

**ASSESSMENT OF BARRIERS ASSOCIATED WITH SCREENING  
PREGNANT WOMEN FOR INTIMATE PARTNER VIOLENCE FROM  
NURSES PERSPECTIVE AT PUMWANI MATERNITY HOSPITAL,  
NAIROBI.**

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**A THESIS SUBMITTED IN THE PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN  
MENTAL HEALTH AND PSYCHIATRIC NURSING OF THE  
UNIVERSITY OF NAIROBI.**

**OCTOBER, 2015**

## **DECLARATION**

I, Simon Nderitu Githui declare that this thesis is my own original work and has not been presented for a degree award at any other University.

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## **DEDICATION**

I dedicate this work to my wife Roselyne Nderitu and my son James Nderitu for their love, support and encouragement. May the almighty God bless both of you.

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## **LIST OF ABBREVIATIONS**

<b>ANC:</b>	Antenatal Care
<b>CBD:</b>	Central Business District
<b>CDC:</b>	Centers for Disease Control and Prevention
<b>ERC:</b>	Ethics and Research Committee
<b>GBVRC:</b>	Gender Based Violence and Recovery Center
<b>IPV:</b>	Intimate Partner Violence
<b>IRC:</b>	International Rescue Center
<b>KDHS:</b>	Kenya Demographic Health Survey
<b>KNH:</b>	Kenyatta National Hospital
<b>MDGs:</b>	Millennium Development Goals
<b>NCK:</b>	Nursing Council of Kenya
<b>OR:</b>	Odds Ratio
<b>PMH:</b>	Pumwani Maternity Hospital
<b>TPB:</b>	Theory of Planned Behavior
<b>PREMIS:</b>	Physician Readiness to Manage Intimate Partner Violence
<b>SPSS:</b>	Statistical Package for Social Sciences
<b>USPSTF:</b>	United States Preventive Services Task Force
<b>VAW:</b>	Violence against women
<b>WHO:</b>	World Health Organization

## **OPERATIONAL DEFINITIONS**

- Antenatal:** The condition or period of being pregnant. For this study, it is the period from when a woman realizes she is pregnant or diagnosed to be pregnant to the time she goes into labor during delivery.
- Barriers:** Something/a situation that make it difficult or impossible to achieve a certain level of functioning. For this study, barriers will mean factors hindering screening for IPV in pregnancy.
- IPV:** Describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. For this study, IPV is any current or previous physical, sexual or psychological harm by a current or former partner or spouse.
- Pregnancy:** The state of carrying a developing embryo or fetus within the female body. For this study, the same definition will be adopted.
- Screening:** It's a strategy used to identify an unrecognized state of health/illness/disease in individuals with or without signs or symptoms utilizing a screening tool. For this study it will mean routine inquiry about risk for IPV, current exposure to IPV or previous exposure to IPV using standard tool every time a pregnant woman seeks care or attends a hospital appointment.
- Survivor:** Any person who has been violated sexually and has lived through the experience.

## **ABSTRACT**

**Introduction:** Intimate partner violence (IPV) is detrimental to the physical, emotional, sexual, social, and mental wellbeing. In pregnancy, it is directly associated with maternal complications and newborn deaths. Globally, the prevalence of IPV among women is 35% while in Kenya it is 13.5% among pregnant women. Despite the adverse outcome of IPV in pregnancy, screening during pregnancy lags behind.

**Study Objectives:** This study sought to assess IPV screening practices and barriers associated to screening from the nurse's perspective.

**Methodology:** The study was conducted at Pumwani Maternity hospital utilizing a cross-sectional descriptive design. 125 participants were randomly selected from a population of 186 nurses. The data was collected using a semi-structured questionnaire and analyzed using Statistical Package for Social Sciences (SPSS) version 20.0. The study was approved by the University of Nairobi-Kenyatta National Hospital Ethics and Research Committee.

**Results:** In the study, 16% (n=20) of the nurses screened for IPV. The results from the study indicated that participants with high level of education were 3 times more likely to screen OR = 3.2 [95% of OR = 1.3 to 7.7], P = 0.011. Those who did not report lack of training as a barrier were 6 times more likely to screen OR = 5.8 [95% of OR =1.5 to 23.4], P = 0.0113. Participants who feared survivors partners reaction were 90% less likely to screen OR = 0.10 [95% of OR = 0.02 to 0.46], P = 0.003. Respondents who disagreed that survivors of IPV would still stay with their abuser were 3 times likely to screen OR = 3.3 [95% of OR = 1.4 to 7.4], P = 0.005.

**Conclusion:** The study demonstrated nurses, organization and survivors related barriers to screening for IPV in pregnancy. Therefore, stakeholders in health sector should improve policies on IPV management.

# CHAPTER 1: INTRODUCTION

## 1.1 Background Information

Intimate partner violence (IPV) is a serious, preventable public health problem and a violation of women's human rights that affects millions of women globally (World Health Organization (WHO), 2014). The term "intimate partner violence" describes physical, sexual, social or psychological harm by a current or former partner or spouse (Center for Disease Control (CDC), 2014). Globally, the prevalence of IPV among women is 35% (WHO, 2014) and in Kenya, 49% of women reported experiencing violence in their lifetime; one in four had experienced violence in the previous 12 months while as many as 1:3 women of child bearing age in Kenya has ever experienced some form of domestic violence (Kenya National Bureau of Statistics (KNBS) and Inner City Fund (ICF) Macro, 2010). IPV among pregnant women in Kenya was estimated to be 13.5%, which is a higher prevalence than many conditions such as hypertension and anemia which are routinely screened during pregnancy (Gazmararian, et al 2000 & Devties, et al 2010).

Many researchers have observed that intimate partner violence is directly associated with negative maternal and neonatal health outcomes. For instance Ackerson and Subramanian, (2009) Abuya, et al (2012) and Jasen, et al (2003), reported the link between IPV and high risk of antepartum hemorrhage, intrauterine growth restriction and perinatal as well as neonatal death. The association between IPV and negative perinatal and neonatal health outcomes is supported by Davis (2008) who asserted that IPV is the leading cause of serious injury and death in the United States among women of childbearing age. Without strategies to reduce prevalence of IPV, achievement of Millennium Development Goals (MDGs) numbers 3, 4 and 5 that aim to



promote gender equality and empowerment of women, reduce child mortality and improve maternal health respectively would be derailed.

Screening for IPV in carefully selected venues within public health facilities where the majority of Kenyan women seek maternal health services, has the potential to improve health outcomes for women and their newborn. Screening in these facilities promotes early detection of violence and hence prompt interventions, which are important for the reduction of the adverse effects of IPV (Boinville, 2013). Despite the crucial benefits, support and recommendation for routine screening of IPV for all women in health care settings (Taft, 2013 & Shears, 2008) routine screening for IPV by health care providers is still low as reported by Stayton and Duncan (2005), Barnett, (2005) and Gutmani, et al (2007).

Nurses and midwives in particular are key in the provision of quality care during pregnancy. They provide perinatal care to include screening for different negative exposures during pregnancy (Nursing Council of Kenya-NCK, 2012). Survivors of IPV in pregnancy are likely to present to these nurses at some point during the pregnancy. This visit to the nurses provides an opportunity for disclosure and intervention that could prevent or reduce the adverse effects of IPV in pregnancy.

## **1.2 Problem Statement**

IPV is a serious worldwide problem with a prevalence of 35% globally (WHO, 2009) and 49% among women in Kenya (KNBS & ICF Macro, 2010) while it stands at 13.5% among pregnant women in Kenya. It is detrimental to the physical, emotional, sexual, social, and mental

wellbeing apart from being a violation of human right (Coker, et al. 2000; Jejeebhoy, et al. 2010; Dunkle, et al. 2004). It's also directly associated with negative effects to both the mother and the newborn to include maternal and newborn deaths (Ackerson & Subramanian 2009). Screening for IPV has the potential to improve health outcomes for women and their newborn. This is because it promotes early detection of violence and hence prompt interventions, which are important for the reduction of the adverse effects of IPV (Boinville, 2013). Despite universal screening recommendations for IPV (American College of Obstetricians and Gynecologists, 2012; WHO, 2013), screening for IPV in health care settings in general, and during pregnancy in particular, is far from being implemented universally. Even after recent evidence in Kenya by Undie, et al (2012 &2013) on high acceptability and feasibility of potential IPV screening interventions from the perspectives of women, routine IPV screening does not still take place in the Kenyan health care settings to include at Pumwani maternity hospital. It is therefore paramount to document the barriers that hinder nurses from screening pregnant women for IPV as a first step in achieving universal screening for IPV in pregnancy.

### **1.3 Justification for the Study**

Antenatal period offers an appropriate opportunity for screening and managing IPV among pregnant women and therefore nurses can do a great deal in preventing the adverse effects of intimate partner violence such as maternal and newborn deaths by screening, advising, managing or even referring pregnant women survivors to appropriate care. This is because nurses and in particular midwives play a critical role in the management and care of pregnant women from the time they become pregnant up-to and until they deliver and even during the postnatal period. In most cases, they are the only healthcare personnel that a pregnant woman comes into contact

with during this perinatal period. It is therefore important to understand any barriers that may hinder their role in screening for IPV in pregnancy if universal routine screening is to be achieved in Kenya. The finding from this study could be used to come up with strategies to improve the quality of care provided to pregnant women at Pumwani Hospital thereby improving the quality of life for the mother and the new born.

#### **1.4 Hypothesis**

H<sub>1</sub>: There is a negative relationship between nurses reported barriers (personal, organization, survivors) and screening pregnant women for IPV.

H<sub>0</sub>: There is no relationship between nurses reported barriers (personal, organization, survivors) and screening pregnant women for IPV.

#### **1.5 Research Questions**

1. What are the nurse's practices in screening pregnant women for IPV at Pumwani Maternity Hospital?
2. What are the nurse's related barriers to screening pregnant women for IPV at Pumwani Maternity Hospital?
3. What are the organization related barriers to screening pregnant women for IPV at Pumwani Maternity Hospital?
4. What are the survivors associated barriers to screening for IPV from the perspective of nurses?

## **1.6 Main Objective**

To assess barriers associated with screening pregnant women for intimate partner violence from nurse's perspective at Pumwani Maternity Hospital.

### **1.6.1 Specific Objectives**

1. To determine nurse's practices in screening pregnant women for IPV at Pumwani Maternity Hospital.
2. To determine nurses related barriers to screening pregnant women for IPV at Pumwani Maternity Hospital.
3. To determine organization related barriers to screening pregnant women for IPV at Pumwani Maternity Hospital.
4. To examine pregnant women associated barriers to screening for IPV from the nurse's perspective.

## **1.7 Study Variables**

### **1.7.1 Independent Variables**

**Nurses related barriers to screening pregnant women for IPV;** Lack of; training, knowledge, confidence to refer, good patient–nurse relationship, mentors, cooperation from other health professionals, cooperation from the police. Nurses view that; it's not appropriate to intervene, it's not their role, the focus on nursing care is on physical health and not emotional problems or mental problems. Nurses concerns for personal; safety, comfort, legal involvement in the case, and misdiagnosis. Nurses; forgetfulness time

constraints, have more pressing issues to address, fear of invading the patient's privacy, and fear of the partner's reaction.

**Organization related barriers to screening pregnant women for IPV;** Lack of; environmental enablers, follow-up resource, support staff, hospital protocol, effective referral systems, support from administration, facility set ups rooms for patient privacy, nurses autonomy

**Pregnant women associated barriers to screening for IPV from the nurse's perspective;** refusal for referral, language barriers, failure of disclosure, decline of referral, effects on their life, survivors psychosocial issues, difficult personalities, survivors would still stay with the abuser, denial of battering as a cause of physical injury, fear of retaliation from the abuser, survivors unwillingness to disclose history of IPV in their medical history, unawareness of their rights, noncompliance with IPV management, survivors view of IPV abuse as normal, survivors play a role in eliciting abuse, stigma from society

### **1.7.2 Dependent Variables**

Screening of IPV in pregnancy

### **1.7.3 Outcome Variables**

Prevention of adverse effects of IPV in pregnancy

Adverse effects in pregnancy e.g. maternal and neonatal death

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction to IPV**

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of women globally. Pregnant women are at a higher risk of experiencing gender-based violence because they are more likely to be in relationships compared to non-pregnant population. The prevalence of IPV in pregnancy in Africa is (37%) (Shamu, et al 2014) compared to what is reported worldwide (35%) (WHO, 2014). But there is a culture of silence surrounding gender-based violence, even women who want to speak about their experiences of domestic violence may find it difficult because of feelings of shame or fear (Khasakhala-Mwenesi, et al 2007).

The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (CDC, 2014). Physical violence involves forceful physical contact that may vary from light pushes and slaps to severe beatings and lethal violence. Sexual abuse includes coercive and physical behaviors varying from trying to persuade someone to perform a sexual act against their will, ignoring "no" responses, to physically forced sex acts, while the term psychological aggression (or emotional abuse) refers to acting in an offensive or degrading manner toward another, usually verbally, and may include threats, ridicule, withholding affection, and restrictions (e.g., social isolation, and financial control) (Teten et al 2009; O'Leary & Maiuro, 2002).

## **2.2 Nurses practices in screening pregnant women for Intimate Partner Violence**

Universal routine screening for IPV means asking every pregnant woman, regardless of their socioeconomic status, educational level, ethnicity or gestation age, about their exposure to IPV. A growing body of evidence supports the efficacy of universal screening in a proscribed manner for optimal detection of IPV. The universal screening includes asking the same direct questions about abuse, whether symptoms are present or the nurse suspects abuse. The nurses should ask the questions with sensitivity and in complete privacy. They should also utilize standardized tool, such as the Abuse Assessment Screen; Hurt, Insult, Threaten, and Scream; The Woman Abuse Screening Tool/Woman Abuse Screening Tool-Short Form; The Partner Violence Screen; Composite Abuse Scale; Conflict Tactics Scale; Index of Spousal Abuse (Family Violence Prevention Fund, 2004; American Nurses Association, 2000).

The questions asked during screening for IPV should be culturally sensitive. Cultural competency means the screener is aware of his or her own biases but still is able to approach screening with an understanding of cultural differences. In addition, it's also recommended that screening should be at the initial prenatal examination, once each trimester, and once at the postpartum visit. It is better to screen more frequently because abuse can begin at any time during pregnancy, and women are hesitant to disclose abuse when initially asked. The pattern of abuse can increase during pregnancy (Paluzzi, et al 2000).

Research indicates that the prevalence of screening for intimate partner violence differs across health care specialties and is, overall, relatively low. Women are commonly not asked about IPV when treated in most health facilities. This is despite the evidence that women experiencing

violence often seek help in emergency departments (Kothari and Rhodes, 2006). This is supported by Hindin, (2006) who reported that midwives are concerned, interested, and knowledgeable about intimate partner violence screening. However, they were inconsistent in their adherence to the universal screening clinical practice. The midwives screened less than half of the recommended time and they did not use any standardized screening assessment tool but based their questions on the content in these tools and their individual clinical styles.

### **2.3 Nurses Related Barriers to Screening pregnant women for Intimate Partner Violence.**

Yonaka, et al (2007) and Maina, (2009) reported that the most significant potential barriers to screening of IPV as identified by health service providers were lack of education and instruction on how to ask questions about abuse, knowledge, language barriers between nurses and patients, a personal or family history of abuse, and time issues. They also reported that health care professionals were hindered in their attempts to screen and offer subsequent help to survivors by other health professionals, partner of the survivor and lack of police cooperation.

Lawoko et al (2014) found an association between health care providers' demographic characteristics, categories of professional and readiness to screen for domestic violence. They reported that gender, and professional category is determinants of the readiness to screen for IPV by healthcare workers in Uganda. Male staff, doctors and participants from private health facility appeared less ready to screen for IPV than female, other staff and participants from public facilities. In addition, Furniss et al (2007) reported different challenges that nurses face when



caring for IPV survivors which include: personal belief issues and time alone with the patient to ask sensitive questions and offer support and safety information.

Health care professionals also reports both real and perceived barriers in conducting regular IPV screening. Sprague et al (2012) and Alpert, (2010), service care providers reported difficulties in discussing IPV, concerns for their personal safety, apprehension about misdiagnosis, fear of invading their patients' privacy or offending them as barriers to routine screening of IPV. In other settings, health care providers also did not think it was their role to screen for IPV, others felt that they had more pressing issues to address discomfort with confronting issues of violence and abuse, some, feelings of powerlessness, personal attitudes, misconceptions about IPV, office Security and personal safety. But Sheila, et al (2012) also reported that personal discomfort with discussing the topic of IPV, concerns for personal safety, concerns of misdiagnosis, forgetting to ask about abuse, personal history of abuse, and lack of confidence to refer survivors as barriers to screening for IPV.

The other perceived barriers to screening for IPV as reported by nurses were, that it is not the nurses role to screen for IPV, health care providers have more pressing issues to address, that survivors should be blamed for IPV, that IPV is rare, In addition, the perception that battered survivors do not want a referral, and that what nurses view as abuse, the survivors view as normal (Furniss, et al 2007).

Fear of invading the patient's privacy and fear of offending clients who are not abused were each reported as barriers to screening, fear of the partner's reaction and making life more difficult for

the victim, fear of police involvement and fear that the survivor would stop seeing the health care provider if he or she asked about abuse were also reported as barriers to screening for IPV (Sheila, et al 2012). However, health professionals suggest that routine screening intervals during prenatal care and after delivery may improve identification of IPV. Nurses would like brief, clear resources that include local IPV services and hotline numbers (Furniss, et al 2007) but survivors of IPV may not seek health care when they encounter providers who appear “uninterested, uncaring, or uncomfortable” about domestic violence (Barbra, 2013).

#### **2.4 Organization Related Barriers to Screening pregnant women for Intimate Partner Violence.**

Health care settings provide a unique opportunity for screening and interventions to survivors of IPV because it provides a trusting relationships, confidentiality and space away from the abuser. There is growing consensus among major medical associations that asking women about their experiences with IPV is important for reducing its incidence and severity. Most recently, in 2013, the U.S. Preventive Services Task Force (USPSTF) released a recommendation stating that “clinicians should screen women of childbearing age for intimate partner violence (IPV) such as and provide or refer women who screen positive to intervention services” This is because health care providers are often the first and sometimes the only professional’s survivors of IPV encounter, and so health care providers can play a crucial role in breaking the cycle of violence and work toward prevention of the same (U.S. Preventive Services Task Force, 2013).

Furniss, et al (2007), Sprague et al (2012), Sheila, et al (2012), Maina, (2009) and Lawoko et al (2014) reported that health care providers reported different facility challenges when caring for

IPV survivors which include: lack of privacy, lack for follow-up resources, legal questions, inadequate support staff, poor working conditions, the lack of an office protocol for addressing IPV, inadequate procedures and locations for screening.

On the other hand, lack of mentoring or role modeling, high work demands, low support and weak autonomy over work, also impacted negatively on the readiness of service care providers to screen for IPV (Lawoko et al 2014; Leppäkoski, et al 2014).

The practice environment in which clinicians work appears to play a role in predicting the likelihood of screening survivors of IPV. Studies indicate that prevalence of screening across health care settings was highest in settings where clinicians were prompted to screen. These settings had resources that service care providers considered “environmental enablers,” such as posters, pamphlets, on-site social workers, and reminder stickers on charts, as well as staff training (Stayton & Duncan, 2005).

## **2.5 Pregnant Women Associated Barriers to Screening for Intimate Partner Violence from the nurse’s perspective.**

Women survivors of IPV hesitate to disclose abuse to formal institutions including healthcare. Pertinent reasons hindering abused women from seeking sanctuary from formal networks include the perceived lack of confidentiality, inappropriate methods of inquiry from care providers, fear of retaliation from the abuser and stigmatizing attitudes from service providers (Okemwa et al 2009; WHO, 2005).

Sheila, et al (2012) reported health care provider's perceptions on survivor's barriers to screening of IPV. The most frequently reported patient-related barriers was that the patient's language interfered with effective screening, the survivors with psychosocial issues and/or difficult personalities are difficult to screen, the abused survivors would stay with the abuser anyway, the survivors would deny battering as a cause of injury, that women feared repercussions of being identified, that survivors would not mention abuse in their medical history, and that survivors are not aware of their rights.

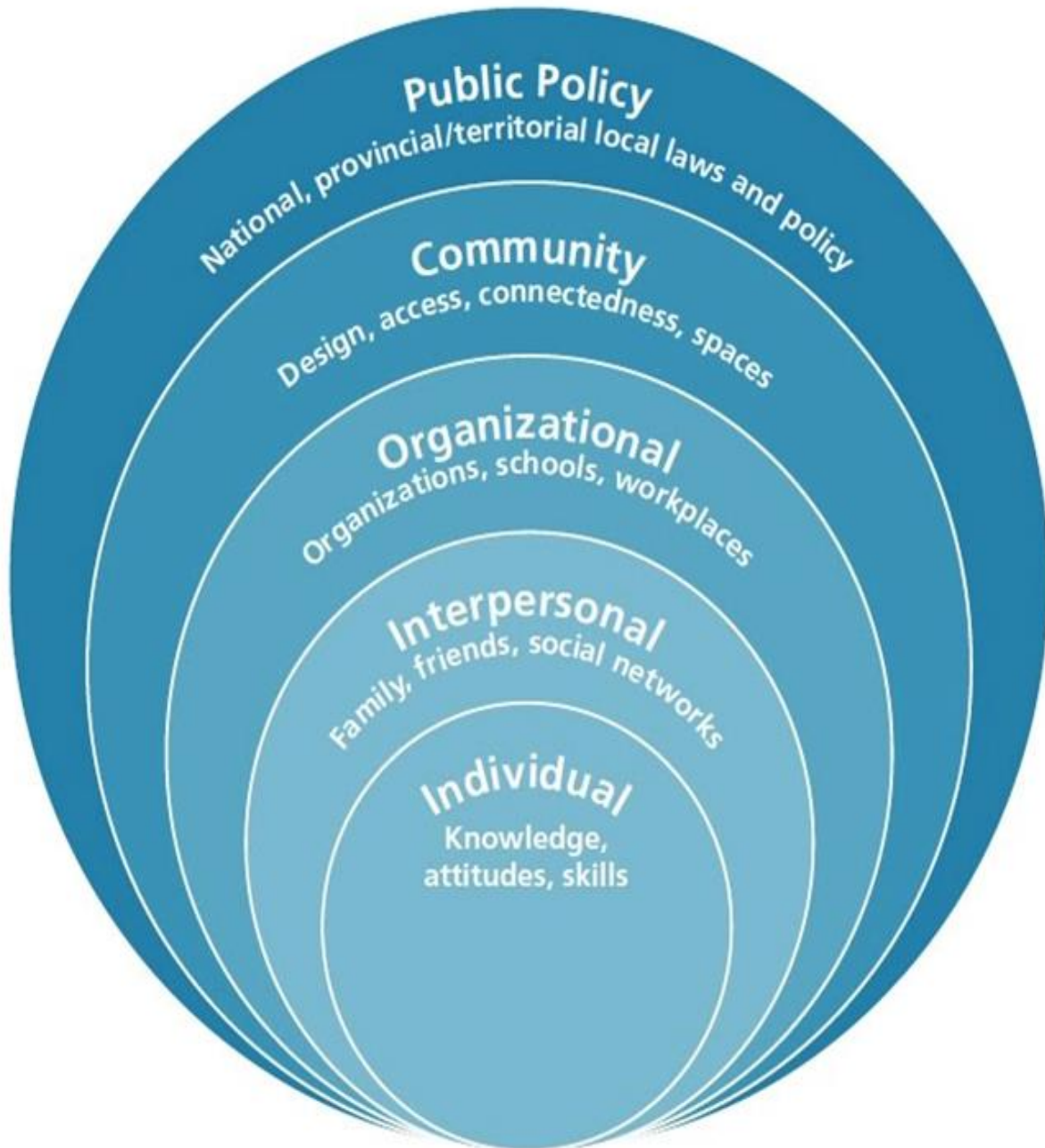
## **2.6 Theoretical Model**

The study is based on the ecological model of health promotion by McLeroy, et al (1988). The model describes the environmental influences on behavior that place individuals at risk for adopting and assuming a health promoting behavior. The model includes five subsystems: intrapersonal, interpersonal, institutional, community and public policy (see Figure 1 overleaf).

1. Intrapersonal factors – includes characteristics of the individual such as knowledge, attitudes, behavior, self-concept, and skills.
2. Interpersonal factors – this includes formal and informal social network and social support systems. Examples include family, work groups, and friendships network.
3. Institutional factors – this includes social institutions with organized characteristics and formal (and informal) rules and regulations for operation.
4. Community factors – this involves relationships among organizations/institutions and informal networks within defined boundaries.
5. Public policy – this involves local, state, national laws and policies.

This model assumes that when implementing any intervention, healthcare providers should take into consideration the inter-influence of the five subsystems. This study will address the intrapersonal, interpersonal, and institutional subsystems. Community subsystem will be incorporated into the interpersonal subsystem while institutional subsystem will be incorporate policy subsystem.

**Figure 1: Theoretical Model**



A Social-Ecological Model for Physical Activity - Adapted from Heise, L., Ellsberg, M., & Gottemoeller, M. (1999)

## **2.6 Conceptual Framework**

As applied to the context of IPV, the intrapersonal subsystem is the nurses' related barriers. Nurses at the intrapersonal level encounter a variety of barriers such as Lack of; training, knowledge, mentors, cooperation from other health professionals, and cooperation from the police. Nurses view that; it's not appropriate to intervene, it's not their role, the focus on nursing care is on physical health and not emotional problems or mental problems. Nurses concerns for personal; safety, comfort, legal involvement in the case, and misdiagnosis. Nurses; forgetfulness time constraints, have more pressing issues to address, fear of invading the patient's privacy, and fear of the partner's reaction.

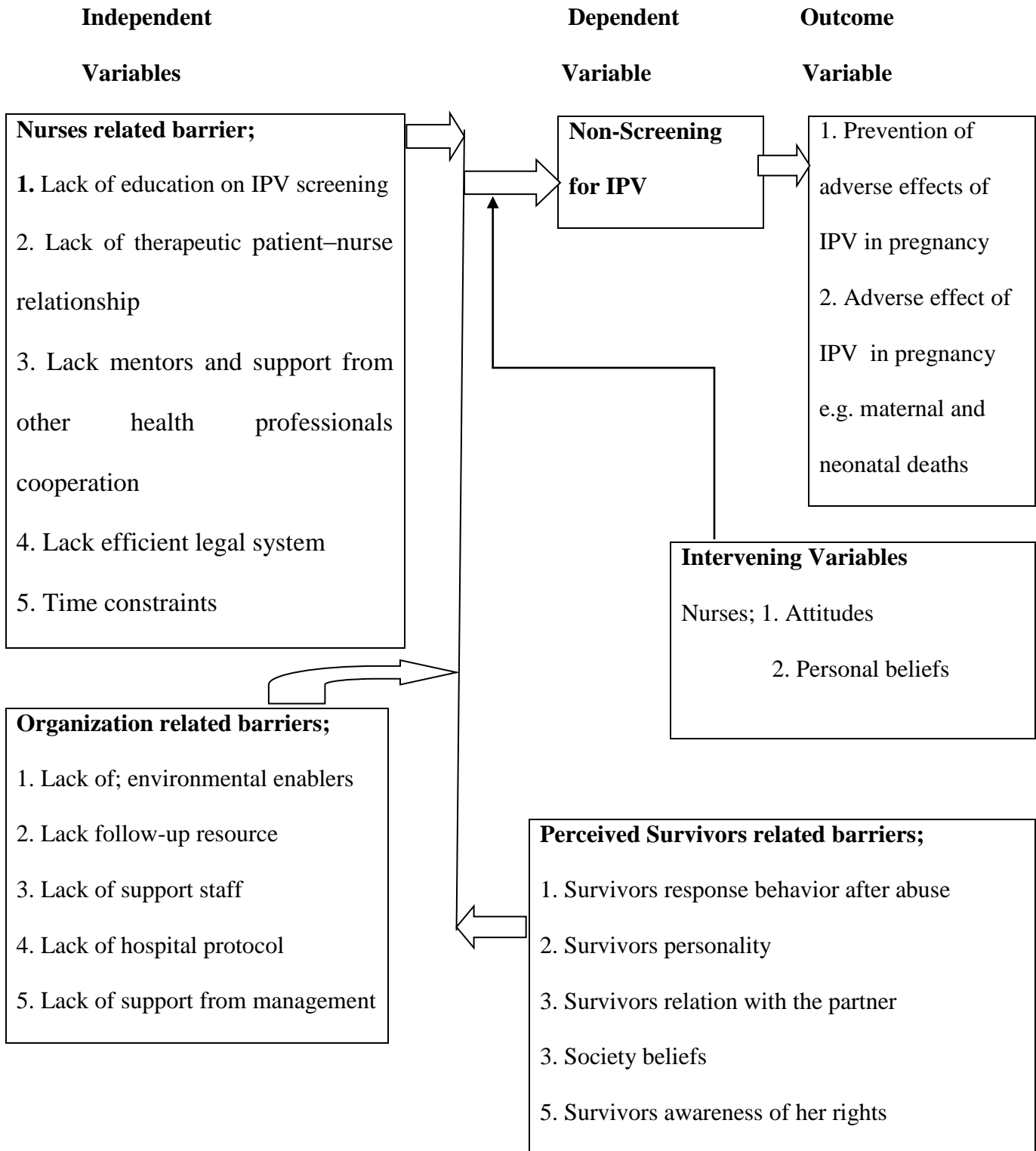
The interpersonal subsystem is related to perceived barriers from the survivor. At the interpersonal level, nurses are confronted by survivors who refuse to disclose or report violence. Other survivor related barriers include refusal for referral, language barriers, and decline of referral. Nurses perceive that survivors with psychosocial issues, and difficult personalities, are difficult to screen. They also view that survivors would still stay with the abuser, survivors would denial battering as a cause of physical injury and they fear of retaliation from the abuser if they report the abuse. Survivors are also unawareness of their rights, they don't comply with IPV management, they view IPV as normal, and they play a role in eliciting abuse, and also they are stigmatized by the society.

At the institutional level, nurses' lack of time to establish a trusting relationship with victims in order to do screening, lack of privacy at the health setting, and the absence of screening protocol.

In addition, nurses lack follow-up resource, support staff, effective referral systems, support from administration, and autonomy. This is illustrated by Figure 2 overleaf.



**Figure 2: Conceptual Framework**



## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 Study Design**

A cross-sectional descriptive design was utilized to collect data at Pumwani hospital.

### **3.2 Study Area**

The study was carried out at Pumwani Maternity Hospital in Nairobi, Kenya. Pumwani Maternity Hospital was purposively selected as the study site since it remains the largest maternity hospital in Kenya and Sub-Saharan Africa and it is the only hospital in Kenya that specializes in maternal and newborn care; and it also serves as a referral facility for all ANC clients from the 42 government health centers in Nairobi County. It is a purely maternity urban public health institution under the management of Nairobi County government. The institution has a bed capacity of 350 and 150 cots with one labor ward, two theatres, four postnatal wards, one antenatal ward, and a special newborn unit and maternal/child health unit. It also serves as a teaching hospital for Pumwani midwifery nursing school, Nairobi University, Kenyatta

University, Daystar University, Baraton University and Kenya Medical Training School. It is about 10 kilometers from the Central Business District (CBD), Nairobi, in the eastern side within Kamukunji constituency and it is surrounded by low income residential areas of Eastleigh, Mathare, Muthurwa and Majengo. The hospital is served by 186 nurses, 20 medical officers, 4 obstetrics/gynecology consultants, 3 pediatric consultants and 14 clinical officers ([savethecradle.org/pumwani-maternity-hospital/](http://savethecradle.org/pumwani-maternity-hospital/)).

### **3.3 Study Population**

The study population comprised all nurses working at PMH. The total number of nurses was 186.

### **3.4 Inclusion and Exclusion Criteria**

#### **3.4.1 Inclusion Criteria.**

Nurses who consented to participate in the study.

Nurses working in the antenatal clinic, antenatal ward, labor ward and maternity theatre

#### **3.4.2 Exclusion Criteria.**

Nurses who did not consent to the study.

Nurses working in the pediatric unit, child welfare clinic and the postnatal ward.

Nurses on leave.

Students nurses.

Nurses on strike.

### **3.5 Sample Size Determination**

Sample size was calculated using the formula below (Fisher, et al., 1998) because the anticipated sample size was small and the prevalence of the outcome of interest is not known. (Naing, Winn, and Rusli, 2006)

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n = the desired sample size.

Z = the standard normal deviate that provides 95% confidence interval (1.96)

p = prevalence of nurses who screen pregnant women for IPV (50% used since no literature found on the prevalence of nurses who screen pregnant women for IPV in Kenya).

q = 1-p.

d = absolute precision (error bound) (0.05).

The desired accuracy of results is at 95% confidence.

### **Sample Size**

$$n = \frac{(1.96)^2 (0.5) (0.5)}{(0.05)^2}$$
$$n = 384$$

Since the population size was less than 10000, the final sample estimate (nf) calculated using the formula:

$$nf = \frac{n}{1 + (n/N)}$$

Where: nf = The desired sample size (when population is less than 10000)

n = The desired sample size (when population is more than 10000)

N = the population of nurses at PMH is 186

$$Nf = \frac{384}{1 + (384/186)}$$
$$= 125 \text{ participants}$$

### **3.6 Sampling Procedure**

Stratified random sampling was utilized to select the 125 nurse's participant from the study population of 186 nurses. The study population was divided into the following strata's: ANC clinic, antenatal ward, labor ward and maternity theatre strata. The number of participants

selected from each stratum was equally proportion to the population of the strata as indicated by the table below. The researcher obtained a list of all eligible nurses' participants from each stratum and then randomly picked the participants from each stratum to obtain the desired sample. The random selection from each stratum was achieved by assigning a numerical value to each participant in each stratum and then a research randomizer computer package was used to generate the desired sample size from all the strata.

The nurses sampled from each stratum were allocated by the following sampling frame;

$$\text{Sample size from each strata} = \frac{\text{Total number of nurses in that strata}}{\text{Total number of nurses in all the strata's}} \times \text{sample size}$$

<b>Strata</b>	<b>Total Number of Nurses</b>	<b>Sample Determination</b>	<b>Sample Size</b>
1. ANC clinic	10	10/135x125	10
2. Antenatal ward	25	25/135 x125	23
3. Labour ward	60	60/135 x125	55
4. Maternity theatre	40	40/135 x125	37
Total	135		125

### **3.7 Recruitment and Consenting Procedures**

#### **3.7.1 Participant recruitment Procedure**

Participants were recruited from the Antenatal clinic, Antenatal ward, Labour ward and Maternity theatre. The researcher did have the intention to conduct the study known during departmental meetings that are held weekly by different units in the hospital. In these meetings, the researcher briefed the potential participants about the purpose of the study. The researcher also posted memos on all notice boards in the hospital. The memos contained the title of the

study, the purpose of the study, eligibility of participants, data collection period and the researcher name and address (see appendix V).

During each data collection session, the researcher liaised with the unit/ward in-charge to ensure that the researcher was stationed in the nursing station/desks during the period of data collection. Upon completion of their shifts in the unit, each of the identified nurses was approached and necessary introductions done. If meeting the stipulated inclusion criteria, consent procedures were then commenced at designated points within the units. This ensured non-disruption of services.

### **3.7.2 Participants Consenting Procedure**

Consent was sought from identified nurses after completion of their duty shifts. To ensure privacy and also minimize disruption of services, the researcher liaised with each unit/ward in-charge to facilitate allocation of designated room in the unit where consenting procedures and interviews was conducted. The process entailed utilization of the participant information sheet and consent form (see appendix I) to comprehensively explain to the potential participants pertinent aspects of the study including the background, nature and objectives of the study, the implications of participation in terms of benefits, utility, compensation and risks of participation. Finally the potential participant was allowed to ask any questions to clarify any aspects they deemed necessary. If they consented to participate, they were taken through the statement of consent declaration (see appendix I) and allowed to sign as appropriately.

### **3.8 Data Collection Instrument and Procedures**

#### **3.8.1 Study Instrument**

A researcher administered semi-structured questionnaire (see appendix II) was used to collect data from the nurses. The questionnaire captured data on each of the objectives of the study and was coded to facilitate data entry and analysis. The questionnaire was developed after a comprehensive review of relevant literature and was tailored to meet the study objectives and answer the research questions. The questionnaire required approximately 30 minutes to be completed. The Questionnaire was pretested at Mbagathi District Hospital ANC clinic to assess it for reliability, clarity and simplicity. Mbagathi hospital has almost similar characteristics with Pumwani hospital since both hospitals are in an urban environment, in the same county, serve urban slums, are public, have nurses with almost similar characteristic like level of qualification. Twelve nurses (10% of the sample size) were interviewed by the researcher and then data was analyzed. The results guided the appropriate adjustments to the study tool.

#### **3.8.2 Data Collection and measurements Procedures**

Data was collected using a semi-structured questionnaire (appendix II). The data was collected over a period of four weeks. The interviews were conducted at the designated points in each unit. This was done following consent procedures.

Data was measured to improve the accuracy of the results from the study. Screening was measured by a response indicating “I screen always” and “I screen most of the time” on the question; How often do you currently screen IPV among pregnant women? A barrier was measured by a yes, strongly agree and agree response on each specific item listed under personal, organization and survivor related barriers. The level of understanding on what screening means

was measured by a score of 3 out of the 4 possible answers in section II of the questionnaire (See appendix II; Section II).

### **3.9 Data Cleaning and Entry**

At the end of each day during the data collection period, questionnaires were checked for completeness, validity and clarity. The data was then entered into a Microsoft Excel program where data cleaning was done. Missing values, Extreme values and inconsistency were identified and corrected. After cleaning, the data was then exported to software for analysis using statistical package for social sciences (SPSS) version 20.0 computer package by the researcher. Each questionnaire was entered against its unique identifier number. Incomplete and wrongly answered questionnaires were omitted during the data entry process. This assisted in data analysis.

### **3.10 Data Analysis and Presentation**

Data analysis was done using the Statistical Package for Social Sciences (SPSS) Version 20.0. Descriptive statistics was utilized to summarize data on participant's characteristics and this was presented in narrative and pictorial format using graphs, charts and tables as applicable. For categorical variables such as gender, level of education, years of practice, and number of professionals working with the participant, frequencies and percentages were computed and presented in frequency tables, pie charts and bar graphs. To test for the association between two variables such as lack of knowledge as one of the personal barrier and screening practices, Chi-square was used. Associations between the variables were calculated at 95% confidence interval at P-value 0.05. Odds ratio was calculated in multivariate analysis to estimate the probability of



any barrier causing non-screening. Qualitative data was coded through content analysis according to the different themes identified before presentation.

### **3.11 Ethical Considerations**

Review of protocol, clearance and approval to conduct the study was sought by presenting the study proposal to The University of Nairobi- Kenyatta National Hospital Ethics and Research Committee. Participants were required to give a signed, voluntary informed consent prior to participation and they were briefed on their rights and the expected benefits of the study. In addition there was no any coercion or inducement to participate. Anonymity of participants was ensured by serializing the structured questionnaires. No form of identification was required from participants or any markers to identify participants noted on any questionnaires. All research tools were accessible by the researcher only. They were stored under lock and key and research information in computers under passwords. Participants were informed of the potential benefits of the study and risks before they participated in the study. The participants were also informed the approximate number of participants to the study that the researcher hoped to recruit. The participants were allowed to ask questions and answers were provided to their satisfaction. The researcher also asked the participants questions on the information provided to ascertain their comprehension about the study before they could sign the consent forms (see appendix I). The researcher and the supervisors had no conflict of interests.

### **3.12 Study Limitations**

The study was conducted only at Pwani Hospital and therefore it only gave a picture of one hospital and therefore generalizability to other hospitals in the country may not be possible.

However Pumwani is the largest maternity in East Africa and therefore results from this hospital could mirror the general state of the country. The study described the barriers as reported by the nurses and depended on self-report whether the nurses screened or did not screen. The study was only able to describe the variables under study and associations between the variables. This forms the basis for further studies to test how causal associations among different variables are interrelated.

## CHAPTER 4: STUDY RESULTS

### 4.1 Introduction

This chapter presents the findings of the study. The findings are presented and interpreted based on the objectives of the study. The results are presented in sections that cover: socio-demographic characteristics of the participants, prevalence of IPV screening, nurse's related barriers, organization related barriers and survivors related barriers. The results are presented in tables, pie charts and graphs form. Data was measured to improve the accuracy of the results from the study. Screening was measured by a response indicating "I screen always" and "I screen most of the time" on the question; How often do you currently screen IPV among pregnant women? A barrier was measured by a yes, strongly agree and agree response on each specific item listed under personal, organization and survivor related barriers. The level of understanding on what screening means was measured by a score of 3 out of the 4 possible answers in section II of the questionnaire (See appendix II; Section II).

### 4.2 Respondents characteristics

#### 4.1.1 Respondents Gender

A total of 125 respondents were recruited for the study, male respondents being (22.4%, n=28) and females respondents (77.6%, n=97) as illustrated in table 1 below.

**Table 1: Respondents Distribution by Gender**

<b>Sex</b>	<b>n</b>	<b>Percentage (%)</b>
Male	28	22.4
Female	97	77.6
<b>Total</b>	<b>125</b>	<b>100</b>

### 4.1.2 Respondents' Age

Majority of the respondents (38.4%, n=48) were between age 40-49 years, while only one (0.8%, n=1) was above 60 years as illustrated in table 2 below.

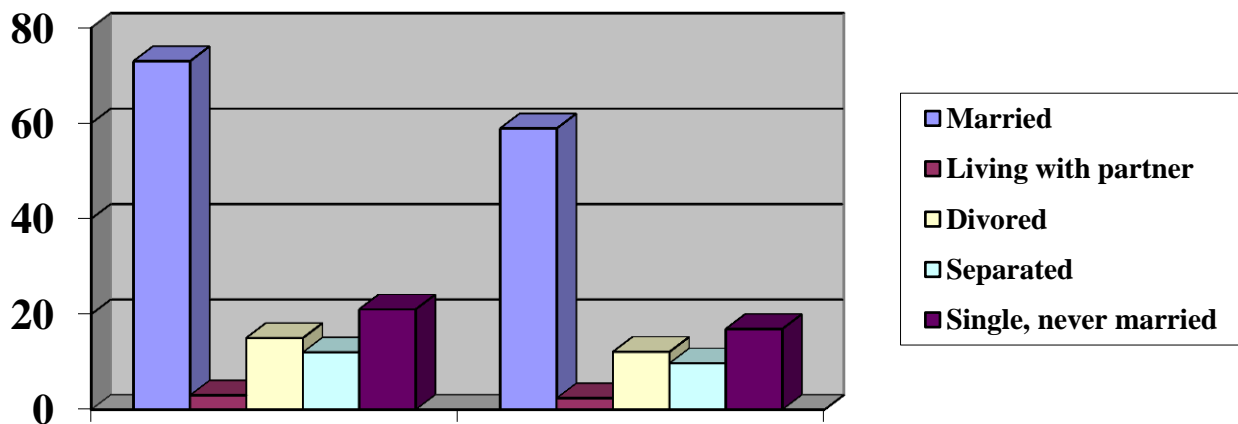
**Table 2: Distribution of Respondents by Age**

Age	n	Percentage (%)
20-29yrs	9	7.2
30-39yrs	39	31.2
40-49yrs	48	38.4
50-59yrs	28	22.4
60yrs and above	1	.8
<b>Total</b>	<b>125</b>	<b>100%</b>

### 4.1.3 Respondents Marital status

Majority of the respondents were married (n=73) and a few (3) were living with a partner as illustrated in figure 3 below.

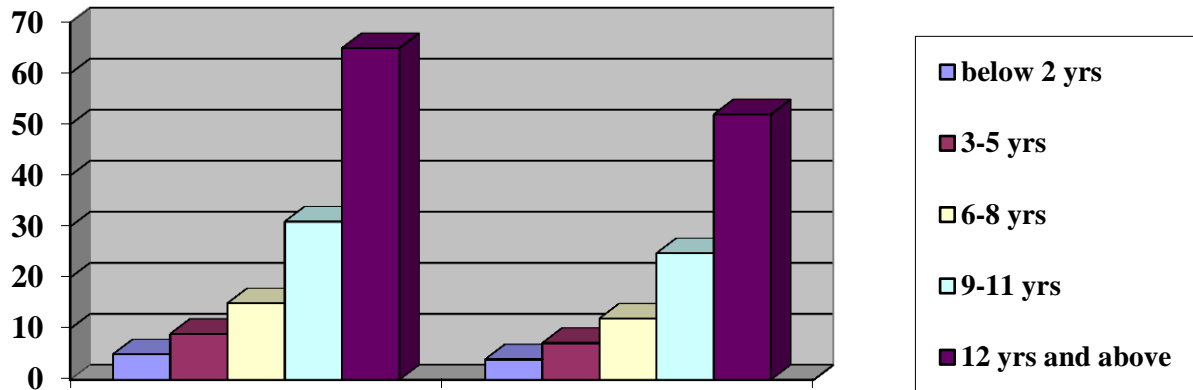
**Figure 3: Distribution of Respondents Marital status**



#### 4.1.4 Respondents Duration of practice in their area of specialty

Majority of the respondents (52%, n=65) had worked for more than 12 years in their area of specialty while a few (4%, n=5) had worked for 2 years and below as illustrated by figure 4 below

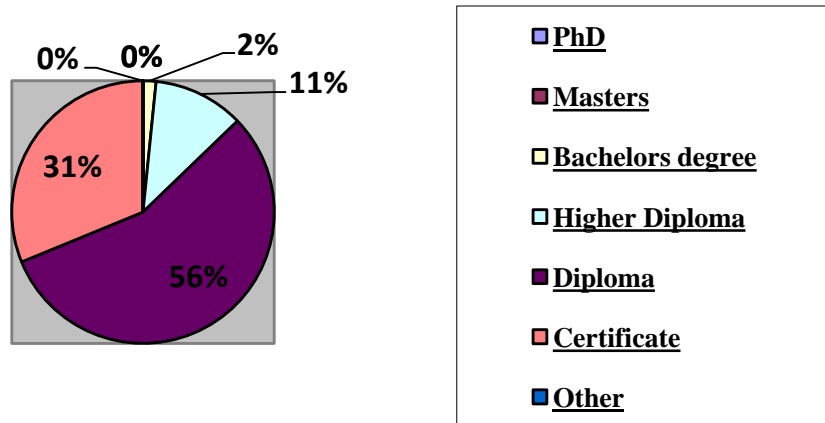
**Figure 4: Respondents Distribution of years of practice**



#### 4.1.5 Respondents Level of education

Majority of the respondents (56%, n=70) had a diploma and none had a masters or a PhD as illustrated by figure 5 below.

**Figure 5: Distribution of Respondents level of Education**



#### 4.1.6 Respondents specialty

Majority of the respondents (62.6%, n=77) were community health nurse, 29.3 % (n=36) were midwives and none was psychiatric or sick child nurse as illustrated by the table 3 below.

**Table 3: Distribution of Respondents area of specialization**

<b>Nurses area of Specialization</b>	<b>n</b>	<b>Percentage (%)</b>
General nurse	10	8.1
Midwife	36	29.3
Community health nurse	77	62.6
Psychiatric nurse	0	.0
Sick children's nurse	0	.0
<b>Total</b>	<b>123</b>	<b>100%</b>

#### 4.2 Screening Practice

##### 4.2.1 Participant understanding on the term “Screening”

All respondents understood the term screening as indicated by all of them scoring at least 3 out of the 4 possible outcomes as illustrated by table 4 below.

**Table 4: Distribution of respondents on their understanding of the term "Screening"**

<b>Understanding on the term “screening” for IPV among pregnant women</b>	<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>
Screening is routine inquiring about risk for IPV	110	88.0
Screening is routine inquiring about current exposure to IPV	107	86.3

<b>Table 4: Distribution of respondents on their understanding of the term "Screening continued</b>		
<b>Understanding on the term "screening" for IPV among pregnant women</b>	<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>
Screening is routine inquiring about previous exposure to IPV	106	85.5
Screening involves use of a standard tool when inquiring about exposure to IPV	108	86.4

#### **4.2.2 Respondents Screening practice**

A few respondents (16%, n=8) screened pregnant woman of IPV, while a majority (84%, n=105) did not screen. This was explained by the respondents as follows:

*"I only screen mothers that I see have physical marks that could indicate battering." "I only screen those who look distressed and those who report battering during history taking." "I don't use any standard tool, I just ask general question like; what is the cause of the physical marks that I see?" "I use history taking and physical examination in screening; I don't use any standard tool. This is illustrated by table 5 below.*

**Table 5: Distribution of respondents Screening or Non-screening practices**

<b>How often do you currently screen IPV among pregnant women?</b>	<b>n</b>	<b>Percentage (%)</b>
Always and Most of the time	20	16
Rarely and Never screen	105	84
<b>Total</b>	<b>125</b>	<b>100%</b>

#### **4.2.3 Situations where Respondents screened for IPV**

Majority of the respondents who did not always screen for IPV among pregnancy did so when pregnant women reported abuse during clinical interview (94.3%, n=82) and when they presented with physical indicators of abuse (93.3%, n=83). This is illustrated by table 6 over leaf.

**Table 6: Distribution of different situations that respondents screened for IPV among pregnant women**

Check the situations listed below in which you currently screen for IPV among pregnant women	Yes	
	n	Percentage (%)
When they are attending hospital appointments	38	42.7
When they are seeking medical care	35	39.3
All new clients	22	25.0
Clients with physical indicators (physical symptoms) of abuse	83	<b>93.3</b>
Those who report abuse during clinical interview	82	<b>94.3</b>
Only if the client seems distressed	36	41.4
I screen randomly	11	12.6

#### 4.2.4 Screening tool

Majority of the respondents 98% (n=123) did not utilize any standard tool while screening for IPV. This is illustrated by table 7 below.

**Table 7: Distribution of different screening tools utilized for screening for IPV**

Which standard tool do you use when screening for IPV in pregnancy?	No		Yes	
	n	Percentage (%)	n	Percentage (%)
Don't use a standard tool	2	1.6	123	<b>98</b>
Hurt, Insult, Threaten, and Scream	125	100.0	0	.0



<b>Table 7: Distribution of different screening tools utilized for screening for IPV continued</b>				
<b>Which standard tool do you use when screening for IPV in pregnancy</b>	<b>No</b>		<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>	<b>N</b>	<b>Percentage (%)</b>
The Woman Abuse Screening Tool	125	100	0	0
The Partner Violence Screen	125	100.0	0	.0
Abuse Assessment Screen	123	98.4	2	1.6
Composite Abuse Scale	125	100.0	0	.0
Conflict Tactics Scale	125	100.0	0	.0
Index of Spousal Abuse	125	100.0	0	.0

#### **4.3: Personal Barriers**

Majority of the respondents (95.2%, n=118) indicated that lack of continuous medical education (CME) as a primary personal barrier. Other major barriers included lack of IPV screening training during the education program (83.7%, n=103) and time constraints due to large number of clients to take care of (62.9%, n=78). This is illustrated by table 8 below.

**Table 8: Distribution of personal barriers**

<b>Personal barriers</b>	<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>
Personal discomfort with discussing the topic of IPV	31	25.0
Concerns for personal safety	41	33.3

**Table 8: Distribution of personal barriers continued**

Personal barriers	Yes	
	n	Percentage (%)
Concerns of misdiagnosis	48	38.7
Nurses forget to ask about abuse	70	56.5
Personal history of domestic abuse	28	22.6
Nurses lack confidence to refer survivors to gender based violence centers	49	39.8
Time constraints due large numbers of clients to take care of	78	62.9
Lack of IPV screening training during the education program	103	<b>83.7</b>
Lack of continuous training education (CME) regarding screening of IPV while practicing	118	<b>95.2</b>
Nurses view that it's not their role to screen for IPV	51	41.1
Nurses have more pressing issues to address	33	26.8
Fear of invading the patient's privacy	38	30.9
Fear of the partner's reaction	62	50.4
Personal fear of legal involvement in the case	81	67.5
Lack of a good patient–nurse relationship	48	39.3
It is not appropriate for the nurse to intervene when she/he encounters a survivor of IPV	26	21.0
The focus on nursing care is on physical health and not emotional problems or mental problems	28	22.6

<b>Personal barriers</b>	<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>
Lack of mentors and role models in IPV screening	105	85.4
Lack of cooperation from other health professionals	67	54.5
Lack of cooperation from the police when the nurse report to them on IPV cases	78	63.9

#### **4.4 Organization related Barriers**

High work load to the nurse was reported as the primary organization barrier (91.1%, n=112). Other major barriers included lack of environmental enablers (86.3%, n=107), lack of hospital protocol that addresses IPV screening (83.6%, n=102). This is illustrated by table 9 below

**Table 9: Distribution of Organization Barriers**

<b>Organization barriers</b>	<b>Yes</b>	
	<b>n</b>	<b>Percentage (%)</b>
Inadequate follow-up resources	98	79.0
Lack of support staff to assist the survivors	92	76.0
Lack of hospital protocol that addresses IPV screening	102	83.6
Ineffective referral systems to refer IPV survivors	100	82.0
Lack of environmental enablers e.g. posters, pamphlets	107	86.3
High work load to the nurse	112	91.1
Lack of support from administration	93	75.6

<b>Table 9: Distribution of Organization Barriers continued</b>		
<b>Organization barriers</b>	<b>Yes</b>	
	<b>n</b>	<b>Percent (%)</b>
Lack of facility set ups (rooms) for patient privacy during screening	89	72.4
Nurses weak autonomy on the management for IPV in pregnancy to include screening	78	62.9

**4.5 Pregnant women related Barriers from the nurse’s perspective**

The respondents perceived the following barriers to be emanating from the pregnant woman. Majority (n=86, 69.9%) agreed that abused survivor would still stay with the abuser, and 68% (n=83) agreed that Survivors are unwilling to disclose history of IPV in their medical history. 66.7% (n=82) of the respondents agreed that stigmatizing attitudes to the IPV survivors from the society and 65% (n=80) agreed that Survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV as barriers to screening. About 65.3% of the respondents agreed that survivors are not aware of their rights in regard to IPV reporting and that survivor’s view of IPV abuse as normal as other barriers to screening. This is illustrated by table 10 over leaf.

**Table 10: Distribution of Pregnant women related barriers from the nurse's perspective**

<b>Pregnant women related barriers from the nurse's perspective</b>	<b>Strongly disagree</b>		<b>Disagree</b>		<b>Agree</b>		<b>Strongly agree</b>	
	<b>n</b>	<b>Percent</b>	<b>n</b>	<b>Percent</b>	<b>n</b>	<b>Percent</b>	<b>n</b>	<b>Percent</b>
Pregnant women survivors with psychosocial issues are difficult to screen	12	9.7	48	38.7	59	47.6	5	4.0
Pregnant women survivors with difficult personalities are difficult to screen	13	10.5	44	35.5	59	47.6	8	6.5
Abused survivor would still stay with the abuser	8	6.5	18	14.6	<b>86</b>	<b>69.9</b>	11	8.9
Survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV	9	7.3	18	14.6	<b>80</b>	<b>65.0</b>	16	13.0
IPV survivors fear of retaliation from the abuser if they report IPV to the nurse	5	4.1	23	18.7	79	64.2	16	13.0
Survivors are unwilling to disclose history of IPV in their medical history	9	7.4	10	8.2	<b>83</b>	<b>68.0</b>	20	16.4
Survivors are not aware of their rights in regard to IPV reporting	8	6.5	15	12.1	<b>81</b>	<b>65.3</b>	20	16.1
Survivors do not comply with IPV management to include screening	6	4.8	28	22.6	69	55.6	21	16.9

**Table 10: Distribution of Pregnant women related barriers from the nurse’s perspective continued**

Pregnant women related barriers from the nurse’s perspective	Strongly disagree		Disagree		Agree		Strongly agree	
	n	Percent	n	Percent	n	Percent	n	Percent
Survivors view of IPV abuse as normal	7	5.6	21	16.9	<b>81</b>	<b>65.3</b>	15	12.1
Survivors play a role in eliciting abuse	10	8.1	44	35.5	59	47.6	11	8.9
Stigmatizing attitudes to the IPV survivors from the society and so they fear to report IPV	6	4.9	12	9.8	<b>82</b>	<b>66.7</b>	23	18.7

#### 4.6 Correlations between respondents non-screening behavior and their demographic characteristics

There was a statistical significance between respondents non-screening behavior and their marital status (P=0.001), education level (P=<0.0001) and their specialty (P=0.48) as seen in table 11 below.

**Table 11: Respondents non-screening behavior compared to their demographic characteristics**

Demographic Characteristics	Screening behavior					
	Screening		Non-screening		Chi Square	P value
	n	%	n	%		
Age 20-29yrs	1	11.1	8	88.9	0.449	0.978

**Table 11: Respondents non-screening behavior compared to their demographic characteristics continued**

Demographic Characteristics	Screening Behavior						
	Screening		Non-screening		Chi Square	P Value	
	n	%	n	%			
Age	30-39	6	15.4	33	84.6		
	50-59yrs	5	17.9	23	82.1		
	>60yrs	0	.0	1	100		
Gender	Male	3	10.7	25	89.3	0.819	0.390
	Female	17	17.9	78	82.1		
Marital status	Married	7	9.6	66	90.4	<b>18.9</b>	<b>0.001</b>
	Living with partner	3	100.0	0	.0		
	Divored	3	20.0	12	80.0		
	Separated	3	25.0	9	75.0		
	Single, never married	4	19.0	17	81.0		
Duration practicing in speciality	below 2 yrs	0	.0	5	100.0	2.51	0.642
	3-5 yrs	1	11.1	8	88.9		
	6-8 yrs	3	20.0	12	80.0		
	9-11 yrs	7	22.6	24	77.4		
	12 yrs and above	9	13.8	56	86.2		

**Table 11: Respondents non-screening behavior compared to their demographic characteristics continued**

		Screening behavior				Chi square	P Value
		Screening		Non-screening			
		n	%	n	%		
Education level	PhD	0	.0	0	.0	<b>20.53</b>	<b>&lt;0.0001</b>
	Masters	0	.0	0	.0		
	Bachelor's degree	0	.0	2	10		
	Higher Diploma	8	57.1	6	42.9		
	Diploma	9	12.9	61	87.1		
	Certificate	3	7.7	36	92.6		
Specialty	General nurse	2	20.0	8	80.0	<b>7.93</b>	<b>0.048</b>
	Midwife	10	27.8	26	72.2		
	Community health nurse	7	9.3	68	90.7		
	Other	1	50.0	1	50.0		
Deployment	ANC clinic	6	25.0	18	75.0	7.97	0.093
	Labor ward	6	21.4	22	78.6		
	Labor ward/Antenatal ward	1	4.3	22	95.7		
	Maternity theatre	2	5.9	32	94.1		
	Antenatal ward	1	8.3	11	91.7		



#### **4.7 Correlations between respondent's non-screening behavior and the reported personal barriers.**

There was a statistical significance between respondents non-screening behavior and the respondents Lack of IPV screening training during their education program (P=0.002), fear of the partner's reaction (P=0.004), lack of mentors and role models in IPV screening (P=0.005), and Lack of cooperation from other health professionals (P=0.016). The lack of training in IPV screening was explained by some of the respondents as follows:

*"I don't think I was trained on screening during my certificate program, which was 12 years ago?" "I think when I was training, the gender based violence was not too common like it is today and therefore I think by then there was no much need for training in screening." "I don't remember the last time we had a CME on gender based violence in the hospital, its rarely discussed." "I have not attended any conference or workshop on screening for gender based violence."*

Lack of mentors was explained by some of the respondents as follows:

*"we don't have mentors in the hospital who can guide us in screening for intimate partner violence."*

Lack of cooperation from other health professionals was explained by some of the respondents as follows:

*"Sometimes when you ask the doctors to review a patient you are suspecting are survivors of intimate partner violence, they don't take you serious".* This is illustrated by table 12 over leaf.

**Table 12: Respondents non-screening behavior compared to the reported personal barriers.**

Personal Barriers	Screening behavior						
		Screening		Non screening		Chi square	P value
		n	%	n	%		
Personal discomfort with discussing the topic of IPV	No	13	14.0	80	86.0	1.272	0.259
	Yes	7	22.6	24	77.4		
Concerns for personal safety	No	12	14.6	70	85.4	0.478	0.489
	Yes	8	19.5	33	80.5		
Concerns of misdiagnosis	No	12	15.8	64	84.2	0.017	0.897
	Yes	8	16.7	40	83.3		
Nurses forget to ask about abuse	No	7	13.0	47	87.0	0.709	0.400
	Yes	13	18.6	57	81.4		
Personal history of domestic abuse	No	13	13.5	83	86.5	2.104	0.147
	Yes	7	25.0	21	75.0		
Nurses lack confidence to refer survivors to gender based violence centers	No	14	18.9	60	81.1	0.964	0.326
	Yes	6	12.2	43	87.8		
Time constraints due large numbers of clients to take care of	No	5	10.9	41	89.1	1.496	0.221
	Yes	15	19.2	63	80.8		
Lack of IPV screening training during the education program	No	8	40.0	12	60.0	<b>9.885</b>	<b>0.002</b>
	Yes	12	11.7	91	88.3		
Lack of continuous training education (CME) regarding screening of IPV while practicing	No	2	33.3	4	66.7	1.380	0.240
	Yes	18	15.3	100	84.7		

**Table 12: Respondents non-screening behavior compared to the reported personal barriers continued**

Personal Barriers	Screening behavior							
	Screening			Non-screening			Chi Square	P Value
		n	%	n	%			
Nurses view that it's not their role screen for IPV	No	13	17.8	60	82.2	0.370	0.543	
	Yes	7	13.7	44	86.3			
Nurses have more pressing issues to address	No	12	13.3	78	86.7	2.110	0.146	
	Yes	8	24.2	25	75.8			
Fear of invading the patient's privacy	No	12	14.1	73	85.9	0.928	0.336	
	Yes	8	21.1	30	78.9			
Fear of the partner's reaction	No	4	6.6	57	93.4	<b>8.367</b>	<b>0.004</b>	
	Yes	16	25.8	46	74.2			
Personal fear of legal involvement in the case	No	8	20.5	31	79.5	0.615	0.433	
	Yes	12	14.8	69	85.2			
Lack of a good patient–nurse relationship	No	12	16.2	62	83.8	0.059	0.808	
	Yes	7	14.6	41	85.4			
It is not appropriate for the nurse to intervene when she/he encounters a survivor of IPV	No	14	14.3	84	85.7	1.174	0.279	
	Yes	6	23.1	20	76.9			
The focus on nursing care is on physical health and not emotional problems or mental problems	No	13	13.5	83	86.5	2.104	0.147	
	Yes	7	25.0	21	75.0			
Lack of mentors and role models in IPV screening	No	7	38.9	11	61.1	<b>7.930</b>	<b>0.005</b>	
	Yes	13	12.4	92	87.6			
Lack of cooperation from other health Professionals	No	14	25.0	42	75.0	<b>5.767</b>	<b>0.016</b>	
	Yes	6	9.0	61	91.0			

**Table 12: Respondents non-screening behavior compared to the reported personal barriers continued**

Personal barriers	Screening behavior						
	Screening			Non-screening			
		n	%	n	%	Chi Square	P Value
Lack of cooperation from the police when the nurse report to them on IPV cases	No	9	20.5	35	79.5	0.828	0.363
	Yes	11	14.1	67	85.9		

#### 4.8 Correlations between respondent’s non-screening behavior and the reported organization barriers.

There was a statistical significance between respondents non-screening behavior and the organization lack of protocol that addresses IPV screening (P=0.014), high work load to the nurse (P=0.006) and nurses weak autonomy on the management for IPV in pregnancy to include screening (P=0.021). Some of the respondents explained the organization barriers as follows:

*“I have not seen any hospital protocol that addresses intimate partner violence.” “We don’t have a protocol here, the survivors we get here, we send them to Kenyatta hospital and Nairobi women’s hospital.”*

The work load on the nurse was explained as follows: *“The numbers of patients we see and attend to are too many and therefore we just focus on their physical needs.” “By the time am starting the clinic, there is a long queue of patients waiting and so I only focus on clearing the queue.” Due to the large number of patients we attend to in a day, I only focus on what brought the patient to the hospital.”*

Lack of autonomy by the nurses was explained as follows: “*The nurse is generally not very empowered to make independent decision to include Intimate partner screening, you need to consult around.*” This is illustrated by table 13 below.

**Table 13: Respondents non-screening behavior compared to the reported organization barriers.**

Organization Related Barriers		Screening behavior					
		Screening		Non-screening		Chi square	P value
		n	%	n	%		
Inadequate follow-up resources	No	5	19.2	21	80.8	0.234	0.629
	Yes	15	15.3	83	84.7		
Ineffective referral systems to refer IPV survivors	No	6	27.3	16	72.7	2.318	0.128
	Yes	14	14.0	86	86.0		
Lack of support staff to assist the survivors	Yes	4	13.8	25	86.2	0.105	0.746
	No	15	16.3	77	83.7		
Lack of hospital protocol that address IPV screening	Yes	7	35	13	65	<b>6.042</b>	<b>0.014</b>
	No	13	12.7	89	87.3		
Lack of environmental enablers e.g. posters, pamphlets	No	5	29.4	12	70.6	2.569	0.109
	Yes	15	14.0	92	86.0		
High work load to the nurse	No	5	45.5	6	54.5	<b>7.562</b>	<b>0.006</b>
	Yes	15	13.4	97	86.6		
Lack of support from administration	No	8	26.7	22	73.3	3.156	0.076
	Yes	12	12.9	81	87.1		
Lack of facility set ups (rooms) for patient privacy during screening	No	8	23.5	26	76.5	1.824	0.177
	Yes	12	13.5	77	86.5		
Nurses weak autonomy on the management for IPV in pregnancy to include screening	No	12	26.1	34	73.9	<b>5.360</b>	<b>0.021</b>
	Yes	8	10.3	70	89.7		

#### **4.9 Correlations between respondent's non-screening behavior and the reported perceived barriers from the pregnant women.**

There was a statistical significance between respondents non-screening behavior and the perceived barriers that pregnant women survivors with difficult personalities are difficult to screen ( $P=0.019$ ) and that abused survivor would still stay with the abuser ( $P=<0.0001$ ). Other perceived barriers that had a statistical significant include; survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV ( $P=0.001$ ), IPV survivors fear of retaliation from the abuser if they report IPV to the nurse ( $P=<0.0001$ ) and survivors are unwilling to disclose history of IPV in their medical history ( $P=0.001$ ). Respondents also reported a correlation between perceived barriers that survivors are not aware of their rights in regard to IPV reporting ( $P=0.039$ ) and that survivors view of IPV abuse as normal ( $P=0.009$ ) with non-screening behaviors.

Survivors related barriers were explained by some respondents as follows; *“These women with difficult personalities don't open up easily so you can't get a lot from them and therefore difficult to screen.”*

Respondents viewed different reasons why the survivors still stayed with the survivor: *“The abused women would still stay with abuser especially when he is the only bread winner of the family and so even if you screen you are not helping much.”* *“Some women from some cultures view abuse as normal especially when their culture encourage and condones the abuse.”*

Other survivor related were explained as follows: *“Most pregnant women denials to have been abused even if they have physical marks since most of them don't want to expose their*

husbands”. “Some fear to be battered more if their husbands learn that they reported them to the nurse especially when their husbands’ are accompanying them to the hospital.” “Some women especially those not educated are not aware that it’s wrong for their husband to beat them.” This is illustrated by table 14 below.

**Table 14: Respondents non-screening behavior compared to the perceived barriers from the pregnant women.**

Perceived Barriers	Pregnant woman	Related	Screening behavior				Chi square	P value
			Screening		Non-screening			
			n	%	n	%		
Pregnant women usually decline referral	survivors	Agree	9	15.8	48	84.2	3.900	0.895
		Disagree	11	16.7	55	83.3		
Screening for IPV will make the life of the pregnant woman more difficult		Agree	7	13.5	45	86.5	4.759	0.492
		Disagree	13	18.1	59	81.9		
Language barrier interfere with effective screening		Agree	8	11.1	64	88.9	3.202	0.074
		Disagree	12	23.1	40	76.9		
		Agree	7	10.9	57	89.1	4.474	0.105
		Disagree	13	21.7	47	78.3		
Pregnant women survivors with difficult personalities are difficult to screen		Agree	6	9.0	61	91.0	<b>11.044</b>	<b>0.019</b>
		Disagree	14	24.6	43	75.4		
Abused survivor would still stay with the abuser		Agree	9	9.3	88	90.7	<b>16.930</b>	<b>&lt;0.001</b>
		Disagree	11	42.3	15	57.7		
Survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV		Agree	10	10.4	86	89.6	<b>12.491</b>	<b>0.001</b>
		Disagree	10	37.0	17	63.0		

**Table 14: Respondents non-screening behavior compared to the perceived barriers from the pregnant women.**

Perceived Pregnant woman Related Barriers	Screening behavior						
	Screening		Non-screening		Chi square	P Value	
	n	%	n	%			
IPV survivors fear of retaliation from the abuser if they report IPV to the nurse	Agree	8	8.4	87	91.6	<b>20.215</b>	<b>&lt;0.001</b>
	Disagree	12	42.9	16	57.1		
Survivors are unwilling to disclose history of IPV in their medical history	Agree	12	11.7	91	88.3	<b>14.375</b>	<b>0.001</b>
	Disagree	8	42.1	11	57.9		
Survivors are not aware of their rights in regard to IPV reporting	Agree	13	12.9	88	87.1	<b>4.808</b>	<b>0.039</b>
	Disagree	7	30.4	16	69.6		
Survivors don't comply with IPV management to include screening	Agree	13	14.4	77	85.6	3.401	0.407
	Disagree	7	20.6	27	79.4		
Survivors view of IPV abuse as normal	Agree	11	11.5	85	88.5	<b>7.694</b>	<b>0.009</b>
	Disagree	9	32.1	19	67.9		
Survivors play a role in eliciting abuse	Agree	9	12.9	61	87.1	2.868	0.259
	Disagree	11	20.4	43	79.6		
Stigmatizing attitudes to the IPV survivors from the society and so they fear to report IPV	Agree	16	15.2	89	84.8	3.915	0.458
	Disagree	4	22.2	14	77.8		



#### 4.10 Multivariate analysis

The results from the study indicates that participants with high level of education were 3 times more likely to screen OR = 3.2 [95% of OR = 1.3 to 7.7], P = 0.011. Those who did not report lack of training as a barrier were 6 times more likely to screen OR = 5.8 [95% of OR = 1.5 to 23.4], P = 0.0113. Participants who feared survivors partners reaction were 90% less likely to screen OR = 0.10 [95% of OR = 0.02 to 0.46], P = 0.003. Respondents who disagreed that survivors of IPV would still stay with their abuser were 3 times likely to screen OR = 3.3 [95% of OR = 1.4 to 7.4], P = 0.005. This is illustrated by table 15 below.

**Table 15: Logical regression to indicate predictors of screening for IPV**

	Coefficient	S.E. of coefficient	P value	OR	95% C.I. for OR	
					Lower	Upper
<b>Higher education level</b>	1.155	.452	.011	3.175	1.310	7.694
<b>Lack of screening training</b>	1.765	.708	.013	5.842	1.459	23.388
<b>Fear of partner reaction</b>	-2.276	.763	.003	.103	.023	.458
<b>Abused stays with abuser</b>	1.181	.420	.005	3.256	1.430	7.414

## **CHAPTER 5: DISCUSSION**

### **5.1 Introduction**

This section presents a discussion of the main findings of the study “Assessment of barriers associated with screening pregnant women for intimate partner violence from nurses perspective at Pumwani Maternity Hospital, Nairobi”. The discussion of the findings is presented based on the objectives of the study. Conclusions are drawn and recommendations made based on the study findings.

### **5. 2 Screening Practices for IPV among Nurses.**

The results of this study revealed that nurses understand what “screening” for IPV in pregnancy entails (Table 4). The nurses agreed that it involves routine inquiring about risk for IPV, current exposure, previous exposure and use of a standard tool when screening for IPV. This finding supports Guruge, S. (2012) and Hindin, (2006) who reported that midwives are concerned, interested, and knowledgeable about IPV screening. They perceived their roles as identifying victims of IP through screening, managing and caring for the survivors and community awareness on IPV.

A low percentage of only 16% (n=20) routinely screened for IPV among pregnant women despite their understanding on what screening means. This is low compared to 26% in Nigeria (John, Lawoko, and Svanström, 2011) and 50% in sweden (Lawoko, 2011) but higher than in Jordan which is 10% (Al-Natouri, 2014). This could be explained by weak a health system in developing country which is yet to embrace the benefits of routine IPV screening (Undie, et al 2012). Baig, et al (2006), Kothari and Rhodes (2006) also found that the prevalence of screening for intimate partner violence differs across health care specialties and is, overall, relatively low.

Women are commonly not asked about IPV when treated in most health care facilities. This is despite the evidence that women experiencing violence often seek help in emergency departments.

Globally, there is an agreement that when screening for IPV, standard tools should be used. These tools include, but not limited to; the Abuse Assessment Screen; Hurt, Insult, Threaten, and Scream; The Woman Abuse Screening Tool/Woman Abuse Screening Tool-Short Form; The Partner Violence Screen; Composite Abuse Scale; Conflict Tactics Scale; Index of Spousal Abuse (Family Violence Prevention Fund, 2004; American Nurses Association, 2000). In the study, 98% (n=123) did not use any standard tool when screening for IPV (see table 7). The respondents reported that they used general question especially when there are leading cues in the survivor's history or physical examination findings. Majority used questions like "What caused the physical injury that you have?" This could be as a result of a weak National Reproductive Health Policy. The policy seeks to ensure access to quality treatment and rehabilitative reproductive health services for survivors of gender-based violence. However the policy does not provide step by step guidelines and tools to be used in the management of gender-based violence to include IPV (MOH, 2009).

### **5. 3 Personal Barriers to screening for IPV among pregnant women.**

Nurse's lack of IPV screening training during their education program and fear of the partner's reaction were some of the personal barriers demonstrated by this study (see table 11). The results indicated that participants with high level of education were 3 times more likely to screen. Those who did not report lack of training as a barrier were 6 times more likely to screen and

participants who feared survivor's partner's reaction were 10% less likely to screen (see table 15). Also, the study revealed that lack of mentors and role models in IPV screening and lack of cooperation from other health professionals as barriers hindering nurses from screening pregnant women for IPV (see table 11).

A large number of the respondents had worked for 12 years and more (see figure 4) and this could explain their response of lack of training and mentors on IPV screening. Like some respondents would put it; *"I think when I was training, the gender based violence was not too common like it is today and therefore I think by then there was no much need for training in IPV screening.* Therefore, Gender Based Violence may have not been a public health concern then and hence the education system then emphasized only on the health priorities of those days. However, in the recent past, there has been a rise in the prevalence of IPV (Kenya National Bureau of Statistics (KNBS) and Inner City Fund (ICF) Macro, 2010). This calls for retraining of health workers in IPV management. As Gutmani (2007) documents, there is a positive associations between provider training and subsequent adherence to IPV screening protocols, knowledge of and communication skills for discussing IPV, and attitudes about the importance of IPV screening.

Respondents from this study feared survivors partners reaction and this hindered them from screening. Nurses' safety concerns could have been related to the inadequacy of security services at the Kenyan public health institution (Turin, 2010). This could be coupled by the nurse's uncertainty on how the partner would react to the survivor and to themselves, considering that he is the perpetrator of the violence. As DeBoer (2013) reports, family member presence during the

provision of care to a client may work to increase client and family member satisfaction, but it can present challenges to health care workers when trying to address sensitive issues such as IPV. This is especially so when the family member present, is the perpetrator of the IPV.

Lack of cooperation from other health care professionals was another barrier from this study. This was explained by the respondents as follows; *“Sometimes when you ask the doctors to review a patient you are suspecting are survivors of intimate partner violence, they don’t take you seriously”*. There has been a strained relationship between nurses and medical doctors in the recent past. This is a worrying trend since the two health professions interact during the care of patients. The two cadres (doctors and nurses) have poor communication relations and mistrust on the quality of care provided by each cadres (Foth, et al 2015). It is of the view of the researcher that optimal relationship and multidisciplinary collaborations among all health care providers should be encouraged if routine IPV screening is to be achieved.

The personal barriers are consistent with findings from Yonaka, et al (2007), Maina, (2009), Sprague et al (2012), Alper, (2010), and Sheila, et al (2012). They report that the most significant potential barriers to screening of IPV are lack of education and instruction on how to ask questions about abuse, hindrance from other health care professionals and concerns of nurses personal safety.

This study however did not find personal history of abuse, lack of confidence and that health care providers have more pressing issues to address as barriers to screening. In addition, difficulties in discussing IPV, apprehension about misdiagnosis, fear of invading the patients’

privacy, forgetting to ask about abuse, and fear of police involvement were also not reported as major barriers to screening in this study as they were reported by others (Furniss, McCaffrey, and Rovi, 2007; Sprague et al 2012; Alper, 2010; Sheila, et al 2012).

#### **5.4 Organization related Barriers to screening for IPV in pregnancy**

The results of this study revealed that lack of protocol that addresses IPV screening, high work load to the nurse and nurses weak autonomy on the management for IPV in pregnancy to include screening as the main organization barriers to screening for IPV (see table 12). The practice environment in which nurses work appears to play a role in predicting the likelihood of screening survivors of IPV. This could be as a result of the hospital lacking an adopted protocol on how to deal with IPV survivors. This is consistent with Lawoko, et al (2014) who argues that lack of an office protocol for addressing IPV is a key barrier to screening for IPV.

Pumwani being a public hospital and the only maternity referral in Nairobi county, few nurses are expected to care for a large number of patients as supported by Wakaba, et al (2014) who reports that the ratio of nurses to patient in 0.43:1,000 in Kenya. This leaves the nurse with no other option but to only deal with the primary problem that made the patient seek medical care. This is demonstrated by some respondents reporting that; *“The numbers of patients we see and attend to are too many and therefore we just focus on their physical needs.”* *“By the time am starting the clinic, there is a long queue of patients waiting and so I only focus on clearing the queue.”* *“Due to the large number of patients we attend to in a day, I only focus on what brought the patient to the hospital.”* This explains the reasons why nurses reported high work load as a barrier to screening. Not having sufficient contact time with patients, limits nurses from

screening IPV. Time is an important factor for IPV screening since more direct time is needed to conduct the screening (Al-Natouri, 2015).

Weak autonomy was reported as another organization barrier faced by nurses while they screen pregnant women for IPV. As some would report; *“The nurse is generally not very empowered to make independent decision to include Intimate partner screening, you need to consult around.* Autonomy creates an opportunity for nurses to experience responsibility for patient outcomes and thus a feeling of significance and identity. As East, et al (2014), nurse’s autonomy is affected and limited by the traditional doctor-nurse role hierarchy. Nurses are viewed and treated as subordinates to the doctors, and this hinders their output.

The organization barriers from this study are supported by the findings from Lawoko, et al 2014, Leppäkoski, et al 2014, Furniss, et al 2007, Sprague, et al 2012, Sheila, et al 2012, and Maina, 2009. Their literature indicates that health care providers reported different facility challenges when caring for IPV survivors. This included: poor working conditions, the lack of an office protocol for addressing IPV, high work demands, weak autonomy over work.

The study however did not find that lack of privacy, poor working conditions, inadequate procedures room and locations for screening to be affecting screening. In the study as well, lack of “environmental enablers,” such as posters, did not impact negatively on IPV screening. However Stayton and Duncan, 2005; Furniss, et al (2007), Sprague, et al (2012), Sheila, et al (2012) Maina, (2009), Lawoko, et al (2014) and Leppäkoski, et al 2014) found them to barriers.

In their literature, they indicated that poor working condition at the place and lack of environmental enablers affected screening for IPV negatively.

### **5.5 Pregnant women related barriers from the nurses perspective**

The results of this study revealed that nurses perceived different barriers to screening pregnant women for IPV that emanate from the pregnant woman (see table 13). These barriers include; pregnant women survivors with difficult personalities are difficult to screen and that abused survivor would still stay with the abuser. Other perceived barriers that had a statistical significant include; survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV, IPV survivors fear of retaliation from the abuser if they report IPV to the nurse, and survivors are unwilling to disclose history of IPV in their medical history.

IPV survivors may still stay with their abusers due to their financial dependence, lack of family support, and fear of losing their children (Oweis et al. 2009). This explains why most of the nurses viewed that survivors would still stay with the abuser and why the nurses thought that the survivors are unwilling to disclose IPV to the nurse. It is the view of the researcher that nurses should provide appropriate care and assure the safety of survivors despite their personal and cultural beliefs about marital relationships.

Nurses viewed that survivor's feared retaliation from the abuser and this hindered them from reporting IPV to the nurse. This could be explained by the financial dependence of survivors to their partners. This is supported by Oweis, et al. (2009), who indicated that survivors of IPV experienced batterers' retaliation, revenge, and increased violence severity and intensity after



their IPV disclosure. The feared retaliation could also explain the survivors unwillingness to disclose IPV and denial of IPV even if the survivors have physical injuries secondary to IPV (Okemwa, et al 2009)

FIDA, (2010) reports that the different cultures in Kenya condone and promote violence against women. They report that there is a power imbalance between men and women where women are considered lesser. This could explain the view of nurses that survivors considered IPV normal and were not aware of their rights in regard to GBV reporting.

## **5.6 Hypothesis Review**

The study results indicate that different barriers interfere with screening pregnant women for IPV. Therefore the study adopts the alternative hypothesis that there is a negative relationship between nurses reported barriers (personal, organization, survivors) and screening pregnant women for IPV.

## **CONCLUSION AND RECOMMENDATION**

### **CONCLUSION**

1. Prevalence of screening for IPV in pregnancy is still low standing at 16%.
2. Personal barriers include lack of IPV screening training during their education program and fear of the partner's reaction as barriers to screening. They also include lack of mentors and role models in IPV screening and Lack of cooperation from other health professionals as barriers to screening.
3. Organization barriers include lack of a hospital protocol that addresses IPV screening and high work load to the nurse not forgetting weak autonomy on the management for IPV in pregnancy.
4. The nurse perceives different barriers that emanate from the pregnant woman. These barriers include; survivors with difficult personalities are difficult to screen and that abused survivor would still stay with the abuser. Other includes; survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV and IPV survivors fear of retaliation from the abuser if they report IPV to the nurse. Survivors are unwilling to disclose history of IPV in their medical history and that survivors are not aware of their rights in regard to IPV reporting and that survivor's view of IPV abuse as normal.

## **RECOMMENDATIONS**

1. A large-scale study is recommended with a sample drawn from all over the country including all healthcare providers. This will provide a picture of the whole country.
2. It will be necessary to interview the survivors and other healthcare providers so as to understand the barriers from their perspective. This study interviewed nurses only.
3. It will also be necessary to conduct an observation study to verify whether nurses screen or don't screen pregnant women for IPV. This study depended on self-report from the nurses on whether they screened or not.
4. Pumwani Hospital should organize continuous medical education to all its health care workers on current updates regarding IPV management.
5. Stakeholders in health should organize awareness campaigns on reproductive rights to include steps a survivor should take following GBV.
6. Stakeholders in health should agree on a common screening tool to be used when screening for IPV in Kenya which the hospitals should adopt while developing hospital protocol on IPV management.
7. Stakeholders in health should consider integrating IPV screening in the routine medical screening during antenatal care.

## TIME SCHEDULE AND WORK PLAN

Activity weeks	8 weeks	10 weeks	1 week	8 weeks	2 weeks	2 weeks	1 week	2 weeks	1 week
Proposal development and supervisor clearance									
Forwarding to KNH-ERC									
Questionnaire pretesting									
Data collection									
Data processing and Analysis									
Report Writing									
Draft report presentation and corrections									
Final report presentation and Submission									
Thesis Defence									

## BUDGET

	<b>Item</b>	<b>Unit</b>	<b>Units required</b>	<b>Cost/ Unit</b>	<b>Total cost (Ksh)</b>
Stationery	A4 Notebooks	Pieces	4	200	800
	Reporter's Notebook	Pieces	4	100	400
	Pens	Pieces	10	25	250
	Pencils	Pieces	6	10	60
	Erasers	Pieces	3	30	90
	Folders	Pieces	10	100	1000
	Clip Boards	Pieces	5	200	1000
	Sharpeners		3	30	60
<b>Sub total</b>					<b>3,660</b>
Services	<b>Photocopy</b>				
	<i>Proposals</i>				
	Drafts	Pages	200	2	400
	Final copies	Pages	300	2	600
	<i>Thesis reports</i>				
	Drafts	Pages	300	2	600
	Ext. Examiner draft	pages	80	2	160
	<b>Printing</b>				
	<i>Proposals</i>				
	Drafts	Pages	200	10	2000
	Final copy	Pages	300	10	3000
	<i>Thesis reports</i>				
	Drafts	Pages	300	10	3000
	Ext. Examiner draft	Pages	80	10	800
	6 Final Copies @ 80 Pages	Pages	480	10	4,800
	<b>Binding</b>				
	<i>Proposals</i>	Copies	12	50	600
	<i>Thesis reports</i>	Copies	12	50	600
	<i>Thesis Reports</i>				
	<i>Research Assistants</i>	Persons	2 for 30 days	1000/day	60,000
<b>Data Processing and Analysis</b>		5	50	50,000	
<b>Communication</b>	Cards	7	1000	7000	
Airtime		6	600		
<b>Sub Total</b>					<b>136,030</b>
Transport	Data Collection Period	Days	60	200	12,000
<b>Sub Total</b>					<b>12, 000</b>
	Dissemination budget	Days	10	2000	<b>20,000</b>
<b>Total</b>					<b>111,690</b>
Contingency	10% of Total				11,169
<b>Grand Total</b>					<b>202, 500</b>

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## **APPENDIX I: Participants Information Sheet and Consent Form**

**Study Title: Assessment of barriers associated with screening for intimate partner violence among pregnant women at Pumwani Maternity Hospital, Nairobi.**

**Investigator:** Githui Simon Nderitu. Tel.: 0735 744 252.

School of Nursing Sciences,

University of Nairobi

Po Box 19676, Nairobi.

**Introduction:** I am a student at the School of Nursing Sciences, University of Nairobi pursuing a Master of Science Degree in Nursing. I am conducting a study titled: **“Assessment of barriers associated with screening for intimate partner violence among pregnant women at Pumwani Maternity Hospital, Nairobi.”** This study is being conducted at Pumwani Maternity Hospital.

The purpose of this information is to give you details pertaining to the study that will enable you make an informed decision regarding participation. You are free to ask questions to clarify any of the aspects we will discuss in this information and consent form. The researcher will also ask you questions regarding the study before you sign the consent form to ascertain your comprehension of the information provided.

**Background and objective:** The purpose of this study is to describe different barriers associated to screening of pregnant exposed to intimate partner violence. The will identifying gaps in the care provided to this women with a view of coming up with suggestions to improve the same. This is because Antenatal period offers an appropriate opportunity for screening and even managing IPV among pregnant women and therefore service care providers can do a great deal

in preventing the adverse effects of intimate partner violence by screening, advising, managing or even referring survivors to appropriate care. Therefore, the finding from this study could be used to come up with strategies to improve the quality of care provided to pregnant women thereby improving the quality of life for the mothers and the new born.

**Participation:** Participation in the study will entail answering questions which will be filled by the interviewer in the semi-structured questionnaire. You will not be subjected to any invasive procedure. The research involves participation of approximately 125 nurses.

**Benefits:** There is no direct monetary benefit in participating in this study. However, the results of the study will be useful in facilitating the understanding of different barriers that prevent nurses from screening for IPV among pregnant women. The findings will be availed to the hospital, other relevant decision makers and stakeholders to aid in putting in place measures that will improve the care given to pregnant women exposed to intimate partner violence.

**Risks:** There are no economic or physical risks to participating in the study. However, due to the time taken in responding to question, you will take a longer time than usual at your work place. Also during the interview, some questions will require you to disclose some personal information that might trigger some negative feelings and possibly anxiety. If this happens, the researcher will refer you to the hospital counselor. The researcher will also endeavor to spend approximately 25 minutes with you.

**Confidentiality:** Confidentiality will be maintained and the information you provide will only be used for the intended purpose of the study. In addition, your name will not be required on any forms or used during publication of the final report thus ensuring your anonymity. All materials used during the study will be under lock and key and only the personnel involved in this study

will have access to them. Electronic files will be saved on password and fire-wall protected computers.

**Voluntary participation:** Participation in this study is voluntary. Refusal to take part will not attract any penalty. You retain the right to withdraw from the study without any consequences. You are free not to answer any question during the interview.

**Compensation:** There is no compensation for participating in the study.

**Conflict of interest:** The research and the supervisors confirm that there is no conflict of interest amongst them.

### **Consent Form**

If you Consent to Participate in the study please sign below:

I hereby consent to participate in this study. I have been informed of the nature of the study being undertaken and potential risks explained to me. I also understand that my participation in the study is voluntary and the decision to participate or not to participate will not affect my employment status at this facility in any way whatsoever. I may also choose to discontinue my involvement in the study at any stage without any explanation or consequences. I have also been reassured that my personal details and the information I will relay will be kept confidential. I confirm that all my concerns about my participation in the study have been adequately addressed by the investigator and the investigator have asked me questions to ascertain my comprehension of the information provided.

Participant's Signature (or thumbprint).....Date.....

I confirm that I have clearly explained to the participant the nature of the study and the contents of this consent form in detail and the participant has decided to participate voluntarily without any coercion or undue pressure.

Investigator's Signature..... Date .....

For any Clarification, please contact any of the following;

Simon Nderitu Githui

Researcher

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The Chairman,

University of Nairobi- Kenyatta National

Hospital Ethics and Research Committee

Tel: 020-2726300 Ext 4435



**APPENDIX II: Study Questionnaire**

**QUESTIONNAIRE ON ASSESSMENT OF BARRIERS ASSOCIATED WITH SCREENING FOR INTIMATE PARTNER VIOLENCE AMONG PREGNANT WOMEN AT PUMWANI MATERNITY HOSPITAL, NAIROBI.**

Serial Number \_\_\_\_\_ Questionnaire Status \_\_\_\_\_ (1=complete; 2= partially complete)

Interviewer ID \_\_\_\_\_ Date of Interview \_\_\_\_/\_\_\_\_/\_\_\_\_

Your honest responses on the following questionnaire will greatly assist in the attempt to identify different barriers hindering Nurses from screening pregnant women of Intimate Partner Violence (IPV) and hence improve recognition and management of intimate partner violence in pregnancy, related injuries and illnesses. Please give out your first, instinctive answer, even if you do not think it is “medically correct.” Do not try to think about what your answers “should” be. All responses will be coded by an identifying number only, kept confidential, and analyzed in group form so that no personal information is revealed. Thank you for taking the time (estimated at 30 minutes) to complete the questionnaire.

***Instructions:** Where applicable; tick the appropriate response or fill responses in the spaces provided, specific instructions are in italicized bold lettering.*

**SECTION I: SOCIAL DEMOGRAPHIC INFORMATION**

<b>NO.</b>	<b>QUESTION</b>	<b>CODE</b>	<b>ANSWER</b>
1	What is your age?	<b>1</b>	[ ] 20-29yrs
		<b>2</b>	[ ] 30-39yrs
		<b>3</b>	[ ] 40-49yrs
		<b>4</b>	[ ] 50-59yrs

		<b>5</b>	<input type="checkbox"/> 60yrs and above
2	What is your gender?	<b>1</b> <b>2</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
3	What is your marital status?	<b>1</b> <b>2</b> <b>3</b> <b>4</b> <b>5</b>	<input type="checkbox"/> Married <input type="checkbox"/> Living with partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single, never married
4	How long have you been practicing in your field of specialty?	<b>1</b> <b>2</b> <b>3</b> <b>4</b> <b>5</b>	<input type="checkbox"/> below 2 yrs <input type="checkbox"/> 3-5 yrs <input type="checkbox"/> 6-8 yrs <input type="checkbox"/> 9-11 yrs <input type="checkbox"/> 12 yrs and above
5	What is the level of your education?	<b>1</b> <b>2</b> <b>3</b> <b>4</b> <b>5</b> <b>6</b> <b>7</b>	<input type="checkbox"/> PhD <input type="checkbox"/> Masters <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Higher diploma <input type="checkbox"/> Diploma <input type="checkbox"/> Certificate <input type="checkbox"/> Other: Specify: _____
6	What is your professional specialty?	<b>1</b> <b>2</b> <b>3</b> <b>4</b> <b>5</b> <b>6</b>	<input type="checkbox"/> General nurse <input type="checkbox"/> Midwife <input type="checkbox"/> Community health nurse <input type="checkbox"/> Psychiatric nurse <input type="checkbox"/> Sick children's nurse <input type="checkbox"/> Other; Specify: _____
7	Where are you currently deployed?	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> ANC clinic <input type="checkbox"/> Labor ward <input type="checkbox"/> Labor ward/Antenatal ward <input type="checkbox"/> Maternity theatre <input type="checkbox"/> Antenatal ward

## SECTION II: SCREENING PRACTICE

What is your current screening **PRACTICE** for IPV among pregnant women?

NO.	QUESTION	CODE	ANSWER
1	What is your understanding on the term <b>“screening”</b> for IPV among pregnant women? <i>(check all that apply)</i> a. Screening is routine inquiring about risk for IPV b. Screening is routine inquiring about current exposure to IPV c. Screening is routine inquiring about previous exposure to IPV d. Screening involves use of a standard tool when inquiring about exposure to IPV	1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
2	How often do you currently screen IPV among pregnant women?	1	<input type="checkbox"/> Always
		2	<input type="checkbox"/> Most of the time
		3	<input type="checkbox"/> Rarely
		4	<input type="checkbox"/> Never screen <b>(Go to section III)</b>
3	Check the situations listed below in which you currently screen for IPV among pregnant women: a. When they are attending hospital appointments b. When they are seeking medical care c. All new clients d. Clients with physical indicators	1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		2	<input type="checkbox"/> No
		1	<input type="checkbox"/> Yes
		1	<input type="checkbox"/> Yes

	(physical symptoms) of abuse	2	<input type="checkbox"/> No
	e. Those who report abuse during clinical interview	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Only if the client seems distressed	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. I screen randomly	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Which standard tool do you use when screening for IPV in pregnancy?	1  2 3 4 5 6 7 8 9	<input type="checkbox"/> I don't use a standard tool (Explain how you screen).....  <input type="checkbox"/> Hurt, Insult, Threaten, and Scream <input type="checkbox"/> The Woman Abuse Screening Tool/Woman Abuse Screening Tool-Short Form <input type="checkbox"/> The Partner Violence Screen <input type="checkbox"/> Abuse Assessment Screen <input type="checkbox"/> Composite Abuse Scale <input type="checkbox"/> Conflict Tactics Scale <input type="checkbox"/> Index of Spousal Abuse <input type="checkbox"/> Others (Specify).....

### SECTION III: PERSONAL BARRIERS

Do the following **PERSONAL BARRIERS** hinder Nurses from screening for IPV among pregnant women?

NO.	QUESTION	CODE	ANSWER	Explain your response
1.	Personal discomfort with discussing the topic of IPV	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Concerns for personal safety	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Concerns of misdiagnosis	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Nurses forget to ask about abuse	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Personal history of domestic abuse	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Nurses lack confidence to refer survivors to Gender based violence care	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Time constraints due large numbers of clients to take care of	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Lack of IPV screening training during the education program	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Lack of continuous training education ( <b>CME</b> ) regarding screening of IPV while practicing	1 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	

10	Nurses view that it's not their role to screen for IPV	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11	Nurses have more pressing issues to address	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12	Fear of invading the patient's privacy	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13	Fear of the partner's reaction	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14	Personal fear of legal involvement in the case	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15	Lack of a good patient–nurse relationship	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16	It is not appropriate for the nurse to intervene when she/he encounters a survivor of IPV	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17	The focus on nursing care is on physical health and not emotional problems or mental problems	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18	Lack of mentors and role models in IPV screening	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19	Lack of cooperation from other health professionals	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20	Lack of cooperation from the police when the nurse report to them on IPV cases	<b>1</b> <b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION IV: ORGANISATION RELATED BARRIERS

A. Do the following **ORGANIZATION** related **BARRIERS** hinder nurses from screening IPV among pregnant women?

NO.	QUESTION	CODE	ANSWER	Explain your response
1.	Inadequate follow-up resources	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
2.	Lack of support staff to assist the survivors	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
3.	Lack of hospital protocol that addresses IPV screening	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
4.	Ineffective referral systems to refer IPV survivors	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
5.	Lack of environmental enablers e.g. posters, pamphlets	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
6.	High work load to the nurse	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
7.	Lack of support from administration	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
8.	Lack of facility set ups (rooms) for patient privacy during screening	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	
9.	Nurses weak autonomy on the management for IPV in pregnancy to include screening	1	<input type="checkbox"/> Yes	
		2	<input type="checkbox"/> No	

**SECTION V: PREGNANT WOMEN RELATED BARRIERS FROM THE NURSES PERSPECTIVE**

To what extent do you agree or disagree with the following barriers that eminent from **PREGNANT WOMEN** that hinder nurses from screening for IPV among pregnant women?

NO.	QUESTION	CODE	ANSWER	Explain your answer
1.	Pregnant women survivors usually decline referral	1 2 3 4	[ ] Strongly Disagree [ ] Disagree [ ] Agree [ ] Strongly Agree	
2.	Screening for IPV will make the life of the pregnant woman more difficult	1 2 3 4	[ ] Strongly Disagree [ ] Disagree [ ] Agree [ ] Strongly Agree	
3.	Survivors language barrier interfere with effective screening	1 2 3 4	[ ] Strongly Disagree [ ] Disagree [ ] Agree [ ] Strongly Agree	
4.	Pregnant women survivors with psychosocial issues are difficult to screen	1 2 3 4	[ ] Strongly Disagree [ ] Disagree [ ] Agree [ ] Strongly Agree	
5.	Pregnant women survivors with difficult personalities are difficult to screen	1 2 3 4	[ ] Strongly Disagree [ ] Disagree [ ] Agree [ ] Strongly Agree	
6.	Abused survivor would still stay with the abuser	1 2 3	[ ] Strongly Disagree [ ] Disagree [ ] Agree	



		<b>4</b>	<input type="checkbox"/> Strongly Agree	
7.	Survivors deny battering as a cause of physical injury even if they have a physical injury associated with IPV	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
8.	IPV survivors fear of retaliation from the abuser if they report IPV to the nurse	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
9.	Survivors are unwilling to disclose history of IPV in their medical history	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
10.	Survivors are not aware of their rights in regard to IPV reporting	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
11.	Survivors do not comply with IPV management to include screening	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
12.	Survivors view of IPV abuse as normal	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
13.	Survivors play a role in eliciting abuse	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	

14	Stigmatizing attitudes to the IPV survivors from the society and so they fear to report IPV	<b>1</b> <b>2</b> <b>3</b> <b>4</b>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly Agree	
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**Thanks for your time.**

**APPENDIX III: Letter to Ethics and Research Committee**

Simon Nderitu Githui,  
School of Nursing Sciences,  
University of Nairobi,  
P.O Box 30197,  
Nairobi.  
Admission No: H56/67875/2013.

19<sup>th</sup> April, 2015.

The Chairman,  
Kenya National Hospital Ethics and Research Committee  
P.O Box 20723-00202  
Nairobi.

Dear Sir/Madam,

**RE: PERMISSION TO CONDUCT RESEARCH AT PUMWANI MATERNITY HOSPITAL.**

I hereby request for approval to conduct a research study titled “**Assessment of barriers associated with screening for intimate partner violence among pregnant women at Pumwani Maternity Hospital, Nairobi.**” at Pumwani Maternity Hospital.

I am a second year postgraduate student at the University of Nairobi, School of Nursing Sciences pursuing a Master of Science degree in Mental Health and Psychiatric Nursing and undertaking this study is a requirement for the course.

Attached is the Research proposal for the study.

Looking forward to your favourable response.

Yours Faithfully,

Simon Nderitu Githui.  
Email Adress: [simgithu04@yahoo.com](mailto:simgithu04@yahoo.com)  
Mobile no. 0735 744 252

#### **APPENDIX IV: Letter to the Medical Superintendent, Pumwani Maternity Hospital**

Simon Nderitu Githui,  
School of Nursing Sciences,  
University of Nairobi,  
P.O Box 30197,  
Nairobi.

19<sup>th</sup> April, 2015.

The Medical Superintendent,  
Pumwani Maternity Hospital,  
P.O.Box 42849,  
Nairobi.

Dear Sir/Madam,

#### **REF: PERMISSION TO CONDUCT RESEARCH AT PUMWANI MATERNITY HOSPITAL**

I hereby request for approval to conduct a research study titled “**Assessment of barriers associated with screening for intimate partner violence among pregnant women at Pumwani Maternity Hospital, Nairobi.**” in your institution.

I am a second year postgraduate student at the University of Nairobi, School of Nursing Sciences pursuing a Master of Science degree in Mental Health and Psychiatric Nursing and undertaking this study is a requirement for the course.

Attached is the Research proposal for the study.

Looking forward to your favorable response.

Yours Faithfully,

Simon Nderitu Githui.  
Email Adress: [simgithu04@yahoo.com](mailto:simgithu04@yahoo.com)  
0735 744 252

**APPENDIX V: Internal Memo**

**INTERNAL MEMO**

TO ALL NURSES

FROM: Simon Nderitu Githui,  
School of Nursing Sciences,  
University of Nairobi,  
P.O Box 30197,  
Nairobi.

**RE: INVITATION TO PARTICIPATE IN A RESEARCH STUDY**

I hereby wish to invite all nurses to participate in a research study titled “**Assessment of barriers associated with screening for intimate partner violence among pregnant women at Pumwani Maternity Hospital, Nairobi.**” in your institution.

The purpose of this study is to describe different barriers associated to screening of pregnant exposed to intimate partner violence. The will identifying gaps in the care provided to this women with a view of coming up with suggestions to improve the same.

Eligible participant to this study include all nurses working in the ANC clinic, antenatal ward, labour ward and maternity theatre. The data collection will be from 1/5/15 to 30/5/15.

Thanks

Simon Githui

Sign:.....