Representing Others: An Exploration of Health Visiting Practices to Address Domestic Violence and Abuse in Black and Minority Ethnic Communities

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A Thesis Submitted in Partial Fulfilment of the Requirements of the University of Brighton for the Degree of Doctor of Nursing

February 2016

The University of Brighton
Abstract
An important aspect of health visitors’ (HVs’) role and responsibility is to identify and respond to domestic violence and abuse (DVA). To date, there has been limited exploration of HVs’ practice knowledge and the nature of their professional relationships during their day-to-day practice in addressing incidents of DVA in black and minority ethnic (BME) communities.

Aim
The aim of the study was to explore the nature of HVs’ practice knowledge and professional encounters when trying to define, identify and respond to incidents of DVA in BME communities.

Design
This study adopts the interpretative lens of a postcolonial feminist theoretical perspective as the focus for analysing the nature of HVs’ knowledge and their practices in addressing issues of DVA in BME communities. Postcolonial feminist thinkers offer the conjecture that knowledge about BME women’s lives must be analysed within the intersecting racialised, gendered and political contexts of their lives. The study utilises a mixed-method approach by conducting semi-structured interviews with twenty health visitors (HV) and documentary analysis of four key professional practice guidance documents on addressing DVA.

Findings
The findings revealed the extent to which HVs’ theoretical and personal knowledge and practice in addressing DVA in BME communities are informed by the racialised, familial, gendered and political settings in which they work. The findings illuminate the complexities that are shaped by the neoliberalist approach to tackling health inequalities in the modern National Health Service (NHS). In particular, the study conceptualise the nature of HVs’ professional relationships with BME women to uncover DVA as a form of hegemonic representation. The findings offer the potential to transform the education and practice of current and future health professionals for the benefit of BME and other marginalised patients or service users.

Implication for Practice
This research recommends a practice model which seeks to prioritise emancipatory knowledge. In particular, there are recommendations on the specific context in which HVs work with BME women to uncover DVA. It is suggested that further research in this area of practice should also explore the impact of a proposed Intersectionality framework for uncovering DVA in marginalised groups. This study represents an original contribution to knowledge by increasing understanding of the ways in which HVs work to address DVA in BME communities. Although implied in the literature, the understanding of HVs’ work at the intersection of DVA, familial and political perspectives have never previously been articulated in HV literature in this way.
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Acknowledgements

I am grateful for the support and encouragement of my family, Richard, Nashton, Tescha, Hunpop, Syd and Savannah. I valued all the love, patience and laughter throughout this journey.

I would like to acknowledge the support I received from the NHS Trust where I work. Especially to Joy Coutts, Rose Regan, Hillary Hindley, Nicola Byrne and Susanne Greaves, who supported me in clinical practice and kept me grounded, and Stephanie Dawe and Catherine Webb, whose influence enabled the value of this work to be embedded in clinical practice.

Special thanks go to my supervisors, Dr Kay Aranda and Dr Huguette Comerasamy, whose support and guidance helped to maintain my enthusiasm for this work. I am grateful for your critical comments.

My gratitude to all the HVs, whose kindness, knowledge, experience and participation made this work possible. This thesis is a tribute to all the survivors of DVA and abuse and to those who stand shoulder to shoulder against injustice.
Declaration

I declare that the research contained in the thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted for a degree.

Signature

Date: 03/02/2016
1.1 Introduction

This chapter provides an introduction to the study by describing the context in which the research was developed and undertaken. It outlines the research question, aim, objectives and the background of the study in order to identify a particular perspective from which health visitors (HVs) respond to domestic violence and abuse (DVA) in black and minority (BME) communities.

The World Health Organisation (WHO) (2014) describes DVA as a global epidemic and an extreme manifestation of gender inequality at every level of society. The evidence shows that international prevalence rates for this type of violence vary considerably between cultural and ethnic groups, demonstrating a lifetime prevalence of 16.30% in East Asia compared to 65.64% in sub-Saharan central Africa. The far-reaching health and social consequences also disproportionately affect women aged between 16 and 40 years where it is the major cause of death and disabilities, with two women dying in the United Kingdom every week as a result (Department of Health, (DH) 2009a/10b; Home Office, 2012). The evidence shows that when DVA is connected to and intertwined with experiences of gender, race and politics, its nature and prevalence is significantly altered (Crenshaw, 1994; Sokoloff and Dupont, 2005; Kelly, 2011; Thiara et al, 2011; Salimbeni, 2011; Maddison, 2013; McDowell, 2013; Rehman et al, 2013).

Current understanding of DVA in intimate relationships can encompass a range of experiences that are linked to injustice and inequalities and may direct attention to some experiences more than others (Dobash and Dobash, 1998; Merry, 2003; Sokoloff et al, 2005; Dutton et al, 2009; Thiara et al, 2011 and Rehman et al, 2013). Likewise the assumptions that underpin different understanding of how power operates within intimate relationship reflect and espouse different epistemological and methodological positions, providing justification for whose experience counts, how this can be measured and what remains unproblematised (Bograd, 1999; Anderson, 2005; Choiniere et al, 2013; O’Campo et al, 2014; Cavanagh, 2012; Mackenzie et al, 2015; Scrivener et al, 2015; Wagner, 2015 and Kelly and Westmarland, 2016). The evidence shows that knowledge about the interconnectedness between DVA, race, ethnicity, gender and politics shape and are shaped by attitudes and beliefs which determine whether or how the problem is identified (Merry, 2003; Sokoloff et al, 2005; Wellock, 2008; Thiara et al, 2011;
Rehman et al, 2013). It is also argued that the pervading gendered discourse invites the understanding of DVA as rooted within patriarchal privileges, originating from white Eurocentric perspectives of male dominance with limited understanding of how women's location at the intersection of race, gender, class, sexual orientation and other systems of oppression and discrimination influence what we know about the phenomenon (West, 2005; Wellock, 2008; Ahmad et al, 2009; Collins, 2009; Rehman et al, 2013; O’Campo et al., 2014; Choiniere et al, 2014; Montesanti and Thurston, 2015), this has prompted Sokoloff and Dupont (2005, p2) to protest:

"The exclusion of women of colour in feminist leadership and scholarship has been identified as contributing to the shortage of race/ethnic minority theoretical perspectives in the domestic violence literature" (Sokoloff and Dupont, 2005, p2)

When considering how to engage in this kind of discussion, it becomes clear that how the problem is defined and measured and whether or not a particular experience is represented is determined by the contested and competing ideas of how power operates within personal relationships and political institutions (Dobash et al, 1998; Carlson, 2005; Dutton and Nicholls, 2005; Thiara et al, 2011; Winstok, 2011 and Montesanti and Thurston, 2015). Black feminist theorists have long been concerned with the hegemonic relationships between knowledge and power and how they shape the condition of BME women’s lives. Similarly, the contested field of postcolonial feminism has included the notion of representation as one of the politically charged concepts disrupting dominant ideas that obscure knowledge about the lives of BME women (Kirkham and Anderson, 2010; Ali, 2007; Hinterberger, 2007; Holmes et al, 2008; Ward et al, 2009; Filson, 2010 and Bickford, 2014) Montesanti and Thurston, 2015 and Gill, 2016). This is especially the case when one seeks to understand how knowledge about BME women’s experiences of DVA might open up opportunities to challenge this kind of male violence.

In 2005 the National Health Service (NHS) introduced the practice of healthcare professionals routinely asking women to disclose whether or not they are victims/survivors of male violence (DH, 2005; National Institute of Health and Clinical Excellence (NICE), (2014). This practice is based upon the idea that empowering health professionals to challenge this type of violence can lead to the empowerment of women and ultimately reduce health inequalities (Salmon et al,
A growing body of evidence illustrates how awareness of DVA influences health professionals’ attitudes and capacity to identify and positively respond to the issue (Salmon et al 2006; Lazenbatt et al, 2007; Wathen et al, 2009; Sprague et al, 2012; Rhodes, 2012; Trevillion et al, 2012; Miller et al, 2015; Bradbury-Jones et al, 2013; Baird et al, 2013; Bradbury-Jones et al, 2013; Feder et al, 2013 and Westmarland and Kelly, 2013). However, the nature of knowledge relating to this phenomenon is contested and very little is known about how HVs’ knowledge of the interconnectedness between DVA, race and politics influence day-to-day practice in seeking to uncover DVA within BME communities.

Health visitors are public health nurses with a professional background in nursing, midwifery or social care as well as postgraduate training to qualify as Specialist Community Practitioners in Public Health Nursing (SCPHN) according to the Nursing and Midwifery Act (NMC) 1997, the NMC Order 2001, and the Code of Professional Standards of Practice and Behaviour for Nurses and Midwives 2015. The theoretical perspectives underpinning this type of nursing adopt a multi-dimensional salutogenic approach which focuses on addressing the social as well as the biomedical complexities of ill-health. This role encompasses a wide range of skills and responsibilities and involves working with a number of statutory and non-statutory agencies and interdisciplinary Community Care teams to support individuals and families with a range of complex health and social needs in a variety of settings (Bidmead & Wittaker, 2008; DH, 2013). A substantial part of the HV’s role includes supporting families affected by DVA and addressing the social, physical and emotional wellbeing of women and their children aged 0-5 years within their homes (Thornbory, 2009; National Health Service England (NHSE), 2014-16).

It can be argued that, through their professional encounters (everyday clinical contacts) and unique access to BME women, HVs could offer insights into the Intersectionality of BME women’s experiences of DVA that might otherwise remain private. However, health professionals including HVs have been criticised for failing to identify the true nature and extent of DVA among BME women or within caseloads (Frost, 1999; Cann et al, 2001; Shipway, 2004; Featherstone and Peckover, 2003/2007; Peckover et al, 2013 Donetto et al, 2013; Appleton & Clemerson-Trew, 2008; DH, 2010a).
The context in which HVs discharge their public health duties to tackle DVA is an important one. This is due to the complexities linked to the radical NHS reforms in the neoliberalist market-style economy against the growing demand for services from an increasingly diverse UK population (The Nuffield Trust, 2010; DH, 2010a; DH, 2013 and Ham et al, 2015). For instance, according to the Office of National Statistics (ONS) (2015) report, over 82% of the UK population of 64.25 million are white British but BY 2050 a projected 30% of the population will be from BME communities. However, the extent to which an HV might come into contact with BME women depends upon the rural or urban location of their work. As a case in point, a review of a health visiting service in urban England reported that, of the 950,000 service users, up to 50% were from BME communities, with over 1 in 10 of the population receiving intensive health visiting interventions (Ealing Hospital NHS Trust, 2012). Thereby underscoring the context in which HVs work with BME women in public health settings.

1.2 Origins of the Study

Within the context of my work, the experience of DVA is seen as a predominant contributory factor to health inequalities, social isolation, economic destitution, child abuse and the deaths of children and adults in safeguarding cases (DH, 2009b; Home Office, 2011; NICE, 2014; NHSE, 2014; LSCB, 2015). The local annual caseload profiling in my area of practice in 2009-14 and evidence from the DH (2005) and London Safeguarding Children’s Board (LSCB) (2014) suggest that DVA concerns make up more than 80% of HVs’ vulnerable persons caseloads, yet fewer than 1% of high-risk DVA cases were uncovered by professionals and even fewer BME families were identified. Similarly, findings from Serious Case Reviews (SCR) Brandon et al, (2012) and the Domestic Homicide Review (DHR) (Home Office, 2009) highlighted the consistent failure of statutory agencies to prevent death and significant harm to women who have reported DVA. Furthermore, an initial practice audit undertaken at the onset of this study also indicated that many of the successful outcomes in addressing DVA rested upon the delicately balanced relationships between practitioners and the BME women they support, and the BME women’s positions within the home, families and even the wider communities.

Knowledge gleaned from health visiting colleagues as well as from my own case files suggests that the ubiquitous nature of the problem and the gendered context in which this phenomenon occurs are not always straightforward. Rather, the
overlapping and interconnected issues of genders, ethnicity, class, (dis)ability, religion, immigration status, and political and economic circumstances appear to determine whether or not DVA is uncovered and addressed. Equally, HVs’ decisions to ask BME women to disclose, and the context in which DVA is identified, are shaped by a range of experiential, personal and professional knowledge as well as organisational culture and political discourses. I observed tensions between familial and organisational politics, for instance, there is a growing body of evidence linking the interconnectedness between BME women’s positions within the family and where and how they disclose DVA (Crenshaw, 1994; Bograd, 1999; Sokoloff and DuPont, 2005; Yuval-Davis, 2006; Conwill, 2010 Siddiqui and Patel 2010; Thiara et al, 2011; Rehman et al, 2013; Hankivsky et al, 2014 and Gill et al, 2016) Yet, contemporary analysis and reviews of HV services rarely acknowledge or include these concerns as integral parts of health assessments or services to address DVA (Jones, 2001; Roberts, 2010; CPHVA, 2010; Elkan, 2012 and NHSE, 2015). Instead, a particular gendered perspective suggests that women are willing to disclose DVA when routinely or selectively asked to do so. Furthermore, this tension was also observed in the relationships between BME women and professionals as they struggled to support the women to leave violent relationships.

Postcolonial feminist doctrine on representation has influenced my own views on the issues of DVA, partly because of the significance of feminists’ work in exposing the intersectionality of the problem, impelling service delivery, and the shaping of the particular way in which a gendered understanding of the problem has developed. I am particularly drawn towards black feminists theorising on the issue, which acknowledge the intersectionality of personal and structural violence and how attention to issues such as ethnicity, race, class, religion (dis)ability and sexuality can identify gaps in knowledge and service provision. In relation to this, a critical approach to knowledge production is adopted in order to reflect the postcolonial feminists theoretical position which asserts that knowledge production in the Western world constitutes a form of hegemonic practice which homogenises women’s experiences and regulates, reinforces and reproduces social differences (Mohanty, 1988; Spivak, 1988; Ang, 1995; Gandhi, 1998; Collins, 2000 and Lewis and Mills et al, 2003). Therefore, it is from these perspectives that this study examines how knowledge about BME women’s experiences are represented, applied and contested within professional relationships between HVs and BME
women to address the issue of DVA. It is also the context in which I now seek to develop an understanding of this issue.

The terms ‘postcolonial feminism’ and ‘black feminism’ are used interchangeably within this thesis and refer to the ideological and political activism underpinning this research.

The term ‘BME’ refers to black or any other minority ethnic women of African, Asian, Caribbean or any other dual (postcolonial) heritage where one parent is from another racial background and it reflects the ways in which women are identified socially, politically and geographically within this thesis.

1.3 Aim and Purpose

This study applies a mixed-methods approach incorporating qualitative data from semi-structured interviews with 20 HVs and documentary analysis of four key professional practice guidance documents to examine the micro-practices (everyday occurrences) of HVs’ work to address DVA. The central research question asked: In what ways do HVs understand DVA within BME communities?

The study examines the nature of HVs’ practice knowledge and practice encounters with BME women by focusing on their nature of professional relationships during their clinical contacts in attempts to uncover DVA. In so doing, the investigation seeks to fulfil the following objectives:

- What constitutes knowledge of DVA generated during professional contacts in BME communities?
- What roles, if any, do race, politics, and gender play during day-to-day professional encounters in attempts to uncover DVA?
- How does this knowledge shape professional relationships and influence the nature of HVs’ contacts when asking BME women to disclose domestic violence incidents?
1.4 Thesis Outline

This thesis is organised into three main parts and comprises of six chapters. Part One consist of chapters One, Two and Three provides a short introduction outlining the origins, aim and purpose of the study. It also contains a review of the literature focusing on postcolonial feminist perspectives as these relate to the study and a conceptualisation of HV's practice and its relationship to their work to define, identify and respond to DVA. The key concepts introduced in Part One also provide the context for examining the HV knowledge base and practice experiences described in Part Three of this study.

Chapter Four constitutes Part Two and details of the theoretical and methodological perspectives and the study’s design. It describes and critiques the process undertaken and introduces the empirical work with HVs as well as the documentary data on key policies, which also form part of the data collection process. The data are described, analysed and interpreted.

Part Three; Comprising Chapters, Five and Six is the heart of the study and is where the empirical data is analysed and presented. The significance of the work is discussed using key insights from the findings to make recommendations for practice, future research and practice development. A reflective stance is adopted and threaded throughout the thesis.
POSTCOLONIAL FEMINIST PERSPECTIVES

2.1 Introduction

This Chapter provides a discussion on postcolonial feminist theory as a justification for examining HVs’ practices in addressing DVA in BME communities. Within the context of this study, postcolonial feminist theory contributes to the analytic framework for understanding the nature of professional relationships and professional encounters as well as the context of the knowledge base underpinning HV work. The emancipatory objectives of this study are to challenge the homogeneity of women’s experience and to prioritise the representation of BME women (Lorde, 1983; Mohanty, 1988; Ang, 1995; Rich, 1984; Loomba, 2005; Collins, 2000).

2.2 Postcolonial Theory

“A political praxis which counters and resists the totalising imperative age-old “legitimate” and scientist bodies of knowledge” (Mohanty, 1998, 334).

Postcolonial feminism is an overtly political discourse that takes a critical stance on injustice and marginalised groups (Lewis and Mills, 2003). One of the central arguments in postcolonial intellectual debate is that knowledge production in the Western world shapes the nature of unequal relationships within society and operates as a form of contemporary imperialism/colonialism and cultural hegemony (Lorde, 1983; Mohanty, 1988; Sandoval, 1991; Spivak, 1993; Weedon, 2003; Collins, 2004). Postcolonial feminist origins and orthodoxies are fragmented and complex and the concept did not develop in a unified way. However, postcolonial feminism has applied the doctrine of representation to intellectual debates and research on race, class, gender and culture in order to examine the legacy of colonialism, patriarchy and imperialism and to resist ideologies and power stemming from Western hegemony (Said, 1978; Chrisman, 1990; Hall, 1990; Ferguson, 1998; Gandhi, 1998; Loomba, 2005).

One of the most notable contributions to colonial discourse has been by Spivak (1988) in her post-structuralist critique of colonialism, contemporary imperialism and Western philosophical dominance. In particular Spivak’s (1998) subaltern studies represent the embodiment of Gramsci’s (1971) cultural hegemony, which articulates a relationship of intellectual and political dominance within social groups, and Foucault’s (1989) notion of discursive formation, which offers a
specific understanding of the alliance between power and knowledge. It could therefore be argued that the epistemological exclusion of knowledge about race, gender and politics within dominant discourses such as medicine, psychology and sociology ultimately reproduce dominant ideas within particular discourse. The Subaltern (social groups at the margin of society) is used to challenge Western philosophical dominance and draw attention to the vexed relationship between the knower (researcher) and the unknown subaltern in history. Spivak (1988) questioned the extent to which investigators can touch (e.g. represent) the consciousness of the subject (women) as we investigate the political differences between women. It is this challenge, which lies at the heart of post postcolonial feminist research.

Although neither Gramsci nor Foucault addressed the issue of colonialism directly, both provided explicitly descriptions of the association between Western realities, economic domination and power. In particular, Gramsci’s ideas of ideological and cultural dominance illustrate that the formation of power takes place at superstructural levels within civil society (private) and political society (state) through spontaneous consent and coercive power. Gramsci argues that:

"These two levels correspond to the function of 'hegemony' which the dominant group exercises throughout society and on the other hand to that of 'direct domination' or command exercised through the state and 'juridical' government " (Gramsci, 1973, 12).

Similarly, Foucault’s (1989) extensive analysis of the relationship between knowledge and power proposed that knowledge is never innocent. Instead, the episteme is governed by a set of discursive rules which operate beyond conscious levels of individual subjects. Earlier, Foucault (1972) cogently argues that knowledge transforms power when lines of legitimacy become established and are invoked by practitioners as a way of legitimising their own authority. At the same time, Spivak (1988) applied Gramsci’s essence of political and ideological dominance of the dominant groups and questioned the relationship between Western and non-Western subjects. Alongside this, Foucault’s (1989) discursive formation is applied to colonial discourse (Said 1993) in order to provide a unique perspective of colonialism. Said (1993) vehemently argues that both colonialism and imperialism are supported by impressive ideological formations which include notions that hegemonic power is socially reproduced and held together within ideological dominance and perpetuated by the unholy alliance between knowledge
and power. To resist the dominance in colonialism and imperialism Spivak argues that:

"In seeking to learn to speak to (rather than to listen to or speak for) the historically muted subject of the subaltern woman, the postcolonial intellectual systematically unlearns female privileges" (Spivak, 1988, 91).

Therefore, this systematic unlearning might also include finding a voice for the marginalised within colonial and within feminist discourse. Foucault’s (1989) discursive and paradigmatic account of power and knowledge has been likened to the colonial conditions that see the continuity of power and knowledge transforming each other and forming a monolithic apparatus accumulated within the state into a web-like force which is legitimised, articulated and reproduced in discursive networks. These positions set out the continuity between post-structuralism and colonial discourse and articulate the epistemic juncture from which knowledge about the Western world is applied and contested within a feminist and colonial critical stance. The ideology of representation is thus problematic, presenting methodological and conceptual difficulties while raising questions about who can and should represent whom in research.

These orthodoxies draw upon their neo-Marxist heritage to critique the validity of Western epistemology by rejecting the binary oppositions upon which patriarchy and colonial authority are constructed and prioritising the matrix of oppressions within/between gender, race, politics and the economic structures that separate women’s concerns (Collins, 2004; Crenshaw, 1995; Sokoloff and Pratt, 2013). Alongside this, postcolonial feminist theorists have vehemently argued that the blinkered focus of racial politics and anti-colonial nationalism merely deflect the internal orthodoxies of injustice and have unwittingly contributed to the double colonisation of women in colonial and feminist theories (Suleri, 1992; Ghandi, 1998). For instance, it is argued that attention to patriarchy in the understandings of DVA has avoided issues of racism and religious and cultural fundamentalism, which frustrate black women’s goal of gender equality (Sahal and Yuval-Davis, 1994).

2.2.1 Racialising Feminism; Prioritising Gender

The overarching emancipatory objective of postcolonial feminist orthodoxies is to address shades of oppression by racialising mainstream feminist concerns, whilst at the same time reconceptualising gender within colonialism and colonial discourse (Rich, 1984; Lorde, 1983; Mohanty, 1988; Sandoval, 1991; Weedon,
The notions of *representation* and *resistance* are key ideological concepts embedded within postcolonial feminism that permit particular ways of understanding the multiple subjective realities that shape the nature of social relationships and knowledge production in the Western world (Gramsci, 1971; Spivak, 1988; Mohanty, 1988; Said, 1987; Sandoval, 1991). However, there is now a focus on magnifying the fluidity of differences to examine how each (e.g. race and gender) transforms and intersects with the other to produce and reproduce inequalities between women.

The symbiotic relationship between political *representation* and *resistance* is acknowledged as fundamental to postcolonial feminist emancipatory objectives and the repudiation of Western epistemology. These concepts, although problematic, have been applied to both interrupt and be disrupted by epistemological and social dominance in the Western world. For instance, Mohanty (1988) appropriated the term third-world feminism to draw attention to the nature of relationships between women. This has included paying attention to the hegemonic nature of social relationships and developing a perspective centred on the understanding of similarities (consensus) and differences (*representation*) to emphasise the ubiquitous nature of power that shapes relationships within institutions and social life. In her seminal work, *Under Western Eyes*, Mohanty questioned the notion of binarism to illustrate how political, scientific, literary, linguistic and cinematic *representation* of non-Western women ignored historical, racial, class, sexuality, and economic differences. In her critique of Western epistemology, Mohanty contended that the homogeneity of women’s concerns has:

“Resulted in the assumption of women as an always – already situated group, one which has been labelled powerless, exploited and sexually harassed.” (Mohanty, 1988, 53).

These ideological perspectives are echoed across early postcolonial thinkers and have emphasised internal divisions within the feminists struggle for gender equality. In response Ang (1995) and Haggis (1998) have applied the *politics of difference* to remind all feminists of our political indebtedness to early feminism, arguing that although early beneficiaries of gender equality focused on the needs of white middle-class women; the legacies has shifted the agenda from a political *sisterhood* towards the multiple subjective realities that shape different women’s lives and a focus on the category of *women* as the subject of analysis within feminism. This focus hinges on the notion that not all women are oppressed in the
same way and it challenges the very idea that all black women, who share a similar ancestry, experience oppression in the same way. Thus, the term ‘postcolonial feminism’, as it relates to this research, implies a relationship of structural domination and a discursive or political suppression of knowledge about the lives of BME women (Mohanty, 1988).

These orthodoxies have remained a site of contestation with the arguments that inherent differences within feminists and colonial discourse have destabilised the potential unity against injustice and fractured its emancipatory objectives, as discussed in an impassioned way by (Lorde, 1983; Rich, 1984, Mohanty 1989 and Ang, 1995). Mohanty (1988) for example insists that the ethnocentric, myopic disregard displayed by colonialism and feminism have elided significant material and historical differences which have shaped black women as the real Other and reinforced the unequal nature of social relationships within contemporary imperialist societies. She asserts the need to focus on contemporary imperialism as a means of recuperating the voices of marginalised groups. For instance, our attention is drawn to how the assessment and service response to women with postnatal depression is based upon the white European experiences of mental illness despite critical evidence demonstrating its ineffectiveness for BME women (Harris, 1993; Cooper et al, 1999; Oates, 2003 Siddique et al, 2005; Edge, 2007/11).

The work of Antonio Gramsci (1971) and his notion of cultural hegemony has been highly influential in shaping postcolonial discourse and postcolonial feminists thinking on the nature of social relationships within culture/institutions. The basic premise of Gramsci’s hegemony focuses on how the unequal distribution of power within contemporary society is reflected and reproduced in different discourses and different intellectual traditions and institutions. By applying Marxist theory to cultural hegemony, Gramsci (1973) theorises that the pervasive nature of cultural imperialism is achieved not by force but by manipulation of the value systems by the ruling classes to ensure that their views become world views. These observations have shaped colonial discourse on postcolonial identities and contemporary relationships within post-modern societies. This hegemonic relationship is also visible in the work of one of the early founders of colonial discourse (Fanon, 1986). Fanon was a psychiatrist and philosopher whose work drew attention to what he called the ideological essence of colonialism and the legacy of the social identity (Fanon, 1986). In his most notable work, Black Skin,
White Masks, Fanon applied his experiences of psychoanalytic theory to the **colonised subject** to illustrate the psychological and material impact of colonialism/imperialism on black immigrants’ identities in France. Fanon proposed that ideological dominance was maintained in postcolonial France not by force but by non-Western subjects being unwittingly coerced into assimilating Western ideals/identities which they adopted as a means of survival. Later, Hall's (1990) attention to the colonial aftermath of cultural identities also implicated the role of the media and literature in propagating and re-presenting subjugated knowledge about colonial identities. However, Hall posited the idea of immigrants actively participating in shaping their postcolonial identities and dismissed the notion of the **innocent bystanders** implied in Fanon’s idealisation.

This is a position which implies that postcolonial identities (colonised and coloniser) are shaped and reshaped by the historical legacies of both the colonised and the coloniser. At the same time, the notion of representation is problematised in Hall’s Gramascian stance on contemporary identities as fluid, changing, interrupted by history and being constantly reshaped against a common historical experience of colonialism. Hall’s (1990) cultural diaspora summarises postcolonial identities as;

> “one shared culture, sort of collective one true self, hiding inside the many other, more superficial or artificially imposed selves, which people with shared history and ancestry hold in common” (Hall, 1990, 298).

Hall (1990) proposes that the plural nature of this cultural alterity is critical to postcolonial struggles because the oneness underlying the more superficial differences ought to remain a powerful frame of reference from which to represent marginalised groups. Both Fanon and Hall have been instrumental in elucidating some of the diasporic context of colonial and postcolonial identities that shapes current understanding of social relationships and, in particular, how social identities are shaped by history, culture, and interactions with each other and the way society influences how we think, act, and feel. Conversely, this also draws attention to some of the complexities linked to the politics of **representation**, particularly in relation to women’s concerns. It also opens up the troublesome question within black feminism of who should therefore represent whom?

The notion of **representation** is a contested terrain in postcolonial feminism and postcolonial feminist reasoning, not least because of the epistemological concerns
about who should represent whom and with what authority? Spivak (1988), in her work on hegemonic *representation*, drew attention to the silence of third-world women (the subaltern) and the moral responsibilities of those who speak on their behalf or represent them. Mohanty (1998) similarly discerns the *representation* of marginalised groups of women by discursively inscribing the term ‘colonialism’ as a relation of structural domination and suppression of the heterogeneity of the women in question. Whilst Mohanty emphatically embraces the emancipatory objective of Western feminism, she rejects the notion of essentialising the idea of the oppressed woman by arguing that;

"the homogeneity of women as a group is not on the basis of biological essentials, but rather on the basis of secondary and sociological and anthropological differences" (Mohanty, 1988, 53).

Mohanty’s views on the political *representation* of women’s concerns call for an open alliance with Western feminism by arguing for a strategic coalition which acknowledges the diverse analytic categories of women’s political, social and racial location (Mohanty, 1988). In addressing the internal orthodoxies of regressive politics, Collins (2000) also warns that black women’s silence emanate from black men’s portrayal and reinforcing the ideas of the *strong black woman*. It is an enduring image which ultimately limits understandings of black women’s vulnerabilities and susceptibility to the multiple jeopardies such as racism, gender, class discrimination, and nationalism. Therefore, the analytic challenge within this framework seeks to focus on the similarities of the oppression regardless of and including the personal, structural and historical differences between BME women.

2.3 Representing BME Women

Some feminists warn about superimposing the homogeneity of BME women’s representation as a powerless situated oppressed group (Mohanty, 1998; Collins, 2000; Hinterberger, 2007). However Anthias and Yuval-Davis (1996) postulate it is difficult to escape the modes of exclusion, inferiorisation, subordination, and exploitation that characterise the political location of different social groups. For instance, a HVs’ work at the intersectionality of poverty, politics and abuse means that it is difficult for them to escape the political binaries of socially excluded groups. Evidence on the political locations of BME women’s lives suggest that BME women experience disproportionate ill-health (including mental illnesses) social inequalities, poverty, unemployment and often, experiences of institutional
racism including access to social justice (Belur 2008; DH, 2010; Thiara et al, 2011; Allen, 2012; Singh et al, 2013; NHS England, 2013 WHO, 2014; Centre for Mental Health, 2013). For example a study commissioned by Bradford District Council (2009) illustrates how infant mortality in England and Wales for mothers born from Pakistan is double the national average with the prevalence of suicide amongst Asian women twice as likely when compared to white British women. Conversely within UK politics BME women account for 1.5% of the Members of Parliament with a population representation of over 15% with less than 0.01% black females prior to 2010 election.

In the UK research has shown that BME women consistently face institutional discrimination including racism when accessing services for DVA Women’s Aid Federation Northern Ireland, (WAFNI) 2007; Siddiqui and Patel, 2010; Thiara et al, 2011 and Rehman et al, 2013) the aforementioned studies illustrates how local and national discriminatory policies and practices within statutory agencies often exclude the experiences of BME victims/survivors from service provisions. For instance the study by Siddiqui and Patel in 2010 illustrates how the systematic failure of statutory services to address the specific cultural context in which some South Asian women experience DVA often unwittingly include the perpetrators in the care-planning of the women they abuse.

Proponents of social justice argues that the failure of institutions to avoid political binaries and to recognise the multiple dimensions of social identities continues to reproduce ethnic inequalities and institutional racism (Anthias and Yuval-Davis, 1992; Macpherson, 1999; Ray et al, 1999; Phillips, 2011). In addressing BME women’s political location, Anthias and Yuval Davis (1992) agonised the failure of Western feminism in assuming an essential position of interest between man and women and ultimately failing to recognise the ethnic minority women as a category for analysis. However attention to the politics of representation unavoidable draw attention to the binaries of BME women’s political location. For example, a report from the UK Ministry of Justice (2013) identified that BME prisoners (male and female) make up 15% of the prison population compared to 2.2% of the general population. On the other hand the UK Guardian newspaper questioned whether the NHS is institutionally racist, by citing how BME worker make up 45% of the NHS workforce but only 5% were at trust board levels and 2.5% chief executive level (Guardian august 2012). Therefore illustrating how substantive representation within institutions might not necessarily guarantee equality or even
social justice. Nevertheless the notion of political representation underscores the wider political debate about BME women’s political location whilst problematising methodological approach to understanding systems of oppression. It is for these reasons black feminists argue that black and marginalised groups should fully participate in the construction and reconstruction of oppositional knowledge and the politics of empowerment as part of the process of representation; thus enabling BME women to find collective expression and to influence the substantial and ideological representation of self and community.

As a black feminist and a researcher I am now faced with the realities of making decisions about whose experiences should be privileged and whose should be problematised. However making such decisions I am drawn towards Ang’s (1995) postulation on the politics of inclusion. Recognising the limitations of the politics of inclusion, Ang (1995) suggests:

“Rather than adopting a politics of inclusion which is always based on a notion of commonalities and community, researchers might need to develop self-conscious politics of partiality, a limited political home which does not absorb difference but within a pre-given and predefined space but leave room for ambivalence and ambiguity” (Ang, 1995, 191)

Black feminist nurses argue that that the critical analytic lens of postcolonial theory can help to reconstruct and represent knowledge about marginalised groups by avoiding the rigid roadmaps within methodological paradigms by deploying conceptual roadmaps to reproduce knowledge that recognise specific situations (Holmes et al, and Bickford, 2014).
Chapter 3: BLACK FEMINIST THEMES AND PERSPECTIVES

3.1 Introduction

In order to fulfil the central objectives of this research, a review of the literature was undertaken to examine key DVA themes and perspectives. The analysis focused on the way in which DVA is defined and contested within organisational culture and dominant discourses by applying the lens of postcolonial feminism. To achieve this, the review is conducted and presented in two parts. Part one reviews the intersectional and contemporary context of black feminist theories and activism and their contribution to the current understanding of DVA. Part two examines the health perspectives with a particular focus on the work of HVs in responding to DVA. The types of literature informing this review comprise empirical research papers, expert opinions and service evaluations. A comprehensive account of the processes of the literature review is located in chapter three.

3.2 The Power and the Problem with Naming

The central ideas in the current UK Government’s definition of DVA illustrates how the exercise of power through coercive and controlling behaviour by the perpetrator as well as the exercise of choice (agency) by the victim/survivor is propagated and resisted within intimate relationships. The UK Government’s defines DVA as:

“any incident or pattern of incidents of controlling or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional” (Home Office, 2013c, 13).

The expanded footnote describes controlling behaviour within the context of DVA as a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to punish, or frighten their victims” (Home Office, 2013c, 13).

Paradoxically, the aforementioned definition is also the context of consciousness-raising exercises within organisational VAWG policies, methodologies and services to promote ideas about the roots of women’s personal oppression and understanding of violence in their personal relationships (Gill, 2011; Home Office, 2011/2012/2015). However, the binaries and complexities of power dynamics within intimate relationships remain contested within different theoretical domains (Dobash and Dobash, 1998; Bograd, 1999; Snowball and Weatherburn, 2001; Browning, 2002; Chancer, 2004; Dutton et al, 2009; Filson et al, 2010; Kelly, 2011; Dempsey & Day, 2011; Cavanagh, 2012; White et al, 2013; Lawson, 2012; Kelly et al, 2013; Montesanti and Thurston, 2015; Gill et al, 2016). For instance, feminist ideas on power exemplify a typology of patriarchal privileges, fuelled by social and cultural arrangements whereby men as a group dominate women as a group within intimate relationships (Kelly, 1989; Mays, 2006; Merry, 2009; Scriver et al, 2015). Feminists argue that, ultimately, violence is a critical aspect of maintaining power within intimate relationships. They contend that when a perpetrator is violent, he gains power; thus, violence is used to gain and maintain power within the relationship. They therefore view the individual’s experiences of personal and social power and control within personal relationships as an aspect of patriarchal privileges.

Similarly, this perspective also carefully avoids the context in which this kind of violence disproportionately affects women (WHO, 2013; United Nations (UN), 2013; British Crime Survey, 2012/13; Peckover, 2013; Home Office, 2015/16). In addition, the focus on a gender-neutral position appears to contradict the UK government’s own position, which focuses on asking women to disclose incidents of DVA within healthcare settings (Home Office, 2012). The context in which this occurs also places responsibility on women to disclose male violence against them. Furthermore, Kelly and Westmarland (2016) argue that removing the explicit reference to ethnicities from the current understandings downplays the familial and racialised context in which some BME women experience extreme forms of violence.

Historically, patriarchal views of gender violence in heterosexual relationships influence the construct of DVA within the Western world. However, the acts
embedded within the aforementioned United Kingdom (UK) government’s definition are underpinned by a number of methodological and conceptual contestations on how gender-neutral power operates within intimate relationships through controlling and coercive behaviours (Dobash and Dobash, 1998; Bograd, 1999; Snowball and Weatherburn, 2001; Browning, 2002; Dutton et al, 2009; Chancer, 2004; Filson et al, 2010; Kelly, 2011; Dempsey & Day, 2011; Cavanagh, 2012; White et al, 2013; Lawson, 2012; Kelly et al, 2013; Montesanti and Thurston, 2015; Gill et al, 2016). It is argued that this gender-neutral position reflects the growing understandings of men as victims and women as perpetrators of violence in all kinds of intimate relationships (Anderson, 2005; Dutton et al, 2009; Straus, 2008; Cavanaugh, 2012; Weldon & Gilchrist, 2012; Cannon et al, 2015). However, proponents argue that the context which prioritises controlling and coercive behaviour ultimately undermines the role of force and physical violence and risks downplaying how emotional and psychological abuse differ and overlap (Kelly and Westmarland, 2014; Campbell and Mannell, 2016 and Gill et al, 2016).

It is from these perspectives that all feminists conceptualise violence in terms of a continuum of personal safety and the victimisation experience to include physical and psychological harm. Critics, however, argue that such a broad and encompassing definition creates specific difficulty in measuring the prevalence of DVA (Zahn et al, 2004). In contrast, some theorists argue that the use of the term *abuse* limits the understanding of the psychological damage that is often associated with *physical* force, such as stalking, rape and sexual assault. The enduring work of Kelly and Radford (1998) and Thiara and Gill (2012) contends that the understanding of *physical* harm cannot be separated from *psychological* experiences and the context in which this form of violation takes place. Kelly and Radford (1989) reasoned that since the perpetrator’s intention is to cause fear, *psychological* is rarely separate from *physical* harm (Kelly et al, 1996; Brownstein et al, 2004; Renzetti, 2004). Based on this understanding, I have also taken the decision to adopt the use of the term ‘DVA’ rather than ‘intimate partner violence’ in this thesis.

A growing body of research continues to challenge gender as the primary predictor of acts of violence and control within intimate relationships but acknowledges that the impact, meaning and intentions may differ by gender. Increasingly, acknowledgement of heterosexual, gay, lesbian and transgender people engaging
in reciprocal violence as well as instigating violence in intimate relationships has highlighted the limitations of the patriarchal construct, which perpetually frames women as victims, disempowered and lacking in agency (Anderson, 2005; Dutton & Nicholls, 2005, 2008; Dutton et al, 2009; Straus, 2008; Cavanaugh, 2012; Weldon & Gilchrist, 2012; Firmin, 2012; King, 2012; Wood, 2015). Arguably, this also raises questions about the notion of domestic violence risk assessment and service responses that have invested in the notion of women as victims and men as perpetrators.

Psychological perspectives contest the idea that a socially reinforced sense of male privilege alone does not adequately explain why a perpetrator (abuser) strives for power in the context of their personal relationships or where this impulse originates. For example, Websdale (2010) and Wagener (2015) question the idea that all men experience social access to social power in the same way. Drawing upon empirical evidence, Eckhardt and Dye (2000) and Dutton et al, (2003/2006) argue that, overwhelmingly, perpetrators of violence have a sense of powerlessness, with low self-image, anger and anxiety compared to non-abusers. They point instead to exposure to childhood shaming, childhood family violence and psychological deficiencies as an adult resulting in their need to gain and maintain power in personal relationships in order to validate a sense of identity and self-worth. This viewpoint avoids some of the contentions represented by feminist ideas on power in personal relationships, propagating, instead, a gender-neutral, mutual and/or family conflict view of DVA. Psychological ideas on DVA regard women as capable of dominance and violence within intimate relationships and men as capable of being victims (Dutton and Corvo, 2005; Dutton and Nichols, 2005; Filson et al, 2010; Cavanaugh, 2012; O’Campo et al, 2014; Bagwell-Gray et al, 2015). However, feminists point to the empirical evidence which shows that, overwhelmingly, women who perpetrate violence against men do so as part of the victimisation response to abuse from men (Kelly and Radford, 1998; Zahn et al, 2004; WAFNI, 2007; Home Office, 2014 and Scriver et al, 2013).

The current DVA definition is imbued with ideas of controlling and coercive behaviours such as emotional, verbal and physical violence, encapsulating a particular interpersonal experience of violence that is also connected to particular cultural and familial contexts. However, neither feminist ideas on patriarchy nor psychological perspectives of power in personal relationships appear to adequately define or explain how violence in the wider social structures of society
reinforce, propagate or reproduce violence in personal relationships. As a case in point, Campbell and Mannell (2015) argue that the current definition of DVA reinforces the homogeneity of women’s experiences of DVA by assuming that power and agency in abusive relationships operate in the same way across race, class, culture and familial contexts. They assert that a gender-neutral definition that seeks to conceptualise the binaries of power and agency is unhelpful. Suggesting instead that ideas of power and agency are a socially constructed part of intimate relationships, enacted, understood and acted on differently by different people in different cultures. From this perspective, the research by Campbell and Mannell (2015) supports a growing body of evidence which shows the multiple ways in which some BME women choose to challenge male violence without either reporting or leaving a violent relationship (Sokoloff et al, 2005; Ahmad et al, 2009; Belur, 2008; Cross-Sudworth, 2009; Wellock, 2007/10; Siddiqui and Patel, 2010; Allen, 2012; O’Campo et al, 2014; Gill et al, 2016). Hence, the same evidence is used for agency by some women and victimhood by others. Ultimately, the practice of routinely and selectively asking all women to leave violent relationships could potentially exclude or downplay the resistance strategies used by some women while prioritising others.

Research shows that the understanding of how violence in personal relationships shapes and is shaped by experiences of racism, gender and politics in the lives of victims/survivors and perpetrators is under-represented within dominant discourses on DVA (Kanuha, 1990; Crenshaw, 1994; Collins, 2000; Merry, 2003; Weedon, 2003; Sokoloff and Pratt, 2005; Wellock, 2007; Thiara et al, 2011; Roach and Momoh, 2011; Campbell and Mannell, 2015). Thus, black feminists argue that the narrow historical context in which knowledge about DVA was developed has obscured the intersectionality of women’s experience of the issue. These are important methodological and conceptual considerations because of their potential to determine how the issue is defined, named and measured, i.e. what counts as DVA in clinical practice. More importantly, these understandings directly influence how services for DVA are commissioned and accessed by BME women.

The UK government argues that the current definition of DVA is aimed at challenging the wider social tolerance of the continuum of violence in different kinds of intimate relationships (Home Office 2016). However, critics argue that the current conceptualisation of DVA power and control as the motivation for this type of violence in personal relationships obfuscates the gendered context of power.
and agency whilst avoiding the interconnectedness and continuum between violence in personal relationships and structural violence (Campbell and Mannell, 2015; Gill et al, 2016). Furthermore, postcolonial feminists’ ideas on DVA contend that neither violence nor power within personal relationships is a monolithic phenomenon. Therefore, the meaning and consequences must represent the intersecting of systems of power, e.g. racism, class stratification, gender inequalities and heterosexual bias, which shape and reproduce violence in personal relationships (Nixon, 2009; Thiara et al, 2011; Sokoloff et al, 2013; Montesanti and Thurston, 2015). Postcolonial feminists argue instead for an understanding where no particular dimensions of gender inequalities are privileged within interpersonal violence. Thus, access to justice, shelter, employment and safety are prioritised along the continuum of women’s experiences of personal and structural violence. Paying attention to the intersectionality of women’s lives in this way illustrates the kinds of power hierarchy that exist between women within personal relationships and within societies. For instance, postcolonial ideas on power in personal relationships argue that not all women have the same access to power within their social relationships; thus, the agency and empowerment in violent relationships do not operate in the same way (Sokoloff et al, 2013; Thiara et al, 2011; Rehman et al, 2013; Campbell and Mannell, 2015).

Colonial discourse on violence maintains that dominance in personal relationships is influenced and reproduced by the legacies of colonialism, which propagates and maintains social identities, regulates social inequalities between and amongst genders, and reproduces and enforces violence in personal relationships through the exercise of invisible powers, contemporary imperialism, language discourse and knowledge within social and political institutions (Ashcroft et al, 2002; Merry, 2003; Parsons, 2007; 2010; Pederson et al, 2013; Maddison, 2013; Taylor, 2013; Montesanti, 2015; Gill et al, 2016). In relation to this, Postcolonial ideas on power illustrate the context in which power in personal relationships is connected to invisible powers in social institutions. These perspectives draw attention to how specific State interventions which vicariously discriminate against women’s entitlement to safety based on their nationalities unwittingly enable perpetrators’ actions through discriminatory laws against women, as evidenced by the experiences of BME women, lesbians of colour and refugee women (Thiara and Gill, 2010; Rehman et al, 2013; Donavan and Hester, 2014; Gill et al, 2016). These studies show how the practice of nationalism perpetuates violence against some BME women with unclear immigration status by forcing them to seek help
from their abusers. However, it is argued that paying attention to power in intimate relationships in this way does not adequately explain the motivation for power within intimate relationships. Furthermore, its critics argue that at an ideological level, this perspective detracts from the powerful evidence that women overwhelmingly and disproportionately experience DVA when compared to men, regardless of ethnicity or economic status (Mckie, 2002; Home Office, 2012; WHO, 2014; Mackenzie et al, 2015 and Kelly and Westmarland, 2016).

3.3 Naming the Problem

Patel and Siddiqui (2010) acknowledges the common struggle against structural violence but posit that this argument threatens to overshadow gender inequality. They argue that violence against BME women within the family cannot be attributed solely to structural violence. Rather, it is part of the wider systems of connection of power and control of women. This implies that the practices of FGM and violence are connected to honour and shame as part of the wider system of patriarchy that is held together through religious and cultural doctrines.

Conversely Horsburgh (1995) and West (2000) emphasised the need to problematise ethnocentric theories into the understanding of practices and patterns of violence that are linked to BME women’s experiences in order to de-essentialise the understanding of DVA. For instance, whereas the term *domestic violence* avoids the gendered context, it reignites the debate concerning the role of women within families, thus avoiding the realities that shape some BME women’s experiences of DVA. This is because the use of the term *domestic* implies that the violation is taking place within the home between intimate partners or might also suggest the notion of “mutual combat” (Carney et al, 2007). However, evidence provided by Siddiqui and Patel (2010); and Thiara and Gill (2012) demonstrates how some South Asian women’s experiences of DVA often expand beyond the context of intimate partners when considering the family and community perception of the woman’s role in upholding familial ideals relating to *honour* and her position as a 'virtuous wife'. In such instances DVA perpetrators may not be limited simply to intimate partners, but may also include the extended family and so-called *guardians* of 'cultural' values. Siddiqui and Patel (2010) argued that these perspectives of violence are important to BME women because they are ultimately linked to how and when some South Asian women seek support and
they have implications for whether or not the experience is recorded as DVA or even a crime.

Some feminists oppose the use of the term ‘victim’ and argue that the term is perceived as an ideation of blame, whereby women are presented as often lacking in agency and as the helpless and passive recipients of male violence (Radford et al, 2000; Renzetti, 2004; Sokoloff et al, 2008; Kelly, 2011). They propose instead that the term ‘survivor’ better illustrates the strength and positivity of the survival strategies, particularly of black women who sometimes endure the experience of DVA over a prolonged period (Thiara et al, 2011; Kelly, 2011). For instance, the use of the term ‘survivor’ as a site of resistance within the feminist perspective illustrates how Asian, African and Black Caribbean women often refuse to support prosecutions of their abusers in order to avoid institutional racism (Mama, 1989; Batsleer et al, 2002; Thiara, 2006). Kelly (2011) invoked the use of the term ‘survivor’ by drawing attention to the help-seeking behaviour of BME women to emphasise the inadequacy of the term ‘victim’, highlighting how some women resist layers of oppression that are linked to the structural domination of racism, cultural taboos and personal violence. At the same time, the use of the term ‘victim’ is further problematised by Kimberly Crenshaw (1994) as she draws attention to how the simultaneous use of the words perpetrator/men and victim/women renders lesbian victims of DVA invisible when all perpetrators are referred to as male. Research into this aspect of DVA is limited, thus making it difficult to effectively validate the claims linked to the strategies adapted by BME women in the UK. However, for the purpose of this research the term ‘victim/survivor’ will be used.

Merry (2009) emphasised the connection between naming (defining) DVA and help-seeking for some South Asian women who are unable to describe the phenomenon. Similarly, the work of Pande (2013) also draws attention to the problem sometimes faced by Hindi-speaking women when talking about sexual abuse that is linked to DVA. Pande (2013) elucidates how the meaning is obscured in Hindi sexual vocabulary because the dominant terms for naming violence, such as rape and child sexual abuse, are linked to honour and shame; thus, the term is obscure and is therefore open to multiple interpretations. Equally, the words for the female and male anatomy are swear-words. This has particular resonance for disclosure, as Gill (2004) noted, because, in relation to their code of honour, victims/survivors of DVA would find it difficult to disclose incidents of
abuse as this would dishonour their family by making public those issues perceived as private family matters. Here, we see how attention to culturally specific practices and interpretations can impact upon the shared meaning but also have significant implications for how experiences are excluded, recorded, validated and supported, especially when it comes to self-reporting of this type of violence.

3.3.1 The Intersectionality of DVA

The concept of intersectionality as a critical analytic paradigm is rooted within black feminist writings. It was applied by Crenshaw (1989) as an analytic framework for conceptualising how experiences of personal and structural violence are shaped by the interrelationships between multiple sources of oppressions and social divisions. Its proponents argue that oppression in the lives of women is neither a singular process nor binary political relations (Yuval-Davis, 2006; Nash, 2008; Hankivsky et al, 2014 Cho et al, 2013). Rather, it is shaped by multiple converging and interconnected systems of discrimination, exploitation and disadvantage (triple jeopardy) that are linked to hegemony within racism, classism, heterosexism, gender discrimination and ethnicities.

A review of the literature illustrates how viewing DVA through the lens of the Intersectionality paradigm demonstrates striking differences between class, gender and race variations (Bograd, 1999; Sokoloff and DuPont, 2005; Conwill, 2010; Montesanti and Thurston, 2015). In particular, by applying the language of Intersectionality to social justice and paying attention to naming, it was possible to expose variations in the rates and prevalence of DVA (Conwill, 2010; Nixon and Humphreys, 2010; MacDowell, 2013 and Pande, 2013; Mackenzie, 2015). For instance, naming women’s experiences of female genital mutilation (FGM) and honour-based violence (HBV) as a form of gender violence rather than common assault produced significant insights into some BME women’s experience of DVA that might otherwise have remained obscure. Likewise, paying attention to the shifting and unstable role of identity politics dispelled the notion of ‘women’s experience of DVA’ and enabled the experiences of marginalised groups to become visible within DVA discourses (Crenshaw, 1994; Yuval-Davis, 2006; Hankivsky et al, 2014). This is based upon the argument that a woman is always constructed and intermeshed in other social divisions such as gender, social class, disability status, sexuality, age, nationality, immigration status, etc. Hence, a Black British middle-class woman’s experience of DVA may be inherently different from
a black disabled woman’s experiences of DVA. The implication concerning what can and cannot be named as DVA represents a critical part of HVs’ work because they have a mandatory obligation to routinely ask women whether they are victims of DVA (DH, 2005; NICE, 2014).

Attention to differences appears to be problematised within the tensions between internal orthodoxies of identity politics (Harding, 2004; Nash, 2008; Bowleg, 2012). Yuval-Davis (2006) argues that this tension is conflated by the methodological challenge within the different analytic levels in which intersectionality is located. For example, attempts to expose invisible and marginalised experiences within social groups appear to create fragmentation and increase the wider categorical identities rather than revealing a fluid and dynamic intersectionality. This is a position that holds particular implications for the notion of how different voices are represented within an intersectionality framework. This is illustrated by Lionnett (1992) and Roach and Momoh (2013), who have examined the practice of FGM to illustrate how the irreconcilable differences between Western and non-Western women’s subjective experiences of their own positions have created a collision between black feminism on the one hand and universalism on the other.

The work of Kanuha (1990) applied the concept of triple jeopardy to racism, sexism and heterosexism by pointing to the role of racism in lesbian and feminist’s communities in silencing lesbians of colour. She argues that the exclusion of the perspective of colour from the definition of Lesbian can be attributed primarily to racism, which manifests itself in a variety of ways. The review suggests that there is a limited understanding of black lesbian experiences of DVA even within the black feminist campaign. This is significant for the understanding of HV work because of the evolving and dynamic nature of the family in contemporary Britain, not least because professional guidance to address the issue of DVA in practice is based upon the ideological construct of heterosexual relationships and the familial constructs of women (recipients of male violence) and men (perpetrators) (DH, 2010b).

Lionnett explores the conflicting view of human rights on the one hand based upon the sovereign individual and the African idealised version of human dignity on the other to illustrate the hegemonic nature of sisterhood relationships. Framing the practice of FGM within patriarchy has drawn upon the notion of gender equality to counter the narrative of collective cultural identity and has problematised the notion of political representation. Furthermore, Boddy (1998/2008) and Braun
(2009) have highlighted the duplicity in the Western feminists notion of human rights, where the practice of labiaplasty is legitimised within institutions but the practice of FGM is simultaneously condemned. Patel and Siddiqui (2011) vehemently argued that subscribing to a cultural framework for understanding violence in the lives of BME women is a regressive form of politics; Arguing instead that dominant patriarchal, homophobic and authoritarian if not fundamentalist ideas framed within culture obscure the gendered realities that systematically dominate BME women’s lives. Rejecting the notion of FGM as a cultural practice, activists argue that the practice is rooted within patriarchal dominance and which control women’s sexuality (Walley, 2002; Patel and Siddiqui, 2011; Momoh, 2013). In addressing the internal orthodoxies of regressive politics, Collins (2000) also warns that black women’s silence emanate from black men’s portrayal and reinforcing the ideas of the strong black woman. An enduring image which ultimately limits understandings of black women’s vulnerabilities and susceptibility to patriarchal dominance, racism and other forms of structural violence.

Notwithstanding, there are valid arguments about the practice of FGM from a human rights perspective, which prioritises the issue of choice, in that children and young girls who undergo the procedure do not always have a choice. As suggested by Roach and Momoh (2013), in most instances girls are not given the choice on whether or not to have FGM, and medical evidence illustrates how some women often experience enduring physical, emotional and psychological trauma and even death (WHO, 2008; UNICEF, 2005; Doctors of the World, 2010).

### 3.3.2 Help-seeking

Emerging evidence has highlighted the growing connection between the intersectionality of ethnicities, institutional and familial ideologies, which play a significant role in the victimisation/survival process and help-seeking behaviour of BME women (Ahmad et al, 2009; Belur, 2008; Cross-Sudworth, 2009; Wellock, 2007/10; Siddiqui and Patel, 2010; Allen, 2012; O’Campo et al, 2014; Gill et al, 2016) please see Table 1 p38. Common experience identified among some ethnic minority women show that reluctance to engage in services may emanate from a lack of trust due to experience of racism, and fear that the abuser might be
exposed to racist treatment by the police (Bent-Goodley, 2005; Thiara, 2011; Siddiqui and Patel, 2010; Allen, 2012).

Evidence from the UK has also demonstrated how the notion of *shame* is a significant factor in South Asian and African/Caribbean women’s lives which prevents them from seeking support and speaking out about an abusive relationship. The notion of shame connected to *family honour* appears to be linked to extreme isolation for some South Asian women, whereby victims/survivors might be ostracised from their family and entire community, and it helps to explain why some women initially seek support from community leaders (Merry, 2003; House of Commons Home Affairs Select Committee (HSAC), 2008; Pande, 2011; Siddiqui, 2011; Siddiqui and Patel 2010).

There is limited empirical data charting the extent to which BME women’s help-seeking process is influenced by the notions of *honour* and *shame* within the context of healthcare settings; however, a criminal justice review and a serious case review have highlighted the extent to which the notions of *honour* and *shame* are used as a justification for DVA, as well as the failings of statutory agencies to protect vulnerable victims of this type of DVA. The report provided overwhelming evidence of the help-seeking strategy used by a teenager who visited the police and social workers on numerous occasions prior to her death to warn them that her life was in danger (Independent Police Complaints Commission (IPCC), 2006). However, the findings reported significant failings by statutory agencies, which summarised a lack of understanding about the familial context in which some women experience DVA. Despite the risks faced by the victim, who was not taken seriously, the mistaken beliefs held by the police and social workers about cultural practices led to the victim being placed back with her family on numerous occasions. While it is difficult to generalise from a single case, reviews have also identified similar themes and responses from previous, lesser-known cases (Gill, 2009; IPCC, 2006; HSAC, 2008/14; Patel, 2013). Similar to other findings, there is evidence to suggest that racism exists (IPCC, 2006; Belur, 2008; Gill, 2009; Allen, 2012). However, there is little evidence to suggest that this is the core issue for BME women seeking support to escape from DVA. Instead, internal orthodoxies within families and patriarchal dominance enforced by community leaders appear to conflate with multiple issues such as economics, religion, migration, nationality and institutional bias within the legislative frameworks, as well as a lack of understanding of the intersectionality of women’s lives within institutions such as

A review of the literature shows that there is a strong association between BME women who live in households and communities with strong patriarchal beliefs which are often reinforced by familial and religious interpretations of male superiority and particular difficulties in challenging male violence (Cross-Sudworth, 2009; Allen, 2011; Ahmad et al, 2009; Siddiqui (2013) and Larasi (2013) highlight growing concern regarding the dominant patriarchal and fundamentalist interpretation of religion, which is often invoked during arbitration tribunals in the adjudication of DVA cases. The concerns draw attention to how community leaders, through the internal systems of arbitration, condone DVA perpetrated by men. Rather, they question the women’s integrity as wives, restore male privileges and actively discourage women from seeking justice in the British judicial system. Earlier findings by Horsburgh (1995) and West (1999) reported that, regardless of ethnic group, women with religious beliefs remain in abusive relationships longer, compared to non-religious women, because of the notion of the sanctity of marriage (Barrett and St Pierre, 1999). This appeared to be consistent with the experiences of BME women seeking support from SBS, where women often report on the actions of statutory agencies, such as the NHS, and often commission faith-based services (Siddiqui and Patel, 2010). The extent and prevalence of this practice is unknown and a search of the literature could not provide conclusive evidence concerning the role of religion in BME women’s help-seeking processes.

Thiara and Gill’s (2012) research points to growing concerns that BME women often face additional violence from multiple perpetrators, such as family members and in-laws, especially when a woman’s virtues or competency as a wife are called into question. Similar evidence from Siddiqui and Patel (2010) identified that violence linked to this type of DVA is normally associated with extreme isolation from the family and local communities. A study by Thiara and Gill (2012) interviewed 12 African Caribbean women and 23 South Asian women and found that 78% of the women experienced severe post-separation violence and abuse. In some instances, the violence and abuse even occurred during court-sanctioned contacts. Perhaps more significantly, in cases where the abuse had been prolonged beyond separation, African Caribbean and South Asian women endured on average 12, and up to 23, years of violence and abuse by former partners and extended families, and for less than 10% of the women the violence began post-
separation. Critically, the study also highlighted that over 58% of the women felt let down by professionals who failed to identify their positions as victims of DVA because they (the women) did not share the same domestic living arrangements with the perpetrator (Thiara and Gill, 2012). It is for these reasons that some feminists have adopted the term ‘Violence Against Women And Girls’ (VAWG) in order to reflect the nature and context of BME women’s experiences.

Siddiqui and Patel (2010) examined the case files of 3,380 BME women who sought support for DVA. The findings emphasised the growing connection between the increasing rates of attempted suicide, suicide, domestic homicide and DVA amongst South Asian women between the ages of 15 and 35. The findings concluded that South Asian women were three times more likely to kill themselves compared to the rest of the UK population, in stark contrast to the 20% suicide reduction rate nationally.

Beyond the experiences of some South Asian women, little is known about different ethnic groups’ help-seeking behaviours. Rather, much of what is known about help-seeking processes in BME women is linked to the biographical narrative and understanding of the intersectionality of race and the political location of BME women (Crenshaw, 1994; Thiara and Gill, 2010 and Sokoloff and DuPont, 2013;). The growing attention to intersectionality continues to shed light on how institutions unwittingly collude with abusers by illustrating how immigration policies usually unintentionally trap victims/survivors with their abuser (Reynolds, 1997; Joseph, 2006; WAFNI, 2007 Agnew-Davis et al., 2009; Siddiqui and Patel, 2010; Thiara and Gill, 2012; and Rights of Women, 2013;). The studies highlighted the context where some women who have no recourse to public funds and are unable to access publicly funded services often return to their abusers due to lack of support. In some instances the focus on the victim’s immigration status often fails to hold perpetrators to account for their crimes. Likewise, studies conducted in North America also suggest that some BME women stay silent about DVA for longer due to the notion of the internalised concept of female strength (Kanuha, 1990; Reynolds, 1997; Razack, 1998; and Richie, 2000;). The findings from this research elucidate why some women do report DVA and they point to the need for similar research in the UK.
3.3.3 The Nature and Prevalence of DVA

Empirical data illustrating the frequency and severity of violence have validated the position that men’s violence against women is an extension of the inequalities between gender within private and social spheres of relationships. However, research into how the issues of race, gender and class intersect with the experiences of DVA in the UK is limited. Evidence produced by Siddiqui and Patel (2010) between 2001 and 2009 examined the issues faced by 582 groups, consisting of 3,380 women from Jewish, Christian and Muslim backgrounds. In addition to DVA, 55% of the women faced issues associated with mental illness, 10% had significant issues with child welfare, and 22% faced immigration/asylum issues and financial destitution; 80% of the women were from a South Asian background, 11% from Africa, and 9% from another racial background. An earlier study undertaken by Gill (2004) identified distinguishing features in South Asian victims/survivors of DVA, which continue to impact upon the severity and duration of DVA as well as their help-seeking processes in leaving violent relationships. Please see Table 1 below.

<table>
<thead>
<tr>
<th>Distinguishing Features in South Asian and Black African/Caribbean Victims'/Survivors’ Experiences of DVA (Gill, 2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple abusers: partners, in-laws, other wives, parents and siblings.</td>
</tr>
<tr>
<td>More cumulative effects because different perpetrators collude.</td>
</tr>
<tr>
<td>Denied sexual orientation where homosexuality is ostracised; being blamed for rape and forced to marry rapists to prevent family shame.</td>
</tr>
<tr>
<td>Divorced women more severely stigmatised.</td>
</tr>
<tr>
<td>Threats of being murdered by own family.</td>
</tr>
<tr>
<td>Rigid gender role; more tightly prescribed role for women reinforced by interpretations of religious text.</td>
</tr>
<tr>
<td>Language and cultural barriers to accessing help.</td>
</tr>
<tr>
<td>Dependence upon male partners for immigration status.</td>
</tr>
<tr>
<td>Reluctance of family members and religious institutions to support women and condemn the perpetrator’s behaviour.</td>
</tr>
</tbody>
</table>

Table 1 Distinguishing Features in Some BME victims'/Survivors’ Experiences of DVA

The human, social and financial cost of DVA to the UK economy stands at £25 billion each year (Her Majesty’s Inspectorate of Constabulary (HMIC) for England and Wales, 2014). Evidence from the Office for National Statistics (ONS) (2013) provides evidence to suggest a lifetime prevalence of 1 in 4 women in the UK experiencing DVA, and that each week two women are victims of domestic homicide. With over 58,000 calls to the police in 2013 alone, the police constabularies across England and Wales receive a call for DVA assistance every
30 seconds. These data can be compared to a figure of 1 in 7 men experiencing DVA and a domestic homicide rate of 1 man every 17 days. In the 2014 Crime Survey for England and Wales (CSEW) it was reported that for DVA in England there are over 1.2 million females and 700,000 cases known to the police. Of these, 57,000 were deemed to be high-risk cases involving a high probability of domestic homicide, and 96% of all the reported cases involved physical injuries. The figures showed an overall increase in DVA of 10%, despite an overall reduction in the national crime rate. This increase might be attributed to significant changes to the reporting and responses of statutory agencies, as well as a number of high-profile campaigns placing DVA on the political agenda.

However, it is not known whether the significantly high recording of physical injuries might be related to the nature of reporting by victims/survivors or the nature of recording of criminal classifications. The report also highlighted that, in addition to these figures, only 21% of victims of DVA report it to the police, suggesting that these statistics may be unreliable due to under-reporting. An in-depth analysis of these statistics is not possible due to the absence of patterns of abuse and a comparative analysis of the prevalence of minority ethnic reporting. As Thiara and Gill (2010) suggested, intimate partner crimes that are linked to the notions of honour and shame may also not be recorded within the context of DVA. It is not known whether these statistics also include and reflect the UK government’s recent changes in the definition of DVA. A problematic aspect of the evidence from the ONS is that data relating to ethnicity are not extrapolated when evidence concerning DVA is recorded by crime agencies. There is also a lack of data on the extent to which DVA relating to honour crimes, FGM and domestic servitude now influences DVA recorded as part of the DVA statistics.

A study by Richardson et al (2002) measured the prevalence of DVA in an inner-city London GP practice by identifying women from 1,207 health records who had attended the surgery for more than 15 years. The study found that 41% reported violence by a current or former partner, and 17% of these women had experienced violence in the last year. Over 20% of the women identified objected to being asked to disclose DVA. The findings did not indicate the prevalence by ethnicity; however, the ethnicities of the women participating in the study included the following: white British 39%, Irish 4%, African 6%, Caribbean 10%, Bangladeshi 1%, Indian 3%, Pakistani 1%, and Turkish Cypriot 10%.
Although there is a paucity in this area of research, this study demonstrates how BME women might have been predicted from and compared to the general population. A case in point is a study of Asian victims/survivors of DVA by Barnish (2004), who found that, on average, Asian women experienced 11.3 years of violent relationships, with over 90% being abused daily. The study also highlighted the context in which BME victims of DVA are also likely to experience violent abuse from more than one perpetrator. Similarly, a study undertaken by Ramsay et al (2001) and reviews by Feder et al (2009, 2011) reported that female victims/survivors of DVA endure at least 35 episodes of violence before seeking help. Feder et al (2011) suggested a lifetime prevalence ranging from 13%-31% to 13%-41% within the general population. This might be compared with the findings of Thiara and Gill (2010) and Siddiqui and Patel (2010), who suggest that BME women are much more likely to remain in abusive relationships, staying in them, on average, for 12-15 years.

The evidence points to a growing awareness of the nature of prevalence of DVA and improvement in the detection rates of DVA in BME communities. There is very little evidence to suggest that DVA is more prevalent in BME communities. Rather, the review appears to demonstrate how the intersectionality of ethnicities and religious practices contribute to BME women staying in abusive relationships over a longer period and prevent them from reporting DVA to statutory agencies. Therefore, the hidden nature of the problem presents some difficulties in estimating whether or not DVA is more prevalent in BME communities. This is especially pertinent for HV services given that the current evidence on the practice of asking women to disclose DVA suggests that women are willing to disclose DVA when asked by health professionals (Tacket, 2004: DH, 2010c; NICE, 2014).

3.4 Part 2: Health Themes and Perspectives

3.4.1 Conceptualising Health Visiting Practice Response to DVA

Health visitors make sense of their work in a particular organisational context propagated by the particular social, cultural and historical context shaped by the gendered nature of women as mothers, child welfare and the influence of the biomedical model/ideology towards health and illness (Cowley et al, 2008; Thornbory et al, 2009; Donetto et al, 2013). At the same time contemporary
professional identities have been shaped by the service’s historical orientation towards home and motherhood. With women comprising over 99% of the HV workforce, evidence provided by the NHS workforce consensus data for 2010 showed that one in five HVs were over 55 years of age (CPHVA, 2010).

While HVs might see themselves as enabling the voices of marginalised women to be heard, their practices are heavily regulated by institutional politics that determine whose experiences are represented and prioritised within services (Robotham and Sheldrake, 2000; Peckover, 2002a; Children Act, 1989/2004; London Safeguarding Children’s Board (LSCB), 2010; Elkan et al, 2012; Luker et al, 2012; NHSE, 2014/15). Hence, health visiting services might be accused of propagating institutional processes that arguably amount to levels of structural violence when they enforce organisational rules that do not prioritise DVA as a significant health concern whilst limiting and/or excluding some women’s access to services (Mama, 1989; Batsleer et al, 2002; Sokoloff and Dupont, 2005; Patel & Siddiqui, 2010; Thiara, 2011). In relation to this, it might be argued that HVs are implicated in imposing a particular reality of the phenomenon which may contradict their stated aim of addressing inequalities linked to DVA.

In practice, tensions may arise when HVs are faced with complex or contradictory encounters, causing an impasse, which may resolve by reification or avoidance. (Peckover, 2002; Salmon et al, 2005; Cross-Sudworth, 2009; Allen, 2011; Ramsay et al, 2012; Trevillion et al, 2012; Baird et al, 2013; Taylor et al, 2013 and Bradbury-Jones, 2015). For example, the evidence suggests that a health practitioner might be less likely to uncover DVA at the first contact with BME women when the abuse is linked to honour-based violence (Wellock, 2007; Ahmad et al, 2009; Cross-Sudworth, 2009; Siddiqui and Patel, 2010; Thiara et al, 2011 and Gill et al, 2016). Furthermore the woman might deny DVA is happening although the HV might have reason to suspect that the woman is being abused.

In such circumstances a HVs’ decision to respect the woman’s right to choose when or how to disclose might conflict with normative judgements about safeguarding risk in relation to DVA and the transformative practices within emancipatory knowing. However reliance upon safeguarding measures might not necessarily protect the woman particularly if the perceived risk does not meet the threshold for state protection. Research has shown that when confronted with critical dilemma, in relation to race, DVA or other sensitive issues, health professionals they might either avoid tackling those issues altogether for fear of
upsetting someone’s culture or to maintain compliance within the professional relationship with patients/clients (Lazenbatt, 2006; Donetto et al, 2013; Taylor et al, 2013; Bickford, 2014); in so doing status quo is maintained. An in-depth study by Whittaker et al (2013) reviewed HVs’ perceptions of their role, suggesting that the overwhelming majority of HVs value their work with women and their families and affirm their commitment to making a difference but feel undervalued within their role. The study also revealed the extent to which HVs themselves recognise the tensions between organisational and political constraints but also want to make a difference. These findings are consistent with earlier research by McGillivray (2008) and Cowley (2002), who also highlight the confusion and unease amongst HVs concerning their role in reforming the NHS and their overlapping boundaries with social work and other community nurse practitioners (Brooks and Rafferty, 2010).

The blurred boundaries of autonomous practice and professional displacement were further highlighted in 2002 with the Nursing and Midwifery Council’s decision to relocate the professional status of HV under the umbrella term of Specialist Community Public Health Nurses. This move appeared to contradict the DH, (2011) HVs Implementation Plan which affirmed their leadership role in the future public health agenda. This has coincided with recent political reform of the NHS which removes the purchasing strategies of public health services and the commissioning of HV services from NHS Primary Care Services to Local Authority social care provision (Health Visiting Implementation Plan, DH 2011).

Despite a number of critical reforms within the practice, HV’s most enduring feature is its public health role in addressing health inequalities (see Table 2, p44 and Table 3, 4p7). However postcolonial feminist epistemology posits the notion that knowers are situated in relation to what is known and to other knowers (Belenkey et al, 1997; Loomba, 2005; Letherby, 2003; Ramazanoğlu and Holland, 2002). Therefore, what is known and the context in which it is known thereby represent the situation or perspective of the knower (Spivak, 1988; Chrisman, 1990; Ang, 1995; Collins, 2000a; Hinterberger, 2007; Mohanty, 2009). Postcolonial feminist theorists extend this argument to the science of nursing by asserting that within knowledge production the practice of representation is directly tied to privileged ontological positions on race, culture and health. For instance a HV might make substantive and descriptive representation of BME women in their day practice in speaking for or on behalf BME women within the wider social and
public health forum through research and co-constructing knowledge about DVA when either validating or discounting experiences of DVA. Therefore, it is from this perspective that HVs might be implicated in both the process of speaking for and representing others. From a postcolonial feminist's perspective it could be argued that a HV authentication process within each connected pattern of knowing are shaped by experiences the representation of knowledge within social and material world. For instance a HV might make substantive and descriptive representations of BME women in their day to day practice, in speaking for or on behalf of BME women within the wider social and public health forum, or through research and co-constructing knowledge about DVA when either validating or discounting experiences of DVA. In relation to this, Chinn and Kramer (2015) calls for knowledge and actions that will eliminate inequality and injustice. They argued that

"Emancipatory knowing is the human capacity to be aware of and critically reflect on the social, cultural and political status Quo and to determine how and why it can come to be that way" (Chinn and Cramer, 2015, 5).

Postcolonial feminist doctrines on political representation argues that knowledge production about the lives of BME within social institutions is a substantive part of reducing inequality by challenging hegemonic knowledge and the homogeneity of women’s interest by making good political representation of BME women's health needs (Holmes et al, 2008; Bickford, 2014). The ideas on social justice within postcolonialism is consistent with the traditional pattern of knowing within nursing discipline. In practice both epistemological paradigms require individual and collective mobilisation against inequality in different ways. On the one hand, ethical knowledge within nursing engages consciousness-raising and asking critical questions about the morality of social injustice. Conversely postcoloniality implores the politically charged ideas of knowledge empowerment to disrupt dominant ideas on class race gender and politics.

Guba and Lincoln (1998) calls for a harmonious nursing praxis where competing ontological and epistemological positons co-exist. However it is argued that the contexts in which nursing representations takes place is shaped by dominant discourse of evidence-based medicine on health and illnesses such as mental illnesses within public health domain (Kirkham and Anderson, 2002; Holmes et al,
Applying the critical lens of postcolonial perspective on nursing implores the use of emancipatory knowledge to examine how the shifting and ever-changing dynamics of race, genders and ethnicity can be applied to the socially constructed experiences of health and illness in order to counter the hegemonic representation that exists within dominant public health discourse.

These ideological perspectives calls upon nursing to take actions and make decisions in nursing based upon a sense of what is right or wrong whist giving a voice to vulnerable persons. As a consequence, it could therefore be argued that empirical pattern of knowing calls for nursing to take a bold stand away from political neutrality and to shape practice within a particular epistemological foundations in order to address the neoliberalists’ ideas on healthcare. Moreover such transformative measure requires nursing to have significant autonomy within health practice and research. Holmes et al, (2008) argues that such autonomy this can only be achieved by challenging the status quo.

<table>
<thead>
<tr>
<th>Health Visiting Commissioned Services And Public Health Outcome Activities In 0-5 years 2014/15</th>
<th>NHSE, 2014, p.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving life expectancy and healthy life expectancy.</td>
<td>Increase breastfeeding prevalence at 6-8 weeks.</td>
</tr>
<tr>
<td>Reducing infant mortality.</td>
<td>Child development at 2-1.5 years</td>
</tr>
<tr>
<td>Reducing low birth weight of term babies</td>
<td>Reducing the number of children in poverty.</td>
</tr>
<tr>
<td>Improving breastfeeding initiations.</td>
<td>Improving school readiness.</td>
</tr>
<tr>
<td>Reducing smoking at delivery</td>
<td>Reducing under 18 conceptions.</td>
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<tr>
<td></td>
<td>Reducing excess weight in 4-5 and 10-11 years old.</td>
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<tr>
<td></td>
<td>Reducing hospital admission caused by unintentional and deliberate injuries in children and young people aged 0-14.</td>
</tr>
<tr>
<td></td>
<td>Improving population vaccination coverage.</td>
</tr>
<tr>
<td></td>
<td>Reducing tooth decay in children age 5</td>
</tr>
</tbody>
</table>

Table 2 Health Visiting Commissioned Services ‘Original in Colour’

3.4.2 The Diverse Context of Motherhood

Despite a number of critical reforms within the practice, its most enduring feature is its role in mothering and child welfare, which exposes the gendered nature of caring for children. For instance, the primary focus on epidemiological concerns such as smoking prevention, childhood immunisation and maternal mental health assessment continues alongside public health monitoring of key risk factors, such
as DVA, drugs and alcohol, and the health and wellbeing of the population (NHSE, 2014/15). Critical reviews of the activities of HV workers drew attention to the social purpose of HV work which includes the surveillance of vulnerable and hard-to-reach population groups to improve their access to supportive and protective services (Cowley, 2010; Donetto et al, 2013). These contexts illustrate complex relationships between HV and public health in support of vulnerable families but also in terms of state-sponsored regulation and representation of BME mothers.

Against the background of universal and specialised services, policy-makers and commissioners are faced with the huge challenge of how best to address the increasingly diverse and complex demands for individualised care and how to provide equity and fairness for all. However, the premise of HV interventions is based upon the notion of facilitating activities to address the impact of physical, psychological and social health needs of individuals and families based on a range of interconnected categories and a hierarchy of differences such as age, language, religion, ethnicity/nationality, social class, (dis)abilities and poverty. This in itself avoids privileging the binaries associated with biological reductionism by focusing on the intersectional mantra which analyses how each concept interconnects to produce hierarchies of health and social inequalities. For instance, mental illness can define a women’s experience of motherhood, or motherhood can shape a woman’s experience of mental illness.

Normative ideas of family construction and motherhood observe that child care and domestic duties remain the responsibility of women (Collins, 2000/2004; Montgomery, 2005; Byrne, 2006; Christopher, 2012; Elliott et al, 2015; Damant et al, 2015). In particular, black feminist theorists have argued that there is a continuum of tension, if not ambiguity, within black women’s standpoint on mothering, in which motherhood is embraced, on the one hand, as a form of self-actualisation and is viewed, on the other, as a burdensome condition that stifles their creativity, exploits their labour and makes them partners in their own oppression (Collins, 2000). These contradictions are critical to understanding HVs’ work with mothers where the dominant risk discourse on motherhood is used to address inequalities but also shapes particular views which may either legitimise mothers or label them as normal, needy, vulnerable or dysfunctional. However, feminists argue that the construction of motherhood is a series of constantly negotiated and re-negotiated relationships. In particular, black feminists point to the specific locations in which mothering takes place, from individual households
to extended families and even community institutions outside the idealised family settings (Reynolds, 2001; West, 2005; Byrne 2006; Damant et al, 2008; Thiara, 2008/11). Feminists work on the construction of motherhood and ethnicity remains limited but contentious. Feminists’ analysis has shown how the pervading Afrocentric view of the strong black woman has in itself operated as a form of political representation, where persistent images of authentic black women are linked to internal orthodoxies of culture, tradition and survival (Batsleer et al, 2002 and Thiara, 2011). Although intended to portray a positive image, evidence provided by Reynolds (1997) and West (2000) has shown how black mothers’ vulnerabilities are overlooked, often in the mistaken belief that they are able to cope regardless of the intersectionalities that shape their lives.

3.4.3 Practice Encounters

In urban parts of England, a significant proportion of the HV caseload consists of BME women (Ealing Hospital Trust, 2012). However, there has been limited discussion in the professional literatures on HVs’ knowledge of the intersectionality of race, class and the political location of BME women’s lives (Peckover, 2003; Elkan et al, 2000; Cowley et al, 2012; Donetto, 2010). Even less is known about how HVs might influence the political representation of BME women within health visiting discourses. The challenges of these perspectives are unearthed during attempts to examine the professional literature illustrating HVs’ work with women.

A review of HV literature exposed the extent to which knowledge representation of BME women experiences of health and ill-health, within key public health discourse, remains marginalised. (DH, 2009; Wellock, 2010; SANE, 2010; Edge, 2010/11; NICE, 2013; Stevenson et al, 2014; WHO, 2014; Marmot, 2014 and Public Health England, 2015). The evidence suggests that health assessments of postnatal depression, breast feeding, DVA and HV Family Health Assessment (FHNA) might not always reflect and represent knowledge empowerment of the diverse context in which HV’s work with BME, disabled and LGBT families. For instance, the information gathered about race, nationality, ethnicity, religion and sexuality is listed as part of HV data surveillance. However this information is not represented within the core dimensions of the individual HFHNA framework. Similarly, within the NHS HV specification, these issues were not part of the analysis and consideration of HV work with BME who experience DVA, postnatal depression or motherhood. This is significant because there is overwhelming evidence showing how experiences of racism, of differing ethnicities, gender,

The micro-levels at which HVs work with families are underpinned by a number of historical and contemporary national agendas to tackle health inequalities (DH, 1988; Luker & Chalmers, 1990; Wanless, 2002; Cowley, 2008; Marmot, 2010; Donetto et al, 2013; NHSE, 2014/15). Critically, these reports do not include understandings of how DVA impacts upon health inequalities. The scope of the public health agenda shaping HV micro-practices can be directly linked to a number of extraordinary political transformations of the NHS in England over the past decades. A notable example is the introduction of the Internal Market introduced by the NHS Community Care Act 19c (1990), which was accelerated under the current government via the Care Act (2014). Most notable is the way in which care is commissioned. For instance, the operational changes in the commissioning of HV services shifted responsibilities from NHS England to private enterprise and social care in 2013 as outlined in table 3 below.

<table>
<thead>
<tr>
<th>Key changes introduced by NHS reforms linked to the DH, 2010c; Wanless, 2011; Lister, 2012; Care Act 1990/2014.</th>
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<tr>
<td>1. Abolish the duty of the Secretary of State to ensure universal and comprehensive services are available to all.</td>
<td>3. Open up an increasing range of services to private competition which can include greater involvement of profit-making and non-profit-making private providers.</td>
</tr>
<tr>
<td>2. Abolish Primary Care Trusts and replace them with GP-led consortia.</td>
<td>4. Require all NHS hospital providers to become autonomous Foundation Trusts and remove the cap on the amount of income Foundation Trusts can receive from private medicine (e.g. fee-paying patients).</td>
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Table 3 Key Changes Introduced by NHS Reforms ‘Original in Colour’

In particular, the Social Care Act (2012) resulted in a number of key health services (including health-visiting) being commissioned from private enterprise. For instance, the drive for efficiency within HV services is based on the number of predetermined outcome measures such as the number of new-births and antenatal contacts rather than the stated aim to search for and identify health needs (Cowley, 2010; DH, 2011-15; NHSE, 2014/15). Critics argued that the introduction of these deep-rooted market reforms are based upon ideological principles rather than evidence-based practice and are least likely to benefit those in greatest need (Coburn, 2004; Dixon, 2012; Lister, 2012: Gilbert et al, 2014; Firth, 2015; Strier et
al, 2013/5 and Ham et al, 2015). It could therefore be argued that the provision of HV services for demographics with greater social deprivation would not attract less market value than services in affluent areas where there are fewer perceived needs. Critics of these reforms argue that these contexts are more likely to fragment and dislocate efforts to address health inequalities.

Conversely, HVs’ encounters with BME communities may be understood within the bio pathological, ecological, and biographic and communitarian models of health practices underpinning the emancipatory objective of addressing health inequalities. These encounters are embedded within Carper’s (1978) fundamental patterns of knowing within nursing epistemology. Within this, the concept of hegemony is emerging as an analytic framework to help provide an understanding of the nature of nursing relationships and nursing knowledge. In particular, the work of Foucault (1984, 1979) and Gramsci (1971) on power and knowledge illustrates how an unequal distribution of power in contemporary society is reflected and reproduced in dominant epistemology in institutions. These are key issues in nursing that are linked to emancipatory knowing and nurses’ ability to recognise social and political problems and address inequalities within the context of their work. As Chinn (2015) has observed:

"Emancipatory knowing cultivates awareness of how problematic conditions converge, reproduce and remain in place to sustain a status quo that is unfair for some groups within society" (Chinn, 2015, 66).

Analysis of the dominance of medical knowledge has provided insights into biomedicine’s dissocialising role in disregarding the social dimensions and medicalising particular social experiences (Hugman, 1991; Doering, 1992; Filc, 2004; Giddings, 2005; Cameron, 2006; Scott-Samuel, 2007; Racine, 2009b and Chinn and Kramer, 2015). In relation to this, the concept of hegemonic power has been used to analyse the nature of nursing autonomy and the centrality of medical knowledge within nursing practice (Kneipp et al, 2014). For instance, Gair and Hartney’s (2001) work focused attention on the extent to which the medical profession still exercises a disproportionate degree of power and dominance over nurses. One case-study examined the exercise of power within multidisciplinary settings and found that the views of medical doctors continue to dominate patient care even within the context of social settings. The study pointed to the extent to which even the lowest rank of the medical team led discharge planning in preference to non-medical staff. Conversely, the work of Marshall et al (2007) drew attention to how the medical discourses on child development are implicated...
influencing the social identity of mothers and the construction of good mothers as synonymous with breastfeeding. This is an ideal that is often promoted by HVs but, as the findings of Marshall et al (2007) suggest, it often takes place outside the realities of women’s daily lives, which include combining work and breastfeeding. Understanding HV work in this way highlights the contradictions within the hegemonic relationships that are reproduced within the dominance of medical science in everyday practice.

It is also a context that is particularly relevant to HVs who are placed in a unique position of trust and relative power which enables women to disclose incidents of DVA, often building long-term relationships and helping women to build their resilience to violence perpetrated by men. On the other hand, a key HV response to addressing DVA involves the safeguarding functions which often criminalise and implicate women who fail to protect their children from exposure to DVA. However, given the vulnerabilities of some BME women who are affected by DVA, it could be argued that HVs are the more powerful agent within the professional relationship. The nature of this unbalanced relationship is considered fundamental to the processes of identifying and responding to DVA (Rehman et al, 2013), but it also highlights the contested relationship between public health theory on health promotion and the overlapping domains that are linked to paternalistic views on individual protection.

"A dominant assumption or hegemonic view of nursing is that nurses’ practise as employees of an agency or a corporation rather than as independent practitioners" (Chinn, 2014, 67).

The work of Carey and Foster (2013) argues that reliance on hegemony has actually increased as the organisational structures become more fragmented and less predictable within health and social care. Alongside this, healthcare science is increasingly called upon to shape ideological boundaries between religion, morality and culture, often established through the consensus of evidence-based research. However, despite an increase in output of practice-based nursing research, the threshold supporting the hierarchy of evidence-based practice remains enshrined within the positivist paradigm underpinning medical research. It is a perspective that might not necessarily prioritise the inherent values of a multiple subjective reality and the interconnectedness between the socio-political intersection of illness and health.
An in-depth study by Whittaker et al (2013) reviewed HVs’ perceptions of their role, suggesting that the overwhelming majority of HVs value their work with women and their families and affirm their commitment to making a difference but feel undervalued within their role. The study also revealed the extent to which HVs themselves recognise the tensions between organisational and political constraints but also want to make a difference. These findings are consistent with earlier research by McGillivray (2008) and Cowley (2002), who also highlight the confusion and unease amongst HVs concerning their role in reforming the NHS and their overlapping boundaries with social work and other community nurse practitioners (Brooks and Rafferty, 2010). The blurred boundaries of autonomous practice and professional displacement were further highlighted in 2002 with the Nursing and Midwifery Council’s decision to relocate the professional status of HV under the umbrella term of Specialist Community Public Health Nurses. This move appeared to contradict the DH’s (2011) HVs Implementation Plan which affirmed their leadership role in the future public health agenda. This has coincided with recent political reform of the NHS which removes the purchasing strategies of public health services and the commissioning of HV services from NHS Primary Care Services to Local Authority social care provision (the Health Visiting Implementation Plan, DH 2011).

In recognising these imbalances nursing theorist postulate that nurses must demonstrate leadership by using their positions in research and practice to uphold the principle mandate for social justice (Bradbury-Jones, 2008; Kagan et al, 2009; Chinn et al, 2013 Fisher and Freshwater, 2013 Bradbury-Jones and Broadhurst, 2015). The concept of emancipatory knowledge aligns with HV practice because of their professional mandate to tackle health inequalities. Furthermore the processes within HV day to day encounter with BME women facilitate critical reflection during management and safeguarding supervision.

3.4.4 The Role of Health Visitors in Identifying DVA

The role of HVs in identifying women affected by DVA in clinical practice was explored in an earlier study by Frost (1999), who explore HVs’ perceptions of DVA committed against women by their male partners (see Table 6, p71). Similarly, a study by Peckover (2003) examined HVs’ practice in relation to DVA. Each study conducted semi-structured interviews with 24 HVs. The extent to which DVA is a significant feature of the HV caseload is reflected in the findings by Frost (1999),
and who noted that 98% of participants reported having some knowledge of DVA in their caseloads where women were abused by men. Peckover (2002) also reported, 33% of 24 HVs reported that fewer than five women were affected by DVA in their caseloads, whereas 7% of HVs reported knowing more than 50% of women who were affected, and in one instance an HV was only aware of two cases of abuse from a caseload profile of 250 families. The continued importance of HV work in addressing DVA is also emphasised in practice documents and research (Elkan et al., 2000; Tandon et al., 2005; Peckover, 2007; DH, 2010c; Cowley et al., 2012; dh, 2012; Home Office, 2012/15; Taylor et al., 2013; NICE, 2014 and Bradbury-Jones, 2015).

The London Safeguarding Children Board report (LSCB, 2015), which provided evidence that over 89% of HVs’ safeguarding caseloads can be directly attributed to DVA as the main or contributory factor. With over 30% of DVA beginning during pregnancy and continuing beyond childbirth, it is also estimated that over 750,000 children witness DVA each year, and 50% of these children sustain physical injuries. However recent evidence form the DH (2010/12) and NICE (2014 illustrates the context to which the problem remains unidentified within health visiting practice.

Early findings from frost (1999) and Peckover (2003) highlighted the gendered nature and extent of the problem and the context in which HVs are more likely to come into contact with some of the most vulnerable groups of women who are of childbearing age and living with DVA. Participants’ responses in both studies indicated inconsistencies in practice knowledge during encounters with DVA within the context of their work, whilst attitudes towards DVA appear to have influenced participants’ decisions not to respond to suspected DVA. The findings suggest that although the private nature of the problem was acknowledged, in practice there were inherent differences in participants’ willingness to address the problem. Since these studies were undertaken empirical evidence continue to demonstrate the correlation between knowledge empowerment of healthcare practitioners and the positive response to DVA (Salmon et al, 2005; Wathen, 2008/9; Ramsay et al, 2012; Trevillion et al, 2012; Baird et al, 2007/13; Taylor et al, 2013; Keeling and Fisher, 2015; Chen and Lo, 2015) coincidentally, recent studies involving HVs continue to demonstrate a significant number of practitioners still felt unprepared to deal with DVA in practice (Bateman and Whitehead, 2004; Allen, 2012; Ramsay et al, 2012; Taylor et al, 2013;) citing discomfort in dealing with the sensitivity of
the issue and incongruence between health professionals and the patient/clients and beliefs about DVA.

Frost (1999) reported that the majority of DVA disclosures were not uncovered by HVs, with more than 70% of HVs reported that the overwhelming majority of DVA disclosures were initiated by the women themselves. Evidence of risk indicators and key vulnerability factors, such as escalating incidents of DVA, a woman’s economic/political circumstances, ethnicity and class could not be extrapolated from the study. However, the findings appear to be consistent with recent evidence suggesting that the overwhelming majority of victims/survivors are willing to disclose incidents of DVA regardless of ethnicities (Cann et al, 2000; Bacchus et al, 2004, 2002; Ramsay et al, 2001; Tacket, 2004; Webster and Holt, 2004; Bond et al, 2006; Price et al, 2007; Agnew-Davis et al, 2009; Siddiqui and Patel, 2010; Thiara and Gill, 2010; DH, 2010b; Baird et al, 2013). Furthermore the evidence in Section 3.3.2 indicate that BME women are less likely to disclose because of the specific context in which some women experiences DVA (Agnew-Davis, 2009; Cross-Sudworth, 2009; Pande, 2011; Siddiqui, 2011; Allen, 2012; Rehman et al., 2013 and Gill et al, 2016). Given that HVs work at the intersection of race, politics and gender, these context might help to explain why DVA is rarely uncovered in practice.

Overwhelmingly the evidence shows that the implementation of routine enquiry and formal educational programme about DVA appear to significantly increase the identification and referral by health professionals and reporting by women (Jones and Bonner, 2002; Salmon et al, 2005; Lazenbatt et al, 2005/7; Tufts, et al, 2008; Gutmanis et al, 2007; Allen, 2012; Feder et al, 2011; Bacchus, et al, 2010; Taylor et al, 2013; Baird et al, 2015; Trevillion et al, 2016). More recently studies undertaken by Taylor et al., (2013) noted that overall nurses showed a greater awareness of the issues and were more likely to respond to appropriately to disclosure. However the practice of asking women to disclose DVA in the UK appeared to be framed around the clinical context of maternity services and there are significant gaps in knowledge about how the practice of routine enquiry differs when women are asked to disclose DVA in their own homes. For instance the evidence suggests that the familial context in which some women live might present specific difficulties for HV when raising the question (Agnew-Davis, 2009; Cross-Sudworth, 2009)
The aforementioned studies did not shed light on HVs’ knowledge of DVA in BME communities, and it is difficult to extrapolate knowledge about BME women’s experiences from either study due to missing data about ethnicity and the political location of the women who participated in the studies. However, a striking feature of the findings by Peckover (2003) was that HVs were reluctant to intervene in BME families, particularly Asian families, as they felt ill-equipped to provide effective interventions for this group. This is consistent with evidence produced by Agnew-Davis (2009), Thiara et al., (2012; 2010), and Siddiqui and Patel (2010) in that BME women consistently reported that their experiences of DVA are marginalised within organisational and professional responses, which often ignore or overlook their needs. In particular, the study by Thiara et al., (2012) revealed how health professionals might unwittingly collude with perpetrators due to a lack of understanding about the particular familial risk faced by BME families, and the perceived powerlessness on their part to intervene due to a lack of appropriate protective services for the women.

The study by Frost (1999) and Peckover (2003) found that only a third of participants emphasised their understanding of the continuum between physical, psychological and sexual violence and abuse. A point of difference between the two studies suggests that HVs who believed that DVA was a rare event appeared to focus on the physical characteristics, rather than other types of abuse, and neither study provided information on the extent of safeguarding concerns on HVs’ caseloads. Feminist theorising on the private nature of the problem could be used to explain why some HVs in both studies emphasised and believed that DVA was a rare event, even in cases where DVA was present. Similarly, the emphasis on physical characteristics by some HVs in both studies appeared to reflect the then dominant discourses which focused on physical violation and violence by men against women.

Frost (1999) reported that the majority of HVs did not object to asking women to disclose incidents of DVA. For instance, when asked whether they asked women probing questions about DVA, more than 93% of HVs reported that their clients did not object if they were asked sensitively. However, the overwhelming majority of HVs cited the fear of damaging professional relationships with women as a barrier to asking about DVA. The view posited here remains consistent with a more recent survey undertaken by the DH (2010c), which found that NHS staff were reluctant to take action to support women because of the fear of damaging professional
relationships with patients/clients. Recent research shows that this is still the position. A review of HV services by Donetto et al. (2013) suggests that HVs continue to avoid discussing sensitive issues with families for fear of damaging their relationships with families. The inconsistency with the women's perspective appears to suggest a lack of understanding about the help-seeking behaviour of women who are affected by DVA and their needs.

Attention is drawn in the literature to the idea that there are different cultural perceptions of what constitutes DVA (Crenshaw, 1991; Sokoloff and Dupont, 2005; Nixon and Humphreys, 2010; Smye et al, 20111; Mackenzie et al, 2015) and more importantly how the issue should be addressed (5). A review of the current health and social care literature found that practitioners were less likely to identify and respond to DVA in marginalised groups without appropriate training and knowledge of how to do so (Jones and Bonner, 2002; Westmarland et al, 2002 Salmon et al 2005; Lazenbatt et al, 2005/7; Tufts, et al, 2008; Wathen, 2009; Gutmanis et al, 2007; Allen, 2011; Feder et al, 2011; Bacchus et al., 2010; Baird et al, 2013; Nayme et al, 2013; Taylor et al, 2013; Cannon et al, 2015; Baird et al, 2015; Trevillion et al, 2016). However these studies provide limited evidence or evaluation of how knowledge about the intersectionality of BME women’s experiences of DVA within training programme improve identification and referral.

Conversely evidence from the literature shows that a health practitioners’ knowledge of inter-familial structures, beliefs about gender role and the interconnectedness between DVA and encounters with racism, gender and class bias are a critical part of shaping attitudes and responses to BME women’s experiences (Belur, 2008; Montalvo-Liendo; Cross-Sudworth, 2009; Nixon and Humphreys, 2010; Acton, 2011; Mackenzie et al, 2014. For instance, evidence from Allen (2012) demonstrates the link between knowledge and attitude, illustrating how racial and cultural stereotyping of marginalised women often undermine sensitive and appropriate response to women and discourage them from disclosing DVA (Lipsky, 2007; Belur, 2008; Cross-Sudworth, 2009; Erez, 2009; Montalavo-liendo, 2009; Sanders-Phillip, 2009; Allen, 2012; Anyikwa, 2015; Acton, 2016). Conversely some BME hide the abuse from practitioners in order to protect the family from shame and avoid repercussion. The studies found that when DVA was defined by practitioners as a cultural norm, evidence of the victimisation/survival process was obscured and opportunities for interventions
were overlooked. It is difficult to extrapolate the extent to which BME are less likely to disclose DVA in UK healthcare system as this area of research is limited.

In a secondary analysis of DVA awareness and recognition amongst community healthcare practitioners and abused women, Bradbury-Taylor et al, (2014) applied the concept of the Johari Window to show how knowledge of DVA might be explained in two distinctive processes: ‘consciousness’ and ‘recognition’.

*Consciousness:* involves taking sensory note of the presence of DVA whilst *recognition,* involves an understanding of the recurrent nature of the phenomenon, naming and identifying the situation as abusive. This therefore illustrates the points of convergence and divergence between the health professionals and the abused woman about abuse. This concept is used to open up the possibilities for identifying the closed, hidden and unknown areas of knowledge gaps, knowledge deficits and knowledge congruence. Similarly, evidence supporting health and social care responses to DVA suggests that recognition is not just about whether or not a practitioner or a woman view the abuse as happening but is also heavily influenced by the coercive role of the perpetrator in downplaying or dismissing the abuse. For instance the concept illustrates the context whereby neither the practitioner nor the abused woman might recognise the abuse and there are some instances where the woman recognises the abuse but the practitioner is unaware, or the practitioner recognises the abuse, but the woman is unaware. Ultimately drawing attention to some of the complexities that are linked to knowledge congruence and how this might affect recognition and disclosure.
3.4.5 Implications for Training

The review shed light on how feminist’s theorising on DVA has influenced some HVs’ knowledge regarding the recognition of DVA during clinical contacts. However, it has been argued that the absence of knowledge empowerment within public health nursing coupled with ineffective knowledge-frameworks in public health has often resulted in the unintended consequences obfuscating inequalities and propagating dominant discourse within public health (Peckover, 2003; Cross-Sudworth, 2009; Feder et al, 2011; Allen, 2012; Litherland, 2012; Taylor et al, 2013; Bickford, 2014; Bradbury-Jones and Broadhurst, 2015; Keeling and Fisher, 2015; Lu and Racine, 2015; Mackenzie et al, 2015 and Mauri et al, 2015). In particular, studies by Mauri et al, 2015 and Mackenzie et al, 2015 emphasised the need for practice knowledge to be specific and reflect the intersectionality of women’s lives and the context in which health professionals work to support them. This was implied in the study by Feder et al, comparative review which demonstrated the significant link between DVA education programme and the increased identification and referral of women experiencing DVA. However, there is limited understanding of how the increased identification of DVA addressed intersectionality of housing, religion, familial and political concerns in the lives of these women.

The absence of nursing discourse on the intersectionality of race, DVA, gender and politics illustrates the extent to which BME women’s experiences of public health remains marginalised. Instead, the evidence suggests that public health discourse DVA and HV Family Health Assessment (FHNA) might not always reflect and represent knowledge empowerment of the diverse context in which health visitor’s work with BME, disabled and LGBT families (Daley and Andrews, 2001; Gair and Hartney, 2001; Whitehead, 2001; Filc, Morgan, 2003; 2004; Scott-Samuel and Springett, 2007; Edge 2010: Hankivsky et al, 2011; Allen, 2015; Bradbury-Jones et al, 2015). For instance, information gathered about the race, nationality, ethnicity, religion and sexuality is listed as part of the HV data surveillance yet this information is not represented within the core dimensions of the individual FHNA framework.

In more recent times, the feminist’s influence on the development of a DVA MARAC risk assessment has led to its inclusion of risk indicators relating to BME experiences, such as the DVA, Stalking and honour-based Violence Risk Identification Checklist (DASH-RIC) (CAADA, 2010). However, one of the issues
arising from this review is the level of disparities within HVs’ knowledge base concerning DVA. At the same time, it appears that the commissioning of training to support this practice is *ad hoc* and even absent in some NHS Trusts, and during some training courses it appears that knowledge about BME women’s experiences is not included (Peckover, 2003; Evans, 2006; Agnew-Davis, 2009; DH, 2010c; NICE, 2014).

A growing body of evidence suggests that there is an urgent need for knowledge about DVA to be embedded in undergraduate training for health professionals (Gutmanis et al, 2007; Smith et al, 2008; Litherland, 2012; Beccaria et al, 2012; DH, 2012; Koci et al, 2014) suggesting that health practitioners are better able to develop positive attitudes towards addressing DVA if training is introduced earlier in training. Conversely evaluations of DVA educational programmes shows that increased knowledge and understandings of DVA did not always lead to a greater willingness of participants to address DVA (Ramsay et al 2012 Nayme et al, 2013) demonstrates the extent to which knowledge empowerment of health practitioners did not always. Instead issues such as the emotional labour of responding to DVA, organisational support, knowledge incongruence between health professionals and the women, knowledge of the intersectionality of women’ lives and the perceived acceptability to address DVA by some health professionals are significant barriers to addressing DVA in clinical practice. (Allen, 2012; Ramsay et al, 2012; Beccaria et al, 2012; Trevillion et al 2012; Jack et al 2012; O’Campo et al 2011; Baird et al, 2013; Ambuel et al, 2013; Bradbury-Jones et al, 2015; Keening and fisher, 2015; Bradbury-Jones and Broadhurst, 2015; Mackenzie et al, 2015; Mauri et al, 2015).

### 3.4.5.1 Domestic Violence and Abuse and Health

Feminists research has illustrated the enduring link between DVA, gender and health inequalities. Evidence uncovered by Walby (2004/9) and Sharpen (2009) suggests that DVA is the greatest cause of morbidity in women aged 19-44 years. It is reported that the cost of DVA to UK public services is over £3.1 billion each year, £1.2 billion of which is attributed to the NHS, with an additional £123 million for GP and mental health resources (Walby, 2004, 2009). According to the DH (2010c), the financial and human resources to tackle DVA in the NHS have eclipsed the cost of cancer, heart disease and diabetes put together (Walby, 2009;
Moreover, there is further evidence outlining the total impact on employers, where DVA is linked to prolonged and repeated sickness, absences and unproductivity, costing over £23 million per year (DH, 2012).

An early study undertaken by Bacchus et al. (2004) examined the prevalence of DVA in 892 women presenting for antenatal care. Their findings reported that the prevalence of DVA inflicted by men on women during pregnancy was 1.8% at the initial appointment, escalating to 5.8% at 34 weeks’ gestation, and ranging from 3.4% and 33%, with the greatest proportion of physical injuries to the abdomen and face. In addition, 13% of the women who reported DVA also reported incidents of DVA prior to their pregnancies. A similar UK study conducted by Keeling and Mason (2008) compared the rate of DVA before and during pregnancy and revealed a very different result. Of the 221 women who participated in the study, 18 reported an experience of DVA, with 11 reporting physical and emotional abuse and 13 reporting a previous experience of violence. However, neither study provided details on how age, ethnicity, employment, existing mental illness or the political location of the women intersect with DVA. It is also not known whether the violence was perpetrated by a new or former partner. Perhaps more significantly, the later study applied the use of psychometric screening tools which may have excluded women with a language or literacy barrier. Despite these anomalies, the growing body of evidence continues to point towards the growing connection between DVA, forced pregnancies, forced abortions, miscarriages and premature labour, and the deaths of women (Gill, 2009; DH, 2010b, 2005).

As a health concern, DVA is considered one of the most pervasive problems for women, often leading to severe physical injuries, psychological distress, long-term disabilities, social isolation and death (Sharpen, 2009; Home Office, 2011; World Health Organisation, 2008/2013; Walby, 2009; HM Government, 2010/2012; DH, 2010b). The immediate and long-term impacts range from physical injuries, such as bruising from a punch or slap, or broken bones, to attempted strangulation, near-drowning experiences, physical disabilities, insomnia, severe mental trauma and, ultimately, death. An early UK study undertaken by Stanko et al. (1998) highlighted the health consequences during a study of 129 women attending a London GP surgery. The study reported that over 10% of the women had been knocked unconscious during the course of their relationship and 5% had broken bones. Similarly, a week-long survey of 196 accident and emergency departments
by Hutchinson et al (1998) revealed that over 25% of serious facial injuries were attributed to DVA.

### 3.4.5.2 Domestic Violence and BME Children

The review found a growing body of literature detailing the experiences of children witnessing DVA (Humphreys, 2007; Humphreys et al, 2008; Sholensky and Friend, 2007; Sharpen, 2009; Peckover, 2013; Stanley and Humphreys, 2014). However there has been limited examination of the experiences of BME children. The Studies reported that, over a 100-day period, 250,000 children in the UK witnessed DVA, and it estimates that this figure rises to 750,000 annually; over 47% of these cases involve physical violence and 13% involve the use of weapons (DH, 2005; Sharpen, 2009); in 90% of these cases, children are in the same room where the violence occurs or are in an adjoining room (McGee, 2000; Mullender et al., 2002; Mullender, 2005). Although the prevalence of BME children within these statistics remains unknown, it is estimated that exposure to DVA follows a similar trajectory to BME women's experiences and help-seeking patterns for those who have been affected by the issue (Thiara and Gill, 2010). The devastating outcomes for children are illustrated in a number of Serious Case Reviews (SCR) where DVA has been a key contributor. A review of 163 SCRs where a child either died or was seriously injured found that DVA was a significant risk factor in 63% of the cases (Brandon et al, 2012). Similarly, reports from the London Safeguarding Procedure (LSCB) also cite DVA as one of the leading causes of child neglect (LSCB, 2013).

It is difficult to ascertain the resilience of BME children's responses to DVA, although the evidence suggests that over 79% of mothers eventually leave their violent partners and 34,000 children live in refuges annually (Sharpen, 2009). A study by Thiara and Gill (2010) interviewed 19 children from South Asian and African Caribbean backgrounds and reported that all the children were happy to be living outside their abusive household. A critical difference appeared to be that older children expressed relief that they were not living with their abusive fathers, and older boys reported feeling sad and angry towards their fathers. The study by Thiara and Gill (2010) concluded that the key differences relating to BME children's experiences of DVA appear to be the responses of service providers. For instance, the study found that statutory services often underestimate the risk from perpetrators when allowing them access to their children following separation. Furthermore, a report from the DH suggests that children from BME
backgrounds face additional stress factors, such as being used as interpreters in sensitive situations, facing isolation from tight-knit communities, and the possibility that practices linked to *izzat* (honour) and *sharam* (shame) (honour-based violence) will act as additional barriers to disclosure. This study offers limited but valuable insights into the experiences of some BME children (Mullender, 2008; DH, 2010c; Thiara and Gill, 2000); however, understanding of how economic, racial and gendered experiences influence children’s experiences of DVA remains complex. For example, children from close-knit families or communities might be faced with separation from extended families as part of the requirements for living in a specialist refuge. The difficulty in making new friends, disruption to their education, and a perceived loss of security may also influence their emotional wellbeing (Humphrey et al, 2006; Mullender, 2008; Baird, 2011; DH, 2010b).

### 3.4.6 Multi-agency Response to DVA

A fundamental postulate of feminists thought is that women need multi-agency protection from violent and abusive partners to keep them safe. This has been illustrated in the outcomes of domestic homicide reviews where the multiple systemic failings of statutory agencies to adequately protect women where DVA was a known concern have been highlighted (Home Office, 2011). Over the last decade there have been a number of DVA national policy and strategy documents outlining the HV’s role and responsibilities in tackling the issue (DH, 2005; DH, 2005; CAADA, 2010; DH, 2010b/c; Cowley et al, 2010; LSCB, 2010; NHS England, 2014; NICE, 2014). However, very few policies have focused on the role of HVs in a multi-agency response to DVA, and even less attention has been paid to the way women seek support during contact with them. HVs were named as one of the key health representatives at a multi-agency conference to protect families from DVA, but there has been very little discussion about their work within the multi-agency context and their contributions to supporting families.

The national MARAC strategy for dealing with DVA was introduced in April 2003, and at present there are over 270 MARACs dealing with over 65,000 high-risk DVA cases each year. The multi-agency collaborative efforts consist of statutory and non-statutory agencies, including the police, housing, refuge, probation, education, social care and health professionals. The aim of a conference is to share information about victims/survivors and perpetrators in order to co-ordinate risk assessments and ensure that effective safety measures are in place to prevent further violence. A performance review of 208 DVA MARACs across the
UK reported on the multi-agency participation in this work (Steel et al., 2011). The review was conducted over a 12-month period and suggested a participation rate of between 34% and 67% by health representatives at these conferences. This might be compared to a 99% and 92% attendance rate by the police and non-statutory agencies respectively. The findings also suggest that BME representation and participation at these conferences ranges between 3.4% and 5.4%. The review provided very little information about the role of health in multi-agency protection, and these statistics raise critical questions about the commitments and role of the NHS in such a multi-agency approach to the protection of victims.

An exhaustive search of the literature could not locate any evidence of the effectiveness of the MARAC response to the needs of BME families who are seeking support. This is especially relevant because the overwhelming majority of DVA victims/survivors who are known to HV services may not meet the threshold for MARAC referral and may instead continue to seek support from HV services. More importantly, not all BME women may be eligible or entitled to access services provided by MARAC. For instance, women with no recourse to public funds and an unclear immigration status would not be entitled to MARAC services, such as refuges, emergency housing or economic support (WAFNI, 2007; Siddiqui and Patel, 2010). This response contrasts with the multi-agency protection of children who are affected by DVA.

### 3.4.7 Conclusion

Postcolonial feminism is an acceptable theoretical focus for understanding the practices arising from HVs’ work with BME women because of the potential it offers for exploring the intersectionality of gender, race and the political nature of the phenomenon under study. It also poses particular questions for this research by addressing the issue of political representation, deciding whose concerns should be addressed and by whom, and how best to ensure that social and political differences are represented in this research. It offers a way of seeing HV’s actions to reduce health inequalities as particular to the hegemonic power within institutions and it is also the basis from which to identify key concepts to be explored through data analysis.
The attention to black feminist perspectives of DVA has problematised the understandings of existing sociological, psychological and feminist understandings of DVA by drawing attention to the hegemonic structures underpinning BME women’s experiences of the phenomenon. The attention to migration, economics, class, nationality, sexuality and familial practices has exposed a number of complexities that are linked to a wider and inclusive perspective of the issue. The contested notion of the exercise of power within personal relationships has problematise the understandings of DVA within different theoretical lens.

An exploration of the literature suggests that there are significant gaps in knowledge about HVs’ encounters with BME women. In particular, there is a paucity in the area of health-visiting research relating to DVA. Evidence from this review suggests that BME women’s lives and responses to DVA are shaped by the interlocking familial, political and the socioeconomic context in which they live. However it is not known how knowledge of this intersectionality impacts upon HV’s capacity to define, identify and respond to DVA. In relation to this, the nature of HV’s knowledge and representation of BME women’s positon is untested. Notwithstanding emerging evidence pointing to the strong correlation between knowledge empowerment and increased identification and response to DVA provides examples of how this might be applied to HV practice.

Findings from this literature review have highlighted the extent to which DVA impacts upon BME women’s health to create specific features of health inequality. In relation to this, women of childbearing age, pregnancies, socio-economic status and racism appear to interconnect and create specific aspects of vulnerabilities which increase the intensity and duration of physical and emotional trauma. An understanding of how these complexities are linked to the diversity of women’s experiences is still emerging, although evidence shows how this limits women’s resilience and the help-seeking experience. The evidence overwhelmingly confirms the adverse impact on women and children and implicates the HV’s role in addressing the issue and the need for domestic violence to be viewed as a serious public health concern.
4.1 Introduction

This chapter is divided into two parts: the first part presents the methodological strategy, including an account of the literature review strategy including summary of findings, an outline of the researcher’s own epistemological orientation and the research design. It also provides a rationale for the particular design employed, and demonstrates how the strategy fulfils the objectives of the study. The second part engages a mixed-methods and discussion of the research design to illustrate the recruitment strategy, methodological rigour, ethical considerations arising from the study, and the strategies and techniques used to organise and analyse the data. A detailed account of the data analysis is provided, including an explanation of how I developed meaning, interpreted the data, and arrived at the thematic interpretation.

4.1.1 Reviewing the Literature

The construction of research questions are designed to seek causal explanation, to predict or control knowledge about how the world works, and to understand, interpret and elicit meaning about a particular phenomenon or experience (Denzin and Lincoln, 2005; Willis, 2007). This means that, when choosing an approach with which to investigate a particular phenomenon, the researcher’s own conceptualisation and world view need to fit with the design, method and methodological approach in order to produce the types of answers appropriate to the research question.

The aim of the literature review was to identify all the relevant literature in order to establish what was known about HV’s knowledge and practice to identify and respond to DVA in BME women on their caseload.

An integrative literature review method was chosen because the framework summarises the existing empirical or theoretical literature to build a comprehensive understanding of a particular phenomenon and it is congruent with the mixed-methodological research approach (Whittenmore and Knafl, 2005). Designing the literature review strategy this way also enabled rigour and helped to
provide a retrievable audit trail to be used at different stages of the research (Wallace and Wary, 2006). The integrative review followed five stages described by (Whittenmore and Knafl, 2005). A critical appraisal of selected articles can be found in Table Six, illustrating how the articles were reviewed, the relevance to this study, gaps identified and conclusion drawn.

4.1.2 Literature Search Strategies

During stage one, a search strategy was developed following consultation with the librarian and background literature was identified and examined at the onset to help craft the initial research question. Based upon an initial overview of the literature as well as knowledge gleaned from practice experience, an initial research question emerged some key words and search terms were used to refine the search and literature review. The key objectives were to;

- Identify the relevant literature, evaluate contributions made and compare existing theoretical perspectives informing knowledge of DVA in BME communities.
- Explore and critique the current processes supporting practice in asking women to disclose incidents of DVA.
- Signpost gaps and or identify new insights from which to build a convincing argument to validate the purpose of the study.
- Identify a theoretical framework for the study
- Highlight the factors that make HV’s knowledge of this phenomenon a significant problem.
- Establish a well-defined research question to help maintain the focus of the study and present the main findings with critical appraisal.
- Build a transferable theoretical framework for this area of practice and research.

In stage two Hart’s (2002) and O’Leary’s (2010) search strategies were adopted to help identify potential literature for this study and to eliminate inappropriate materials. The strategy included searching the topic and the methodology as subject headings see Table 5, p67 for details of the databases searched. The topic literature, focused on HVs understandings of DVA as they define, identify and respond to the problem. The strategy applied a number of search terms relating to DVA in order to identify studies with the same meaning. For example, using the Boolean operator, keywords such as; *domestic violence, domestic abuse,*
interpersonal violence, battered woman and intimate partner violence AND health visitor OR nurs* OR health professionals AND minority ethnic OR culture OR race OR Intersectionality. The initial combined search terms yielded no direct result. However a revised search strategy using keywords such as 'domestic violence', 'domestic abuse', 'interpersonal violence', 'battered woman' and 'intimate partner violence', combined with search terms; health visit*, health*, nurs*, health professional (Please see Figure 1, p65 Figure 2, p68 and Table 5, p67 for literature review and search strategy). A similar approach was undertaken for the topic and theoretical reviews adding search terms race* OR ethnic* OR culture OR knowledge OR understanding OR Intersectionality.

Figure 1 Integrative stages of Literature Review 'Original in Colour'

Online library searches were undertaken via University of Brighton and NHS libraries using subject words nursing and midwifery, health professionals, social policy sociology and psychology on cross search. Studies published in languages other than English and anecdotal evidence were excluded. The search was limited to years 2005-2016, to reflect the introduction of routine enquiry (DH, 2005). However, research conducted with HVs prior to the introduction of routine enquiry were included because of their potential to add value to the specific nature of this research question. Studies involving social workers, midwives and other healthcare workers were also included because of the potential for transferable knowledge to the specific nature of HV work. Due to the specific nature of the HV’s discipline seminal work conducted with HVs more than 15 years ago was included in the review.

Studies undertaken in other disciplines such as psychology and sociology were included to enable greater insights into the conceptual difficulties and complexities in defining and naming DVA. Manual method, which included tracking citations
from references and bibliography, known Authors, discussions with fellow researchers, contacts with known authors as well as searches of specific sites such as UK DH and Home Office online sites used with limited success (See Table 4, p66; Table 5, p67; table 6, p71-77). During the first phase, a computerised search produced 1,981 references of which 1847 were excluded for reasons of topic, either because they did not directly related to the context of health or social care or the studies did not address the issue of knowledge/education relating to DVA or the research question. At times difficult to compare and critique some articles because of the different theoretical traditions and partly because most to the work did not appear to build on the work of each other. From this, theoretical influences were at times obscure.

In the third phase a total of 136 full articles were read of which 101 studies were excluded on the grounds of the context and description given of identification and referral of DVA. Finally 35 studies were identified. The excluded studies focused mainly on electronic screening tools exclusive risk assessment tools. The characteristics of the selected studies were set out on a review template adapted from Crowe et al, (2012). The studies were analysed on the basis of their design, method and research validity and reliability. A number of the studies were conducted using a variety of data collection and research method, including secondary analysis and in two instances studies published from the same research were included because they differ in their approach and report on the data. Transferability and generalisability relating to sampling was a limitation in a number of the studies.

<table>
<thead>
<tr>
<th>Identifying Inclusion Criteria</th>
<th>Identifying exclusion criteria</th>
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<tbody>
<tr>
<td>1. Studies that examine professional’s knowledge of DVA in BME communities.</td>
<td>1. Studies conducted/published in language other than English.</td>
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<td>2. Studies that examine professional knowledge of DVA.</td>
<td>2. Studies that did not meet the main focus of the paper.</td>
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<td>3. Studies conducted in similar profession such as social care.</td>
<td>3. Studies that included self-reporting of DVA (e.g. reporting via electronic device) excluded because of the lack of focus on professional knowledge.</td>
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<td>4. Studies conducted more that 10 years ago included because of the specific focus on DVA and HV’s practice; including studies undertaken prior to the introduction of routine enquiry.</td>
<td>Papers with anecdotal evidence.</td>
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Table 4 Literature Review Inclusion and Exclusion Search Strategy
Table 5 Example of Databases Searched and articles identified 'Original in Colour'

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<th>Databases searched</th>
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<tr>
<td>British Nursing Index</td>
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<td>Cumulative Index Nursing &amp; Allied Health Literature</td>
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<td>PsychINFO</td>
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STAGE 1: Studies identified through database and hand search after applying search terms combined.
STAGE 2: Number of articles remaining after search limits inclusion and exclusion criteria applied.
STAGE 3: Number of articles remaining after abstract assessed for eligibility against research question, aims and objectives. Duplicates removed from each database.
STAGE 4: Number of suitable full text articles after further exclusion/inclusion e.g. suitable for transferable knowledge.
Search Strategy: PRISMA Flow Diagram (Moher et al, 2009)

Stage 1 electronic searched for academic

Stage 2 screening of articles titles and abstract

2 additional articles used from citations list and through specific government, health sites and other grey literature

Stage 2: detailed review applied search limits/inclusion/exclusion criteria against article titles.

1981 total articles

1847 articles excluded

134 full-text articles

Stage 3: 136 full text

Detailed review applied; total duplication removed. Exclusion criteria against full text article and research aims and objectives

101 articles excluded including 21 duplicates.

Stage 4 data extraction and review of included articles

Stage 4: 35 articles included

35 additional articles with potential for knowledge transfer included in the review

7 of the 35 empirical studies directly relating to HV knowledge included in the review

Figure 2 PRISMA Flow Chart Literature Review: ‘Original in Colour’
The search generated a range of studies including literature review, editorials and empirical research relating to health professional’s experiences knowledge about DVA. However the review of the literature found limited empirical research focusing specifically on HVs’ practices to address DVA beyond the work of (Frost, 1999; Peckover, 2002a; Bateman and Whitehead, 2004; Allen, 2012; Bradbury-Jones, 2013 and Taylor et al, 2013). Furthermore a comprehensive review of the literature found limited empirical evidence of how HVs respond to the issues of the intersectionality of race, gender politics when responding to DVA (see Table 6, p71-77 for details of the critical appraisal of the empirical studies used in section 2.4 of this document.

The review in chapter Three has delineated the ways in which existing research rarely prioritise, the issues of the intersectionality of race, gender, politics and DVA, ultimately influences and reproduces the homogeneity of women’s experiences and fails to represent marginalised groups. For instance, service provision for women seeking support for DVA is based on the pervading views about the nature and prevalence of DVA. However, evidence shows that knowledge which influences and informs the provision of services does not always include the representation of BME women’s experiences. These contexts also demonstrate the interconnectedness of knowledge and power and demonstrate the gaps in existing research methodology.

Findings from this literature review have highlighted the extent to which DVA impacts upon BME women’s health to create specific features of health inequality. In relation to this, women of childbearing age, pregnancies, socio-economic status and racism appear to interconnect and create specific aspects of vulnerabilities which increase the intensity and duration of physical and emotional trauma. An understanding of how these complexities are linked to the diversity of women’s experiences is still emerging, although evidence shows how this limits women’s resilience and the help-seeking experience. The evidence overwhelmingly confirms the adverse impact on women and children and implicates the HV’s role in addressing the issue and the need for domestic violence to be viewed as a serious public health concern.

Despite a plethora of emerging research illustrating the importance of health interventions in reducing the intersectionality of DVA, health, race and politics (Thiara et al, 2011; Rehman et al, 2013; Montesanti and Thurston, 2015; Gill et al, 2016 and Mackenzie et al, 2015). These concerns were rarely reflected in the
empirical studies and knowledge frameworks relating to DVA and health. This is significant because of the requirement for HVs to identify and respond to disclosure of DVA remains the cornerstone of their practice to address the health impact of DVA (DH, 2005; NICE, 2014). The Knowledge informing the nature and prevalence of DVA as it relates to HV practice does not appear to reflect issues relating to social identities and the intersectionalities of BME women’s lives. Therefore this research aims to answer the following questions:

- What constitutes knowledge of DVA generated during professional contacts with BME communities?
- What roles, if any, do race, politics, and gender play during day-to-day professional encounters to uncover DVA?
- How does this knowledge shape professional relationships and influence the nature of HVs’ contacts when asking BME women to disclose DVA incidents?
The Role of HVs in identifying DVA; Literature Review Appraisal: adapted from Crowe et al (2012).

<table>
<thead>
<tr>
<th>Author</th>
<th>Year and place of study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Findings: Comparative Review</th>
<th>Gaps: Implications for this study</th>
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<tr>
<td>Cann et al, 2001. UK</td>
<td></td>
<td>Comparative survey of levels of detection, knowledge and attitudes in healthcare workers in different specialist areas.</td>
<td>Doctors, nurses is specialist practice including HVs.</td>
<td>Nurses and community health workers reported significantly better knowledge and positive attitude that other health care professionals. Overall nurses lack effective knowledge and skills.</td>
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<td>Feder et al, 2001. UK</td>
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<td>Anonymous Survey of health professionals’ attitude and clinical practice towards DVA. Evaluation of training needs, identify characteristics of professionals and practice that influence attitude to routine questioning.</td>
<td>140 HVs, 180 practice nurses, 380 general practitioners.</td>
<td>32% of respondents thought that health visitors should routinely ask compared to 14%practice nurses and 14% GPs. Profession was the most significant factor associated with the view that DVA is a health concern. HV were more likely to view DVA as a health concern.</td>
<td>Findings contradict studies showing that health professionals do not object to asking about DVA. Suggests that DVA knowledge and intervention need to be context-specific and service-led.</td>
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<tr>
<td>Peckover 2003. UK</td>
<td></td>
<td>Feminist post-structuralist methodological approach. Investigate Health Visitors’ Understanding of DVA.</td>
<td>Semi-structured interviews with 24 health visitors and female service users.</td>
<td>HVs had a low awareness of DVA on their caseloads. Difficulties naming DVA linked to the broad range of physical and psychological abuse. HVs did not routinely ask women about DVA</td>
<td>Sampling strategy. Study conducted before the introduction of routine enquiry and subsequent change in DVA definition.</td>
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<td>Author And Year</td>
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<td>Morgan, 2003. USA</td>
<td>Self-administered survey assessing the DVA educational needs of health care staff. Found limited knowledge of DVA. Prior to educational programme staff lacked sufficient knowledge and skills on DVA.</td>
<td>147 Medical staff, midwives and gynaecology nurses took part in an educational programme.</td>
<td>Educational programme appeared to follow and biomedical model of physical health programme. Participant who experienced DVA were more likely to act as a barrier to reporting. Study identify the need for effective educational programme and policy to provide practitioners with appropriate knowledge and skills.</td>
<td>Practice knowledge to identify and report DVA should be contextual depending upon the areas of specialities.</td>
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<td>Westmarland et al, 2004. UK</td>
<td>Report from a pilot programme to introduce routine enquiry. Measuring the effectiveness (pre and post) knowledge/training following the introduction of routine enquiry.</td>
<td>General practitioners.</td>
<td>GPs had different levels of awareness of the issue but provided positive feedback on knowledge empowerment but cited practical difficulties with asking such as time, resource. Knowledge empowerment focused upon the Duluth Power and Control Wheel.</td>
<td>Knowledge of the Intersectionality of women’s lives not included.</td>
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<td>Evanson T.A 2006. USA</td>
<td>Systematic review of community health nurses’ knowledge of domestic violence.</td>
<td>Community home visiting nurses.</td>
<td>Multiple gaps in knowledge exist; research needs to capture the reality in which community nurses practise.</td>
<td>The review acknowledges the multiple realities which shape community nurses’ practice but provides limited insight into how diversities within families and ethnicities influence knowledge of DVA.</td>
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<td>Bond et al, 2006. UK</td>
<td>Practice-base service evaluation amongst health professionals; following an education programme to identify and report DVA.</td>
<td>Community practice-based staff including nurse practitioners and midwives.</td>
<td>The use of psychometric by healthcare staff questionnaires increased reporting however differences in ethnicities not known.</td>
<td>Knowledge of the Intersectionality of women’s lives not included.</td>
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<td>Davila, R (2006) USA</td>
<td>Service evaluation of a pre and post-theoretically based DVA service programme amongst public health nurses.</td>
<td>Public health nurses.</td>
<td>Significant knowledge improvement following a DVA educational programme.</td>
<td>The supports the need for DVA knowledge empowerment in practice.</td>
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<td>Price et al, 2007. UK</td>
<td>Part one of a longitudinal study 82 community midwives: Semi-structured interviews self-completion questionnaires, face to face interviews and focus groups following the introduction of an educational programme and routine enquiry.</td>
<td>Community midwives.</td>
<td>Reported six-fold increase in identification of DVA. The study identified increased positive attitudes, increased knowledge, skills and identification of women experiencing DVA. However some decrease noted over time.</td>
<td>The research recommend distinction between initial routine enquiry and long term specialist management of family violence. Implication for health visitors who manage women on a longer-term basis. Access to resources appears to compliment knowledge empowerment. The study did not reference the intersectionality of women’s experiences of DVA as part of the knowledge empowerment.</td>
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<td>Lazenbatt et al, 2007</td>
<td>Postal survey questionnaire.</td>
<td>Hospital and community midwives.</td>
<td>Reporting of DVA routine enquiry diminished with lack of appropriate knowledge and skills. Hospital based midwives consistently under-estimate the prevalence of DVA compared to community-based midwives.</td>
<td>Professional intimacy with women in their own homes appears to influence disclosure. However, findings from Wellock (2008) suggest that community-based routine enquiry represent a greater risk for some BME women.</td>
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<td>Smith et al, 2008</td>
<td>Quantitative survey asking nurses to identify barriers that prevent them from reporting DVA.</td>
<td>Postal questionnaires of 184 registered nurse.</td>
<td>The nurses did not identify issues of race and ethnicities as barriers to reporting DVA. However the overwhelming majority of nurses cited not enough evidence and patient confidentiality as reasons for not getting involved.</td>
<td>Women’ safety was not a significant feature in asking women to disclose. Analysis of study did into identify participants’ knowledge of help-seeking behaviour in different patient groups. Some participants cited discomfort although this is not clarified in the study.</td>
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<td>Gutmanis et al, 2007</td>
<td>Postal survey of nurses and physicians’ attitude and behaviour in respect to routine enquiry.</td>
<td>Physicians and nurses.</td>
<td>Educational programme found fear of offending women, feelings of powerlessness and real world resources prevent staff, contextual knowledge and preparedness directly linked to practitioners’ decision to ask women to disclose DVA.</td>
<td>Identify the need for contextual knowledge empowerment and educational programme. Issues of race, ethnicity, familial and institutional politics not included in educational programme.</td>
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<tr>
<td>Jack et al, 2012 Canada</td>
<td>Case-study approach to identify core components of DVA intervention programmes</td>
<td>69 Family nurse partnerships and focus groups with abused women.</td>
<td>DVA Educational interventions tailored to the specific practice needs of nurses delivering interventions</td>
<td>Successful risk identification in clients with multiple and diverse health and social care needs linked to specific educational programme. The study supported the findings of Price et al, (2004) and O’Campo et al, (2011).</td>
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<tr>
<td>Litherland, 2012</td>
<td>Literature review to investigate health visitors’ role in the identification of domestic abuse.</td>
<td>Review of DVA screening tools. Comparative review of routine versus selective enquiry and barriers to identification.</td>
<td>The review supports the principles of routine enquiry. Screening tools yield higher rates of disclosure. The study acknowledge that women conceal abuse as part of their coping strategies. HVs identified as being ideally placed to undertake routine enquiry.</td>
<td>Barriers to identification do not consider how issues of race, ethnicities, genders and politics influence victimisation process and whether this is reflected in existing screening tools.</td>
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<tr>
<td>Trevillion et al, 2012 UK Nayme et al, 2013. UK</td>
<td>Qualitative investigation into service users and health professionals’ experiences of service intervention to address DVA.</td>
<td>24 mental health professionals and community mental health service users.</td>
<td>Some health professionals did not consider routine enquiry to be acceptable compared to the acceptability of all service users. Reported lack of appropriate knowledge and organisational support for addressing DVA. Although psychiatrist reported significantly greater knowledge of the impact of DVA, they did not feel as ready as nurses to use their knowledge to assess and manage disclosure.</td>
<td>Dominance of the medical model, availability of resources and lack of appropriate knowledge and skills relating to DVA influenced understandings of DVA.</td>
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<tr>
<td>Ramsay et al, 2012 UK</td>
<td>To measure DVA knowledge, attitudes and clinical practice of selected UK primary healthcare clinicians prior to an identification and referral educational programme.</td>
<td>Prospective observational cohort of 183 GPs and nurses.</td>
<td>Poor detection of DVA identified in the study. Clinicians felt poorly prepared to address DVA. WITH 80% stating that they did not have sufficient knowledge of DVA resources.</td>
<td>Identify urgent need for graduate and post graduate DVA education to effectively shape practice. Survey of practice knowledge did not address issues of the intersectionality of women’ experiences of DVA.</td>
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<tr>
<td>Beccaria et al, 2012 Australia</td>
<td>Qualitative investigation into student nurses understandings of intimate partner violence (IPV).</td>
<td>Student nurses.</td>
<td>Student nurses had limited understanding of what constitutes IPV. Participants did into understand the significance of the intersectionality of DVA, social, economic and health.</td>
<td>The study highlighted the importance of DVA knowledge in graduate educational programmes.</td>
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<td>Allen, 2012. Ireland</td>
<td>Mixed method investigation into Irish Traveller women experiences of DVA.</td>
<td>Irish Traveller women and 90 service providers.</td>
<td>Irish traveller women experience discrimination in accessing services for DVA that is linked to the absence of culturally-sensitive knowledge and service responses.</td>
<td>Knowledge of culture and ethnicities can significantly add to the understanding of the needs of minority ethnic women’ experiences of DVA and help-seeking behaviour.</td>
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<td>Baird et al, 2007 and 2013. UK</td>
<td>Longitudinal study and multi-method approach to evaluate the degree to which practice changes into routine enquiry have been maintained.</td>
<td>Midwives.</td>
<td>Knowledge and confidence to ask women to disclose DVA increased and maintained over time with training, suggesting that DVA training should be mandatory. Participants felt that more thought was required to address the needs of ‘particular groups of women’.</td>
<td>The study did not address the issue of contextual knowledge and whether or not issues of the Intersectionality of women’ lives were included in the training programme. Limitations in translating hospital-based practice as emerging evidence suggests disproportionate risk in asking BME women to disclose DVA in their homes.</td>
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<tr>
<td>Ambuel et al, 2013. USA</td>
<td>Qualitative investigation into health professionals' knowledge of DVA following the implementation of a change programme in emergency and primary care settings.</td>
<td>Doctors and nurses.</td>
<td>Reported increased understanding of policies and procedures. Knowledge of DVA remained unchanged. Identification and referral of DVA increased and sustained over two years.</td>
<td>Knowledge empowerment of women by health professionals appeared to increase DVA reporting. Health care professionals’ perception of DVA incongruent with abused women’ perception of DVA.</td>
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<td>Taylor et al 2013</td>
<td>Critical incident technique aimed at exploring health community health professionals’ beliefs about domestic abuse and the issue of disclosure.</td>
<td>Midwives, health visitors and GPs and 14 women.</td>
<td>Finding show points of convergence and divergence between health professionals and women’s knowledge. Women and Health professionals do not always share the same view of DVA. Many women did not recognise their situation as abusive.</td>
<td>Complexities that are linked to the understandings of DVA. The study offered a conceptual framework (Commons Sense Model) from which strategy to ask all women about DVA can be developed.</td>
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<td>Bradbury-Jones et al, 2015. See also Taylor et al, 2013. Study linked to Taylor et al 2013. UK</td>
<td>Phase two- Secondary Analysis. Investigation into domestic abuse awareness and recognition among primary healthcare professionals and abused women.</td>
<td>Semi-structured individual 29 Midwives, health visitors and GPs and 14 women.</td>
<td>The study a conceptual framework (AWARE), consciousness and recognition. Knowledge incongruence about DVA between health professionals and abused women.</td>
<td>Knowledge empowerment frameworks to address DVA should address the strategies and responses adopted by abused women health professionals. Abused women can exercise silence as a means of control. Professional silence linked to a number of complex factors including personal experiences of DVA, inappropriate knowledge and the traumatic responses to the emotional labour of addressing DVA.</td>
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<td>Keeling and Fisher, 2015. UK and Australia</td>
<td>Feminist investigation into health professionals’ response to women’s disclosure of domestic violence.</td>
<td>Interview with 15 abused women.</td>
<td>Health professionals inadvertently mirror the behaviours of abusive partners through inappropriate actions or inactions.</td>
<td>Health professionals were not fully equipped to sensitively ask women about DVA. Asking women about DVA must be sensitive to the context and based upon appropriate knowledge.</td>
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<td>Author And Year</td>
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<td>Bradbury-Jones and Broadhurst 2015. UK</td>
<td>Qualitative investigation into student nurses’ and midwives’ knowledge, confidence and educational needs regarding recognition and response to domestic abuse.</td>
<td>Interviews with student nurses and student midwives.</td>
<td>Students view the issue of DVA as important with some having sound knowledge of the nature and consequences but lack confidence in recognising and responding to abuse.</td>
<td>Study identified issues of gaps between theory and practice. Practitioners ill-prepared. A proposed knowledge empowerment framework could direct attention to the political aspect of BME women’s experiences.</td>
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<td>Mackenzie et al, 2015</td>
<td>Literature review exploring two theoretical perspectives with implication for knowledge of DVA, literature synthesis of how to improve understandings of women’ help-seeking and response to services.</td>
<td>Knowledge of intersectionality offers a means of enhancing knowledge of how the social and political becomes enacted in the personal.</td>
<td>Requires further investigation of the efficacy of this framework and exploration of how this can be embedded in practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mauri et al, 2015 UK and Italy</td>
<td>Explore midwives’ knowledge and clinical experiences of DVA among pregnant women.</td>
<td>Semi-structured interviews.</td>
<td>Diversity of women’ experiences influence common understandings of DVA. Cultural taboos and women’ unwillingness to disclose influence professional’ knowledge of the issues. Specific training and screening tools advantageous.</td>
<td>Findings suggests that the specific nature of health professionals’ knowledge and context in which they work influence outcome for women.</td>
<td></td>
</tr>
</tbody>
</table>
4.1.3 Philosophical Underpinning

Since there are different ways of seeing the world and different possible answers to these research questions, it is imperative that the perspectives adopted in this thesis are clearly explained and justified in order that the objectives and outcomes may be rigorously evaluated (Willis, 2007; Denzin and Lincoln, 2005). As a methodological approach, postcolonial feminism is rooted in the critical theoretical paradigm, and a postcolonial perspective on knowledge production provides the opportunity to expose the colonising process of knowledge production about BME women’s experiences of DVA and to reframe the way we think about the phenomenon.

The social constructionist ontological position believes that the nature of realities is subjective and contextually and historically bound (Gergen, 2009). Social constructionism as a philosophical branch of knowledge development assumes that our understanding of the world, and the significance and meaning we ascribe to a particular event, are developed from our relationships with those around us (Gergen, 2009). This means that we make sense of the world and experience a particular phenomenon around us depending on, gender, social position, age, (dis)ability, sexuality and economic circumstances. We make sense and respond to other people’s experiences based upon historical encounters with the phenomenon, which influence our capacity to make sense of their world.

One of the key characteristics of the social constructionist ontological stance is that the formation of social relationships is one of the key ways in which human beings make sense of experiences around them in order to create meaning. This is taken to mean that relationships have the potential to shape our interactions with one another during our everyday encounters, and that the context in which those interactions take place can significantly alter the way we view a particular phenomenon (Gergen, 2009). For example, within the context of this study, HVs develop their knowledge of DVA and the meaning they ascribe to it, not as separate individuals but in coordination with other HVs and the way in which the problem is defined, named and articulated by others.

4.1.4 The Epistemological Perspective

A social constructionism ontological and epistemological perspective is consistent with a postcolonial feminist theoretical perspective because each acknowledges
the material existence of reality/realities while at the same time recognising that there are different ways of seeing and knowing about the world (Harding, 2004; Haraway, 1991; Ramazanoğlu and Holland, 2009; Collins, 2009; Gergen, 2009). In particular, feminist researchers are concerned with how people come to understand what they do and the meaning they attribute to those actions, while recognising the subjective and historical context in which knowledge about the world develops. In this regard, postcolonial feminist thinkers acknowledge the hegemonic nature of knowledge production, which might either liberate or dominate a particular perspective or worldview.

This means that, in order to understand the way in which HVs create meaning about DVA during their conversations, I must adopt a critical analytic stance towards existing knowledge informing HV practices and the understandings of DVA. What I am seeking to describe and explain is rooted within the historical, political, gendered and racialised subtleties of human realities, which cannot be realised by counting, measuring and testing a hypothesis. The knowledge described is assumed to be complex, interwoven within the public and private lives of participants and embedded within the political, social and gendered structures of day-to-day lives. HVs are not a homogenous group, nor can they be described as innocent bystanders or neutral in their interactions with the women they encounter. To gain access to this kind of understanding requires an exploration of the personal, political, professional and institutional culture that governs and influences how they work.

The issue of postcoloniality in relation to knowledge production and social relations is fundamental to the aim and objectives of this study. This is because it is argued that hegemonic knowledge remains at the heart of imperialist structures within political organisations and it is the context through which hierarchical relationships are established and reproduced and truth and reality are established (Spivak, 1988; Mohanty, 1988; Sandoval, 1991; Ashcroft et al, 2002). This is explicit in the work of Ashcroft et al (2002) who appropriated a postcolonial interpretation of English literature to demonstrate how historical moments of colonially ideological dominance continue to be reproduced in the 21st century.

4.1.5 Qualitative Paradigm

Some qualitative researchers argue that, since we cannot separate ourselves from the world around us, researchers must play an active role in creating meaning with
participants (Belenky et al., 1997 and Denzin and Lincoln, 2008). While this might lead to claims of bias at all stages of the research process, a number of strategies have been developed to ensure the trustworthiness of this research approach, including a process of self-reflection during the research process, methodological rigour, and critical audit trails (Willis, 1992 and Hanson, 2013).

The commonalities in qualitative research strategies reject a single unified approach to knowledge development. Rather, it is posited that research is situated in context, and the meaning of reality is transcendent and socially constructed. Within this, researchers often face critical and moral dilemmas over the issues of validity and the verification of data, and the representation of marginalised voices. Denzin and Lincoln’s (2008) metaphorical inscription of the bricoleur and quilter-maker illustrates the ever-changing nature and shades of objectivities within qualitative research design and the postmodern approach to knowledge development. This perspective has led to criticism that, as a process of research, it is less scientific. Unlike quantitative research, no attempt is made in qualitative enquiry to lay particular claims to truth, and some researchers argue that it is unhelpful to measure or compare methods of reliability, since they cannot be measured by the same yardstick (Campbell and Bunting, 1991). However, the qualitative methodological approach acknowledges the subjective nature of knowledge production, but also emphasises the inductive approach to finding meaning from a particular perspective. Therefore, decisions to adopt quantitative, qualitative or critical methodological approaches are not based upon whether or not one is particularly more accurate or better than the other; rather, it is a matter of the appropriateness of the methodology for producing the answers to the particular question and the intention of the research (Denzin, 2005; Letherby, 2003).

A central goal of the critical research methodology in nursing is to produce knowledge that can be used to critique the socially constructed borders of health and social inequalities. A qualitative approach appears to be an appropriate fit with which to conduct this research because of the possibility of exposing, representing and interpreting HVs’ knowledge and practice encounters with the multiple subjective realities of BME women’s lives.
4.1.6 Postcolonial Feminist Methodology

A central goal of the critical research methodology in nursing is to produce knowledge that can be used to critique the socially constructed borders of health and social inequalities. The emancipatory goal is to challenge the ideological limitations which separate an objective reality from a subjective knowing and to use the knowledge gained to transform human lives (Ray, 1992; Wells, 1995 Denzin, 2005; Confortini, 2011 and Aranda et al, 2015). Therefore enabling the space and creativity to articulate hidden and complex ideas in order to promote political representation and to challenge injustice.

Postcolonial feminist methodological approaches to knowledge and the qualitative interpretative paradigm are inextricably linked to the critique of imperialism and colonialism, which rejects the notion of a single interpretative truth and is concerned with the ways in which knowledge about marginalised groups is obtained, interpreted and represented back to the world.

The feminist’s approach to research does not privilege a particular technique for gathering evidence or analysing data. Rather, it upholds the ethical commitment to conduct research in a non-exploitative and transparent manner, to produce credible knowledge, justify the rules of the method, and provide a clear rationale for decisions taken during the research process (Campbell and Bunting, 1991 and Letherby, 2003). Letherby (2003) argues that the single most distinguishing feature of feminists’ research is the overtly political nature of emancipatory commitment to material and social change. Therefore, research should start from the premise that the nature of reality is hierarchal and unjust. However, some postcolonial feminist theorists argue that focusing on this approach can result in the rigid depiction of BME women as an oppressed group lacking in agency (Mohanty, 1998; Kelly, 2013). In so doing they reinforce the negative of BME women as perpetual victims whose lives are defined by violence. For example, Thiara (2013) invoked the racialised construction of African Caribbean women as strong and lacking in “cultural needs”, as well as the construction of collective victimhood experiences to illustrate how negative stereotyping can lead to the perception of African Caribbean women as more resilient to violence and thus leave them unprotected. To address these concerns I have adopted the strategy of emancipatory knowing. Bickford’s (2014) asserts that avoiding such analytic pitfalls must engage the praxis of emancipatory knowing, to demystify the conditions that create cultural essentialism by re-creating knowledge and
analysing systems of exclusion and institutions e.g. science, representation and languages as instruments against essentialism.

Tensions within the politics of *representation* as it relates to this research are infused with power relations and troublesome ethical questions which have the potential to essentialise women’s concerns. Furthermore, the material conditions of people’s lives are inherently subjective, contradictory and complicated; thus, the degree to which *representation* can transform power relations and improve inequalities remains contested, not least because it involves making critical decisions about whose voice should be silent and whose should be heard. Therefore, a critical interrogation of how the practice of *representation* in this study has effectively recuperated the feminist claim of political efficacy can only be measured by the strength of this research in drawing attention to knowledge about the lives of BME women’s experiences of DVA (see figure 3 below).

**Figure 3 Feminist Methodology ‘Original in Colour’**
4.2 Research Methods

This is a multi-method design using postcolonial feminist theories and philosophical approach as outlined earlier in this chapter; the methodological design is guided by (Letherby, 2009; Willis et al, 2007 and Saldana 2012). The design began with the conceptualisation of the research aims and objectives, the identification of the data collection strategy, and the gathering of empirical evidence, moving beyond mere descriptions of textual data towards an explorative and interpretive technique to uncover patterns and themes while searching for hidden meanings in HVs’ conversations. Documentary texts from four key policy and practice guidance documents were analysed as part of the empirical data in order to place the HVs’ narratives in context (Wodak and Meyer, 2001). The issues of trustworthiness and rigour are discussed throughout the remainder of this chapter.

4.2.1 Recruitment Strategy

The intention of the selection process was to conduct semi-structured interviews with 20 HVs, selected from dedicated NHS community care settings, who regularly work with BME women. The recruitment sites were chosen because of the enriched and diverse demographic make-up of BME women on HVs’ caseloads, as well as the subtle diversities of practice experiences from the recruitment sites. I ensured that the selected participants reflected the ethnic diversity of each recruitment site (Gerrish and Lacey, 2006; Bryman, 2008). In addition, four policy documents were selected as part of the empirical data (see Figure 4, p84 and Figure 5, 85). The policy documents were chosen because each contributed directly to HV practice and influenced organisational procedures to provide services for BME women experiencing DVA. As part of the approval to take part in the study, the HV managers gave permission for the interviews to be conducted during working hours at no additional cost to the HVs.

All potential participants were given full information about the purpose of the study, the potential implications of taking part, the potential benefits of the research to practice and the potential risk to themselves including how disclosure of risk to patients would be addressed. A detailed information pack outlining the purpose of the research, consent, risk, benefits and the governance of the research is located in Appendix One. The recruitment steps and strategy are outlined in figure 4 and 5. The researcher followed the process of ethical approval from the University of
Brighton and each participating NHS Trust’s research and development department. Twenty HVs participated in this study and were recruited from across two Community NHS Trust urban sites.

**Figure 4 Recruitment Process: ‘Original in Colour’**
Invitation to Participate in a Research Project

The aim: To explore health visitors’ understanding of intimate partner violence in black and minority ethnic women.

The purpose: is to gain insight into the barriers presented by disclosure for BME women in the hope of addressing the negative health impact associated with non-disclosure.

The findings: the data will be collated and analysed to present and inform the current practices, policies and procedures for managing intimate partner violence.

Participation in the study: will involve face-face or telephone semi-structured interviews lasting approximately 1 hour. The interviews will be audio-taped alongside written field notes.

ABOUT THE STUDY This is a qualitative multi-design study including interviews, documentary analysis and literature reviews. The interviews will explore themes around health visitors’ understanding of intimate partner violence, the nature of the client and patient relationship and the strategies used to facilitate disclosure.

Participation is completely voluntary and you will be free to withdraw at any time until the start of data analysis. Due to the sensitive nature of the topic being discussed, access to child protection supervision is critical to participation. All data will be anonymised during analysis and destroyed 3 years after completion of this study. Information gathered during the study will not be shared with your employer. However an anonymised summary of the study will be available to the general public following publication.

I will be undertaking a series of presentations at the Schedule Health Visiting Forum where you will be able to clarify any concerns you may have and ask further questions about the project. A summary of the result will be available to you before wider dissemination either in one-to-one or group settings.

If you are interested in participating in this project and would like further information please contact me at: norma.sarsby@gmail.com or call me on my mobile.

Kind Regards
Norma Sarsby
4.2.2 The Participants

The HVs who participated in the study were registered nurses or midwives who had undertaken additional formal professional development to register with the Nursing and Midwifery Council as specialist public health practitioners. Prior to the interviews, participants were asked to provide an overview of their biographical and professional details. This provided the basis for the participants’ profiles shown in Table 7, p87.

For ethical reasons and to protect the identity of each participant, names and ethnicities were anonymised and I have limited the amount of personal information provided by participants due to the interconnectedness of HV networks and the small population of practitioners. As part of the governance strategy for this research, I invited five representatives from non-statutory agencies to support the direction of the study as part of a steering group. However, following some re-commissioning and organisational restructuring, this was no longer possible due to unplanned redundancies and resource implications. Attempts at further recruitments proved complex due to limited response.
<table>
<thead>
<tr>
<th>Group A</th>
<th>Professional Characteristics</th>
<th>Age group</th>
<th>Years in practice</th>
<th>Interview location,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jayjay, Indera, Ronny, Marella, Martine, Jennieve,</td>
<td>Specialist community practitioners (Health Visiting), Registered General Nurse and Registered Midwives. Specialist Community Practice Teacher. Registered Mental Health Nurse. Practice Lead</td>
<td>Aged 45 and over</td>
<td>&gt;20 years</td>
<td>Face-to-face, NHS premises.</td>
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<tr>
<td>Group B</td>
<td></td>
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</tr>
<tr>
<td>Kemi, Pamella, Tami, Marykay, Jennifer</td>
<td>Specialist community practitioners (Health Visiting), Registered General Nurse and Registered Midwives. Specialist Community Practice Teacher. Liaison HV</td>
<td>35-50 years</td>
<td>10-15 years</td>
<td>Telephone and face-to-face. NHS premises.</td>
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<tr>
<td>Group C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorna, Tamara, Yenka, Erica, Ester, Janet, Indera, Danielle</td>
<td>Specialist community practitioners (Health Visiting), Registered General Nurses and Registered Midwives. Specialist Community Practice Teacher. Practice lead.</td>
<td>35-50 years</td>
<td>5-10 years</td>
<td>Face-to-face, NHS premises.</td>
</tr>
</tbody>
</table>

Table 7 Characteristics of Participants ‘Original in Colour’
4.3 Data Collection

There are three distinguishing features of a feminist research method: the types of research question being asked; the location of the researcher within the process of the research; and how the researcher uses the knowledge gained about women’s lives to make a difference (Letherby, 2003). This requires the researcher to pay close attention to the methodological congruency of the data collection, as the tool must enable the data collected to represent participants’ views as accurately as possible; it is also necessary to adopt a non-exploitative approach during the fieldwork.

The empirical data for this study included semi-structured face-to-face and telephone interviews with twenty HVs as well as textual documentary evidence. Interviews and textual documentary analysis are popular methods of data collection in emancipatory research because language as a form of social interaction and textual data provides the means to analyse structural relationships, concepts of power, and the historical context that legitimises meaning and understanding within organisation (Wodak and Meyer, 2001; Lejano, 2006; Silverman, 2006). Interviews and documentary analysis were also chosen as a method of data collection because it is a method I am comfortable with and it is a process that will enable me to elicit key information as it arises. Moreover, interviews are the bedrock of feminist research because they offer the possibility of naming or representing a particular phenomenon (Oakley, 1990; Letherby, 2003). This approach is also consistent with social constructionism since interviewers and interviewees are seen as co-constructing meaning while paying attention to the balance of power during the research process. Other methods of data collection such as participant observation were considered but discounted because of potential ethical concerns that might place both participants and the women at risk.

Consideration was given to the potential impact of a pilot study on HV resources (Polit and Beck, 2006). However it was decided that a pilot study would not necessarily add significant benefit to this research because the interview processes appeared to be relatively straightforward. Despite careful planning during this stage of the process, I nevertheless encountered a few unforeseen issues. For instance, when participants were asked, ‘How would you describe your understanding of DVA?’ the majority of respondents merely repeated the newly publicised national definition. This meant that the research question had to be rephrased and adapted, and the questions had to be asked in different ways. It
was during this early stage that I abandoned efforts to capture critical thoughts during interviews, as I discovered that taking notes was distracting and disrupted the flow of the interviews; instead, critical reflections were captured immediately after the interviews as post-interview diaries.

Attention to power relations during the research process has been the cornerstone of feminist research with women. Some feminist researchers emphasise the need for participants to set the agenda during data collection as a way of breaking down hierarchy during the interviews (Letherby, 2003). This may be appropriate in some instances, depending on the nature of the research question, but when considering this approach I felt that it would not have been an appropriate strategy for addressing the research question. Instead, I adopted Silverman’s (2009) strategy of using open-ended questions to maximise the potential for greater participation by the HVs; concurrently, it enabled me to maintain control over the direction of the questions. Semi-structured interviews were determined as appropriate for this study because they enabled me to represent participants’ voices as much as was humanly possible, while at the same time actively engaging in the co-construction of knowledge with HVs. Letherby (2003) postulates that finding such a balance in feminist research is a crucial part of addressing inequality, exploitation, and even betrayal of data sources. During the interviews I worked to overcome these issues by allowing participants to recall their experiences in their own words. Discrepancies were clarified both during and after the interviews where necessary and I ensured that transcription and interpretation remained truthful to the intentions of the interviewees.

Foddy (1993) considers how people often give their views about a particular topic in a way that is consistent with their views on that topic whilst also being aware of perceived demands of the context in which they are being asked a particular question. It is also acknowledged that participants’ responses are likely to be shaped by their perceptions of the researcher and their position on a particular subject. Bearing this in mind, the researcher can only aim to represent ideas that are co-constructed and convey the meaning they ascribe to a particular response during the interviews, rather than give a direct representation of the participants’ thoughts.

It was evident that some participants were aware of their position of power, knowledge and expertise during the interviews and were keen to utilise the session as a cathartic exercise to air their views and opinions about the issue of
DVA and other political concerns in HV. Others appeared less confident, mistrustful of me and apprehensive, perhaps fearing that the exercise was an evaluation of their practice in relation to DVA. I recognised the value that both positions might add to the intention of the research objective and was aware that interactions during interviews would also be governed by the unique personal and professional perspectives of both the researcher and participants. This meant performing the delicate task of reaffirming the purpose of the interview questions and reassuring participants about the value of their contributions to the study. To some extent, this reflects the particular focus of this research, which is concerned with how discursive practices are legitimised and how they are subverted or even resisted in practice. Prior to each interview I reminded participants of the sensitive nature of the interview and encouraged them to withdraw or take a break if they felt uncomfortable. There were no concerns relating to the sensitivity of the interviews.

As part of the strategy and interview framework, a general interview guide was constructed to ensure that all the participants were asked similar questions. The parameters of the conversations included the following subheadings:

- Exploring how HVs define their understanding of DVA in BME communities.
- Relationship with client: how the relationship shapes or is shaped by understanding of DVA.
- HVs’ position in practice.

(See Appendix 4 for full interview schedule and Table 8, p93 for details of documentary text and Table 11, p99 for interview schedule).

Feminist researchers are encouraged to celebrate their position as the insider researcher by drawing upon their own experiences throughout the research process instead of adopting the position of objective bystander (see section 1.2 Origin of the Study). However, it is argued that the insider researcher faces the paradoxical position of being in tune with participants’ experiences and institutional working practices while facing challenges to the legitimacy of the knowledge gained because participants may over-identify with the researcher (Silverman, 2006).

I would consider myself an insider researcher because of my background as an HV, my ethnic background and my involvement in working with BME women who have been affected by DVA. For the most part, this was a beneficial perspective during the collection of data, as it enabled me to establish professional intimacy
with the participants and to understand the kinds of nuances that shaped the HVs’ responses to my questions. For instance, when HVs talked about SCRs in relation to their understanding of DVA, I was able to explore this position in greater depth without altering the flow of interaction because I already had knowledge and understanding of the process. Dwyer and Buckle (2009) warned that the insider perspective can lead to a loss of objectivity, with researchers unconsciously making the wrong assumption or participants being coerced into revealing sensitive information about themselves or their organisations. Throughout the interviews I was aware of these potential biases and the need to protect the integrity of the research. Practical steps were taken prior to the research to outline the boundaries of the relationship during the interviews (see Participants’ Information Sheet, Appendix 1 and Risk Assessment in Appendix 3).

As part of the criteria for taking part in the study, participants agreed that the interviews would be audio-recorded and transcribed into textual data. The processes of data handling and data storage were fully explained as part of the consent process as outlined in Appendix 3. The interviews lasted between 40 minutes and one hour, depending on the nature of each discussion. Fifteen interviews were conducted face-to-face on NHS premises, and the remaining three interviews were conducted via telephone; in the latter case I sought reassurance from the participants that they were located within safe NHS premises where they could not be overheard during sensitive discussions. Following each interview the recorded transcripts were checked, duplicated on a second recording device and transcribed to written text. I also reminded participants at the start of each interview that they must not refer to identifiable data or cases when talking when referring to particular caseload experiences.

During the data collection stage, a number of practical issues arose which impacted upon the timeliness of the process. It had been anticipated that data collection would take place over 12 weeks; however, a number of HVs had flexible working patterns or worked part-time, and a number of scheduled interviews had to be cancelled due to sickness, annual leave and statutory work commitments. In two instances I took the decision to cancel the interviews altogether in order to avoid placing unnecessary stress on the participants; subsequently, the data collection period was extended to eight months. I was aware that participation in the study might impact upon the HVs’ caseload management due to the sensitive nature of their work and the statutory obligations of clinical practice. However,
assurances were provided by HV managers that they would be willing to address any potential shortfall if necessary. The last two interviews were omitted due to manual corruption of the recording devices. Following discussions with academic supervisors, no attempts were made to replace these interviews, as I felt that data saturation had been achieved. All the records pertaining to the two participants were destroyed according to university and NHS guidance outlined in Appendix 1, 5 and 6.

4.3.1 Documentary Text

The documents identified for analysis were selected because of their capacity to contextualise HVs’ practice and knowledge of BME women’s experiences of DVA see Table 8, p93. Each document contained policy guidance for HV practices which directly influence organisational procedures for women and families living with DVA. Fairclough’s (2003) approach to analysing text emphasised the consistency between textual documentary analysis and feminist research in the following ways:

- The descriptions of social processes and structures give rise to the production of text from which individuals or groups as social and historical subjects create meaning.
- Documentary analysis in emancipatory research offers the potential to expose opaque and transparent structural relationships of dominance, discrimination, power and control as manifested and legitimised within text.
- Documentary texts operate as a form of representation of organisational discourse within political structures.
Responding to violence against women and girls, the role of the NHS (2010) Department Of Health  
NHS report  
This document contains a report from the UK NHS task force on the experiences and the lives of women and girls who are accessing services from the UK NHS.

Improving Safety Reducing Harm: Children Young People And Domestic Violence: A Practical Toolkit For Frontline Professionals (2009)  
National guidance for NHS front-line staff  
The document contains professional guidance for key front-line NHS staff who work directly with women and children.

Nursing Union position document and practice Guidance  
Document guidance on organisational and professional responses to DVA.

London child protection procedure (LSCB) 2010  
National Guidance on child safeguarding procedures.  
Child protection procedural manual and legislative guidance for healthcare professionals.

Table 8 Documentary Data for analysis ‘Original in Colour’

The documents listed in Table 8 above contain explicit and implicit professional guidance as well as mandatory and statutory directions for HVs and organisational practices in relation to identifying and responding to DVA. Documentary analysis was selected as part of the empirical data because of the suggestion by (Silverman 2005 and Lazar et al, 2005) that merging documentary text and context as part of an analytic strategy provides a powerful enrichment of the understanding and interpretation of raw data because it challenges the researcher to search deeper for implicit meaning found in everyday language, text and talk. Together with the raw data derived from the interviews, the contents were coded, analysed and themed as part of the data analysis strategy.

The documents were chosen as part of the overall purposive data collection strategy and were consistent with the feminist methodological approach to research and knowledge production (Fairclough, 2003; Lewis and Mills, 2003; Lazar, 2005; Denzin and Lincoln, 2008 and Ramazanoglu and Holland, 2009). The documents were reviewed and selected following a framework for establishing authentication, credibility, representation and meaning, in relation to the aims and objectives of this research (Fairclough, 2003 and Wodak and Meyers, 2005).
4.3.2 Ethical Considerations

Ethical approval was sought and obtained from the University Of Brighton School Of Health Sciences and the Research and Development Governance department prior to commencing data collection as well as from the participating NHS Trust. (See appendices 6, 7 and 8 and Table 10, p98). The enduring principles contained in the Nuremberg Code for Research Involving Human Rights, Schwartz et al (2002) and the Royal College Of Nursing Advisory Group (1993/2004) helped to guide ethical decision making in this research.

For ethical reasons, HVs were selected for this study through a purposive sampling strategy based on rigorous inclusion and exclusion criteria (in Table 9, p94 below and Table 10, p98) to ensure full representation of the HV cohort (Letherby, 2003; Ramazanoğlu and Holland, 2009).

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be cleared by the NHS Trust occupational health department as fit and eligible to work with vulnerable families.</td>
<td>Participants who are on sick leave as a result of psychological distress will not be eligible to take part.</td>
</tr>
<tr>
<td>Participants must have a clear understanding of the research and the potential to evoke emotional trauma in order to give informed consent.</td>
<td>Participants who are awaiting psychological assessment or undergoing treatment for acute psychological distress will not be included in the study.</td>
</tr>
<tr>
<td>The researcher must have sight of the ‘fit to practise’ letter from the designated occupational health department or the participant’s registered general practitioner where concerns exist.</td>
<td>Participants who exhibit visible signs of distress will not be eligible to participate. Visible sign of distress may include inappropriate crying, incoherent conversation or a lack of understanding about the project.</td>
</tr>
<tr>
<td>Participants must be accessing child-protection supervision; this was to minimise the risk to families HV’s caseload and maintain the integrity of the research. Child-protection supervision is a mandatory requirement for all HVs who are having direct patient contact.</td>
<td>Participants undergoing performance management or disciplinary procedure relating to practice or personal conduct will not be included.</td>
</tr>
<tr>
<td></td>
<td>Participants who do directly manage HV caseload will not be included.</td>
</tr>
</tbody>
</table>

Table 9 Inclusion and Exclusion Criteria "Original in Colour"
Respect for Person and Autonomy are key elements of the ethical research principles for research involving human subjects (Denzin and Lincoln, 2005 & Ramazanoglu and Holland, 2009). Therefore, the key ethical considerations were to prevent distress or harm to anyone participating in the investigation, to ensure that participants fully understood the processes in order to give valid consent to take part, to protect participants’ privacy and dignity at all times, and to ensure that the researcher’s conduct and process reflected the standards and principles outlined in Christians (2005), the UOB Guidance on Good Practice in Research Ethics and Governance (2010) and the NMC Code of Professional Standards of Practice and Behaviour for Nurses and Midwives (2015). I also needed to consider specific issues relating to the potential disclosure of unsafe clinical practice and the disclosure of personal experiences of DVA, should any be uncovered during the study. It should be noted that health visitors were not required to disclose personal information of abuse, (see Table 10, p98 and Table 11, p99 Interview Guide).

A key aim of the study was to ensure that participation was entirely voluntary and free from coercion (Seedhouse, 1997). With this in mind, I approached the research project as part of the ethical dimension of my professional obligations to ensure honesty and openness in the project. Prior to and during the interviews, participants were given the opportunity to withdraw from the process unconditionally, and I provided clear guidance for participants on how to report concerns regarding the research process or the researcher’s conduct.

One of the first ethical considerations was whether or not to include or withdraw participants who disclosed that they were victims/survivors of DVA prior to or during the research process. This was especially important given that 1 in 4 women in the UK experience DVA at some point in their lives (DH, 2012), it was likely that this would be the case. Research also shows that health and social care professionals' choices can be influenced by their own experience of personal trauma. Recognising the risk and health implication of vicarious and secondary traumatic stress, researchers suggest that there is a link between low morale, emotional exhaustion and professional ambivalence within caring professions (Crothers, 1995; Robinson et al, 2003; Baird, 2003; Munger et al, 2015; Humphrey, 2016; O’Mahony et al, 2016 and Taylor et al, 2016). It was therefore
highly likely that some of my potential participants had experienced DVA and taking part might evoke traumatic memories for them.

HVs also work at the intersection of traumatic cases of DVA, child abuse and other distressing human conditions. I was mindful that personal experiences of DVA might have influenced their attitudes and responses during the interviews, and this might trigger unsolicited disclosure during discussions. After careful consideration and discussion with my supervisors and the research ethics departments, it was agreed that a distress protocol should be included to help manage the risk and support the emotional wellbeing of the participants as outlined in Appendices 1 and 3. It was agreed not to exclude HVs who were victims of DVA. Based upon the distress protocol and to protect the emotional welfare of participants, HVs who were undergoing treatment for acute psychological distress would not be eligible to take part.

To help manage this potential risk, all participants were provided with information on how to access practical help and psychological support via their employers, occupational health services, or their own GPs (see participants’ information sheets, Appendices 2, 4 and 8), a service which is free to all NHS employees. In addition, each participating NHS Trust operates a robust fitness-to-practice framework by providing a rigorous process of emotional and practical support to all HVs working with vulnerable DVA caseloads. This is a mandatory process known as safeguarding supervision, and all HVs have an obligation to take part in the process. One of the criteria for taking part in the study was a requirement for all participants to be up to date with their 'safeguarding supervision' sessions. It was decided during ethical approval discussions that interviews would be terminated should participants display signs of emotional distress and the need for support. During the interviews no participants disclosed any incidents of on-going DVA; however, some participants appeared to use personal insights into the phenomenon to illustrate their responses, and this is evidenced in later chapters.

It is acknowledged that the process of undergoing treatment for psychological trauma may increase vulnerability and may impact on any decision-making process. I was also mindful that excluding these prospective participants could be discriminatory and could potentially discriminate those with valuable contributions. Therefore participants who were likely to be experiencing psychological distress would need the express permissions from their General Practitioner. A detailed
account of the risk assessment, ethical considerations and distress protocol is contained in appendix 3 of this document. In order to meet the criteria for participation in the study and to ensure the integrity of the research, a robust risk assessment and action plan was implemented. A detailed account of the risk assessment, ethical considerations and distress protocol is contained in Appendix 3 of this document.

Due to the demographically small number of HVs, participants were given pseudonyms and no identifiable or traceable data were included in the raw publication. The participants' information profiles were deliberately minimised and anonymised in order to protect their identities. Access to participants and research sites followed a rigorous procedure, including obtaining managers' permission, as well as careful negotiation with each participant.

Personal information relating to this research is kept in a locked cabinet at the researcher's home. Participants were informed that such data would only be used for the purposes of this research and all personal details would be destroyed three months after the completion of the study, while anonymised data would be stored for three years following publication of the study. Storage of up to three years would enable the researcher to clarify concerns and verify data if necessary. The storage of data relating to this research complied with the Data Protection Act 1998 and the University of Brighton data storage and handling guidance. Data stored on electronic devices were encrypted and password-protected with anti-virus and firewall protection.

A key aim of the study was to ensure that participation was entirely voluntary and free from coercion (Seedhouse, 1997). With this in mind, I approached the research project as part of the ethical dimension of my professional obligations to ensure honesty and openness.
### Potential Risk and Ethical Consideration and Actions and Response

| Potential impact on resources where participants might be asked to take time off work to participate in the study. | The researcher will travel to participant’s place of work to minimise disruption to participants’ caseload. The interviewer will pay particular attention to the timing of the interview which is approximately 1 hour. The interviews will not take place at participants’ residence or outside the designated NHS premises allocated for interviews. Conducting research on designated NHS sites will also ensure the physical safety of the researcher and participants. |
| Participants may become distressed during the interview. The sensitive nature of the subject means that discussion may evoke memory of distress. | Participants will not be asked to give personal details relating to caseload or themselves (please interview schedule questions). Interviews may be terminated if participants become distressed or show signs of emotional trauma during the interview. If the interview is terminated due to emotional distress, participants may be withdrawn from the study and they will be encouraged to access psychological support from their GP or from their occupational health department. Participants are given full information on how to withdraw from the research and how to escalate concerns about the conduct of the researcher and research concerns. Each research site provides dedicated psychological support employees which can be accessed through a self-referral process to the respective occupational health department in confidence. Academic supervisors will be informed for de briefing and review and I will also access psychological support through my employment occupational health department if necessary. This service is also a confidential self-referring process and personal details relating to this incident will be kept strictly confidential. |
| Participants may disclose risk of violence to a vulnerable child or adult on their caseload whose life is at risk. | In the event of a practitioner disclosing knowledge of harm about a vulnerable person on their caseload who is in danger and it is clear that a crime is being committed, as outlined in the participants information sheet: The practitioner who is making the disclosure will be informed that I will notify the local safeguarding contact through a Section 47 of the Childrens’ Act (1998) and (2004) referral so that steps can be taken to protect the family. The University of Brighton academic supervisors will also be notified and the line manager may be informed depending on the nature of the risk and reference to fitness to practice. |
| Due to the small number of participants there is a potential that they may be identified from the data. | In order to minimise the risk of identification, participants will be recruited from two community health Trusts. Participant’s details will be anonymised. No direct quote that could potentially lead to identification of participants will be published |

**Table 10 Ethical Considerations, Actions and Responses ‘Original in Colour’**
**Interview Schedule Question Guide**

Introduce the study and explain the purpose of the interview.
Check that participants understand the purpose and nature of the study and how to complain if they have concerns.
Verify consent/rules about confidentiality.
Check that people know what will happen to the data; thank participants.

**Warm-Up Questions**
Tell me about your career and what led you to health visiting?
How long have you practiced as a HV?

**Theme One: Exploring Knowledge of DVA Facilitating Disclosures.**
Tell me about your case load, what are your demographics and your client groups?
How would you describe your understanding of DVA?
Tell me about how you ask BME women about DVA? What strategies do you use if you suspect that one of your clients is experiencing DV?
Tell me about the type of DVA that are specific to your client groups?
In your own words what factors help or would help would influence BME women to tell you about DVA?
Do you feel that HVs are best placed to ask about DVA? Who should they ask and why?

**Interview Schedule Question Guide**
When was the last time you received training for DVA; was this effective if so why? What difference did this make to your practice relevance, impact?
Do you routinely ask women about DVA and if so when did this practice start?
Do you think the DH policy on DVA is effective and if so why?

**Theme Two: Relationship with Client; How Relationship Shapes or Is Shaped By Understanding.**
Describe your experience of looking after BME women who disclose DVA on your caseload.
How did they come to your attention?
Was there a change in the relationship after you knew about the DV and if so what was the change?
Tell me about how you manage difficult relationship following disclosure; how do you maintain rapport with women?
What guidance do you use to determine DVA risk or vulnerability for women?
What support strategies are in place for victims? Is this adequate? If not how best can this be improved?

**Theme Three: Practice Culture**
Do you feel that asking women about DV has changed the nature of health visiting and if so how?
How effective is the risk assessment framework that you use?
What would you like to see included in DV policies?
What changes would you like to see in the current DH policies?

**Table 11 Interview Schedule Guide**
4.3.3 Issues with Validity and Reliability

Silverman (2006) highlights the interrelated concepts of reliability and validity as a qualitative measurement for both quantitative and interpretive research paradigms but underlines the degree to which these two concepts are used differently within social scientific research.

In interpretive research paradigms, it is argued that it is impossible to establish universal criteria for what counts as valid knowledge across multiple theoretical systems (Ramazanoglu and Holland, 2002). From a healthcare perspective, researchers are faced with the dilemma of how to produce reliable and valid knowledge that is useful. In relation to these complexities, some feminist researchers have argued that, although the processes of interpretation might be skilled, creative and reasoned, this may not address the epistemological difference between the researched and the researcher (Letherby, 2003). I was conscious of different views and perspectives held by participants during the interviews, as well as the different political interests within organisational procedures and personal practice in relation to DVA. As an HV myself, it was not possible for me to set aside my personal and professional experiences that helped to shape my interpretation of the data; however, during the early stages of analysis I took the pragmatic decision to invite participants to comment on the early findings. Only three participants demonstrated an interest. Nevertheless, this provided a useful perspective in reaffirming early conceptual thoughts while offering participants the opportunity to negotiate potential discrepancies.

Feminist research doctrine questions the claims to value-free research but recognises the partiality of the insider researcher. Researchers have also identified some of the methodological ethical, confidentiality, exploitation and conflict associated with being an insider researcher (Mullins, 1999; Burns et al, 2010; Kim, 2012; Hanson, 2013 and Humphrey, 2016). During the research I was conscious of my own intersubjective biography as an HV/researcher from a BME background. This positioned me as an insider-outsider researcher with the particular advantage of insider knowledge and insight into the ambiguities that arose during the study, but it may also have limited my ability to challenge culturally entrenched roles and practices. In addressing these concerns, I took the following steps:
- Choice of research sites and participants that were not connected to me personally or my place of employment.
- A managed process of informed consent where participants were given a full account of the research process, including how safeguarding concerns would be addressed if disclosed during the research.
- All participants were given full written information on how to escalate concerns about the researchers’ conduct and or the research process.
- Regular debriefing with my academic supervisors as well as my safeguarding supervisor.

I also recognise my own sense of displacement within the academic settings. Haraway (1991) maintains that feminists approach research with maps of unconsciousness that are influenced by gender, class, race and nationality. Collins (2004) illustrates the double-bind position of black women in academic settings. She argues that many black female intellectuals have made creative use of the marginality of their outsider within status to produce black feminist thought that reflects a special standpoint on self, family and society. I recognised both the value and limitations of my own insider-outsider status. Discussions with my academic supervisors helped to create and maintain sociological distance. I wrote a reflective summary contact sheet following each interview to serve as an aide-memoire for future reference; this also prompted me to make the following entry after a particular insightful interview:

"The outsider within, neither the outsider nor insider within health-visiting or the academic world" Reflective Summary (December 2012).

Since the interpretation of data will be influenced by the researcher’s own personal and theoretical perspectives, it is important to ensure openness and transparency at every stage of the process. Richardson (2005) suggests demonstrating methodological congruency as well as providing a critical audit trail of the processes and strategies used to construct participants’ words. I also followed Letherby’s (2003) suggestion of achieving validity by being open and transparent about the objectives of the research and the researcher’s own views on the socially constructed nature of knowledge production.
4.4 Data Analysis: Documentary Analysis

4.4.1 Introduction

"Feminist researchers cannot determine in advance what interpretation can be made of their data, but they can reflect on how interpretation is made, what concept, assumptions and rules are drawn on and why they use some categories rather than others" (Ramazanoğlu and Holland, 2002, 117).

It is argued that documentary analysis is a critical part of emancipatory research because it offers the potential to interrogate how text can directly influence changes in knowledge, attitudes, beliefs and values (Fairclough, 2003; Lazar et al., 2005 and Spicer, 2006). In relation to this research, the analysis of the practice guidance documents that are shaped by a particular discourse might ultimately reorder or reinforce HV’s understandings of BME women’s experiences of DVA and contribute to the construction of BME women’s identities as service users within the NHS.

The goal of the data analysis strategy was to use a thematic approach to explore, describe and explain HVs’ understanding of BME women’s experiences of DVA. The analysis also provides a critical perspective on the relationship between HV’s understanding of DVA and the political discourse within the documentary text. Data interpretation was guided by the feminist intersectionality analytic framework as described by McCall (2005), Nash (2008) and Cho et al, (2013). To achieve this, the analytical process was guided by a combination of Ramazanoğlu and Holland’s (2002), Braun and Clarke’s (2009) and Wodak and Meyers’ (2001) feminist critical discourse analyses of language and textual data.

It is argued that documentary analysis is a critical part of emancipatory research because it offers the potential to interrogate how text can directly influence changes in knowledge attitudes, beliefs and values (Fairclough, 2003; Lazar et al, 2005 and Spicer, 2006). In relation to this research, the analysis of the practice guidance documents that are shaped by a particular discourse might ultimately reorder or reinforce HV’s understandings BME women’s experiences of DVA and contribute to the construction of BME women’s identities as service users within the NHS.

Thematic analysis is a method of identifying, analysing and reporting patterns within data, and a critical theoretical paradigm is concerned with analysing opaque as well as transparent structural relationships of dominance, discrimination, power
and control as manifested in language and text (Wodak and Meyers, 2001). Thematic analysing of textual data and voices of participants appeared to be a methodological fit because of the opportunity to incorporate the ethics and critical stance towards power relations of this framework and providing a clear account of the knowledge produced.

4.4.2 Thematic Analysis

Thematic data analysis can be described as a continuous and iterative process, with distinctive and overlapping analytic phases (see Table 12, p103). Each phase enables the researcher to derive new discoveries and insights from the data, and to use new understanding to make judicious decisions about how to use the new information to enhance the data collection and to move iteratively between the data to search for deeper meaning, whilst developing more abstract and conceptual thoughts (Spivak, 1985; Mohanty, 1988; Sandoval, 1991; Lionnet, 1992; Ramazanoğlu and Holland, 2002; Lewis, 2003; Saldana, 2005; McCall, 2005; Nash, 2008; Cho et al, 2013 and Braun and Clarke, 2006). The process demands that researchers take clear steps to explain the validity, transparency and relevance of the processes during the interpretive phase in order to achieve the objective of the study. With this in mind, the analytic processes for this thesis were guided by (Braun and Clark, 2009 and Saldana, 2013).

<table>
<thead>
<tr>
<th>Phase</th>
<th>Actions</th>
<th>Description of Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 &amp; 2</td>
<td>Familiarising self with data and generating initial codes</td>
<td>Transcribing, reading, re-reading and listening to the audio recordings. Coding and reviewing codes</td>
</tr>
<tr>
<td>3</td>
<td>Searching for patterns and themes</td>
<td>Reviewing codes and attempting to organise data into potential themes</td>
</tr>
<tr>
<td>4 &amp; 5</td>
<td>Reviewing patterns, defining and naming themes</td>
<td>Cross-referencing, re-matching the themes back to code extracts across data sets and linking into story telling</td>
</tr>
<tr>
<td>6</td>
<td>Producing report and writing for analysis</td>
<td>Selecting extracts to illustrate themes, analysing themes and relating to research questions</td>
</tr>
</tbody>
</table>

Table 12 Recursive Phase Analysing the Data ‘Original in Colour’
Textual representations from HVs’ conversations created units of meaning or concepts which were coded and later produced conceptual boundaries classified as categories. The categories in turn generated sub-themes, moving to themes and later one overarching theme, shifting between an iterative and linear process (See Table 12, p103; Table 13, p109; Table 14, p112; Table 15, p114: From Text to Codes to Categories and Sub-themes). The process of moving beyond the analytic phase and searching for deeper meaning was aided by the work of Guest et al (2012), Silverman (2006), and Wodak and Meyers (2005).

4.4.3 Data Interpretation: Phases One and Two

Very early on in the research process I decided to use the NVivo software package as part of the data organisation strategy. The literature on this process offers contrasting opinions on this approach to analysing data, with proponents arguing that this data software package significantly improves the capacity to interact with large volumes of data, as it has the flexibility to add and retrieve code throughout the analytic process (Richardson, 2005; Bazeley, 2007). Conversely, Saldana (2012) warns of its potential pitfalls, in that coding can become deterministic and rigid when the software privileges a particular coding and retrieval process.

I used the coding processes advocated by Saldana (2012), which utilise an approach based on coding sections of the text that emphasise the intellectual efforts of the researcher. Data interpretation and data synthesis were guided by feminist intersectionality analytic principles outlined in Tables 15, 16 and 17 (McCall 2005; Nash, 200 and Cho et al, 2013). For the most part, the use of the NVivo software proved to be an effective, timely and efficient method of managing the data sources. For instance, data organisation within the NVivo software also enabled me to link the raw data transcripts to reflective notes, field notes, academic supervision notes, and seminal literature and to synchronise transcripts with audio recordings that could easily be retrieved.

I began by listening to each interview searching for an overall sense of the participants’ understanding of the phenomenon. I submerged myself in each transcript, seeking to capture the essence of the case file examples presented by the participants, and focusing on descriptions of their encounters with BME women and the avoidance of some discussion. I applied my knowledge and experience as an HV to make decisions about how the encounters appear to reveal different
kinds of relationships rather than stated professional contact. In order to place
some textual data from the interviews within their context and to search for
meaning, I listened to the emphasis placed upon particular spoken words, pauses
or repetitions and built relationships between codes and construct categories and
subcategories.

The immediacy of accessing multiple data sources helped to reduce the danger of
becoming overwhelmed by the sheer volume of data to be processed; it also gave
me the confidence to ask simple questions of the data and to use the software
package as an aid to building conceptual maps. The capacity to create new coding
files within the NVivo software provided a useful audit trail which allowed me to
abandon ideas and return to them later, if necessary, in an uncomplicated way
(see Figure 6 below) Interpreting the Data developing meaning). Although the
NVivo software is designed for data analysis processes from multiple paradigms,
the focus appears to lend itself towards a grounded theory approach. Nevertheless
applying both manual and an electronic coding strategy helped to provide analytic
flexibility within the coding strategy.

![Figure 6 Interpreting the Data: Developing Meaning 'Original in Colour'](image)

Although the NVivo software is designed for data analysis processes from multiple
paradigms, the focus appears to lend itself towards a grounded theory approach.
The need to pay attention to managing the large volume of data often detracted
from the meaning and interaction with the depth of the data because of the
tendency to over-rely on the analytic abilities of the software. Ultimately, I took the
decision to return to manual coding and analysis with the assistance of the NVivo
software, as it became clear that this software did not always offer a significant advantage over a manual approach.

I enlisted the support of a transcriber, because I did not feel that I had the necessary skills to achieve the speed and accuracy required within a reasonable timeframe. My initial attempts to transcribe followed an earlier suggestion from a mentor that first-hand transcribing of the data would lead to a deeper immersion in the data and improve understanding. However Foddy (1993) argues that first-hand transcribing offers the researcher the opportunity to re-live the immediacy of the interview without relying on an imperfect memory recall. However it became necessary to balance what was realistically achievable with a pragmatic view of the timeline for completion of the project. Throughout the course of the data analysis phase, I continued to revisit the audio recordings and to refer to my interview summary contact and paper transcriptions in order to maintain intimacy with the data.

Throughout the course of the data analysis phase I continued to revisit the audio recordings and refer to my interview summary contact and paper transcriptions in order to maintain intimacy with the data. I therefore began the coding processes by reading through the corpus data to gain an overall sense of the participants’ discussions and making notes on the salient points (Braun and Clarke, 2006). I arrived at each code by using a combination of specific and eclectic coding strategies, following a detailed reading approach used by Guest et al (2012) and Saldana (2013). For instance, the first coding cycle included attribute and structural versus descriptive and in vivo coding (see Saldana, 2013). These features provided an exploratory overview for contrasting, comparing and describing the raw data.

I interrogated each sentence, searching for meaning by asking questions that were shaped by the analytic objectives of the study. I arrived at the codes by reading the interview transcripts and textual data from the selected documents line by line, listening to the audio recordings, and returning to the interview contact summary sheet. Simultaneously, annotations, indicating the initial thoughts of what the text represented, were used to create meaning units (code descriptors). During coding I found that I had a particular memory of the interviews and I followed Braun and Clarke’s (2006) suggestion of recording reflective thoughts on the data as they emerged. I then returned to the transcribed interviews and selected documentary
text to code manually with the assistance of the NVivo software. This cyclical process was repeated for each interview and categories emerged from this process. Simultaneously, I began to generate questions aimed at seeking clarity and affirmation of these emerging concepts.

Coding in NVivo helped to isolate individual lines or phrases that could be linked precisely to each interview with automatic numbering. The process generated a significant amount of codes. Each portion of text that contained ideas and recurring or distinctive topics was selected. However, I quickly realised that I needed to move on to the next analytic stage and to begin creating meaning from the codes. Drawing on my own theoretical and conceptual interest as a postcolonial feminist researcher, I made decisions about what the word or phrase revealed, using participants’ expressed views and linking them to the core tenets of the intersectionality analytic framework to determine which code should be assigned to each meaning unit (see Tables 15, p114; Table 16, p115; Table 17, p118 and Table 18, p121).
<table>
<thead>
<tr>
<th>Source</th>
<th>Transcript</th>
<th>Key Words And Phrase</th>
<th>Meaning Units</th>
</tr>
</thead>
</table>
| **Pamella,**  
6.2.2 | So it provided me with just basically an ability to acquire knowledge, to acquire more information from clients when I talk to them about DVA and to find out a bit more about what is happening in their lives without actually saying the words ‘domestic violence’, | 1 Ability to acquire knowledge.  
2 Acquire more Information from clients when I talk to them about DVA.  
3 Find out a bit more about what is happening in their lives without actually saying the words ‘domestic violence’ | 1 Knowledge about DVA.  
DVA disclosure.  
2 The nature during professional encounter.  
3. Intentionally avoiding naming DVA linked to the acceptability of talking about DVA.                                                                                                                                 |
|            |                                                                                                                                                                                                          |                                                                                                                                                                                                                       | Educational and training.  
Naming violence and abuse.  
Physical and non-physical violence.  
Disclosure  
Asking about DVA.  
Attitude towards DVA                                                                                                                                 |
| **Indera,**  
3.2.  
6.2.3 | I think for example in the Bangladeshi community it’s something that is not discussed and it’s not you know, it’s very difficult for the woman to come forward and admit that it’s happening. It brings shame on the family, and more importantly the extended family, and not just the Bangladeshi community, I think in other communities as well. If a woman asks for help, it’s therefore brought to the attention and then the ripples go out into the wider family circle and that’s a big issue in these communities. | 1 In the Bangladeshi community it’s something that is not discussed.  
2 It’s very difficult for the woman to come forward and admit that it’s happening.  
3 It brings shame on the family, and more importantly the extended family.  
4. If a woman asks for help, it’s therefore brought to the attention and then the ripples go out into the wider family circle and that’s a big issue in these communities. | 1 Hidden nature of the problem.  
2 Awareness or assumptions of women’s position within particular family and community.  
3 Awareness of shame that is linked to familial and cultural beliefs.  
4. Awareness of the role of the community in resisting disclosure                                                                                               | Stereotyping and blaming.  
Shame and denial  
Disclosure.  
Access and barriers to support.  
Religion  
Attitude towards DVA.  
Family and kinship.  
Ethnicities and race                                                                                                                                             |
<table>
<thead>
<tr>
<th>Source</th>
<th>Transcript</th>
<th>Key Word and Phrases</th>
<th>Meaning Units</th>
<th>Codes</th>
</tr>
</thead>
</table>
| Marykay, 1.1.6.2.4 | Yeah, I think that yeah, the Asian population actually, well it's probably very prevalent to begin with and also they are much more hidden about it, yes, and also very difficult to work with in a sense, that they often don't engage with the services. | 1 The Asian population actually, well it's probably very prevalent to begin with.  
2 Asian population actually, well it's probably very prevalent to begin with and also they are much more hidden. and also very difficult to work with in a sense, that they often don't engage with the services” | 1 Stereotypes and assumptions about the hidden nature of DVA are repeated as if factual.  
2 The Asian population homogenised and labelled as difficult. Difficulties in accessing and providing services. Awareness of help-seeking pattern. | Stereotyping and blaming.  
Trust and mistrust.  
Others’ differences and similarities.  
Attitude towards DVA.  
Blame and denial  
Belonging. |
| Kemi, 4.1.6.2.4 | And then the lady came to me in clinic probably a week after and explained all that was happening to her and that she had been to the Imam with black eyes and what have you, and the Imam says she talks too much to she knows too much, whatever, that she should pipe down, so that’s why she had the black eye. | 1 And then the lady came to me in clinic.  
2 She had been to the Imam with black eyes and the Imam says she talks too much to she knows too much, whatever, that she should pipe down, so that’s why she had the black eye” | 1 Nature of professional contact help seeking physical abuse  
Help seeking strategies adopted by some women. Power and control. How religion is used to interpret and determine women’s position. Awareness of the power and control outside intimate relationships | Physical and non-physical abuse.  
Help seeking  
Access and barriers to support.  
Ethnicities and race.  
Blame and denial  
Gender |

Table 13 Developing Meaning from Code and Text 'Original in Colour'
<table>
<thead>
<tr>
<th>Source</th>
<th>Transcript</th>
<th>Key Words And Phrase</th>
<th>Meaning Units</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH, 2010: 2.0</td>
<td>The prevalence of DVA shows little variation in terms of ethnicity. However, some DVA involves culturally specific forms of harm, particularly affecting black and minority ethnic communities. These include forced marriage, FGM and so-called ‘honour’ crimes and killings. Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels, namely:</td>
<td>The prevalence of domestic violence show little variation in terms of ethnicity. DVA involves culturally specific forms of harm affecting black and minority community. FGM and so-called honour crimes and killings. Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels</td>
<td>Knowledge about DVA. Ethnicity and race: not measured in DVA statistics Help Seeking: Difficulties in accessing and providing services. Awareness of help-seeking pattern. Attitude towards DVA Shame and stigma. Defining abusers and victims. Gender and gendered. Power and control. How religion is used to interpret and determine women’s position. Awareness of the power and control outside intimate relationships</td>
<td>Stereotyping and blaming. Trust and mistrust. Others’ differences and similarities. Attitude towards DVA. Blame and denial Belonging. Defining DVA</td>
</tr>
<tr>
<td>Source</td>
<td>Transcript</td>
<td>Key Words And Phrase</td>
<td>Meaning Units</td>
<td>Codes</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LSCB 2010: 4.0.0</td>
<td>Frequent movers can find it difficult to access the services they need. For those already socially excluded, moving frequently can worsen the effects of their exclusion. (LSCB, 2010)</td>
<td>1 Frequent movers 2 Access to services 3 Social exclusion 4. Worsen the effects</td>
<td>1 Housing stable living conditions. 2 Access to services and provision of services 3. Socio-economic circumstances of women living with DVA.</td>
<td>Finance and income. Access and barriers to support. Isolation. Status. Caseload profiling. Child protection. Understanding risk. Safety</td>
</tr>
</tbody>
</table>
The issues of DVA are compounded by historical structures in society which condone the view that a man is master of his domain and are illustrated in the workings of many institutions such as the Crown Prosecution Service and, until recently, the police.

<table>
<thead>
<tr>
<th>Source</th>
<th>Transcript</th>
<th>Key Words And Phrase</th>
<th>Meaning Units</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCN, 2000 1.1.2</td>
<td>The issues of DVA are compounded by historical structures in society which condone the view that a man is master of his domain and are illustrated in the workings of many institutions such as the Crown Prosecution Service and, until recently, the police.</td>
<td>1 DV compounded by historical structures in society. 2 Society condones the view that a man is master of his domain 3 Illustrated in the workings of many institutions such as Crown Prosecution Service and until recently the police.</td>
<td>1 Hidden nature of the problem linked to historical views in society. 2 Gendered and patriarchal context in which DVA occurs. 3 Personal violence links to structural violence.</td>
<td>Attitude towards DVA. Family and kinship. Gender and gendered. Personal violence structural violence. Regulation and structural Defining abusers and victims</td>
</tr>
</tbody>
</table>
## Analytic Categories Intersectionality Intercategorical Approach adapted from Hankivsky et al 2014

<table>
<thead>
<tr>
<th>Analytic Categories</th>
<th>Principal Determinants</th>
<th>DVA Intercategorical interpretation and synthesising</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Chronological measure of physical aging process.</td>
<td>May not determine victimisation process or ability to access service.</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Tradition: biological difference male female. Personality traits, attitudes, behaviour, values relative power and influence ascribed by society.</td>
<td>Socially constructed roles and relationships. How power is ascribed to gender. Connected to values ascribed by familial ideals. How experience of DVA Interconnected to religion and ethnicities.</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>Discrete homogenous and fixed categories of differences. Signifier of biological difference.</td>
<td>Discrimination, marginalisation, alienation and segregation, hegemony and internalised racism. How experience of DVA Interconnected to gender, age, religion and ethnicities.</td>
</tr>
<tr>
<td><strong>Ethnicities</strong></td>
<td>Characterised by shared nationality, culture or language primarily a self-definition self-construct, feelings and preference, ethnic knowledge, participate in predetermined role. Language: Communication. Constitute language community</td>
<td>Determinants and boundaries of ethnic identity rest within each ethnic group member rather than prescribed by researcher. Perception of DVA might differ according to investigator and subject. Determine access, rights and privilege. Experience of DVA Interconnected to gender, age, language, ethnicities, social class, education and race.</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Experiential: Totality of the ideas, beliefs, values, knowledge and way of life of a group of people who share a certain historical, religious, racial, linguistic, ethnic or social background.</td>
<td>Meaning of DVA sometimes self-directed or imposed externally. Subjected to stereotyping, racism and essentialism.</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>Essentialist; biological characteristics such as anatomy.</td>
<td>Social values ascribed. The interpretation may be physical, mental. Less clinical</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analytic Categories</td>
<td>Principal Determinants</td>
<td>DVA Intercategorical interpretation and synthesising</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Notion that humans have innate sexual urges that propel them towards sexual activities</td>
<td>Society prescribes and codifies sexual activities. May legitimise some and not others. Sexual orientation runs along a continuum which incorporates homo, hetero, bi and trans sexual classification. Surpass simple classification.</td>
</tr>
<tr>
<td>(Dis)ability</td>
<td>Any restriction or lack of impairment or ability to perform an activity within the manner or range considered normal for a human being</td>
<td>Implicit binary construct, framed as lacking agency. Explore resistance strategy and help-seeking process</td>
</tr>
<tr>
<td>Religion</td>
<td>A belief in some particular object, God or many gods. Relates to practice such as prayer, following a set of doctrines: religious ceremony and emotional attachment to a religious belief system a way of experiencing reality.</td>
<td>May determine available resource, access to service but need can be overlooked as self-sufficient. Resources to challenge institutional ideals</td>
</tr>
<tr>
<td>Class and socio-economic status</td>
<td>Class: social mobility and class permeability. Socio-economical stratification, historical, economic and social conditions.</td>
<td>May determine available resource, access to service but need can be overlooked as self-sufficient. Resources to challenge institutional ideals</td>
</tr>
<tr>
<td>Education</td>
<td>Linked to class and socio-economic positions. Sub-categories of primary, higher and postgraduate education.</td>
<td>May determine available resources, access to service but need can be overlooked as self-sufficient. Resources to challenge institutional ideals. Experience of DVA Interconnected to gender, age, religion and ethnicities and race.</td>
</tr>
<tr>
<td>Geography/National</td>
<td>Economic and political divide. Western and non-Western Eurocentric values. Former colonial subject. Domination in colonialism linked to contemporary imperialism.</td>
<td>Determine access, rights and privilege. Experience of DVA Interconnected to gender, age, religion, language, ethnicities and race.</td>
</tr>
</tbody>
</table>

Table 15 Intersectionality Analytic Category ‘Original in Colour’
4.4.4 Phases Three and Four

The purpose of developing analytic categories was to identify distinctive and interrelated analytic tools that could help to classify critical features of the phenomenon under study. Dey (1993) suggests that categories must relate to other categories generated by an appropriate analytic context and rooted in the relevant empirical material. Moving between Phases One and Two involved an overlap of processes. I allowed the categories to emerge from the data naturally by using my research question as the focus of my analysis, alongside creative imaginings to search for patterns. Once the categories were created and assigned, the next stage was to reorganise and reconfigure the categories by looking at patterns of differences, similarities and irregularities and enlisting visual maps from NVivo. This process provided the basis for theming the data. Data analysis was at this stage driven by the convergence of listening to the participants talk, reviewing the theoretical debates and key analytic concepts in Tables 16, p115 and Table 17, p118 in the literature, and returning to my research question.

Central tenets of intersectionality analytic framework
(adapted from Hankivsky et al, 2012)

| Human lives cannot be reduced to single characteristics. | Social locations are inseparable and shaped by interacting and mutually constituting social processes and structures which, in turn, are shaped by power and influence by both time and place. |
| Human experiences cannot be accurately understood by prioritising one single factor or constellation of factors. | The promotion of social justice and equity are paramount. |
| Social categories/locations such as race/ethnicities, genders, class, sexuality and ability are socially constructed, fluid and flexible | |

Table 16 Core Tenets of Intersectionality 'Original in Colour'

I moved between Phases Three and Four, recursively searching for confounding evidence within the emerging patterns. While I was simultaneously aware of the emerging contradictions and tensions within the participants’ conversations and tensions with participants, a lack of consensus in participants’ perspectives prompted me to conduct a much deeper search of the data. At the same time, I sought to develop a multi-analytic perspective driven by the key analytic concepts from the voices of the participants (Jackson and Mazzei, 2012). I followed the
proposition of Ramazanoglu and Holland (2009) that, in feminist research, advanced interpretation cannot be made from the data alone; rather, creative imagining can be drawn by connecting ideas, experiences and realities, and using epistemological assumptions to decide what concepts, assumptions and rules to draw upon. The thematic presentation in this thesis reflects the main ideas and conclusions derived from this study.

4.4.5 Phases Five and Six

Phases Five and Six overlapped, as when I began to write I found it helpful to prepare summaries of the meanings of each sub-theme and theme. This was a ‘movable feast’, as the process of writing and re-reading the extracts from each theme helped to provide clarity, and more coherent stories began to emerge. All the potential themes were listed and later mapped onto sub-themes and three potential themes.

According to the literature reviewed, the theoretical perspectives underpinning the feminist intersectionality analytic framework are grounded within three distinctive yet overlapping frameworks: anti-categorical, intercategorical and intracategorical. Each holds the potential to analyse how systems of domination propagate DVA and social inequalities in different ways (see Tables 15,114 and Table16, p115).

Nixon and Humphreys maintain that applying an intersectionality framework to the understandings of DVA offers the potential to hold traumatic reality in a state of consciousness and give victims a voice of empowerment. Evidence from the data, as well as focusing on the objectives of the study, lent itself to an intercategorical data analysis approach during phases Five and Six. For instance, the emerging data suggest that, while it was necessary to focus on knowledge of gender as a site of domination, it was also necessary to interrogate how knowledge of gender identities is shaped by race/ethnicities, class and the intersection with DVA to shape help-seeking behaviour (McCall 2005; Nash, 2008; Hankivsky et al, 2012 and Cho et al, 2013). Attention to the analytic categories suggested that an intracategorical approach would enable the study to fulfil the research objectives of this study.

I arrived at the three themes following a rigorous process of familiarising myself with the data to create an overall sense of each interview, followed by the generation of initial codes. Codes were assigned to categories, and these
categories emerged as patterns which were later reassigned to sub-themes and connecting themes.

Each category then became a summary of the thematic discussions which are illustrated in the findings chapter of this thesis. As we can see from Table 18 p121, Janet’s dilemma illustrates the confusion and power that are linked to defining/naming the terms ‘violence’ and ‘abuse’ to describe a particular violation. Each appears to act as a powerful agent in conveying the potential to downplay or expose the violation. Similarly, Pamella’s discussion illuminates how encounters with BME women might reproduce DVA silence or stigma when HVs intentionally avoid naming violence. Conversely, Ronny’s critical reasoning helped to demystify the confusion that naming sometimes brings by drawing upon a range of experiential, formal and intuitive knowing to articulate the micro-hegemonic nature of violent and abusive relationships. Together, the importance of naming DVA emerged as a significant issue.
### Feminist Intersectionality Analytic Framework
(adapted from McCall, 2005; Nash, 2008; Cho et al., 2013) used in Phases Four, five and Six

<table>
<thead>
<tr>
<th>Analytic Strategies</th>
<th>Methodology</th>
<th>Complexities</th>
<th>Context of this research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-categorical</td>
<td>Based on a method that deconstructs analytic categories. Relational</td>
<td>Applied in complex multiple dimensions.</td>
<td>BME women’s lives considered too complex, irreducible. Multiple characteristics, fluid and flexible.</td>
</tr>
<tr>
<td>Intercategorical</td>
<td>Adopts existing analysis categories, e.g. race, gender, but considers the relationships of inequalities among social groups. Considers the changing praxis of inequalities including multiple and conflicting dimensions.</td>
<td>May ultimately prioritise or omit key categories. Removes binaries. May limit possibilities of new emerging categories.</td>
<td>BME women’s social locations are inseparable and shaped by mutually interacting social process. Experience of DVA linked to gender, race and mothering. Victimisation process.</td>
</tr>
<tr>
<td>Intracategorical</td>
<td>Interrogate boundaries between categories. Hybrid of anti- and intercategorical approach. Analyses categories independently. A relational approach.</td>
<td>Acknowledges the stable and even relationship that social categories represent but critical stance towards categories.</td>
<td>Acknowledges stable and fluid boundaries between BME women’s identities and their experiences of DVA.</td>
</tr>
</tbody>
</table>

Table 17 Feminist Intersectionality Analytic Framework ‘Original in Colour’
The themes were conceptually linked and presented as an overarching theme (see Table 19, p122; Table 20, p123; Table, 21, p125 and Table 22, p126 and Figure 7, p124 Figure 8,127). During this phase it also became apparent that sub-themes had to be collapsed into further sub-themes. For instance, Themes One, Two and Three were collapsed into a single theme to tell a coherent story of the kinds of encounters that shaped the way HVs defined and named the problem. The aim was to ensure that the sub-theme formed a coherent pattern and that the extracts fitted into the sub-themes while avoiding overlaps. At this time it also became apparent that some themes lacked clarity. For instance, Theme One appeared to be fragmented; therefore, I decided that some extracts had to be moved to more appropriate sub-themes, while other extracts had to be discarded and some sub-themes were renamed (see Table 20, 21, 22). Sub-theme, themes and overarching themes). The conceptual ideas reflecting the consensus of HVs’ understanding and practice experience unfolded in the themes as follows:

- **Epistemological issues**: the meanings ascribed to DVA are links that are inclusive of personal and practice wisdom, and they are contextual; thus, naming becomes significant in legitimising or discounting the issue.
- **Representation**: ethnic groups are shaped by the binary construct of Western and non-Western identities, lacking in agency and needing others to speak on their behalf.
- **Intersectionality**: issues of ethnicity, gender, religion, immigration, poverty, class and political and familial ideology influence the conceptualisation of the problem. The interconnectedness of each concept propagates confusion within HV services but also reproduces discrimination and diminishes the resistance strategy to challenge male violence.

These conceptual ideas revealed the micro-hegemonic practices of health-visiting work. These conceptual ideas emerged from an examination of the day-to-day practices of HVs’ work as well as an analysis of the documentary data. Conceptualising HVs’ work in this way exposed knowledge about the micro-hegemonic structures that are linked to the context in which they work with BME women.

The final thematic map in Figure 7 was derived from a repeated and iterative process of revisiting the sub-themes, reading for consistency, and reorganising the data and, at times, the structure of the whole theme. The aim was to demonstrate
more accurately, for example, how HVs’ understanding of the problem shaped or was shaped by the intersectionality of the encounters with BME women. Therefore, Theme One was linked to how participants defined DVA in each sub-theme, thereby demonstrating the hierarchy of meaning within that theme. A detailed analysis was provided for each theme and the stories within the sub-themes were linked back to each theme in order to form a coherent story of how HVs understand DVA in BME communities.
<table>
<thead>
<tr>
<th>Transcript</th>
<th>Keyword phrase</th>
<th>Meaning units/ code descriptor</th>
<th>Concepts/Sub-Theme 1: Naming: Lost for Words: The Power and Problem of Naming Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>So it provided me with just basically an ability to acquire knowledge, to acquire more information from clients when I talk to them about DVA and to find out a bit more about what is happening in their lives without actually saying the words ‘domestic violence’. Pamela, 2.0:6.2.2</td>
<td>1 Ability to acquire knowledge. 2 Acquire more Information from clients when I talk to them about DVA. 3 Find out a bit more about what is happening in their lives without actually saying the words ‘domestic violence’</td>
<td>1 Knowledge about DVA. 2 The nature during professional encounter. 3. Intentionally avoiding naming DVA linked to the acceptability of talking about DVA.</td>
<td>Category: Attitude towards DVA. Category: Knowledge about DVA. Category: Naming violence and abuse</td>
</tr>
<tr>
<td>I don’t know if it’s the word ‘violence’, and I never thought about it in that respect, but I think when we talk about domestic violence, definitely physical abuse springs to mind, and there’s that stigmatising that taboo on physical abuse, but the thing is, even if there was there wasn’t physical abuse and there was other types of abuse, chances are the physical abuse would eventually manifest, it then…” (Janet, 3.1: 6.2.2).</td>
<td>1. I don’t know if it’s the word ‘violence’. 2. I never thought about it in that respect. 3. When we talk about DVA, definitely physical abuse springs to mind. 4. And there’s that stigmatising that taboo on physical abuse. 5. Even if there was there wasn’t physical abuse and there was other types of abuse, chances are the physical abuse would eventually manifest, it then</td>
<td>1 Prioritising physical violence. 2. Reflecting, knowledge and awareness 3. Physical violence prioritised. 4. Social attitude towards DVA. Stigma and shame. 5. Sense-making demystifying and critically evaluating. Imagining, experiences and prior knowledge.</td>
<td>Stigma and shame. Control and exploitation. Historical context in which knowledge about DVA emerged. Stigma and shame. Control and exploitation. Historical context in which knowledge about DVA emerged.</td>
</tr>
</tbody>
</table>

Table 18 Participants Text to Category/Concepts and Sub-theme Part A ‘Original in Colour’
<table>
<thead>
<tr>
<th>Transcript</th>
<th>Keyword phrase</th>
<th>Meaning units/ code descriptor</th>
<th>Concepts/Sub-Theme 3: At The Intersection With Professional Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>And then the lady came to me in clinic probably a week after and explained all that was happening to her and that she had been to the Imam with black eyes and what have you, and the Imam says she talks too much to she knows too much, whatever, that she should pipe down, so that’s why she had the black eye” (Kemi, 4.1).</td>
<td>1. The lady came to me in clinic. 2. And explained all that was happening to her and that she had been to the Imam with black eyes. 3. She had been to the Imam with black eyes and what have you, and the Imam says she talks too much to she knows too much, whatever, that she should pipe down.</td>
<td>Access to services Contact with women Help-seeking Religion Disclosure Attitude towards DVA Intervention Control and resistance Gender masculinity</td>
<td>Disclosure: women appear to disclose at crisis point. Religion: issues of religion and familial practice prevent women from disclosing. Help seeking: issues of religion and family ideology shape the way women seek help. Attitude towards DVA: DVA is condoned and community leaders collude with perpetrator. DVA remains hidden.</td>
</tr>
<tr>
<td>Frequent movers can find it difficult to access the services they need. For those already socially excluded, moving frequently can worsen the effects of their exclusion. (LSCB 2010: 4.0).</td>
<td>1. Frequent movers. 2. Access to services 3. Social exclusion 4. Worsen the effect.</td>
<td>1 Housing: unstable living conditions. 2 Access to services and provision of services. 3. Socio-economic: circumstances of women living with DVA</td>
<td>Socio-economic conditions homelessness. Access to services: unable to access HV service due to frequent house moves. Training and education: Knowledge of social and economic position. Contact with women.</td>
</tr>
</tbody>
</table>

| Table 19 Participants Text Code to Category /concepts and Sub-theme- part A 'Original in Colour' |
The prevalence of domestic violence shows little variation in terms of ethnicity. However, some domestic violence involves culturally specific forms of harm, particularly affecting black and minority ethnic communities. These include forced marriage, FGM and so-called ‘honour’ crimes and killings. Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels, namely: (DVA toolkit 2010; 2.0)

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Keyword phrase</th>
<th>Meaning units/ code descriptor</th>
<th>Concepts/Sub-Theme 3: At The Intersection With Professional Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>The prevalence of DVA shows little variation in terms of ethnicity. However, some domestic violence involves culturally specific forms of harm, particularly affecting black and minority ethnic communities. These include forced marriage, FGM and so-called ‘honour’ crimes and killings. Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels</td>
<td>1. The prevalence of DVA shows little variation in terms of ethnicity. 2. DVA involves culturally specific forms of harm affecting black and minority community. 3. FGM and so-called honour crimes and killing. 4. Stigma and shame are powerful factors in preventing women of all cultures from seeking help. 5. Women and children from some communities may be affected on three interacting levels</td>
<td>1 Knowledge about DVA. 2. Ethnicity and race: not measured in DVA statistics. 3. Defining DVA. 4. Attitude towards DVA. 5. Shame and stigma. 6. Gender and gendered: children DVA and HBV. Power and control. How religion is used to interpret and determine women’s position. Awareness of the power and control outside intimate relationships</td>
<td>Knowledge: key elements that determine nature and prevalence not measured. Ethnicity and race: influence the nature and context of DVA. Excluded from measurement. Gendered context in which familial ideologies of DVA. Shame and Stigma: linked to specific beliefs about gender.</td>
</tr>
</tbody>
</table>
Figure 7 Final Thematic Map ‘Original in Colour’
<table>
<thead>
<tr>
<th>Text talk</th>
<th>Categories</th>
<th>Concepts/meaning units</th>
<th>Sub-themes</th>
<th>Theme One</th>
</tr>
</thead>
<tbody>
<tr>
<td>So it provided me with just basically an ability to acquire knowledge, to acquire more information from clients when I talk to them about domestic violence and to find out a bit more about what is happening in their lives without actually saying the words ‘domestic violence' <em>(Pamella, 2.0:6.2.2)</em></td>
<td>Attitudes towards DVA(stigma) Knowledge about DVA. Naming violence and abuse</td>
<td>Stigma and taboo linked to naming DVA. Prioritising physical violence.</td>
<td>Sub-theme 1: Lost for words: The Power and Problem With Naming Names</td>
<td>At The Intersection with Professional Encounters</td>
</tr>
<tr>
<td>I think someone who is from Western Europe or European who experiences domestic violence is probably more likely to report it because they are so aware of what's right and what's wrong, and they can speak out a lot better for themselves. But where you have cultures where black women or ethnic minority groups, where it's accepted and it's the norm, they're less likely to ever disclose and report it&quot; <em>(Pamella, 4.0: 6.2.3).</em></td>
<td>Others' differences and similarities. Isolation. Rights and responsibilities Race and ethnicities. Migration and settlement Attitudes towards DVA</td>
<td>Binary construct of Western and non-Western identities are used to construct and represent the women as lacking in agency. Assumptions and stereotypes creating social identities as more tolerant of DVA Hegemonic knowledge</td>
<td>Sub-theme 2: Representing Other Women's Perspectives</td>
<td></td>
</tr>
</tbody>
</table>

Table 21 Text to Category to Concept, Subtheme and Theme: ‘Original in Colour’
And then the lady came to me in clinic probably a week after and explained all that was happening to her and that she had been to the Imam with black eyes and what have you, and the Imam says she talks too much to she knows too much, whatever, that she should pipe down, so that’s why she had the black eye” (Kemi, 4.1).

The prevalence of domestic violence shows little variation in terms of ethnicity. However, some domestic violence involves culturally specific forms of harm, particularly affecting black and minority ethnic communities. These include forced marriage, FGM and so-called ‘honour’ crimes and killings. (See section 9 for more details) Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels, namely: (DVA toolkit 2010, 2.0).

<table>
<thead>
<tr>
<th>Text talk</th>
<th>Categories</th>
<th>Concepts/meaning units</th>
<th>Sub-themes</th>
<th>Theme One</th>
</tr>
</thead>
<tbody>
<tr>
<td>And then the lady came to me in clinic probably a week after and explained all that was happening to her and that she had been to the Imam with black eyes and what have you, and the Imam says she talks too much to she knows too much, whatever, that she should pipe down, so that’s why she had the black eye” (Kemi, 4.1).</td>
<td>Finance and income. Family and kinship Gender and gendered. Disclosure. Physical and non-physical Attitudes towards DVA.</td>
<td>The intersection between religion and familial ideologies Hegemonic and patriarchal dominance Hegemonic masculinity informed by male privileges, women’s submissive position. Intersectionality of ethnicity, familial, migration, rights, naming and gender.</td>
<td>Sub-theme 3: Encounters at the Intersection</td>
<td>At The Intersection with Professional Encounters</td>
</tr>
<tr>
<td>The prevalence of domestic violence shows little variation in terms of ethnicity. However, some domestic violence involves culturally specific forms of harm, particularly affecting black and minority ethnic communities. These include forced marriage, FGM and so-called ‘honour’ crimes and killings. (See section 9 for more details) Stigma and shame are powerful factors in preventing women of all cultures from seeking help. Women and children from some communities may be affected on three interacting levels, namely: (DVA toolkit 2010, 2.0).</td>
<td>Knowledge about DVA. Race and ethnicities. Defining DVA. Family and kinship Gender and gendered. Others’ difference and similarities Shame and stigma. Family and kinship. Naming violence and abuse Others’ differences and similarities.</td>
<td>The intersection between religion and familial ideologies Hegemonic and patriarchal dominance Hegemonic masculinity informed by male privileges, women’s submissive position. Intersectionality of ethnicity, familial, migration, rights, naming and gender.</td>
<td>Sub-theme 3: Encounters at the Intersection</td>
<td></td>
</tr>
<tr>
<td>Table 22 Category Concept sub-theme and Theme 'Original In Colour'</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.1 Introduction

The intention of these findings chapter is to represent the participants’ and practice knowledge and documentary discourse of DVA. For clarity, this study seeks to answer the central question: In what ways do HVs understand DVA in BME communities? It considers the nature of practice knowledge generated during day-to-day contact with BME women by asking what roles do race and politics play during day-to-day encounters to uncover DVA. It describes how HVs’ knowledge shapes professional relationships and influences the nature of contacts when asking BME women to disclose incidents of DVA.

Key policy documents were analysed alongside HV’s conversations. These documents were analysed alongside HV’s conversations because they contain ideological representation of aspects of institutional discourse which might be shown to shape practice culture and contribute to establishing, reinforcing or influencing the nature of professional relationships with BME women.

5.1.1 Health Visitor’s Encounters with DVA in BME Communities

The chapter is organised and presented in three themes and narrated in sub-themes. Theme One: ‘At the Intersection with Professional Encounters’ describes the knowledge and practice informing the way participants and documentary texts define DVA. Theme Two: ‘The Subaltern Speaks in Tongues: Commonalities and Contradictions’, explain the inherent contradictions in practice when HVs identify DVA. Finally, Theme Three: ‘Postcolonial Conditions’, explore individual, practice and institutional response to DVA disclosure. See figure 8 below.

Figure 8 Themes and Overarching Theme
5.1.2 Theme One: At the Intersection with Professional Encounters

5.1.3 Introduction

The data in this theme also offer insight into how HVs use their clinical encounters, as well as their personal and experiential knowledge, to shape the way in which they describe and define DVA. Examples are provided from HVs’ conversations and documentary text.

‘At the Intersection with Professional Encounter’ involves three main elements:

- Sub-theme one: Lost for Words: The Power and the Problem of Naming Names,
- Sub-theme Two: Representing Other Women’s Perspectives,
- Sub-theme Thee: Encounters at the Intersection. (See Figure 9).

![Diagram showing the structure of Theme One]

Figure 9 Subtheme One

5.1.4 Sub-Theme One: Lost For Words the Power and the Problem of Naming Names

Naming appears to play an important role in shaping participants’ conceptualisation of the problem. In conversations, participants applied complex combinations of abstract and practical knowledge when defining the problem of DVA. I began by asking HVs to describe the nature of DVA in their clinical caseload:

“And domestic violence... I would say domestic violence wasn’t something that was discussed as openly as we’re getting more used to doing. I think ... We didn’t do the routine questioning and to be honest with you... no we didn’t, there wasn’t the questioning; there was not the questioning; you knew
it was going on and the only way you knew it was going on was if you happened to hear conversations that were going on in the street – it was second- or third-hand information” (Jayjay, 2.1).

The historical professional silence on addressing DVA is evident in the majority of participant’s conversations and remains consistent with earlier findings from (Peckover, 2003; DH, 2010c/12). Similarly more than 50% of participants cited long-term, persistent difficulties related to defining and talking about (naming) DVA. Janet alludes to possible reasons:

“I don’t know if it’s the word ‘violence’, and I never thought about it, I never thought about it in that respect, but I think when we talk about domestic violence, definitely physical abuse springs to mind, and there’s that stigmatism, that taboo on physical abuse, but the thing is, even if there wasn’t physical abuse and there was other types of abuse, chances are the physical abuse would eventually manifest, it then…” (Janet, 3.1).

Janet’s deliberation highlights some of the conceptual complexities and contradictions that participants appear to struggle with. It was evident that some HVs struggled with the complex gendered, political and racialised context in which DVA occurs. These conceptual difficulties appeared to be conflated by the complexities of social identities as summarised in Jayjay’s discussion:

"It's segregating society into different pockets of cultural religious beliefs isn’t it, and when you’re looking... When I go into a home and I am saying ‘Could you tell me what your ethnicity is?’ they may say ‘Black British.’ I don't then say ‘Oh, what generation are you, from Africa, the West Indies, whereabouts were you from, which village is that?’ I don’t have that kind of information" (Jayjay, 0.0).

Similarly to Jayjay, some HVs described the ever-increasing complexities that are linked to the understanding of identity politics. Far from representing a simple addition of social identities such as race we see how ideas of knowledge empowerment within HVs’ services might not necessarily be straightforward. A different perspective emerges from Ronny:

“It’s ... how can I put it into words because I am no good at words? It could be from a woman to a man, it’s about physical violence, it’s about emotional manipulation and behaviour towards women, it’s about isolating them, moving them from their friendship network systems, it’s about taking away their rights in terms of finances, their friendship, so it’s physical, it’s
emotional, it’s sexual, it’s about violence and power and control” (Ronny, 1.0).

Ronny’s definition and reflects the contested UK government’s gender neutral position of how power and control operate in violent relationships (see section 3.2). As noted, in Chapter Three, focus on the coercive and controlling nature of DVA, attention to power implicates women in perpetrating violence whilst downplaying the role of patriarchy and the gendered context in which this kind of violence happens (Filson et al., 2010; Kelly, 2011; Dempsey & Day, 2011). The conversation continues:

I don’t think it manifests differently. Some people argue about… I have heard it argued that it’s a cultural thing and that in some cultures it’s accepted, and it’s the way to treat people but I don’t actually think that’s the case from my caseload when I talk to people, I don’t think it matters which culture you are from, I think the presentation is the same (Ronny, 7 - 0.07)

Coincidentally Ronny avoids naming the racialised and familial context of the phenomenon. However, emerging evidence in Table , p38; shows distinguishing features of BME women’s victimisation/survival process. Lack of awareness of these contexts might also lead HVs to unconsciously disregard the intersectionality of some BME women’s experiences (Choudry, 1996; Gangoli et al, 2006; Wellock, 2010). Notwithstanding a different view from Tamara:

“……I think it depends on what is constitute as domestic violence, if it’s just male to female, yes but if you are looking at it from a wider spectrum to say intimate partner violence I could say that it does not identify and recognise the extremities, so like forced marriage and things like that, it doesn’t cover these things. It didn’t cover violence portrayed by children and family members. It was just focused on violence between mother and a father” (Tamara, 0.0).

The conversation from Tamara also reflects a growing awareness of violence from children to mother and the limitation of the current definition to adequately explain these contexts:

“When physical violence occurs, other forms of abusive behaviours are perhaps more common. These may include: threats, intimidation, manipulation or isolation; keeping a woman without money, locked in or deprived of food; or using her children in various ways to frighten her or enforce compliance. It can also include systematic criticism and belittling comments aimed to destroy self-esteem. Domestic violence is rarely found to be a one-off event and attacks tend to become more frequent and increasingly severe over time” (RCN, DV strategy, 2000).
Implicit in the documentary text is the intersectionality of DVA and the social and economic context of women’s experience as mothers. Similarly, services such as emergency housing, safety planning and routine enquiry appear to be targeted at particular groups of women with children; thus carefully prioritising the experiences of women who are mothers. The notion of race and ethnicities were not a significant feature. When asked about BME women’s experiences of DVA, issues of race, ethnicities were not a significant feature, instead interconnection between physical and non-physical violation were mentioned, as demonstrated by Martine:

“So I just think it’s emotional and financial abuse, you know, it’s not just the idea that domestic violence is physical abuse. I think there’s a run-up to it, it doesn’t just come out of nowhere. Usually it’s a combination of things, isn’t it? It’s not just one thing, it’s that their whole world is controlled by somebody else, really” (Martine, 3.0).

Thus far we have seen that defining the problem in a particular way not only excludes particular experiences but illuminates the complexities and confusion that are linked to the understanding of DVA. In the following extract, Indera draws attention to further problems with naming DVA:

“I think domestic violence/abuse, it covers many areas and when you speak to families, because it’s previously very much been known as domestic violence, the clients, and possibly not professionals, but the clients very much, in their minds, just define that as physical abuse, and they don’t or haven’t been aware that it’s many other… It takes on many other elements of the emotional abuse, financial abuse, verbal abuse and sexual abuse – they tend very much to sort of class it as ‘I am either hit, or I am not hit, and if I am not hit, I am not suffering from domestic abuse, domestic violence doesn’t affect me.’ So I think that’s been quite a shift in recent years for us as health visitors” (Indera, 1.3).

A conceptual shift acknowledged in Indera’s conversation, thus demonstrating how women exercise the power to name what counts as DVA but sheds light on how women might prioritise their resistance to male violence. Paradoxically, the contradiction in naming DVA is also evident between the women and the HVs and might impact on the goal to uncover DVA in practice. Returning to Lorna’s conversation:

“Yeah, I think it has made an impact because the term ‘domestic violence’ is quite drastic isn’t it? Whereas I think it used to be all sort of wrapped in cotton wool a little bit, so although we would deal with the issues and talk about things, it was all done in a very nice, nice way to try not to upset people
perhaps or to, you know.. Obviously you don't want to inflame the situation” (Lorna, 1.1).

The extracts from Indera and Lorna, together with old terminology such as ‘battered wife’ (Prizzey, 1974), also explain the historical but contested context of early feminist discourse that brought domestic violence into the social consciousness more than four decades ago. During this time, the conceptual binaries of women as victims/survivors and men as perpetrators were emphasised. Indeed most HVs reported that clients readily recognised physical violence as a DVA problem, but psychological abuse was an ambiguous and difficult concept; drawing attention to Bradbury-Jones et al (2014) conscious and recognition, notion of understanding DVA in Chapter 3. In contrast to Lorna and Indera, Tamara uses the diversity of the families on her caseload to define DVA:

“I think it depends; I think it has a cultural sort of connotation to domestic violence and how people from different backgrounds determine what constitutes domestic violence. Some people for example, some women may not see what is happening to them as domestic abuse. Sometimes circumstances as well in my experiences has led these women to kind of accept what is happening to them. Some of them might know it is abuse but because of their personal circumstances...” (Tamara, 0.0).

Cultural essentialising is observed as we see how Tamara explains that women’s ability to passively accept DVA is linked to their culture. The comments also ignore the coercive and controlling strategies used by perpetrators and allude to how powerful beliefs and values might alter response to DVA. Using her considerable experience in working with diverse and complex families, Marykay offers further insight:

“God. Well I have sort of come across so many different forms of it really, but I suppose it’s any sort of violence or threat of violence to a family member from a family member. Generally, I mean like it could be partners, ex-partners, it could be mother-in-law to daughter-in-law, you know. I see it… yeah, it has to be family-related, am I right?” (Marykay, 1.1).

The familial understandings of DVA is consistent with Gill’s (2004) conceptualisation of BME women’s experiences of multiple perpetrators and how women might collude with men. In this way, not only gender but also personal,
cultural, racial, economic, or political contexts might contribute to the complexities in naming DVA.

5.1.4.1 Summary

The findings revealed that a much broader and gender-inclusive understanding of DVA leads to practitioners’ avoidance of naming the gendered context in which this kind of violence happens. When attention is drawn to the coercive and controlling nature of DVA, the role of patriarchy and the intersectionality of BME women’s experiences of DVA is obscured. The findings emphasised the contradictions between HVs and the women, and confusion about the continuum of DVA. Furthermore, the historical professional silence, stigma and shame relating to DVA, continue to influence the level of acceptability of naming and responding to the issue. An understanding of DVA which avoids the conceptual binaries of male female also appears to lead to an understanding of multiple perpetrators. The focus on naming DVA exposes the complexities and often confusions between HVs but hold the potential to include the voices of marginalised groups and their experiences of DVA.

5.1.5 Sub-Theme Two: Representing Other Women’s Perspectives

In this sub-theme, the concept of Representing Other Women’s Perspectives is invoked to describe and explain HVs’ knowledge about the racialised and political context in which some women experience DVA. The concept of Othering appears suited to understanding HVs’ knowledge about the representation of BME women. This is observed in Martine’s response:

“… I think for us as Western women, I think sometimes we don’t even… We have to learn that ourselves, is that we’re not even starting on a level playing field because some women are so not aware of what their human rights are actually. I mean that’s how I look at it, they just, they don’t, they just think they are less or they deserve less…” (Martine, 3.0).

Martine’s conversation emphasises how women’s access to power and challenge to the patriarchal dominance continue to evolve in an unequal way. Assumptions about moral values and Social division constructed in the binaries between Western and non-Western societies is used to explain how these inequalities
remain intact or is reproduced through the process of migration. Reference to the women’s ignorance of their rights also implies a double jeopardy of DVA and accessing services as Tamara explains:

“Immigration status for example, not being able to work or not having a job, being in a relationship where the partner is the dominant earner or just language barrier is another thing. Lack of understanding of British culture and what that is here as in domestic violence, perhaps where some of these people are from it is seen as the norm” (Tamara 1.2).

Crucially, the avoidance of gender by Tamara is subtle and the attention to power dynamics opens up the possibility of how the exercise of power might operate in same-sex relationships in BME communities. Similar to Martine, Tamara is aware of how the process of immigration and settlement to the UK fail to disrupt the patriarchal domination of some women. Equally, racial stereotyping is evident here, as broad categories of Western and non-Western women were often used by HVs to represent the levels of social needs, economic conditions and entitlement to social welfare, Pamella explains further;

“I think someone who is from Western Europe or European who experiences domestic violence is probably more likely to report it because they are so aware of what’s right and what’s wrong, and they can speak out a lot better for themselves. But where you have cultures where black women or ethnic minority groups, where it’s accepted and it’s the norm, they’re less likely to ever disclose and report it” (Pamella, 4.0).

Western women are spoken about by Pamella as having a greater sense of knowing what is right and what is wrong. Homogenising the women in this way undermined the representation of significant socio-political differences between BME women and first and second generation migrants. On the other hand, attention to how power and agency operate suggests that some BME women chose to challenge male violence without either disclosing or leaving that violence (Mannell 2015). From these context the cultural currency of Other begin to emerge, Marella;

“I see a lot of women who … now I am talking about Muslim women who don’t have the right to talk to anybody. For instance we can phone home and say ‘I want to speak to Fatima’ or whatever, ‘I want to make an appointment’ and the husband answers the phone and says ‘I am the house man, I am Fatima’s husband, talk to me’ because they don’t want their wife to talk, they don’t want their wives to open up, and maybe the… What I think is the husband, maybe he’s got something to hide” (Marella, 1.1).
Whereas Pamella and Tamara present a view of BME women as having culturally intrinsically different values and attitudes towards DVA, attention to differences are shaped by the women’s religion. Muslim men are also viewed with mistrust and particularly powerful and often controlling HV’s access to the women. as noted by Marella, the perpetrators’ strategies to control the BME women and the HVs were a common theme within HVs’ conversation: The focus on culture continues:

“I think for example in the Bangladesh community it’s something that is not discussed and it’s not… you know, it’s very difficult for the woman to come forward and admit that it’s happening. It brings shame on the family, and more importantly the extended family, and not just the Bangladeshi community, I think in other communities as well. If a woman asks for help, it’s therefore brought to the attention and then the ripples go out into the wider family circle and that’s a big issue in these communities” (Indera, 3.2).

Indera explain how experiences of DVA are interconnected to access to power in personal and familial institutions, illustrating how power and violence in personal relationships are connected to familial ideas and institutional politics. Patriarchal dominance of some women is maintained through the cultural ideas on the notions of shame (izzat) and family honour (sharam), contradicting the national definition and UK laws on DVA (Patel and Siddiqui, 2011& Home Office, 2013c). The gendered nature of the violence is invested in the ideas of the woman’s role as a wife and maintaining her purity as a woman, which are shared by the community (Patel, 2013). It is also linked to why violence towards women that is linked to 'honour', 'shame', and FGM is seen as part of the overall UK national and local strategy to tackle gender violence (Home Office 2012). In the following documentary text, we see how these particular discourses are now visible within discourse on DVA:

“Professionals should respond in a similar way to forced marriage as with domestic violence and honour-based violence (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child’s safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments etc.)” (LSCB, 2.0).

Neither gender, nor race, nor culture is privileged in the current operating protocols which the NHS and other statutory agencies apply to respond to domestic violence. In the following DVA definition we see how the practice of FGM, and honour-based crimes are all viewed as part of the continuum of gender violence as:
“In 2004, the Government’s definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and so-called ‘honour crimes’ (which can include abduction and homicide) now come under the definition of domestic violence” (LSCB, 5.0).

Implicit in the black feminist ideas on DVA, is the need to uphold the rights of the individual and to protect them from imposed harmful practices that damages their physical, sexual and emotional health. This is noted in the UK government’s position on crimes of honour: Naming FGM and honour-based crimes as DVA is intended to reduce the stigma and cultural essentialising that are linked to the aforementioned violations (LSCB, 2010; Home Office, 2013a). The extent to which this is being achieved is difficult to ascertain. Jennifer explained:

“I mean there are things like the policies on forced marriage and FGM obviously. I mean locally... I mean locally there’s just other guidance around MARAC and the CAADA DASH and filling in risk assessments and things – I mean locally it is ... well it is but I am not sure it’s always used, it is supposed to be our policy that we do ask all women on... especially... well on every first visit, about if they have had any experience of domestic violence, but I know it’s not everybody... not everybody feels able to do so” (Jennifer, 3.1).

A disconnect between national agenda and local policy is suggested here. When asked about their use of DVA assessment, only a minority of HVs drew upon these understandings to illustrate BME women’s experiences and only two admitted to having these understanding as part of their training on DVA. Significantly the DASH-RIC tool is designed to reflect the ethnic and cultural context in which some BME women experience DVA.

“But with relation to domestic violence? I don’t know. I mean I had a case recently that was an African family, a black African family and that was an unusual one for me in that it was around kind of witchcraft and voodoo and that kind of thing. The father was saying that the mum had joined a church and was being very much influenced by it, an African church and that they
were encouraging her to read these books about witchcraft and things like that, and that she was sort of saying that he was an unfit father and that he should die, bizarre… sort of describing really bizarre behaviour. And he was… so he was saying he felt her mental health was the issue, but when it was looked into, she actually had a mental health assessment and she… They were both very intelligent, educated people and, you know, so when it was looked into, the sort of outcome at the moment… (Lorna, 1.2).

Lorna has provided an explicit account of the kind of confusions that is linked to an ever-expanding definition to include the discrete racialised and familial context. This scenario also elucidates the overlapping connections between DVA, mental illnesses, religious, gender, class and other cultural practice that might mask or conflate issues of DVA. As noted in the literature review, when practitioners are faced with complex situation in practice a sense of powerlessness might prevail whilst some might avoid the issue altogether whilst the abuse continues. The conversation is taken up by Jayjay:

“No, no. I think we try to be so PC, we fail, politically correct; can we say this, can we say that, can we say the other? We do still make assumptions I think” (Jayjay, 2.0).

The responses from Jennifer and Jayjay also shed light on the extent to which labelling violence as inherently cultural or racial, rather than gender specific, can lead to thinking that all BME women have the same experience, e.g. all South Asian women are subjected to honour-based violence. As I return to Martine’s conversation we see how attitudes toward BME perpetrators are shaped by a particular way of thinking:

“Yeah, I think that yeah, the Asian population actually, well it’s probably very prevalent to begin with and also they are much more hidden about it, yes, and also very difficult to work with in a sense, that they often don’t engage with the services. Why is that? I think that… well it’s probably more accepted within their culture actually and also very often they’re inter-married, it’s family related, you know, and it’s just … it has to be kept underground really rather than this… they don’t want the involvement, they don’t want the stigma of it and they’re very controlling, they’re actually very controlling anyway often to the women – it can be that the women are underdogs and they mustn’t speak out, they’re not allowed to speak out and they’re frightened, that sort of thing” (Martine, 0.0).

A view of DVA as being more prevalent in the South Asian population was particularly common amongst HVs. The women are represented as lacking in agency, unable to stand up for themselves, more vulnerable to, yet more tolerant
of male violence. Conversely, particular practices within families are seen as powerful agents of control. A sense of hopelessness is conveyed as we see how the women are placed beyond the reach of HVs and the perpetrators are imbued as being particularly powerful.

5.1.5.1 Summary

These conversations with HVs and documentary text illustrate how experiences of DVA are often intertwined with familial and cultural location of some women’s lives. Specific conditions, such as employment, immigration status, social class, and language barriers intersect with gender to reproduce particular experiences of isolation, access to services, and influence decisions to disclose incidences of DVA. The complexities that are linked to the intersectionality of DVA and the socio-political location of BME women appear to mask the true prevalence of DVA. Participants’ observations of Other Women’s perspectives illuminated how attempts to describe the diverse context in which some women experience DVA often undermine the heterogeneity of women’s socio-political positions and create confusion. HV’s knowledge of BME women’s experiences shows the powerful ways that ideas within cultures, ethnic groups and families often perpetuate or mask DVA. The data reveals how the hegemonic structures within familial institutions undermine legislation to protect women. However, the focus on a particular context might also have unintended consequences, whereby particular ethnic groups might be defined and homogenised in particular ways, which may influence HV’s understanding of the individual needs of each family.

5.1.6 Subtheme Three: Encounters at the Intersection

The HVs in this Sub-theme all work in different social and diverse locations across the participating NHS Trusts. The conversations began with participants discussing the demographic of their caseload profile. Janet, Yenka and Jennieve described the nature of their caseloads;

“Well my caseload is 500 on average and I would say BME women are 400, so that’s what, 90%? Yeah, so it’s a large, large per-cent” (Janet, 1.1).

The numerical representation in HVs’ caseloads, their ethnicities, language, and employment, housing needs, access to welfare, drug and alcohol dependency,
uptake of immunisation, post-natal depression, familial structure/support and DVA disclosure constitutes important information gathered and used to create a profile of the caseload and local health needs. Against this background, the challenges linked to delivering individualised care are captured in Indera’s frustration as she describes the impact upon her caseload:

“They tend to want… they want one to one… When they come to seek advice, they want one to one and it’s very difficult to encourage them to go to a group where you could be very focused giving that advice with two or three other people with the same problems but that the … it doesn’t work” (Indera, 2.1).

Indera has succinctly summarised the intersectionality of HV’s work and the gaps between service delivery and service demands. For instance, whilst it might be more efficient to conduct group discussions, some women might not necessarily want to disclose sensitive information within a group setting. At the same time, it would be impossible to respond to all the women with individual concerns during a group session due to time constraints and limited access to resources, such as the availability of interpreters. More profoundly the statement shows the contradiction in HVs’ work, where care is not necessarily delivered to those in greatest needs but to those with greatest access. Therefore potentially masking the true nature of the problem in BME communities. The conversation continues

“OK. I don’t think so. I think abuse is wide in all ethnic groups, whether they’re BME or Caucasian, or wherever they could come from; I think it’s wide everywhere” (Danielle, 2.1).

HVs were divided in their opinions when asked a specific question about the prevalence of DVA in BME caseloads there was less consensus as to the role of ethnicity in shaping the prevalence of the problem:

“I think abuse is wide in all ethnic groups, whether they’re BME or Caucasian, or wherever they could come from; I think it’s wide everywhere…..” (Erica, 1.1).

Here Jayjay offers a different perspective:

“I am thinking… being specific, I am thinking of some of the Asian cultures that I’ve seen, that the families will actually prevent any professional seeing anything going on within the family homes. I also think certainly some of my African families, they wouldn’t necessarily come and speak to the health visitor, they may well go to their preacher or their pastor and talk to them
about... you know, if there’s problems within the family unit, they wouldn’t come to me” (Jayjay, 3.1).

Jayjay has rationalised how the specific nature of some BME women’s experiences creates difficulties in measuring the problem, particularly when analysed against the familial structure and community arrangement of some families. Our attention is drawn to the strategies or help-seeking processes used by some groups of women and the role of religious and community leaders who can be implicated in masking the true nature and extent of the DVA in families, the discussion continues with Marykay:

“Yeah, I think that yeah, the Asian population actually, well it’s probably very prevalent to begin with and also they are much more hidden about it, yes, and also very difficult to work with in a sense, that they often don’t engage with the services” (Marykay, 1.1).

Cultural stereotyping? Or reflecting the nature of the interconnectedness between culture and the prevalence of DVA on her caseload? Together with a simplistic view the of help-seeking behaviour of some BME women avoid the complexities of how access to power influence the nature of DVA. It is difficult to contest the prevalence of DVA because HVs do not formally collect DVA data relating to ethnicities and it is not prioritised by commissioners (ONS, 2006; Cowley et al., 2012; NHSE, 204/15 & NICE, 2014). Furthermore, HV services are more likely to be involved with BME families whose lives are already shaped by social isolation, poverty and DVA (Donetto, 2010; NHSE, 2014a). Evidence shows that BME women are more likely to belong poorer socio-economic groups (Acheson, 1988; Elkan et al, 2001; Marmot and Wilkinson, 2006; Cowley, 2008; DH, 2010b/c) which might lead participants to develop a distorted view of the prevalence of DVA, as demonstrated in the following conversation with Jennifer:

“I mean it’s probably a huge generalisation and it’s probably totally inaccurate but I sort of see it as... like in our Asian community we have the problem that is very family-orientated so often they live with grandma, they live with the siblings and all the rest of it, so like when you do come across issues of domestic violence, they cover up for each other and that’s a huge issue and it’s often denied. Like one person would be saying it and others will deny it, so then the person that reported it in the first place will often then start denying it and saying ‘Oh no, no, it was all a mistake, it was a one-off and it was never going to happen, it’s never happened before and it’s never going to happen again’ and it’s all covered up within the family really, so I think that’s one issue. And it seemed to me within the black community it was more a question of ... it shows a weakness if they admit to it, and they’re not
really willing to do that either, and I think it’s very important for us as professionals, I don’t think it matters what colour you are, is to make it blatantly obvious that it’s something that covers across every culture, every ethnicity, you know, it’s just part and parcel of being in relationships that it can happen, and it happens to... it can happen to anybody” (Jennifer, 7.2).

Jennifer’s observation shows how it is possible for some women to endure years of abuse or choose not to report the abuse. Normative ideas on the victimisation/survival process implicate the BME women in their own abuse when they are being positioned as untrustworthy and unconsciously complicit in condoning the violence. (See Chapter 3.3.2 Help-seeking Behaviour of BME Women). Similarly, the notion of the strong black women is suggestive in the comment “shows a weakness if they admit to it”, might lead to homogenising other BME women as being more resilient to DVA. The racialised construction of the strong black women syndrome has been used to explain how professionals often overlook or fail to identify incidences of DVA in African Caribbean women when they their vulnerabilities are overlooked in this way (West, 2005 and Thiara, 2011). A different perspective was presented by Pamella when asked to describe the nature of her encounters with some BME women:

“The only time that I sometimes find it sad is when like in the cases I have mentioned where women have no recourse to public funds and there isn’t really anything out that that, you know, if a woman is experiencing domestic violence, there aren’t that many options for her, you know, in the sense that where does she go, and if she leaves the perpetrator how is she going to survive? Most of these women are not working, there is no way they are going to have money and if they are placed in a refuge, usually the place where they are placed is so far away from anybody or everyone that they know, that a lot of them end of returning or coming back to the perpetrator” (Pamella, 1.15).

The conversations describe how DVA is intertwined with dimensions of nationalities, poverty, immigration and the power of the perpetrators within families. In this instance, we see how it is possible for some black African, Caribbean or Asian immigrants (depending on settlement status) who are fleeing DVA to not be entitled to access the kind of support outlined in the national Violence Against Women and Girls (VAWG) strategy. ²Equally, as Pamella ²Survival might then depend on the support of the family regardless of education and or economic status. Under current UK immigration law, non-European migrants with an unclear immigration status or a conditional settlement visa have no entitlement to social and multi-agency support, such as emergency money or housing, when fleeing domestic violence (Siddiqui and Patel, 2010; Women’s Aid, 2007).
suggests, BME victims/survivors are less likely to report DVA to statutory agencies for fear of deportation and/or the consequences of separation and deportation (Siddiqui and Patel, 2010); in contrast, European migrants who are victims/survivors of DVA do not face these restrictions. In my discussion with Martine I asked her to provide an example of a BME family that she had recently supported:

“...She was married for a long time, the baby was IVF and they were both Jewish and obviously she’s a French culture, he was English from a very wealthy family and very abusive, sort of controlling individual ....And then on one occasion they were celebrating Passover and they were in his family home and her mother’s a wonderful cook and they were celebrating slightly differently so she sent special food over so that they could share it at the table, and she gave it to the mother-in-law beforehand and then when she went in the evening the food wasn’t on the table and she asked, and it just exploded into an enormous row, and he hit her across the head, and on her face in front of his parents... She is divorced, she said that it’s really difficult because he is a solicitor, his dad is a solicitor...” (Martine, 3.1).

Although not explicit, the notion of class and gender complementarity is implied, as we see how family relations appear to be organised around a strict adherence to established beliefs and less traditional orthodoxy (Horsburgh, 1995), and it could be argued that the violence directed towards the younger woman appears to be linked to the unequal positions occupied by the women within the family. By contrast, Kemi presents a different account of her caseload, which is significantly more deprived but consists of more than 59% South Asian families:

“And then the lady came to me in clinic probably a week after and explained all that was happening to her and that she had been to the Imam with black eyes and what have you, and the Imam says she talks too much to… she knows too much, whatever, that she should pipe down, so that’s why she had the black eye” (Kemi, 4.1).

Kemi provides a powerful example of how patriarchal religious interpretations of religious orthodoxies by faith leaders play a powerful role in condoning and justifying violence within relationships. From this example we see how the religious interpretation of women’s positions in marriage, requiring them to honour and obey their husbands, and the interpretation of men as heads of household can be used to infer female submission and male superiority (Holy Bible, Colossians 3:18;

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3 Gender complementarity is a theoretical view held by some in Judaism, Christianity and Islam that men and women have different but complementary roles in marriage, family life, and elsewhere. It is held that these roles are biblically prescribed.
Corinthians 7, 3; Rehman et al., 2013). This context of violence and oppression is reflected in feminist theorising on the role of religion in patriarchal ideology that legitimates female subordination. Kemi continued:

“And what happened? And then she said it was not just the partner who is perpetrating, but also the in-laws were beating her up in the house and... was she pregnant? She had a new baby and she had another little one, and rang them up and everything else, I think she left, she just left with the baby and the milk and the little one in the buggy so I think she was penniless so I gave her (some money) make sure she got enough money for her transport down to housing, which housing were aware she was coming, doing the social care referral and everything else, and what happened?” (Kemi, 4.1).

Kemi’s distressing encounter demonstrates the complexities and interconnectedness of some BME women’s lives and the context in which children also experience DVA. The emphasis on the woman’s pregnancy not only emphasised her vulnerabilities, but also appeared to support the existing data which suggests that 25% of all DVA starts during pregnancy (ONS, 2006; NICE, 2014).

5.1.6.1 Summary

The experiences of HVs working at the intersection of DVA, ethnicity, and economic and social class appear to shape their understanding of the nature and prevalence of the issue. The conversations point to specific difficulties accessing women when DVA is connected to the familial and the power of community leaders in masking and condoning the problem. This supports previous research by Siddiqui and Patel (2010) and Siddiqui (2013). The HV’s experiences also appears to contradict guidance provided by the DH (2005) which suggests that women are willing to disclose DVA when asked to do so. The participant’s graphic accounts of some BME women’s experiences illustrate how issues of migration, unemployment, homelessness and familial practices can unwittingly force women to remain in violent relationships. This is particularly true for BME women who do not have rights and access to services because of their nationality.

5.1.7 Conclusion To Theme One

The participants’ discussions in this theme illustrate how a wider and inclusive understanding of DVA expose the conceptual difficulties in naming DVA and in
particular BME women’s experiences. Paradoxically attempts to articulate the racialised and familial context of DVA expose specific features of Othering but expose how powerful familial ideas and religious orthodoxies often undermine equalities between women and the legislation to protect them and reinforce violence in personal relationships. There are significant disparities between individual practice and levels of understandings of DVA. Some HVs’ discussion revealed critical insights into BME women’s experiences of DVA whilst others less discerning. Nevertheless, discussions about the racialised context in which some BME women experience DVA appear to create specific features of Othering. This is underscored by the lack of trust between the HVs and the women and their families.

Specific conditions, such as employment, immigration status, social class, and language barriers intersect with gender to produce particular experiences of isolation, access to services, and influence decisions to disclose incidences of DVA. The complexities that are linked to the intersectionality of DVA and the socio-political location of BME women appear to mask the true prevalence of DVA. From the participants’ discussions, it appears that the familial context in which some HVs encounter some BME women who are affected by DVA might lead the HVs to believe that the phenomenon was more prevalent in BME communities. The discussions do illustrate the issue of historical professional silence about DVA, shame, stigma and lack of understanding of women's identities also influence and undermine abilities to name and define the problem and expose significant gaps in practice knowledge about DVA.

5.2 Theme Two: The Subaltern Speak in Tongues: Commonalities and Contradictions

5.2.1 Introduction

This theme, illustrated in Figure 10, p145 describes HV’s practice and institutional processes to identify DVA within BME communities. Sub-theme Four, ‘The Problem with the Subaltern Speaking out’ tells the story of how practice to identify DVA implicates HVs in speaking for and about (representing) BME women’s experiences of DVA. In this theme the sub-themes are:
### 5.2.2 Sub-theme Four: The Problem with the Subaltern Speaking Out.

HV’s practice asking women to (speak out) disclose incidents of DVA appears to be unregulated. The following discussions and document analysis reflect the extent to which HVs are implicated in representing BME women’s experiences when asked about their practice in identifying incidents of DVA:

"Finally, services need to be accessible to women from all backgrounds (eg ethnic groups, any sexual orientation, transgender, people with mental health issues, people with physical and learning disabilities, women of all ages and women from different faith communities) and in a variety of settings" (e.g. urban, rural, for travellers). NHS DV report 7.1

According to Montesanti and Thurston (2015) structural violence is marked by deeply unequal access to services such as housing, health and other services. The aforementioned text and HVs conversations demonstrates how institutional politics enable or prevent some BME women from speaking out: The participant’s conversations describes how asking all women to disclose DVA is part of their everyday practice:

“Yes I do, that is part of my assessment when I do the new birth or when I do removal-in contacts with families, I do ask them how their relationships are like, whether they have experienced any domestic violence, any domestic abuse, and that’s a routine question that’s included in my assessment” (Erica, 1.1).

Throughout the conversations the participants overwhelmingly agreed that women should be asked at clinical contacts to disclose DVA but there was limited agreement on the strategies of how this should be carried out;
“I think it should be routine because there’s nobody … sometimes people are very good at covering up these kind of things. The number of couples I have seen over the years… to start with, I can think of quite a number – there was nothing really to let you know on the first meeting” (Kemi, 2.1).

Consistent with Erica’s and Kemi’s response is evidence on DVA disclosure, which suggests that routinely asking women to do so at clinical contacts can increase the *perceived acceptability* and reduce the stigma that prevents practitioners from asking women about DVA (Bacchus et al., 2004; Hester and Shepard, 2010; Taylor et al, 2013; NICE, 2014 and Bradbury-Jones; Broadhurst, 2015). Different from Jennieve and Janet:

“Particularly with the Asian families, I can remember one particular case where it was really difficult to talk to the mum. It was again quite an affluent family. The houses where I worked were huge, so we got a lot of Asian families with the grandparents and then another eight families living in there” (Jennieve, 2.1).

"I find they BME women make excuses and they tell you things like ‘Oh it’s OK now, it’s OK now,’ so it’s something of the past and then they get on with it, and not sort of thing could it happen again, and if it does what do I have in place to deal with it? They do play it down a lot more than other ethnic groups”. (Janet, 2.0)

Janet’s conversation demonstrates how the notion of blame might arise. However research has shown that some BME woman might actively deny DVA if they do not feel safe to disclose (Fernandez, 2007; Wellock, 2007; Thiara et al, 2011 Gill et al, 2016). On the other hand, Jennieve highlighted how the familial living arrangements of some families create specific barriers to disclosure. The evidence from chapter 3 also shows how BME women exercise power in abusive relationships by choosing when and how to disclose or when to leave their abusers.

I think we have to start with education, almost changing the mind-set of BME people, because I think it’s almost re-educating people as to what constitute domestic violence because some of them don’t actually realise that what’s happening to them is actually domestic violence (Tamara 2.1).

Tamara’s conversation echoes the situation whereby some HV and some BME women do not always share the same understanding about what constitute DVA. This limits the opportunity for HVs to persuade all women to disclose but present
specific challenges for women whose experiences might be shaped by cultural and familial beliefs: as explained in the following interview with Jennifer:

“Yes, as long as I can get them on their own, yes, I would always routinely ask at the first visit” (Jennifer, 2.0).

Access to women and the privacy to speak to women about DVA was a key concern for most participants who wanted to ask women to disclose as described by Marella:

“We only do one visit and I don’t think there’s anybody, any woman, unless she is in really a critical position, who would want to discuss domestic violence with a stranger”. (Marella, 2.0)

Furthermore the emphasis placed on the first visit by Jennifer is important because it is one of the only statutory visits an HV is required to undertake with a woman following childbirth. However rationing of health care also limits services provided to all women as the majority of HVs admit to only undertaking a single visit with families and limiting the opportunity to build relationships with the women and to ask and disclose DVA. Whilst the overwhelming majority of HVs admitted to supporting the practice of routine enquiry, not everyone felt at ease with it, Marella explains why:

“They are going to ask me why I am asking that, ‘Do I look like somebody who is being beaten up or whatever?’” (Marella, 2.0).

The need to jealously guard their professional relationships with the families within their caseloads were commonly spoken about. Daniella is equally uneasy about the practice:

“Yeah, I mean I did, I must say I did feel quite awkward when I first had to do it because…but I haven’t found that anybody has been offended which was a bit of a concern that people might be offended with the suggestion that…” (Danielle, 2.1).

Whilst some participants struggle to overcome practical and conceptual difficulties when attempting to undertake routine enquiry, others appear to develop their own strategy to reach to the women.

“When I talk about … when I talk to women about domestic violence, particularly BME clients, I always say to them ‘It’s not something that’s talked about in our group – it’s not something that is talked about,’ but I always let them know that it is very common and not talked about” (Janet, 1.1).
Assumptions about a particular ethnic groups’ help-seeking behaviour is homogenised and the use particular characteristics of their own social identities as a strategy to gain the women’s trust and demonstrate empathy was a common strategy used by HVs from different ethnic groups. At the same time, drawing upon her personal knowledge and her perceived affinity with the woman, the use of self is applied to persuade the woman of the value of speaking out about DVA. Evidence produced by Thiara and Gill (2010) suggests that some BME women withhold DVA disclosure as part of the victimisation process. Indera explained a different strategy:

“I think it’s sort of... it’s listening to experienced practitioners who work with really women that have fled domestic violence and it’s learning what helped them make the decision and follow through the decision and change their lives. I think that because we can’t... I can’t understand what it’s like for that woman because I am not in that position and you can have the training and you can empathise with them, but I still don’t know how she feels and how she can be best helped, so I think it’s invaluable actually taking the learning from people that have worked with these women” (Indera, 1.2).

The conscious rationalisation by Indera acknowledges the limitations of formal knowledge, and knowing what works and how to apply the right skills to support women is seen as specialist knowledge and skills by some participants. The need for empathy is called upon but is discounted as inadequate, instead the capacity to provide meaningful support is also considered an integral part of the process of disclosure. Thinking ahead and recognising the implication of disclosure and the need to support BME women to make decisions about their lives highlights the emancipatory objectives of routinely asking women to disclose. For the most part the participants appear to judge the effectiveness of routine enquiry with a ‘yes’ disclosure but acknowledge the need for training in this area of practice.

“I mean I … They have shaped understanding and some training that has gone with it is… but you do feel a pressure to ask and sometimes it’s very difficult to shape the questions to ask and I think that that is where more training would be very helpful” (Indera, 5.2).

The excerpt also shows the extent to which the issue of political representation and the intersectionality of women’s experiences of DVA are intertwined. For instance, homogenising black women this way appears to underscore the need for representation however if women do not participate in routine enquiry, this might limit the opportunity for effective representation in practice knowledge and services.
"I think with the white client, they are more open to disclosure. They would actually come and tell you and disclose to you, whilst I find that with minority ethnic women, you would have to go and seek these women and question and look for behaviour changes and ask. With the white English parents, they are less likely to stay in the relationship. They are more likely to move on to another relationship whilst the minority ethnic client would stay in the relationship for different reasons, whether it is financial or the main reason would be immigration or lack of understanding or language barrier". Tamera 4.3

Ronny explained why some BME women might not necessarily respond to routine enquiry:

“If I was being abused, depending on your attitude towards me, how long I know you, how you ask the questions, I may not tell you anything. But if I have a working relationship where I know you, I see you, I talk to you, my attitude toward you is one of general interest – that is what I am talking about in terms of relationship” (Ronny, 1.1).

Empathy, attentive listening, paying attention to what is being said, how it is being said, and when, acknowledges the need for self-awareness and sensitivity. It is implied here that clinical expertise can be acquired by talking directly to the women and listening to their stories and their needs. The need for trust and developing reciprocal relationships with clients was talked about by most participants. However, this can open up a range of ethnical and professional dilemmas, as Tami explains:

“I have a case of a woman who said to me, ‘My husband said if I dare tell anyone that she is dead, if she ever tells a professional’ so she begged me not to disclose this and she said to me ‘If you really want me to tell you more, then you won’t take this or refer me to Social Services’, so I had to say to her, ‘Well how long is she going to suffer with this?’ and she said ‘I am trying to cope with it but I will do it in my own time’, she said she will move out. So I stayed with this woman for a long time before she actually did the decision, she was so scared, she thought… But in the end I had to say to her ‘Look, I have to tell the Social Services if you’re not going to move out of this house, from the aggression you described to me’ so that’s when she decided ‘OK I will do what you ask me to do, but please don’t tell Social Services’. It was a very difficult one because I couldn’t possibly let go thinking about the safety of the children and the safety of the woman. I told her a lot of stories of what she might go through, but she insisted that she wants to leave the property in her own time, so I had to kind of use my experience and my skills in making sure she gets the support, or put the support in place” (Tami, 2.3).
A sense of holding on and feeling responsible is explicit here. The personal and emotive nature of DVA disclosure illustrates the complexities within the borders of HVs therapeutic and non-professional relationships. The field of interpersonal communication and the use of self-disclosure is a familiar process which is often used to facilitate empathetic relationships and is frequently applied to address the balance of power in professional relationships and to engender trust and empathy. However it is a potentially delicate ethical tightrope which might precipitate mistrust and undermine the wider strategy for women to speak out about DVA. For instance, HVs are professionally obliged to report all high-risk disclosures to other statutory agencies. Therefore, failing to do so would compromise the professional integrity of the practitioner. Likewise, if the woman is unaware of this procedure prior to disclosure, then the relationship could be viewed as deceptive. Whilst the use of self-disclosure may be effective in some circumstances, the vulnerability and particular disempowered position of the woman is also noted. A contrasting view was presented by Marella, where there is a different response to disclosure:

“And the next thing she will move to whatever, and she all for money and a gypsy sort of person, so it was sort of indicated that it looks like her claims of domestic violence are not really genuine, she is doing them for the purpose of moving from place to place” (Marella, 2.0).

In this extract attention is drawn to the inferior position of the woman as we see how doubting the veracity of the woman’s experience may lead to mistrust and genuine victims being wrongly labelled. At the same time, it can be seen how some of the complexities are linked to the nature of the participants’ caseloads and how these may lead to erroneous clinical judgements.

“I mean in recent times I have had experience working alongside families with domestic violence and for me, from my experience, what I find is that BME women tend to … they are not very open about it. I don’t think… initially I don’t think anyone would be open about domestic violence, I think once the topic is sort of out in the open, that there has been some episodes of domestic violence, I find that BME women tend to sort of play it down, or they tend to sort of still cover it up, or make excuses. I find they make excuses and they tell you things like ‘Oh it’s OK now, it’s OK now,’… from my experience or from my understanding of it, I find the population a bit private, they are a bit more … (big pause)… They allow you into so much of their lives, so they … you don’t get to build that relationship with them, whereas another group you might get to know, you might be able to discuss and to perhaps talk a little bit about your family or your experiences, whereas they
tend to be a lot more closed and not forthcoming with information” (Janet, 0.0).

The issues of trust and mistrust between HV and the BME women is evident. Nevertheless it appeared that the women were also being stereotyped and blamed. The understanding of how the intersectionality of some women’s lives might isolate them from services was not always evident in participant’s conversations. When asked whether there was a difference in the way BME women presented with DVA. Ester replied:

“Well they may be more … In a way it’s quite complicated really when you think about it because they may be able to act in a way that masks those risk factors” (Ester, 1.2).

The response was unclear. I asked for clarity:

“I think probably because of a better command of the language, maybe a difference in status, different social classes …Well, more likely to be probably in employment and have enough regular income, you know, not so much depravity” (Ester, 1.2).

The response was confusing even when I asked for clarity, suggesting that the deception might be linked to particular ethnic groups or ‘depravity’. Ester’s body language became uncomfortable and it was therefore unproductive to pursue this line of questioning. However, this kind of response was untypical of my conversations with the HVs as the overwhelming majority appeared to speak openly about how race, ethnicity, class, and cultural practices influenced the experiences of DVA. The conversation continued with Tami:

“I have seen that in a lot of BME women but I can tell you that BME women would hide the fact that they are going through that, they kind of blame themselves for causing the violence, or eventually explain it away that ‘Maybe it was my fault, I shouldn’t have raised my voice at my husband – that’s why he slapped me” (Tami, 5.1).

Tami’s response is consistent with contested feminist theorising on the victimisation response to DVA. The notion of self-blaming is linked to the victims’ resilience and low self-esteem and is used to explain why women remain in abusive relationships as they mistakenly adjust their behaviour to please the perpetrator. It reflects the coercive strategies used by perpetrators who might perceive the women as deserving to be punished. The statement from Tami demonstrates HV’S unique access to women and the opportunities they might
have to help BME women challenge and reject ideas of self-blaming; a different view from Pamella:

“But where you have cultures where black women or ethnic minority groups, where it’s accepted and it’s the norm, they’re less likely to ever disclose and report it. I worked somewhere once and I had a colleague where she was from an ethnic minority group and it was quite sad sometimes with the things she used to come and say, but then how do you explain that that’s domestic violence and how do you explain that actually that’s not acceptable” (Pamella, 4.0).

Implicit in Pamella’s view is the normative notion of DVA and an idea of *learnt victimisation* within all BME groups as we see how the women are positioned as more resilient to violence. Pamella’s response also implies that the collective victimisation experience for BME women was more likely to be an intergenerational phenomenon that led to greater acceptance within particular groups. The conversation continued with Yenka:

“… I think minorities… I feel there is a lot more… there is that vulnerability because of our cultural… I keep saying our… ethnic minorities cultural influences and ‘You are not brought up this way,’ because if people have grown up in homes where this was the norm, them they just carry on and think it’s OK to live like that, because ‘Oh, mum endured it so I have to endure it.’ You find mums saying ‘Oh, stay for the children’ which is, you know… so all of that, that stuff does have an impact on what people decide to do or not to do within…” (Yenka, 5.0).

The women are collectively blamed for their silence. The idea of a learned familial helplessness is posited here. Evidence of South Asian women’s strategies presented by Abraham (2013) challenged the idea that passivity (or perceived helplessness) and silence are synonymous, by arguing that women strategically negotiate their own personal and structural constraints to end violence perpetrated against them.

5.2.2.1 Summary

Discussions with the HVs suggested two different approaches to addressing the problem. The first strategy appears to involve educating women about the issue to prevent violence from occurring in the first place, whilst the second strategy appears to be aimed at preventing repeated attacks. However, the conceptual difficulties identified in theme one appear to contribute to some of the practical difficulties in asking women to speak out against DVA. Furthermore it is
questionable whether a disease prevention model of intervention aimed at educating women might ultimately blame the women for failing to prevent the violence from happening in the first place. A point of convergence and divergence between the HV’s knowledge of DVA and the BME women’s perceived attitude towards disclosure and the HVs is used to illustrate why DVA remains covered up (see Bradbury-Jones et al, (2013) AWARE framework). Detailed conversations with the HVs also revealed different attitudes associated with asking women to disclose DVA.

The evidence points to the lack of effective or adequate guidance and/or failure by organisations to monitor the practice of routine enquiry. It is a position which might explain the lack of empirical research in this area. The ways in which some participants construe or speak with and on behalf the BME women to identify DVA appear to be based upon a homogenised view of the BME women. Opportunities to represent BME women in local policies via information gathering during their encounters with the women appear to be chaotic and there is urgent need for appropriate training. The sub-theme provides evidence of how some participants struggle to use their own power to enable women to speak out about DVA.

5.2.3 Sub-Theme Five: Regulations and Regulatory

The theme Regulations and Regulatory describes institutional processes approach might shape the nature of professional relationships when asking women to disclose. The neoliberalist functions of organisations, procedures, and professional cultures appear to be linked to the process of asking and disclosing. However Chinn and Kramer (2015) insist that nurses must be vigilant to the socio-political context in which they function: Kemi describes the nature of DVA disclosure during clinical contacts.

“But half an hour, you zoom in, zoom out, you don’t see anything and they won’t tell you anything either” (Kemi, 10.0).

One of the performance measures for clinical effectiveness is the number of face-to-face contacts undertaken by HVs on a daily or weekly basis. These key performance indicators are outcome measures determined by, and linked to, the national priorities and public health agenda. (See Table 2, p44 and table 3, 47).

4 The home visits are mostly prescriptive, predetermined and prioritised by a number of activities, such as number of new birth visits, immunisations, postnatal depression, smoking, drug and alcohol misuse, breastfeeding and sudden infant death.
The factors governing the amount of time available for asking women about DVA were discussed:

“Now we have visits and you have got so many visits that your time is so limited that you try, you try, or you hope that she is not going to… As much as you have asked the question, you hope that she is not going to tell you too much because you know that you have got another three new births to do, so capacity, in terms of capacity of health visitors, that would need to be addressed” (Janet, 12.1).

DVA routine enquiry is not a key performance indicator for HVs (NHSE, 2015/16). This is contradictory to the national guidance on routine enquiry and safeguarding children procedure documents (DH, 2005; Sharpen, 2009; NICE, 2014). The comments by Kemi and Janet provide evidence of the strategies used by HVs to meet their performance targets. A similar view from Jennieve:

“Sometimes, sometimes it’s a little bit about a tick box, you know, ‘Everything all right at home? Any issues?’ Tick, tick, tick. What are you going to…? If she suddenly says to you ‘Well yeah actually I got beaten up last night,’ and ‘Oh right, OK, is everything all right now?’ If it doesn’t go anywhere, if you’re not going to support it and listen” (Jennieve, 5.12).

The time constraints describe by participants accurately describe the neo-liberalist conditions that healthcare services operate in and which to undermine health equality. The comments from Jennieve also allude to the context whereby disclosure from the woman might not always lead to support or the women might later decide not to accept support this link to. Comments from Janet and Indera in Sub-theme Four and Lona and Jennifer in Sub-theme Three. It is a position which appear to contradict important evidence which support the practice of routine enquiry and for some women living in violent relationships this might be the only opportunity to disclose and escape the violence. (Bacchus, 2004; DH, 2005; Sharpen, 2009 &NICE, 2014). A returning to Indera’s conversation:

“I mean, well, the nature of how we find out has changed and that impacts on our work, and the majority I would say of the ways that we actually find out about domestic abuse in the family actually comes from police reports, which is I suppose something that maybe has happened over the last four years, so when an incident occurs of any kind of magnitude and sometimes they’re very minimal, sometimes they’re quite extensive, that’s often how we are notified that something is going on in the home” (Indera, 2.2).

The evidence from the findings thus far demonstrates the extent to which criminalising DVA now shapes the nature of disclosure.
The increasing number of notifications by the police also reflects recent changes to the legislation (DH, 2010b; Home Office, 2012 and the Crime and Victimisation Act 2003/2015; However, as we have seen in Theme One, some women’s social and political status may prevent them from reporting even the worst forms of violence: Danielle

“So as I say we tend to…. We are fairly reactive in that say when I have had dealings it has been because I am reacting to a … notification…” (Danielle, 5.0).

The extent to which HV practice is regulated by organisational process and institutional priorities is evident here as we see how the overwhelming majority of HV’S response to DVA is shaped by the criminal justice system. Interaction with the woman also demonstrates how the child protection gaze has focused attention on mothering, seeing her as complicit in the abuse of her own child if she fails to take action against the perpetrator to protect her child. Jennifer explains:

“And she said ‘If I ring the police, the social worker will take the baby away from me.’ I said ‘No they won’t, having the baby on the child protection register is one thing – that’s so we can get you help that you both need, but if you don’t ring the police you are not protecting her, therefore you are more likely to have her taken away…’, so trying to explain” (Jennifer, 10.1).

For the most part, HVs spoke about using legislative functions to gain women’s compliance. Jennifer is explicit about where the blame lies when protecting children from exposure to DVA. Framing the question from a child protection perspective has shifted the responsibility away from the perpetrator and the focus is on the woman’s position as primary caregiver. This is a position that is also explicit in Kemi’s view:

“So sometimes, even if somebody is concerned, they may withdraw their concern, whereas if it’s a social care referral and you’re looking at the child’s interests, whether they are consenting or not, you do that referral anyway because it’s child protection, so from that perspective the choice goes really” (Kemi, 6.1).

The conversations revealed a perspective which alternates between coercion and consent via threats of legal sanctions. For the most part it appears that the women did not always view this approach as positive, often taking back control by disengaging or undermining the process. It might also be possible that participants who frame disclosure within a child protection context might do so defensively to avoid blame in the event of an SCR, or they might view this position as the only
means of accessing resources for women whose needs do not meet the threshold for social intervention. Kemi explains the safeguarding framework:

“But regardless of that framework I am looking at the needs of the child, the child is my focus and then I’m looking at the parenting capacity, what is impacting on that parenting capacity to prevent that child achieving whatever milestones or achieving whatever support or environment that is conducive to that optimum development, so I am looking at that holistically anyway. Two, I also observe the dynamic in the home when I go there, so if I become aware of something, I will pick it up there and then, and if, let’s say, having said that, it makes…” (Kemi, 1.0).

The descriptions of their encounters to address DVA given by Danielle, Pamella, Jennifer and Kemi are suggestive of defensive practice. HV practices have been implicated in a number of national SCRs where women and children have been seriously injured or killed as a result of DVA. These failings have been publicised in a number of policy documents which have subsequently called for HV practice to be focused on a children-centred system, as acknowledged in Jayjay’s remarks:

“I think processes have changed which therefore has actually had an impact on our knowledge and our skills at assessing and evaluating risk. I think where we have had the Serious Case Reviews, where domestic violence has come out as being one of the root causes, our training has changed as well, so I think we’re far more aware of the impact of domestic violence on the child” (Jayjay, 4.1).

“And Serious Case Reviews sometimes can be quite traumatic on you as an individual and you really do go back and you think a lot about… you know, you reflect and think about how you practise, and how things could have been done differently” (Pamella, 8).

The context in which SCRs and Internal Management Reviews take place is based upon the legislative framework of managing child protection risk, where the focus is on the protection of children (LSCB, 2010). This is a contentious aspect of managing DVA risk, as it is linked to the competing priorities of children and adult safeguarding obligations. Statutory agencies, including HV services, have a legal obligation to take action to protect children affected by DVA, thus upholding Article 19 of the 1989 UN Convention on the Rights of the Child. At the same time the personal and emotional cost of managing DVA is evident in Pamella’s conversation.

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When a child dies from serious forms of neglect or abuse, the local inter-agency responsible for child protection conducts a SCR to identify how local professionals might prevent a similar tragedy from happening again. This review is usually
5.2.3.1 Summary

The practice to uncover DVA is chaotic and inconsistent. This sub-theme presents HVs’ responses to DVA as conflicting and contradictory. The analysis of HV practice in identifying DVA shows how a neoliberalist approach to health care is capable of reproducing the isolation and marginalisation of some of the most vulnerable groups of women. At the same time it is a context which graphically illustrates the incongruence between a market style economy in healthcare and responding to individual health care needs. At the same time these conversations also illustrate the growing demands on the UK NHS. However, these actions are mostly reactive with limited opportunity for preventative or collaborative work with women.

The theme illustrates the extent to which HVs can contribute to a better understanding of the social and political positions of some women who seek help for DVA and the need for emancipatory knowledge to be a critical part of the critical lens which guides day-to-day practice. The context calls for the visibility of emancipatory knowledge as a critical part of a HV’s responses to DVA. For instance, a model of empowerment proposed by Bradbury-Jones and Broadhurst (2015) demonstrates how an emancipatory framework might transform HVs practice in response to the issue. The processes of management and safeguarding supervision could also play a vital role in directing HVs towards a critical space from which to question the hegemonic structures and knowledge/practice imbalance between protecting the welfare of vulnerable women whilst safeguarding children.

5.2.4 Sub-theme Six: Other Women’s Risk

The issue of risk emerged as a significant feature in HV’s discussion when talking about DVA disclosure. However there was a lack of consensus on how risk is understood within the intersectionality of BME women’s lives. I asked Janet to talk about her assessment for identifying DVA:

“I think sometimes mothers overly made-up worry me as well but that’s more I think sometimes to do with postnatal depression, but again you sort of have to link sometimes to why are they postnataally depressed, what’s happened there, what has happened in the background?” (Jennieve, 1.0).
The subjective nature of health assessment and prescriptive view of victimhood is observed in Jennieve’s conversation. Whilst there are a number of DVA risk assessment tools, the HVs rarely spoke about these and appear to have limited knowledge of them.

“We... well this is more mental health and then this is more mental health, we don’t use a specific risk assessment for domestic violence, but what we might do is ask whether the mother is feeling low or depressed which is towards, geared towards postnatal depression but it can be sort of alongside and in conjunction with domestic violence, or it has been used alongside domestic violence” (Janet, 22.1).

There was no agreement on how DVA risk is measured; less than 30% of the practitioners appeared to have any knowledge of the national multi-agency DASHRIC tool and even fewer had undertaken the appropriate training for its use. The use of the DASH-RIC tool was introduced across statutory agencies to promote a collective understanding of DVA risk threshold for providing services to women. The conversation continued with Marella:

“No, as far as I know we don’t have that kind of tool. You know it’s like the way I am thinking now, it’s like it will be a postnatal depression assessment” (Marella, 1.2).

The conversations with Janet and Marella illustrate a significant gap in HV practice mostly because the use of the DVA risk assessment threshold is a critical part of the multi-agency response to DVA. This is because the use of risk assessment ultimately determines whether or not the women receive services as well as the level of interventions a woman might receive:

“I think we have to make quite quick assessments, you know, we meet families for the first time and you’re doing lots of different elements but it’s sort of... If you are looking at extended family members when you are doing the assessment, it’s looking at the interaction between them and even in a short assessment I think you do get a gut feeling about whether things are OK or whether there could be an issue depending on how the partner interacts with you, and also interacts with his partner and the new baby because it’s normally a new baby” (Indera, 1.3).

Intuitive knowing is implied here. A number of participants reported using the Edinburgh Postnatal Depression Scale (EPDS) as a way of determining whether or not a woman is at risk of DVA. Postnatal depression assessments at new birth visits are designed to uncover a pathophysiological response to childbirth and it is one of the outcome measures for HV practice. However, a review of the literature
could not find evidence to support the use of EPDS to predict DVA risk. It could be argued that using the postnatal depression scale in this way might help to identify depression that could be linked to DVA. Despite having caseloads of over 350 families, the majority of HVs reported that they have never participated in or referred a woman to MARAC, even in cases where severe DVA was established.

“I haven’t had any form of support. I know of these benefits simply because of my work in MAPPA because we have the Community Safety Team sitting on the panel, so I know from all the… because each service has to do a presentation I have become aware of the role in MARAC” (Kemi, 6.2).

This statement ought to be viewed with some concern given the nature of HV caseload and the interconnectedness with DVA, poverty and the political context in which some BME women experience DVA. The purpose of MARAC is to ensure that multi-agency services for victims/survivors such as housing, legal protection, financial and support are coordinated and delivered to women. As we have seen in Theme One and Sub-theme Four, for some of the most high risk and vulnerable victims the HV contact and family assessment might be the only opportunity for women to access MARAC. It is also worth noting here that women who do not have recourse to public funds are not entitled to access the services. The conversation continued with Martine:

“But I think we do need a lot more training around the risk assessment side of it...” (Martine, 4.1).

Similarly to Janet, Marella and Indera, Martine’s conversation show the extent to which knowledge about DVA is missing from pre- and post-registration training for nurses. This particularly this is concerning, given that HVs are specialist practitioners with extended safeguarding responsibilities for vulnerable families and teaching student nurses. A review of the literature suggests that in over 89% of HVs’ vulnerable caseload, DVA is the main or contributing factor (LSCB, 2010). This connection is evident in HVs’ discussions:

“I mean definitely in terms of policies, a lot of it centres more around child protection and safeguarding children, so in terms of, you know, you coming across domestic violence, there is more focus on protecting the child and safeguarding the child rather than actually thinking about ‘Well, you know, what can we do for the person who is experiencing domestic violence, how can we support them and help them?’” Pamella, 1.0). “So it’s all well and

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6 Furthermore, a review of the EPDS by Edge (2007/8) found evidence that the psychological rating scale did not reflect the intersectionality of BME women’ experiences of mental health.
good, you know, I think to safeguard the children and keep them safe, but I don’t think a lot is done in order to support the people that are actually experiencing domestic violence and I still think that that needs to change significantly – it really does” (Pamella, 4.0).

Pamella and Martine are acutely aware of the gaps in their knowledge base and thus far adopted strategies to compensate. Her statement also provides an explicit account of how safeguarding policies direct HV practice towards a child safeguarding perspective. A review of 200 domestic violence homicides in England, recommend the urgent need for statutory agencies such as health, police, education, probation and social care to address the issue of risk assessment in practice (Home Office, 2013b). Furthermore the HVs taking part in this study regularly take part in safeguarding supervision. Safeguarding supervision operate as a quality assurance framework for preventing death or serious harm to high risk and vulnerable families. The quality assurance process includes ensuring that practitioners have the appropriate training to identify and support DVA risk. This was also acknowledged within the documentary data:

“All NHS staff should have – and apply – a clear understanding of the risk factors for violence and abuse, and the consequences for health and well-being of violence and abuse, when interacting with patients” (DH DV Report, 2010c, 3.0).

The conversations with HVs also suggest that they were not always equipped to respond to DVA disclosure. This was also illustrated in Sub-themes Four and Five. As the stories unfolded, it appeared that organisational lack of attention to DVA risk management might also have implications for the practitioners’ welfare:

“I mean I was caught up in a home fairly recently where there was domestic violence actually full-blown, verbal and some amount of physical. The child was present, and I still stayed in the house, not because of heroics but I was thinking about that child, because I thought if I felt this way, this poor child who can hear all this, is trying to get parents’ attention and was being ignored because of that heated argument that was ongoing, I hadn’t seen the child, I was meant to be seeing the child but the mum asked me to leave” (Yenka, 4.1).

Although not always acknowledged, the personal and emotional risk to HVs is once again evident. Yenka’s casefile example illustrates the vulnerabilities of practitioners who carry out home visits. Practitioners might not always be aware

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7 Access to safeguarding supervision was an essential criterion for taking part in this study.
that there is DVA in the home and therefore cannot always predict such exposure to violence. In contrast the HVs often spoke about the psychological impact of managing DVA cases:

“And again it’s that kind of... you just feel anxious don’t you? You go home and you feel anxious because you then have to work on that, you have to investigate, you have to try and make contact with the mum, you have to be aware of a risk assessment for yourself, the idea is that you bring them into the clinic. So you are having to sort of think about contacting that mother but also keeping her safe, keeping yourself safe so it’s a lot to think about, but wanting to offer her a space, a private space in which you can actually assess her parenting, assess the child and at the same time ask her if there’s any further help and support that she needs, so it’s a lot of work, it’s a lot of work” (Martine 1.1).

The emotional labour of managing complex cases was evident in the conversations. The majority of practitioners conveyed a sense of personal responsibility for the safety and welfare of the families on their caseloads. Others struggled to deal with the trauma of feeling inadequate. There is very little evidence in the literature on how HVs cope with traumatic interventions relating to violence and abuse in families and even less is known about their responses to DVA.

5.2.5 Conclusion

The context in which participants ask women to disclose or uncover DVA appears to be linked to a number of ideological and practical concepts which shape healthcare delivery. The data highlight to this context, where organisational constraints, lack of appropriate training and target driven strategies significantly undermine attempts to routinely ask women to disclose DVA. In applying Caper’s fundamental pattern of nursing knowledge nursing theorist have charged nurses with responsibility to use the knowledge gained within practice to challenge the status quo of injustice (Carper, 1978; Racine, 2003; Munhall, 2007; Bickford, 2014 and Snyder, 2014). However the evidence from the findings thus far demonstrates the extent to which DVA might remain unchallenged when HVs are faced with the opportunity to support women to resist male violence.
In Theme One, the HVs presented strong views on the extent to which race, politics, economics and gender were critical features in work with BME women. However the intersectionality of these concerns was not reflected in their understandings of DVA risk. There was lack of understanding of some women’s culture and even the processes of victimhood were articulated as a key factor in the nature of a professional relationship. This invites the participants to hold the view of some BME women as potentially deceptive and untrustworthy. In so doing, negative characterisation and stereotyping of the women they encounter appear to collapse inherent differences between ethnicity, class, and abilities into a composite ‘Other’, thus encompassing the notion held by some HVs that BME women are responsible for their own predicament. Each HV’s own personal history, ethnicity, and gender influence their motivation and choices in their interactions with the women. The findings suggest that public health strategies continue to fall short of addressing the structures of inequalities stemming from the multiple challenges that suppress disclosure and ultimately undermine safety. For instance the findings show that the structural processes within services are inadequately to prepare HVs with the knowledge and skills to critically evaluate their work and to challenge and change unfair practice. As a result the findings demonstrate how some HVs developed traumatic responses to their own feelings of disempowerment whilst others adopt the strategy of least resistance through child safeguarding practice. Chapter 4.3.2, illustrates the devastating impact that continuous exposure to traumatic clinical caseload can have upon some practitioners although there is no suggestion that this was happening.

5.3 **Theme Three: Postcolonial Conditions**

5.3.1 **Introduction**

The theme Postcolonial Conditions describes institutional and practice response to women who disclose and who escape the dominance and isolation of violent and abusive relationships. Postcolonial conditions represent the aftermath: the impact and consequences after DVA is uncovered. Outcomes for BME women are
shaped by an interlocking matrix of gender, race, and politics, as will be explored in this theme (see Figure 11, p163). The subthemes are:

- Subtheme Seven: The Power and the Problem with Resisting DVA.
- Subtheme Eight: Resisting Intersectionality.
- Subtheme Nine: Personal Violence Structural Violence.

Figure 11 Theme Three

5.3.2 Sub-Theme Seven: The Power and The Problem of Resistance

Consideration of outcomes of DVA interventions occupied a significant part of HVs’ discussions. For the most part, participants were implicated in the process of supporting women following disclosure of DVA. Given that the goal of DVA disclosure is to challenge and resist male violence it could be argued that the interventions from HVs constitute a form of resistance. Kemi describes the aftermath of disclosure for some BME women:

“I think with disclosure, I guess sometimes it’s like a load off the person, something that they have been hiding, covering up, they have shared it, and in sharing it they didn’t get a negative response, they have been met with a supportive response, they have been met with choices, they have been met with resources, things that can be… practical things that can be done to help because like even the Community Safety Team, there’s so much that they do to support people if they want to stay in their homes, a safe room, this and that, you know, injunctions, there’s support which will help with injunctions and what have you, so those women are enabled to stay in an environment which is supportive, they don’t have to reproach themselves like in the past, they have had to go elsewhere and break up their support network just for the sake of a violent…” (Kemi, 0.0).

Kemi’s comment illustrates a particular idealised empowerment for women who speak out about DVA, which does not reflect the realities described in Themes One and Two, nor the realities following disclosure. Research has shown that there are considerable differences between different ethnic groups in terms of the
victimisation/survival process (Ahmad et al, 2009; Wellock, 2008; Gill et al 2015). For instance, it would be quite challenging to create a 'safe room' in the victim/survivor’s home, given the familial context in which some BME women experience DVA with multiple perpetrators. The home might therefore become a more dangerous place (Siddiqui and Patel, 2010). Moreover it could be argued that the idea of a safe room illustrates how violence can be sanctioned by institutions when measures to protect women focus upon limiting the violence instead of preventing it. The discussions show that aces sing services for DVA can have very different outcomes for different women. Tamara provides a vivid example of this:

“Because there was a young child involved, I had to report the case to Social Services. Since I have reported the case to social services I find that it has damaged the relationship between this lady and I because she no longer feels that she is able to trust me as a professional because she felt that she came to me for help but because of the nature of my job I had to tell her that I had to disclose and pass the information on to another service which would be social services. Since then, this lady stopped engaging so I feel that she is possible still experiencing domestic violence but she would never tell me. This is what’s happening” (Tamara, 2.8).

The evidence from the literature indicates that women from ethnic minority backgrounds typically experience anxiety and lack of trust when they engage with services. This is partly because the BME women might not see themselves as victims in need of help but also because involving statutory agencies might be frowned upon within the community and because of pressure from the family to disengage with services (Nash, 2005 ; Allen, 2011). On the other hand supporting and signposting women to practical and emotional support was seen as essential to the empowerment of women.

Yenka give insight into the aftermath of disclosure:

“It’s difficult when it comes to emotional abuse because there’s no... you know, the physical, you have got the scars to show you have been physically assaulted by a partner, or if you are being deprived of monies and stuff, you can’t afford to buy anything, you go on begging, but the emotional scarring from the effect of the abuse and I think particularly in the black and ethnic minority groups, we have … I kind of liken it to an illness. Say someone get diagnosed with cancer, there’s kind of embarrassment and they keep it quiet
and don’t access support and stuff, and the same goes for domestic violence.” (Yenka, 2.1).

The tragic aftermath and often invisible gendered consequences of DVA is laid bare by Yenka. This tension between information sharing, safeguarding children, and consent is a familiar clinical dilemma in most participants’ case file descriptions. The consequences for BME women and primary care givers and the consequences of disclosure was a common feature in HVs conversations about the impact of DVA.

“Mum then thought I was working alongside Social Services to try and take away her child and that’s how they see it, and because she was aware of how the system works, when I then started to go into the house based on the Merlin, she then became very quiet, very withdrawn and only sort of answered precise and sort of straight to the point and very careful about what she said” (Janet, 4.1).

The tension between the need to safeguard children and protect adults from DVA was evident in all the case files presented within this research. These scenarios highlight the extent to which BME women’s fear of the outcomes of disclosure often dominates professional relationships. So far the women have all withdrawn their cooperation with the HVs. In contrast, the following conversation with Jayjay highlighted how practitioners readily based DVA interventions on arbitrary assumptions about the women:

“Now there was a case that I was involved in as a line manager to a health visitor where we had just started getting the Form 78s (which are the Merlins now I think), and the woman had called the police, she was an African lady, she called the police because her husband and her had separated and she was concerned about the safety of herself and her children. Anyway, the police went in, we got the Form 78, and the health visitor put it in her diary to go and do a visit – it was in an area that was quite an affluent area for ‘London’, it was private houses... not that you should make assumptions, but it wasn’t usually... it wasn’t somewhere that you would expect there to be problems, which sounds very biased and quite ridiculous really but we make these assessments whether we like it or not” (Jayjay, 0.0).

Although not explicit the nature of unequal partnership between the police and HV service is intimated here. Such profiling of victims and perpetrators can dominate the micro-practices of a HV’s caseload, and some practitioners might be oblivious to the dangers of DVA disclosure. As suggested by Jayjay, despite raising concerns about the woman’s safety, assumptions about class and financial status may have contributed to the misconception about the level of risk faced by the
woman, as we see how the initial assumptions about the woman’s safety were based on the postcode, and reliance upon the assessment provided by other agencies might have influenced the urgency with which agencies responded to the woman. This is significant because police services are more likely to focus on the crime instead of child safeguarding. Jayjay continued:

“Anyway she had it in her diary to pop round to see the woman because the telephone number was wrong or whatever, and before she got there, the father took the children for contact and topped himself and the children. So that made us as a team really look at what we were doing with these form 78s where there were safeguarding concerns, because I don’t think until then....Until it happens on your caseload... there’s so many other priorities that are going on that you overlook it, and it wasn’t... It hadn’t been a family where the concerns had been identified at the new birth visit, there had been nothing in the children’s records, nothing had come to light first, there had been no other Form 78s – all the research at the time was saying a woman has to experience it 33 times before she makes a... you know, goes for some help – maybe this was her 33rd time, who knows? But unfortunately those children lost their lives” (Jayjay, 3.0).

In this instance, the outcome also illustrates the kind of institutional failure that can happen when agencies do not work together and to listen to the voices of women who raise concerns about their own safety. However there is no evidence to suggest that the tragedy could have been prevented.8 There is no suggestion that this is the case presented by Jayjay. The tragic outcome described by Jayjay is consistent with the findings from over 200 domestic homicides reviews by the UK Home Office (2012). The reviews found that in the overwhelming majority of cases, victims/survivors including BME women had warned professionals in statutory agencies that they were afraid of the perpetrator.

5.3.3 Summary

The scenarios in this sub-theme have highlighted the extent to which HVs, BME women and other statutory agencies are implicated in shaping (represent) outcomes for women following DVA disclosure, and how the process can lead to professional dilemmas. However there is limited understanding about their lives in post-separation violence. This might be because the nature and prevalence of pre-separation violence is still emerging, although research shows that BME

8. The literature shows that whilst there might be commonality between all ethnic groups, professional response and lack of insight into the intersectionality of women’s lives amplify post separation violence for BME women (Nash, 2005; Thiara and Gill, 2012; Thiara, 2013).
women tend to experience a wider range of serious abuse post separation and some might remain in abuse for longer (Richie, 2003; Nash, 2005; Anthias, 2011; Thiara and Gill, 2012; Thiara, 2013).

It could be argued that the focus of HVs’ work with women to tackle DVA could also create the invisibility of men who are victims of DVA and also undermine the scrutiny of the perpetrator’s behaviour. Equally, it is argued that an HV’s judgement is shaped by middle-class authority and is used in traditional and contemporary practice to address health inequalities that have focused and continue to focus upon working class women (Peckover, 2003; Heggie, 2011). The data in this sub-theme and the review in Chapter 3 and 4 suggests that the protection of children and the protection of women are intertwined. Despite national guidance to support professional decision-making relating to DVA interventions, HVs appear to struggle with the complexities that dominate BME women’s lives. The data so far show the possible kind of tragic outcomes for women when institutions fail in their duty of care to protect them following disclosure. The sub-theme provides evidence of how some participants struggle to use their own power to enable women to speak out about DVA.

5.3.4 Sub-Theme Eight: Resisting Intersectionality

In this sub-theme, HVs provided their own views on whether the processes to address DVA had changed practice culture. When the conversations turned to issues of resource and professional autonomy, some HVs were fatalistic about the practice to address DVA;

“… I am sorry, but it takes funding and it’s staff. At the end of the day it’s not about computers, it’s about staff, it’s about having enough people on the ground that that phone gets answered or the clinic gets covered or ... you know, and it is about that, and all during the summer when we were really short-staffed I know that that was one thing, we couldn’t always make sure there was a health visitor in the clinic and it’s when things like that start happening that women stop coming because they just feel well, you know, it’s almost like you’re saying ‘No, we can’t cope, no, we don’t want to see you.’ It is that message isn’t it? That is effectively what you’re saying, you know, we can’t cope, and women are really sensitive to that so I think they have to feel that there’s no stigma attached to it and they can rely on it being
there when they need it, not just when you can manage it, do you know what I mean? I feel that anyway” (Martine, 5.2).

The statement also reflects the dichotomies that are linked to increased awareness and identification of DVA and the resulting impact on services within the current economic constraints in the NHS. This is significant because, the HV Implementation Plan 2011-15 outlines the vision to strengthen the workforce with over 4200 HVs by 2015 and a strategy to reform the service to improve access to families with the greatest needs (DH, 2011). Although HV recruitment has increased significantly under the current political administration, this is being undermined by increased birth rates, immigration/migration, and the economic climate of reduced funding to the NHS which impacts on HV resources (Buck and Dickson, 2013; Naylor et al, 2015). Demographic shifts that are linked to unemployment, housing and homelessness, and parental mental health concerns in inner cities also place greater demands on HV services (Thornbory et al., 2009; Cowley et al., 2012). A sense of being overwhelmed is captured by Jayjay:

“Today we have much bigger caseloads, health visiting... you know, we have got quite a mobile population in health visiting terms as well, caseloads grow, we move streets around – who you saw at your new birth visit is no longer your named health visitor so at the one-year and two-year health review, you may not be seeing your health visitor, it may be a nursery nurse” (Jayjay, 8.1).

A collective sense of despair was at times visible when HVs spoke about the professional distance between the local population and HVs, it can be seen that a lack of continuity in care increasingly disconnects HVs from their caseloads. This was a common thread throughout participants' conversations. Nevertheless, local strategies can be employed by services to deal with the impact of the growing population and perceived diminishing resources. Jayjay’s comment “we move streets around” describes is a common strategy used by managers. Reallocation of geographical boundaries is often a temporary solution that redistributes caseload equity in densely populated areas of deprivation.

As noted by feminist theorists, structural violence is underscored by deeply unequal access to services which then recreates conditions that valorise the intersectionality of BME women’s lives (Montesanti and Thurston, 2015; Wellock, 2010; Gill et al, 2016). Furthermore, the data so far has shown an inherent need to develop an empowerment framework which takes into account the specific challenges faced by BME women. Despite such strategies HVs were clear about
the extent to which the practice of asking about DVA continues to reshape the nature of practice culture, as explained by Kemi:

“So I don’t think knowing more about DV has improved practice. I think if anything it causes more stress to health visitors because they know that they are missing out a lot of this, they are not able to pick it up because of the pressure they are under and they only deal with it when it becomes really extreme, so it’s like an iceberg really, we are only dealing with the tip of it, most of it is submerged and I know we are missing quite a bit of it” (Kemi, 9.1).

DVA as a significantly hidden phenomenon within caseloads was a source of anxiety for a number of participants. An indication of being overwhelmed by the practice to tackle DVA. Coincidentally the process of Safeguarding Supervision as a process which is intended to support HVs to identify and manage difficult caseload was rarely spoken about by the participants. Participants were acutely aware of the bigger picture and wider political influences shaping the extent to which DVA remained significantly hidden within their caseloads. In the following excerpt Lorna reflects on how the macro-practices of HVs also impact on the day-to-day realities and outcomes for women accessing the services:

“I think the issue at the moment is the staffing levels make it very difficult and I think that is a consideration in the way they’re sort of dealing with the issues over here… because it literally does depend on how many staff you have got as to whether you can do everything you want to do and whilst it is a priority, it is kind of… I suppose there is that aspect of it, that it is like you’re asking the question, it’s almost like if you don’t ask the question, you may not get the answer, and if you haven’t got the staff to deal with it, then do you want to ask that question if you can’t take it anywhere, and that’s always been one of the arguments about that, you know, asking routinely” (Lorna, 10.1).

The views of Martine, Jayjay, Kemi and Lorna about their practice were reflective of the overwhelming majority of participants’ discussions about their caseload. The conversations also convey the isolation and somewhat disconnection between practitioners within the team and between them and other professionals. This might be because of the semi-autonomous way that each HV manage his/her caseload with personal professional responsibility for each caseload, instead of a (corporate) team approach to caseload management; reflecting Baldwin’s (2012) suggestion that that the ambiguity within HV’s role, commissioning targets, child-protection responsibilities, as well as the expanding and overlapping roles with
Social Care and other community nurses often create uncertainty, stress and lack of professional boundaries.

A sense of perpetual crisis management and being overwhelmed is conveyed, as we see how a different perspective is offered by Jayjay who captures the potential knock-on effects:

“And I think that might be why we are not learning from the Serious Case Reviews because there’s so many other factors going on within that family. It sounds awful but the domestic violence is probably way down the road, the problems we were trying to manage was the disengagement with health visiting services, the poor educational attainment, the poor immunisation uptake, there’s so many other health indicators that are going on that, if you like, it’s masking what that root is actually doing to the family” (Jayjay, 0.0).

Non-engagement with professionals, as part of the victimisation/survival strategy, is also evident. Jayjay appears to suggest that despite a number of high-profile DVA tragedies, there is little opportunity to implement the learning outcome. The opportunity to learn and grow from DVA tragedies appears to be overshadowed by the strategy of non-engagement, both by the women and at times the HVs themselves. This is significant because the undertaking and dissemination of learning from Serious Case Reviews (SCRs) is seen as one of the most effective safeguarding strategies to prevent DVA homicides and DVA tragedies from re-occurring (H M Government, 2009). Whilst junior HVs appeared to focus on the day-to-day consequences of practice interventions, senior HV, including Ronny, took a more strategic overview of the profession:

“I think health visitors have reached a point where they are so worried about something going wrong and being vilified that they are forgetting to support women. Every little thing that happens, they want to run to Social Services and I think in some ways that puts a block on the effectiveness with you and this woman” (Ronny, 7.1).

The process of SCRs appears to have a profound impact on the day-to-day practice of HVs, practice even in cases where the HV is not directly involved. Although the majority of participants were not themselves directly involved in SCRs, most were either involved in a learning event or knew an HV who might have been affected, resulting in significant personal and professional consequences (e.g. disciplinary procedures). Therefore, fear of being blamed or
held negligible might lead practitioners to avoid being implicated in the outcome of an SCR:

“So I think nationally… I know they have got the Health Visiting Implementation Plan but I don’t think they are going to make it by 2015, there are too many problems with that. Caseloads are too large and there’s too many bureaucracy, there’s too much paperwork. And even though there are child protection safeguarding policies in place, we spend more time filling out the papers than we are actually protecting children, and I think something has to be done about that” (Ronny, 9.1).

The conscious and unconscious defensive reaction was evident in a number of conversations. For instance, prioritising clinical record-keeping was seen by some HVs as an effective defensive strategy against future potential recrimination. Ronny’s reference to the Health Visiting Implementation Plan draws attention to the key priorities of the NHS and Public Health England (2014) for reforming and modernising HV service to address health inequalities by 2015. Whist some participants seemed ambivalent or fatalistic about the direction of practice, others conveyed a sense of positivity. In some instances the interviews with HVs appeared to provide the opportunity to scrutinise and reflect upon their own practice, such as in Pamella’s contemplation on the experience of SCR following a tragic DVA outcome:

“I don’t know whether it changed the way that I practise in a sense because in many ways I think a lot of the things that they did discuss at that time, they were things that I personally as a professional was already doing. I think what it just reminded me of is the fact that I have always got to be vigilant when I do my work and I have always got to look even beyond what I am seeing in front of me and always do, just trust my gut instinct when I don’t think… when I think something just doesn’t seem or sound right and to go with that and ask questions – more probing questions – when I am not sure, when I am not certain. And Serious Case Reviews sometimes can be quite traumatic on you as an individual and you really do go back and you think a lot about… you know, you reflect and think about how you practise, and how things could have been done differently. But when I have come out from such cases I am always quite relieved because the things that should have been done, I would have definitely gone out of my way or done my best with regards to that, so I think the one thing I always remember is to always, always be vigilant and always ask questions and always try and look at the bigger picture and try and think is there anything else that I could be missing that I have not seen or I am not understanding? And if something bothers me, I should investigate it further, definitely” (Pamella, 2.1).

The emotional and personal impact is profound in Pamella’s narrative. As we have also seen in Sub-theme One, intervention strategies by health professionals can
often result in tragic outcomes for families. Although evidence points to a lack of effective change following SCR, we can see from Pamella’s involvement that some health HVs might feel traumatised and a sense of personal responsibility for the outcome. Similarly, we see from Ronny how some could be hypervigilant about the women on their caseloads and might even react to suspicions about DVA in a professionally defensive way.

5.3.5 Summary

An analysis of HVs’ views about the impact of DVA disclosure indicates a level of vicarious trauma that is linked to HVs’ empathetic engagement with the often tragic outcome of DVA. For the most part, participants demonstrated an emotional and personal investment that was linked to particular outcomes and appeared hypervigilant about organisational procedures which implicates them in negative outcomes for women. These findings suggests that there is a need to have a greater understanding of how HVs’ emotional resilience influence their work to address DVA.

Data from participants suggested that greater awareness about DVA has resulted in a sense of disempowerment, and a collective and individual responsibility for the organisational failure to adequately address the problem. The data also shed light on the extent to which the transition in practice regarding DVA remains in a state of flux. The HVs appear to be actively engaged in a strategy of defensive practice to avoid being blamed for tragic outcomes, thus maintaining the status quo. The data also show that DVA cannot be addressed in isolation; as we have seen from the case file examples, despite the tragic outcome for some families, the social and political conditions in which HVs work can limit lasting change or provide little opportunity to implement learning from tragedies linked to DVA.

5.3.6 Sub-Theme Nine: Personal Violence Structural Violence

In this sub-theme, HVs provide a vivid connection between contemporary imperialism and the consequences and outcomes for the women. The outcomes for some BME women can be linked to the intersectionality of their lives and organisational structures which shape service delivery. These are exemplified in case file discussions and documentary analysis of practice guidance:
“The issues of domestic violence are compounded by historical structures in society which condone the view that a man is master of his domain and are illustrated in the workings of many institutions such as the Crown Prosecution Service and, until recently, the police” (RCN, 2.0).

The nature of multi-agency relationships was discussed by HVs as being critical in shaping outcomes for women. During the conversations HVs described the kind of outcomes that were shaped by the hegemonic structures within local, national and international institutions that influenced the outcomes for women. However the evidence for this study as well as findings from research show how show internalised cultural messages of male privileges as well as religious reinforcement of male superiority might legitimise DVA in BME women’s lives (Siddiqui and Patel, 2010; Kanyeredzi, 2013; Rehman et al, 2013). As noted in this chapter the experiences of overcoming such violence might be compounded by the double jeopardy of institutional failure as well as the internal orthodoxies of religion and politics. The majority of HVs spoke passionately about the perceived injustice, as we can see from Pamella:

“The other thing is that some of them are women that don’t have recourse to public funds or they are an asylum seeker, or even if they are not an asylum seeker, they’re an illegal immigrant and they may not want to talk about that and raise it up and bring it up because they are going to put themselves in a very … they feel they are going to put themselves in a very difficult position whereby they might either get deported from out the country or it could cause problems for them if they are applying to stay or remain in the United Kingdom, so that’s one of the things that I find with…And a lot of the women that do have no recourse to public funds tend to mainly come from black and ethnic minority groups so… and so that’s two of the things I tend to come across” (Pamella, 0.0).

The interconnectedness between ethnicity, immigration, economics and DVA was a common feature of some of the cases discussed by HVs. However the emotive issue of immigration, access to public funding, and support for immigrant women fleeing DVA is part of a wider political and moral debate which appears to have implications far beyond HV practice. On the one hand, proponents of social justice might argue that civilised society has a moral obligation to protect and safeguard the basic human rights of those exposed to a life of violence; on the other hand, others might point to the limitations of a social system which is incapable of absorbing unregulated demands for services curtailed by economic constraints. Whatever the argument, current Eurocentric regulation on immigration explicitly discriminates against non-member states whose geo-political location mostly
includes non-white postcolonial immigrants (Siddiqui and Patel, 2010; Keskinen 2011). However a different and contrasting view by Jennieve on policies to address diversity:

“...I think we have lost our way in this country in terms of offering so much support to black and ethnic minorities that the white working class has got lost and I think we need to re-direct that to everybody, and start looking at policies around what’s going on out there in terms of domestic violence for everybody, and having that understanding of how it links in together, rather than separating” (Jennieve, 1.1).

The complexities that are linked to addressing the issues of diversity and inclusiveness are summarised by Jennieve. As the statement suggests, when the political gaze is focused upon race alone, issues of class and white ethnicity can create specific features of inequality and isolation, as the following conversation suggests:

“...Well most women will ask you ‘Well what am I going to do then? Does it mean I have to leave this place? Where are you going to send me? If it is a refuge, what is it like, will I have a job, will I have money, am I going to lose my friends?’ Those are the kind of questions the women tend to ask: ‘Are you going to take my children away?’ you know, ‘What happens to him, you know, he’s the one who has caused all these problems, what is actually going to happen with him?’” (Pamella, 8.1).

The consequences of disclosure I and the reality of service interventions are captured in Pamella’s paraphrase. Depending on the risk, service interventions might not necessarily produce the outcome envisaged as some women are often re-housed at a significant distance from their families and support networks. Some mothers might even face additional hardship because of the gender of their children because refuges do not accommodate boys over the age of 12. Hence the women entitled to refuge accommodation must decide whether or not to accept emergency housing without their teenage or adult sons. Similarly, a family might need to consider the impact of being uprooted from their support networks, separating siblings, finding new schools for children, and facing the financial burden of starting life over again (Worrall et al, 2008; Humphreys et al, 2008; DH, 2010b; Home Office, 2012; LSCB, 2014). In such instances the HV is powerless to support the woman yet must continue to provide support to ensure her safety. As the data suggest, women remain unsafe because a lack of safety provision leaves them vulnerable to ongoing violence. I continue the conversations with Marella:
“For instance I remember now a woman in my caseload, this woman was Egyptian and she was living with this husband who was a taxi driver, her parents were not in this country and she had about four kids with this man and he was always battering and beating her up and she really didn’t know what to do, she had nowhere to go. So she ended up being moved, you know, she decided that she had to take authority over herself, you know, so she was helped by a certain organisation to leave London….. She ran away from the husband and the kids, yeah” (Marella, 1.1).

The cases presented by Erica and Marella expose the complexities and inadequacies of the welfare system, which aims to protect women from the violence of poverty. Despite the recognition of financial abuse within the UK government’s own definition of DVA, the gendered nature of a woman’s role as full-time caregiver often leaves them dependent on their partner’s income and excludes them from basic welfare support. This is a position which could be exploited by the perpetrator to prevent the woman from exposing the abuse. In the following case files, we see the kind of desperation this can lead to:

“And even if you were to say to a woman well we’re having this discussion and I would like you to self-refer, most women don’t feel confident enough to self-refer and I don’t blame them because I have sat on the phone myself and if you’re phoning a number and first of all you don’t know who is going to pick up and then secondly you don’t know… you know, if you can’t get through for a day or two days, you give up, you” (Martine, 0.0).

“She went down and they give her emergency housing but then the week after she went back to the man, so when I followed her up, being non-judgemental, whatever it was, I was trying to find out what happened and she said ‘Well it was the financial…’ – she had no money, she couldn’t even afford milk for the baby. I said you rang social care?’ and she said ‘Yeah, it was just too hard.’ So she had to go back, so she went back” (Kemi, 0.0).

The evidence from Pamella, Erica, Marella, Martine and Kemi draws attention to the commonality of the everyday reality of government policy that women should be asked to disclose DVA. Despite resources being directed towards women disclosing DVA, it is nonetheless women who appear to encounter the structural inequality of access to services, caring role and financial hardships. Yet still positive outcome for a woman often relies upon a co-ordinated response from multiple agencies. As we can see, important gaps exist between the point of disclosure, support, safety measures, and holding perpetrators to account. For example, the lack of availability of emergency finance and housing at the point of disclosure will ultimately determine whether or not a woman returns to the violent
relationship. Moreover, the HVs themselves appear to be powerless to harness the multi-agency support at the critical moment. This is critical because MARACs are held monthly and HV services are not available during the evening or at weekends, thus highlighting the need for services to work closer together to address particular gaps and overlaps. This concept also acknowledges statutory safeguarding guidance:

“Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police” (Safeguarding Adults at Risk, 1.0).

The HVs often spoke about their role in supporting women who return to violent and abusive relationships, but it is not known whether HVs continue to ask women to disclose DVA in such circumstances, or whether the women would voluntarily disclose incidents of future DVA. Jayjay provides an account from her case files:

“We had another case quite recently where the woman had been subject to unbelievable abuse; there was... I mean her husband was... well he was an animal. He drugged her, he brought his friends in for sex with her, obviously there was... I mean it sounds awful, of course there was physical abuse, of course there was emotional abuse, she had got three other children and then she’d had enough, she managed to leave him, ran away to... quite locally because she had a sister that was nearby but he fought her and won the custody of the children. Now quite how he did that I don’t know. Yes I do! He was saying that she’d got all of these mental health issues and basically he was able to demonstrate with the powers that be that he was the safe, sensible adult” (Jayjay, 2.1).

At face value it could be argued that the power of masculine violence (which views entitlement to sex as a form of male privilege) appears to be sanctioned by the legislative structure of safeguarding legislation. In this instance, it is not known to what extent the woman may have endured DVA as a result of her mental illness or whether this might have been the precipitating factor. 9 Throughout the data it appears that when DVA was interconnected to drugs, alcohol and mental illnesses, there might be little incentive to hold the perpetrator to account or to provide urgent interventions for victims who might also have complex needs.

9 UK research found that over 89% of HV vulnerable caseloads included the common features of drugs misuse, alcohol and DVA, also known as the ‘toxic trio’ (Crowley et al., 2012).
Jayjay perceives the award of child custody to the perpetrator as a form of double injustice for the woman:

“The long and the short of it is he got the children and she ended up hanging herself. The health visitor was still the health visitor for the younger children and kept raising concerns about the husband – she was concerned about the impact all of this was having on the young boys. Anyway, other services felt that ‘no, no, no, he told a good story, he was fine, there weren’t any problems.’ The eldest son jumped off the bridge off the …., a year ago and that’s just now finished, a Serious Case Review, and his younger brother has been in and out of mental health institutions since he was a teenager. So, you know, as health visitors we need to be able to empower the women to make those changes but we also need to be able to communicate with the other agencies what we’re trying to do. All too often they don’t fully understand that we work with these families even when there isn’t a crisis, and it may be that domestic violence is going on when we’re visiting, but people will only tell you when they’re ready to tell you” (Jayjay, 2.1).

The intersectionality of masculine violence, the violence of poverty and mental illness appear to intersect with the collective failure to believe the women and provide effective safeguards to prevent a tragic outcome. The recognition that the tragic outcome of DVA often has far-reaching human, financial, social, and psychological costs, even when women manage to escape years of violence and abuse, is evident throughout this text. In observing how powerful organisational partnerships often fail to take action when HVs raise concerns, Jayjay aligns the position of HVs with that of the victim. The complexities in such cases cannot be fully enumerated here, but research shows that the failure of multiple agencies to execute appropriate protocols and prevent tragedy is a common theme. Unlike the police, social care and probation, HVs do not have statutory powers to enforce particular actions during clinical encounters. Often, HVs not only have a professional interest in cases, but also feel a personal connection to the victims and the outcome following disclosure.

5.3.7 Summary and Conclusion to Theme Three

The concept of structural violence illuminated some of the ways in which HVs encountered inequalities that reinforced and compounded a woman’s experience of personal violence. The data in this thesis highlight the extent to which practice to tackle DVA for all women is beginning to improve. However there are examples of disparities between ethnic groups. Health Visitors casefile examples denote the
pervasive nature of the phenomenon and how the complex interconnectedness between race/ethnicities, mental illness, political, familial and institutional ideas often disproportionately impact upon different ethnic groups and can lead to tragic outcomes for women regardless of ethnicity. The findings also identify the need for greater insight into post separation violence can lead to extreme isolation for some in the lives of BME women. There is a sense that the powerful insight captured from HVs’ practice knowledge is not reflected in the wider practice knowledge about DVA or used to inform the development of services. The extent to which HVs contribute, develop and lead their service appear to be limited.

The examples also shed light on how systems designed to support victims/survivors can be manipulated by perpetrators, resulting in double jeopardy of BME women’ victimisation. From a postcolonial feminist perspective, violence of masculinity, racism, classism and poverty have intersected with the fragmentation and lack of cohesive support for women in the conversations regardless of race or ethnicities. In this thesis the notion of ethnicities and familial practices sheds light on how some BME women exercise power in violent relationships. However as the sub-theme suggests, when institutions fail to adequately protect women, ultimately those with less access to financial resources often endure the worst outcome. The chapter appears to support the pervading view that BME women rarely disclose DVA but has provided insight into the need to empower HVs to provide better advocacy for the women they support. This theme provides a persuasive account for a review of service delivery and organisational culture, which inadvertently perpetuate both physical and psychological harm to women when they resist male violence.
Chapter 6: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter, the key findings from the study are summarised and discussed and the contribution to knowledge is presented with reference to the stated aims of the study. An assessment of the theoretical contributions underpinning this study is made, and the strengths and limitations of using a postcolonial feminist lens combined with an intersectional analytic framework are evaluated. Some general conclusions are drawn with key recommendations for health policies, education, practice and future research. The analytic objectives of this study were to explore, describe and explain the following:

- What constitutes HVs’ practice knowledge of DVA generated during professional contacts with BME communities?
- What roles, if any, do race, politics and gender play during day-to-day professional encounters to uncover DVA?
- How does HVs’ knowledge of DVA shape professional relationships and influence the nature of their contacts when asking BME women to disclose incidents of DVA?

6.2 Discussion of Key Findings: Study Objective One

The first objective of the study was to explore and describe the nature of HVs’ practice knowledge of DVA generated during professional contacts with BME communities.

- The findings reveal the intersectional nature of DVA which is more inclusive and complex than previously appreciated by HV policy and practice.

6.2.1 Return to the Intersection

The documentary data and HVs’ knowledge articulate a perception of DVA that illuminates the continuum between intentional physical, sexual and psychological violation within personal relationships, thus reflecting the historical dominance of feminist ideas in the HV knowledge base (Peckover, 2002a; Dobash and Dobash, 1998; Home Office, 2012 and Westmarland and Kelly, 2013). The findings also revealed that HVs’ practice knowledge is grounded within the complex and subjective nature of professional encounters with BME women and is influenced by the multiple and often conflicting theoretical discourses underpinning their work.

Furthermore, in-depth analysis of the data in Chapter Five illustrates how access to power within personal relationships as well as within institutions varied significantly among women, regardless of their positions as mothers, their social class or economic status. For instance HV’s ideas on gender, mothering, religion, familial ideas of honour and shame, financial destitution and institutional politics perpetuate DVA, preventing some women from accessing services and limiting HVs’ access to women. Meanwhile, others gave examples of how women’s experiences of ethnicity, class, postnatal depression, child safeguarding, health, homelessness, poverty, immigration, nationality and language barriers were all interconnected to produce distinguishing features of dominations which determine BME women’s response to male violence.

Applying the concept of intersectionality to HVs’ knowledge base shows how experiences of DVA on HV caseloads are shaped by the complexities of women’s identities but appear to create confusion in defining, identifying (naming) and responding to DVA. For instance, when DVA was defined as a straightforward gender/class issue, HVs appeared more likely to define and name the problem by adopting the strategy presented in Figure 12, p182 and Figure 13, p184. Although a number of participants reportedly avoided using the terms ‘domestic violence’ or ‘domestic abuse’ altogether during their discussions with BME women, naming appears to be more contradictory and confusing when HV’s experiences were interrelated with ethnicity and familial ideas. Conversely, the documentary data revealed a similar contradiction by describing a gender-inclusive model of DVA as outlined in Figure 12, p182; while simultaneously ignoring women as victims/survivors and directing the practice of routine enquiry towards women as victims/survivors. Specifically some participants were confused about what could and could not be called DVA while others struggled to define the phenomenon altogether.

The majority of HVs acknowledged violence connected to practices of FGM, honour and shame as a continuum of DVA, often implicating multiple perpetrators. However, participants were less confident about asking women about forms of DVA that were connected to these contexts. A wider and more inclusive understanding of DVA creates confusion about who can or cannot be called
victims or perpetrators. Some participants were baffled when trying to distinguish between mental illnesses, practices involving witchcraft, and DVA, while others were confused in their understanding of parental discipline, child abuse and DVA and some expressed concerns and embarrassment about talking to BME women about the sensitive racialised and familial context of some BME women’s experiences for fear of offending the women’s cultures. These contexts highlight some of the methodological practicalities raised by McCall (2005) and Garry (2011) who argue that the absence of a central concept within an intersectionality framework creates more complex and blurred identity categories with wider theory and practice gaps.

According to the literature reviewed, an intersectionality DVA framework considers how systems of domination such as race, gender, sexuality, (dis)ability, economics and politics interact to create unique experiences for individuals who are subjected to this type of violation (Crenshaw, 1994; Bograd, 1999; Sokoloff and Dupont, 2005; Cramer and Plummer, 2009; Erez et al, 2009; Conwill, 2010; Salimbeni, 2011; Kelly, 2011 and Cho et al, 2013). The concept of intersectionality has been applied to the criminal justice system, and within health and social care to help provide an understanding of individual and collective experiences of DVA. (Sokoloff and Dupont 2005; Conwill, 2010; Nixon and Humphreys, 2010; Hankivsky & Cormier, 2011; Hankivsky et al, 2012). However, the complexities unearthed in this study reflect the reservations of McCall (2005) and Nash (2008) regarding the methodological challenges in linking an intersectionality conceptual framework to practice. Arguably, by drawing attention to the inter-subjectivities of how privileges and oppressions often co-exist and vary within ethnic groups and familial institutions, it is possible to underscore the heterogeneity of women’s experiences of DVA.

The emergence of Black, South Asian and Caribbean women as the predominant ethnic groups in these areas appears to reflect the demographics of HV caseloads and the context in which they work to support these women. Garry (2011) and Mattsson (2014) contend that the strength of an intersectionality framework as an anti-oppression tool can be applied to any context regardless of gender, race or social class. Careful examination of the casefiles presented by the HVs illustrates the commonalities between white working class and BME women on their
caseloads. Similarly, assumptions about middle-class women’s experiences of DVA led to the perception that they were better equipped to resist male violence.

The findings support a growing body of evidence in the literature which shows a significant shift in practice knowledge and attitude, whereby health professionals view DVA as an important health concern which negatively impacts upon the lives of victims/survivors (Price et al, 2007; Davidov et al, 2012; Trevillion et al, 2012; Ambuel et al, 2013; Bradbury-Jones et al, 2013; Beynon, 2015; Bradbury-Jones and Broadhurst, 2015). This is significant because knowledge of routine enquiry is underpinned by research showing the perceived acceptability of practitioners asking women to disclose incidents of DVA in clinical practice (Tacket, 2004; McCloskey & Grigsby, 2005; DH, 2010c; NICE, 2014; Bradbury-Jones and Broadhurst, 2015). However, this finding shows that 60% of participants received postgraduate DVA training compared to 20% who perceived pre-registration training, while only 5% reported that their training included knowledge about BME women’s experiences. Similarly, an analysis of key practice data used in this study appears to focus on the gendered context of DVA. These contexts also highlight the epistemological gaps in organisation discourse and research methodology in addressing the health and social inequalities linked to DVA.

This study builds upon previous work illustrating how feminist theorising on gender and patriarchy influences HVs’ knowledge of DVA (McKiernan, 1993; Radford 1996; Frost, 1999; Peckover 2003; Litherland, 2012). As noted by Frost and Peckover, there are significant differences in the levels of understanding among the HVs in their knowledge and practice for addressing DVA. However, unlike the findings of Frost (1999) and Peckover (2002a) (who focused on gender as the key signifier for male violence), the focus on multiple dimensions of HVs’ practice encounters with BME women revealed a much broader and inclusive understanding of DVA as outlined in Figure 12.
The data were sufficiently convincing to justify the conclusion that an intersectionality model of understanding DVA adequately represent HVs’ practice knowledge of BME families (Yuval Davis, 2006; Anderson, 2006; Conwill, 2010; Nixon and Humphreys, 2010; Cho et al, 2013; Hankivsky et al, 2012; Kelly, 2013 Racine and McDowell, 2013). However health data revealed that HVs’ day to day practice when identifying and responding to DVA does not yet reflect this understanding. Instead, the casefile examples presented by HVs suggest that the overwhelming majority of practitioners as well as the documentary data, direct practice towards the context shown in Figure 12 and Figure 13 p184.

The knowledge supporting the fluidity and ambiguities of categories of dominations are evident in HVs’ understandings of ‘victims/survivors’ and ‘perpetrators’ and ‘naming’ of DVA (Hankivsky, 2010; Ramsay, 2014). For instance, some HVs articulated the view that some African and Caribbean women were more likely to normalise DVA and were more tolerant of, and resistant, to DVA, while other HVs presented the view that BME women, including those with a greater social and financial dependency are more likely to remain in abusive relationships for longer. Over 20% of the participants believe that BME women were more likely to be complicit in their own abuse, however, an intercategorical analytic approach to the categories of race/ethnicities, gender and politics allowed an insight into HVs’ understandings of BME women’s identities as a dynamic relational concept rather than an essence. These ideas were striking during HVs case file example discussions.

According to Cho et al (2013), an intercategorical framework of analysis that focuses on how structures of domination intertwine and mutually reshape identities, rather than privileging a particular axis of power, can expose
commonalities and differences between and within social groups. Nevertheless, McCall (2005) acknowledges the value of analytic categories within an intersectionality framework but rejects the notion of identities on which categories are based. Pointing to the flaws in some categorical approaches, McCall argues that an analytic approach that focuses on the binary construct of gender as 'male' and 'female' is flawed since gender identities are shaped by multiple sexes and multiple genders.

The understandings presented by HVs and the context in which they work support the pervading heteronormative views of families and women (victims/survivors) and men (perpetrators). For instance, there is limited evidence in HVs’ discussions relating to how issues of sexuality and (dis)ability intersect with experiences of DVA, race and mothering. This appeared to reflect the heteronormative ideas on family within HV discourse and the context in which health work with women takes place. However, evidence from the literature review presented in Chapter Three exposes how the intersection of DVA with sexuality, race and gender expose the triple jeopardy of Black lesbians’ experiences of DVA. Nevertheless the analysis of the racialised and political context of the case files presented by HVs shows how violence in the lives of BME women is fuelled and perpetuated by women’s access to power in relationships and within institutions. This approach acknowledges the complexities within identity categories whilst interrogating the categorical boundaries as outlined in Figure 13.
Black feminists have noted the significant absence of empirical research into BME women’s victimisation/survival experiences, particular African Caribbean women (Sokoloff and Dupont, 2005; Collins, 2000; Bell and Mattis, 2000; Bell et al, 2009; Kanyeredzi, 2013). In addition, Collins (2000) argues that the social construction of the ‘strong black woman’ has contributed to the double-bind effect of under-reporting of DVA by BME women, who feel that they are expected to cope with violence. Similarly, Thiara and Roy (2010) and Thiara (2011) argue that the assumptions that BME women are more tolerant of violence are rooted in the essentialist racialised construction of African and Caribbean women as being strong and naturally resilient to adversity (Reynolds, 1997).

The work of Allard (1991) provides examples of how negative stereotyping of BME women has prevented them from receiving equal and sympathetic treatment from statutory services. However there is no suggestion within the HV text that this is the case and there is insufficient evidence from this research to make a reliable assertion about African Caribbean women’s experiences of accessing health-visiting services. Conversely, the data provided evidence of HVs’ compassionate responses to the women’s position, often using their own resources to support some of the BME women who faced financial destitution. Nevertheless, these discoveries provide the context from which to challenge the prevailing ideas on the
nature and prevalence of DVA and to conduct future research. Furthermore, the evidence presented by the HVs suggests that health professionals, community and religious leaders, as well as extended families play a significant role in naming or silencing BME women’s experiences of DVA.

6.2.2 Summary

HVs’ practice knowledge for defining, identifying and responding to DVA is observed as complex, chaotic and often contradictory. However, the knowledge presented in this study corresponds with the implicit ideas of an intersectionality framework of DVA. Within healthcare settings, Hankivsky et al (2014) sees the intersectionality public health model as expanding beyond the gender-specific and social determinants frameworks and such a model is proposed in Figure 13. Recognising the transformative elements that intersectionality brings to knowledge about DVA, Nixon and Humphrey (2010) also contend that we need to develop a more accurate picture of diversities but reiterate the need for a straightforward unambiguous message that DVA is dangerous to women.

The evidence presented in this thesis demonstrates that the contextual knowledge relating to the intersectionality of ill-health, child safeguarding, DVA and the political location of women’s lives has been an enduring feature of health-visiting work (Frost, 1999; Luker and Chalmers, 1990; Elkan et al, 2000; DH, 2011; Cowley, 2013; Donetto et al, 2013). However, these contexts are not embedded within the health-visiting discourse and are rarely visible in health needs assessments and analyses of BME women. This perspective suggests that researchers, practice educators, policy-makers and practitioners need to adopt a multi-dimensional analytic approach to bring to the forefront some of the complexities that shape experiences in order to understand the differences in needs and outcomes.

6.3 Discussion of Key Findings: Study Objective Two

What role, if any, do gender, race, and politics play during day-to-day encounters between HVs and BME women to uncover DVA?

- Perceptions about race and gender and politics as well as institutional culture influence HV’s capacity to uncover DVA.
6.3.1 Colonial Aftermath

The conversations with HVs, documentary data and a review of the literature revealed that institutional politics, as well as the familial context in which some BME women experience DVA, influence HV practice in seeking to uncover DVA. The empirical findings from this study show that the HV were aware that some women’s nationality prevented them from accessing services. However, for the most part it was HVs’ knowledge of ethnicity, class and women’s socio-economic status, and the neo-liberalist health service culture that influenced identification of and response to DVA. A key evidence from this study shows that HVs rarely uncover DVA via routine enquiry, rather, the overwhelming majority of identified cases were linked to multi-agency referrals, mostly from the police and those women who chose to disclose to their HV. Crucially, the overwhelming majority of HVs did not disagree with the practice of routine enquiry, and close examination of the data suggests that women rarely disclose DVA when asked to do so during home visits.

Some HVs reported that this contradiction directly influenced their decision to ask women about DVA. For example, detailed questioning revealed how some participants framed the questions about DVA to avoid disclosure in order to meet the target for the required number of newborn visits. Asking about DVA was seen as time-consuming, which would impact on their ability to conduct the required number of newborn visits and therefore reduce their performance. The practitioners reported that discussions about DVA required them to spend extra time with women in order to build relationships and gain women’s trust. Others avoided the question altogether because they felt powerless to intervene in the complex familial context in which they encountered the problem and felt unable to support women who were not entitled to services or could not meet the threshold for support because of their nationality or economic status. The response from HVs reflects the neoliberal ‘value-based visions’ of public health commissioning (NHSE, 2010) where the core elements of HV practice to identify and address individual healthcare needs are set against the market-forces efficiency drive. Arguably, the failure to include DVA within the core specification of HV services also reflects the dominance of medical knowledge within public health services. The evidence from this thesis raises critical questions about the ethics of this
practice given that DVA is a key contributory factor in the overwhelming majority of safeguarding cases (Humphreys, 2008; LSCB, 2014).

The majority of HVs admitted to deliberately framing assessments to avoid disclosure because they felt overwhelmed and often powerless to support women who were not entitled to, or were excluded from, services because of their nationality. Studies undertaken by CEDAW (2013) have drawn attention to how policies within health, social care and the criminal justice system often exclude some of the most vulnerable groups of women within society. This study argues that the collective failure of organisational policies to address needs, such as the provision of language interpreters, and challenging ignorance amongst employees, not to mention the practice of removing children from the care of their mothers and sending women back to their countries of origin where they often experience greater abuse, is a form of institutional racism. There is very little evidence to suggest that this is entirely the case within health services. Four HVs provided graphic illustrations of personal involvement in cases which had tragic outcomes for the women who returned to their violent partners as they could not access the services to protect them. This appears to reflect the outcome of over 200 domestic homicide reviews conducted by the Home Office (2013b), illustrating the failure of services to respond appropriately to women seeking help for DVA.

Reviews of BME women’s experiences in accessing DVA services by SBS (2010), Kanyeredzi (2013) and Larasi (2013) point to a number of systemic failures that were linked to institutional racism and institutional failure to frame services within the understandings of cultural specificity, taking into account issues of race, ethnicity and sexuality. These highlight how issues of lack of recourse to public funds automatically exclude some of the most vulnerable BME women from state protection against violence. In this study, the HVs reported their own powerlessness to support these women. Larasi (2013) argues that specialist BME VAWG services, which do not undermine or devalue differences, are the most effective means of resisting male violence. The need for service reform is identified at a time when most health and social care budgets are being significantly reduced against the backdrop of an increasingly diverse population fuelled by greater European integration and by increased migration to and
settlement in the UK (Coburn, 2004; Dixon, 2012; Lister, 2012; Gilbert et al, 2014; Firth, 2015; Strier et al, 2013/5 and Ham et al., 2015). The findings from this research appear to contradict the outcomes from a number of key practice-based studies demonstrating the effectiveness of routinely asking women to disclose DVA in clinical practice (Bacchus et al, 2002/10; Tacket et al, 2003; Mezey et al, 2003; MacDonnell et al, 2006; Lazenbatt et al, 2009; Thiara, 2012; Baird, 2013; DH, 2005; Salmon et al, 2005; Humphreys, 2008; Feder et al, 2009; 2009; Sharpen, 2009; WHO, 2008/13; Howell and Johnson, 2011; Bacchus et al., 2012; Connor et al, 2013 and Rose et al, 2013). In this study, the HVs’ disciplined focus combined with their child safeguarding-orientated approach to visiting women in their homes is crucial to the analysis of routine enquiry. The aforementioned studies have been at the centre of the national guidance assisting HVs to identify and report DVA (Sharpen, 2009; DH, 2010c; NICE, 2014; NHSE, 2015). The HVs’ own conversations of their practice in identifying and reporting DVA suggests that the familial context in which home visits take place and the conflicting organisational priorities often limit the effective implementation of this practice. Although all the participants supported the practice of routine enquiry, the evidence from this research suggests that there is very little guidance on this that might be applied to the context of HVs’ work with BME women in their homes. This may be because the aforementioned studies were undertaken in particular health settings such as maternity units, emergency departments and GP surgeries where practitioners had one-to-one access to women. This is significant because the contexts in which GPs and midwives encounter BME women often create specific opportunities for assessments which do not always include the presence of the perpetrators. Conversely, the majority of HV encounters with BME women are likely to take place within their homes. However, the HVs’ conversations about their visits illustrate how suspected perpetrators often dominate and control their access to women and actively prevent them from asking about DVA.

Coincidentally, the contexts in which GPs and midwives encounter BME women remain rooted within the dominance of medical discourse. There has been limited empirical research into BME women’s response to DVA disclosure and a notable absence of studies investigating the context in which HVs identify and report DVA-affected BME women in their homes to address DVA. Similar reviews by Feder et al. (2009/13) also raised concerns about the effectiveness of routine identification
and reporting of DVA. However these systematic reviews did not include studies to reflect the context in which HVs work with women in their homes. The data from this study suggests a need for further research in this area of practice and a need to develop a framework for assessment to include the intersectionality of BME women’s lives in health assessments. Such a framework must also reflect the sensitivities that are linked to the context in which disclosure is sought or achieved.

The data indicates that the context in which HVs apply knowledge of race, gender and politics to identify DVA is not always straightforward. This appears to reflect the heuristic nature of their practice encounters with BME women in seeking to address health and social inequalities. For instance, the data in theme two revealed that the often complex and unpredictable nature of clinical encounters with BME women, the lack of appropriate training regarding DVA, as well as the subjective nature of health-visiting assessment often lead to different interpretations of DVA risks. Instead, the participants reported that the training mostly centred on child safeguarding, parental mental health, substance misuse, and the criminal aspect of DVA. This helped to explain why the majority of participants reported using the EPDS (Cox et al, 1989) and the Child and the (CAF) tools to uncover DVA. The participants’ conversations suggest that the use of these assessment tools meets policy recommendations which focus on the welfare of the child and the recognition that family members and carers are crucial for safeguarding children (LSCB, 2014/15).

A review of the literature in Chapter Three provides evidence that challenges the use of the EPDS in BME groups and questions the suitability of its use to help predict DVA (Edge, 2010/11), together with querying the use of postpartum depression as a key indicator for DVA (Humphreys, 2007a; Rose et al, 2011). As a case in point, some HVs emphasised how social class rather than race was more likely to determine women’s experiences, citing examples where middle-class women were better able to challenge male violence, undermining practices to uncover DVA and institutional attitudes to them. Conversely, case file examples also demonstrate how some HVs believed that middle- and working-class BME women were equally subjected to DVA and domination that was connected to familial politics of FGM and honour-based crimes. Other case file examples revealed the dichotomous position of middle-class BME women whose access to
power outside their familial context did not reflect their position of subordination within the familial institution. For instance, the data showed how it is possible for educated professionals earning the primary income within their families can be abused by older women in the family, thus indicating age as a predictor of DVA.

The findings show that HVs’ knowledge of race, ethnicity and families is shaped by their knowledge of the diasporic formation of migrant settlers, providing insights into their caseload demographics, Eurocentric ideas and assumptions about race and ethnicity, such as the idealised notion of Western (i.e. educated and privileged) and non-Western women (as uneducated, poor, mostly disempowered and lacking the capacity to know that DVA is wrong). In some instances, the social identities of BME groups were constructed through negative stereotyping rather than reflecting individual behaviour. The work of Abraham (2013) and Hankivsky et al (2012) has shown how negative stereotyping often undermines resistance strategies used by some BME women and can lead to assumptions that they passively accept abuse or protect the perpetrators. In contrast, feminist theorising on the process of victimisation considers perceived helplessness as a by-product of the strategies used by perpetrators to control and dominate their victims (Kelly and Radford; West, 2005; Thiara, 2011). However, the work of Crenshaw (1994) offers the suggestion that some black women may use their silence as a form of political empowerment which protects black men from greater state violence, which is linked to greater disparity within the criminal justice system. For example, in this study some HVs were more likely to view South Asian women as perpetrators or as complicit in their own abuse. This was often balanced against the view that South Asian women were more likely to suffer at the hands of multiple perpetrators who were also women, thus reflecting the context of honour-based violence. Conversely, some HVs suggested that African and Caribbean women were viewed as being better able to cope with violence, while others reflected the context of help-seeking behaviour where these groups of women are more likely to seek support from community leaders, family elders or religious leaders regardless of class. There is no evidence to suggest that these contexts consciously impact upon the way HV’s respond to BME women during disclosure.
6.3.2 Summary

The absence of a multi-dimensional understanding of DVA appears to shape the confusing, chaotic and contradictory approach to identifying DVA and illustrates the need to develop a greater understanding of how the intersectionality of women’s lives can include positive disclosure. This contradiction is noted in the multi-layered understanding of gender, as men can also be named as victims and women as perpetrators too; however, an essentialist approach to routine enquiry focuses only on women (e.g. mothers) as victims when HVs ask about DVA. This is likely to have far-reaching consequences, with the probable exclusion of victims/survivors whose familial make-ups do not fit societal prescribed norms. Of equal importance are the economic and political contexts in which HVs discharge their public health duties. The evidence from HVs shows that the consequences of the pervasive market-style healthcare economy, with its competing aims, undermine efforts to identify DVA and support victims/survivors. Case file examples show that, even in cases where women take direct action to resist male violence, the current eurocentric ideas based on the doctrine of Nationalism shape access, privileges and entitlement to services, which ultimately discriminates against some of the most vulnerable victims/survivors (mostly BME non-Europeans) who eventually return to their abusers. This position also contradicts the UK Government’s own commitment to uphold the UN Human Rights Convention to tackle violence against women and girls (Home Office, 2011).

The evidence from Chapter Five shows that when faced with decision-making power and the primacy of the healthcare economy, the HVs appear to relinquish their advocacy role, adopt the strategy of least resistance and invoke legislation that appears to arbitrarily impose child protection rules which barely differentiate between the victim/survivor and the perpetrator. The HVs intended to ask women about DVA. However as the data confirms, the complexities and contradictory context in which they work influenced participants’ abilities to frame questions about DVA within a gender-inclusive perspective/health promotion context, recognising both men and women as potential victims/survivors and perpetrators, while others intentionally adopted a gendered perspective, focusing on women as victim/survivors and men as perpetrators of DVA. A similar position is noted in the DH (2010c) and NICE (2014) contradiction between a gender-inclusive definition of DVA and the guidance which specifically directs health professionals to ask
women about DVA. The process of the allocation of scarce healthcare resources is noted by HVs and it is likely to become more transparent through the application of an intersectionality framework which calls for the re-allocation and redesign of services. A model of empowerment that encourages the engagement of community groups could entrust the self-empowerment with a sense of ownership and partnership working. To truly engage an intersectionality framework, victims/survivors need to be fully included in the emancipatory process to build resilience within institutions to challenge and eradicate male violence.

6.4 Discussion of Key Findings: Study Objective Three

To explore how HVs’ knowledge of BME women’s experience shapes professional relationships when women are asked to disclose incidents of DVA.

- Professional relationships during encounters to respond to DVA disclosure were found to be a contradictory form of hegemonic representation.

6.4.1 Nature of Professional Relationships

The postcolonial theoretical perspective of political representation emerged as an important analytic theme throughout this thesis and it is the site of analysis of the nature of social relationships. The notions of representation and power imbalance within professional relationships are embedded in the data from this study. This was evident within the organisational discourse conceptualised in Chapter Three, the document analysis presented in this study, and in HVs’ conversations about their practice knowledge and service interventions to address DVA with the BME communities on their caseloads. An exploration of HV practice has drawn upon the postcolonial feminist doctrine of representation to reveal that the practice of addressing DVA within BME communities constitutes a form of hegemonic representation.

As noted earlier the conversations with the HVs suggest that the overwhelming majority of HVs are implicated in naming DVA and speaking with and on behalf of BME women as part of their professional obligations to respond to DVA. This includes co-constructing meaning with BME women, validating women’s experiences during disclosure, representing and making critical decisions about BME women’s positions as mothers and/or victims/survivors of DVA during multi-
agency interventions to protect women, and undertaking assessments of BME women during home visits. However, the HVs’ discussions revealed the conflicting nature of their relationships with women that naming brings.

The findings in Chapter Five graphically illustrate the juxtaposition in which HVs are entrusted with intimate details about women’s lives while at the same time being conscious of their professional obligations, thus creating a power imbalance in their relationships with the women. This was observed in the prevailing hegemonic nature of their statutory obligation to safeguard children from DVA (DH, 2010b; Home Office, 2012; LSCB, 2014) and their work with women to address health and social inequalities (Cowley et al, 2008; CPHVA, 2010; Luker et al, 2013; DH, 2014; NHS England, 2015). The findings revealed that some HVs were acutely aware of how child protection procedures informed by dominant ideas on mothering, public health, and medical knowledge on child development were counterintuitive to gender equality. This led some to voice concerns that different political agendas now prioritise the regulatory function of parenting and often blame or overlook the vulnerabilities of mothers experiencing DVA.

Postcolonial doctrine on representation suggests that the context in which HVs are implicated in naming DVA and speaking with and on behalf of BME women as part of their professional obligations constitutes a form of political representation (Mohanty, 1991; Sandoval, 1991; Ang, 1995; Hinterberger, 2015; Spivak, 1998; Ali, 2007 and Celis, 2013). Document analysis in this study and HVs’ interviews illustrate limitations of how institutions are also implicated in representing BME women. including co-constructing meaning with BME women, validating or challenging women’s experiences during disclosure, representing and making critical decisions about BME women’s positions as mothers and/or victims/survivors of DVA during multiagency interventions to protect women, and setting thresholds concerning whose experiences can and cannot be included in service provisions. However the literature review as well as HVs’ conversations about their practice suggest that these do not always reflect BME women’s views on DVA and practice to address the issue (Siddiqui and Patel, 2010; Tiara, 2011). The findings also show that the HVs’ health needs assessment framework rarely includes the intersectionality of BME women’s lives instead, they invoke a child protection framework of blame and responsibility.
Conversely, feminist strategy for democratising knowledge suggests that the views, needs and interests of BME women need to accurately reflect women’s experiences (Ali, 2007; Nash, 2008; Mirza, 2013). It was, at times, difficult to see how this could be achieved in this research because the diverse and disparate descriptions of BME women’s experiences created specific difficulties in developing a coherent representation and resistance strategy. For instance, the HVs’ conversations about their practice encounters with BME women suggest that the women did not always agree on what constituted DVA and the HVs did not always support the practice guidance on who can and cannot access services. Some HVs were clearly aware of how the process of representation or indeed misrepresentation creates or reinforces an imbalance of power within the professional relationship with BME women. It could therefore be argued that the neoliberal organisational culture which undermines DVA disclosure is a form of misrepresentation. Not least because a failure to identify and challenge DVA masks the intersectionality of women’s experiences of DVA and vicariously reinforces health inequalities.

Furthermore the HVs’ description of their practice encounters with BME women accurately reflects the conceptualisation of hegemonic power-representation within healthcare settings proposed by Filc (2004), Carey and Foster (2013) and Scott-Samuel and Springett (2007) This was observed in the contradictory nature of the HVs’ professional relationships in regulating women’s roles as mothers while safeguarding children and at the same time supporting the women to challenge and name male violence. Supporting the women to name and expose DVA is observed as a form of political representation, however, the HVs’ statutory function to regulate women’s role as mothers while simultaneously enforcing organisational policies to protect children was observed as a form of hegemonic power.

The findings show that, for the most part, the HV’s function in responding to DVA disclosure mostly invokes legislative power. This in itself appears to blame the women for failing to protect their children from the perpetrators. For instance, a number of HVs described calling upon safeguarding legislation to gain women’s compliance in disclosing DVA, and a number admitted to being aware of the contradictory role they occupy within institutions. The historical silence on DVA that pervades health-visiting and the contemporary practice which undermines the function of routine enquiry cannot be viewed in insolation from the wider political
institutions in which they occur. From these contexts, the HV’s role might be seen as exercising the subaltern function. According to Gramsci, 1971;

"The apparatus of state coercive power … legally enforces discipline on those groups who do not consent either actively or passively. This apparatus is, however, constituted for the whole of society in anticipation of moments of crisis of command and direction when spontaneous consent has failed" (Gramsci, 1971, 12).

The practice between institutions (including health visiting) and BME women in the context of addressing DVA has drawn attention to how knowledge and power within social relationships are reproduced through the acts of speaking on behalf of and representing others. For instance, the data provide evidence of how dominant ideas on the DVA victimisation process and Eurocentric views on motherhood influence access to and exclusion from services. Conversely, case file discussions illustrate how knowledge gained from HVs’ unique access to BME women was used as evidence to challenge and expose DVA that is connected to familial ideals about women’s morality. In-depth analysis of the policies also revealed the contradiction that shapes the supportive and regulatory functions of HV work.

Postcolonial feminist doctrine on the nature of social relationships argues that the practice which involves (subjective construction or objective formation) speaking on behalf of others involves representation and therefore cannot be separated from power inequalities (Spivak, 1985; Sandoval, 1991; Gandhi, 1998; Lionnet, 1992; Duveen, 2001; Loomba, 2005; Hinterberger, 2007). Thus, this analysis of an aspect of HV work is defined as hegemonic as utilised in the concept of hegemonic representation and power/knowledge in order to develop a theoretical understanding of the knowledge base that informs HV practice.

The work of Gramsci (1971), Spivak (1998) and Stoddart (2008) enables us to understand that the relationships between HVs and BME women typify a form of hegemonic representation. This builds upon previous analysis of the dominance of medical discourse within public health nursing and provides the context in which to analyse institutional practices as well as the day-to-day encounters underpinning health visiting work (Gair and Hartery, 2001; Mahon-Daley and Andrews, 2002; Filc, 2004; Samuel-Scott and Springett, 2007). The findings remain consistent with the cumulative effect of hegemonic power but shed light on the discursive strategies adopted by HVs to help BME women expose the intersectionality of male violence.
This perspective has expanded the understanding of HVs’ work with BME women, providing new theoretical insights mainly because it provides the notion of hegemonic representation which has not been applied to HV practice in addressing DVA in this way before (Spivak, 1988; Mohanty, 1988, Ang, 1995; Ali, 2007; Hinterberger, 2015).

Feminist theories concerning the issue of hegemonic representation and power/knowledge, and the reproduction of social power, refer to how the existing model of intersectionality can disrupt the reproduction of social power. These ideas proved useful for understanding how the prevailing discourse informing an understanding of DVA and service provision to resist male violence often unwittingly reproduces the intersectionalities of inequalities, reflecting instead the legacy of how knowledge about race, politics and familial influence on DVA has been systematically excluded from the dominant discourse on DVA. However, the concept of intersectionality has not been fully utilised within healthcare (Van Herk et al, 2010; Hankivsky et al, 2014; Racine, 2010), and even less within the HV discourse. Paradoxically, these views were reflected in the literature and the HVs’ conversations concerning their formal knowledge regarding DVA in their training practice preparation and postgraduate development.

The evidence provided by HVs suggests that the practice knowledge guiding their work with BME families did not always reflect the intersectionality of their work in addressing health inequalities. In-depth discussions with participants suggest that this was linked to the historical context in which knowledge about BME women’s experiences of health and DVA was omitted from the nursing and DVA discourse. Scholars from different intellectual disciplines have noted the unequal distribution of power within contemporary relationships and the extent to which this is reproduced in dominant ideologies such as medicine (Foucault, 1989; Hugman, 1991; Peterson, 1997; Ferguson, 1998; Filc, 2004; Waitzkin, 1991; Gair and Hartney, 2001). This was certainly the case in the findings from HV’s practice and acute care practitioners practice by Peckover (2002a) and Rose et al (2012).

While feminist work has been visible within HV practice, the evidence from this study shows how knowledge about mental illnesses and child development appears to have overshadowed the racialised, familial, political and gendered context in which BME women experience this phenomenon. At the same time, the HVs who participated in this study used their intimate professional contacts with
BME women to provide a unique perspective on DVA which might otherwise have remained hidden in the dominant health and safeguarding discourse.

The findings graphically illustrate the contradictions between personal (lay) knowledge and organisational objectives and draw attention to the dichotomous positions whereby HVs struggle with valuing the caring nature of their relationships with the women and the regulatory function of their role when addressing DVA. Applying the ideas of Gramsci’s hegemonic power to HV practice in this way helps to establish how race, gender and contemporary imperialism operate as a matrix of oppression and a form of political representation. The focus on postcolonial feminism helped to demonstrate that gender may not be the only oppressive feature within HVs’ work with women as very little is known about HV’s encounters with women who are living with disabilities, or even about mothers in same sex relationships. Together with the intersection of DVA with ethnicity, sexuality and disability and how these might influence victimisation/survival’s experiences. However, attention to the salutogenic context of HV’s work also provides evidence of a narrative which exposes the intersectionality of their work as a form of resistance.

6.4.2 Summary

As noted earlier, a strategy of non-engagement with the practice of routine enquiry is considered as a form of political resistance. Research has shown that appropriate representations are influenced by identity, politics, social position, and life history, all of which are intertwined with the professional discourse and services provided to address health disparities. However, an analysis of health visiting practice suggests that the prevailing social model of health, which seeks to promote advocacy and community development within health-visiting, is increasingly shifting towards a public health discourse of an individualistic approach to health effectiveness and disease control (Edge, 2011; Donetto et al, 2013; NHSE, 2014).

The counter-hegemonic strategies of social representation within healthcare strategies proposed and developed by Racine (2003/9), Kirkham and Anderson (2002) and Hankivsky et al (2012) demonstrate the critical links between epistemological orientations and structural inequalities within healthcare settings. In particular, Anderson argues that applying the critical lens of postcolonial
feminist interpretations and ideas might equip nursing with the ability to meet the epistemological imperatives of giving voices to subjugated knowledge and uncovering existing inequalities. Similarly, a critical review of public health policies has also called for a greater integration of the intersectionality of health experiences to be reflected in public health policies and policy analysis (Anderson, 2004; Racine and Petrucka, 2009; Bowleg, 2012; Hankivsky et al, 2012). As shown in this study, HVs’ work has contributed to a wider and more inclusive understanding where differences can be accommodated and inequalities exposed.

Evidence from these data shows that while HVs may see themselves as advocating on behalf of BME women, the context in which they represent them remains heavily regulated and is mostly governed by the antagonistic ideologies underpinning the demand for services and the availability of resources. In this study, the evidence shows that HVs' knowledge of race, gender, family and health is shaped by the dominance of medical discourse. In contrast, the case file discussion appears to challenge these realities and thus a contradiction prevails.

6.5 Methodology Theoretical Contribution: A Reflective Perspective

Applying a postcolonial feminist methodological approach to the understanding of HV work with BME women and their experiences of disclosure for DVA has helped to produce unique insights that transcend what we know about HV’s knowledge and practice in this area which is imbued with these understandings of race, gender and politics.

The methodological approach, which focused on the multiple subjective realities of HVs and the context in which they work draws attention to how knowledge and understanding of DVA, influenced by contemporary imperialism (e.g. racism, poverty, nationalism and structural violence), are shaped by the hegemonic structures presented within personal and institutional relationships (Gramsci, 1971; Rich, 1984; Mohanty, 1988 and Spivak, 1988). The intersectionality analytic framework reveals the complexities, confusion and contradictions in HVs’ knowledge and practice in addressing DVA with BME communities. Willis et al, (2007) argues that adopting a mixed method approach can help to answer broad and complex research question and provide stringer evidence for conclusion. On the other hand methodological purist argues that researchers should always work with one or the other. The process of data analysis in this research was time consuming and challenging when learning how to adapt and merge two different
sets of data and approaches. This principle of triangulation was nevertheless rewarding.

6.5.1 Design Challenges and Lessons Learned

A recognised limitation of the study is linked to the urban location of the data collection sites, however, this is balanced by the diverse caseload demographics held by the participants.

Ideally, it would have been useful to select a rural site as well as an urban site; unfortunately, limited resources and recruitment challenges prevented this approach. On-going and practical difficulties in recruiting members to a focus group meant that the contribution from the focus groups (of BME women who had previously accessed DVA services) had to be abandoned. However, rigor was promoted by data triangulation and a process of reflexivity and regular sessions with academic supervisors. The decision to interview HVs from different NHS Trusts was advantageous in maintaining the anonymity of the participants and created the opportunity to discuss sensitive practice issues. Ethical issues and the limitations of interviews as a research method have been discussed earlier, and similarly, the inherent difficulties in undertaking practice-based feminist research and the steps taken to enhance the trustworthiness of the study have been addressed in the reflective account of the research process. Despite these limitations, the study aims and objectives were satisfied. Due regard was given to the aims of the study and each objective was examined to represent an equal and substantial feature of the study.

A merit of the study is the innovative and analytic framework applied to guide the analysis of documentary data and HVs’ narratives which promoted rigour. For instance, the mixed method approach was adopted because of the capacity to enhance the quality of evidence through corroboration of findings and the principles of triangulation. Furthermore adapting the core tenets of intersectionality analytic framework outlined in tables 15,16 and 17, provided greater insight that might have otherwise overlooked. However learning how to adapt textual discourse analysis with thematic analysis effectively proved to be challenging and time consuming. In this instance the methodological congruence between critical discourse analysis Fairclough (2003) and Braun and Clarke (2009) thematic analysis proved to be effective.
The postcolonial feminist analytic framework promoted a conceptual vision to enable the fusion of representation and the intersectionality inductive abductive approach to derive a plausible interpretation. Theoretical concepts underpinning postcolonial feminist ideas on intersectionality are rarely discussed or applied within healthcare, nursing knowledge, DVA theories and/or nursing research and the use of such concepts in this thesis is considered to be its main strength.

The postcolonial feminist doctrine of representation emerged as a central theme and is threaded throughout this thesis to help expose the interconnected layers of power imbalance in the professional relationships between HVs and the women and the women and institutions. Thus conceptualising HVs' responses to DVA as a form of hegemonic representation. For instance, the view that HV practice constitutes a form of hegemonic representation was evident in Chapter Two and was supported by the narrative in the data throughout Chapter Five because of the recognised role of HVs within the state apparatus (Whitehead, 2001; Peckover, 2002b; Filc, 2004; Springett, 2007), which enforces particular disciplines on women who do not consent or respond to DVA within the formation of the social, political and medical sphere of public health practice. The focus on issues of race, class, politics, and economics in the empirical data has helped provide an understanding of how knowledge about BME women is represented and reproduced within the health-visiting discourse. Conversely, the notion of representation helped to expose the heterogeneity of BME women's experiences when attention is drawn to the diversity of women's political location.

Feminism acknowledges the contradiction that the doctrine of representation which involves speaking on behalf of others is a site of contestation within postcolonial feminism and feminist research. (Letherby, 2003; Hinterberger 2007; Ramazanoğlu and Holland, 2009). This is because of the potential to misrepresent those participating in the research and the research subject. This in itself raises critical questions about the use of power in this research; e.g., it asks which ethnic groups in the research should be privileged and which should be excluded, or whether or not HVs can produce legitimate knowledge about BME women. Spivak (1988) insists that those claiming to speak for marginalised groups must interrogate how their work might be implicated in power relations and the production of knowledge of 'Others'. To this end, I wish to argue that this research process has been engaged in partial political representation because HVs’
practice knowledge and practice encounters involve speaking about and on behalf of BME women and in so doing producing and reproducing knowledge about their lives. The extent to which this has been an effective political strategy can be assessed as follows.

The first includes the political representation which challenges the primacy of gender as an explanatory model for DVA and raises awareness about the issue in this area of practice which may not otherwise have been exposed in this way. The second is linked to the resistance strategy of the research which has drawn attention to how hegemonic knowledge within clinical practice, micro-hegemonic powers within BME women’s relationships and the hegemonic relationships within organisational cultures reproduce and are reproduced by structural inequalities. Ultimately the personal and professional benefit derived by the feminist researcher as well as the researcher’s abilities to manage and integrate conflicting ideas and difficulties during the research process must be considered as part of the trustworthiness of the research.

This work, which sets out to challenge the homogeneity of women’s experiences of DVA, has been, for the most part, a challenging and complex process. This is because not all BME women’s perspectives were visible in this research. Therefore it is difficult to argue that this research represents the experiences of all BME women. This is considered a limitation of the study and a challenging aspect of postcolonial feminist research. However, earlier in the project I made a pragmatic decision to follow the analytic guidance outlined by Ang (1995) who suggests that feminist research and practice should not avoid the assumption of a common identity and should instead adopt the politics of a partial and limited political home which does not absorb differences or assume a common ground. The approach taken by this research acknowledges the differences as well as the similarities in women’s strategies to resist male violence and in so doing it recognises the limitations within the politics of representation. HVs’ intimate professional contacts with women also place them in a unique position to gain first-hand knowledge about BME women’s resistance strategies and, in some instances, to use this insight to gain access to some of the most inaccessible victims/survivors. It is also important to note that the HVs who participated in this study represented a range of ethnicities. These positions shed light on the
complex pattern of power relations that shape their involvement in the politics of representation and legitimise HVs’ epistemological location within this research.

Mohanty (1988) also warned against the analytic pitfalls of discursively homogenising BME women as powerless and exploited by identical issues and desires. However, the particular hegemonic knowledge unearthed by HVs must be viewed within the context and political nature of this research in which BME women may be over-represented. This is because practice knowledge and encounters with BME women operate from a particular vantage point where the women on the HVs’ caseloads might be described as an 'already situated group' whose lives are interconnected by a set of predetermined features, e.g. mothering, DVA, and economic, political and social circumstances, meaning that HVs are more likely to be actively and closely involved with BME mothers who are already affected by DVA, financial destitution, mental illnesses, homelessness or drug and alcohol misuse (Robinson et al, 2000; Cowley, 2008 and Thornbury et al, 2009).

This research has shown how these problems are often compounded by religious, familial, and political hegemonic practices. Furthermore, HVs are less likely to have contacts with the overwhelming majority of BME women whose lives are not affected by the aforementioned categories of oppression. Paradoxically, the microscopic attention to the intersectionality of BME women’s lives could promote a negative imagery of BME women and create artificial differences which ignore an understanding of the commonalities, and differences between women’s experiences. This was certainly confirmed by one HV during the research.

However, the expositions that are shaped by historical differences of social justice, rights and privileges and the intersectionality of BME women’s lives have been, for the most part, a powerful analytic tool which has brought a new understanding of why DVA in BME communities is rarely uncovered by health professionals. This might not otherwise have been achieved and it is underscored by the data, as is evident in this research. Applying the analytic concepts of intersectionality helped to illuminate how, given that not all women share the same experience of being women and not all women who experience DVA share the same familial context, experiences are linked to ethnicity, religion and culture. Therefore, attention to the
issues which shape women’s experiences of DVA must look beyond the all-
encircling notion of women.

6.6 Analytic Summary

HV’s knowledge of the intersectionality of gender, race and nationalism, and how familial and institutional ideologies are intertwined, explains how access to power within personal relationships and within institutions often perpetuates and reproduces personal violence in the lives of BME women. However, the research also exposed some of the challenges linked to postcolonial feminist research methodology. Focusing on the intersectionality of BME women in this manner revealed views of BME women’s responses to DVA as disempowered, uneducated and seemingly more tolerant of and resilient to DVA. These findings confirm some feminists’ claims that analytic presuppositions which homogenise the notion of oppressions ultimately reproduce the very conditions they seek to avoid (Mohanty, 1988; Butler, 1990; Ang, 1995; Nixon and Humphreys, 2010). An example would be the labelling of Western women as educated and modern, whilst non-Western women are seen as powerless, uneducated and lacking in agency. However the attention paid to the intercategorical differences within social categories helped to acknowledge differences and continuity between genders, thus avoiding the analytic pitfalls of labelling BME women who experienced DVA in personal relationships as poor, heterosexual or tradition-bound. The analysis of power within personal relationships and within institutions illustrates how DVA occurs in multiple genders. In fact, it is access to power in their personal relationships and within institutions that creates the matrix of oppressions in their lives.

These findings open up the possibility of an intersectionality analytic framework being applied to a broader and inclusive category of analysis regardless of the subject under investigation. These findings exemplify the unique perspective of this research as well as the strengths and challenges of a postcolonial feminist research methodological approach. The knowledge base provided by HVs is outlined in Figure 14, p204 and Figure 15, p210 and suggests that an intersectionality practice model would support the multiple subjective dimensions

Figure 14 Health Visitor’s Understandings of DVA Among BME Women ‘Original in Colour’

6.6.1 Reflective Account

The researcher came to the study initially with experience in health-visiting, supporting women who were affected by DVA and later providing strategic guidance in this area of practice. The approach adopted reflects the researcher’s own political beliefs that are shaped by the ontological perspectives of a postcolonial heritage that is embodied within the racialised, gendered, and socio-political realities which shape our social world. Knowledge gained from clinical experiences and personal encounters with BME women as well as working from the vantage point of front-line and strategic service delivery provided the background for this research and ultimately influenced the context which inspired the political nature of this research.
The experience of engaging with the research process was occasionally challenging and frustrating, partly because of my own experience as a new researcher, developing new skills and engaging with the difficult subject matter. I also found the experience rewarding and learned a great deal about the research process. I am particularly aware of the significant personal and professional growth which has ensued from my interactions and discussions with the HVs, my academic supervisors and my engagement with the practical aspects of this work; in particular, I value the HVs who entrusted me with their views, especially those HVs who challenged the essence of my work with their own ideas about the issues discussed.

I entered the research process in search of a particular truth about knowledge however, by immersing myself within the research process and the practice of refection. I came to realise that my knowledge about the gendered nature of reality could not be explained by patriarchy alone. Instead my epistemological position shifted towards the complex interplay of social identities and social relationships espoused by postcolonial feminism. The process of conducting this research, using a postcolonial lens to research the topic of DVA, was both surprising and rewarding. For instance a personal journey of discovery led to a greater understanding of my postcolonial heritage and identity, however as noted in Chapter Five, my professional distance from my professional identity as an HV as well as a non-academic researcher created specific features of professional isolation, which are identified by Collins (2004) and Hanson (2013) as the 'outsider within'. In particular, I struggled to manage the contradictions of my own political ideas on health inequalities with the realities of the NHS health reforms and the neoliberal policies described throughout this thesis and this often led to tensions between theoretical ideas and health practice realities.

The process of writing was often difficult and painful. This was partly because of the complexities of adapting the densely theoretical ideas of postcoloniality to nursing practice but, for the most part because of the realities of responding to the traumatic nature of DVA within my research and professional life. The critical reflective process also drew my attention to the possibility of the risk of secondary traumatic stress and/or vicarious trauma as outlined in Chapter Four (Crothers, 1995; Robinson et al, 2003; Baird, 2003; Munger et al, 2015; Humphrey, 2016; O'Mahony et al, 2016; Taylor et al, 2016). The literature suggests that this kind of
traumatic response to hearing and thinking about horrific events can continue well after the encounter. I was certainly aware of my own vulnerabilities, particularly during the process of data analysis (see full discussion in section 4.3.2).

I experienced both my supervisors as supportive and this often helped to place the importance of my work into perspective. The processes of reflection and writing were cathartic yet I often found it difficult to capture the essence of what I was feeling, although this improved over time. Nevertheless, these experiences led me to focus on the very personal and professional agenda needed to challenge this type of violence.

The knowledge underpinning contemporary imperialism and postcoloniality is only just emerging in the research process, however, it has encouraged researchers to look again at old problems with a new understanding. It is also a powerful tool which holds the potential to interrupt ideas about power in the research process although, surprisingly, this is not widely utilised by European educational health institutions. This is noted by Racine in her work in public health with first- and second-generation Canadian immigrants.

"The researcher’s commitment is to re-present data, not to contribute to Othering the marginalised knowledge in an alternative dominant discourse. Thus recognising that racism, gender discrimination and classism are not mere constructions of the mind but exist in the real world" (Racine, 2003, 94).

The findings from the data helped to illuminate how assumptions about social identities can impose particular labels but can also reflect the realities of individual experiences, however, it was sometimes difficult to escape the binaries that shape postcolonial identities. Furthermore, the attention paid to the intersectionality of BME women’s lives and the diversities of BME women’s positions aided an understanding of how diversities helped to repudiate the homogeneity imposed by the construction of binaries and Otherness.

The ideas of hegemonic power indicate that this research is a form of representation and resistance and a similar view of HV practice to address DVA is observed, particularly in their work with BME women. The parallels are also discernible in the practices of interviewing, which are reproduced in this study, and are still remains critical aspect of HV work. These contexts expose the intersecting boundaries between theory and practice. A postcolonial feminist lens provided the context through which to examine different kinds of encounters and to interpret
them using key concepts within the intersectionality of BME women’s lives in order to understand the hegemonic nature of the professional relationships. Key guidance within the interpretative and analytic phase was provided by Jackson and Mazzei who argued:

"Qualitative data interpretation and analysis does not happen via mechanistic coding, reducing data to themes, and writing up transparent narratives that do little to critique the complexities of social life: such simplistic approaches preclude dense and multi-layered treatment of data" (Jackson and Mazzei, 2012, p1)

The process of interpretation is integral to the research process, although it is often complex and difficult to articulate. It is also a crucial site of power for the feminist researcher, which raises ethical and epistemological concerns in the context of emancipatory research. Kirkham and Anderson (2010) argue that the process of social justice research illustrates the tension between advocacy and the interpretation of data, which are linked during the interpretative phase, and this dilemma of which I was acutely aware.

Part of the resistance strategy of this research sought to address the issues through development of organisational policies, procedures, education and training in professional practice. Using the experience and knowledge gained from this research I have had the opportunity to develop and heavily influence polices and practice education within my professional life. This has been achieved by working with BME women, as well as by influencing colleagues, including at the management level to adopt an intersectional approach to policy development. These actions not only help to address the gaps between research and clinical practice when addressing DVA (Peckover, 2007; Siddiqui and Patel, 2010; Sokoloff and Pratt, 2013) but also provide a platform from which issues about ethnicity, sexuality, religion and politics are prioritised. Within my own place of work, the identification and reporting of DVA has increased 100% with issues of DVA now prioritised on the Trust Safeguarding agenda.

6.7 Contribution to Knowledge

Previous research investigating HV’s knowledge of DVA has used either qualitative or feminist methodological approaches which focused on the gendered nature of practice knowledge. This study has focused on HVs’ understanding of the interconnectedness between the gendered, racialised and political context in
which HVs work with BME women. Consequently the findings contribute new knowledge for HVs’ practice in identifying DVA in BME communities that had not previously been described. The following aspects of the findings of the study make original contributions to HVs’ knowledge and practice:

1. The study shows that HVs rarely uncover DVA when asking women to disclose. However postcolonial feminist appropriation of the Subaltern show the extent to which HVs are implicated in speaking with and on behalf of BME women about DVA.

2. The findings revealed that HVs knowledge of BME women’s experiences of DVA reflect a complex yet gender inclusive perspective that is consistent with the intersectionality of the gendered, political and racialised context of their work to address the issue.

3. Institutional culture as well as knowledge and perceptions about race, gender and politics influence HV’s capacity to uncover DVA and reveal the chaotic nature of the practice to uncover DVA.

4. Professional relationships during encounters to respond to DVA disclosure were found to be a contradictory form of hegemonic representation. HVs’ practice knowledge when utilised to define, identify and respond to DVA is observed as complex, chaotic and often contradictory.

These contributions to knowledge draw attention away from the gendered, psychological and child protection approach to defining, identifying and responding to DVA. HVs’ knowledge of BME women’s experiences of DVA supports an intersectional model of understanding which describes DVA as intertwined with the hegemonic powers in personal relationships and within institutions.

The notion of an intersectional framework for understanding DVA is not yet visible in the health-visiting discourse, and is not always discernible by the HVs themselves. However, the concept of intersectionality and the hegemonic location of their practice for addressing DVA emerged as dominant features of their work. This research study indicates that intersectionality frameworks for service delivery
and an explanation of practice knowledge of DVA are required. These findings also have implications for HV and other health and social care professions, including undergraduate and postgraduate clinical education, practice and research.

6.8 Recommendations and Conclusions

This study demonstrates that HVs’ practice experience and knowledge of DVA reflect an intersectionality-oriented model. The HVs described their encounters with BME women to identify and respond to DVA. Although each participant demonstrated different levels of interaction and engagement with the practice of routine enquiry, key principles from an intersectionality framework are identified in practice knowledge. The findings reflect a small number of participants; however, the recommendations are embedded in the proposed framework outlined in figures: 14 and 15.
Figure 15 An Intersectionality Framework for Identifying and Responding to DVA 'Original in Colour'
6.8.1 Recommendations for Policy

The representation and intersectionality of women’s experiences should be actively reflected in the decision-making processes within commissioning and service levels for the allocation of social care resources and evaluation of service provisions. A new integrated community approach might be trialled, taking into account the views and participation of the women in policy development.

6.8.2 Recommendations for Practice

HVs’ core assessments of health needs should be informed by and reflect an appropriate assessment tool that represents the multiple diverse contexts in which BME women live regardless of race or ethnicity.

There is a need to develop a practice model for identifying and responding to DVA in the lives of BME women, taking into account the conceptual framework which integrates the understandings of how women’s identities intersect, alter and change according to their political positions.

Continuing professional development should engender the knowledge and skills that focuses on the intersectionality of DVA in BME women’s lives as integral to understanding health inequalities.

There is an urgent need to evaluate the use of the DASH-RIC tool to ensure that understandings relating to BME women’s help-seeking behaviour are reflected in the assessment tool. Training on the use of the revised tool should be a mandatory part of all HVs’ professional development.

Existing assessment frameworks, such as child protection and EPDS should reflect the diverse context in which DVA occurs and how experiences of mental illness and child abuse intersect with DVA and experiences of racism.

Conditions for confidential routine enquiry with victims/survivors should be created within community-based services and, in particular, the context in which HVs work with all women.
6.8.3 Recommendations for Education

Curricula for undergraduate nurses should include the systematic and progressive introduction of knowledge and skills to instil in them the confidence to ask all women and especially BME women about DVA in practice.

Knowledge about the intersectionality of race, genders politics and DVA should be embedded within the health community-based theoretical framework that will promote discipline-specific and multi-agency dialogue within family healthcare services.

This might open up the space for specialist safeguarding nurses and safeguarding supervisors to develop knowledge and skills in this area of practice and for knowledge in this area of practice to be embedded within routine safeguarding training.

6.8.4 Recommendations for Research

The findings of the study suggest an urgent need to understand more about the victimisation process and resistance strategies adopted by BME women.

In light of the findings and HVs’ assessment of their knowledge deficit and gaps in practice, further research might seek to identify effective education programmes to support the understanding of differences between women. This could help to elucidate how women may respond to HVs’ practice in seeking to uncover DVA in not just BME women but applied to the context of diversities for all women.

Opportunities for methodological advance using postcolonial feminist research methodology and, in particular, Intersectionality methodology, should be promoted, applying different methods of data collection when researching the lives of BME women and where applicable to issues of diversity.

Service evaluation should be applied to the DVA service model that is provided by HVs in an inter-professional context.

Finally, there is an urgent need to revise how internal management reviews of all SCRs and domestic homicide reviews are conducted in clinical practice and, in particular, to understand the psychological and professional impact upon HVs and the context in which learning from the reviews takes place. As the evidence in this research has shown, learning outcomes from traumatic cases provide very little
incentive for HVs to take a proactive approach to addressing the issue and can often impact upon some practitioners in an enduring way.

All the HVs considered the lack of resources available to address DVA in the lives of all women and in particular in the lives of BME women as being of primary importance. However, based upon the current economic climate and reformation progress within the NHS, the practice of uncovering DVA should be embedded within the wider restructuring and prioritising of health needs in order to minimise the need for additional resources.

A number of the aforementioned recommendations from this study have been acknowledged and implemented by the researcher’s employers. These have been evaluated with positive outcomes in improving services for women. A bespoke DVA training programme is now available to a workforce of over 8,000 employees; together with specialist DVA roles, and a re-evaluation of safeguarding supervision a multi-agency safeguarding action plan now prioritises DVA and emphasises equality and diversity. Preliminary audit results show that there is an increased identification and referral of DVA cases across all social groups. The multi-agency strategy produced as a result of this work has now been adopted and includes co-signatories from five local authorities.

6.8.5 Dissemination of Learning

I intend to disseminate the knowledge gained from this research in the following ways:

- Peer reviews in both BME focus and mainstream journals
- Health and social care conferences (specific to BME as well as all women).
- Health and social care journals
- Serious case reviews (specific to BME women)
- Health visiting forums (specific to BME women as well as all women)
- Social media including tweeting and Facebook account.
- Specialist MARAC forums (specific to BME women).
- BME women forums
- Health, social and academic conferences.

In particular, the outcome of this study will be shared directly with the HVs who participated in this study either via individual briefing or at the regular health-visiting forum. The work thus far has been met with enthusiasm following
presentation at a number of local and national conferences. Much of the knowledge gained from this study has contributed to and produced a number of health-visiting practice policies, procedures education and training. I am particularly keen to pursue postdoctoral opportunities to further this work within health leadership and policy development.

6.9 Conclusions

This research understands HV work with BME families as a form of hegemonic power which regulates and legitimises particular Eurocentric ideas on social and political identities. It draws attention to how hegemonic representation of DVA experiences is superimposed by organisational culture and a strong prescriptive and consensual nature underpinned by the regulatory and salutogenic context of HVs’ work with BME women in addressing DVA. The idea of hegemonic representation is attributed to Gramsci (1971) and his ideas on pervasive power ideology reproducing dominance via force and consent. The structure of knowledge and practice ideas underpinning HV practice is observed as a form of hegemonic representation but also implicates HVs’ work in exposing and challenging male violence as a form of resistance (Belenky et al, 1997; Whitehead, 2001; Chinn and Kramer, 2015).

The examination of HVs’ practice of uncovering DVA in BME communities has contributed to the existing scholarship. The analysis, which focused on the micro-levels of HV practice, illustrates a number of gaps and differences, confusion, chaos, and duplicity in the understanding of how issues relating to ethnicity and the socio-political location of the women intersect and influence experiences of DVA. This can be attributed to the application of postcolonial feminist theoretical perspectives to a practice issue. An examination of the micro-practices of HVs’ encounters with the women revealed how the internal political apparatus of coercive discipline within the formation of multi-agency practices regulates outcomes and enforces disciplinary responses to the victimisation/survival strategies adopted by BME women. However, applying the analysis to HVs’ day-to-day practices in this way represents a new epistemological insight which helped to conceptualise HV practice of uncovering DVA as a form of hegemonic representation. The crucial issue within this argument is whether these contradictions might be overcome. The argument which notes HVs’ work as a form of hegemonic contradiction permits the understanding of a form of apolitical
consciousness that relies upon a common code of political passivity which is embodied within the strategy that avoids actions designed to uncover DVA. These contexts have also drawn attention to the knowledge base that underpins HVs’ work, the need for further research in this area of practice and a coherent strategy to address differences between women’s experiences of DVA.

Approaching the study in this way has enabled me to bring to light a practice issue that was linked to my professional encounters with the women and it has challenged my own practice in relation to the political representation of BME communities within healthcare settings. Furthermore, HVs’ conversations validate the work of the feminist activists who argued against a multicultural perspective and called for the problem to be framed within the wider context of Violence against Women and Girls. These findings are significant in relation to DVA in the HV discourse. Although implied in practice, Frost (1999) and Peckover’s (2007) way of addressing BME women’s experiences has never before been articulated in HV practice knowledge and processes. Furthermore, this finding provides evidence of a steady increase in HVs’ overall knowledge and awareness of the ubiquitous nature of the problem and the extent to which the problem previously remained hidden. These contexts represent an original contribution to the HV discourse which, although implied, has never before been articulated within the HV literature. It is nonetheless a compelling notion which suggests how social change within marginalised groups can be hindered by the absence of an appropriate knowledge base through which to uncover health disparities and guide service delivery.

The data from this study were sufficiently convincing to support the proposal for an intersectionality model of understanding as discussed in Chapter Three and Five and further elaborated by McCall (2005), Collins (2009), Wingfield (2009), Nixon and Humphreys (2010), MacDowell (2013), Sokoloff and Dupont (2013), Ken (2010), and Bradbury-Jones and Broadhurst (2015), which has been applied within the wider context of healthcare settings by Anthias (2012), Yuval-Davis (2006), Anderson (2006) and Racine (2015). The analytic focus, which adopts an intercategorical approach that does not privilege gender, conceptualises a much broader and gender-inclusive understanding not necessarily visible within the dominant discourse of DVA. This perspective underestimates neither the value of a patriarchal framework nor the gendered context in which DVA occurs, rather, it
provides a space within feminist discourse from which the voices of marginalised groups can be heard.
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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BME</td>
<td>Black And Minority Ethnic</td>
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<td>CAF</td>
<td>Common Assessment Frame Work</td>
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<td>CPHVA</td>
<td>Community Practitioners And Health Visitors Association</td>
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<td>CSEW</td>
<td>Crime Survey for England and Wales</td>
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<td>DHR</td>
<td>Domestic Homicide Review</td>
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<td>DVA</td>
<td>Domestic Violence And Abuse</td>
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<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HBV</td>
<td>Honour based violence</td>
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<td>HMIC</td>
<td>Her Majesty’s Inspectorate of Constabulary</td>
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<td>HV</td>
<td>Health Visitor</td>
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<td>IPCC</td>
<td>Independent Police Complaints Commissioner</td>
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<td>MARAC</td>
<td>Multiagency Risk Assessment Conference for domestic violence</td>
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<td>NHSE</td>
<td>National Health Service England</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute For Health And Social Care Excellence</td>
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<td>ONS</td>
<td>Office Of National Statistics</td>
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<td>SBS</td>
<td>Southall Black Sisters</td>
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<td>SCR</td>
<td>Serious Case Reviews</td>
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<tr>
<td>SCPHN</td>
<td>Community Practitioners in Public Health Nursing</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UNICEF</td>
<td>United Natation Children’s Fund</td>
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<tr>
<td>OUB</td>
<td>The University Of Brighton</td>
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<tr>
<td>WAFNI</td>
<td>Women’s Aid Federation Northern Ireland</td>
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<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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GLOSSARY

Caseload Profiling: A systematic auditing of the caseload demographics to assess the levels of health and social needs of the local population.

Domestic Abuse, Stalking and Honour-based Violence Risk Identification Checklist (DASH-RIC): A national multi-agency domestic violence risk assessment tool used to identify the level of risk to which a victim is exposed.

Female Genital Mutilation: Female genital mutilation (FGM) is defined by the World Health Organisation (WHO) as “the range of procedure which involves the partial or total removal of the external female genitalia or other injury to the female genital organ whether for cultural or other therapeutic reasons.

Honour-Based Violence: This can be described as a collection of practices that are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

Listening Visits: A series of planned therapeutic home visits undertaken by health visitors for the purpose of uncovering emotional needs. The principles of health visiting are embedded within the contacts; however, the purpose is to enable the woman to reflect upon emotional concerns and goal-setting to overcome them.

London Safeguarding Children Board (LSCB): A statutory body that is responsible for ensuring that all agencies working with children, young people and families work well together to promote the safety of children.

MERLINS: Police intelligence notifications containing information on criminal offences committed by and safeguarding risks associated with individuals who have close contacts with children and vulnerable adults.

Multi-Agency Risk Assessment Conferences (MARACs): Safety planning meetings where information is shared on the highest-risk domestic abuse cases between representatives of the local police, health, child protection and housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
**New Birth Visits:** Statutory assessments of all families in the UK following the birth of a child. The visits are undertaken by a health visitor between days 10 and 14.

**Routine Enquiry:** A process used by front-line health professionals to ask women to disclose incidents of domestic violence and abuse during all contacts.

**Safeguarding Supervision:** A mandatory procedure for quality assurance via peer support to ensure that quality and standards to protect vulnerable families on health visiting caseloads are upheld.

**Serious Case Review (SCR):** A forensic analysis of serious neglect, abuse and homicide (often relating to DVA); the purpose is to provide a critical review of individual and/or collective actions of professional involvement with the victim. A critical element of a Serious Case Review is to implement the learning outcomes to prevent a similar tragedy from happening.

**Vulnerable Persons Caseloads:** Families or individuals with multiple social and/or medical needs requiring additional support and intervention from more than one statutory agency.
Appendices

Appendix 1: Participants Information Sheet Research

**RESEARCH TITLE**: Exploring Health Visitors’ Understanding of Intimate Partner Violence in Black and Minority Ethnic Communities.

Thank you very much for your interest in my research project. Before deciding to be part of this project, it is important you understand exactly what the research will involve.

Please read carefully through the following information - it is in 2 parts:

**Part 1**: Explanation of the purpose of this study, and what will happen if you decide to take part.

**Part 2**: Further detailed information about the conduct of this study.

Please do not hesitate to contact me at any time for further clarification on any aspect of this study.

**Part 1 What is the purpose of this study?**

The purpose of this study is to explore the Health Visitor's understanding of Intimate Partner Violence (IPV) in Black and Minority Ethnic Women (BME), and how the Health Visitor facilitates disclosure from this client group.

The aim is to gain a better understanding of the gaps in disclosure of IPV to Health Visitors and to provide an insight into how best to address these issues. This study is also part fulfilment of my professional doctorate degree.

Please read the attached abstract of this study in conjunction with this information sheet. The abstract contains the summary of this project.

**Why should I take part?**

Health Visitors have an important and key professional relationship with the BME women they visit or are in contact with, and consequently have unique access to them.
Intimate Partner Violence is a significant part of the safeguarding caseload for each Health Visitor, and you, as a Health Visitor, are in a unique position to participate and influence this area of practice through your participation in this study.

To date, little is known about the dynamics within this professional relationship, the reasons for under-reporting by BME women, or the reasons why so few Health Visitors identify these victims of IPV.

Participating in this study will contribute towards a much better understanding of this phenomenon and facilitate best practice in addressing the health inequalities in this client group now and in the future.

**Do I have to take part?**

No, it is entirely your choice to decide whether to take part or not.

If you would like to take part, please retain this information sheet, and sign and return the consent form to me.

If at any point in time you wish to withdraw from this study you are free to do so (up to the beginning of data analysis), and without the need to offer any reason.

**What will happen to me if I take part?**

You will be one of 20 Health Visitors selected from 2 different NHS Community Trust sites.

Your data will be collected during semi-structured face to face or telephone interviews, lasting approximately 1 hour. The interviews will be audiotaped, alongside written field notes. The recordings will be later transcribed, made anonymous, and stored in a sealed envelope that will be placed in a locked secure storage cabinet.

All electronic data will be password protected, and where necessary, storage devices will be encrypted.

Computers used for this study will only be accessible to the researcher of this project and will contain anti-virus and firewall protection.
In some instances, it might be necessary for me to contact you for further clarification. This is to ensure that your views are clearly represented or to seek further understanding of the issues discussed. You will be required to give your name, contact number and your ethnicity. The ethnicity data is to ensure that views of all Health Visitors are represented within this study.

Personal details will not be published as part of this study. No identifiable details will be published, and where necessary, pseudonyms will be used.

During this study you will not be asked to give client details or any information that will breach patient confidentiality.

You will be given full details on how to raise concerns if you are unhappy with any part of the conduct of this research.

How long will this study last?

I anticipate interviews to commence in May 2012, with conclusion of your part in this study by December 2012. You will only be required to attend an interview on one occasion. However, in some instances it may be necessary to contact you via telephone for further clarification of data from this interview. Verification will only relate to existing data.

The Analysis and Write Up of this study will conclude in December 2014.

At the end of this study, you will be notified and offered a presentation of the findings of this study in a location convenient to you.

What are the possible disadvantages and the risks of taking part?

There are no known disadvantages to taking part in this study. However, it is acknowledged that this is a sensitive issue therefore discussions relating to this topic could evoke feelings of distress. In such instance, the interview may be terminated if it is evident that you are experiencing distress.

In the unlikely event that the interview is terminated, all data pertaining to your interview will be destroyed according to the University of Brighton Guidance on Handling Personal Data.

You will also be encouraged to contact your Occupational Health Department or your General Practitioner, for support.
It will be agreed with your employer that you can participate in the interview during your working hours, as long as this does not disrupt your day-to-day duties.

Interviews will be conducted in a private office in your area of practice to minimise disruption and to ensure confidentiality.

Where necessary the interview could be conducted over the telephone but will still be audiotaped.

How will disclosure be handled?

All information will be treated with the strictest of confidence except where safeguarding/legal concerns are disclosed, such as a crime being committed where a vulnerable child or adult life is at risk. The mechanism for such consideration is based upon the safeguarding risk assessment framework currently used in Health Visiting practice, and can be found in The London Safeguarding Procedure, 2010, and in Section 47 of the Children's Act 1989 & 2004. (Please see attached).

In cases of suspected safeguarding concerns where a vulnerable person life is at risk, the researcher is obliged by law to escalate these concerns to the Safeguarding Lead and or the Police; using the National Safeguarding Reporting Procedure to initiate a (Section 47; The Children' Act 2004) referral. All disclosures will be handled in accordance with your local Trust policy on handling safeguarding disclosure. In such instances, you will be informed of the actions beforehand and the incident will be discussed with my academic supervisor. Depending on the nature of disclosure, it may become necessary to discontinue your participation from this study.

What are the possible benefits of taking part?

This study provides an excellent opportunity to further and more fully explore the current understandings of Intimate Partner Violence in BME communities and to share knowledge of best practice. It is anticipated that this study will offer a major contribution to the understanding of why so few BME women actually disclose to their Health Visitors.
More importantly, it is anticipated that the findings will offer a major contribution to ways of best addressing the gaps in disclosure rates, and in the longer term, address the adverse health impact of IPV.

The findings will be available to policy makers, educational institutions and a wider audience via national and international publication.

The aim is that the knowledge gained will be used to best address the health inequalities and health consequences for this particular client group.

Will I be eligible to participate in this study?

In order to meet all the criteria necessary for participation in the study, and to maintain the integrity of this research, you must meet the following:

1. Accessing child-protection supervision to minimise the risk to families on your caseload and maintain the integrity of the research. Child-protection supervision is a mandatory requirement for all Health Visitors who are having direct patient contact. This process is also embedded within the statutory and safeguarding framework of The London Procedures 2010 and Children ‘Act 2004.

2. You must be directly managing your own caseload.

3. You must not be undergoing performance management or disciplinary procedures relating to your clinical practice.

4. You must also be able to fully understand this project and be able to consent to take part in this study.

5. You must be available for one to one discussion about this project or be able to attend the presentation. This is an essential requirement to ensure that you are given the opportunity to scrutinise this project in full and make an informed decision about participating.

The next step?

Take time to consider this proposed project.

Once you are satisfied that you fully understand this project and decide to participate, simply complete the enclosed consent form and return it to me.
in the prepaid envelop provided. I will then contact you to organise a time and date for the interview.

Should you need more information about this study, please do not hesitate to contact me.

Please also note that attendance to the planned presentation is an essential criterion for participating.

What happens when the research study finishes?

If you wish, we will send you a summary of the findings when this research project is complete.

You will also be invited to a presentation of the preliminary findings.

The information will be disseminated for publication and will be available to service users, commissioners and service providers.

All personal information such as names, ethnicity and contact numbers will be destroyed within 3 months of completing this study by shredding and in accordance with the University of Brighton Confidential Waste Disposal Guidance. This can be found at www.brighton.ac/hss/fregc.

Anonymous data will be stored for 3 years following completion of this study.

Storage of up to 3 years will enable the researcher to clarify concerns and verify data where needed. This will not be used for further research. The storage will comply with the Data Protection Act 1998 and the University of Brighton Data Storage and Handling Guidance.

Data stored on electronic devices will be encrypted, and password protected with regular anti-virus and firewall protection. A website will be created where progress and information about this project can be found. This will be sent to you following ethical approval.

No data will be stored on public computers.

The website will be created by the University of Brighton Information Technology Department, and will not contain any personal data relating to this research. It will be used only to advertise this research project and to
provide updates on the progress of this study. The information for the website will be scrutinised by the University of Brighton Faculty Research Ethics Governance Committee.

**Part 2 What if there is a problem?**

It is unlikely that you will encounter a problem.

I will be conducting the interviews, with access to a Steering Group and 2 Academic Supervisors, for advice and support. This will ensure that this study is conducted in a safe and ethical manner.

All information will remain confidential (except for safeguarding disclosure, as outlined in Part 1). In some instances, it may be necessary for my Academic Supervisor to have access to your anonymous data.

The Steering Group will provide advice because of their experience in supporting BME women with IPV, but they will not have access to the research data.

This research is approved by the University of Brighton Research Planning Approval, Faculty Regulatory Ethic Governance Committee, your local Research and Governance Department, and the NHS Integrated Research Approval System. However, if you have any concerns regarding the conduct of the researcher, this can be referred to your Governance Department and the University of Brighton Faculty Research Ethics and Governance Department.

Concerns about the conduct of the research can be raised in the first instance to:

**Professor Julie Scholes**
FREGC Chair
Centre for Nursing and Midwifery Research
Mayfield House 266
Falmer, Brighton, East Sussex, UK
BN1 9PH
Tel: +44 (0) 1273 644029
Email: j.scholes@brighton.ac.uk.
Will my taking part in this study be kept confidential?

I will only have access to all the information collected during this project, and in some instances, my Academic Supervisors will see the anonymous data. (Names, addresses and contact details will not be shared with Academic Supervisors).

All the information will be kept on a secure personal computer, only accessible to me with and with secure password protection. All information you provide will be treated confidentially and you will not be identified in any report or publication arising from this project. No identifiable data will be published and all quotes will have pseudonyms.

What will happen to the results of this study?

At the end of this study the researcher will send a report of the findings for publication.

This study will be presented at health conferences and nursing forums, and to patient representative groups.

This information will also be accessible to the public including your employer.

I will be happy to present the findings to you personally and at a location convenient to you.

Who is organising and funding the research?

This research is being completed as part fulfilment of my professional doctorate studies at the University of Brighton with some financial support from my employer, North East London Foundation Trust.

To participate in this study you must agree by signing the enclosed consent form. Please retain a copy of this information sheet and consent form for your information.
Appendix 2: Consent To Participate In the Study

CONSENT FORM

I agree to take part in this research which is to;

Explore Health Visitors’ Understanding of Intimate Partner Violence in Black and Minority Ethnic Communities.

NAME OF RESEARCHER; Norma Sarsby

The researcher has explained to my satisfaction the purpose of the study and the possible risk involved  YES  NO (delete as appropriate)

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to data analysis, without giving reason.

3. I agree to take part in the above study.

Please initial box

4. I agree to the interview consultation being audio recorded

5. I have received information on how to complain about the conduct of the research if necessary

6. I agree to the use of anonymised quotes in publications

7. I agree that my current practice meet the inclusion criteria outlined in the participant’s information sheet and that I am eligible for participation in this study.

8. I have been given clear information on the handling of serious safeguarding risk disclosure that may arise during interview.

9. I agree that anonymised data may be stored for up to 3 years following completion of this study.

Please tick box

Yes  No

Name of Participant  ____________________________  Date  ____________________________  Signature  ____________________________

Name of Researcher  ____________________________  Date  ____________________________  Signature  ____________________________
Appendix 3: Risk Assessment And Risk Management Strategy

Risk Assessment

Please tick the appropriate boxes.

Will the research study involve:

1. Causing participants physical damage, harm or more than minimal pain?  
   Yes   No X

2. Manual handling of participants, vigorous physical exercise, or physical activity from which there is a likelihood of accidents occurring?  
   Yes   No X

3. Intrusive physiological or psychological interventions or procedures? These might include: the administration of drugs or other substances; taking samples (e.g., blood, saliva or urine) from participants; use of probes or other equipment to measure or monitor bodily performance; techniques such as hypnotherapy.  
   Yes   No X

4. Exposure of participants to hazardous or toxic materials, such as radioactive materials?  
   Yes   No X

5. Inducing psychological stress, anxiety or humiliation?  
   Yes   No X

6. Questioning of participants regarding sensitive topics, such as beliefs, painful reflections or traumas, experience of violence or abuse, illness, sexual behaviour, illegal or political behaviour, or their gender or ethnic status?  
   Yes X   No

7. Vulnerable groups of people, for example children, people with learning disabilities or mental health problems?  
   Yes   No X

8. Groups where permission of a gatekeeper is normally required for access to its members, for example ethnic groups?  
   Yes   No X

9. Access to records of personal or confidential information?  
   Yes   No X

10. Any other risk not identified above  
    Yes X   No

Sufficient safeguards and monitoring procedures must be put in place in relation to any anticipated risks. If you answer “yes” to any of the above questions, you should describe the safeguards and monitoring procedures in place on a separate sheet of paper and attach it to this application form.
TITLE: Exploring Health Visitors’ Understanding Of Domestic Violence and Abuse In Black And Minority Ethnic Communities

Potential Safeguarding Risk And Strategy For The Research Project

Participants will be asked to talk about their understanding of supporting BME women who are victims of intimate partner violence. The interview will not ask health visitors to talk about their personal experiences of intimate partner violence and personal patient information will not be discussed (please see questionnaire schedule document). I have outlined a series of actions and measures in the event of disclosure or safeguarding concerns about participant's clinical practice. It is recognised that this is a sensitive topic therefore it is likely that the interview process might evoke psychological distress for participants. I have outlined a number of potential risks in the paragraph below as well as proposal for minimising and managing concerns.

POTENTIAL RISK AND ETHICAL CONSIDRATION;

1. Potential impact on resources where participants might be asked to take time off work to participate in the study.
2. Participants may become distressed during the interview. The sensitive nature of the subject means that discussion may evoke memory of distress.
3. Participants may disclose risk of violence to a vulnerable child or adult on their caseload whose life is at risk.
4. Due to the small number of participants there is a potential that may be identified from the data.
5. Participants might be overheard during confidential discussion.
6. Risk of further stigmatising BME women by targeting them as a site for research.

MINIMISING THE RISK IN RESPONSE TO THE ABOVE

1. The researcher will travel to participant’s place of work to minimise disruption to participants’ caseload. The interviewer will pay particular attention to the timing of the interview which is approximately 1 hour. Where necessary, interviews could be conducted over the telephone to minimise the impact on resources. Clinical leads and participants will be given full information about the timing and location of the project. The interviews will not take place at participants’ residence or outside the designated NHS premises allocated for interviews. Conducting research on designated NHS sites will also ensure the physical safety of the researcher and participants.
2. Participants will not be asked to give personal details relating to caseload or themselves (please interview schedule questions). Interviews may be terminated if participants become distressed or show signs of emotional trauma during the interview. In the unlikely event that the interview is terminated, all data pertaining to the terminated interview will be destroyed according to the University of Brighton confidential waste management protocol such as shredding in a safe building. If the interview is terminated due to emotional distress, participants may be withdrawn from the study and they will be encouraged to access psychological support from their GP or from their occupational health department. Each research site provides dedicated psychological support employees which can be accessed through a self-referral process to the respective occupational health department in confidence. Academic supervisors will be informed for debriefing and review and I will also access psychological support through my employment occupational health department if necessary. This service is also a confidential self-referring process and personal details relating to this incident will be kept strictly confidential. The contact number for the occupational health department will be provided for participants if needed.

3. In the event of a practitioner disclosing knowledge of harm about a vulnerable person on their caseload who is in danger and it is clear that a crime is being committed, as outlined in risk number three above; the following actions will be taken; The practitioner who is making the disclosure will be informed that I will notify the local safeguarding contact through a Section 47 of the Children’ Act [1998]; [2004] referral. The University of Brighton academic supervisors will also be notified. Handling disclosure will be fully outlined in the participant information sheet document.

4. In order to minimise the risk of identification, participants will be recruited from two community health Trusts. The interviews will be conducted in a private room on NHS sites where details of the discussion cannot be overheard by others. Personal information such as names, contact telephone number and location of work will not be used within the data. This information will be kept in a locked cabinet at all times and will only be used for the purpose of this research. No direct quote that could potentially lead to identification of participants will be published and where it is necessary to use direct quotes, this will be anonymised. All personal details will be destroyed three months after the completion of the study or
three months after the study is terminated. Anonymised data will be stored for 3 years following publication. Storage of up to three years will enable the researcher to clarify concerns and verify data if needed. The storage will comply with the data protection Act 1998 and the University of Brighton Data storage and handling guidance. Data stored on electronic devices will be encrypted and password protected with regular anti-virus and firewall protection. After 3 years all data will be destroyed by shredding or incineration.

The storage of data will fully comply with the University of Brighton Guidance on handling personal information and in accordance with the Data Protection Act [1998]. This means that data such as audio tapes and written transcripts will be stored in a locked cabinet at all times when not in use. Information stored on electronic devices will be password protected and where possible encrypted.

5. All interviews will be conducted in a private room where details of discussions cannot be overheard. All participants will be given full and detailed explanation of the project to ensure informed consent. Every effort will be made to meet with participants to answer any potential question they might have. All health visitors who agree to take part in the study must be accessing child protection supervision. This is because the process of child protection supervision is designed to give one to one risk assessment of the management of vulnerable and safeguarding caseload, as well as monitor key function such as professional development, clinical practice and to guide and support the management of difficult case-load (The London Procedures, 2010). Health visitors who are undergoing performance management will not be included in the project. Potential participants who show an interest in the project will be given a minimum of at least two weeks to decide. This is to ensure that they have taken the time to read the information sheet and scrutinised the project. All participants will be given full information on how to take action if they have concerns about the conduct of the research. I am not employed by either participating Trust and currently do not have an association with potential participants. All contacts for the research are dedicated number and email sites and will not include my personal contact.

In order to meet the criteria for participation in the study and to ensure the integrity of the research, you must meet the following;

- Access to child-protection supervision; this is to minimise the risk to families on your caseload and maintain the integrity of the course. Child-
protection supervision is a mandatory requirement for all health visitors who are having direct patient contact.

- Must be directly managing your case-load.
- Must not be undergoing performance management or disciplinary procedure relating to your practice.
- You must also be able to fully understand the project and be able to consent to take part in the study.
- One to one discussion about the project or attendance to the presentation is an essential criteria to ensure that you are given the opportunity to scrutinise the project and make an informed decision about participating.

ADDRESSING THE POTENTIAL ISSUE OF STIGMATISING BME GROUPS WITHIN THIS RESEARCH.

As mentioned within the text, targeting BME groups as a site for research could potentially lead to profiling and stigmatising an already vulnerable group. To minimise this risk during my research, I am proposing that the participant information sheet and all verbal presentations will clearly outline the rationale for the study and why this client group is being researched (please see participants’ information sheet). Further information and link to the national website supporting BME women will also be placed on the researcher’s university webpage.

I wish to acknowledge here that these measures might not be sufficient to reduce this potential risk. However, one of the criteria for participating in this research also includes access to child protection supervision. The process of child protection supervision ensures that all practitioners are up-to-date with mandatory and statutory training relating to safeguarding including IPV before they are eligible to participate in supervision. Studies undertaken by (Taket 2002; Feder, 2010 and Rose et al, 2011, found that education and training were critical factors in reducing IPV stigma. This project will also seek further guidance from the steering group on potential strategies for addressing this issue. Finally, both participating community Trusts already offer mandatory IPV training as part of their ongoing professional development for health visitors.
ADDITIONAL INFORMATION IN REDUCING STIGMA

There is no evidence to suggest that BME women are more likely to experience incidences of IPV. However a difference in the way this group of women experiences this phenomenon creates barriers to identifying and reporting during clinical contacts.
THE FOLLOWING DISTRESSED PROTOCOL TO BE USED AS PART OF ASSESSING SUITABILITY FOR PARTICIPATION;

Protocol To Follow If Participants Become Distressed During Participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in our research into PTSD, as some by definition will already be suffering from psychological trauma as a result of their previous experiences. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage.

Registered with the NMC, and so has experience in monitoring and managing situations where distress occurs. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because most of the participants with PTSD will be approached through contacts in professional services and so there will usually be an existing structure set up to deal with extreme distress which professionals can implement. However it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

**Mild distress:**

**Signs to look out for:**

1) Tearfulness

2) Voice becomes choked with emotion/ difficulty speaking
Appendix 4: Ethical Approval NHS

North East London NHS Foundation Trust

Research and Development Office
North East London NHS Foundation Trust,
1st Floor Maggie Lilley Suite,
Goodmayes Hospital,
Barley Lane,
Goodmayes,
Essex, IG3 8XJ

Date: 20th June 2012

Dear Norma Sarsby

Re: R&D #2321 - Exploring the Health Visitor’s Understanding of Intimate Partner Violence in Black and Minority Ethnic Communities

I am pleased to inform you that the above named study has been granted approval and indemnity by Professor Martin Orrell, Director of Research and Development North East London NHS Foundation Trust. You must act in accordance with the North East London NHS Foundation Trust’s policies and procedures, which are available to you upon request, and the Research Governance Framework. Should any untoward events occur, it is essential that you contact your Trust supervisor and the Research and Development Office immediately. If patients or staff are involved in an incident, you should also contact the Governance and Assurance department, in Goodmayes Hospital, and complete the Incident and Reporting Form, namely the IR1 form.

You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

Sandeep Toot
Research and Development Manager, North East London NHS Foundation Trust
Appendix 5: Ethical Approval NHS

North Central London Research Consortium
3rd Floor, Bedford House
125 - 133 Camden High Street
London, NW1 7JR

25th July 2012

Ms Norma J Saraby
59 Brent Close
Dartford
Kent
DA2 6DH

Dear Ms Saraby,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

<table>
<thead>
<tr>
<th>Study Title:</th>
<th>A Qualitative Study; Exploring Health Visitors' Understanding Of Intimate Partner Violence in Black And Minority Ethnic Women.</th>
</tr>
</thead>
<tbody>
<tr>
<td>R&amp;D reference:</td>
<td>12MHS30</td>
</tr>
<tr>
<td>REC reference:</td>
<td>N/A (REC not required as the study will interview NHS staff)</td>
</tr>
</tbody>
</table>

Barnet Enfield and Harlingey Mental Health Trust
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If any information on this document is altered after the date of issue, this document will be deemed INVALID

Please ensure that all members of the research team are aware of their responsibilities as researchers which are stated in page 2. For more details on these responsibilities, please check the R&D handbook or NoCLoR website: http://www.necton.nhs.uk

We would like to wish you every success with your project

Yours sincerely,

Mabel Sall
Senior Research Governance Officer
Appendix 6: University of Brighton research sponsorship

03 August 2016

Dear REC Committee

University of Brighton research sponsorship

I am writing to confirm that the University of Brighton will act as research sponsor as required under the Department of Health’s Research Governance Framework, for the project entitled ‘Exploring Health Visitors’ Understanding Of Intimate Partner Violence In Black And Minority Ethnic Communities’ to be carried out by Norma Sarsby (FREGC Approved Manuscript Reference FREGC-12-008.R1).

If there are any general questions about the university’s approach to research governance, please contact Hilary Ougham, Academic Research Officer on 01273 644184 or H.Ougham@brighton.ac.uk

Yours sincerely,

Prof. J. Scholes RN DipN DANS MSc Nursing D.Phil
Chair of Faculty of Health Research Ethics & Governance Committee
Appendix 7: Ethical Approval UOB

University of Brighton
Doctoral College

01273 642618

Mrs N Sarsby
59 Brent Close
Dartford
DA2 6DH

27 January 2012

Dear Norma

Application for the Research Plan Approval

I write to confirm that your Research Plan Approval has now been approved by your Thesis Panel.

If you have any administrative queries during the course of the project which are not answered by the University of Brighton Code of Practice for MPhil, PhD and Professional Doctorates, please get in touch with your Research Student Administrator, for further information. I hope the project goes well.

Name: Norma Jennifer Sarsby
School: School of Nursing and Midwifery
Research Student Division: School of Nursing and Midwifery
Supervisors: Dr K Aranda
Degree: Nursing (Professional Doctorate) (Part time)
Effective start date: 17/Sep/2009
Title of program: In what ways do health visitors understand black and minority women's experiences of intimate partner violence
Expiry date: 16/Sep/2014

Research Student Administrator

Fiona Sutton
Appendix 8 Context of health visiting work

- The search for health needs
  - Public health epidemiological data collected during contact, local and national prevalence. Provide health intelligence about local communities.
  - Local activities shape and are shaped by national policies. Caseload profiling, clinical audits, service users feedback, key performance indicators.
  - Influencing policies affecting health

- Stimulation of an awareness of health needs
  - Communicating public health messages. Health prevention strategies. Identifying 'at risk groups' in local population. Delivered through early intervention health promotion and health enhancing activities delivered through ante and postnatal visits, parenting classes, group activities.
  - Facilitating health enhancing activities

- Enhancing activities
  - Health promotion and health enhancing activities delivered through ante and postnatal visits, parenting classes, group activities.

- Facilitating health enhancing activities
  - Health promotion and health enhancing activities delivered through ante and postnatal visits, parenting classes, group activities.