Knowledge, Attitude and Practice of Healthcare Providers Who May Come in Contact With Women Who Have Experienced Intimate Partner Violence: a Qualitative Research

Master of Public Health Integrating Experience Project

Professional Publication Framework

By

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Executive Summary:

The most common form of violence that women experience is from intimate partner (IPV). Intimate partner violence includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner). A multi-country study conducted by WHO on reporting domestic violence shows that the prevalence of women who have experienced violence ranges from 15% to 59%, while the prevalence of women ever experiencing intimate partner violence ranges from 22% to 47%. IPV, as with many other problems, may require regular, repeated messages from physicians to convince battered women to end their involvement with their abusive domestic partner. Although a number of surveys have discovered the burden of domestic violence in Armenia since 2007, Armenia still has gaps in statistics on domestic violence clarifying time trends due to the lack of a surveillance system for domestic violence.

This study assessed the knowledge, attitudes, and practices of general practitioners, gynecologists/obstetrics and emergency department clinicians regarding intimate partner violence among their patients in Yerevan, Armenia. The study investigator conducted 3 in-depth interviews and 3 focus group discussions in policlinics and hospitals, where overall 17 healthcare providers participated. Directed content analysis was used to analyze the data.

The study findings showed that Armenian healthcare providers are knowledgeable of domestic violence and its types. They can recognize violence through physical and non-physical signs; but because of the lack of practice, skills and knowledge on how to deal with victims, they are not able to manage those cases. The findings also showed a number of barriers and facilitators, which either help or impede the healthcare provider to ask about violence and to support the victim.

A new study should be conducted, which will be able to cover both rural and urban areas of Armenia. Healthcare specialists need to be trained in order to identify and deal with domestic violence, including Intimate Partner Violence.

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List of Abbreviations:

CDC – Center for Disease Control and Prevention

FGD - Focus Group Discussions

GP - General Practitioner

HIV - Human Immunodeficiency Virus

ID - Identification Number

IDI - In-depth Interview

IPV - Intimate Partner Violence

KAP - Knowledge, Attitude, Practice

NGO - Non Governmental Organization

SES - Socio-Economic Status

TTCI - Tape-Transcribe-Code-Interpret

WHO - World Health Organization

1. Introduction

Domestic violence consists of a pattern of coercive behaviors used by a competent adult or adolescent to establish and maintain power and control over another competent adult or adolescent. These behaviors, which can occur alone or in combination, sporadically or continually, include physical violence, psychological abuse, stalking, and nonconsensual sexual behavior. [1] The term 'domestic violence' is used in many countries to refer to partner violence but the term also can encompass child or elder abuse, or abuse by any member of a household. 'Battering' refers to a severe and escalating form of partner violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behavior on the part of the abuser. [2] The American Academy of Experts in Traumatic Stress Disorder identifies the three most common types of domestic violence as child abuse, abuse of a spouse or domestic intimate partner, and elder abuse. [3]

Violence against women is any act of gender-based violence that results in, or has likelihood to result in: physical, sexual or mental harm or suffering of women, pressure or illogical deprivation of liberty, whether occurring in public or in private life. [4] The most common form of violence that women experience is intimate partner (IPV). [5] Intimate partner violence includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i. e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner). [6] IPV exists along a continuum from a single episode of violence to ongoing battering. [7]

This section addresses the magnitude of the problem, risk factors, outcomes, strategies and description of the situation in Armenia.

1.1 The Social-Ecological Model: A Framework for Prevention

The direct goal of the framework is to stop violence before it begins. Prevention needs understanding of essential factors that influence occurrence of violence. Four-level social-ecological model (Figure 1) described by CDC and WHO is used to better understand violence and the effect of potential prevention strategies. [8,9] The model helps to understand the range of factors that place people at a risk for violence or protect them from experiencing or perpetrating violence. The model considers factors associated with individual, relationship, community and societal characteristics. All these factors form a complex, where the factors interplay among each other.

The first level of the model covers individual factors. Individual factors include biological and personal history factors that increase the possibility of becoming a victim or perpetrator of violence. Some of these factors are age, income, education level, previous history of abuse. Prevention strategies at first level are often intended to indorse attitudes, beliefs, and behaviors that directly prevent violence. Particular approaches can include education and life skills training.

The second level of the model focuses on the close relationship factors, which may increase the likelihood of experiencing or perpetrating violence. A person's closest members of social circle, such as: peers, partners and family members, may influence person's behavior and contribute to person's range of experience. Prevention strategies at this level of the model may include

parenting or family-focused prevention programs, mentoring and peer programs premeditated to decrease conflict, foster problem solving skills, and promote healthy relationships.

The third level of the model aims to explore the factors associated with the characteristics of the community (schools, workplaces, and neighborhoods). Prevention strategies at this level are aiming to influence the social and physical environment, e. g., by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the climate, processes, and policies within school and workplace settings.

The last level of the social-economical model is the societal one. This level examines the societal factors that help create an environment in which violence is encouraged or inhibited. These factors include social and cultural standards that support violence as a justified way to resolve conflicts. Other societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

1.2 Magnitude

IPV is prevalent and affects women worldwide. [10] On average, 30% of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner. [11] Over 600 million women still live in countries where domestic violence is not a crime and, in an average minute, about 24 women are victims of rape, physical violence, or stalking by an intimate partner. [12,13]

A WHO multi-country study reports the prevalence of women who have experienced violence ranges from 13% to 59%, while the prevalence of women ever experiencing intimate partner violence ranges from 22% to 47%. [14] In the prevalence of physical or sexual violence

experienced by women and committed by their current husband/partner wide diversity was found —from 75% in Bangladesh to 16% in the Dominican Republic. Bangladesh, where men rather than women, were asked about (perpetrating) IPV, stands out as having the highest rates of both physical and sexual violence. [15]

1.3 Risk Factors of Intimate Partner Violence

US Centers for Disease Control and Prevention distinguishes individual, relationship, societal, community factors. [8,9,16] Some risk factors for IPV victimization and perpetration are the same. [16] Among individual risk factors, the US Centers for Disease Control and Prevention mention: young age, emotional dependence and insecurity, depression, belief in strict gender roles (e. g., male dominance and aggression in relationships), and history of experiencing physical discipline as a child. Relationship factors are as follows: marital conflict-fights, tension, and other struggles, marital conflict-fights, tension, and other struggles, marital instability-divorces or separations. One of the societal factors is traditional gender norms (e. g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions), and finally the community factors are: poverty and associated factors (e. g., overcrowding), low social capital-lack of institutions, relationships, and norms that shape a community's social interactions, weak community sanctions against IPV (e. g., unwillingness of neighbors to intervene in situations where they witness violence). [16]

Some women may be more vulnerable to becoming victims and less capable of exiting violent relationships. [17] Primary risk indicators for intimate violence include: violence in the family of origin, socioeconomic factors (unemployment, SES, overcrowded family),[16] personality

characteristics such as low self-esteem, aggressive or delinquent behavior,[16] substance abuse and situational factors related to one's life. [18]

Many risk indicators in the family of origin are linked and can be passed on to future generations. [18] These risk indicators include exposure to abuse, alcoholism, and aggressive/depressed personality-style parents. [18] Aggression does not unavoidably follow from alcohol intoxication, but alcohol is the drug constantly related to intimate battering. [18] Alcohol and IPV also are associated, where IPV is higher in relationships where one or both partners have problems with alcohol, compared to relationships where neither of them do. [14] Achieving secondary education level, by either the woman or her partner, decreases IPV, when compared to situations where neither the woman nor her partner completed that level. [14] Any history of abuse has a strong association with increased risk of IPV, with reports of abuse of the woman's mother, her partner's mother, or both (compared to no known/reported abuse of either mother). Other experiences of violence also are associated with past year IPV, with a history of childhood sexual abuse of the woman, childhood physical abuse of her partner, or both, are consistently associated with increased risk of IPV, compared to no reports of abuse by either partner. The higher the SES, the lower the risk of IPV. [14]

1.4 Outcomes of Intimate Partner Violence

Violence has immediate impact on women's health, which in some cases can be fatal. Physical, mental and behavioral health consequences also can persist long after the violence has already stopped. [19] The consequences of violence tend to be more severe when women experience more than one type of violence (e. g., physical and sexual) and/or multiple incidents over time. [20,21]

The outcomes can be divided in four categories: physical, mental, sexual/reproductive, behavioral. [22]

Physical outcomes of IPV are: poor health, chronic pain, memory loss, problems walking and carrying out daily activities. [14] Women with a history of violence are more likely than other women to report a number of chronic health problems such as headaches, chronic pelvic pain, back pain, abdominal pain, irritable bowel syndrome, and gastrointestinal disorders. [23–28]

Among IPV's most common effects on sexual and reproductive health are gynecological disorders (vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections) and trauma (tearing of the vagina; fistula (a tear between the vagina and bladder or rectum, or both); hemorrhaging, infection or ulceration; and other genital injury or complications during childbirth), unintended pregnancy, abortion/unsafe abortion, HIV and sexually transmitted infections, maternal mortality and other pregnancy-related consequences (low maternal weight gain, miscarriage and stillbirth and low-birth-weight babies). [14,19,23,24,26,27,29–36]

Both physical and sexual violence are associated with a greater risk of adverse mental health outcomes among women. [24] IPV is associated with a number of negative health behaviors. The more severe the violence, the stronger its relationship to negative health behaviors by victims. [19,37,38] The most widespread outcomes include depression, suicide attempts, post-traumatic stress disorder, other stress and anxiety disorders, sleeping or eating disorders and psychosomatic disorders. Women who report a history of early sexual abuse often later report feelings of worthlessness and difficulty distinguishing sexual from affectionate behavior, maintaining appropriate personal boundaries, and refusing unwanted sexual advances. [21,30,36,39]

The health impact of IPV on woman's health maybe direct, as physical violence and indirect, as mental, psychological violence. [2]

A number of health disorders associated with IPV may be a direct result of the physical violence: bruises, knife wounds, bone fractures, traumatic brain injury, back and/or pelvic pain and headaches. Other conditions are the result of the indirect effect of IPV on the cardiovascular, gastrointestinal, endocrine and immune systems through chronic stress or other mechanisms. [25,28,40]

1.5 Strategies against Intimate Partner Violence

Violence may take place within very different societal contexts, and the degree to which it is allowed by a community will naturally influence the kind of strategy needed. [41]

Based on the social-ecological model, described above, few prevention strategies were implemented. [42] Approaches implemented on a large scale are public awareness campaigns and modifications of the criminal justice sector. However, the evaluations of awareness campaigns too often stop at process indicators such as quantity of materials disseminated, exposure to materials, or measures of changes in knowledge only, and few attempts have been made to measure the impact of criminal justice responses on rates of intimate-partner violence or sexual violence. There is a need for outcome evaluations of evidence-based strategies and a systematic approach to primary prevention that ensures widespread implementation of strategies addressing factors at all levels of the ecological model. [42]

Most women come into contact with the health system at some point in their lives – when they seek contraception, for instance, or give birth or seek care for their children. [20] This makes the health care setting an important place where women undergoing abuse can be identified, provided with support and referred if necessary to specialized services. Unfortunately, studies show that in most countries, doctors and nurses rarely enquire of women whether they are being

abused, or even check for obvious signs of violence. [43–45] Existing interventions have focused on sensitizing health care providers, encouraging routine screening for abuse and drawing up protocols for the proper management of abuse. [46]

The Convention on the Elimination of all forms of Discrimination against Women states that discrimination against women violates the principles of equality of rights and respect for human dignity. [47] The Convention states that discrimination is an impediment to the participation of women, on equal term with men, in the political, social, economic and cultural life of their countries. [47] The Convention is the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations. [48] Countries that have ratified or acceded to the Convention are legally bound to put its requirements into practice. They are also obligated to submit national reports, at least every four years, on measures they have taken to fulfill with their treaty obligations. [48]

Over the last 30 years, international human rights agreements together with advocacy by women's groups have successfully induced many governments to review penal and civil legislation in regards to gender-based violence. These changes include criminalizing domestic violence and marital rape, eliminating provisions that allow perpetrators of rape to escape criminal sanctions by agreeing to marry the victims, and revising criminal procedures to make it easier to prosecute offenders. [49]

1.6 IPV Reflection in Healthcare

The impact of intimate partner violence on the healthcare system is significant. Abused women are more likely to communicate with health services than with any other professional agencies.

[50,51] Literature suggests that primary care providers, gynecologists/obstetricians and emergency department physicians have essential role in identifying and preventing IPV. [52–54]

Primary care clinicians potentially have a crucial role in the identification of, and primary professional response to domestic violence. [53] General practitioners have the opportunity to see all members of families and consequently they can potentially identify family violence. Ideally GPs could provide prevention given their contact with the all family members. [55] Therefore, General Practitioners should know what the effects of family violence might be. [55] Despite their significant role, most clinicians and nurses have received little or no training and are currently not prepared to provide an effective response to domestic violence by even identified and documenting domestic violence. [53,56–59]

The literature suggests that victims of IPV are often being identified through a gynecological examination. [52] The fact that IPV is not raised during routine examinations for women seeking obstetric and/or gynecologic care is a critical missed opportunity. [52] The lack of training, education among practitioners and societal misconceptions to which medical personnel are not immune are also contributing factors of not including IPV screening in gynecologists' routine procedures. [52]

In a study completed in 2004, one in three women who presented to emergency departments reported experiencing physical or sexual abuse at some point in their lifetime, and one in seven women in emergency departments reported physical violence in the past year. [54]

As IPV can be severe, emergency department clinicians as well as ambulance physicians can also come in contact with IPV victims. When a person enters the health care system for

emergency care, nurses, physicians, and other professional health care providers become the key persons with the potential to identify victims, interrupt the cycle, and begin intervention. [60–62] Screening is regarded as a method for early identification of violence and its consequences. International experience shows that screening for domestic violence could be implemented within clinical settings. [63–66] Routine screening for IPV identification are endorsed by numerous studies. [67]

A study that examined screening rates showed that only 13% of victims of IPV presenting to an emergency department were asked about violence. [68] To address the low rates of screening, a number of studies have explored barriers to IPV screening among various health care professionals such as emergency department health care workers, obstetricians/gynecologists, family physicians. [69,70]

Barriers for IPV screening are discovered to be almost the same among health care providers of diverse specialties and settings. [67] The interventions, which need to be designed in order to overcome the barriers and increase IPV-screening rates are more effective if they include strategies in addition to provider education. [67] As a conclusion from the Waalen et al. study, it is possible to assume that low education of clinicians about IPV is a barrier for screening. [67] Sometimes physicians only focus on physical health and forget about their patient's emotional status. Focusing on patient's emotional status can help them to identify a victim of IPV. [71] Physicians interviewed in a study in Columbia mentioned that one of the largest barriers to detecting IPV was patients' unwillingness to disclose the abuse or patients' belief that the abuse is not physician's concern. [71]

Clinicians from the emergency department mention that they do not have the type of a relationship with the patient in which they are able to communicate well enough to be able to ask that kind of personal/intimate questions. [71]

Studies on the knowledge, attitudes, and beliefs of physicians and nurses in response to domestic violence response have revealed important barriers to addressing domestic violence. [67,72] Usually mentioned barriers include lack of knowledge, training, issues of patient disclosure, self-efficacy, system-level support, and time. [67,72] Major healthcare provider barriers included time constraints, lack of experience in responding to domestic violence, patient reluctance to disclosure, lack of awareness and doubt in community resources, lack of effective interventions, and stereotypes toward patients facing domestic violence. [53] The patient barriers mentioned in the same study included humiliation, confidentiality issues, normalization, fear of consequences, presence of other family members in the clinic, and cultural barriers. [53]

The quality of the clinician-patient relationship operated both as a barrier and a facilitator. Long-lasting patient relationships were mentioned by some clinicians as deterring clinician investigation and patient disclosure. [53] The social stigma associated with domestic violence may obstruct disclosure in the context of long-lasting patient relationships. [53] The findings of the Feder's study also showed that close patient relationships could be facilitative to IPV victims. Clinicians could utilize the trust built in the relationship to facilitate a deeper discussion of home life, potentially leading to disclosure and then to action. [53]

IPV, as with many other problems, may require regular, repeated messages from physicians to convince battered women to end their involvement with their abusive domestic partner. [52]

To support victims, health care providers need more than just knowledge of domestic violence issues, being sensitive to specific local cultural values and backgrounds of their female patients is also very important. [73]

1.7 Situation in Armenia

The situation concerning domestic violence in post-Soviet countries, of which Armenia was a part until 1991, is different from the situation in the Western countries, as the movement against the domestic violence started only in the 1990s. [74] Although a number of surveys have estimated the burden of domestic violence in Armenia since 2007, Armenia still has gaps in statistics on domestic violence clarifying time trends due to the lack of a surveillance system for domestic violence. [75–77]

1.7.1 Magnitude

Domestic violence is prevalent in Armenia. [77] A survey on domestic violence in 2011 conducted by the Proactive Society NGO for the Organization for Security and Co-operation in Europe office in Yerevan indicated that 59. 6% of the respondents had experienced domestic violence during their life. [77] A nationwide survey conducted by United Nation Population Fund and National Statistical Service of the Republic of Armenia in 2008 showed that 25. 0% of ever-partnered surveyed women had been subjected to psychological violence, 61. 0% of the same group of women were exposed to controlling behavior, and 9. 5% of women were subjected to physical and/or sexual violence. [78]

1.7.2 Strategies against Intimate Partner Violence

Armenia is a State Party to all the major relevant international human rights conventions and regional human rights instruments. [79] However, no specific law addressing violence against women exists in the criminal code of Armenia. Draft laws on domestic violence and trafficking

are, though, in the process of being elaborated. [79] Based on the Strategic Action Plan on Combating gender-based violence, by the end of 2015, special centers for victims, law on domestic violence and special social, medical and legal support services provided to victims of gender-based violence should have been started. Currently nothing is yet implemented. [80] Two shelters for women victims of domestic violence are currently operating in Armenia: the Women's Rights Center and the Women's Support Center. Besides providing safe housing for the victims, these organizations are also working in other directions, such as law enforcement, supportive services**,** raising awareness and educational campaigns. Number of NGOs currently work in the field of Intimate Partner Violence, through hot-lines and consultations.

2. Purpose

The above provided review of literature gave a lot of information about importance of domestic violence in aspect of public health. As mentioned various methods exist to identify and provide help to the victim of Intimate Partner Violence, but it is visible from the literature that Armenia lacks those methods and infrastructures. Huge gap in domestic violence field, particularly in field of IPV, gives rationale for this study.

One of the primary methods of identifying victims is screening in hospitals and polyclinics. Literature suggests that medical providers have more facilitators in terms of identifying the victims, than any other medical agencies. [50,51] No studies have been conducted to describe the knowledge, attitude and practice of Armenian health providers, who get in touch with victims of IPV.

This study will help to develop a view on Armenian clinicians' preparedness of identifying and working with this sensitive population.

The study assessed the knowledge, attitudes, and practices of general practitioners, gynecologists/obstetrics and emergency department clinicians regarding intimate partner violence among their patients in Yerevan, Armenia.

The research questions of the study were:

What are the knowledge, attitude and practice of intimate partner violence among general practitioners, gynecologists/obstetrics and emergency department clinicians, who may come in contact with women who have faced intimate partner violence in Yerevan, Armenia?

What are the barriers and facilitators for the general practitioners, gynecologists /and or obstetrics and emergency department clinicians to identify the intimate partner violence victim in Yerevan, Armenia?

3 Methods

3.1 *Study Design*

Qualitative research with directed content analysis was implemented to address the research questions. I conducted semi-structured in-depth interviews (IDI) and focus group discussions (FGD). In-depth individual interviews and focus groups had different participants. To complete in-depth individual interviews student investigator approached physicians from hospitals: Emergency Department doctors and Gynecologist/Obstetricians. The described interviewing method was chosen, because those doctors, who work in the hospitals have tight schedule and the individual interview with them took place in the hospital. General Practitioners and

Gynecologist/Obstetricians from polyclinics were invited to participate in FGDs, which took place in the polyclinics in order to help the participants feel comfortable in familiar environment. Knowledge, Attitude and Practice (KAP) model was used as a base for the study guide. [81] KAP provides access to quantitative and qualitative information. The KAP leads to new tangents of a situation's reality, investigates the knowledge, attitude, and practices of specific themes; identify what is known and done about various health-related subjects. KAP gave opportunity to identify the knowledge of clinicians about the issue, their attitude towards it, as well as the practice they had or theoretically may have.

3.2 ***Study participants and Sampling***

The study was conducted in Yerevan, Armenia. The study population were general practitioners working in Yerevan policlinics, Gynecologists/Obstetricians working in both Yerevan policlinics and hospitals, clinicians working in the emergency departments of Yerevan hospitals and having an ambulance service, who were fluent in Eastern Armenian. The sampling strategy was convenience within purposive sampling technique. [82] Initially, the student investigator contacted NGOs working with the victims of domestic violence. With the help of convenience within purposive sampling technique clinicians working in policlinics and hospitals who met the study criteria were approached.

3.3 ***Study Guide***

The student investigator used a semi-structured interview guide based on a guide from a relatively similar study. [50] In order to address all the research questions in addition to the KAP, barriers and facilitators domain was added to the guide for victim identification. Another domain was added to determine the recommendations from providers. The guide has three domains: 1. Knowledge, Belief, and Practice, 2. Barriers and Facilitators, and 3. Providers'

Recommendations and Closing. The student investigator revised and edited the initial guide to ensure comparability with the Armenian context and added an additional domain on barriers and facilitators for identifying the victim in order to answer to all the research questions posed by the study. The guide was translated from English into Armenian (Appendix 1).

Vignettes were also used in line with the study guide. The vignettes aimed to investigate healthcare providers' KAP towards IPV. The vignettes were examples from a study conducted in Armenia (Appendix 2). [83] During focus-group discussions and individual interviews three vignettes were presented to the participants. Each of the vignettes had some sub questions, which facilitated the discussion. After completing the questions in the study guide, the interviewer read aloud the vignettes. Each vignette was discussed separately. After completing the discussion of the third vignette, the student investigator collected demographic information.

3.4 ***Study Rigor***

In order to have a rigorous qualitative study, the research team clearly identified and accurately described research participants, which will assure credibility. [84] The student investigator discussed data relevance, meaning to the study context, and data accuracy with other research team members in order to ensure conformability. [84] I summarized the discussion with the participants, to make all the points clear, thus trustworthiness was assured. Moreover, two methods of data collection addressed the trustworthiness. [84]

3.5 ***Ethical considerations***

The Institutional Review Board of the American University of Armenia approved the study protocol. Before conducting the interview, each of the participants read the consent form to him or herself. A copy of the informed consent was left with the participant. The protocol assured confidentiality of the study participants. The interview was recorded after obtaining the oral

consent from the participants. Business cards and brochures from an NGO were distributed to protect study participants from emotional pressure and discomfort

3.6 ***Data Collection***

The data collection process was conducted from March to April 2016. Three FGDs were conducted with 14 participants. All the FGDs took place in the polyclinics, where the participants were working, in order to make them comfortable in their familiar surroundings. The mean duration of the interviews was approximately 45 minutes, varying from 41 to 46 minutes. Three IDIs were conducted in the hospitals, where the physician worked. The mean duration of the interviews was 41 minutes, varying from 36 to 47 minutes.

3.7 ***Data Management***

Interviews were directly transcribed from the spoken Armenian into written English for the sake of time. The data were stored on the student investigator's computer, the participants had ID numbers in order to keep personal information secured. No personal identifiers (name of the patient, phone number, address) were collected during study. In case if any participant used identifiable information during the interviews that information was not transcribed. Audio recordings were password protected. Only the research team had access to the data. Audio recordings and paper interviews were destroyed at the completion of the study.

3.8 ***Data Analysis***

The data were collected primarily through in-depth interviews and focus group discussions, open-ended questions, as well as vignettes were used, followed by targeted questions about the predetermined categories. Themes were predetermined on the theoretical framework, which was mentioned above. The theoretical framework was taken from a similar study conducted in

United Kingdom. [81] Based on the answers of the participants, the coding process started by including and classifying the codes for the each domain of the framework. Coding bywords and meaningful phrases, sentences of responses helped to identify themes and common patterns which emerged from the data. Textual data were manually analyzed.

4 Results

The five thematic areas reported here were predetermined by the theoretical framework. Within each of these thematic areas, a number of categories emerged and are detailed here.

4.1 *Socio-demographic characteristics of the participants*

Overall 17 healthcare providers participated in the study. All but one of the FGDs were GP, with the other being a Gynecologist/Obstetrician. Two of the IDI participants were Gynecologists/Obstetricians and one was an Emergency Department doctor.

The mean age of the participants was 46. 5 years old and the mean number of years in practice was 16. 6. Table 1 describes the socio-demographic characteristics of the participants.

Table 1: Socio-demographic characteristics of the participants

Participants	**Type of Interview**	**Number of Participants**	**Age (Mean & Range)**	**Sex**		**Years of Practice (Mean & Range)**
				F	**M**	
General Practitioners	FGDs	13	50, (44-61)	13		21. 27, (10-40)
Gynecologist/Obstetricians	IDIs, FGDs	3	40. 3, (30-47)	1	2	15. 3, (6-25)
ED physicians	IDI	1	26	1		2
Total		17	46. 5, (26-61)	15	2	16. 6 (2-40)

4.2 ***Knowledge***

This theme explores the knowledge of study participants about "domestic violence" and the types of it. The theme shows what study participants know about the prevalence of IPV among their patients and among Armenian population. The categories in this theme cover also the knowledge of participants about signs, which may help them to identify the victim of IPV, when she does not speak explicitly. This theme includes three categories: 1. What is violence? 2. Identification of violent cases 3. Commonality of the Issue.

What is violence?

All of the participants were knowledgeable about the meaning of the term "violence". The majority of them described at least two or three different types of violence such as physical violence, sexual assault and mental violence. According to some of the participants violence was as an act against human rights and defined it as everything "what might offend" the human.

"It is not only physical, but also psychological. They suppress so much. Starting from the basic tease, which they call a joke, finishing with full psychological suppression, like "Who are you? What are you?" ***FGD1P1`, 48 y/o, Female***

"When he has sexual relations without woman's wish. " ***FGD2P2, 45 y/o, Female***

"I understand a step which is against the rights or wishes of a human being" ***IDIP2, 30y/o, Male***

"Violation of rights and suppression of ego. The suppression and limitation of the person, violation of the laws" ***FGD1P1`, 40y/o, Female***

"When the husband is reserving himself rights to verbally abuse, beat" ***FGD1P5, 44 y/o, Female***

Some of the participants tried to distinguish "violence" and "strictness" from each other and tried to explain the condition, which maybe Armenian society accepts. So participants mentioned that strictness is something different then the violence, and strictness is acceptable for our society. This finding shows the link between participants' knowledge and attitude towards violence.

"Maybe the word "Violence" is very rude, you can say strictness, and we can understand. . . for example my husband did not allow me to work in the hospital, because of night shifts. Now what is that? Is it violence? I don't think it is violence. " ***FGD2P2, 45 y/o, Female***

Identification of Violence Cases:

Health care professionals who participated in the study described signs which may lead them to the identification of the victim. The student investigator have grouped the mentioned signs in the following way: a. Physical signs: Participants mentioned scrapes, bruises, injuries, and the penetration of reproductive organs, black eye and bruises on the arms as the main signs. Moreover, few of the physicians mentioned that they cannot recognize non-physical violence if no obvious sign of physical injury is present. And the physicians do not even come across in their everyday practice with cases of non-physical violence, as long as the woman would not refer to the physicians unless there is a physical injury or a consequence of it. And b. Non-physical signs and symptoms: According to the majority of participants it is not necessary for a woman to have bruises or any visible signs to be suspected as a victim of violence. The participants described various non-physical signs and symptoms which may lead them to the

final conclusion about patient's violence status, such as patient's behavior (not talking, looking only to one point, frightened), complains (headaches), looks, appearance.

"Scrapes, bruises, injuries, why not the penetration of reproductive organs. Those are the main. We may consider that the woman is victim of an abuse, if there are some consequences" ***IDIP2, 30 y/o, Male***

"…She didn't speak, she didn't answer her mother's questions at all, awfully drawn, depressive, stressed. I thought to myself, that there is something wrong with her. " ***FGD3P1, 48 y/o, Female***

"According to complaints. [Means the physicians may identify the victim based on her complaints, without physical defects] If there is something they will tell…" ***FGD2P2, 61 y/o, Female***

Commonality of Violence:

Most of the participants highlighted that the violence is more common in Armenia, than we know. According to them most of the cases are concealed due to the various reasons and nobody discusses it. The participants mentioned the impunity of men and the defenselessness of women in small towns and villages as one of the reasons or most common reason. Another reason mentioned by few of our participants is that although the violence is a common issue people don't talk about it as they don't know that they are being abused.

"…well maybe in the city [means Yerevan] that percent is not very prevalent, but in the villages and in small. . . . our men find themselves not punishable" ***IDIP1, 26 y/o, Female***

"I guess it is prevalent, but they talk few about it" ***IDIP2, 30 y/o, Male***

"I think that it is quite prevalent, just maybe we don't know about it…… Because it is concealed, it is another thing. Nobody will hang their dirty linen outside, so it is concealed" ***FGD1P3`, 50 y/o, Female***

"I think that the big part of victims of violence, they don't know that they are being abused, and those who abuse, they don't know that they are abusing" ***FGD1P1`, 40 y/o, Female***

Some of the participants told that society may sometimes encourage the abuser to abuse by letting him to stay unpunished, and also the society may think that it is the victim's fault and the abuse is her punishment.

"It's a boy, he is strong, he is self-confident (ռ ւ ժ ը ստե ղ և ա, ղ ռ ւ խը ստե ղ և ա), he can do whatever he wants and he is not a floor cloth or henpecked, let me say this way" ***IDIP3, 47 y/o, Male***

"Group of males might think that this particular woman behaved herself in some wrong way, that is why the male beat her, and he did well if he beat her" ***IDIP1, 26y/o, Female***

Other participants mentioned that Armenian society accepts the violence and the girls are raised in a way that violence is normal type of behavior for them, so the girls don't know that they are abused and that is why the topic is not discussed.

"Our society accepts that violence, and our whole nation will never stand and fight against it. Because it is included in our Armenian blood, in that gene, in our Armenian cell. Man is not a man if he is not sure, if he is not strict, if he is not requiring…. " ***FGD1P2, 51 y/o, Female***

"…they from the youngest age are already being nurtured that they should be obedient, they should be silent, and they should be obedient to their husbands whatever the husband will do.

Weather is going to cheat on them, he's going to hit them, and the woman needs to be silent. "

FGD1P4, Female

4.3 ***Attitude***

This theme covers study participants' perception of IPV, and the way how they perceive their role in the solution of the issue, the possibility of other specialists involvement in the solution of the issue. From this theme 2 categories were identified: 1. Perception of healthcare professionals of IPV, 2. Healthcare specialists' role in the Solution of the Issue.

Perception of healthcare professionals of IPV:

Most of the participants told that violence is a negative phenomenon and cannot be counted as normal. Almost all the participants agreed that IPV can never be justified. Few participants were thinking that some kind of "strictness" will be more helpful, and it will let the women be more organized, self-confident.

"No situations can justify violence, if it wasn't for example for self-defense, but it is already wrong to call it violence. " ***IDIP2, 30 y/o, Male***

"It would be hardly accepted as normal, that abnormal phenomenon" ***FGD3P2, 44 y/o, Female***

"In any case, I think violence is a negative phenomenon; it's not a normal thing. " ***FGD2P2, 45 y/o, Female***

"Yes why not, let them be abused in some way. It is in their favor, that after sometime they are going to be organized, self-confident, differing the wet from the dry (Armenian proverb, for right and wrong)… But that stringency should be on its moderate level" ***FGD1P2, 51 y/o, Female***

Healthcare specialists' role in the Solution of the Issue:

Very few mentioned that the physicians may be involved in the problem solving.

The predominant part of the participants mentioned that healthcare specialists' role in this filed is limited only by talking or giving advice. Some participants mentioned that healthcare specialist have nothing to do with that issue and it is not under their competence to solve that kind of issues.

"Nothing else, with the help of advises. No other ways, moreover we are not specialists for that. " ***FGD3P2, 44 y/o, Female***

"I see our role in assisting. It's very complicated, but we may talk with all the involved stakeholders. " ***FGD2P2, 45 y/o, Female***

"Not we. We are just GPs. " ***FGD1P5, 44 y/o, Female***

The majority of the respondents mentioned that nobody should involve in the issue, besides the partners. However when asked if there is need of any specialist's help for the solution most of the participants agreed that the help of the psychologist is needed and the couple should involve psychologist in the solution of their issue. Some of the participants mentioned NGOs as a component to be involved in the solution of the issue. And one of the participants mentioned the

influence of the friends of the abuser, which may act as a way to solve the issue. And almost all the participants saw the role of legal entities as final concluders of the issue.

"I know that every victim of violence, even if there is only a doubt of violence, is criminally liable, and if they applied to the hospital or just the doctor, imagine it was a home visit, it needs to be reported to the legal entities. " ***IDIP2, 30 y/o, Male***

*"They're types of relationships, especially husband-wife relations, where nobody have right to intervene, just two of them will decide what they need. "****FGD1P5, 44 y/o, Female***

"Psychologists, doctors, we also" ***FGD2P1, 60y/o, Female***

"…Psychologist's help, because it is a stress, that person needs to get out from that condition, understand that their life is continuing. " ***FGD3P1, 48 y/o, Female***

"The opinion of his (intimate partner's) friends, that you cannot do that. It is wrong. But in Armenian conditions I'm not sure if it is possible to organize. " ***IDIP1, 26 y/o, Female***

4.4 ***Practice***

This theme explored the steps healthcare providers are implementing against IPV, how comfortable are they to ask their patient about their violence status, and how skillful they feel they are in addressing this issue. The theme covers following categories: comfortability to ask a question, steps against IPV, skills and trainings.

Comfortability to ask a question:

For this particular theme the participants' opinions were equally distributed. One half of the participants were quite comfortable in asking questions about IPV to their patients, or even if

they were not comfortable they admitted that it is part of routine procedure, which and being a doctor allows them to ask any questions, taking into account the benefits of their patients. So they have rights to raise such questions. The other half of the participants mentioned that they won't ask any questions to the patient, because they don't have rights to intervene. One of the participants added that she will not ask the patient, but if the patient herself will start to tell then the physician may at least show a direction, but not go into the details.

"If I obviously see. . . when I see that the eye is bruised or something else, I will think and ask if someone beat her, what the reason of that bruised eye is. I have to know that. " ***FGD2P2, 45 y/o, Female***

"While being a doctor, you can ask any question, if it is beneficial for the patient. " ***IDIP2, 30 y/o, Male***

"I do not have any right I think, for that however. . . (The phone rings and the participant continues after the call) and also no ethical right. " ***IDIP3, 47 y/o, Male***

"It doesn't matter if you want to or no. It's another thing when you suspect that there was that kind of thing (means violence), and you cannot reserve yourself a right to ask that. But they are people who are coming and just starting to complain, telling their life stories. You should show the direction in that case, your help should be in showing the right direction. " ***FGD1P1, 47 y/o, Female***

Steps against IPV:

The participants' opinions divided in three different categories when talking about steps which need to be implemented against IPV. As healthcare providers didn't see their role in the solution of the issue the most common step implemented by them against IPV was referral of the victim

to the police and report to the legal authorities. However, none of the participants, who mentioned reporting to police knew based on which law or order this procedure is implemented.

Another option as a possible solution for the issue was referring the victim to the psychologist, here it is again seen, that healthcare professionals prefer not to intervene, because as already told they don't see their role in the field. The third group of participants told that they see their help only in advising, talking and nothing else. One of the participants mentioned that healthcare specialists are very busy and they don't have any time for that.

"...violence should. . . . strictly. . . . legal entities should deal with the consequences of violence first of all, doctors from their side, and the victim and the abuser. I think the presence and participation of other people is not preferable. " ***IDIP2, 30 y/o, Male***

"Now police is pushing. Each trauma is notified to the police. " ***FGD2P3, 61 y/o, Female***

"Healthcare workers are usually so busy, that they do not have time for that, but let's say, by talking they may help. " ***IDIP3, 47 y/o, Male***

"Psychological approach can be used again. Nothing else, with the help of advises only. No other ways, moreover we are not specialists for that. " ***FGD3P2, 44y/o, Female***

"The doctor should deal with the healing of that patient, I think the doctor's responsibility is to report to legal entities, as concealing the violence is also a delict. " ***IDIP2, 30 y/o, Male***

"Healthcare worker can only treat her physically, but I don't think that we have the right to intervene in her family. " ***FGD1P2, 51 y/o, Female***

Most of the participants only after probing mentioned that they might send the victim to the NGO. And in most of the cases they were not aware about organizations, which are focusing on the help to women and that is why they didn't how to use these resources. . Some just had very uncertain idea of NGOs and participants claimed that those organizations are not actively working. Only one participant knew the name of the organization and had practice of referring victims there. A clear link between knowledge and practice is seen here. It is obvious that the participants were willing and were ready to refer to those organizations, but because of the lack of the information and skills they did not implement the practice of referring the patients.

"The problem is that we, doctors, are not that informed that there are specific organizations to which we can in that situation refer, yes, we understand that in Armenia there could be that kind of organizations but we, unfortunately, are not informed" ***IDIP1, 26 y/o, Female***

"Well I guess I'll just refer her to Women's Resource Center, I think. So they are more civilized" ***IDIP3, 47 y/o, Male***

Skills & Trainings:

The majority of the participants noticed that special skills to deal with IPV victims, are needed, mostly psychological skills and they did not poses those skills. None of the participants had ever taken part in any training focusing on either domestic violence, or intimate partner violence and the majority of the participants express their readiness to participate in such trainings, if such would be organized. Only two of the participants had trainings in familial psychological field.

"I remember, in my time we had such subject, which now does not exist "Ethics and Psychology of Family life", I remember, I had in the school. " ***FGD3P3, 46 y/o, Female***

"We had familial psychology course, I am very pleased with it. I learned so much" ***FGD3P4, 50 y/o, Female***

"I think every person, should also be a psychologist, particularly physicians. And in this case, I think, that all of us will be ready to at least provide psychological help" ***IDIP2, 30 y/o, Male***

Some participants never had training and still refused to participate in any, giving various reasons for that, such as not working with that contingent, lack of time. Some participants mentioned that even if they had those special skills to deal with the victim the time allocated for each patient is not enough, so the opportunity to help is very small.

"Because that contingent is not coming to us, they are not sharing their delicate issues of their family with us. We will be trained to do what?" ***FGD2P1, 60 y/o, Female***

"I will just simply have no time for that. I would really like to do something but I really don't have time. " ***IDIP3, 47 y/o, Male***

"I agree that we may study, ok so let us study for us in order to have some skills, so that we can use them in the future. " ***FGD3P1, 48 y/o, Female***

"All the patients are coming based on appointments, I don't think that 10-15 minutes are enough for psychological help, because after each word there is opening a new one, and that talk cannot be limited by only 15 mins" ***FGD3P1, 48 y/o, Female***

4.5 ***Barriers & Facilitators***

This theme explores barriers and facilitators, which help to ask the patient about IPV and provide support to the victim. This theme covers the following categories: barriers in asking and supporting, facilitators in asking and supporting, differences in work depending on Social Status/Age/Education:

Barriers in asking and supporting:

The opinions were very diverse in this theme. Some of the participants mentioned that the "inner closed status" and woman's unwillingness to answer the questions, the presence of the husband or the relatives may be a barrier for asking and finding out about the IPV. Other participants mentioned woman may not trust the physician, this was mainly the opinion of GPs, they explained it because all GPs know population in the particular area and women are afraid that physicians may disseminate the information about them. Few participants mentioned that a barrier could be the fact that the specific issue is not physician's business. Another participant mentioned that some physicians may not ask the patient questions about IPV, because of subconsciously expecting the patient to reject all the questions.

"…only the inner closed status for not opening the violence, not finding out it. " ***IDIP1, 26 y/o, Female***

"Maybe. . . . when her husband is next to her or the relatives of her husband are with her. Something like this. " ***IDIP3, 47 y/o, Male***

"The opinion of the society. They may think that we can disseminate information about them, we can become source of information. " ***FGD3P4, 50 y/o, Female***

"…and if you ask she'll say: it's none of your business" ***FGD1P5 44 y/o, Female***

"I think, the answer that we subconsciously already expect. I think in 90% of the cases and even more if even we doubt that there is violence here, we don't ask, because we subconsciously understand that she will answer "No, nothing like that happened". ***IDIP2, 30 y/o. Male***

When talking about the barriers in providing support, the majority of the participants answered that woman's fear is the biggest challenge. Participants mentioned some reasons for the fear, among those reasons were mentioned the fear from the husband, e. g., if he will know that the woman disclosed to the physician and got support from them, the husband may start behaving himself even worse, another reason was about referring to NGO, if a physician will refer to NGO, woman may not go there because she will be afraid that her husband would find out about it, and one reason was the fear to stay alone. Few participants mentioned that woman's wish is very important in providing support.

"I think in most of the cases the fear can be a barrier for the victim of the violence, that her husband can behave himself worse, if she will go to any NGO, or if she just discloses that issue." ***IDIP2, 30 y/o, Male***

"We will ask "do you need some help?', but if she said no we don't have a right to go enter deeper." ***FGD2P1, 60 y/o, Female***

Facilitators in asking and supporting:

The majority of the participants mentioned that the trust and the respect towards the physician is a big facilitator. Some of the participants mentioned that long-term relations with the patient are certainly facilitating the process of asking and identifying. Few of the participants mentioned the condition of the woman at that moment may be a facilitator, so the participants described her scared and closed condition both as barrier and as facilitator. One of the participants mentioned that it is very important that the patient would be fair with the doctor, tell the truth. One of the participants told that physician's psychological status may be a facilitating factor, if the

physician gets stressed from the woman's condition, then he/she will support her. And there were some participants, who were sure that there is no right to ask or support.

"The trust, the respect towards each other, if the patient understands that she visits the doctor for a specific help, it really helps, but if she just came, because of the need, in many cases, all of that conceals. The patients to be fair with us, for sure, to be simple, clear. Tell us the truth. "

IDIP2, 30 y/o, Male

"The condition of the woman at that moment, so if the woman is super-scared at that moment"

IDIP1, 26 y/o, Female

"Only my psychological status at that moment, how I would perceive that situation, only that"

IDIP3, 47 y/o, Male

"Well you know how, you yourself just find that you don't have any right to ask. " ***FGD1P2, 51 y/o, Female***

The answers about support provision were expressing the same meaning. Majority of the participants mentioned that the if the NGOs were working more active it would definitely help the physicians and be a huge facilitating factor in this area. Some participants mentioned that the wish of the woman is playing the main role in provision her support and this factor was mentioned both as barrier and as facilitator.

"More active work of NGOs, raising the issue. So the more they will talk about the issue, the more solutions there would be suggested. [ինչքան շատ խոսվի խնդրի մասին, էտքան

ավելի շատ լուծումներ կառաջարկվեն] and the doctor for himself/herself might desire which one is more actual and corresponding for the specific couple. " ***IDIP2, 30 y/o, Male***

"Probably her wish, is the major factor, which can facilitate or challenge us. " ***IDIP1, 26 y/o, Female***

Differences in work depending on Social Status/Age/Education:

The majority of the participants admitted that nowadays youth is more knowledgeable of their rights and in general they are more progressive, some participants mentioned that it is easier to work with younger population, however there were participants who told the opposite. Participants also mentioned that because of more knowledgeability the youth population is more difficult to abuse. All of the participants thought that educational level is very important and it is very different and easy to work with educated people, some of the participants mentioned that although the education is important the upbringing is more important. And when talking about the social status some participants mentioned that it is difficult to work with socially deprived population, because they in most of the cases think no option to avoid or get rid of the intimate partner exists.

"Nowadays the youth is more knowledgeable of their rights and what they might want, or might be less tolerant, in comparison with older women" ***IDIP1, 26 y/o, Female***

"No I don't think, that is possible nowadays to abuse a 19 years old. They are progressive. It is vice versa nowadays, I think. " ***IDIP3, 47 y/o, Male***

"The more person is educated, the more he/she is protected" ***IDIP2, 30 y/o, Male***

"Generally, not the education, but the upbringing, mostly the intellect and not the education. A person can be not educated, but also can be so intellectual…" ***FGD3P3 46 y/o, Female***

"For sure, it is just one thing when you talk with a patient, who is mature, is independent in some way, and it is totally other thing when you speak with an adolescent patient or with a socially deprived, who thinks that there is no option to avoid. . . . get rid of the intimate partner. " ***IDIP2, 30 y/o, Male***

4.6 ***Provider's Recommendations***

This theme explores the opinions of healthcare providers about the interventions that need to be done in the field of IPV, for future improvement. The category included in this theme is future interventions.

Future Interventions:

The majority of the participants mentioned that it would be pointless to make interventions in medical field, they did not imagine any change there and mentioned that no standardized intervention may be implemented, because in medicine every case is specific. Almost all participants responded that interventions should be done in legal sphere, such as enforcement of the law, punishment for the abuser, etc. All the participants agreed that the interventions need to be started from educational level, from nurturing, from school, family. Educational field was decided to be start-point of changes by almost all participants. Some also mentioned awareness raising as the main start point fort the improvement in IPV field.

"I think it's pointless. To try to change anything in the medical area, for example what? I just cannot imagine what can we change?" ***IDIP3, 47 y/o, Male***

"Maybe for the medical filed, it will be difficult for me to say anything, medical help is implemented according to first aid and depending on the severity of physical injuries, and it is difficult to say anything because it depends on the case. " ***IDIP1, 26 y/o, Female***

"I think that people just need to be aware both about their rights and liabilities. If they are aware and the law would be protected, and not only just written on the paper, already with that people would be protected. " ***FGD3P2, 44 y/o, Female***

"Well, it should start from the school, that in our educational infrastructure now that years are added for wasting time (ժամանակը ապառելու համար տարիներ են ավելացրել), yes?? That high school, or I don't know what, it would be better if they would teach this kind of subjects, just in school starting from that age, so that children would be able to enter the life. "

FGD3P3, 46 y/o, Female

5 Discussion

The study findings showed that Armenian healthcare providers are knowledgeable of domestic violence and its types. They can recognize violence through physical and non-physical signs; but because of the lack of practice, skills and knowledge on how to deal with victims, they are not able to manage those cases. The findings also showed a number of barriers and facilitators to asking about violence and supporting its victims.

This study is the first that assessed healthcare providers' knowledge, attitudes, and practices, as well as barriers and facilitators for identifying and dealing with victim of intimate partner violence in Armenia. The study was the first to use a long version of consent form. The consent

form included all the information, which the participant may question. The information was provided in the "Frequently Asked Questions" format. All the participants had their version of consent form, after distribution of the forms, the interviewer discussed all the points included in the consent form. The discussion made easier the process, and cleared all further confusions and misunderstandings.

The study revealed that healthcare professionals had knowledge about domestic violence and its types. They were able to define domestic violence in their understanding, which was more of an act against human and his/her wishes. These findings correspond to the similar results from studies conducted in United Kingdom in 2012 and in Brazil in 2009. [81,85] Psychological abuse was one of the most common types mentioned by the participants. When talking about it, participants mentioned suppression and limitation of the person, this description stand near the actual definition of psychological violence. This particular finding also was described in other study as well. [86]

One of the most interesting findings of the current study is the identification of the victims by the healthcare providers. The participants have mentioned two ways of identification, based physical and non-physical signs. So, some of the participants stated that they will ask the patient about violence if they'll see any physical sign (bruise, scrapes etc.) and others mention that psychological signs (behavior, look, etc.), may also help to identify the victim, that will make them suspect violence, and similar findings were discussed in another qualitative study. [81,87]

Participants most common answers about steps against IPV were as follows: not intervening)/referring to psychologist, referring to legal entities and advising/talking. Few told that their help may be only in providing medical care. This answer can be explained because the

healthcare providers do not see their role in addressing this particular issue, no other person should be involved in the solution besides the partners. And the majority of participants answered the opposite that their steps would be referring the patient to the legal authorities and/or psychologists. Despite the fact that most of the participants were ready to refer the victim to legal entities they didn't know based on what law or order it is done. The same situation was described in a study conducted in Turkey. [88] The findings of another study conducted in Angola showed that the healthcare providers focus more on medical specialties, which tends to overshadow their perception, involvement in intimate partner violence issue solution, which was corresponding to the findings of the current study. [87] A qualitative study investigated in India suggested in the results that based on the answers of some of the participants, physicians should not screen for IPV, as the physician cannot be aware of the whole situation. [89] The international literature provides information about reporting to the legal authorities based on a reporting law, this is not far from our findings as our participants are also referring their patients to the legal authorities, because of law. [90,91]

Participants almost had very vague idea about shelters, hot lines and NGOs which are available in Armenia against IPV. When identifying the victim there were participants, who wanted to help them, but they didn't have enough knowledge to refer them to either NGO or shelter, or call hot line. This is explained with the lack of skills, knowledge about the management of this type of patients. The study in United Kingdom showed that primary health practitioners were not sure of the resources available in their practices to help. [81] Another study conducted in Malaysia also had similar findings. [92]

The literature provides as evidence corresponding to the current study results, and as those contradicting to the study findings. Some studies showed that health professionals see their role

in helping, personal support or encouragement of the victims to get out of the situation of violence. [85,93] Other studies shows that physicians may also not see their role and think of the issue as a very private one. [94]

According to study participants they may face a number of barriers when asking their patients about abuse or when trying to support them. The barriers mentioned by the participants of our study are the lack of trust, fear from the husband/partner, woman's wish to disclose, inappropriateness of asking the questions, presence of the husband/relatives of husband. The mentioned barriers are consistent with international literature. In one of the studies it was found that patients report that they do not disclose because of fear of their partner's retaliation, shame, humiliation, denial, and a belief that health care professionals cannot do much to help them. [67,95,96]

Besides the barriers the participants mentioned facilitators, which may help them to ask and provide support. Among those facilitators participants mentioned trust, respect towards the physician, long-term relations with physician, and woman's wish to disclose and be supported. These findings are consistent with international literature. [81]

5.1 ***Strengths and Limitations***

The study has a number of strengths, first of all this is the first study that aimed to assess healthcare providers' knowledge, attitude and practice, as well as barriers and facilitators for identifying and dealing with victim of intimate partner violence in Armenia. Secondly, the majority of the participants were chosen from those primary health care facilities, which cover major part of our population, thus they deal with diverse population. Then, all the participants were interviewed in a comfortable and familiar for them environment (policlinics, hospitals),

which let them feel more open during the interviews. Another strength of the study is the maintenance of rigor through comfortability, credibility, trustworthiness. And additional strength of this research was the inclusion of a longer, more detailed informed consent which more closely aligned itself with the international standard. In particular it was decided to test an informed consent which alluded to the sensitive issue of domestic violence and how this possibly might result in harm to the participants from material discussed in the interviews. It was found that the participants tolerated the following sentence well.

> *As the topic is sensitive the possible consequence of our discussion* ***might be emotional pressure: you could feel sad, down or depressed after the focus group. When we will finish the discussion I will provide you contacts, which you can use in case of emotional imbalance.***

This experience should be considered when developing informed consent in the future so that potential harm to participants can be adequately addressed.

The study has several limitations. Firstly, the study only covered health professionals working in Yerevan and therefore there is no information from rural areas. Additionally, the number of participants was small (17) and saturation may not have been reached. Additionally, because of lack of time, the data were transcribed directly from taped Armenian to written English without going through the process of transcribing into written Armenian and then translating from written Armenian to written English.

Lapadat and Lindsay report that the Tape-Transcribe-Code-Interpret (TTCI) method which the investigator used, is of paramount importance.[97] It is interesting to note that no reports could be found in the literature specifying that in research using more than one language that the

technique should be TTTCI with the third "T" being "translate". This heretofore unnoticed limitation may come from an assumption on the part of some investigators that this would be an understood practice. On the other hand, as it is not specified in the Methods sections of the extant literature there may be variation in the process.

Transcription is an interpretive process which relies on decisions regarding sentence structure and punctuation and other cues which occur during the interviewing process. [98–100] Although primarily focusing on errors associated with using voice recognition software for transcribing data, MacLean, Meyer and Estable's article also sets out guidelines that could have been more closely followed in this research. [101] If the TTTCI process of transcribing the data of the interviews had been followed comparisons with previous studies such as Sardaryan's could have been more closely explored. [83]

MacLean, Meyer and Estable also point out that when dealing with emotionally laden materials, as with this research, inaccuracies can occur. [101] There can be denial or "mis-hearing" of words. Because the translation was done as a one step process with the investigator listening to the tapes and then directly translating, this could have introduced inaccuracies in transcription.

This research gives us an opportunity to suggest that with future research the TTTCI method should be considered in the research plan, included in the time line and described in the methods. This would enable clarity in future research involving participants and interviewers of one language such that data is reliably translated into the language of presentation. Future research could include a comparison between the two methods: method 1: listen to the interviews in Armenian, transcribe the interviews into Armenian and then translate the data into English for coding/analysis and interpretation; method 2: interview in Armenian, transcribe into Armenian, code/analyze in Armenian and then interpret for an English readership. Given the complexity of

Armenian, as Twinn found with Chinese focus groups, there is a possibility that direct translation by the investigator may have introduced bias. [102]

Lapadat and Lindsay stress the advantage of the investigator transcribing the interviews as it allows the investigator to become familiar and intimate with the data which the investigator did in this study and was a strength of the research. [97]

It should be noted that the investigator transcribed four pages from one of the FGD's into Armenian and then translated that material into English. These four pages were compared to the transcript that had been provided previously by the direct translation method and no major or important differences were identified. Therefore, we can assume that all of the data that was collected in this research project are accurate and valid.

5.2 ***Recommendations***

Based on the findings and on the discussion several recommendations are suggested. First, physicians, independently from their specialization, should be trained in the medical schools to identify violence, including intimate partner violence. Secondly, they also should be trained to deal with violence, as a part of their routine work. Third, the NGOs should start working more actively in the sphere of healthcare, particularly by providing leaflets, brochures, and cards to doctors. Organization of trainings, workshops, seminars will lead to higher knowledge score among healthcare providers and thus will lead to correct practice of the cases. Fourth, an expanded study needs to be conducted, which will cover also rural areas. The study will help to capture the whole situation and address it. Fifth, mandated screening and awareness raising are needed, among both women and physicians.

5.3 ***Conclusion***

This study aimed to assess knowledge, attitudes, and practices of those health providers who may come in contact with victims of IPV. The results showed that participants had knowledge of violence, they identified it as an act against human rights, and they were knowledgeable about types of violence. The participants mentioned different methods to identify the victim, such as with the help of physical and non-physical signs, however they did not know what steps should follow identification of the victim, and they did not have skills and knowledge of how to deal with victims of IPV.

The provided recommendations will help to expand provider training and community support, as well with the help of the provided recommendations our research knowledge will increase. Healthcare providers should understand their role in elimination of the issue, and for that the attitude should be changed. The mentioned recommendations are able to lead to the change in knowledge, attitude and practice.

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Figure 1: Social-Ecological Model: A Framework for Prevention [8,9]

Appendix 1: Demographic characteristics (English and Armenian)

1. Age _____
2. Gender: ☐Male ☐Female
3. Specialization:

   ☐ General practitioner

   ☐ Gynecologist/Obstetrician

   ☐ Emergency doctor

Ժողովրդագրական տվյալներ

1. Տարիք _____
2. Սեռ. ☐Արական ☐Իգական
3. Մասնագիտացում.

   ☐ Ընտանեկան բժիշկ

   ☐ Գինեկոլոգ/մանկաբարձ

   ☐ Ընդունարանի բժիշկ

Appendix 2: Study Guide (English, Armenian)

Instrument

ID:

Date:

Place:

Time:

English

As I have already mentioned I would like to assess the knowledge, attitude and practice of general practitioners, gynecologists/obstetrics and emergency department clinicians regarding identification and addressing intimate partner violence among their patients in Yerevan, Armenia. I would kindly ask you to share your personal experience with me which will help us to find a way to improve the care you and your parents receive.

Knowledge

1. What do you understand by the term "domestic violence"?

   Probe: Do you know any types of violence? When will you think of violence? Should a woman have trauma/bruises to be called victim of violence?
2. What do you know about the Intimate Partner Violence prevalence in Armenia and particularly among your patients?

3. In case a woman doesn't speak explicitly of intimate partner violence what would make you consider that she has been exposed to it? **Probe:** What are the cases where you would be sure that your patient is a victim of IPV? Could you provide a typical example?

Attitude

In terms of its influence on society what do you think about IPV? What kind of influence does it have on the society?

Do you think that other people than the family members of the victim might be involved in addressing this issue?

What healthcare professionals in your opinion meet patients who have experienced IPV?

How do you see you role of health care professional in addressing intimate partner violence?

Practice

What do you do when you face IPV case? What would your actions be after a patient discloses experiences of intimate partner violence? Do you respond? May you refer the victim to other organizations (police, NGO, shelter)? How should they be treated? Could you provide an example?

How would you describe your preparedness in working with victims of intimate partner violence? **Probe**: Have you ever felt that you need more special skills or recources to respond such cases with IPV? Could you provide an example? What can increase your preparedness?

Do you know any order or rule according which you should act in case of violence cases?

Have you ever participated in training courses on domestic violence? If yes, were they useful and how? If no, if some organizations will conduct such trainings will you participate and how you see its practical implication in your practice?

Barriers and Facilitators

1. How comfortable are you with the idea of directly asking your patients about domestic violence?

   Probe: In your perspective what are the ethical and legal considerations to ask your patients about violence?

2. What would the challenges be in:
   a. Asking women about intimate partner violence?
   b. Off ering support to women disclosing that they are experiencing domestic violence?
3. What makes it easier for you in:
   a. Asking women about domestic violence?
   b. Off ering support to women disclosing that they are experiencing domestic violence?
4. In your opinion will there be any differences in dealing with victims of IPV depending on their age/social status/educational level?

Providers' Recommendations

1 What are the potential interventions to be done on legal /medical/educational level?

Probe: In your opinion, what would be the best solution of this issue?

2 In your opinion what can improve the situation in Armenia regarding IPV approaches?

Probe: Where should be the start point of the changes?

3 Is there anything else you would like to discuss before we finish?

ID:

Ամսաթիվ:

Վայր:

Ժամ:

Ինչպես արդեն նշել էի, հետազոտության նպատակն է գնահատել Երևանյան ընտանեկան բժիշկների, մանկաբարձ/գինեկոլոգների և անհետաձգելի բուժօգնության բաժանմունքի բժիշկների գիտելիքները, վերաբերմունքը և փորձը զուգընկերոջ կողմից բռնության ենթարկված կանանց նույնականացման և մոտեցման հարցում: Ես կխնդրեի կիսվել Ձեր ամձմական փորձով, որը կօգնի մեզ բռնության ենթարկված կանանց հանդեպ ցուցաբերվող օգնությունը բարելավվելու միջոց գտնել:

Armenian

Գիտելիք

1 Ի՞նչ եք հասկանում «ընտանեկան բռնություն» ասելով:

Փորձ. Դուք գիտե՞ք ընտանեկան բռնության որևէ տեսակներ: Ե՞րբ Դուք կմտածեք ընտանեկան բռնության մասին: Արդյո՞ք կինը պետք է վնասվածքներ/արյունազեղումներ ունենա, որպեսզի անվանվի բռնության զոհ:

2 Ի՞նչ գիտեք զուգընկերոջ կողմից իրականացվող բռնության տարածվածության մասին Հայաստանում և մասնավորապես Ձեր հիվանդների շրջանում:

3 Այն դեպքում, երբ կինը բացահայտ չի խոսում իր զուգընկերոջ կողմից իրագործված բռնության մասին, ի՞նչ նշաններ կդրդեն Ձեզ մտածել այդ ուղղությամբ: Որո՞նք են այն դեպքերը երբ Դուք համոզված կլինեք, որ տվյալ անձը զուգընկերոջ կողմից իրագործված բռնության զոհ է: Կարո՞ղ եք օրինակ բերել:

Վերաբերմունք

1. Ի՞նչ կարծիքի եք զուգընկերոջ կողմից իրականացվող բռնության ազդեցության մասին հասարակության վրա: Ի՞նչ տեսակի ազդեցություն այն ունի հասարակության վրա:
2. Արդյո՞ք այլ մարդիկ՝ բացի զոհի ընտանիքի անդամներից, կարող են որևէ կերպ ներգրավված լինել այս հարցի լուծման մեջ:
3. Ո՞ր բուժաշխատողներն են ավելի հաճախ շփվում տվյալ խնդրով կանանց հետ: Ինչպե՞ս եք պատկերացնում Ձեր դերը՝որպես բուժաշխատող, զուգընկերոջ կողմից իրականացվող բռնության դեմ պայքարի մեջ:

Գործունեություն

1. Ի՞նչ եք անում կամ կանեք, երբ ունենում եք զուգընկերոջ կողմից բռնության դեպք: Ի՞նչ գործողությունների կդիմեք, երբ Ձեր հիվանդը բացահայտի, որ բռնության զոհ է: Որև՞է կերպ պատասխան տալիս եք դեպքին: Արդյո՞ք կարող եք զոհին ուղեգրել այլ կազմակերպություն (ոստիկանություն, Հասարակական կազմակերպություն, կացարան): Ի՞նչ տակտիկայով պետք է նման հիվանդները բուժվեն: Կարո՞ղ եք օրինակ բերել:
2. Ինչպե՞ս կնկարագրեք Ձեր պատրաստվածությունը զուգընկերոջ կողմից բռնության ենթարկված կնոջ հետ աշխատելու համար: **Փորձ.** Երբև՞է զգացել եք. որ կարիք ունեք հավելյալ յուրահատուկ հմտությունների կամ ռեսուրսների տիրապետելու: Կարո՞ղ եք օրինակ բերել: Ի՞նչը կարող է Ձեր պատրաստվածության վրա դրական ազդել ըստ Ձեզ:
3. Դուք գիտեք որև՞է հրաման կամ օրենք որը կսահմանի Ձեր գործունեությունը բռնության ենթարկված դեպքերի հետ աշխատելիս:
4. Երբևէ՞ որևէ վերապատրաստում անցել եք ընտանեկան բռնության վերաբերյալ: Եթե այո, ապա ըստ Ձեզ այն օգտակար էր և ինչ տեսանկյունից: Եթե ոչ, եթե որևէ կազմակաերություն կազմակերպեր նման վերապատրաստման դասընթացներ, կցանկանայի՞ք մասնակցել և դրա պրակտիկ օգտագործումը տեսնել Ձեր աշխատանքի մեջ:

Խոչընդոտներ և Խթաններ

1. Որքանո՞վ անկաշկանդ Ձեզ կզգայիք հիվանդին հարցնելու ընտանեկան բռնության մասին: **Փորձ.** Ձեր կարծիքով որոնք են օրենսդրական և էթիկական նկատառումները հիվանդին բռնության մասին հարցնելու դեպքում:
2. Ի՞նչ խոչընդոտների Դուք կարող եք հանդիպել, երբ

   հարցնեք կանանց ընտանեկան բռնության մասին:

   առաջարկելով աջակցություն այն կանանց՝ բացահայտելով նրանց

   ընտանեկան բռնության զոհ լինելը:
3. Ի՞նչ կարող է օգնել Ձեզ, երբ

հարցնեք կանանց ընտանեկան բռնության մասին:

առաջարկելով աջակցություն այն կանանց՝ բացահայտելով նրանց ընտանեկան բռնության զոհ լինելը:

4. Ձեր կարծիքով կարող է տարբերություն լինել զոհերի հետ աշխատանքի մեջ, կախված նրանց տարիքից, սոցիալական վիճակից և կրթության աստիճանից:

Հետագա ուղղությունը և Փակում

1. Ձեր կարծիքով որոնք են հնարավոր միջամտություններ իրավական, բժշկական և կրթական ոլորտներում: **Փորձ:** Ըստ Ձեզ, ինչը կարող է այս հարցի լավագույն լուծումը լինել:

2. Ձեր կարծիքով ի՞նչը կարող է բերել Հայաստանում իրավիճակի բարելավման: **Փորձ:** Ո՞ն է փոփոխությունների սկզբնակետը Ձեր կարծիքով:
3. Կա արդյո՞ք ինչ-որ բան, որի մասին մենք Ձեզ չհարցրեցինք, բայց կարծում եք, որ անհրաժեշտ է այդ մասին խոսել:

Appendix 3: In-depth Interview Consent Form (English and Armenian)

American University of Armenia

School of Public Health

Institutional Review Board #1/Committee on Human Research

Consent form

Hello, I am Zaruhi Arakelyan; I am a physician and graduate student in the School of Public Health at the American University of Armenia (AUA). I am conducting a research study under the supervision of my faculty at AUA. The main aim of the study is to assess knowledge, attitude and practice of Obstetricians, Gynecologists, General Practitioners and Emergency Services Physicians who may come in contact with women who have experienced intimate partner violence.

You are being invited to participate in this study as you are a professional who may come in contact with women who have experienced intimate partner violence. You and other health professionals are being invited to participate in this study in order to expand to expand the understanding of society about physicians' knowledge, attitude and practice towards domestic

violence in Armenia. You were selected to participate in this study either based on convenience or NGO provided your contacts. Your participation involves individual interview.

What are the study procedures? What will I be asked to do?

I will interview you at a convenient time for you. The interview will last approximately 1 hour.

You are free to decline to answer any of the questions asked. Questions will be asked covering different areas: 1. Knowledge, Attitude and Practice 2. Barriers and Facilitators 3. Providers' recommendations.

I am asking you to allow me to audio tape the interview so that I might understand better the results by listening to them again. This audio tape will be transcribed, by me, and then the tape will be destroyed after the data will be analyzed.

What are the risks or inconveniences of the study?

As the topic is sensitive the possible consequence of our discussion **might be emotional pressure: you could feel sad, down or depressed following the interview. When we will finish the interview I will provide you contacts, which you can use in case of emotional imbalance.** Also, participating in this research study may be an inconvenience given the time that it takes to complete the interview.

What are the benefits of the study?

While you may not directly benefit from this research, your participation may identify ways to help women who may have been exposed to intimate partner violence or who have experienced it and this may assist in their treatment. Your participation may contribute to the improved care not only of women in Armenia but across the region as well. The role that the medical

professional has in the experience of the victim of intimate partner violence is an under-researched area which needs investigation.

Will I receive payment for participation?

There is no compensation for participation.

Are there costs to participate?

There are no costs to you to participate in this study.

Can I stop being in the study and what are my rights?

Your participation in this study is completely voluntary. You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate. All you would have to do is contact me or the Research Team (as described below).

How will my personal information be protected?

I will protect the confidentiality of your data. All study data will be locked in a secure location, on a password protected computer and your name will not be attached to the data. Any master key, audio recording, and other data described in the next paragraph will be maintained in accordance with the security provisions of the next paragraph until destroyed by me.

Audio tapes will be transcribed by me and then the audio tape will be destroyed on or before May 25. At the conclusion of this study, the findings may be published. There will be a thesis of this project held on line at the AUA website. Statements which you have made may be included in

publications and in the thesis. However, in any publication and in the thesis, your name and identifying information will not be used so that your confidentiality will be protected.

Do you agree to allow your interview to be recorded? If **YES,** I will turn on the recorder when we start the interview.

Please be aware that it is within your right to ask to turn off the recorder at any time during the interview, whenever you want to. If **NO,** I will take notes during the interview, if you do not mind.

Who do I contact if I have questions about the study?

Take as much time as you like before you make a decision to participate in this study. I am ready to answer any questions you have about this study. If you want to contact me at a later date or want to voice concerns or complaints about the research, my contact information is as follows: Dr. Zaruhi Arakelyan, (+374-55)20 41 22, zaruhi_arakelyan@edu. aua. am .

Additionally, as I am a student who will be graduating in May I would like to provide you with the name of one of my faculty advisors who will be available to discuss this study with you long into the future: Serine Sahakyan, (+374-60) 61 25 61), serine_sahakyan2@edu. aua. am .

If you would like to discuss your rights as a research participant, discuss problems, concerns or if you come to believe that you have not been treated fairly during this study you may contact the Human Subject Protection Administrator of the American University of Armenia, Dr. Kristina Akopyan -(+374 60) 61 25 61) akopyank@aua. am .

Do you agree to participate? Please say YES or NO. **If yes,** shall we start?

Հայաստանի Ամերիկյան Համալսարան

Հանրային առողջապահության բաժին

Գիտահետազոտական էթիկայի թիվ 1 հանձնաժողով

Իրազեկ համաձայնության ձև

Բարև Ձեզ, ես Առաքելյան Զարուհին եմ. ես բժիշկ եմ և համատեղ Հայաստանի Ամերկյան Համալսանի (ՀԱՀ) Հանրային Առողջապահության բաժնի ավարտական կուրսի ուսանող: Այժմ ես ֆակուլտետի հսկողության ներքո հետազոտություն եմ իրականացնում, որի հիկմնական նպատակն է գնահատել Մանկաբարձ-Գինեկոլոգների, Անհետաձգելի բուժօգնության բժիշկների և Ընտանեկան բժիշկների գիտելիքը, վերաբերմունքը և փորձը, ընտանեկան բռնության ենթարկված կանանց վերաբերյալ: Դուք հրավիրված եք մասնակցելու այս հետազոտությանը, քանի որ Ձեր մասնագիտության բերումով հնարավոր է շփվեք զուգընկերոջ կողմից բռնության ենթարկված կականց հետ: Դուք և այլ բուժաշխատողներ հրավիրվել եք մասնակցելու այս հետազոտությանը, քանզի Ձեր օգնությամբ ավելի կընդլայնվի հասարակության

պատկերացումը զուգընկերոջ կողմից իրականացվող բռնության վերաբերյալ բժիշկների գիտելիքների, վերաբերմունքի և փորձի մասին: Դուք ընտրվել եք հետազոտությանը մասնկացելու համար հարմարության սկզբունքով կամ Ձեր տվյալները տրամադրել է Հասարական Կազմակերպությունը: Ձեր մասնակցությունը այս հետազոտությանը սահմանափակվում է հարցազրույցով:

Ինչպիսի՞ն է հետազոտության ընթացակարգը: Ի՞նչ է ինձնից պահանջվում:

Ես կանցկացնեմ հարցազրույցը Ձեզ հարմար ժամի: Հարցազրույցը կտևի մոտ 1ժամ: Դուք ունեք իրավունք պատասխան չտալու Ձեզ ուղղված հարցերին: Հարցերը վերաբերվեւմ են տարբեր ոլորտների. 1. Գիտելիք, Վերաբերմունք և Փորձ 2. Խոչընդոտներ և Խթաններ 3. Բուժաշխատողների առաջարկություններ: Ես Ձեր թույլտվությունն եմ խնդրում մեր հարցազրույցը ձայնագրելու համար: Վերլսելով ձայնագրությունը ես ավելի հստակ կկարողանամ մեկնաբանել հետազոտության արդյունքները: Ձայնագրությունը կարձանագրվի գրավոր կերպով և այնուհետև ձայնագրությունը կոչնչացվի տվյալների վերլուծությունից հետո:

Որո՞նք են հետազոտության ռիսկերը և անհարմարություններ:

Քանի որ թեման, բավականին ծանր է, հարցազրույցի հնարավոր հետևանքներ կարող են լինեն տրամադրության անկումը, զգացմունքային ծանրաբեռնումը, ընկճախտը:

Հարցազրույցի ավարտից հետո ես Ձեզ կտրամադրեմ տվյալներ, որոնք Դուք կարող եք օգտագործել հուզական անհավարակշռության դեպքում: Հետազոտության հետ կապված այլ անհարմարություն կարող է լինել հարցազրույցի տևողությունը:

Որո՞նք են հետազոտության հետ կապված շահերը:

Չնայած որ հետազոտության արդյունքում Դուք չեք ունենա որևէ անմիջական շահ, Ձեր մասնակցությունը կարող է բացահայտել օգնության ուղիներ այն կանաց համար, ովքեր ենթարկվել են կամ կարող են ենթարկվել բռնության զուգընկերոջ կողմից, որն էլ իր հերթին կաջակցի նրանց բուժմանը: Ձեր մասնկացության շնորհիվ կարող է բարելավվել կանանց բուժսպասարկմանը ոչ միայն Հայաստանում, այլև տարածաշրջանում: Բուժաշխատողների դերը սահմանափակ է ուսումնասիրված զուգընկերոջ կողմից բռնության ենթարկված կանանց հարցում:

Արդյո՞ք կստանամ դրամական պարգև մասնակցության համար:

Մասնակցության համար որևէ փոխհատուցում նախատեսված չէ:

Արդո՞ք նախատեսված է որևէ վճար մասնակցության համար:

Մասնակցությունն անվճար է:

Կարո՞ղ եմ արդյոք դադարեցնել մասնակցությունը տվյալ հետազոտությանը և որոնք են իմ իրավունքները:

Ձեր մասնակցությունը այս հետազոտությանը լիովին կամավոր է: Դուք պարտավոր չէք մասնակցել նրան, եթե չեք ցանկանում: Եթե համաձայնել եք մասնակցել հետազոտությանը, բայց հետագայում մտափոխվել եք, կարող եք ցանկացած պահի հրաժարվել մասնկացությունից առանց որևէ տուգանքների և հետևանքների: Դրա համար պարզապես անհրաժեշտ է կապ հաստատել ինձ կամ հետազոտական թիմի հետ (ինչպես նկարագրված է ստորև):

<u>Ինչպե՞ս են իմ անձնական տվյալները պաշտպանվելու:</u>

Ես կապահովեմ Ձեր տվյալների գաղտնիությունը: Հետազոտության ամբողջ տվյալները կպահվեն ապահով տեղում, ծածկագրով պաշտպանված համակարգչում, և Ձեր անունը չի կցվի տվյալներին: Ցանկացած ձայնագրություն և այլ տվյալներ, որոնք նկարագրված են հաջորդ պարբերությունում, կկիրառվեն անվտանգության բոլոր կանոններին համապատասխան: Ձայնագրությունները գրավոր կերպով կարձանագրվեն իմ կողմից, այնուհետև ձայնագրությունը կոչնչացվի կամ Մայիսի 25ին կամ ավելի վաղ: Հետազոտությունն ամփոփելուն պես, արդյունքները կարող են հրապարակվել: Այս հետազոտության թեզը առցանց կտեղակայվի ՀԱՀ կայքում: Ձեր կողմից արված որոշակի արտահայտություններ կարող են տեղ գտնել թեզի և հրապարակման մեջ: Այնուամենայնիվ, որևէ հրապարակման կամ թեզի մեջ Ձեր անունը կամ նույնականացվող ցանկացած տվյալ չի օգտագործվի՝ այսպիսով պաշտպանելով Ձեր տվյալների գաղտնիությունը:

Այսպիսով, Դուք տալի՞ս եք Ձեր համաձայնությունը հարցազրույցը ձայնագրելու համար։

Եթե **ԱՅՈ,** ես կմիացնեմ ձայնագրիչը, երբ մենք սկսենք հարցազրույցը։

Ցանկանում եմ տեղեկացնել, որ Ձեր իրավունքն է հարցազրույցի ցանկացած պահի պահանջել անջատել ձայնագրիչը։

Եթե **ՈՉ,** ես գրի կառնեմ Ձեր կողվից տրամադրված տեղեկությունները, եթե Դուք դեմ չեք։

<u>Ու՞մ հետ պետք է կապ հաստատել հետզաոտության մասին հարցերի դեպքում։</u>

Օգտագործեք այնքան ժամանակ, որքան հարկավոր է հետազոտության մասնակցելու որոշում կացացնելու համար։ Ես պատրաստ եմ պատասխանել հետազոտությանը վերաբերող Ձեր բոլոր հարցերին։ Եթե ցանկանաք կապ հաստատել ինձ հետ ավելի ուշ կամ ունենաք բողոքներ և/կամ խնդիրներ հետազոտության վերաբերյալ, իմ կոնտակտային տվյալները հետևալն են. Զարուհի Առաքելյան, հեռ. (+374-55)20 41 22, էլ-փոստ <u>zaruhi_arakelyan@edu._aua._am</u>։

Կցանկանայի հավելել, որ ես ավարտելու եմ մայիս ամսին, և այդ նպատակով տրամադրում եմ Ձեզ հետազոտական թիմի անդամ՝ Սերինե Սահակյանի կոնտակտային տվյալները, ում հետ կարող եք կապ հաստատել հետագա հարցերի դեպքում. , (+374-60) 61 25 61), <u>serine_sahakyan2@edu._aua._am</u>

Եթե կցանկանաք քննարկել Ձեր իրավունքները՝ որպես հետազոտության մասնակից, դրա հետ կապված խնդիրներն ու մտահոգությունները կամ եթե կարծում եք, որ Ձեզ հետ ճիշտ չեն վարվել կամ որևէ կերպ վիրավորել են հարցազրույցի ընթացքում, Դուք կարող եք դիմել ՀԱՀ գիտական էթիկայի հանձնաժողովի համակարգող՝ Քրիստինա Հակոբյանին հետևյալ կոնտակտային տվյալներով՝ (+374 60) 61 25 61) akopyank@aua.am:

Համաձա՞յն եք մասնակցել, պատասխանեք **ԱՅՈ** կամ **ՈՉ:** Եթե ԱՅՈ, կարո՞ղ ենք սկսել:

Appendix 4: Focus Group Discussion Consent Form (English and Armenian)

American University of Armenia

School of Public Health

Institutional Review Board #1/Committee on Human Research

Consent form

Hello, I am Zaruhi Arakelyan; I am a physician and graduate student in the School of Public Health at the American University of Armenia (AUA). I am conducting a research study under the supervision of my faculty at AUA. The main aim of the study is to assess the knowledge, attitude and practice of Obstetricians, Gynecologists, General Practitioners and Emergency Services Physicians who may come in contact with women who have experienced intimate partner violence.

You are being invited to participate in this study as you are a professional who may come in contact with women who have experienced intimate partner violence. You and other health professionals are being invited to participate in this study in order to expand the understanding of

society about physicians' knowledge, attitude and practice towards intimate partner violence in Armenia. You were selected to participate in this study either based on convenience or NGO provided your contacts. Your participation involves focus group discussions.

What are the study procedures? What will I be asked to do?

The focus group of will have 3–7 participants. A focus group is where a small group of people are brought together in a private room to engage in a guided discussion on a specific topic. We will have a discussion on possible scenarios of intimate partner violence which may exist in Armenia.

Before the focus group begins, I will state that all of the information provided in the focus group is private and should not be told to anyone else or discussed outside of the group.

What are the risks or inconveniences of the study?

As the topic is sensitive the possible consequence of our discussion **might be emotional pressure: you could feel sad, down or depressed after the focus group. When we will finish the discussion I will provide you contacts, which you can use in case of emotional imbalance.**

Also, participating in this research study may be an inconvenience given the time that it takes to complete the focus group.

What are the benefits of the study?

While you may not directly benefit from this research, your participation may identify ways to help women who may have been exposed to intimate partner violence and domestic violence or who have experienced it and this may assist in their treatment. Your participation may

contribute to the improved care not only of women in Armenia but across the region as well. The role that the medical professional has in the experience of the victim of intimate partner violence is an under-researched area which needs investigation.

Will I receive payment for participation?

There is no compensation for participation.

Are there costs to participate?

There are no costs to you to participate in this study.

Can I stop being in the study and what are my rights?

Your participation in this study is completely voluntary. You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate. All you would have to do is contact me or the Research Team (as described below).

How will my personal information be protected?

I will protect the confidentiality of your data. All study data will be locked in a secure location, on a password protected computer and your name will not be attached to the data. Any master key, audio recording, and other data described in the next paragraph will be maintained in accordance with the security provisions of the next paragraph until destroyed by me.

Audio tapes from the focus group discussion will be transcribed by me and then the audio tape will be destroyed on or before May 25.

At the conclusion of this study, the findings may be published. There will be a thesis of this project held on line at the AUA website. Statements which you have made may be included in publications and in the thesis. However, in any publication and in the thesis, your name and identifying information will not be used so that your confidentiality will be protected.

With respect to the audio recording of the focus group, to you allow the focus group discussion to be recorded?

If **YES,** I will turn on the recorder when we start the focus group.

Please be aware that it is within your right to ask to turn off the recorder at any time during the focus group, whenever you want to. If **NO,** I will take notes during the focus group, as long as none of you object.

Who do I contact if I have questions about the study?

Take as much time as you like before you make a decision to participate in this study. I am ready to answer any questions you have about this study. If you want to contact me at a later date or want to voice concerns or complaints about the research, my contact information is as follows: Dr. Zaruhi Arakelyan, (+374-55)20 41 22, zaruhi_arakelyan@edu. aua. am .

Additionally, as I am a student who will be graduating in May I would like to provide you with the name of one of my faculty advisors who will be available to discuss this study with you long into the future: Serine Sahakyan, (+374-60) 61 25 61), serine_sahakyan2@edu. aua. am .

If you would like to discuss your rights as a research participant, discuss problems, concerns or if you come to believe that you have not been treated fairly during this study you may contact the

Human Subject Protection Administrator of the American University of Armenia, Dr. Kristina Akopyan -(+374 60) 61 25 61) akopyank@aua. am .

Do you agree to participate? Please say YES or NO. **If yes,** shall we start?

Հայաստանի Ամերիկյան Համալսարան

Հանրային առողջապահության բաժին

Գիտահետազոտական էթիկայի թիվ 1 հանձնաժողով

Իրազեկ համաձայնության ձև

Բարև Ձեզ, ես Առաքելյան Զարուհին եմ. ես բժիշկ եմ և համատեղ Հայաստանի Ամերկյան Համալսանի (ՀԱՀ) Հանրային Առողջապահության բաժնի ավարտական կուրսի ուսանող: Այժմ ես ֆակուլտետի հսկողության ներքո հետազոտություն եմ իրականացնում, որի հիկմնական նպատակն է գնահատել Մանկաբարձ-Գինեկոլոգների, Անհետաձգելի բուժօգնության բժիշկների և Ընտանեկան բժիշկների գիտելիքը, վերաբերմունքը և փորձը, զուգընկերոջ կողմից իրականացվող բռնության ենթարկված կանանց վերաբերյալ:

Դուք հրավիրված եք մասնակցելու այս հետազոտությանը, քանի որ Ձեր մասնագիտության բերումով հնարավոր է շփվեք զուգընկերոջ կողմից բռնության ենթարկված կանանց հետ: Դուք և այլ բուժաշխատողներ հրավիրվել եք մասնակցելու այս հետազոտությանը, քանզի Ձեր օգնությամբ ավելի կընդլայնվի հասարակության պատկերացումը զուգընկերոջ կողմից իրագործվող բռնության վերաբերյալ բժիշկների գիտելիքների, վերաբերմունքի և փորձի մասին: Դուք ընտրվել եք հետազոտությանը մասնկացելու համար հարմարության սկզբունքով կամ Ձեր տվյալները տրամադրել է Հասարական Կազմակերպությունը: Ձեր մասնակցությունը այս հետազոտությանը սահմանափակվում է ֆոկուս խմբում քննարկումով:

Ինչպիսի՞ն է հետազոտության ընթացակարգը: Ի՞նչ է ինձնից պահանջվում:

Ֆոկուս խումբը կամզված է լինելու 3–7 մասնակիցներից: Ֆոկուս խումբը մարդկանց այն խումբն է, որոնք հավաքվել են միասին առանձին սենյակում որոշակի ուղորդվող քննարկում անելու նպատակով: Մենք կքննարկենք զուգընկերոջ կողմից իրականացվող բռնության հնարավոր օրինակներ: Մինչ ֆոկուս խմբում քննարկման սկիզբը, ես կնշեմ, որ մասնակիցների կողմից տրամադրված բոլոր տեղեկությունները գաղտնի են և չեն կարող քննարկվել այլ անձանց հետ և առհասարակ այս սենյակից դուրս:

Որո՞նք են հետազոտության ռիսկերը և անհարմարություններ:

Քանի որ թեման, բավականին ծանր է, հարցազրույցի հնարավոր հետևանքներ կարող են լինեն տրամադրության անկումը, զգացմունքային ծանրաբեռնումը, ընկճախտը։ Հարցազրույցի ավարտից հետո ես Ձեզ կտրամադրեմ տվյալներ, որոնք Դուք կարող եք օգտագործել հուզական անհավարակշռության դեպքում։Հետազոտության հետ կապված այլ անհարմարություն կարող է լինել հարցազրույցի տևողությունը։

Որո՞նք են հետազոտության հետ կապված շահերը։

Չնայած որ հետազոտության արդյունքում Դուք չեք ունենա որևէ անմիջական շահ, Ձեր մասնակցությունը կարող է բացահայտել օգնության ուղիներ այն կանաց համար, ովքեր ենթարկվել են կամ կարող են ենթարկվել բռնության զուգընկերոջ կողմից, որն էլ իր հերթին կաջակցի նրանց բուժմանը։ Ձեր մասնկացության շնորհիվ կարող է բարելավվել կանանց բուժսպասարկմանը ոչ միայն Հայաստանում, այլև տարածաշրջանում։ Բուժաշխատողների դերը սահմանափակ է ուսումնասիրված զուգընկերոջ կողմից բռնության ենթարկված կանանց հարցում և կարիք ունի հետազոտությունների։

Արդյո՞ք կստանամ դրամական պարգև մասնակցության համար։

Մասնակցության համար որևէ փոխհատուցում նախատեսված չէ։

Արդո՞ք նախատեսված է որևէ վճար մասնակցության համար։

Մասնակցությունն անվճար է։

Կարո՞ղ եմ արդյոք դադարեցնել մասնակցությունը տվյալ հետազոտությանը և որոնք են իմ իրավունքները:

Ձեր մասնակցությունը այս հետազոտությանը լիովին կամավոր է: Դուք պարտավոր չեք մասնակցել հետազոտությանը, եթե չեք ցանկանում: Եթե համաձայնել եք մասնակցել հետազոտությանը, բայց հետագայում մտափոխվել եք, կարող եք ցանկացած պահի հրաժարվել մասնկացությունից առանց որևէ տուգանքների և հետևանքների: Դրա համար պարզապես անհրաժեշտ է կապ հաստատել ինձ կամ հետազոտական թիմի հետ (ինչպես նկարագրված է ստորև):

Ինչպե՞ս են իմ անձնական տվյալները պաշտպանվելու:

Ես կապահովեմ Ձեր տվյալների գաղտնիությունը: Հետազոտության ամբողջ տվյալները կպահվեն ապահով տեղում, ծածկագրով պաշտպանված համակարգչում, և Ձեր անունը չի կցվի տվյալներին: Ցանկացած ձայնագրություն և այլ տվյալներ, որոնք նկարագրված են հաջորդ պարբերությունում, կկիրառվեն անվտանգության բոլոր կանոններին համապատասխան:

Ձայնագրությունները գրավոր կերպով կարձանագրվեն իմ կողմից, այնուհետև ձայնագրությունը կոչնչացվի կ - ամ Մայիսի 25ին կամ ավելի վաղ: Հետազոտությունն ամփոփելուն պես, արդյունքները կարող են հրապարակվել: Այս հետազոտության թեզը առցանց կտեղակայվի ՀԱՀ կայքում: Ձեր կողմից արված որոշակի արտահայտություններ կարող են տեղ գտնել թեզի և հրապարակման մեջ:

Այնուամենայնիվ, որևէ հրապարակման կամ թեզի մեջ Ձեր անունը կամ նույնականացվող ցանկացած տվյալ չի օգտագործվի՝ այսպիսով պաշտպանելով Ձեր տվյալների գաղտնիությունը։

Այսպիսով, Դուք տալի՞ս եք Ձեր համաձայնությունը հարցազրույցը ձայնագրելու համար։

Եթե **ԱՅՈ,** ես կմիացնեմ ձայնագրիչը, երբ մենք սկսենք հարցազրույցը։

Ցանկանում եմ տեղեկացնել, որ Ձեր իրավունքն է հարցազրույցի ցանկացած պահի պահանջել անջատել ձայնագրիչը։

Եթե **ՈՉ,** ես գրի կառնեմ Ձեր կողմից տրամադրված տեղեկությունները, եթե Դուք դեմ չեք։

<u>Ու՞մ հետ պետք է կապ հաստատել հետազոտության մասին հարցերի դեպքում։</u>

Օգտագործեք այնքան ժամանակ, որքան հարկավոր է հետազոտության մասնակցելու որոշում կացացնելու համար։ Ես պատրաստ եմ պատասխանել հետազոտությանը վերաբերող Ձեր բոլոր հարցերին։ Եթե ցանկանաք կապ հաստատել ինձ հետ ավելի ուշ կամ ունենաք բողոքներ և/կամ խնդիրներ հետազոտության վերաբերյալ, իմ կոնտակտային տվյալները հետևալն են.

Զարուհի Առաքելյան, հեռ. (+374-55)20 41 22, էլ-փոստ <u>zaruhi_arakelyan@edu._aua._am</u>։

Կցանկանայի հավելել, որ ես ավարտելու եմ մայիս ամսին, և այդ նպատակով տրամադրում եմ Ձեզ հետազոտական թիմի անդամ՝ Սերինե Սահակյանի կոնտակտային տվյալները, ում հետ կարող եք կապ հաստատել հետագա հարցերի դեպքում. , (+374-60) 61 25 61), serine_sahakyan2@edu._aua._am

Եթե կցանկանաք քննարկել Ձեր իրավունքները՝ որպես հետազոտության մասնակից, դրա հետ կապված խնդիրներն ու մտահոգությունները կամ եթե կարծում եք, որ Ձեզ հետ ճիշտ չեն վարվել կամ որևէ կերպ վիրավորել են հարցազրույցի ընթացքում, Դուք կարող եք դիմել ՀԱՀ գիտական էթիկայի հանձնաժողովի համակարգող՝ Քրիստինա Հակոբյանին հետևյալ կոնտակտային տվյալներով ՝ (+374 60) 61 25 61), akopyank@aua.am

Համաձա՞յն եք մասնակցելու, պատասխանեք **ԱՅՈ** կամ **ՈՉ**: Եթե ԱՅՈ, կարո՞ղ ենք սկսել։