to correct spelling and grammatical errors, as suggested by Miles et al. (2014). Furthermore the researcher wrote down some of her ideas in the margins of the transcripts to inform the analysis process, as advised by Creswell (2013). The organisation of data in this systematic way helped to streamline and facilitate the second stage and other higher levels of data analysis.

4.3.2. Disassembling data

Disassembling simply means breaking down into smaller pieces. This stage involves breaking down the data into smaller fragments and assigning codes or labels to each of the fragments (Yin, 2016).

The researcher disassembled the data by breaking the transcripts down into smaller fragments using coloured pens. This was undertaken manually, and thereafter codes were assigned to each of the fragments. The manual method of data analysis was employed here due to the small sample size and amount of data collected at each phase of the study. It also allowed the researcher to see all of the fragmented data at once when spread out on the table in order to manipulate the data to form a concrete idea. Furthermore, it allowed the researcher the act of touching the data, which may trigger additional data from memory, as recommended by Saldaña (2013). All of the data collected in the field including the observations, interviews and FGD transcripts were subjected to this mode of dissembling. The ensuing fragments were

then put into Microsoft Word using font colour, comments boxes and underlines to join smaller fragments together to form a continuous flow or sentence. This process was guided by the research objectives and the theoretical framework of the study. The coded transcripts were discussed with the research supervisor for scrutiny and advice. The researcher repeated the coding process several times, moving between compiling and disassembling until she and the supervisor were satisfied with the codes that emerged.

4.3.3. Reassembling data

The third stage of Yin's analytical cycle is reassembling. This entails searching for patterns from the coded fragments of data in the transcripts and rearranging and remerging fragmented data into groups or clusters to form themes (Yin, 2016). Themes are broad units of information that consist of several codes aggregated to form a common idea (Creswell, 2013, p. 186).

For this research the researcher arranged the coded data in a tabular form with the research objectives and the theoretical framework as its guide. The table headings were themes, subthemes and examples. Codes denoting similar patterns or ideas were put under corresponding or appropriate themes or subthemes. The researcher moved backward and forward from the disassembling stage to the reassembling stage several times until the coded data were subsumed under the appropriate themes. Data from the individual face-to-face interviews, FGD transcripts and observation reports all underwent the processes involved in this stage.

After the researcher completed the grouping and regrouping of the coded data the outcome was shared with the researcher's supervisor for her comments and inputs. After critical discussion and sharing of ideas, the tables were redone and the data were regrouped in a different form to make more sense of the themes generated.

The researcher later regrouped the themes into themes external to performers and themes internal to performers according to the theoretical framework that guided the research (Wile, 1996).

The data obtained from the non-participant observation and individual face-to-face interviews to describe the midwives' current screening practice for IPV of pregnant women and to determine and describe the factors that influence the midwives' screening were grouped into ten themes. The themes were further collapsed into five themes and their related subthemes due to the presence of related ideas. Two of the themes were related to midwives' screening

practice, one theme with five subthemes which were internal to the performers (midwives) and the remaining two themes with three subthemes each which were external to the performers (midwives).

The FGD yielded four themes: three of them were actual challenges encountered by the participants when using the AAS tool to screen pregnant women during their antenatal visits, while the remaining one was made up of suggestions on the modification of the AAS tool.

The themes from the analysis of observational data were used to triangulate the data obtained from the individual face-to-face interviews and the FGD.

Coded data were interpreted to see how they fit into specified themes. This led to the next stage of analysis, which is interpretation of data

4.3.4. Interpreting data

Yin (2016, p. 221) states that interpreting is the craft of giving your own meaning to your findings. It also involves abstracting the data further than the codes and themes to a greater meaning of the whole data (Creswell, 2013). Yin (2016) suggested that the researcher may wish to disassemble or reassemble the earlier tabulated data in a new way if she cannot make sense out of it or is not satisfied with the interpretation or has difficulty obtaining a logical interpretation before drawing a conclusion about the findings.

This researcher interpreted the meaning of each extract of data, and related the meaning to the subthemes and theme of the analysed data. This was done with all the transcripts from the observations, individual face-to-face interviews and FGD. Where the meaning assigned to the extract did not fit the subtheme or theme, the extract was moved to the appropriate subtheme or theme where it fitted.

The interpretation for the individual face-to-face interviews was carried out twice so as to reach a logical interpretation. The researcher and her supervisor disassembled the transcript again and again and reassembled it until a logical interpretation was derived. The same process or procedure was employed with data from the FGD.

The raw and interpreted data were thereafter separately given to two qualitative research experts to interpret individually. These qualitative researchers are Associate Professors lecturing in the Department of Nursing Sciences and the Department of Sociology at ABU,

Zaria. Both understood the context of IPV because one of the experts is a nurse who worked in the clinical area before becoming an academician. The second qualitative researcher is an expert in gender studies and victimology.

The purpose of giving the raw and interpreted data to the qualitative researchers was to see if the meaning assigned to the subthemes and themes by the researcher fit the extracts. The advice received from the two qualitative researchers was used to refine the final analysis. The final analysis was shared with the research supervisor, who confirmed that it addressed all study objectives.

Table 2: Summary of themes for member checking with participants

Phase and number of themes	Data source	Objectives of the study	Themes	Subthemes
Phase one (five themes)	Non-participant observation and individual face-to-face semi-structured interviews	1. To describe midwives' current screening practices for IPV among pregnant women in a northern Nigerian hospital. 2. To determine and describe the factors that influence midwives' screening of pregnant women for IPV in a northern Nigerian hospital.	1) Selective screening for IPV. 2) Discriminatory screening of HIV-positive women for IPV.	
			3) Midwives' internal hindrances to IPV screening.	3a) Midwives' personal discomfort in asking IPV-related questions. 3b) Perceived mistrust of midwives by pregnant women. 3c) Midwives' own perceptions of IPV as a personal matter. 3d) Midwives' lack of skills to screen for IPV. 3e) Midwives avoiding responsibility.
			4) Midwives' external hindrances to IPV screening.	4a) Antenatal card-related hindrances. 4b) Workload-related hindrances. 4c) Institutional hindrances.

			5) Structure-related hindrances.	5a) Lack of space for privacy. 5b) lack of referral centres for IPV. 5c) Lack of resources for managing IPV victims.
Phase two and three (four themes)	Non-participant observation and FGD	3. To determine the challenges encountered by midwives in using the original AAS tool among pregnant women in a northern Nigerian hospital. 4. To adapt the AAS tool for screening pregnant women for IPV in northern Nigeria	1) AAS tool-related challenges. 2) Practice-related challenges. 3) Pregnant women-related challenges. 4) Recommendations for IPV screening.	4a) Need for a standard introductory statement in the screening tool. 4b) Need for midwives to have confidence during screening.

The refined final analyses were given to each research participant separately to verify whether the interpretation given by the researcher to the themes and subthemes matched what they said, to serve as member checking, as advised by Holloway and Wheeler (2010). They looked at the findings individually and after a few days gave the researcher their comments on the findings. The participants all expressed agreement with how the researcher captured all that they said in the interviews. Most of them reiterated and placed emphasis on the need for institutional support and the resources for successful implementation of routine screening in the future.

Although the participants agreed with all interpreted data, they were concerned with the subtheme 'Midwives avoiding responsibility' (under theme: Midwives' internal hindrances to IPV screening), which was derived from this extract: "we [midwives] will write high risk or confidential in front of the antenatal card…, so that the doctor may ask her [pregnant women]" in the individual face-to-face interview. In explaining this, the majority of participants highlighted that writing the word 'Confidential' on the pregnant women's antenatal card so that doctors can ask the pregnant women about their problem does not mean that they (the midwives) are avoiding responsibility as midwives, but was meant to draw the attention of the doctors to the need to spend more time on the identified pregnant women suspected of experiencing IPV. The researcher discussed with her supervisor whether to

delete it or not, and it was agreed to remove it from the analysis since there were only three excerpts in the subtheme.

The findings for the FGD were also given to the participants to verify the interpretations that the researcher gave to the findings as member checking. They were all satisfied with the interpretation of the data. The final analysis was completed to draw up a conclusion for the research.

4.3.5. Fifth and final stage in data analysis – concluding

Concluding is the fifth stage of Yin's analytical cycle; this is an overarching statement or series of statements that raises the interpretation of a study to a higher conceptual level or broader set of ideas (Yin, 2016, p. 235). The data from non-participant observations were triangulated with the individual-face-to face interviews in phase one to provide a comprehensive idea of the findings. It was concluded that routine screening of pregnant women for IPV was not being practiced by midwives in the research setting, and that factors which are both internal and external to the midwives serve as hindrances to their practice.

The data from phase two, non-participant observation were also triangulated with data from phase three, the FGD, providing a broad concept about the challenges of using the AAS tool. It was concluded that the AAS tool was not specific for IPV screening, and hence it was adapted to suit the contextual setting in Nigeria for midwives to use.

4.4. Scientific rigour of the study

In order to ensure the scientific rigour and trustworthiness of a study, criteria of judging the quality, methodological soundness and adequacy of the qualitative research are applied. This involves evaluating the thoroughness of the research through a procedure that is verifiable (Guba & Lincoln 1989; Holloway & Wheeler 2010). The criteria employed in this research study were credibility, transferability, dependability and confirmability, which are outlined below.

4.4.1. Credibility

This is synonymous with internal validity and focuses on the participants identifying the true meaning giving to a situation in their own social context and not according to the researcher's

idea. In other words, the researcher's interpretation of situations should be same as the participants' views (Holloway & Wheeler 2010). Credibility was achieved in this study through prolonged engagement on site, member checking and triangulation

4.4.1.1 Prolonged engagement on site

The researcher stayed on site for about 12 months during the research. This was to ensure that the researcher immersed herself in and understood the situation so as to prevent misinformation or distortion of information and to establish a rapport with the participants.

The researcher also shared both the raw and analysed data with her supervisor, who is an experienced qualitative researcher. The researcher and her supervisor discussed how the researcher analysed and interpreted her data until both were satisfied with the interpreted data and how the interpretations matched the raw data of the researcher.

Two experienced qualitative researchers were given a subset of both raw and analysed data from each phase to verify whether the interpretation given by the researcher to the data matched the extracts that emerged from the research. The interpretation of the two qualitative researchers largely tallied with the interpretation of the data by the researcher. Where there were discrepancies the researcher had further discussion with the qualitative researcher to gain a deeper understanding of their comments. The researcher sought further advice from her research supervisor, and all of these inputs were incorporated into the final analysis of the data.

4.4.1.2. Member checking

This is the process of verifying the interpreted data of the research to see if the participants' reality (interpretation of the situation) is present or not; this can occur during data collection or data analysis. This process allows the participants to correct errors or misinterpretations of the data, clarify their views and provide additional information (Holloway & Wheeler, 2010).

The member checking performed the following functions in this research, as suggested by Guba and Lincoln (1989):

- It provided the participants with the opportunity to correct any misinterpretations of the data generated from the participants.
- It gave the participants the opportunity to add additional information which may have been forgotten during the interview process.

- It allowed the participants the opportunity to judge the adequacy of the interview and interpreted data.

Member checking was done after the analysis of data from all phases of this study to verify whether the researcher's interpretations of the data reflected the participants' views.

4.4.1.3. Triangulation

This is a strategy to confirm the credibility of research. It involves using different methods of data collection, different theories or different methodology to examine the same phenomenon under study (Holloway & Wheeler, 2010). This research employed different methods of data collection to triangulate the phenomenon under study: non-participant observation, individual face-to-face interviews and an FGD.

Phase one of the study utilised non-participant observation and individual face-to-face interviews with participants. The researcher triangulated the ensuing data with observations through that process, and was able to find some similarities in the data generated from the observations and individual face-to-face interviews. Some of the findings included structural-related factors, antenatal card-related and workload-related factors to screening for IPV.

Phases two and three of the research employed mainly the non-participant-observation method, which was triangulated with the FGD. The researcher was able to use these two methods of data collection to confirm the existence of AAS tool-related challenges, practice-related challenges and recommendation to IPV screening.

4.4.2. Transferability

This is a process in which findings from a research study can be applied to other similar situations or participants. To achieve this, the researcher provided a thick description of the research, which is the account of the complex processes involved in the research and a holistic description of the phenomenon under study. An audit trail was also kept by the researcher, which is a detailed description and documentation of the research process (Holloway & Wheeler, 2010). The description of the sample and setting of the research was provided in detail, with a view to giving a clear understanding of how representative the sample and setting were and the extent to which the findings can be generalised to a similar settings and samples.

4.4.3. Dependability

This is the result of the process through which the findings from a research study are made consistent, stable and accurate (Holloway & Wheeler, 2010). The methodology was followed diligently according to standard and universally endorsed rules of the scientific community. Where the researcher had to deviate from laid-down rules she documented every decision-making process and reasons for such deviations. This was to enable the outside viewer to judge and understand the salient factors that led to such decisions and interpretations, as recommended by Guba and Lincoln (1989). Dependability was also achieved in this research by keeping a dependability audit trail; that is, the researcher documented all the logic processes and the methodological decisions in the research as well as the step-by-step technique of data analysis, which led to the production of subthemes and themes. These were described in detail to give the research dependability, as suggested by Flick (2009).

4.4.4. Confirmability

This refers to the assertions that the data, interpretations and findings of the research are rooted in the context and are not the assumptions of the researcher herself (Guba & Lincoln, 1989). Confirmability was achieved in this research by the researcher bracketing herself before embarking on the research. Bracketing can be defined as the process of suspending one's belief and prior assumptions about a phenomenon (Holloway & Wheeler 2010). A confirmability audit trail was also kept, which included the communications between the researcher and her participants during the individual face-to-face interviews and the FGD. A detailed description and documentation of the data collections process, analyses and compression of the data were also kept. The coded data were shared with the researcher's supervisor and two other qualitative researchers for peer debriefing and verification of the interpreted data. Member checks were carried out with the participants for all of the phases of the research to verify the interpreted data.

4.5 Conclusion

To conclude this chapter, data were managed using Microsoft Word for easy retrieval using a password to protect the information. Thematic analysis was conducted using Yin's five stages of analysis cycle as a guide in analysing the data. Thereafter verification of the analysed data was carried out with two experienced qualitative researchers to ensure credibility of the study. Member checking was also conducted with the research participants. Five themes

emerged in phase one, four themes in phases two and three. The findings will be discussed in the next chapter.

CHAPTER FIVE: FINDINGS OF ALL OF THE PHASES IN THE STUDY

5.1. Introduction

This chapter is divided into three sections. The first section describes the sample of participants. The second section discusses the findings related to phase one, which had two objectives: 1) to describe midwives' current screening practices for IPV among pregnant women in northern Nigeria, and 2) to determine and describe the factors that influence the midwives' screening of pregnant women for IPV in a northern Nigerian hospital. The third section discusses the findings of phases two and three, which had the following objectives: 1) to determine the challenges encountered by the midwives in using the AAS tool among pregnant women in a northern Nigerian hospital, and 2) to adapt the AAS tool for screening pregnant women for IPV in northern Nigeria. The findings of each phase informed the subsequent phase; however, these are presented together in this chapter for technical purposes and to demonstrate the coherence of the whole process.

5.2. Section 1: Description of sample

The sample constituted ten female participants who practised as Registered Nurses and Midwives. They were all employed in the research setting during the time of the study. They are all females and working in the research setting. The hospital authority preferred female midwives working in the antenatal and labour ward than male midwives. It is common in Nigeria and the continent for pregnant women to prefer female midwives to attend to them during their pregnancy and labour (Rizk, El-Zubeir, Al-Dhaheri, Al-Mansouri, & Al-Jenaibi, 2005). The male midwives (accoucheurs) end up working in outpatient departments, accident and emergency and administrative positions. This is still a challenge accoucheurs face in Nigeria.

Two of the participants had Bachelor degrees in Nursing Sciences (BNSc). The remaining eight had only diploma qualifications, but three of them are enrolled and undergoing the degree programme in universities in Nigeria. The nursing education system in Nigeria is similar to those in other African countries, which was brought in by missionaries and started as hospital- based education with its School of Nursing attached to the hospital. In South Africa the nursing programmes have been converted/moved to university-based education, whereby nursing is offered as a degree in the universities or colleges of nursing that are affiliated to universities (Dolamo & Olubiyi, 2013).

In Nigeria, reform of nursing education is on-going to meet the requirements of the national policy of education and job placement. Nursing education in Nigeria is hospital-based education which is under the Ministry of Health, and as such does not benefit from nor is recognised by the Ministry of Education. This further impinges its growth as it does not enjoy funds and other resources allocated to tertiary institutions, with related problems of job placement and upward movement in one's career (Ayandiran, Irinoye, Faronbi, & Mtshali, 2013; Yusuf, 2017). Efforts have been made by the Nursing and Midwifery Council of Nigeria to move it from hospital-based to university-based education. Provision was made for those nurses who are already registered and working, whose employers cannot afford to give them leave, and nor can the nurses quit their jobs to earn the degree. They will have to proceed either through a part-time nursing programme or distance learning nursing programme at the university.

The ages of the participants ranged from 32 to 58 years. The indication is that the average age of the midwives were 46 years, agile and had the professional experience to communicate effectively with pregnant women who may have experienced IPV.

Six of the participants were Chief Nursing Officers, one of them was a Principal Nursing Officer, two were at Senior Nurse Midwife level and the remaining one was a Nursing Officer. Although the management does rotate the midwives to other units every five to eight years, they have all spent a minimum of three years in the ANC, which qualified them for this study. The senior position (Chief Nursing Officers) of most of them in the hospital was advantageous to the study because they lent their private offices to the researcher to conduct the interviews with the junior midwives. Furthermore, they may facilitate the screening of pregnant women for IPV in future since they are among the managers of the hospital.

Two of the participants had spent 32 years of service in the research setting, three of the participants had spent between 23 and 27 years in service, while the remaining five participants had spent between 3 and 17 years in service as midwives. The prolonged years spent working as a midwife was also an added advantage to the study, because the midwives had accumulated years of experiences to be able to effectively identify, communicate and manage the emotion of pregnant women who may have experienced IPV.

The same participants took part in all the phases of the study, but only seven midwives completed all phases of the study. One participant withdrew from the study at the beginning of phase two for medical reasons, while two participants left at the end of phase three of the

study. The retention strategy used in maintaining most of the participants in the study was compensation. They were compensated for their time, inconvenience and expertise with the sum of 3000 naira in phase two of the study, and another 3000 after the FGD session. In total participants received 6000 naira, which is equivalent to 300 rand (ZAR300) for participation in all phases of the study. This is also supported by the National Health Research Ethics Council (NHREC, 2012).

5.3. Section 2: Findings from phase one of the study

There were two objectives for this phase. The first was to describe midwives' current screening practices for IPV among pregnant women in a northern Nigerian hospital, and the second was to determine and describe the factors that influence midwives' screening of pregnant women for IPV in a northern Nigerian hospital. The data collected through non-participant observation and individual face-to-face interviews were triangulated.

Analysis of the triangulated data from the two sources of data collection revealed five themes with related subthemes. These were further divided into two main categories of results (in line with the objectives). The first two themes related to midwives' current screening practices for IPV and included:

1 Selective screening for IPV; and
2 Discriminatory screening of HIV-positive women for IPV.

The last three themes related to internal and external factors that influence midwives' screening practices, and are in line with objective two and the human performance concepts of Wile's model:

1. Midwives' internal hindrances to IPV screening
   a. Midwives' personal discomfort in asking IPV-related questions
   b. Perceived mistrust of midwives by pregnant women
   c. Midwives' own perceptions of IPV as a personal matter
   d. Midwives' lack of skills to screen for IPV
2. Midwives' external hindrances to IPV screening
   a. Antenatal card-related hindrances
   b. Workload-related hindrances
   c. Institutional hindrances

3. Structural hindrances to IPV screening
    a. Lack of space for privacy
    b. Lack of referral centres for IPV victims
    c. Lack of resources for managing IPV victims.

5.3.1. Selective screening for IPV

This theme was generated mostly from the data from non-participant observation, which were later supported by the individual face-to-face interviews. Data analysis from non-participant observations revealed no routine screening of pregnant women for IPV by midwives. This was further confirmed in the triangulation of data from individual face-to-face interviews, as shown in the extracts below.

Participant 3:

> *"…, we just have to be sensitive to women as we interact with them, once we sense they might be going through abuse in their home, we will ask them specific questions about abuse."*

Participant 2:

> *"it is not every pregnant woman that I meet whom I will ask direct question, but if I sensed they might be experiencing abuse, I will pick them and ask direct question. That is what guides me"*

Participant 4:

> *"..., in the process of examining and palpating, we ask questions if we find anything strange on the pregnant woman."*

Data also revealed that midwives felt competent to identify abuse by the mere sighting of signs and symptoms of abuse, such as the outward appearance or behaviours of some pregnant women, as illustrated in the extracts below.

Participant 7:

> *" From experience we know when we see intimate partner violence victims. They don't need to tell us because we can detect it from their mood that they are victims. That is how we identify them*."

Participant 10:

"sometimes on our own, when we [midwives] *see the look in their faces, somehow we know what is going on at home and we might ask"*

Participant 5:

"…, we will know as midwives if she is not happy then we will interview her in a polite manner, in a cool environment in another cubicle where there is nobody. She will be able to tell us what's in her mind"

Participant 9:

"There are some women that by merely looking at their faces you can see that they are not happy. We can go close to such women and then ask 'What is happening? I was looking at you, you have not been talking since morning'."

Participant 4:

"If we notice that the patient is not gaining weight as she is supposed to during pregnancy or her haemoglobin level has dropped due to poor nutrition …, then we will know that something is happening to her. Maybe she is being abused, then we can ask her questions."

5.3.2. Discriminatory screening of HIV-positive women for IPV

This theme which emerged from the data that showed that some midwives had the perception that IPV is more prevalent in HIV-positive patients than in HIV-negative patients. They believe that HIV-positive pregnant women are more vulnerable to IPV, and therefore use this attribute as an identifying criterion for IPV in pregnant women, as demonstrated in the following extracts.

Participant 3:

"…., However there are some [patients] *like this last example I gave you, the woman is coming from the PMTCT* [Prevention of Mother-to-Child Transmission of HIV] *clinic. If I am able to fish her out I will be comfortable to ask her anything because I want to go in depth to really know. There is no doubt in my mind about this patient. I know she is a victim of abuse."*

Participant 6*:*

"Majority of this violence comes with women that are HIV positives. That is why you will see such pregnant women always looking depressed. If I identify them, I will screen them."

Participant 7:

> *"HIV-positive status causes more violence in couples, especially when the wife is positive and the husband is negative. Therefore whenever I find such woman I will screen her."*

5.3.3. Midwives' internal hindrances to IPV screening

This theme and its related subthemes were derived from data related to factors internal to performers (midwives) that hinder midwives' screening practice for IPV among pregnant women in northern Nigeria, and are graphically presented in Figure 3.

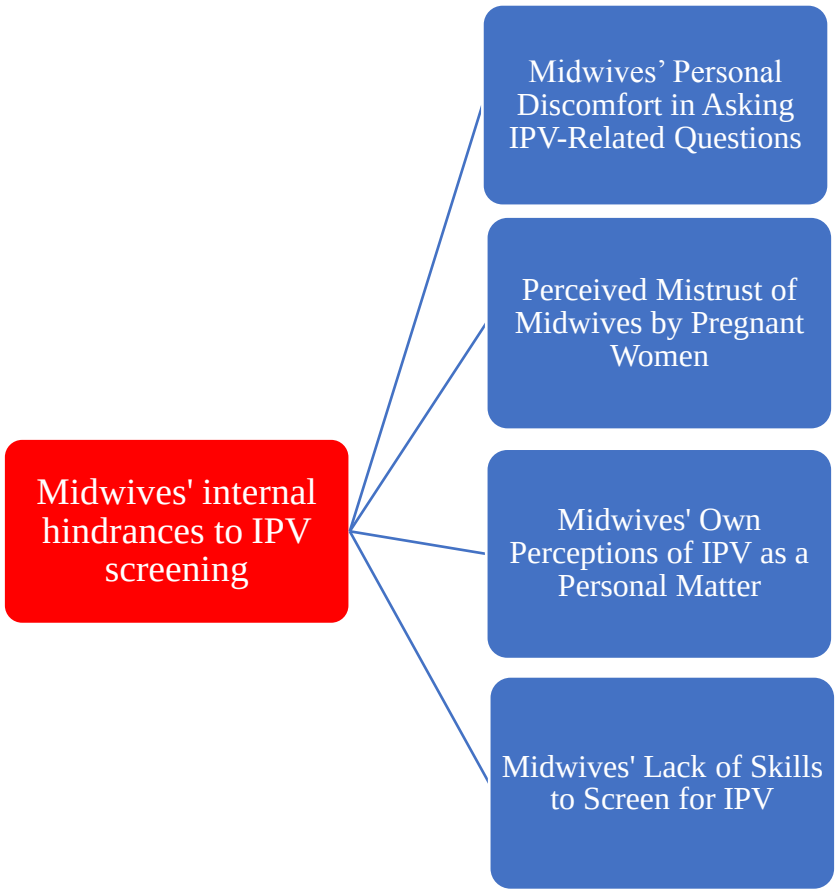


Figure 3: Midwives' internal hindrances to IPV screening and its subthemes.

5.3.3.1. Midwives' personal discomfort in asking IPV-related questions

This subtheme emerged from data on midwives' feeling of discomfort in asking pregnant women IPV-related questions as factor that hinders routine screening of pregnant women. The data revealed that midwives only ask pregnant women whom they suspect of having

been abused, because of their discomfort with discussing IPV questions. This is demostrated in the following extracts:

Participant 3:

> *"Honestly speaking, for some women I will not be comfortable putting such questions in the tool to them because it is personal".*

Participant 8:

> *"I will only screen women that I suspect of being victims but not everybody. This is because some patients might not be comfortable with the kind of questions we may ask. I am not comfortable asking every women these questions."*

Participant 1:

> *"If I suspect the patients are going through abuse, I may ask. But I will not just see a normal pregnant woman or patient and start asking her questions of abuse. It will just be uncomfortable for me to do so, she might think ... 'Ah! What does this woman want from me?'."*

Participant 2:

> *"When I start having patients coming frequently with visible signs of violence, it will motivate me to screen. Otherwise I am not sure how one can just ask any woman these questions."*

The data further revealed that midwives asked indirectly about IPV if they sensed that the pregnant women might be being abused, because of the discomfort they feel in asking IPV questions, as illustrated below:

Participant 4:

> *"... I cannot just ask 'Is your husband abusing you?' I can't ask like that, because am not comfortable with such direct questioning. But I can ask indirectly. There must be a problem of abuse before we can tackle it."*

5.3.3.2. Perceived mistrust of midwives by pregnant women

This subtheme was generated from data related to participants' perception that pregnant women do not trust the midwives enough to take them into their confidence and tell them the truth of what is going on in their marriages or relationships. This is demonstrated in extracts from different participants below.

Participant 1:

> *"Most pregnant women will not just come out to tell us, no matter how much we asked them, they will keep their abuse to themselves. They may not want to share the secret of their homes to strangers especially if they don't trust us* [midwives]. *Rememeber, some of us come from the same communities with them."*

Participant 7:

> *"For some of these pregnant women, no matter what we do or explain about preofessional confidentiality, I don't think they still accept our assurances on the confidentiality of their words. This will make it very difficult to get answers to these IPV questions."*

Participant 10 supported this, as follows:

> *"Some patients might not want to give you details on the actual truth and some may feel you want to intervene in their own personal life and decide not to tell you more. It's a matter of trust between us and them really."*

According to participant number 3, unless there is trust between the midwife and the pregnant woman screening will be impossible:

> *"There are deep-seated problems which people don't talk about unless they find somebody that they feel is a confidante. So far I do not think pregnant women see midwives as such, so I doubt if they will open up even if we asked."*

Participant number 7 stated that pregnant women will not expose what they perceive to be secrets to the midwives:

> *"... they may not even say it out because there are trying to cover their secret, they will not talk until they are pushed to the wall, but that is not easy for us. We need to build a trusting relationship first. That can be a long way though."*

5.3.3.3. Midwives' own perceptions of IPV as a personal matter to pregnant women

This subtheme was generated from data related to midwives' own perceptions of IPV as a personal matter to pregnant women in disclosing IPV. Thus the midwives' own perceived culture and religion in the northern region of Nigeria also play a role in the screening for and disclosure of IPV in pregnant women. This was demonstrated by an extract from participant 6:

> *"We don't go into that* [screening] *because of the cultural aspect of this environment, virtually all the pregnant women and even some of us feel such issue* [IPV], *Islamically, is between husband and wife."*

Participant 5 supported the barrier to screening for IPV in this region, as follows:

> *"In this part of the country we are introverts or something like that. So when things like abuse happens, we don't come out to say anything about it, we hold it within ourselves. That is what we learnt from childhood."*

This was further explained as follows:

> *"You know this area even if there is routine screening, they* [pregnant women] *will not expose it to us, and they will be keeping calm while dying in silence. It's our culture."*

In a similar vein, participant number 4 explained the cultural taboos associated with intimate or domestic relationships in the region as follows:

> *"Even myself as a woman, can I just come and meet you for the first time and tell you my husband is beating me or he is sexually abusing me? I can't say it, it's not possible. So how can I ask another woman to share that with me?"*

5.3.3.4. Midwives' lack of skills to screen for IPV

This subtheme was generated from the data that relate to the midwives' competencies in performing screening for IPV, due to inadequate training, as illustrated by the xtracts below:

Participant 1:

> *"As a midwife, I was not trained to identify pregnant women that have been victim of intimate partner violence, we have never had such trainig. So I would not even try to do something I was never taught."*

A similar sentiment was experessed by participant 6:

> *"We have not been trained at all on intimate partner violence and screening so I, for one, do not know how to screen for IPV."*

Other participants emphasised the need for training for identification of pregnant women experiencing IPV because of recognition of their lack of these important skills as midwives. This is demostrated in the following qoutes:

Participant 9:

> *"We have to go for the training to be able to screen for IPV. All the people involved have to be trained"*

Participant 7:

> *"We need to go for the training so that it will cover us in case of any legal action against us."*

Participant number 5 also recognised the lack of skills as a barrier to screening for IPV and the significance of skills acquisation to screen professionally:

> *"We need skills to be able to screen pregnant women for IPV because we were not trained, we can't be expected to just know this."*

Participant number 10 added:

> *"They should train us so that we will be able to identify cases of intimate partner violence, know how to ask the questions and use the IPV screening tool."*

Data further revealed that participants were certain that acquiring skills for screening pregnant women for IPV will encourage them to screen for IPV among pregnant women, as illustrated in the extracts below.

Participant 2:

> *"We should be trained in skills acquisition to identify women with IPV, it will motivate us"*

Participant 6 highlighted the need for hospital management's commitment to the training needs of midwives on IPV, as follows:

> *"The hospital management should provide the resources for this IPV training to hold, then I will be motivated to care more for the pregnant women because I do not have the skills to screen for IPV."*

The above was further supported by participant 5:

> *"The hospital managements have not done anything to assist us regarding IPV traning and its screeening. We have not been trained to screen for intimate partner violence in this hospital."*

As participant 1 stated:

> *"I have attended many continuing education training on different things but not on intimate partner violence, so I do not have the skills to screen or treat IPV."*

Participant 8 revealed that IPV and its identification were not included in the midwives' training in midwifery school:

> *"There was no structured course on identification of intimate partner violence in pregnant women in midwifery school, therefore I do not have the skills to screen"*

In addition to the data that revealed midwives' lack of skills for IPV screening, the following recommendations were made regarding how this identified gap can be bridged. This further supported the participants' recognition of their lack of skills in IPV screening.

Participant 3:

> *"They should include IPV screening in Nursing and Midwifery curriculum so that it will extend to the hospital - so that as the hospital is employing the new staff they will come with the skills for screening."*

Partcipant 4 added:

> *"The Federal Government should approve it, and the Nursing and Midwifery Council should also approve it, then send it to the School of Nursing curriculum where student nurses are being trained. Therefore when students are screening for IPV, it will extend to the hospital."*

It can be seen that despite the internal factors identified as hindrances to the midwives' routine screening for IPV among pregnant women in northern Nigeria, they still welcomed the idea of screening pregnant women for IPV.

5.3.4. Midwives' external hindrances to IPV screening

This theme and its related subthemes were derived from data related to factors external to performers (midwives) that hinder midwives' screening practice for IPV among pregnant women in northern Nigeria. These are graphically presented in Figure 4.

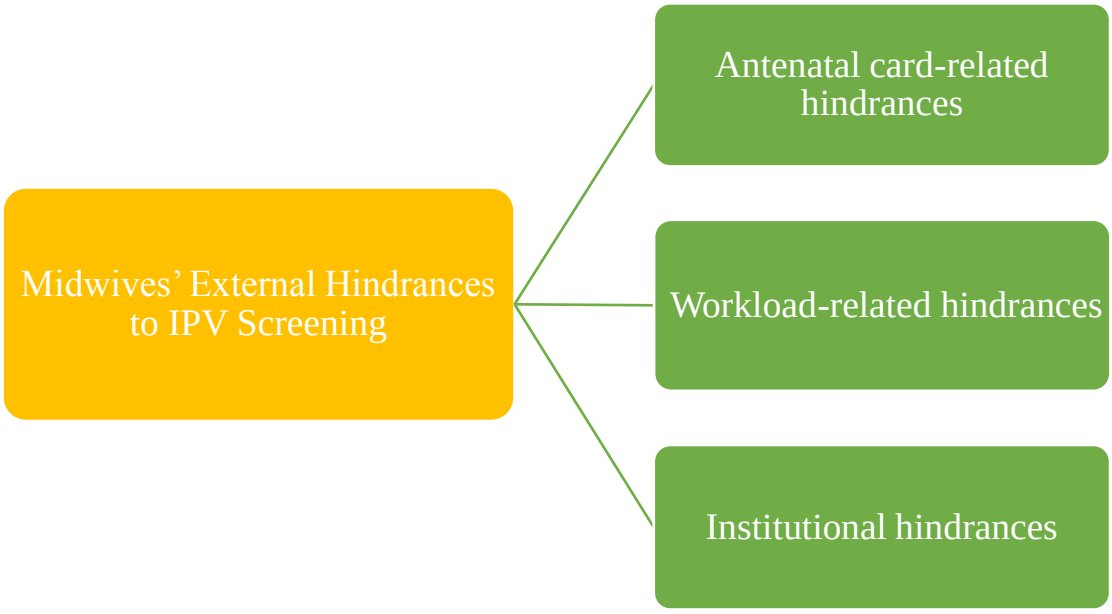


Figure 4: Midwives' external hindrances to IPV screening and its subthemes.

5.3.4.1. Antenatal card-related factors hindering screening

This subtheme was generated from data related to the absence of screening questions on the current antenatal card. Data revealed that the current antenatal card has preset questions, which do not include questions on IPV, which will be put to the pregnant women during booking. This was confirmed by the following extracts:

Participant 2:

"Even if we want to screen for IPV, we cannot. There are no questions on the antenatal card relating to intimate partner violence, so we stick to the questions on the antenatal card."

Participant 4:

"If IPV questions are on the antenatal card and there is a column for it, we will be able to do our job [screening], *but it is not, so we can't."*

Participant 8:

"If there was a column in the antenatal clinic card for IPV questions, we probably could do it but we do not have a routine form or anything that we have to fill on IPV, so we can't do it."

Participant 6:

"There is no column on the antenatal card that can contain IPV questions. Maybe the screening questions can be on a separate sheet."

Participant 9:

"Although we see pregnant women with problems every day, we only ask what is expected of us as midwives using the antenatal card."

The researcher also observed that the antenatal card contained a long list of questions including bio-social data, medical history and obstetric history at the front of the card. The inside of the card contained space for the doctor to comment on gestational age, position of baby, presentation of baby, weight of expectant mother, blood pressure, urinalysis and remarks. There is also column for all investigations done, such as haemoglobin test, blood genotype, blood grouping, and HIV test. There were no questions related to IPV and no space for such. This indicates that screening questions were not contained on the current antenatal card, so will have to be put on a separate paper/card in future.

5.3.4.2. Workload-related hindrances

This subtheme emerged from the data that showed increased workload, such as too many patients, insufficient staff and insufficient time, as a factor that serves as a hindrance to midwives' screening practice for IPV among pregnant women.

Data revealed that the midwives need to attend to too many patients per day in the ANC, and due to this large number the midwives find it difficult to undertake screening for IPV. This is illustrated in the following extracts.

Participant 5:

> *"Even if I am to screen, I will not be able to. Like today alone in this clinic, we saw 70 women. There is no way I can even screen all these women, even if I want to."*

Participant 3:

> *"… when I come to the clinic, I am overwhelmed with work. I don't even have time to sit and discuss one on one with my patients ... so the workload is really affecting effective service in this place and that is why I don't screen even if I want to."*

Participant 8 supported this, as folllows:

> *"The work is too hectic to now add screening for IPV…. You can see the number of clients now. But we are trying our best in caring for pregnant women*."

Data further reveal that midwives were so engrossed in performing the normal routines of working within the ANC that they do not pay attention to other aspects of nursing care in looking after pregnant women. This is demonstrated in the extracts below.

Participant 3:

> *"Let me be sincere with you, I have not been paying attention to this area of IPV screening because of the huge workload. All my concern is on let me just come and work and go."*

As participant 7 confirmed:

> *"The midwife should be sensitive and this is an aspect that I think we have allowed workload to cloud our minds* [because of huge workload they just do the routine]. *The attitude right now is let me just do the routine and go."*

Another extract from participant 5 supported this, as follows:

> *"I am sure a lot of them* [victims of abuse] *are among these women we are seeing here every day. But we don't pay attention and we allow workload to absorb us."*

Data further revealed the increased workload as due to the insufficient staff in the ANC, which is demonstrated in the following extracts:

Participant 8:

"We usually have about 60 to 70 clients in a day, does that mean each of us will screen about 15 patients?…, do you understand? It will affect our staff strength and workload."

Participant 3:

"We don't have enough midwives compared to the number of patients we have here, sometimes we see about 100 to 150 patients per day and we are only eight midwives and we run shifts. It is not all the eight midwives that will be on the ground at once. There is a shortage of staff generally in the hospital."

Participant 7:

"There are many patients, but few midwives because we are lacking staff in this hospital. Honestly, as you can see, we [staff] *are not many. It's only three of us and all these pregnant women."*

Another extract from participant 8 highlighted the inadequacy of midwives for standard practice:

"We are not adequate in number for standard practice of screening everyone. That is why we are incapacitated to do most of the thing"

This subtheme was further confirmed through data triangulation of non-participant observations, where the researcher observed the increased workload experienced by staff first- hand. For instance, she observed that the ANC runs from Monday to Friday with different groups of pregnant women under different teams of doctors, but with the same midwives. These teams and corresponding groups of pregnant women have designated days for visiting the clinic. For example, there are teams A, B, C, D and E; pregnant women in 'team A' visit only on Tuesdays, while those in 'team D' visit only on Thursdays. Every Wednesday is for booking new patients, but is also the visiting day for pregnant women in 'team C'. There are three midwives in attendance per day (two junior and one senior) to see about 70-80 patients. Most of the work is being carried out by the junior staff while the senior staff do the paperwork/ administrative work.

Another observation was of the crowds of pregnant women attending the ANC, especially the booking day clinic, and the insufficient time midwives had to spend with each patient conducting routining assessments, as a hindarance to screening of pregnant women for IPV. This was further confirmed in the following extracts, where midwiveees raised their fear that

screening pregnant women for IPV will further deplete the time available for them to do their routine work.

Participant 9:

> *"Screening for IPV might consume a lot of our time and we may not have enough time for our normal routine antenatal care like palpation, urine testing. It may take about 15 minutes more for us to screen one client and we cannot afford such a time with the number of patients we see every day."*

Another extract, from participant 3, supported this:

> *"We do HIV screening for pregnant women and counsel them regardless of whether the result is positive or negative on every booking day. So all these things are time-consuming, I don't know how it will be when we add this one to it because of too many patients to see with limited time."*

5.3.4.3. Institutional hindrances

This subtheme was generated from data that showed how the absence of institutional support, such as non-formalisation and no policies for screening pregnant women for IPV, in a northern Nigerian hospital hindered the midwives' screening practice. Data revealed that the midwives were not comfortable with screening for IPV without the approval of the hospital authority. This is illustrated in the extracts below.

Participant 5:

> *"… before we can screen we must first have approval from management, because if anything comes out of it we will have a legal backing from the authority concerned.*"

Participant 2:

> *"We were not given the approval by the management to screen pregnant women for IPV in this clinic."*

Another extract from participant 5 highlighted the absence of directives from the hospital management to screen pregnant women for IPV:

> *"We have not been directed to ask such questions* [screening for IPV]. *The only thing we do is to give health education to pregnant women, even the health education that we give here* [antenatal clinic] *is not individualised, it is in a group."*

Data further revealed the lack of formal policies to guide the midwives on screening pregnant women visiting the ANC for IPV as an institutional hindrance to their screening for IPV. This is illustrated in the following extracts.

Participant 2:

> *"There is no procedure in this hospital that requires us to ask our patients about intimate partner violence. So we have not been practising* [routine screening] *it in this hospital."*

Participant 1:

> *"Actually is not in our guidelines to routinely screen pregnant women for IPV, so I have not been screening.*"

Participant 4:

> *"There is no guiding procedure on screening pregnant women for IPV and I have never come acroos any."*

Data also revealed the readiness of the participants to routinely screen pregnant women for IPV, if a screening tool and policies are provided to guide them. This is demonstrated in the following extracts:

Participant 5:

> *"Once it is routine that we should be screening for IPV in the hospital then we should have laid down questions to ask and then the procedure to follow. For now, we don't have such."*

Participant 1:

> *"We will screen if screening for IPV is in our scheme of work, but for now we do not have guidelines on what to do."*

5.3.5. Structure-related hindrances to IPV screening

Three subthemes emerged from data related to poor infrastructure and facilities as external factors that hinder midwives' screening practices for IPV among pregnant women. The subthemes are closely related to the physical environment construct of the theoretical framework that guided the research and included lack of space for privacy, lack of referral centres on IPV and lack of resources for managing IPV victims (Figure 5).

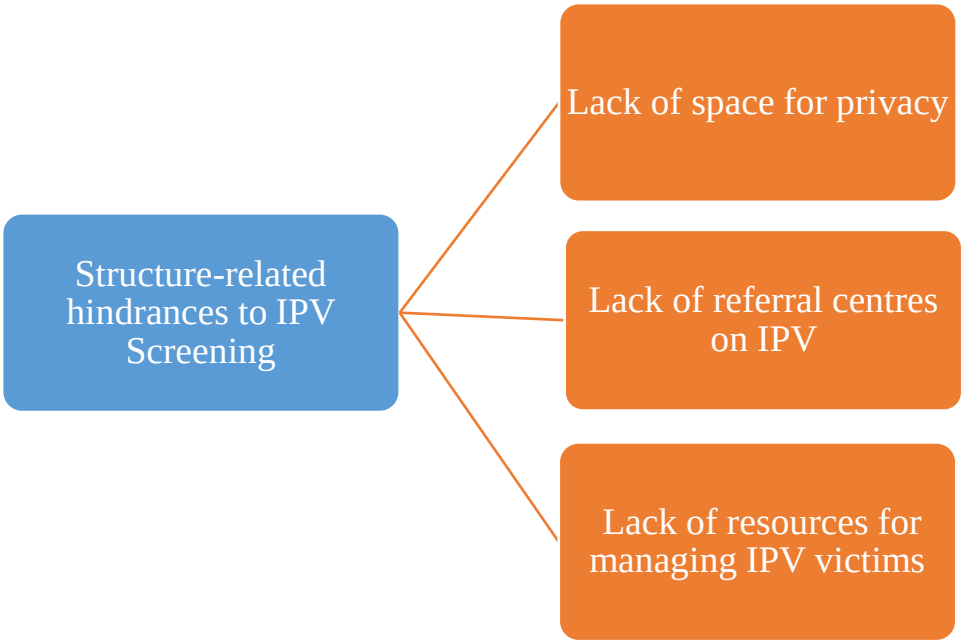


Figure 5: Structure-related hindrances to IPV screening and its subthemes.

5.3.5.1. Lack of space for privacy

This subtheme emerged from data related to the challenges of inadequate space for privacy in the ANC. This was further confirmed by the researcher during the non-participant observation as part of the triangulation of data, where she noticed that all patients are seen in one large waiting room. A midwife was checking blood pressure while two other midwives were booking new pregnant women separately and asking them about their medical, obstetric and family history – all at the same time in the large waiting room. However, there were different cubicles set aside for patients who are referred to the medical doctors for further assessment and management. The set-up of the large waiting room made it difficult to conduct private discussions, thus confirming lack of privacy for IPV screening. Further extracts that confirmed this subtheme are highlighted below.

Participant 6:

> *"…, there is no space for private matters like IPV. Most of the things we do, like health education, we do them in groups, here in the same hall."*

In the two extracts from data below, midwives were concerned that the researcher was asking about private space for midwives to do assessments and screening for IPV when it was even difficult to get adequate spaces for doctors to conduct their own private consultations with their patients.

Participant 5:

> *"When we are doing booking, this place is usually so choked up, we don't have space. Sometimes the available cubicles are not even enough for doctors to consult let alone for creating a private place for us and patient to discuss intimate issues like IPV comfortably in this. It is imposible."*

Participant 7 further supported the above view:

> *"In fact this place is so inadequate, we sometimes take some pregnant women to Surgical Out Patient Department (SOPD) clinic to see them there as new clients so as to decongest this place. We cannot ask sensitive matters in this space."*

Participant 3 added:

> *"With time this place must be changed, because it is not convenient for even ordinary history taking ... On Wednesdays we use the SOPD to book our clients because this place is not good for booking many patients due to lack of private space. But that cannot go on forever, especially if we now have to ask such sensitive questions as IPV."*

Participant number 2 summarised the necessity of privacy for IPV screening:

> *"If privacy is provided I know some women will be able to voice out what they are facing in their homes but the way our clinic is, such facility has not been created."*

5.3.5.2. Lack of referral centres for IPV

This subtheme emerged from data highlighting how the absence of centres to refer IPV cases to for safety (as often found in the developed countries) discourages midwives from screening pregnant women for IPV. Data revealed that participants felt that it was pointless to screen for IPV when one cannot do anything further when IPV is detected or established. This is demonstrated in the extracts below.

Participant 9:

"We have different centres where we refer patients with different problems, like people with HIV, but on intimate partner violence, we don't have a centre for it. So we don't screen because if we find that someone is indeed abused in their marriage, what will we do? I think it would be irresponsible for me to raise the patient's hopes by asking and then failing to refer her appropriately."

Participant 2 confirmed that the lack of referral centres is a challenge:

"It's easy to screen for HIV because you know where to refer HIV-positive patients to. Apart from the referral centre for HIV, we do not have any referral centre for IPV victims, so it will be difficult for us to screen when we cannot help victims."

Participant 1 showed how the midwives felt helpless about lack of referal centres for IPV victims:

"Even if we screen these women for IPV and we find that they are indeed abused, where do we refer them to for help? There are many victims of IPV in our society, but we can't ask them to tell us because we cannot refer them for help. At least I do not know where I can refer them to in this area."

5.3.5.3. Lack of resources for managing IPV victims

This subtheme emerged from data related to the absence of resources for managing those women who could be identified as being in abusive relationships as a hindrance to screening for IPV by midwives. Data revealed midwives' expressions of concern regarding what could be done to provide facilities to help the pregnant women, as well as how the absence of such can lead to loss of confidence in the midwives or health care system itself, if no help was provided, as depicted in the following extracts.

Participant 3:

"…. But if they are not helped, they may say to others 'The midwives only want to know your family matters and talk about it, they will not do anything to help out of the situation.' This may lead to most of them keeping the abuses to themselves. I think we should have resources to manage those that are victims of abuse in this hospital. If the pregnant women are helped when they tell us about their problems, they will spread the news and I think some of them will start coming out. Even those that don't want to come out before."

Participant 6:

"What do we do for these women after we identify them as victims of abuse? Do we say – thank you for telling me and fold our arms? No, they will expect us to do something. There

have to be solutions or benefits for patients coming out to vioce their problem. Right now, there is nothing. So we cannot screen for problems we cannot solve."

Data also revealed the absence of resources in the hospital as the government's responsibility, with participants stating that they do not have resources for IPV victims because the government does not prioritise IPV nor make provision for it. This was found to influence the screening of pregnant women for IPV negatively, as demostrated in the following extract from paticipant 7:

"…This is the government facility, we rely on what the government sees as priorities and provides resources for. We cannot take or have what they [government] *have not given us. If the government is not priopritising IPV and giving us reseources to manage it, we cannot screen women for IPV."*

The findings from phase one of the study showed there were selective screening practices by midwives. Also, there were no pre-set questions on IPV on the antenatal card to screen pregnant women in the ANC clinic. This informed the next phase of the study, in which the AAS tool was adopted and used to screen pregnant women in-order to adapt it. The challenges of using the AAS tool in the Nigerian context were ascertained, and recommendations made on the adaptation of the AAS too. These are presented in the findings of phase two and phase three below.

5.3. Section 3: Findings of phases two and three of the study

Phase 2 of the study generated data from non-participant observations during the screening process and phase 3 generated data from the FGD at the end of the screening process. The objectives were to determine the challenges encountered by the midwives in using the AAS tool among pregnant women in a northern Nigerian hospital and to adapt the AAS tool for screening pregnant women for IPV in northern Nigeria. Findings from these phases are presented in the subdivisions of this chapter.

The data sources from both phases (non-participant observation and FGD) were triangulated and revealed four themes associated with the use of the AAS tool:

1. AAS tool-related challenges
2. Practice-related challenges

3. Pregnant women-related challenges.

Further to the challenges, data analysis revealed another theme, termed ‘Recommendations for IPV screening’, which is the fourth theme. The findings were then used to adapt the AAS tool into the IPV Assessment Screen (IPVAS) tool.

5.4.1. AAS tool-related challenges

This theme emerged from data related to the questions on the original AAS tool addressed abuse and not IPV. Some of these questions were identified by participants as creating challenges in obtaining precise answers from the pregnant women. Participants highlighted the problematic questions and made recommendation on how such questions should be changed, as demonstrated in the extracts below.

Participant 3:

> *“The Question number 4* [of the original AAS Tool] *asks: Has anyone forced you to have sexual activities? It is not clear whether the question relates to the pregnant woman’s own husband or anyone in general. My thinking is that from the way it is being asked, every one of them will say no. This is because they will interpret anyone to mean a stranger. Perhaps the question should be direct and replace ‘anyone’ by ‘husband’.”*

An extract from participant 10 went further to explain that the word ‘anyone’ should not be in IPV questions, because the tool is meant for couples who are in intimate relationship, and especially married women. The word ‘anyone’ may be interpreted by the women to insinuate that they could be having affairs outside of marriage, an issue that is a taboo in the northern region of Nigeria:

> *“… this screening tool is particularly referring to pregnant women. If you say ‘anyone’, it suggests extramarital affair and it is not allowed in our culture and should not even be hinted at, in a tool.”*

Participant 5 suggested that the word ‘anyone’ or ‘someone’ be replaced with ‘partner’ and ‘husband’ to reflect the intimate relationship without reducing the usefulness of the tool:

> *“Instead of putting ‘anyone’, there should be ‘partner’ or ‘husband’ there because the pregnant women were reluctant to answer those questions with ‘anyone’ or ‘someone’.”*

All the participants shared the view that some words in the tools can be removed or rephrased to make the tool more precise, without reducing its ability to assess IPV.

This was confirmed by the researcher during the non-participant observation, where some pregnant women were observed to be startled at the screening questions. Some pregnant women even exclaimed "What kind of question is this?".

The researcher also observed another pregnant woman laughing in amusement and being a bit surprised as the midwife was asking her the screening questions. It was obvious that she has never been asked such questions before and nor did she expect to be asked such questions. Her general outward behaviour showed that she was wondering whether the screening is targeted at her.

Data further revealed that the participants were not comfortable with asking certain questions and also noticed some underlying tension in the pregnant women in responding to those questions, as observed during the non-participant observation. The researcher also observed a pregnant woman's face fall in the course of being screened, and it could be seen that her responses became reluctant and half-hearted as the screening progressed.

Participant 10 highlighted that some of the pregnant women hesitated before answering some questions, especially Question 4 from the original AAS tool, which asks 'Within the last year has anyone forced you to have sexual activities?', as illustrated below:

> *"… it was not easy getting their response because they were reluctant to answer some of the screening questions, especially Question 4."*

Participant 3 added:

> *"Most of the pregnant women were reluctant to answer Question 4."*

Data further revealed that the questions were awkward and the pregnant women were uncomfortable in answering them, as illustrated by an extract from participant 9:

> *"To some women, I think the questions were embarrassing… I could hear some pregnant women saying 'Hmmmm!'* [a sign of being hesitant or not wanting to answer the question] *before answering."*

5.4.2. Practice-related challenges

This theme emerged from data related to the difficulties experienced by the participants over the period of 8 weeks during implementation of the screening process using the original AAS tool. The challenges included the days for screening, that is, whether screening for IPV

should be done on specific dates, for example on the first booking date or on repeated dates, as illustrated in this extract from participant 7:

> *"The booking day is still better, all things considered, so as to avoid repetition. This is because it is the day that we have fresh patients."*

The researcher observed screening of pregnant women on booking day to be more organised than on any other days, although there were more pregnant women attending the ANC on booking day than on other days.

An extract from participant 3 explained why the midwives should screen on booking day:

> *"Booking day is a day when we are opportune to have one on one interaction with the pregnant women more than any other days."*

Participant 6 supported the above statement, as follows:

> *"We might have seen some pregnant women before and instead of repeating the screening on her again it is better we screen new people*."

5.4.3. Pregnant women-related challenges

This theme emerged from data related to challenges posed by the personality and attributes of the pregnant women themselves in the course of screening them. Data revealed that the pregnant women do not trust the screening process nor the intention of the midwives, even after they (participants) had explained the purpose of the screening to put them at ease. The pregnant women still showed signs of uneasiness upon seeing the screening tool, as illustrated in this extract from participant 7:

> *"... upon seeing the screening paper, several of them became scared ... They think it is something that will be recorded and in these parts of the country people are afraid of recording of their words, whether written or on tape. Even after I had explained why I was screening, they remained scared."*

As participant 2 attested:

> *".... the pregnant women were actually scared to open up, maybe it happened or did not happen, but they were generally scared*."

Participant 3 highlighted the uncooperativeness and unwillingness of pregnant women to answer the screening questions, and went on to narrate her own personal experiences. She

particularly mentioned the issue of pregnant women who become tense, afraid and clam up once they see the screening tool or once the midwives begin to ask questions on IPV. She opined that such fear was probably due to anticipated consequences that may follow if the disclosure becomes public or just out of shame. She added:

> *"… it is a fact that most of them were scared to open up. This may not automatically mean that they have been victims and are afraid of the consequence of disclosure, but it sure suggests something like that."*

5.4.4. Recommendations for IPV screening

This theme was informed by triangulated data from the challenges encountered by the midwives during screening, which resulted in the adaptation of the original AAS tool. The adaptation of the original AAS tool was done in order to address the challenges raised by midwives, thus making the AAS tool more suitable for screening pregnant women for IPV in northern Nigeria.

Two subthemes emerged from the recommendations from the participants' use of the original AAS tool and the non-participant observations by the researcher (triangulation of data from both):

1. Need for a standard introductory statement in the screening tool; and
2. Need for midwives to have confidence during screening.

5.4.4.1. Need for a standard introductory statement in the screening tool

This subtheme was generated from data that highlighted the need for the new screening tool for IPV to have a common introduction, as a recommendation from all participants after they had engaged and used the original AAS tool for a period of 8 weeks. The recommendation on the need for a standardised introductory statement in the screening tool was in order to be able to explain the benefits of screening to pregnant women and to establish rapport. This is demonstrated in the extract below, from participant 3:

> *"… after explaining to them that the reason for conducting the screening is to help women … I got some yesses* [that is, go ahead]*."*

As participant 10 attested:

"… telling them that this screening is to prevent future reoccurrence and whatever they say, is private..., they become more willing and free-flowing."

An extract from participant 7 confirmed the significance of properly introducing the screening tool to pregnant women:

"When I explained to them our reason of doing the screening is to help women…, they came out to tell me the problem they are actually passing through, like the woman that came to tell us how her husband uses her name to borrow money. He did not pay it back and she was invited to appear in court on her expected date of delivery."

Data further revealed the need for the midwives to establish rapport with the pregnant women before screening them, in order to encourage the pregnant women to be comfortable to talk about issues in their relationship or their marriage, as illustrated in the following extracts.

Participant 2:

"… if personally am going through emotional or physical abuse, I may not tell my close friends, let alone a midwife who is more or less a stranger. Unless I feel am connecting with a person and the person has something to give me, I will not just start telling them personal details. So midwives must connect with the pregnant women first."

Participant 5:

"There is a level of intimacy that I will have with a midwife before I will tell my problem to her."

Data also revealed the difficulty of finding out the truth about IPV in the marriage of a pregnant woman that one is meeting for the first time, especially in the northern part of Nigeria, as demonstrated in this extract from participant 3:

"It's very difficult, even if the person does not have cultural inhibitions against disclosure, to just open up to somebody she is just meeting for the first time, whether nurse or not. There must be a relationship you have established with that person, for the person to say what she is going through …. The point I am trying to make is that, it's very difficult to just get a pregnant woman from the crowd of pregnant women and make her say those personal things. It will take a relationship or something, for her to say that."

Data revealed that it was not only the midwife-patient relationship that is important, but also the manner of approach with the patient, as illustrated in this extract from participant 9:

"It depends on the relationship and the way you talk to them, you must use the right approach in talking to your client. That is when you will see them opening up."

During non-participant observations the researcher saw different ways in which the midwives tried to introduce the AAS tool to pregnant women, which confirmed the need for a single and simple standardised introductory statement.

5.4.4.2. Need for midwives to have confidence during screening

This subtheme was generated from the data that highlighted the need for the midwives to show confidence during screening of pregnant women for IPV in the ANC. Data revealed that midwives asking questions from memory was helpful in building confidence in the pregnant women, as it forestalled the incidents of getting scared when they saw the screening tool, as demonstrated in the following extracts.

Participant 7:

"... at a point I decided to make it casual, I kept the paper away and I noticed that this eased the tension."

Participant 5:

"... I was asking without a paper. When I finished the screening interviews, I would put their numbers on it."

Participant 3 highlighted memorising the screening questions as time went by:

"... as time goes on I just ask the questions because it was already in my head"

During the non-participant observation in the screening process the researcher observed some of the participants asking the questions without paper, after which they then filled in the responses and put the patient's number on the screening tool. It is noteworthy that virtually all of them asked the questions in the prescribed order and were then able to fill in the responses.

An extract from participant 10 highlighted screening of pregnant women with the screening tool along with booking them with the antenatal booking card:

"... as I was booking pregnant women with their booking card, I used the screening tool as part of their booking too."

The researcher observed the participant booking pregnant women with the antenatal booking card and then later reading the questions from the screening tool that was kept beside the antenatal card. She went back to the antenatal card and back again to the screening tool.

5.6 Conclusion

This chapter described the sample and discussed the findings from the different phases of the research study. It was recommended that the original AAS tool should be adapted to suit the Nigerian context by rephrasing the word ‘anyone’ as ‘husband’, having a standard introduction statement, and the midwives portraying confidence when screening pregnant women for IPV.

The continuation of the adaptation process, in which the new screening tool was developed in phase four of the study, is presented in the next chapter.

CHAPTER SIX: ADAPTATION OF THE ABUSE ASSESSMENT SCREEN TOOL

6.1. Introduction

This chapter presents phase four, the final phase of the study, which is the adaptation of the AAS tool, the new IPV screening tool, and confirmation of the suitability of the new screening tool.

6.2. Adaptation of the AAS tool

Adaptation is the process of making something suitable for use in a new or different environment (Soanes & Stevenson, 2004). The original AAS tool, which was developed in 1991 by the Nursing Research Consortium on Violence Against Women (Laughon et al., 2008), was used in phase two of this current study by participants to screen pregnant women for a period of two months. Thereafter an FGD was conducted with the same participants to identify the challenges of using the AAS tool in the Nigerian context.

The findings suggested that the original AAS tool needed to be modified to be more specific for IPV. This was done for the purpose of adapting it to be more suitable for screening for IPV among pregnant women in northern Nigeria, in line with the objective of the study, which was to develop and confirm the IPV Assessment screening tool for pregnant women in Nigeria as a modification of the AAS tool. Based on the findings from phases two and three of the study, the AAS tool was modified. The whole adaptation process, including data collection and analysis in all phases took 12 months.

The researcher used the findings from phases two and three of the study in the adaptation of the AAS tool process, as follows:

1. Using the recommendation for an introductory statement, the following statement was added into the old AAS tool:

   > "Intimate partner violence (IPV) is the physical, sexual, economic, psychological or other harm or threat, against a woman by her husband or partner. We are putting these questions to pregnant women who are attending antenatal clinic in order to be able to identify and help those women who may be experiencing IPV in their marriages or intimate relationships. Please answer the questions sincerely."

2. To address question 4 in the original AAS, which previously stated "Within the last year, has anyone forced you to have sexual activities?", the researcher changed this question to **"Within the last year, has your husband or partner forced you to have sexual activities against your will?",** as seen in Question 6 in the new tool (Figure 6).

3. Questions 1, 2, 3 and 5 of the original AAS tool (Appendix A) were also amended by the researcher, using the recommendation from the participants, where she changed 'someone' or 'anyone' to 'husband' or 'partner':
   - **i.** Question 1 previously stated in the original AAS tool "Have you ever been emotionally or physically abused by your partner or someone important to you?". The researcher changed this to **"Have you ever been emotionally or physically hurt by your husband or partner?"**
   - ii. Question 2 previously stated "Within the last year have you been hit, slapped, kicked or otherwise physically hurt by someone? If yes whom-----, total number of times." The researcher changed this to **"Within the last year have you been pushed, shoved, slapped, hit, kicked, choked or otherwise physically hurt by your husband or partner? If yes, please estimate the total number of times**". These were changed based on the recommendations from participants and "choked" was included based on the study of (Laughon et al., 2008).
   - **iii.** Question 3 previously stated "Since you have been pregnant, have you been hit slapped, kicked, otherwise physically hurt by someone? If yes by whom---- total number of times" This was changed to **"Since you have been pregnant, have you been hit slapped, kicked, or otherwise physically hurt by your husband or partner?" If yes, please estimate the total number of times".**
   - iv. Question 3 also includes a body map and scale in the original AAS tool. The body map and scale were separated and assigned different numbers, so the body map is now Question 4 and the scale is Question 5. This led to an increase in the number of questions from 5 to 7 in the new tool.
4. The question on the body map in the original AAS tool previously stated "Mark the area of injury on a body map". The researcher changed this to **"Please mark the body part affected by your injury on the body map provided here"** in the new tool (IPV Assessment Screen or IPVAS tool).

5. The question on the scale in the original AAS tool previously stated "Score each incident according to the following scale." This was changed to **"Please tell me if there have been any of the following in your marriage/relationship:"**
6. Question 5 in the original AAS tool previously stated "Are you afraid of your partner or anyone in your life?". The researcher changed this to "**Are you afraid of your husband or partner?"**.

The new tool (the IPV Assessment Screen or IPVAS) for IPV screening was developed through the above steps (see Figure 6). This was then taken to the same participants to use and to confirm its suitability.

INTIMATE PARTNER VIOLENCE ASSESSMENT SCREEN TOOL

Intimate partner violence (IPV) is the physical, sexual, economic, psychological or other harm or threat, against a woman by her husband or partner. We are putting these questions to pregnant women who are attending antenatal clinic in order to be able to identify and help those women who may be experiencing IPV in their marriages or intimate relationships. Please answer the questions sincerely.

1. Have you ever been emotionally or physically hurt by your husband or partner?

   Yes ☐ No☐

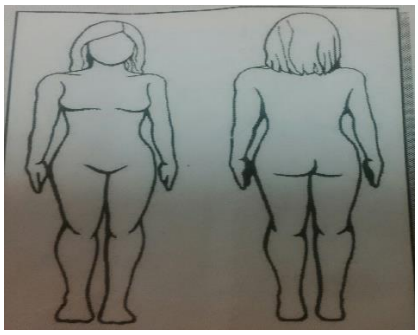
2. Within the last year have you been pushed, shoved, slapped, hit, kicked, choked or otherwise physically hurt by your husband or partner? Yes ☐ No ☐

   If yes, please estimate the total number of times _____

3. Since you have been pregnant, have you been hit slapped, kicked, or otherwise physically hurt by your husband or partner? Yes ☐ No ☐

   If yes, please estimate the total number of times _____

4. Please mark the body part affected by your injury on the body map provided here.



5. Please tell me if there have been any of the following in your marriage/relationship:

   - 1= threats of abuse, including use of weapon ☐
   - 2= slapping, pushing with no injuries and /or lasting pain ☐
   - 3= punching, kicking, choking, bruises, cuts, and (/or) continuing pain ☐
   - 4= beating up, severe contusions, burns, broken bones ☐
   - 5= head injury, internal injury, permanent injury ☐
   - 6= use of weapons, wound from weapon ☐

(If any of the descriptions for the higher number apply, use the higher number.)

6. Within the last year has your husband or partner forced you to have sexual activities against your will?Yes ☐ No ☐

   If yes, please estimate the total number of times _____

7. Are you afraid of your husband or partner? Yes ☐ No ☐

Figure 6: The IPV Assessment Screen tool

6.3. Confirmation of the IPV Assessment Screen (IPVAS) tool process

The new screening tool (IPVAS) was then given to the seven participants who took part in all of the previous phases of the study, to use in order to compare it with the original AAS tool and confirm its suitability.

The participants were given both the old and the new tool. They were to evaluate and assess whether the adapted tool met all their recommendations and was suitable for their context. They were asked to write confirmatory letters to indicate their responses. In providing their responses the study participants each wrote individual letters (see Appendix P).

6.3.1. Suitability of the new screening tool (IPVAS)

This theme emerged from the data confirming that the new screening tool is more elaborate, self-explanatory, easy to understand and specific in identifying IPV. It also demonstrated participants' support for the newly adapted tool for IPV screening, as seen in the extracts below.

Participant 3:

> *The new screening tool is much better as it is more specific on intimate partner violence unlike the previous one*

Participant 10:

> *This new tool for intimate partner violence is self-explanatory, easy to use and understand*

Participant 7:

> *The latest tool is more elaborate and easier for the client to understand*

Participant 6:

> *The latest tool was elaborate and simple for the client to understand*

Participant 2:

> *The new tool is easy to understand and has the intimate partner violence in it.*

The above statements from participants show that the new tool (IPVAS) is suitable to use for screening for IPV in pregnant women in the context of Northern Nigeria. The letters from participants are attached in Appendix P.

6.4. Conclusion

The Intimate Partner Violence Assessment Screen (IPVAS) tool for pregnant women in northern Nigeria was developed and confirmed as a modification of the AAS tool. The AAS tool was selected for adaptation because it has questions on pregnancy in it and has short questions. Based on the findings of phases two and three, the IPVAS was developed, and given to study participants to confirm whether it was suitable in their context. This led to the refined IPVAS tool.

A discussion of the findings is presented in the next chapter.

CHAPTER SEVEN: DISCUSSION

7.1. Introduction

This chapter presents a discussion of the findings of all phases of the study. Wile's HPT model, which guided the current study, was further used to guide a comprehensive discussion of the findings.

7.2. Screening practice of midwives for IPV

The current study revealed that the midwives do not routinely screen pregnant women attending the ANC in northern Nigeria. However, they employed selective screening, which is similar to case-finding methods to screen abused women. This was by seeing or sensing signs and symptoms of abuse, suspecting or thinking their patients might be abused by sensing their mood and interpreting the moody patients as possible victims and identifying patients at high risk of abuse, such as the HIV-positive patients. As such, the midwives missed the opportunity to screen, because not all victims of IPV present with physical symptoms of abuse.

Similar findings have been reported in other African countries, including Zimbabwe, Kenya and South Africa. In Zimbabwe Shamu et al. (2013) found that the midwives did not screen all pregnant women for IPV but only screened when they recognised obvious signs of IPV, such as physical injuries on the body parts. In Kenya Maina (2009) reported that screening for IPV was only conducted on women with obvious signs of abuse such as bruises. In South Africa Hatcher et al. (2016) reported that midwives were likely to disregard subtle cases of IPV and to focus more on those pregnant women with obvious physical injuries.

It is worrying that despite the high incidence of IPV in Africa, the African midwives including those from Zimbabwe, Kenya and South Africa do not practice routine screening. In other words, the practice of the midwives on the African continent is not up to standard or comparative with others internationally.

Mauri et al. (2015) also conclude that it is hard to identify IPV without physical signs of abuse, and as such it is a hidden problem. This calls for routine screening of pregnant women by midwives in Nigeria and other Africa countries, since IPV cannot easily be detected. However, with routine screening for IPV women experiencing abuse can easily be identified, treated and referred to save the lives of both the mother and the unborn child.

Contrary to the current study and studies in other African countries, in Australia Eustace et al. (2016) reported that routine screening for IPV was done for all women who presented in the ANC with or without signs of physical injuries, because all pregnant women were asked to complete an online form for IPV in the clinic, thus ensuring that all women were screened. The African continent is far from achieving this, and problems such as lack of a steady power supply and no internet make it difficult to conduct online screening.

Recently countries like the USA have achieved routine screening, as reported by Williams et al. (2017). Midwives in the USA routinely screened for IPV in ANC using a screening tool. In addition they assessed for danger and assisted in planning for safety for the pregnant women in need of it and referred to other services. Hindin (2006) also reported that midwives routinely screened for IPV at the initial visit of pregnant women, but on subsequent visits they used some clues which were prompted by their gut reactions, including behavioural and physical signs and symptoms and cultural clues, to screen pregnant women (Hindin (2006). However, such screening practices were inconsistent with the recommendation of the ACOG for universal screening, which requires screening once every trimester and once postpartum, making a total of four times during pregnancy.

Other studies with findings contrary to those of this current study have been reported in developed countries such as the UK, New Zealand and Sweden (Baird et al., 2013; Lauti & Miller, 2008; Stenson et al., 2005). Boinville (2013) reported that midwives do routinely screen pregnant women for IPV in developed countries, although the screening rate is low. Considering the level of awareness and availability of resources in developed countries, there may be other barriers hindering them from screening patients for IPV. In a systematic review of screening practices in developed countries by Alvarez et al. (2017) it was found that routine screening is being done in Canada, the USA and Belgium, but still not up to the ACOG recommendation of screening pregnant women four times in the index pregnancy.

Unlike in the current study, where midwives showed some hesitance in accepting their role in routine screening for IPV due to their inadequacies, such as lack of skills, various studies (eg. Feder et al., 2009; Price et al., 2007) have reported that midwives accepted the responsibility of screening pregnant women for IPV in other countries. They list their unique position in the midwife-patient relationship and the number of encounters they have with pregnant women during their antenatal visits as ideal for such routine screening. Clearly, assisting the midwives in overcoming their inadequacies through training, among other things, may play a

significant role in improving their competencies and willingness to conduct routine screening for IPV.

The current study revealed discriminatory screening of HIV-positive pregnant women for IPV by the midwives instead of routine screening. The reason stated by the midwives was that IPV is more common in HIV-positive than in HIV-negative women. They might not be totally wrong, because studies have highlighted the links between IPV and HIV in women both on the continent and internationally. In Tanzania Maman et al. (2002) reported that IPV was significantly increased in HIV-positive women compared with HIV-negative women. It was also reported in Kenya and Uganda that HIV testing of pregnant women during antenatal visits triggers violence against the women when their partner gets to know of the test results. They explained that this may be because the test was carried out without the women consulting their husband, and the men may not want to take responsibility for their wives' HIV-positive status (Hatcher et al., 2013; Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2006).

Contrary to this, some studies highlighted that IPV may be the triggers for HIV risky behaviour in women. In South Africa Jewkes et al. (2006) reported that women experiencing IPV are more at risk of having HIV because their male partner that perpetrates IPV is more likely to also be practising HIV risky behaviour such as having multiple sexual partners and having frequent sexual intercourse. They then introduce HIV to their wives, who may not be able to negotiate condom use to protect against HIV. Similar findings were reported in India, where women experiencing IPV were more prone to HIV than non-abused women, because their abusive husband is likely to have contracted HIV and transferred it to their wife (Decker et al., 2009).

Furthermore, studies conducted in the USA have shown that similar to those reported on the African continent, the fear of IPV by women affects effective communication with partners to negotiate condom use and discuss HIV status, leading to risk of contracting HIV (Campbell et al., 2008; Phillips et al., 2014).

Midwives should routinely screen pregnant women who present to the ANC for IPV, counsel and refer for further management. Though, HIV screening is mandatory for pregnant women visiting ANCs in Nigeria, including routine screening for IPV may further help in preventing

both IPV and HIV. Thereby in preventing IPV we may also be preventing HIV in pregnant women.

7.3. Midwives' internal hindrances to IPV screening

The study revealed that the midwives' internal hindrances to routine screening of pregnant women for IPV include midwives' personal discomfort in asking IPV-related questions, perceived mistrust of midwives by pregnant women, midwives' own perceptions of IPV as a personal matter, and midwives' lack of skills to screen for IPV.

7.3.1. Midwife's personal discomfort in asking IPV-related questions

The current study revealed that midwives were not comfortable in iniating the topic of IPV with all their patients. This may be because IPV is a sensitive topic or because they do not want to ruin the midwife-patient relationship that they may have developed between them (McCosker-Howard, Kain, Anderson, & Webster, 2005). Zijlstra et al. (2017) reported that personal discomfort with opening discussion on IPV with patients was associated with viewing IPV as a delicate issue. It could also be due to fear of making a false diagnosis of the situation and fear of destroying their relationship with their pateints. Other studies indicated personal discomfort as a hindrance to effective screening for IPV (Chang et al., 2009; Dichter, Wagner, Goldberg, & Iverson, 2015).

Guillery et al. (2012) found that personal discomfort in initiating IPV screeening was related to fear of giving a wrong label to the condition to the patients, which hinders the screening practice of midwives. This personal discomfort in initiating IPV screening may be due to inadequate training of midwives on IPV identification and related issues. Gutmanis et al. (2007) stated that training of participants in their study on IPV identification and related issues increased the personal comfort level of initiating IPV screening with patients. A sytematic review on barriers to screening for IPV by Sprague et al. (2012) found that personal discomfort with opening conversations on IPV with patients were seen across all specialists involved in providing healthcare to patients.

7.3.2. Perceived mistrust of midwives by pregnant women

The findings of the current study revealed that there is perceived mistrust of midwives by pregnant women regarding the confidentiality of their disclosure. Shamu et al. (2013) reported a similar finding in their study: that midwives perceived non-disclosure of IPV by pregnant women to the midwives to be as a result of lack of trust in the confidentiality of their disclosure. Hatcher et al. (2016) found that midwives believe pregnant women are usually afraid to disclose abuse because such disclosure might get back to the perpetrator, thereby leading to more abuse and losing economic provision by the perpetrator.

Bacchus et al. (2010) found that six months after a post-training intervention of screening, midwives still complained of women's reluctance to trust them on the confidentiality of their words. Baird et al. (2013), however, found that as time goes on, with repeated visits of pregnant women to the clinic and the development of the midwife-patient relationship, pregnant women were able to disclose abuse. Lauti and Miller (2008) and Stenson et al. (2005) stated that a trusting relationship is needed for pregnant women to disclose abuse to their midwives, which may facilitate disclosure of abuse to the midwives. Guček, Petek, and Švab (2016) also supported the current findings, that among the factors that deterred midwives from screening patients for IPV is the perceived lack of trust and sincerity on the side of the patients in disclosing abuse.

Feder et al. (2009) found in their review that the mistrust of midwives by pregnant women was due to the latter's doubts about midwives' intentions in screening them. The pregnant women are not sure of what may happen to them after their disclosure to midwives. Other studies have revealed that pregnant women were unwilling to disclose abuse due to mistrust of midwives regarding the confidentially of their disclosure and the fear of involvement of law enforcement and child protection services if they were to disclose abuse (Bullock, Bloom, Davis, Kilburn, & Curry, 2006; Prust et al., 2017; Renker & Tonkin, 2006). Midwives should ensure confidentiality of the disclosure of women, and their intention for conducting IPV screening should be stated clearly. Available resources and assistance for abused women in the hospital and communities should be communicated to pregnant women, in order to clear mistrust from women and encourage disclosure.

7.3.3. Midwives' own perceptions of IPV as a personal matter

It was also found by the current study that some midwives perceive IPV as a personal matter of the pregnant women. They attributed non-disclosure of IPV to the culture of shame of pregnant women in northern Nigeria, who are usually shy, ashamed and secretive. These midwives perceived IPV as a private issue between couples and, as such that it was a cultural taboo for women to disclose abuse to an outsider. This finding is similar to those of Edin and Högberg (2002) and Ellsberg (2006). Hatcher et al.'s (2013) study in Kenya revealed that IPV is seen as a normal practice in couples and that the society has accepted it. In other societies, where it is not accepted, pregnant women are being deterred from speaking out about IPV to midwives in order to protect the family image (Mauri et al., 2015). Rather, disputes are handled by the extended family (Hatcher et al., 2013). Shamu et al. (2013, p. 519) termed non- disclosure of IPV as a "culture of silence" in which pregnant women remain mute when asked about IPV.

Similar findings were also reported by Al-Natour, Qandil, and Gillespie (2016) in their phenomenological study of nurses' role in screening for IPV in Jordan. They found that nurses perceived that women may not disclose IPV to them if they were to screen them. They attributed this to the Jordanian culture of hiding abuse in order to protect their family's status. The study by Williams et al. (2017) in the USA indicated that culture is perceived to be important in the willingness of pregnant women to disclose IPV to health practitioners. They stated that Hispanic women are less willing to disclose abuse than the American women. However, the values clarification method can be used to change the midwives' preconception of IPV as a private issue which pregnant women will not disclose. Midwives should explore their core values by identifying their own attitudes, to assist them in understanding the values that are important in caring for pregnant women. Values clarification is a method in which core values are explored and expressed in order to clarify and choose the most appropriate values that will be beneficial to their profession (Uustal, 1977).

7.3.4. Midwives' lack of skills to screen for IPV

The current study revealed a lack of skills, such as lack of or inadequate training, and inadequate knowledge and education on screening against IPV, as an internal hindrance to midwives screening pregnant women for IPV. Similar findings have been reported in Jordan, Canada and The Netherlands (Al-Natour et al., 2016; Gutmanis et al., 2007; Zijlstra et al.,

2017). In South Africa it was also reported that lack of skill and inadequate training on IPV-related issues resulted in pregnant women who presented with physical signs of abuse in the clinic not being asked about them (Hatcher et al., 2016). A similar finding was also reported in Tanzania by Laisser et al. (2011), where lack of skills was a big challenge encountered by midwives in screening for IPV.

Unpreparedness for IPV screening is one of the factors that has been repeatedly reported in other countries. For instance, a study by Mauri et al. (2015) revealed that midwives in Italy find it challenging to identify victims of IPV, and as such they feel unprepared to screen for IPV. They are also scared of mismanaging the situation if their patients were to screen positive. Finnbogadóttir and Dykes (2012) reported that midwives in Sweden also avoid screening for IPV because they lack the knowledge and skill to manage the patient and the situation if they were to turn out positive. It was also reported that lack of education on screening for IPV deterred other health providers from screening; this ranged from not knowing the appropriate manner to adopt in broaching the discussion of IPV with their patients to not knowing what to do if the patients were to disclose abuse (Sprague et al., 2013; Zijlstra et al., 2017). The need for education on IPV screening cuts across all health providers.

The findings of the present study also revealed that the midwives saw the need to include screening for IPV in the antenatal routine, and support the inclusion of IPV screening in their in-service training programme and Nursing/Midwifery school curriculum. Their justification is that the new registered midwives will then have the skills to screen and discuss IPV issues comfortably and effectively. Mezey et al. (2003) supported the suggestion of IPV training in the Midwifery programme to form part of the midwives' education. The midwives will then have the requisite skills to screen and discuss IPV issues with pregnant women who are experiencing abuse, in a calm and professional way. This finding is consistent with that of Conn et al. (2014), who stated that IPV education should be included in the existing school training programme and should be made compulsory for all health providers in order to screen for IPV effectively.

Baird et al. (2013) in their five-year follow-up study of the Bristol Pregnancy Domestic Violence programme revealed that with training and ongoing training on IPV, some of the barriers perceived by midwives to be hindering them from screening pregnant women against IPV were reduced. A similar finding was reported by Gutmanis et al. (2007), who found that

training of health providers meant they were able to attain increased feelings of preparedness to screen, self-confidence and comfort with initiating and discussing IPV after disclosure of IPV by patients.

Bacchus et al. (2010) advise that a one-off training of midwives will not achieve routine screening of pregnant women, but that ongoing training and continuous education and support are needed for effective and routine screening of pregnant women for IPV. Other studies also advise that training for IPV should be channelled towards practical screening skills, access and availability of resources in both hospitals and communities, a clear referral route for midwives, a support programme for women experiencing IPV, collaboration with other agencies involved in IPV, and training of IPV advocates in the clinical setting to give support to midwives and pregnant women (Bacchus et al., 2010; Feder, Wathen, & MacMillan, 2013; O'Campo et al., 2011).

The internal hidrances are an attitudinal problem of the midwives which affects effective screening for IPV. Continuous education and training of midwives on IPV screening and related issues will increase the midwives' comfort level, skill and knowlegde, and improve their attitude towards routine screening for IPV.

7.4. Midwives' external hindrances to IPV screening

These are the factors that are external to the midwives, which hinder them from routinely screening pregnant women for IPV in the ANC. These include antenatal card-related hindrances, workload-related hindrances and institutional hindrances.

7.4.1. Antenatal card-related hindrances

The current study identified absence of IPV-related questions in the antenatal booking card as a factor that hindered the midwives from screening pregnant women for IPV. This finding is consistent with that of Hatcher et al. (2016), who reported that the antenatal green card, used in the intake of information on pregnant women visiting the ANC for the first time, does not contain information on IPV. Hence they do not screen pregnant women for IPV, since they do not know what to ask of them. The absence of screening questions on the antenatal booking card or intake forms did not give the midwives the opportunity to ask or be aware that they should ask patients visiting the ANC about IPV (Finnbogadóttir & Dykes, 2012).

O'Campo et al. (2011), in support of this, found that midwives may lose their confidence in screening pregnant women for IPV when they do not know the appropriate questions to ask or when to ask their patients about IPV in the absence of screening questions.

A study by Spangaro et al. (2011) found that among the factors that facilitated screening for IPV in the study area was the inclusion of short scripted questions for IPV in the intake form for pregnant women in the clinic. These questions were easy to ask and document because they were combined with other questions asked during the booking process for pregnant women. The practice prevented the dilemma of whether to ask or not, since all pregnant women were routinely screened during their antenatal visit to the clinic.

In recognition of the absence of screening questions on IPV in the antenatal card, as identified in other studies as a factor that hindered midwives from screening for IPV, Alvarez et al. (2017) and the ACOG (2012) call for the inclusion of standardised screening questions on IPV on the antenatal booking card or routine intake forms. This, they argued, will facilitate the screening of pregnant women for IPV, whether abuse is actual or merely suspected. The idea for the inclusion of screening questions for IPV on the antenatal card to remind midwives to screen is a good one, but the current study found that there is limited space to include IPV screening questions on the antenatal card. However, the IPV screening questions may be put onto a separate sheet and attached to the antenatal card.

7.4.2. Workload-related hindrances

Too many patients, time constraints and insufficient staff were identified as having hindered midwives' screening practices in the current study. This is consistent with the findings of many other authors. For instance, Laisser et al. (2011) reported that routine screening of women for IPV was not conducted in Tanzania due to the high number of women attending the clinic and lack of sufficient time to manage the emotions of the women. The current study also revealed that because of the huge workload, midwives give priority to other competing routine work, not paying attention to patients that may be victims of IPV. Lack of prioritising routine screening of IPV has been reported by other studies in both developed and developing countries (Natan et al., 2012; Stenson et al., 2005). Workload affects IPV screening by midwives, but with routine screening the danger of miscarriage and other health implications caused by IPV may be reduced. Hospital staff can be increased to share other responsibilities so that attention may be given to IPV screening.

Baird et al. (2013) found that midwives may become apprehensive about possible positive responses on IPV by their patients. This apprehension arises due to the additional routine work that will need to be done, coupled with the additional time they will need to spend to handle the emotional reaction of the patients. Conn et al. (2014) revealed that participants in their study in an orthopaedic clinic did not initiate screening for IPV because of the limited time they had to consult with their patients and the high number of patients. This is also seen in the study of Sprague et al. (2013), who found that owing to the many patients seen in the fracture clinic and inadequate time to discuss IPV- related issues, health providers refrained from screening their patients for IPV.

The current study further revealed that there are many things being done in the daily routine antenatal care of pregnant women that are time-consuming and may further hinder the midwives from screening for IPV, thus agreeing with the findings of Bacchus et al. (2010) and Eustace et al. (2016), who reported that due to the busy nature of ANC and the limited time they have to spend with patients, midwives find it difficult to screen pregnant women effectively for IPV.

The problem of insufficient time also negatively affects the midwives in their capacity to build a trusting relationship with pregnant women. This in turn negatively affects pregnant women's disclosure of abuse to the midwives, which also affects effective screening by the midwives (Guillery et al., 2012; Williams et al., 2017). Other studies also indicate insufficient time as a constraint to routine screening of pregnant women (Baird et al., 2013; Lauti & Miller, 2008).

Shortage of staff was also revealed as a hindrance to routine screening of pregnant women in the ANC in this study. Shamu et al. (2013) and Hatcher et al. (2016) found that due to insufficient staff in the clinic the midwives are not ready to take on the new or additional role of screening pregnant women for IPV. In their study Laisser et al. (2011) conclude that screening for IPV will only be done when the hospital management is prepared to hire additional staff in the ANC. Several other studies have identified insufficient staff, which affects the workload in the ANC, as an important factor that hinders screening (Guček et al., 2016; Hooker et al., 2015).

7.4.3. Institutional hindrances

Absence of institutional support for IPV screening, such as lack of formalisation of IPV screening by the hospital authority and absence of policy and guidelines are seen as hindrances to the screening of pregnant women for IPV by midwives in the current study. Screening pregnant women for IPV without formal approval from hospital management could be a challenge when litigations arise and the midwives who screen for IPV are left to fend for themselves in the court of law. This was also highlighted in the study by Al-Natour et al. (2016), who reported that in the absence of approval from the hospital authority the midwives do not screen their patients for IPV due to fear of being involved in a police or legal tussle which may warrant the direct or indirect involvement of the hospital authority.

Other studies have reported that formal approval of screening for IPV improves screening practices. For instance, McCloskey et al. (2005) stated that approval of screening, in various sites of their study increased the frequency of screening by midwives in the USA. Spangaro and her colleagues (2011) also reported that screening rate increased and remained sustained for a long period due to institutional support in Australia.

The finding of the study that absence of policies on IPV screening may have served as a hindrance to routine screening of pregnant women in the ANC is consistent with those of Al-Natour et al. (2016) and Clark et al. (2017). The midwives complained of lack of procedures to follow, and not being certain of what to ask, when to ask and what to do when IPV was disclosed by pregnant women in this study. These complaints were echoed by other midwives in the study of Prust et al. (2017). Eustace et al. (2016) found that the absence of guidelines on screening of pregnant women for IPV and action to take in the case of possible positive disclosure of IPV by pregnant women also affect screening for IPV. Sprague et al. (2013) reported that the participants in their study complained that while they know the procedure to follow and what to do after screening for child abuse, they do not know the procedure to follow after screening pregnant women for IPV.

Screening programmes that were successful have effective policy, unambiguous screening protocols and approval from the hospital authority as prominent facilitators to IPV screening in the clinical setting, as reported in systematic reviews of screening programme (Alvarez et al., 2017; O'Campo et al., 2011). Clearly there is need for formal approval and policy on IPV screening by midwives in Africa. These will help to boost the confidence level of midwives

to carry out initial IPV screening of pregnant women, thereby reducing the maternal and perinatal mortality rate in Africa countries.

The external hindrances to IPV screening are organisation problems which can be solved by the hospital authority and government. The hospital management should give formal approval of IPV screening, provide policy and guidelines to guide midwives in effective screening for IPV and increase the number of staff working in ANC.

7.5. Structure-related hindrances to IPV screening

The current study revealed inadequate space to provide privacy for midwives and their patients to discuss IPV-related issues as a hindrance to midwives' screening practice. This is similar to other reports where insufficient space to carry out history-taking with pregnant women during booking in the ANC was identified as a factor that hindered midwives from screening for IPV (Laisser et al., 2011; Shamu et al., 2013).

An environment similar to the large waiting room described in the current study was reported by Williams et al. (2017) in a study conducted in an emergency department. Here patients' beds were narrowly packed together and only demarcated by a drape, and discussions between the patients and health providers could be heard by other patients and their relatives, thereby inhibiting routine screening for IPV. Other studies confirmed that lack of space for privacy affected their routine screening practice for IPV (Sprague et al., 2013; Zijlstra et al., 2017).

Privacy is important for routine screening to be executed by midwives, so that midwives and their patients will be comfortable to discuss IPV and its related issues. In the absence of this, confidentiality cannot be ensured or avoidance of a third party listening to their discussions (who may be her partner). The implication of this is that pregnant women may be endangered when abuse is disclosed. Therefore privacy affects routine screening for IPV (Baird et al., 2013; Bermele et al., 2018; Price et al., 2007).

The findings of the current study revealed that absence of referral centres and resources hinder midwives from screening for IPV. The absence of resources and referral centres such as shelters, designated places for IPV victims and transit homes in the hospital or community to manage positive IPV cases in pregnant women further deterred midwives from screening for IPV (O'Campo et al., 2011). Laisser et al. (2011, p. 6) reported that problems that cannot be addressed should not be screened for in the first place, calling it "an ethical dilemma" to

screen and not to have the resources to help victims of IPV. Similar findings was reported by Lauti and Miller (2008) in their study, where lack of resources and referral centres to refer pregnant women who might have screened positive to IPV to in order to access the necessary services also affected their screening for IPV. Adequate information on the available resources in the hospital and communities, as well as ways of accessing these resources, should be communicated to victims of IPV. Hatcher et al. (2016) confirmed that lack of referral centres in the communities for appropriate management of victims of IPV makes it futile to screen for IPV.

O'Campo et al. (2011) reported that IPV screening programmes that have support for IPV victims, such as referral centres that provide mental health services, empowerment programmes, emergency services, social services, access to lawyers, safe shelters and collaboration with other agencies working with IPV victims, were successful. Spangaro et al. (2011) confirmed that availability of resources in the hospital such as social services personnel on-site and on call boosted midwives' confidence in screening. Availability of resources in the hospital and communities will encourage midwives to screen for and pregnant women to disclose IPV.

Prust et al. (2017) and Hatcher et al. (2016) suggested that referral to IPV centres should not be taken lightly as this facilitates pregnant women's access to social services, support and safety. Midwives should be aware of the available and access to resources for IPV victims in the hospital and communities to facilitate referral to services for support and safety of IPV victims. These services include mental health service and other services provided by law enforcement, the judiciary and social services. There is also a need for the government to provide appropriate funds to create centres to care for abused women and empowerment programmes. The non-government organisations can collaborate with the community's leaders to build shelters that will accommodate abused women for a short period before the women can get permanent accommodation, as is the practice in South Africa (Lopes, 2016).

7.6. Challenges faced by midwives in using the original AAS tool

The AAS tool was chosen for use in the current study because of its short questions, the fact that it was easily understandable, its time-effectiveness in screening and its pregnancy-related questions (Laughon et al., 2008). It is further confirmed by Shoffner (2008) that the AAS tool was created precisely for screening pregnant women for abuse. In selecting the AAS tool

the researcher was guided by the recommendation of Rabin et al. (2009, p. 443), who stated that "AAS was the only screening tool that asked specifically about abuse during pregnancy and therefore important for obstetric populations" in their systemic review of IPV screening tools. Moreover it was felt that since the AAS tool also has been tested against other screening tools, and found to have relatively good validity and effectiveness in identifying abuse in pregnant women (Feder et al., 2009; Laughon et al., 2008), it would be easier to use or adapt in the current study.

The AAS tool has been successfully used with safety assessment for interventions in increasing women safety behaviour to prevent future occurrence of IPV and reduce its effect on mother and child (McFarlane et al., 2002; McFarlane, Parker, Soeken, Silva, & Reel, 1998). McFarlane et al. (1998) found that pregnant women who were assessed for IPV with AAS tool at the same time provided information on safety plan and access to resources in the community. Implemented the safety behaviour after the first session of the intervention. Though pregnant women used different resources such as health care, law enforcement, legal service, shelter, and supportive counselling to end abuse even at 6 and 12 months post intervention. McFarlane, Soeken, Reel, Parker, and Silva (1997) concluded that, it was system failure for pregnant women to use different resources at 12months of intervention to end abuse. Midwives should go beyond providing information on resource in the community to coordinating the referral resources to effectively prevent future abuse of pregnant women.

However, when the AAS tool was actually used in the current study findings revealed that midwives as research participants were not comfortable with some of the questions in it. Their discomfort came from Question 4, as indicated in this quote from one of the participants;

> *"The Question number 4* [of the original AAS tool] *asks: Has anyone forced you to have sexual activities? It is not clear whether the question relates to the pregnant woman's own husband or anyone in general. My thinking is that from the way it is being asked, every one of them will say no. This is because they will interpret 'anyone' to mean 'stranger'. Perhaps the question should be direct and replace 'anyone' by 'husband'."*

Another participant indicated that Question 4 of the original AAS tool may suggest that the pregnant women had extramarital affairs:

"… this screening tool is particularly referring to pregnant women. If you say 'anyone', it suggests extramarital affair and it is not allowed in our culture and should not even be hinted at, in a tool."

These findings are unique to the current study. Previous studies have not highlighted problems with the identified question in the AAS tool as a handicap. A study where an item was removed from the AAS tool was reported by Laisser et al. (2011) who, in their pilot intervention study in the outpatient department modified the original AAS tool by removing the question on ranking of violence, the body map and a question on pregnancy. They justified the exclusion of ranking of violence on the grounds of lack of time for additional training of their participants and the fact that non-pregnant women were also among women screened for IPV. Their participants complimented the screening tool in easing their task, because of its short and easy to understand questions. Also Spangaro et al. (2011, p. 134) used short "scripted questions" which were a modification of the original AAS tool questions. The short-scripted questions contained two questions from the AAS tool and two other questions not specifically on abuse. This tool is called the New South Wales Health Screening Questions (NSW screening tool). Routine screening was achieved in their study, although their participants complained about the NSW screening tool not being able to identify the different forms of abuse and being too rigid.

The findings revealed that the AAS tool needs to be modified to reflect the intimate partner in it, since IPV is the physical violence, sexual violence, stalking and psychological aggression or other coercive tactics by a current or former intimate partner to his or her spouse or partner (Breiding et al., 2015). As such the husband or partner of married and unmarried women respectively should be included in the new IPV screening tool. Shoffner (2008, p. 43) and the ACOG (2012, p. 3) suggested that words that may stigmatise the victims further, such as 'abuse', 'rape', 'battered' and 'violence' should not be included in a screening tool. As such these words were not included in the IPVAS tool.

The findings in the current study revealed that the midwives have some challenges in actively screening pregnant women for IPV on days apart from booking day. Booking day is when new intakes of pregnant women visit the clinic and involves the midwives taking the medical, obstetric and family histories of the pregnant women. It also involves filling in of intake forms and carrying out several tests to screen against other diseases. The findings suggested that screening should be done on booking day, since this is a day when they have more interactions with pregnant women and activities are more organised. Similar findings were

reported by Eustace et al. (2016), that screening for IPV on booking days was easier because there was the opportunity for midwives to become acquainted with their patients. Baird et al. (2013) confirmed that screenings were mostly conducted at the first booking visit of pregnant women in their study. Bacchus, Mezey, and Bewley (2002) also indicated in their study that screening for IPV was done at the initial booking of pregnant women.

However, Lauti and Miller (2008) found that screening at the initial booking may not be the appropriate time because pregnant women may not disclose abuse since they have not yet established a relationship with the midwives. They suggested subsequent visits to screen pregnant women for IPV. Edin and Högberg (2002) suggested that screening pregnant women for IPV may be done on the booking day but was preferable at a subsequent visit, to enable a lapse of time for the midwives to be able to establish some level of interaction with the pregnant women before screening them.

The participants in this current study suggested that screening should be done once and on booking day, since this is the day when they have the opportunity to interact more with pregnant women. Spangaro et al. (2011) and Renker and Tonkin (2006) stated the contrary in their studies, arguing that pregnant women may not divulge abuse to midwives at the first contact, and therefore a repeated screening is necessary to allow pregnant women time to become at ease with the midwives so as to disclose abuse. Moreover, the cycle of abuse tends to increase with time. At the time a pregnant woman first visits the ANC she might be in the calm or honeymoon phase of the cycle and that may be her first contact with the midwives (Walker, 1980). If screening was done at that time, she might not be experiencing abuse and her response will be negative. If screening is not repeated at her subsequent appointment with the midwife in the clinic, she might not have the opportunity to disclose abuse. This was supported by Bacchus et al. (2002) in their finding that violence began late in some of their participants' pregnancies and they had been screened in the earlier part of their pregnancies. The screening was not repeated late in their pregnancies, so therefore they did not get the chance to disclose abuse to the midwives.

It was reported that pregnant women may not disclose abuse at their first contact with the healthcare provider, even when they are assured that help and support will always be provided whenever they are in need of it. Knowing this, women are aware of where to get help when in need, even when screening is not repeated (O'Doherty, Taket, Valpied, & Hegarty, 2016). Baird et al. (2013) in their conclusion cautioned that screening for IPV at the

first visit only may deprive the midwives from developing a trusting relationship with pregnant women in subsequent visits, and suggested that screening should be repeated six months later.

Another challenge that the midwives encountered in the course of screening pregnant women for IPV in the present study was that pregnant women were reluctant and sometimes even scared to disclose abuse. This finding is supported by Laisser et al. (2011), who reported that women were reluctant and appeared disturbed to be screened. Prust et al. (2017) and Williams et al. (2017) in their studies indicated that pregnant women will not disclose abuse when screened. This may be due to shame or embarrassment to admit abuse, because of the stigma around abuse, and therefore they will be reluctant to be screened. Also, lack of trust of the midwives' intention for screening, uncertainty about confidentiality of the disclosure and being associated with violence further scared some pregnant women about being screened for IPV in other studies (Bacchus et al., 2002; Shamu et al., 2013). The midwives in Nigeria and other African countries should clarify their intentions to conduct screening for IPV, and reassure pregnant women of the confidentiality of what may be disclosed.

7.7. Incorporating an introductory statement into the AAS tool

The current findings highlighted the need for a standard introductory statement in the screening tool in order for midwives to have confidence during screening. Similar recommendations were made by the ACOG (2012), which suggested that before initiating IPV screening with the pregnant women some explanation in the form of a statement should be read to them, so that the woman will understand that the screening is not targeted at her because the midwife suspects abuse in her marriage, and to indicate that it is a universal practice. Shoffner (2008) indicated that the reasons for screening pregnant women for IPV should be explained to the women and also that the process is a routine practice, so that they will not be doubtful of the screening process. This supports the need to add an introductory statement that is standardised for all midwives. A short statement in the form of an explanation was framed at the beginning of the screening questions as an introductory statement, which each midwife will read out to the pregnant women before starting the screening; this has also been supported by others, including Bermele et al. (2018) and Thackeray et al. (2010). Thackeray et al. (2010) further suggested that the introductory statement should be precise, not condemnatory, and indicate what the pregnant women stand

to benefit from the screening. These suggestions were adhered to in framing the introductory statement in the IPVAS tool.

The inclusion of an introductory statement in IPVAS tool promises to enhance rapport between midwives and pregnant women, thereby establishing a relationship between them. Hopefully the added introductory statement will assist in putting pregnant women at ease to divulge information about abuse in their home and also create trust in the midwife-patient relationship, as suggested by Feder et al. (2009) and Mauri et al. (2015).

In the current study the researcher observed midwives showing confidence by asking the questions in a casual, conversational manner without using the screening tool. Similar findings were reported by Williams et al. (2017), who found that asking the screening questions without reading directly from the screening tool elicited disclosure, trust and rapport with the patients. The screening of pregnant women for IPV without reading directly from the screening tool by the midwives showed their mastery of the screening questions and IPV-related issues, thereby instilling confidence in pregnant women to disclose abuse. Stenson et al. (2005) and Spangaro et al. (2011) confirmed that putting the screening questions with other routine antenatal questions made the screening process flow in an ordinary, conversational manner. The study of Baird et al. (2013) found that screening pregnant women for IPV in addition to asking questions about their mental health and well-being in the ANC increased midwives' confidence level in discussing IPV-related matters.

It was also indicated that midwives who showed confidence while screening pregnant women for IPV got positive responses from pregnant women (Bacchus et al., 2002). Price et al. (2007) advised that midwives should show confidence and skills when screening pregnant women for IPV in order to increase the chance of disclosure of abuse by pregnant women. Show of confidence while screening by the midwives in this study produced positive responses from the pregnant women.

7.8. The Intimate Partner Violence Assessment Screen (IPVAS) tool

The final product of the current study was the IPVAS tool. The adaptation was confirmed to be contextual and more suitable for the research setting by the participants through their confirmatory letters after they had used and compared it with the original AAS tool. Williams et al. (2017) reported that confidence in a screening tool and procedure is very important in effectively and routinely screening pregnant women for IPV. In the absence of this, the midwives will not want to use the screening tool since they do not have conviction and

confidence in its ability to identify IPV effectively in the pregnant women population at large, therefore hindering its use.

7.9. Strength and limitation of the study

The strength of this study is in the research design which is panel longitudinal qualitative research. Panel longitudinal research allows the researcher to interview the same participants several times in the same study. Data obtained from panel longitudinal research can be reliable (Neuman, 2011).

Attrition of participants or loss of participants from a study over time (Polit & Beck, 2012) has been reported to be a limitation of this design. However, this limitation was not much experienced in the current study because the researcher used some retention strategies to retain participants in the study. In addition, she was always present at the research setting to observe the participants and encourage them to continue screening pregnant women for IPV. The retention strategies used were compensation and provision of refreshments.

7.9.1. Compensation

According to the Department of Health (2015, p. 22) participants in a research study, especially a longitudinal study, should be well compensated for their time and inconvenience and transportation costs that they might have incurred. In this study participants were compensated for their time and inconvenience and for sharing of their expertise.

Three thousand naira was given for participation in phase 2, and another 3000 naira was given after the FGD session as compensation for their time and inconvenience and sharing of expertise. In total participants received 6000 naira, which is equivalent to 300 rand (ZAR300) for participation in all phases of the study. Compensation of participants for their participation in research is promoted and has been done in the previous studies (Duma et al., 2009; Sullivan & Cain, 2004). This is also supported by the National Health Research Ethics Council (NHREC, 2012).

7.9.2. Refreshments

Drinks and snacks were provided to participants during the FGD. This was to show appreciations to participants and to boost their zeal to continue participating in the study, as

advised by the South African Department of Health South Africa (2015) and Higgins and Hawkins (2005).

In the current study ten participants were recruited and interviewed in the first phase of the study. In the second phase of the study only one participant withdrew due to emergency eye surgery, which prevented her from participating in the screening of pregnant women for IPV with the AAS tool. In the third phase of the study two participants withdrew, because one was out of the country on leave and the second could not be reached even though she was aware of the date and time for the FGD. The attrition of participants did not affect the final findings of the research because those who withdrew from the study were exposed to the same screening procedure as those that participated fully in the study.

Because of the qualitative nature of the study the findings were generated from a hospital in the northern part of Nigeria and may not be generalised to the whole country. However, there are similarities between the midwives in the northern part of the Nigeria and those in the southern part of the country in terms of training received, registration with the NMCN examination and antenatal practice in the country. The study findings can therefore be transferrable to the southern part of Nigeria with little or no adaptation, which means that the IPVAS tool can be used in the southern part of Nigeria.

7.10 Conclusion

The chapter presents a discussion of the findings with relevance to the literatures. The findings highlighted that routine screening for IPV is not being conducted, but rather that selective screening of pregnant women with obvious signs of abuse is done. The current study suggests that both the internal and external factors indicated as hindrances to routine screening should be tackled through effective education of the midwives on IPV-related issues and interventions of both the hospital managers and federal government in provision of resources, private space, increased staff and above all formal approval and policies on IPV screening. The study also indicated that the AAS tool is not specific for IPV screening – hence the adaptation of it into the IPVAS tool, which reflects the intimate partner within it.

The recommendations and conclusion of this study are discussed in the next and last chapter.

CHAPTER EIGHT: RECOMMENDATIONS AND CONCLUSION

The current study was a qualitative research study on the process of adaptation of the AAS tool to aid midwives' screening practice for IPV. The findings revealed and conclusions made during this journey have resulted in a number of recommendations. The recommendations are presented below in line with the findings.

8.1. Recommendations for further research

The findings of this study resulted in the adaptation of the AAS tool. However, the new tool, the Intimate Partner Violence Assessment Screen (IPVAS), has not been validated for its suitability for the Nigeria context for which it was designed. A research study that is both quantitative and qualitative is needed to test the statistical sensitivity and specificity of the IPVAS tool, in order to ascertain its reliability and validity. Further research is also required on the acceptability of the adapted screening tool to pregnant women in both the northern and southern part of the country. Such a study may also highlight whether there are cultural or religious differences in the pregnant women's views on IPV screening.

8.2. Recommendation for policy-makers

The current study revealed the absence of policies or formal approval for mandatory routine screening for IPV in pregnant women presenting to health settings for antenatal care. This was identified as a hindrance to midwives' practice of routine screening for IPV. As a continent, Africa is still lagging behind others in achieving SDG 3, which targets the reduction of the maternal mortality ratio to 70 per 100,000 live births. The current maternal mortality ratio is still above 500 per 100,000 live births in countries in Africa (World Health Organization, 2015). The recommendation for routine screening of pregnant women for IPV as a matter of policy may not only reduce the maternal and perinatal mortality rate but will also ensures healthier lives for those experiencing abuse.

It is therefore recommended that policy-makers, including the Ministry of health, Nursing and Midwifery Council of Nigeria (NMCN) and hospital management, should make explicit policies for the routine screening for IPV for midwives.

As a strategy for implementing this policy, the Ministry of Health should give formal approval for the mandatory routine screening for IPV of pregnant women presenting to

hospital for antenatal care by midwives. They should also provide policies to guide the midwives on when to screen, where to screen, how to screen, and what to do when there is positive disclosure of abuse, as informed by the findings of this study. This policy should be explicit in providing guidelines such as the referral pathway, resources available for IPV victims and incorporation of the screening questions on the antenatal card.

In addition, the NMCN should liaise with the Ministry of Health to develop the policies for the routine screening of pregnant women for IPV by midwives, and also formulate policies to include IPV screening in the training of midwives.

The hospital management on their part should ensure the formal approval of IPV screening and ensure that policies on routine screening of pregnant women for IPV in the hospital ANC by midwives are effectively communicated to the midwives. They should also ensure effective implementation of the policies by midwives. Evaluation of the implementation of these policies should be conducted from time to time to ensure that the midwives are carrying out the routine screening properly.

8.3. Recommendation related to midwifery practice

8.3.1. Appropriate day and time for screening

The current findings revealed challenges on the best day and most appropriate time to screen pregnant women for IPV. The findings also suggested that screening should be done once and this on a booking day. The booking day is the day that pregnant women visit the ANC for the first time. However, the literature indicated that violence tends to escalate with time, and that at the time the pregnant woman visits the ANC for booking she might still be in the calm or honeymoon phase in the cycle of abuse, when she has not experienced violence. Therefore, if she was to be screened during booking and only that one time, she would screen as negative and may never have the opportunity to be screened again. This study therefore recommends that policy on the appropriate day and time of screening should be developed in consultation with the midwives.

8.3.2. Inclusion of IPV questions on the antenatal booking card

The current study revealed that lack of pre-set questions on IPV on the antenatal booking card hinders midwives from routine screening of pregnant women for IPV. Even as a

continent we do not have pre-set questions on IPV in the booking card. The findings also indicated that there is limited space on the antenatal card, even if the pre-set questions on IPV were to be incorporated. The literature revealed nevertheless that incorporating IPV screening questions into the pre-set questions on the antenatal booking card has yielded positive responses from pregnant women. Therefore the study recommends that the IPV screening questions should be put on a separate card attached to the booking card, to remind and ease midwives' practice of routine screening of pregnant women for IPV in Nigeria and on the continent.

8.3.3. Midwives' perception of IPV as a private matter

The current study revealed that midwives have perceptions that IPV is a private matter and that it is culturally wrong for pregnant women to disclose abuse to healthcare providers. This is a hindrance to routine screening of pregnant women for IPV. Hence the recommendation that midwives should be educated on value clarification by health educators via seminars or workshops where their personal values, professional values, family values and other core values are examined. The attitude that IPV is a private issue that should be condoned should be discouraged. It should be made clear that IPV is a public health problem in society that needs to be managed by midwives and other healthcare providers in the health setting, to prevent maternal and perinatal mortality and improve women's quality of life.

8.4. Recommendation for hospital management

8.4. 1. In-service training

The current study revealed that midwives lack skills to conduct IPV screening of pregnant women presenting in the heath setting for antenatal care. This was identified as a hindrance to midwives' practice of routine screening for IPV. It is therefore recommended that in-service training of midwives on IPV screening should be conducted to equip the midwives who are already in service for IPV screening. This is necessary because such training was not provided to them during their pre-service training. It is also recommended that experts on IPV both nationally or internationally be identified and sourced by hospital management to come and provide in-service training on IPV. Currently the number of IPV experts in Nigeria is not known, hence the reference to international experts in training of midwives on IPV-related issues and identification.

Such in-service training should be made compulsory for all midwives caring for pregnant women in order to ensure that they have the skills and competencies in screening pregnant women for IPV, even when they are not working in the ANC. This is so that when reshuffling of midwives' duties is carried out, those that fall under the ANC would already have the skills to screen pregnant women for IPV.

The hospital management should provide funds and make rosters to register midwives that will be released to attend the in-service training. This will ensure that different midwives attend the in-service training at different times, so that eventually all midwives will have the skills and competencies to screen for IPV.

8.4.2. Staff employment

The current findings revealed the presence of a huge workload and shortages of staff for routine screening of pregnant women for IPV in the ANC. This hinders midwives' practice of routine screening for IPV. It is therefore recommended that more midwifery staff should be employed in the hospital to alleviate the workload of midwives in the ANC. The pregnant women are numerous and far outstrip the number of midwives. This is compounded by midwives having limited time to carry out their daily responsibilities in the ANC. An increase in staff will alleviate this and the workload will be reduced. The government will make budgetary provision for this or the hospital management may consider reshuffling of staff, so that more staff with the requisite midwifery skills are redeployed to the ANC from other units.

8.4.3. Provision of private space

The current study revealed a lack of private space to conduct screening for IPV among pregnant women attending the ANC as a major hindrance to routine screening for IPV. It is therefore recommended that more rooms be allocated in the ANC to provide privacy for discussing sensitive matters such as IPV. These rooms can be created from some of the open waiting halls in the ANC in the research setting. The current ANC can also be transferred to a larger place that has more private rooms to conduct IPV screening, for example, the Surgical Outpatients Department which has more rooms to spare or any other space that has more private rooms to accommodate the increasing population of pregnant women. This will be a short-term plan.

For the long-term, the government should make budgetary allocations for this and the hospital management should build structure for the ANC. This structure should have more private rooms to provide privacy for history-taking during booking and discussion of IPV-related issues with pregnant women.

8.4.4. Resources

The findings of the current study also indicated a lack of resources as a hindrance to routine screening of pregnant women for IPV. The hospital management should make resources available for IPV victims in the hospital, such as an on-site psychologist attached to the ANC, and a hotline phone for IPV response. They should also collaborate with other agencies that handle IPV cases, such as shelters in the communities, non-governmental organisations that care for IPV victims, law enforcement agencies and lawyers. These will motivate and further build the confidence of midwives to screen and the confidence of pregnant women to disclose abuse, since both parties will be sure that there are resources to support pregnant women who are victims of abuse.

8.5. Recommendation for social services providers

The current findings revealed lack of IPV centres that provide care for IPV victims, and this constituted a hindrance to IPV screening by the midwives. It is therefore recommended that creation of centres for abused women should be encouraged. Budgetary allocation should be provided to the department of social development by the federal government to build IPV centres in the communities. Non-governmental organisations should be encouraged to build such centres too in the communities. This will provide temporary accommodation and rehabilitation for IPV victims, and will ensure holistic care for them, such as support, social services and safety. Empowerment programmes by the government should also be incorporated in the centres to ensure that when the women leave the centres they will have a skill to fall back on to enable them to fend for themselves if necessary.

8.6. Recommendation for institutions of nursing education

The findings of this study also highlighted the need for development and inclusion of modules on gender-based violence into the curriculum of the undergraduate nursing

programme at the universities and the diploma nursing programmes too. This curriculum should be explicit on the course contents, unit and level or year at which it is to be taught in the school. This will ensure that newly employed midwives are already equipped with the knowledge and skills needed in screening women for IPV when they commence work in the hospital.

8.7. Recommendation for the Nursing and Midwifery Council of Nigeria

The findings revealed a lack of the requisite skills among midwives for IPV screening as a result of not being trained on this in the nursing schools. In addition, such skills are not offered in the mandatory continuous education programme organised by the NMCN. It is therefore recommended that a course on gender-based violence should be included in the NMCN curriculum and made compulsory as part of the evaluation criteria for all nurses or midwives in their final qualifying examinations before being registered. A gender-based violence course should also be included in the mandatory continuous education programme for nurses and midwives who are applying for renewal of their licences.

8.8. Conclusion

This study demonstrates that routine screening for IPV is not a current midwifery practice in northern Nigeria. Discriminatory practices of screening for IPV among HIV patients and selective screening were found to be common among midwives. Wile's HPT model, which was adopted as the theoretical framework for this study, helped in organising the factors that hindered the midwives' screening practice into internal and external factors to the midwives' performance. This highlighted recommendations that can be addressed specifically by midwives and those interventions required by hospital managers, institutions of nursing education, and policy-makers, among others. With adequate education and training of the midwives the internal factors that hinder their screening practice can be eliminated, while the external factors will need the intervention of hospital authorities to eliminate or mitigate their effects on screening for IPV.

This study has been able to accomplish the design of a new screening tool, called the Intimate Partner Violence Assessment Screen (IPVAS), which is specific in identifying IPV and suitable for use in northern Nigeria. Although it is not statistically tested, the new tool holds great promise that midwives will be comfortable with its use and pregnant women will be at

ease to disclose abuse when screened with it. This study has also contributed to the existing knowledge on IPV screening and factors hindering screening for IPV among pregnant women in northern Nigeria. It is largely a pioneer study in northern Nigeria, and it is expected that it will generate ideas for future studies to take off and build upon.

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Appendices

Appendix A: Abuse Assessment Screen Tool

Figure 3. Abuse assessment screen.

1. Have you **EVER** been emotionally or physically abused by your partner or someone important to you?
   ❑ YES ❑ NO

2. **WITHIN THE LAST YEAR**, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   ❑ YES ❑ NO

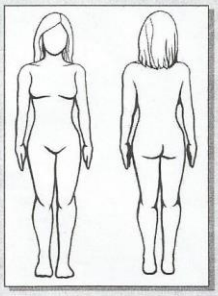
   If YES, by whom _____
   Total number of times _____

3. **SINCE YOU'VE BEEN PREGNANT**, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   ❑ YES ❑ NO

   If YES, by whom _____
   Total number of times _____

   Mark the areas of injury on a body map.
   Score each incident according to the following scale

   1 = Threats of abuse, including use of a weapon
   2 = Slapping, pushing; no injuries, and/or lasting pain
   3 = Punching, kicking, bruises, cuts, and/or continuing pain
   4 = Beating up, severe contusions, burns, broken bones
   5 = Head injury, internal injury, permanent injury
   6 = Use of weapon; wound from weapon
   If any of the descriptions for the higher number apply, use the higher number.



4. **WITHIN THE LAST YEAR,** has anyone forced you to have sexual activities?
   ❑ YES ❑ NO

   If YES, by whom _____
   Total number of times _____

5. **ARE YOU AFRAID** of your partner or anyone in your life?
   ❑ YES ❑ NO

Developed by the Nursing Research Consortium on Violence and Abuse. Readers are encouraged to reproduce and use this assessment tool.
Adapted by Pregnancy Support Project, Boston College, William F. Connell School of Nursing. Available on www.NNVAWI.org.

Appendix B: UCT Ethical Clearance

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 •
Email: shumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

17 March 2016

HREC REF: 101/2016

Prof S Duma
Division of Nursing & Midwifery
Health & Rehab Sciences
F-45-OMB

Dear Prof Duma

PROJECT TITLE: ADAPTATION OF THE ABUSE ASSESSMENT SCREENING TOOL FOR MIDWIVES IN NORTHERN NIGERIA (PhD-candidate-A Musa-Maliki)

Thank you for your response letter dated 15 March 2016, addressing the issues raised by the Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th March 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

The HREC acknowledge that the student, Ayishetu Musa-Maliki will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

Appendix C: ABUTH Ethical Clearance

HEALTH RESEARCH ETHICS COMMITTEE

AHMADU BELLO UNIVERSITY TEACHING HOSPITAL

SHIKA - ZARIA, NIGERIA.

E-mail: abuthshika@yahoo.com *website: www.abuth.org*

Chairman of Board: **Chief. Shuaib Oyedokun Afolabi** *Fnil*
Chief Medical Director: **Prof. Lawal Khalid,** *MBBS, FMCS, FWACS, FRCS(ED) mnl*
Chairman, Medical Advisory Committee: **Prof. Abdullahi Mohammed,** *MBBS, FWACP, FICS*
Director of Administration: **Barr. Ishak Bello,** *LL.B, BL., LL.M, PGDM, AHAN, FCAI*

Our Ref: ABUTH/HREC/CL/05 *Date:* 30th June, 2016

Your Ref:

ABUTH HREC FULL ETHICAL CLEARANCE CERTIFICATE

Development of a Screening tool to aid Midwives' Screening practice for intimate Partner violence (IPV) among Pregnant Women in Northern Nigeria

ABUTH Ethics Committee assigned number:	-	ABUTHZ/HREC/V1 / 2016.
Name of the principal Investigator:	-	**Ayishetu Musa Maliki**
Address of the Principal Investigator:	-	Dept. of Nursing Science, ABU Zaria
Date of receipt of valid application:	-	6Th May, 2016
Date of meeting when final determination On Ethical approval was made:	-	7Th June, 2016

This is to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been reviewed and given **full approval by the Health Research Ethics Committee.**

Please note: this approval dates from ***30Th June, 2016 – 30Th June, 2017***

No participant recruitment into this research may be conducted outside these dates.

All informed consent forms in this study must carry the ABUTH HREC number assigned to this research and the duration of ABUTH HREC approval of the study.

This HREC expects that you submit your application as well as an annual report for ethical clearance renewal 3 months prior to expiration of study dates. This is to enable you obtain renewal of your approval and avoid interruption of your research.

If there is delay in starting the research, please inform the ABUTH HREC so that starting dates can be adjusted accordingly.

No changes are permitted in the research without prior approval by ABUTH HREC, except in circumstances outlined in national code for Health Research Ethics: **http://www.nhrec.net.**

ABUTH HREC reserves the right to conduct compliance assessment visits to your research site without prior notification.

30/6/2016

Prof. Aisha.I. Mamman MBBS, FMCPath
Chairman, ABUTH HREC

Appendix D: Research Information Sheet for Midwives

My name is Ayishetu Musa-Maliki, a PhD student researcher in the Department of Health and Rehabilitation Sciences, University of Cape Town, South Africa. I am carrying out a research on the "Adaptation of the Abuse Assessment Screening Tool for Midwives in Northern Nigeria".

Brief Description of the Study

Intimate Partner Violence (IPV) during pregnancy affects women and their unborn children, as both may suffer serious health consequences. Developed countries have routine screening practices for identifying IPV victims among pregnant women in the course of their antenatal visits. It is not certain how and if Nigeria hospitals screen for IPV as there is only a limited and inconsistent literature on it. The purpose of this research is to investigate midwives' current screening practices for IPV and to adapt the Abuse Assessment Screening (AAS) tool to aid midwives' screening practice for IPV among pregnant women in northern Nigeria.

Expectation from Potential Participants in this Research

If you agree to participate, this research will engage you in four sessions of research activities spread over 12 months.

The first is the non-participant observations where I will observe the routine activities carry out by you, to see if you screen for IPV. I will then interview you for about an hour to one and half hours. You will be free to choose the time and venue for the interview. In the second session, I will give you a screening tool to screen pregnant women coming for antenatal care for about two months. I will observe as you screen the pregnant women to identify difficulties that may arise from using the tool. I expect you to use this screening tool to screen pregnant women during antenatal clinic. The third session will require you to participate in a focus group discussion (FGD) along with other midwives that have agreed to participate in the research. In the fourth session, I will give you the new screening tool that I have developed using the findings from this study. I expect you to use the new screening tool to screen pregnant women during their antenatal visit to see if the new tool is suitable for use. Then you will comment on the effectiveness, suitability and usability of the screening tool in writing to me.

The interview and FGD sessions should ordinarily be audio-recorded to be fruitful and rewarding. If, however, you object to recording we shall make do with just note-taking. The recorded information will be transcribed, analysed, and reported as research findings for my PhD thesis.

Be assured that information provided will not be linked to you directly. Hence, your name and address will not be required for this research. For analysis purposes, should the need for a name arise, you will be identified with a coded name (to be chosen by you if you so desire). Furthermore, the information obtained from you will be treated with utmost confidentiality.

Benefits and Risks

The information you will share with me, will not have a direct benefit to you, but it will help me to adapt Abuse Assessment Screening tool that will assist midwives in the future to easily identify pregnant women who are in an abusive relations for treatment and referral to protect them and their foetus. There may be potential risks attached to this research, but for participants who have been in abusive relationship will receive support through counselling and treatment from psychologist. The information given will be used purely for this research and **you will have access to the findings at the end of the research study.**

Cost: The research will not cost you anything to participate, other than your time for the interviews/discussions and to screen patient during their antenatal visits. You will be reimbursed for your time, inconvenience, expertise and transportation to the site with R150 at the end of the screening process in phase two and after FGD in phase three.

Voluntary participation

Your participation in this research is important to me but you are free to withdraw from it at any time with no consequences to you. You can ask questions anytime on areas that you do not understand and be assured of prompt clarification.

Thank you for going through this letter, I really appreciate it. If you are willing to participate in this research, please sign the attached consent form.

Thank you once more.

You may contact me, my supervisor and/or chair of Human Research Ethics Committee (HREC) for more information, at any time, on these phone numbers and email addresses.

Ayishetu Musa-Maliki:

07038159582. aishaudu@yahoo.com

Supervisor: Professor Sinegugu Duma: +27824492635 sinegugu.duma@uct.ac.za

Chair of HREC: Professor Marc Blockman
+27214066496
Marc.blockman@uct.ac.za

The University of Cape Town, Faculty of Health Science Human Research Ethics Committee can be contacted on 021 406 6338 in case participants have any questions regarding their rights and welfare as research subjects on the study.

Appendix E: Informed Consent Form for Midwives

Researcher: Mrs Ayishetu Musa-Maliki

Research Title: Adaptation of the Abuse Assessment Screening Tool for Midwives in Northern Nigeria.

I _____ (participant's name) have read the information sheet, understand fully what the study is about and I have had my entire questions answered. I know what is expected of me, the risks and benefits involved in this research, and I am ready to participate.

I know my participation will help in the adaptation of a screening tool for intimate partner violence which will be used in the future by midwives in northern Nigeria.

I know that the research involves four sessions, that I may have to partake in all, and that I am free to choose the time and venue that is convenient to me for the interview.

I know that my participation is voluntary and that I can withdraw anytime from this research without consequences to me. I also know that the information I shall provide will be treated with anonymity and confidentiality and will be used purely for this research only.

I understand that participating in this research will not cost me money and I will be reimbursed for my transportation cost and time involved in this research.

I know that if I have further questions, requests for information, or other concerns about this research, to contact the researcher on this number: 07038159582 and email: aishaudu@yahoo.com. Or the supervisor, Prof. Sinegugu Duma on this number +27824492635 and email: sinegugu.duma@uct.ac.za or chairperson of research ethics committee, Prof. Marc Blockman +27214066496 and email:Marc.blockman@uct.ac.za

Date _____ Participant's signature _____

Date _____ Researcher's signature _____

Appendix F: Observation Checklist (Pre-Screening)

DATE: ---------- TIME: ---------- PARTICIPANTS ----------

Objective	Category	Descriptive notes	Reflective notes
Midwives' current screening practice for intimate partner violence	Routine activities Screening for other diseases At booking		
Factors that influence screening practices of midwives	Physical and Social Environmental		

Appendix G: Interview Guide

Introduction: The term screening refers to the application of standardized questions according to a procedure that does not vary from place to place. Intimate partner violence is the physical, sexual, economical, psychological or other harm against a pregnant woman by her partner or spouse. To screen for IPV is therefore to apply a standardized tool to a pregnant woman with a view to determine if she has been victim of intimate partner violence.

1. In the context of what I have just explained to you about screening. After two months of observing you I notice you people have not been screening, why?
2. What guided procedure do you use to screen?
3. What do you think can help you to screen more pregnant women for IPV?
4. If there was a screening tool for IPV among pregnant woman, what questions do you think should be added in screening for IPV? Please explain why. What should be avoided?
5. Are there questions that you would not be comfortable asking, please explain why?
6. How do you document women that have been abused by their partner?
7. What are the resources available for the women for use in the hospital and community?
8. How do the pregnant women have access to it? In other words how was it communicated to the women?
9. How has the information on available resources in the community influence your practices?
10. As a midwife, how were you trained to identify pregnant women that have been victims of IPV?
11. How was your programme in midwifery school structured to accommodate identification of IPV in pregnant women?
12. What continuous education programme, in-service training, or self-study are in place to improve your practice? How are the hospital management and government assisted with that? Probe.
13. What has the hospital management done to assist with identifying pregnant women experiencing IPV? In terms of clear goals and policy? Please explain more.
14. How has the physical environment influenced the screening of pregnant women? Please elaborate.

15. Apart from what you have told me, what do you think will motivate you to screen/ take care of pregnant women in antenatal unit? Please explain. Probe. What will demotivate you?
16. Is there any other thing you will like to add?

Thank you.

* Probing questions will be used to elicit more information according to each research objective or for further clarity on the participant's views.

Appendix H: Observation Checklist Used During Screening

DATE: ---------- TIME: ---------- PARTICIPANTS ----------

Objective	Category	Descriptive notes	Reflective notes
Suitability/challenges of using the Abuse Assessment screen (AAS) tool	Pregnant women's reaction or demeanour during and after screening. E.g. disturbed, comfortable, feel insulted, etc. Midwives' behaviour with the use of the AAS tool, handling and disposition of IPV cases, documentation, etc.		

Appendix I: Information Sheet for Pregnant Women

My name is Ayishetu Musa-Maliki, a PhD student researcher in the Department of Health and Rehabilitation Sciences, University of Cape Town, South Africa. I am carrying out research on the "Adaptation of the Abuse Assessment Screening Tool for Midwives in Northern Nigeria".

Brief description of the study

Intimate Partner Violence (IPV) during pregnancy affects women and their unborn children, as both may suffer serious health consequences. Developed countries have routine screening practices for identifying IPV victims among pregnant women in the course of their antenatal visits, it is not certain how and if Nigeria hospitals screen for IPV. The purpose of this research is to investigate midwives' current screening practices for IPV and to adapt the Abuse Assessment Screening (AAS) tool to aid midwives' screening practice for IPV among pregnant women in northern Nigeria.

Expectation from pregnant women

I will observe the midwife when she is screening you (pregnant women) using the Abuse Assessment screen tool, to check if it is difficult or easy for the midwife to ask the questions and if you understand the question. It is fine, whether you answer the question or not. I will not interfere or speak during the screening session. Whatever is discussed between you and the midwife will be handled with utmost confidentiality. Your name and address are not required. I will observe the session using an observation checklist.

Benefits and Risks

There is no direct benefit to you, but the research will help me to adapt the Abuse Assessment Screening tool and this should assist midwives in the future to easily identify pregnant women who are in abusive relations for treatment and referrals to protect them and their unborn baby. Support will be provided through counselling from psychologists, if you required. The information elicited will be used purely for this research.

Cost: The research will not cost you anything other than the time required for the midwife to screen you

Voluntary participation

Your participation in this research is important to me but you are free to withdraw from it at any time with no consequences to you. You can ask questions anytime on areas that you do not understand and be assured of prompt clarification.

Thank you for going through this letter, I really appreciate it. If you are willing to participate in this research, please sign the attached consent form.

You may contact me, my supervisor and/or chair of Human Research Ethics Committee (HREC) for more information, at any time, on these phone numbers and email addresses.

Ayishetu Musa-Maliki:
Duma: 07038159582.
aishaudu@yahoo.com

Supervisor: Professor Sinegugu
+27824492635
sinegugu.duma@uct.ac.za

Chair of HREC: Professor Marc Blockman
+27214066496
Marc.blockman@uct.ac.za

The University of Cape Town, Faculty of Health Science Human Research Ethics Committee can be contacted on 021 406 6338 in case participants have any questions regarding their rights and welfare as research subjects on the study.

Appendix J: Consent Form for Pregnant Women

I _____ (pregnant women's name) have read the information sheet, understand fully what the study is about and I have had my entire questions answered. I know what is expected of me, the risks and benefits involved in this research and I am ready to participate.

I know my participation will help in the adaptation of a screening tool for intimate partner violence which will be used in the future by midwives in northern Nigeria.

I know that my participation is voluntary and that I can withdraw anytime from this research without consequences to me. I also know that the information I shall provide will be treated with anonymity and confidentiality and will be used for this research only.

I understand that participating in this research will not cost me money. Counselling service by a psychologist will be available, if I need one.

I know that if I have further questions, requests for information, or other concerns about this research, to contact the researcher on this number: 07038159582 and email: aishaudu@yahoo.com. Or the supervisor, Prof. Sinegugu Duma on this number +27824492635 and email: sinegugu.duma@uct.ac.za or chairperson of research ethics committee, Prof. Marc Blockman +27214066496 and email:Marc.blockman@uct.ac.za

The University of Cape Town, Faculty of Health Science Human Research Ethics Committee can be contacted on 021 406 6338 in case participants have any questions regarding their rights and welfare as research subjects on the study.

Date _____ pregnant woman's signature _____

Date _____ Researcher's signature _____

Appendix K: Confidentiality Form for FGD

This form is to affirm confidentiality of information obtained from the FGD among participants of the discussions.

I _____ (participants name) hereby agree not to communicate or disclose publicly the information discussed during the FGD with anybody outside the focus group participants and the researcher.

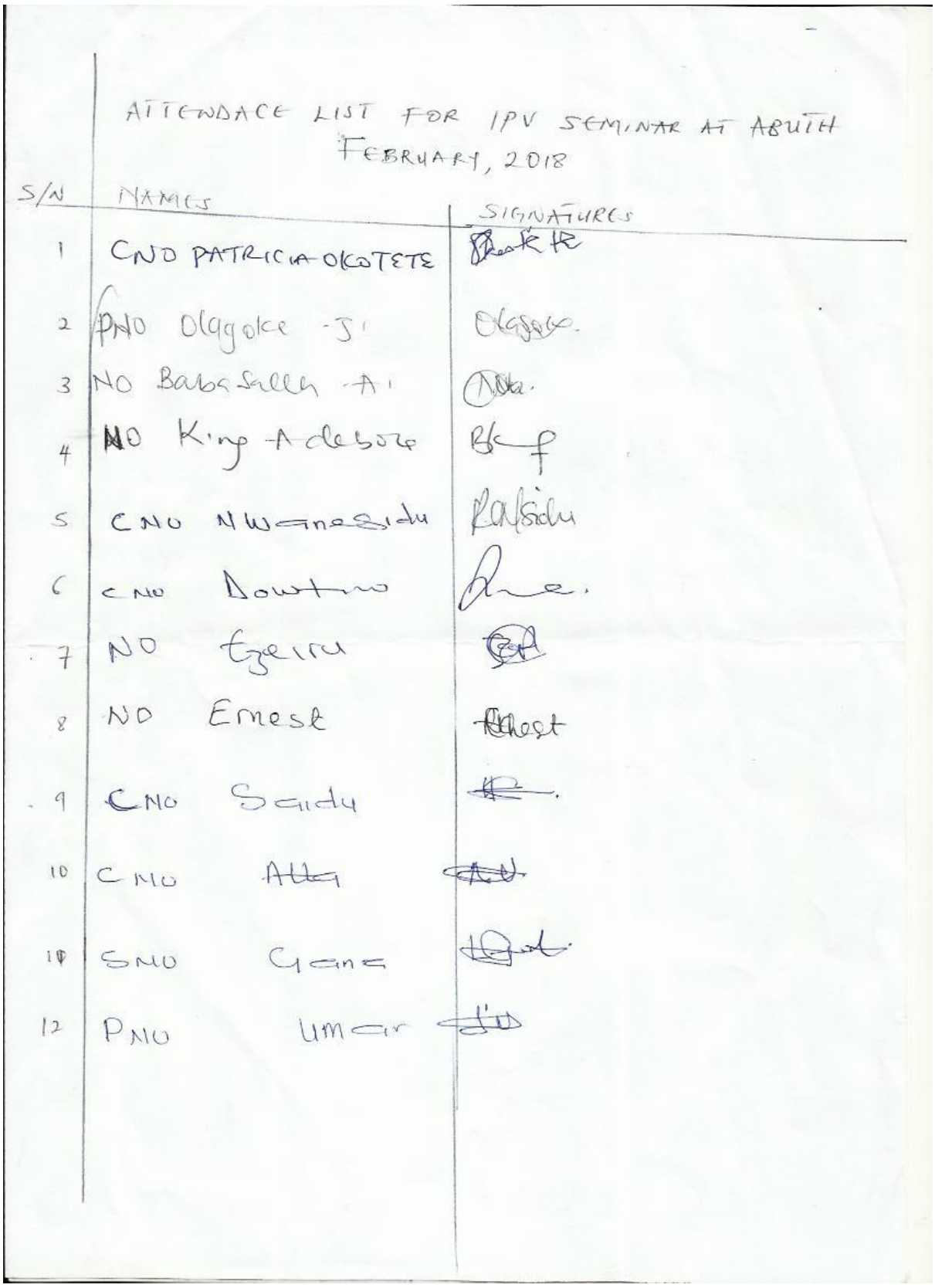
Participant Signature _____ Date _____

Researcher signature _____ Date _____

Appendix L: FGD Guide

1. What were your experiences of using the Abuse Assessment Screen tool to screen pregnant women for IPV?
2. What were the challenges encountered when asking the questions in the course of using the Abuse Assessment Screen tool to screen the pregnant women?
3. In which better ways can these questions be asked of the pregnant women?

Appendix M: Attendance List of Midwives at IPV Seminar



ATTENDACE LIST FOR IPV SEMINAR AT ABUTH
FEBRUARY, 2018

S/N	NAMES	SIGNATURES
1	CNO PATRICIA OKOTETE	
2	PNO Olaggoke -J.	
3	NO Baba Salla -A.	
4	NO King Adebola	
5	CNO Nwaneshu	
6	CNO Dowtwo	
7	NO Tgeiru	
8	NO Ernest	
9	CNO Sandy	
10	CNO Atta	
11	SNO Gana	
12	PNO Umar	

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

HUMAN RESEARCH ETHICS COMMITTEE
28 JUN 2017
HEALTH SCIENCES FACULTY

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) This serves as notification of annual approval, including any documentation described below.			
☑ Approved	Annual progress report	Approved until/next renewal date	30.6.2018
☐ Not approved	See attached comments		
Signature Chairperson of the HREC		Date Signed	29/6/2017

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	23/06/2017		
HREC REF Number	HREC REF 101/2016	Current Ethics Approval was granted until	30th March2017
Protocol title	ADAPTATION OF THE ABUSE ASSESSMENT SCREENING TOOL FOR MIDWIVES IN NORTHERN NIGERIA		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	☐ Yes ☐ No ✓		
If yes, could you please provide the HREC Ref's for all sub-studies? **Note:** A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	PROF SINEGUGU DUMA		
Department / Office Internal Mail Address	DEPARTMENT OF HEALTH AND REHABILITATION SCIENCES		

1.1 Does this protocol receive US Federal funding?	☐ Yes	☐ No ✓
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	☐ Yes	☐ No ✓
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget.	☐ Yes	☐ No ✓

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Appendix O: Extension of ABUTH Ethical Clearance

HEALTH RESEARCH ETHICS COMMITTEE

AHMADU BELLO UNIVERSITY TEACHING HOSPITAL SHIKA, ZARIA, NIGERIA.

E- mail: abuthshika@yahoo.com website: www.abuth.org

Chief Medical Director: Prof. Lawal Khalid, MBBS, FMCS, FWACS, FRCS(ED) mni

Chairman, Medical Advisory Committee: Prof Adamu Ahmed, MBBS, (ABU) LLB (ABU), BL, FWACS, FICS, FACS.

Director of Administration: Alh. Abdulraheem Sallau, BA(Pub. Admin) PGDPA, MPA, (ABU) AHAN, ACIPM.

Ag. Chairperson : HREC Prof Aisha I. Mamman MBBS, FMCPath

NHREC/10/12/2015 D-U-N-S NUMBER: 954524802

ABUTH/HREC/ CL/05 *30th June, 2017*

ABUTH HREC FULL ETHICAL CLEARANCE CERTIFICATE

Development of a Screening tool to Aid Midwives Screening Practice for Intimate Partner Violence (IPV) among Pregnant Women in Nigeria.

ABUTH Ethics Committee assigned number:	-	ABUTHZ/HREC/V1/2016
Name of the principal Investigator:	-	**Ayishetu Musa Maliki**
Address of the Principal Investigator:	-	Dept. of Nursing Sciences A.B.U, Zaria.
Date of receipt of valid application:	-	6th May, 2016
Date of meeting when final determination On ethical approval was made:	-	7th June, 2016

This is to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been reviewed and ***given full approval by the Health Research Ethics Committee.***

Please note: this approval dates from **30th June, 2017 - 30th June, 2018**

No participant recruitment into this research may be conducted outside these dates.

All informed consent forms in this study must carry the ABUTH HREC number assigned to this research and the duration of ABUTH HREC approval of the study.

This HREC expects that you submit your application as well as an annual report for ethical clearance renewal 3 months prior to expiration of study dates. This is to enable you obtain renewal of your approval and avoid interruption of your research.

If there is delay in starting the research, please inform the ABUTH HREC so that starting dates can be adjusted accordingly.

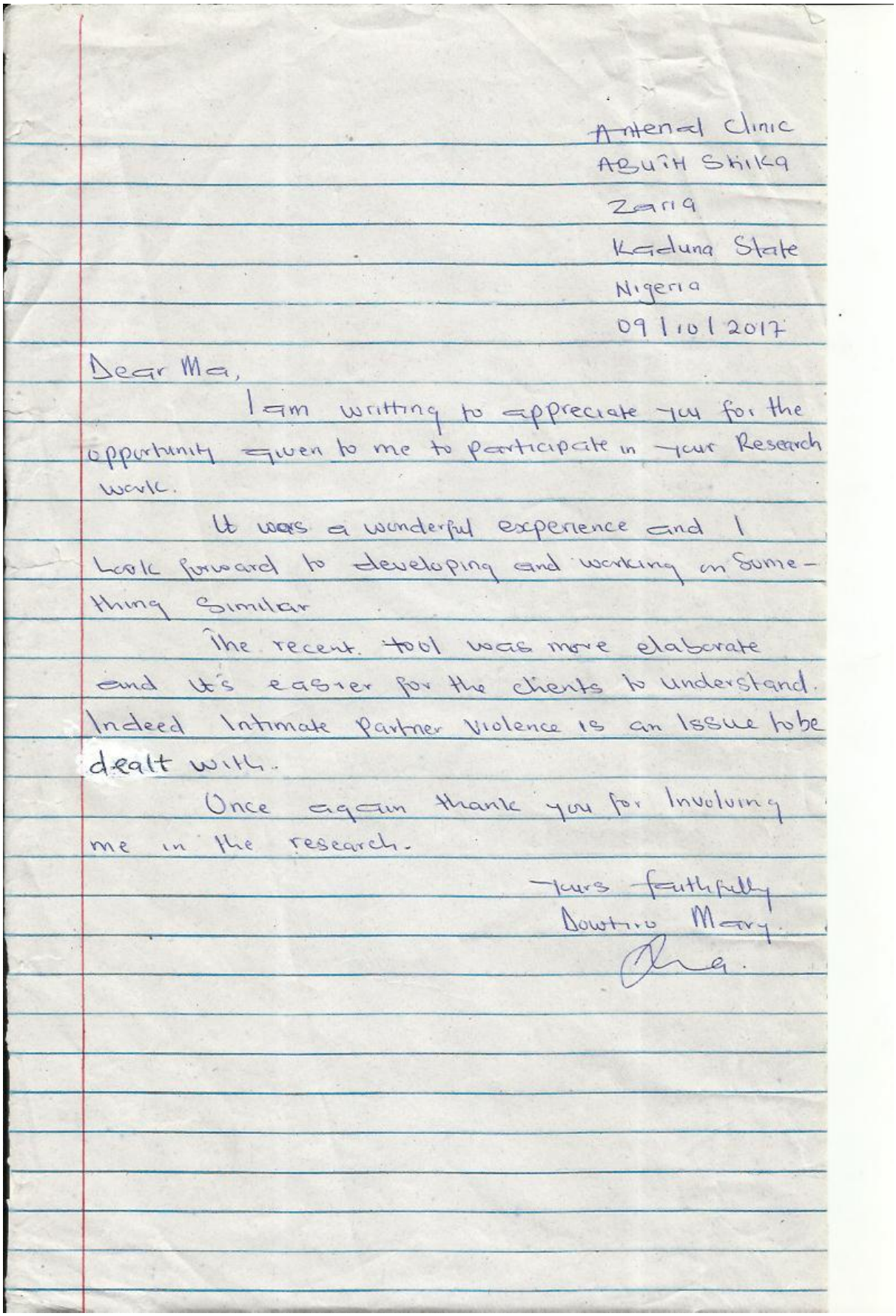
No changes are permitted in the research without prior approval by ABUTH HREC, except in circumstances outlined in national code for Health Research Ethics: **http://www.nhrec.net.**

ABUTH HREC reserves the right to conduct compliance assessment visits to your research site without prior notification.

Abdul 30/06/2017

for **Prof. Aisha. I. Mamman** *MBBS, FMCPath*
Chairperson

Appendix P: Letters of Attestation of the Effectiveness of the New IPV Assessment Screening Tool from Research Participants



Antenal Clinic
ABUTH Shika
Zaria
Kaduna State
Nigeria
09/10/2017

Dear Ma,

I am writting to appreciate you for the opportunity given to me to participate in your Research work.

It was a wonderful experience and I look forward to developing and working on Something similar

The recent tool was more elaborate and it's easier for the clients to understand. Indeed Intimate Partner Violence is an issue to be dealt with.

Once again thank you for Involving me in the research.

Yours faithfully
Dowtiu Mary.

Antenatal Clinic
Abuth Shika.
Zaria.
Kaduna State
Nigeria.
19/10/2017.

Dear ma,

I appreciate the privilege given to me to be a part of this research work. The new tool is easy to understand the Intimate partner violence in it. It will help our client to be at ease when screening.

Thank you once more.

Yours faithfully
King Adebola.

IVF ROOM
A.B.U.T.H.
Shika Zaria
Kaduna State
Nigeria.

Dear Ma,

I will Like to express my sincere appreciation for sharing your work with me I looked at your drawings and illustrations it make sense to me.

The new tools iesed is more explanatory and clearer. Intimate partner Violence it is an issue affecting the Nigeria Society at Large and Zaria in particular that must be given prompt attention. I know that I am not yet there and I know that I will one day be there by God's grace.

Mrs Patricia Oketete.

Oketete

Antenatal Clinic.
ABUTH Area.
Kaduna State.
Nigeria.
18/10/17

Dear Ma,

It was a great previlege to be a participant in this research. The new Screening tool is much more better as it is more specific on Intimate partner violence unlike the previous one.

Thanks yar as we look foward to Implementing this tool in our antenatal Clinic.

Yar Faithfully.

Ciana Linnet.

Antenatal Clinic
A.B.U.T.H
Shika, Zaria
Kaduna State
Nigeria

Dear Ma,

Thanks for the opportunity given to me to part take in your research work.

It broaden my knowledge on how to carry out a similar research work.

The last tool (new screening tool) that was used was more elaborate and simple for the client to understand. The issue of ~~interpersonal~~ part Intimate partner violence is a situation to be taken seriously so that we can be able to prevent future occurence and manage the existing ones.

Thanks Once again for giving me the chance to be part of this research work. I know that I am not yet there but one day the sky shall be my limit

Yours Sincerely

Mrs Hadiza Saidu

ANTENATAL CLINIC
ABUTH - SHIKA,
ZARIA,
KADUNA STATE
NIGERIA
10/10/17

DEAR MA,

I write to appreciate this great privillage to be part of this research work.
It was a wonderful experience and opportunity as well as a way forward in this great area of research.

This new tool for intimate partner violence is self explanatory, easy to use and understand. Indeed it will help our client to be comfortable in rolling out their problem in their relationship.

I look forward to the final work of this research.

Thank you

Yours Sincerely

[signature]

R. Nwaiwodu Mrs

Antenatal Clinic
ABUTH
Shika - Zaria
Kaduna State
Nigeria

Dear Ma,

Thank you for exposing us to issues on intimate partner violence screening.

The new screening tool has general introductory statement that I read to the women, so that they do not feel singled out to be screen for IPV.

There is no confusion on the questions, since it read "husband" and "anyone" again as such easy to understand.

I look forward with collaborating with you in future.

Yours Sincerely
Barr. Saleh Aisha.