Assessment of the Use of One Stop Crisis Centers to Help Survivors of Violence Against Women and Girls: the Case of Thailand

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Declaration

I, Robert James Torrance, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Date: 16th FEBRUARY 2024

Abstract

Introduction: Non-partner sexual violence (NPSV) and intimate partner violence (IPV) are prevalent in Thailand and most commonly affect women and girls. In pursuit of a coordinated, multisectoral, and trauma-informed state response to NPSV/IPV, the government of Thailand introduced One Stop Crisis Centers (OSCCs) in 1999. Despite the rapid growth of the OSCC model in Thailand, the extent to which OSCCs are meeting the needs of survivors remains largely unexplored. In this study, I sought to address this knowledge gap.
Methods: The aim of this thesis was to further our knowledge and understanding of the challenges and opportunities of using the OSCC model to help survivors of NPSV/IPV in Thailand. An exploratory study design was adopted using qualitative methods. Semi-structured interviews with OSCC staff were undertaken. OSCC staff were recruited from university-affiliated, regional, general, and community hospitals. Framework analysis adopting a thematic approach was employed to support qualitative data analysis.
Results: The findings indicated a wide range of survivor help-seeking and disclosure preferences and behaviours, although numerous, substantial barriers were identified as contributing to survivor silence. The study exposed problematic views and social norms impacting the response of OSCC staff to NPSV/IPV, including an acceptance of marital rape, survivor-blaming, and interrogation of survivor accounts. The findings also revealed institutional challenges to a trauma-informed OSCC response, including the use of untrained, non-specialised male doctors to perform forensic examinations and the unavailability of OSCC services outside working hours.
Conclusion: The study underlined the benefits of employing a social norms lens and foregrounding efforts to enhance access when seeking to improve the response of OSCCs in Thailand to NPSV/IPV. The pursuit of greater standardisation of the OSCC response and the institution of referral pathways were identified as key to addressing a wide array of the challenges identified in this study.

Integrating statement

The decision to undertake a DrPH in Public Health and Policy at the London School of Hygiene and Tropical Medicine was a consequence of my desire to transition from improving health and wellbeing at an individual level, which I sought to do daily in my role as a junior doctor, to promoting health and wellbeing at a population level. The decision to undertake a DrPH, as opposed to a PhD was due to my interest in gaining first-hand exposure to public health and policy decision-making, thus the opportunity to undertake core modules and a placement in an institution seeking to promote public health were critical to my decision to opt for this doctoral format. Supporting my transition into public health and policy, in my master of bioethics (MBE) degree immediately preceding my commencement of the DrPH, I cross-registered with the school of public health at my institution, undertaking three modules in international public health.

The DrPH programme has three components, two compulsory modules followed by two research projects, namely Research Project I or *Organisational or Policy Analysis* (OPA) and Research Project II which is the doctoral thesis. The core modules were *Understanding Leadership, Management and Organisations* (ULMO) and *Evidence Based Public Health Policy (EBPHP)*. To assess understanding of the core content of these modules I was required to submit one paper for the ULMO module and two papers for the EBPHP module. The paper for ULMO I grounded in my experiences of the challenges faced working as a junior doctor in the UK, undertaking a strategic analysis of the Accident & Emergency department at Aintree University Hospital, with a view to improving organisational efficiency and effectiveness. For the first EBPHP paper, I conducted a systematic review of interventions that promote active commuting in working-age adults. During my compulsory modules, I

commenced conversations with Melissa Alvarado at the UN Women Regional Office for Asia/Pacific in Bangkok in which we discussed the need for research on violence against women and girls (VAWG) in Thailand. Undertaking an exploration of multisectoral coordination of the state response to VAWG in Thailand emerged as both a research priority for UN Women and a topic of academic interest, given its complexity and interdisciplinary nature, which subsequently became the topic of my OPA. Therefore, for the second paper for EBPHP, I sought to lay some preliminary groundwork for my OPA, producing a paper entitled "*An Influencing Strategy to Get Primary Prevention of Violence Against Women and Girls onto the Agenda of the Thai Government.*"

To support my OPA research, I was immensely fortunate to be offered a UN Women internship, which also provided valuable exposure to national health policy-making. During my OPA, friends and acquaintances expressed an interest in the research I was conducting in Thailand and a number of those individuals courageously shared their personal stories of experiencing VAWG. These discussions led to a greater appreciation of the prevalence of this hidden pandemic and the gravity and breadth of the short-term and long-term consequences of VAWG. It became apparent in these conversations that furthering an understanding of barriers to access to support is of central importance to efforts to enhance the support that survivors receive, as only a minority of the individuals with whom I spoke about their experiences sought help from state or non-state actors.

The OPA research revealed the centrality of the one stop crisis center (OSCC) model to Thailand's national response to VAWG. Yet, an initial review of the literature generated concern that, even though the OSCC model was now well-established in Thailand, little research had been undertaken to examine the response of OSCCs to VAWG in Thailand. I

decided that the focus of my thesis would be on the OSCC model. My initial proposal was to elicit the much-needed perspectives of survivors on the accessibility and response of the OSCC model, in addition to the perspectives of OSCC staff. Unfortunately, despite considerable preparation before the data collection period, involving numerous conversations with Thai VAWG researchers, I was unable to recruit survivors for this study (see Appendix 1).

The lack of funding for my doctorate presented a significant challenge throughout my degree, necessitating that I conduct part-time consultancy work to generate income. I undertook two research consultancies on the influence of social norms on VAWG perpetration in Somalia for the United Nations Office for Project Services and a further research consultancy on women's economic empowerment in Uganda, funded by the Bill & Melinda Gates Foundation. In addition, I served as a seminar leader on master's modules at LSHTM, namely Health Systems and Health Policy, Process, and Power. In addition to providing a necessary source of income, these research projects and teaching opportunities furthered my knowledge of topic areas related to my doctoral research.

A further challenge experienced during my thesis was that in October 2022, my primary supervisor became unavailable to provide supervision, shortly before the critical data collection period was due to commence in Thailand. A replacement primary supervisor was appointed in May 2023 to provide support in the final stages of my write-up. It was explained in my first supervision meeting with my new primary supervisor that I had not collected sufficient data during the data collection period at the beginning of the year and so it was decided that I would return to Thailand to collect more data. The required number of interviews was successfully achieved in this second data collection period.

Acknowledgements

It is a privilege to have space to thank all those who helped me along my doctoral journey. It would be impossible to credit every contribution and I also have my suspicion that there have been people that have helped me behind the scenes without my knowledge so to all those I have not included in this section I offer my warmest thanks.

First and foremost, I wish to thank my family for sharing the load, offering encouragement, advice, financial support, accommodation, warm vegan meals, and washing machines along the way. So thank you, Dad, Margaret, Andrew, Julie, Peter, Maeve, David, Christine, and Granny Lipper. To my late mum Jane, your love and influence have exceeded your years. Nobody was more deserving to be here with me at the end.

I wish to thank my primary supervisor, Prof Beniamino Cislaghi for introducing me to research on violence against women and girls and social norms. I hope to continue to conduct research in these areas for the remainder of my career. Thank you Ben for your thoughtful, expert feedback and guidance, for always being available for supervision meetings, and for responding so efficiently and effectively to challenging financial circumstances by providing essential paid employment to help get me over the line with my doctorate. I could not be more grateful to you for the incredibly rewarding opportunities you facilitated, including an internship with UN women, research consultancies in Somalia and Uganda, and involvement in research for the Lancet Commission on Gender and Global Health, amongst many others.

To my secondary supervisor, Prof Anthony Kessel, thank you so much for your wise, considered, and balanced input on my various research activities, not limited to my OPA and

thesis. I could not be more grateful to you for always being available for feedback, references, signatures, supervision meetings, and (superb!) career advice, often at unreasonably short notice. On countless occasions, you exceeded your responsibilities and offered empathetic, pastoral support in difficult times. I am incredibly grateful.

To Prof Manuela Colombini, I cannot articulate how fortunate I felt to discover that a world-leading expert on VAWG and the OSCC model had kindly offered to provide supervision in the latter stages of my doctorate. But even then, I underappreciated how invaluable your contributions would be in so many ways and at so many levels. I am very cognisant of the burden that you altruistically assumed. Thank you for sharing your knowledge and for offering important and detailed feedback on written work. I suspect very few academics would be willing to join supervision meetings with a doctoral student while on holiday!

To Prof Graham Medley, thank you so much for your guiding hand, wisdom, and thoughtful inputs during a turbulent time, and for assuming significant additional administrative burdens. For going beyond the call of duty to attend supervision meetings and provide feedback on written work, I am very grateful indeed.

To Khun Kasina Limsmarnphun, thank you for kindly sharing your expertise and research experiences in VAWG and the OSCC model in Thailand. I am immensely grateful to you for your helpful input into the thesis proposal and your guidance on participant recruitment.

This research would not have been possible without the hard work and experience of the interpreters. Thank you to Dr Kornwika, Khun Panida, Khun Treesukondh, Khun Napaporn,

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To Melissa Alvarado and the Ending Violence Against Women team at the UN Women Regional Office for Asia and the Pacific, I could not be more grateful to you for a truly absorbing internship and for your substantial and varied contributions to both of the research projects conducted in Thailand. I hope that you find the research useful as you continue to work tirelessly to prevent VAWG and minimise its consequences in Thailand and beyond. Thank you Dr Montakarn Chuemchit for your guidance on research ethics processes in Thailand and for sharing valuable contacts.

To my dear friends Chang-Ho Yoon, Zaev Suskin, Andrew Bradley, Henry Cust, and Ciara Menzies, thank you for listening to my ramblings, offering emotional support and stimulating intellectual discussions, and for providing much-needed comic relief. You have now realised

your dreams of acquiring a working knowledge of the accessibility and response of the OSCC model in Thailand. Your certificates are in the mail.

My doctorate is dedicated to Pauline McConnell and her lovely family she left behind.

Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DF	Dynamic framework
DrPH	Doctor of Public Health
DV	Domestic violence
ER	Emergency room
ESP	Essential Service Package (UN)
EVAW	Ending violence against women
FDPA	Family Development and Protection Act
GDP	Gross Domestic Product
GRP	Gross Regional Product
INGO	International non-governmental organisation
IPV	Intimate partner violence
LMIC	Low- and middle-income country
LSHTM	The London School of Hygiene & Tropical Medicine
MDT	Multi-disciplinary team
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
NGO	Non-governmental organisation
OPA	Organisational or Policy Analysis
OSCC	One Stop Crisis Center
RQ	Research question
RTP	Royal Thai Police
SAMHSA	Substance Abuse and Mental Health Services Administration
NPSV	Non-partner sexual violence
TIP	Trafficking in Persons
TNS	Theory of Normative Spectrum
UN	United Nations
UNFPA	The United Nations Population Fund
VAWG	Violence against women and girls
WHO	World Health Organization

Glossary of terms

Violence against women and girls	Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.
Non-partner sexual violence	Acts of sexual violence committed by any person that is not a current or former husband or male intimate partner.
Intimate partner violence	Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.
Intimate relationship	An interpersonal relationship that involves physical or emotional intimacy.
Trauma-informed care	Realizing the widespread impact of trauma, recognizing the signs and symptoms of trauma among clients and staff, responding by integrating knowledge about trauma into practice and policy, and proactively resisting re-traumatization.
Sex	Different biological and physiological characteristics of males and females.
Gender	Socially constructed norms, behaviours, activities, relationships and attributes that a given society considers appropriate for men and women.
Case management	A health care process in which a professional helps a patient or client develop a plan that coordinates and integrates the support services that the patient/client needs to optimize the healthcare and psychosocial possible goals and outcomes.

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1. Chapter 1: Introduction

1.1. Background

Violence against women and girls (VAWG) is a global public health, human rights, and social justice concern (1,2). VAWG can be defined as "*any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*" (3). Recent global estimates show that 31 per cent of women aged 15-49 have experienced physical and/or sexual violence from an intimate partner or sexual violence from a non-partner in their lifetime (defined as aged 15 years and older)(4). The widespread prevalence of VAWG is so significant that the United Nations (UN) has declared VAWG a 'global pandemic' (5).

VAWG can lead to numerous short-term and long-term consequences on the physical health and mental well-being of women and girls, including physical injuries, depression, anxiety, unwanted pregnancies, sexually transmitted infections, perinatal complications affecting both mothers and infants, suicidal ideation, and death (6,7). VAWG can also have an indirect impact on the health and well-being of women and girls. VAWG is a risk factor for smoking, stress, alcohol and substance abuse, and poor nutrition (8). VAWG negatively impacts women and girls' access to education and participation in productive employment (2). VAWG also poses a significant economic burden on health systems. A study conducted in the United States (US) estimated that the annual healthcare cost of intimate partner violence (IPV) alone is USD 19.3 million for every 100,000 women aged 18-64 years (9).

VAWG has also been described as a 'hidden pandemic' given that many incidents are not revealed (10). Contributors to under-reporting of VAWG include shame and stigma, financial barriers, cultural beliefs and norms, and a lack of awareness of available services, such as health, psychosocial and legal support (11,12).

1.2. Overview of study context

Thailand is a constitutional monarchy with a unitary parliamentary system. The population of Thailand is approximately 72 million people (13), including an estimated 4.9 million non-Thai residents, most of whom are from Cambodia, Lao PDR, Myanmar, and Viet Nam (14). Thailand became an upper-middle income country in 2011 (15). Migrant workers constitute approximately ten per cent of Thailand's labour force. Of these, 50.2 per cent are female, 20 per cent lack legal status (undocumented migrants), and 68 per cent are from Myanmar (16). Thailand has a policy on universal health coverage instituted in 2002 that entitles every Thai citizen to essential health services (17). Documented and undocumented migrants can receive healthcare under Thailand's universal health coverage policy (16,18), although both groups are required to present legal documents such as a work permit or a passport to healthcare institutions, which could lead to detention or deportation for undocumented migrants (19). Approximately 90 per cent of Thailand's population is Buddhist, four per cent are Muslim, two per cent are Christian, and the remaining four per cent are from other religions or no religion (20). The majority of Muslims in Thailand are located in the South region of Thailand.

1.3. Gender equality and VAWG in Thailand

In recent decades, the Thai government has implemented numerous policies to promote gender equality and tackle VAWG. Thailand ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (21) in 1985 and the Beijing Platform For Action in 1995 (22). The latter is widely considered the international bill of rights for women. In 2007, Thailand included provisions for the promotion of gender equality and prevention of sex discrimination in the revised Constitution B.E. 2550 (23) and introduced the Domestic Violence Victim Protection Act (DVVPA) (24). In 2019, the Family Development and Protection Act (FDPA) was developed to replace the DVVPA to more effectively tackle domestic violence in Thailand (25), although this law did not come into effect, which has been attributed to concerns regarding its implementation (26). An amendment to Thailand's penal code in 2019 included harsher punishments for sexual violence and the removal of the three-month statute of limitations in rape cases (27).

Not all policy and legal changes to promote gender equality and tackle VAWG have been universally accepted as promoting women's rights and there are still significant challenges that need to be overcome. In 2019, the Thai government actioned the decision to revoke the enrolment of women into the Royal Police Cadet Academy - ten years after the acceptance of women into the academy (28) - significantly increasing the likelihood that female survivors of VAWG need to report violence to a male police officer. The amendment to Thailand's penal code in 2019 has been criticised as narrowing the definition of rape (27). Women's representation in national parliament at 15.7 per cent is lower than average for East Asia and upper-middle-income countries (29). Women also undertake 3.2 times more unpaid domestic work than men (29). Educational institutions commonly require students to dress according to their sex assigned at birth, serving to perpetuate harassment and discrimination experienced by transgender individuals (30).

These regressive changes in gender equality policies in Thailand in recent years (e.g., narrowing of rape definition) appear to reflect ingrained sexism amongst actors and institutions with high decision-making power. General Prayut Chan-o-cha assumed office as prime minister of Thailand after a military coup d'état in August 2014, serving until August 2023. A constitutional amendment in 2016 proposed by General Prayut's party, the National Council for Peace and Order (military junta), tightened military powers in Thailand (31). Shortly after assuming office, General Prayut received criticism from international media outlets for attributing the femicide of a female British tourist in Koh Tao, Thailand to her decision to wear a bikini, commenting that "*can they [tourists] be safe in bikinis ... unless they are not beautiful*?" (32).

Contrastingly, in 2023, the social democratic Move Forward Party won the majority of seats in the Thai general election, a party that proactively advocated for gender equality in Thailand in their manifesto. The largest proportion of women appointed as members of parliament in the general election was achieved by the Move Forward Party (33). Yet, despite achieving a lower house majority, the leader of the Move Forward Party, Pita Limjaroenrat was blocked from becoming prime minister as he was unable to receive support from unelected senators appointed by the previous military government. As a result, the leader of the more conservative Pheu Thai Party was appointed to prime minister, extending the legacy of the military junta after its rule and disempowering the Move Forward Party in their proactive pursuit of gender equality.

Like most countries globally, Thailand has a high prevalence of VAWG. The WHO global prevalence study reported that the lifetime prevalence of intimate partner violence (IPV) among ever-married/partnered women aged 15 years and older in Thailand is 24 per cent (4). IPV can be defined as "*any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship*" (34). The global prevalence study did not report a Thailand-specific prevalence figure for other forms of VAWG, such as non-partner sexual violence (NPSV). NPSV can be defined as "*acts of sexual violence committed by any person that is not a current or former husband or male intimate partner"* (35). A multi-country study aggregating physical and sexual violence undertaken by WHO in 1999 reported that 41.1 per cent of women in cities and 47.4 per cent of women in selected provinces in Thailand have experienced these forms of VAWG in their lifetime (36). Research suggests that most cases of VAWG presenting to healthcare institutions in Thailand are for physical (73%) or sexual (18%) violence, mirroring global VAWG prevalence estimates (37,38).

The true prevalence of VAWG in Thailand may be higher than the reported figures given under-reporting (39,40). Social norms are among the contributors to underreporting in Thailand. For example, a consequence of the importance of protecting the family institution in Thailand is that survivors of IPV choose not to report VAWG as it is considered a private, family matter (40). Lack of sensitisation of healthcare staff in Thailand to VAWG has also been identified as a contributor to underreporting (39).

1.4. Thailand's health system response to VAWG

A key landmark in the history of Thailand's state response to VAWG was the introduction of One Stop Crisis Centres (OSCCs) in 1999, following the example of the inception of the OSCC model in neighbouring Malaysia (41,42). Prior to the introduction of OSCCs, the health sector response to VAWG was limited to the provision of non-specialist services in hospitals by general healthcare providers (42).

The OSCC model has been adopted predominantly by low- and middle-income countries (LMICs) and serves to provide a single, safe location for survivors to receive coordinated, multisectoral, and trauma-informed care (39,43). Survivors attending these centres can receive health, judiciary, police, and social welfare services (44). In addition to seeking to improve the health sector response to identified cases, the OSCC model has also been used in many countries to enhance the accessibility of care by eliminating fees for services and through OSCC awareness-raising efforts (45).

The OSCC model was introduced in Thailand to address insufficient and inadequate hospital services, lack of staff knowledge/skills for responding to VAWG, and problematic referral systems for survivors of VAWG in Thailand (39,42). OSCCs in Thailand are located within university-affiliated, regional (>500 beds), general (200-500 beds), and community (10-150 beds) public hospitals, under the governance of the Ministry of Public Health (MOPH) (40,46). OSCCs in Thailand are mandated to provide timely, 24-hour crisis support for survivors of VAWG, including the following functions (42):

1. History taking and examination
2. Forensic evidence collection, ensuring confidentiality is observed
3. Coordination with other actors as required by the case, which may include, for example, social workers, police, public prosecutors, teachers, and shelter staff
4. Provision of essential medical treatment and counselling

5. Provision of legal assistance
6. A survivor risk assessment for repeated violence and exacerbation of consequences of violence
7. Provision of temporary shelter
8. Rehabilitation and follow-up
9. Telephone hotline
10. Education initiatives targeting the general population
11. Detailed recording of VAWG data

To ensure access to available staff 24/7, OSCCs are mandated to be located in the emergency room where possible (42). In addition to supporting the institution of OSCCs in public hospitals across Thailand, the MOPH have also provided guidelines and an OSCC manual for healthcare professionals to use to inform their response to VAWG (42)(47). The OSCC manual stipulates the services that should be provided, as listed above, although it does not explicitly state which healthcare providers are required to carry out these various functions (47). This may in part be due to variation between hospitals in the availability of healthcare providers. The OSCC manual provides specific advice for coordination with actors located outside the hospital, such as the police, public prosecutors, Ministry of Social Development and Human Security (MSDHS), as required by law (47). For example, for survivors of human trafficking who have experienced VAWG, the OSCC manual has a requirement of mandatory reporting to the police in accordance with the Anti-Trafficking in Persons Act (2008) (48). The OSCC manual guidance for coordination in cases of IPV is underpinned by the DVVPA (24). For example, in a case of VAWG in which the survivor's home is considered unsafe, the OSCC is required to coordinate with the Ministry of Social Development and Human Security (MSDHS) to arrange temporary accommodation. In cases of violence perpetrated

against girls, OSCC staff are required to observe the provisions in the Child Protection Act (2003) (49).

Despite challenges faced during the implementation of the first OSCC in Thailand, the initial pilot centre was perceived to be a success (39), and after a further pilot of 20 OSCCs (42), the decision was made to roll out the OSCC model to every hospital in Thailand (26). Linking the OSCC up-scaling initiative with the Queen's 72nd birthday celebrations has been identified as reflecting high-level government support and contributing to the rapid expansion of the OSCC model in Thailand (50). In 2018, the Office of the Permanent Secretary (MOPH) reported that there were 10,611 OSCCs across the country (51,52). OSCC governance and oversight challenges identified in the first research project of my DrPH programme (Organisational or Policy Analysis or OPA) (26), however, raises the question of whether this figure reflects the government mandate that every public hospital must have an OSCC, rather than representing the effective functioning of OSCCs. An alternative estimate of the number of OSCCs in Thailand is approximately 800 (53). The discrepancy between these figures raises the question of whether subdistrict health centres are included in the national figure even though these centres typically have only one community nurse and one or two public health technical officers (54), limiting their capacity to fulfil MOPH's requirements of an OSCC service in Thailand.

The OSCC model in Thailand does differ to some extent from other models; for example, concerning the role of non-governmental organisations (NGOs). Grisurapong (2004) explained that in other countries in the Asia/Pacific region NGOs are responsible for providing psychological support and accommodation, whereas "*in Thailand, it has been determined that training of hospital staff to carry out these tasks by themselves are more*

effective and give a better chance in sustainability of the [OSCC] program" (42). It is possible that Thailand's approach was influenced by the difficulty faced in Malaysia in transferring responsibility from NGOs to the Malaysian Ministry of Health, with the former providing staff and expertise to facilitate the initial roll-out of the OSCC model (41). However, the findings of the OPA indicate that NGOs do play a role in filling in gaps in the Thai government's response to VAWG; for example, by taking on the responsibility of VAWG case management in settings with resource restrictions or providing shelters for survivors of VAWG (26) (for a definition of 'case management' see glossary of terms). The OPA also revealed that in some regions NGOs actively participate in multidisciplinary team (MDT) meetings in cases of VAWG (26).

The findings of the OPA indicated that a further difference between OSCCs in Thailand and some other settings is that non-health actors involved in the OSCC response are not resident in the OSCC (26) (26). These non-health actors typically do not come to the OSCC when there is a case (26). This may in large part be due to the fact that, in contrast with some OSCC models in other settings, the OSCC Manual does not require non-staff to attend the OSCC when there is a VAWG case (42,47). One participant in the OPA, however, expressed the belief that external actors are required to attend the OSCC in person, suggesting a lack of clarity amongst OSCC staff with respect to OSCC policy (26), with implications for the relationship between hospital and non-hospital staff in practice.

1.5. Why research on the OSCC model in Thailand is important

Critical examinations of OSCCs in Thailand are needed to establish whether these OSCCs are serving their intended purpose of providing coordinated, multisectoral, and trauma-informed care for survivors of NPSV/IPV. Despite the expansion of the OSCC model in Thailand

following its inception in 1999, research examining the challenges and opportunities of using OSCCs to help survivors of VAWG in Thailand appears to be lacking, notwithstanding Grisurapong's (2004) caution that national roll-out of the OSCC model should not proceed without systematic assessment (42).

The value of this formative research is magnified by the large number of OSCCs currently operating in Thailand and the prevalence and gravity of NPSV/IPV. Studies undertaken in Thailand exploring the complications of rape perpetrated against women and girls revealed that 15 per cent of cases resulted in pregnancy, 10 per cent of survivors contracted a sexually transmitted infection, and many survivors sustained significant physical injuries (39,55). The response to VAWG may be time-sensitive requiring an efficient, coordinated health systems response, thus research is needed to assess whether this is being achieved. The likelihood of obtaining forensic evidence dramatically reduces 72 hours after rape (56). Post-exposure prophylaxis for HIV and emergency contraception are most effective within 72 hours following sexual intercourse (57,58).

Kanungbutr, Junhavat & Nintachan (2011) indicated that evaluations of OSCC effectiveness in Thailand could help support funding for OSCCs (59). They noted that whereas, initially, the OSCC in Pathum Thani Hospital did not receive funding, financial support was provided by the Thai Health Promotion Foundation and the Pathum Thani governor's office once it had become apparent to decision-makers that the OSCC was offering a valuable service (59).

Lessons learned from an examination of OSCCs in Thailand could also be of interest to neighbouring countries in the Asia-Pacific region[1]; Viet Nam, for example, is currently following Thailand's example launching its second OSCC in 2022 (60).

1.6. Thesis structure

The first chapter of this thesis provided overviews of VAWG, the study context, gender equality and VAWG in Thailand, the health system response to VAWG in Thailand, and some reasons why research on the OSCC model in Thailand is important. Chapter two presents the aim, objectives, and research questions of the thesis. Chapter three presents the findings of a literature review exploring the global, regional, and Thailand-specific challenges and opportunities of using OSCCs to help survivors of VAWG. Chapter four provides an overview of social norms and explains why and how a social norms lens is employed in this study. It then presents and discusses the conceptual frameworks used in this study. Chapter five presents and discusses the methods used in the study, ethical considerations, and the importance of considering one's epistemological foundation, before offering reflections on the influence of my subjectivity and biases on the research process. Chapter six presents the key findings of the study. It is divided into three sections, with each section aligned with one of the three research objectives. Chapter seven discusses three key emerging themes from the research before presenting the strengths and limitations of the study, recommendations for policy and practice, and finally, opportunities for further research.

[1] A representative from the UN Women Regional Office for Asia/Pacific expressed the belief that many countries in the Asia-Pacific region follow Thailand's lead in their pursuit of socio-economic development (conversation during OPA)

2. Chapter 2: Aim, objectives, and research questions

2.1. Aim

The aim of this thesis is to further our knowledge and understanding of the challenges and opportunities of using the OSCC model to help survivors of NPSV/IPV in Thailand. This in turn should help to inform future evaluations of the effectiveness of OSCCs at meeting the needs of survivors.

2.2. Objectives

The objectives of the thesis, which map onto the research questions, are as follows:

Objective 1: To explore the help-seeking and disclosure preferences and behaviours of survivors of NPSV/IPV and the factors influencing survivors' responses.

Objective 2: To examine the views of OSCC staff on NPSV/IPV and explore the influence of social norms on the OSCC response.

Objective 3: To investigate the institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV.

2.3. Research questions

In this thesis, I attempt to answer the following research questions (RQs):

RQ1: What are the views of OSCC staff on survivors' help-seeking and disclosure preferences and behaviours and the factors that influence survivors' responses to NPSV/IPV?

RQ2: What are the views of OSCC staff on NPSV/IPV?

RQ3: Do social norms influence the response of OSCC staff to NPSV/IPV?

RQ4: What are the institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV?

In this thesis, I seek to address outstanding research questions from the first research project of the DrPH, the OPA (26). The OPA was a qualitative study examining the coordination of the response of the Thai government to all forms of VAWG, with interviewees predominantly working for the Thai government at a central level (see Appendix 2) (26). The state response to NPSV/IPV at the service-provision level will be the focus of the thesis, in which I seek to elicit the experiences and perspectives of OSCC service providers.

3. Chapter 3: Literature review

3.1. Introduction

This section summarises the global, regional, and Thailand-specific literature on the challenges and opportunities of using OSCCs to help survivors of VAWG. Given that a systematic literature review of barriers and enablers to the implementation and effectiveness of the one stop model for intimate partner and sexual violence in LMICs was recently undertaken by Olson, García-Moreno, & Colombini (2020) (45), the decision was made not to undertake a further systematic literature review, but instead to focus on primary data collection in this study. A narrative literature review was undertaken to identify any articles not included in the systematic literature review, such as articles published after 2020.

3.2. Global and regional literature on the challenges and opportunities of using OSCCs to help survivors of VAWG

Despite the popularity of the OSCC model, there is a lack of published studies in the global literature scrutinising the effectiveness of the OSCC model at meeting survivors' needs (37,45). Olson, García-Moreno, & Colombini's (2020) comprehensive systematic literature review on barriers and enablers to the implementation of OSCCs reported several concerns regarding the effectiveness of the response to intimate partner and sexual violence at OSCCs, although the review reported variable confidence evidence using the CERQual (Confidence in the Evidence from Reviews of Qualitative Research) approach (45,61). The review identified 13 barriers with a high CERQual confidence level, including i) lack of basic medical supplies, facility equipment and survivor comfort items; ii) lack of adequate psychosocial services and staff; iii) compromised confidentiality and privacy; iv) lack of

services on nights and weekends; v) lack of community awareness of one stop centre services; and vi) weak referral networks and lack of referral options (45). The systematic review did not identify any high CERQual confidence level enablers, although it reported the following moderate CERQual confidence level enablers i) supportive laws and policies on violence against women; ii) standardised policies and procedures; iii) regular interagency meetings to coordinate services and support, address challenges, and delegate tasks; iv) support from higher leadership; v) availability of on-site psychological services and support groups; vi) hospital-based one stop centres better equipped to provide a full range of services, including medical services; and vii) OSCC staff leaders designated as 'champions' (45).

Of the 42 OSCC studies identified in Olson, García-Moreno, & Colombini's (2020) systematic review, almost half were studies conducted within the WHO South-East Asia Region (62). This may in part be due to the fact that Malaysia is attributed as engendering interest in the development of OSCCs in other countries. Studies from within the WHO South-East Asia Region (62) published after Olson, García-Moreno, & Colombini's (2020) systematic review reported similar findings. A critical review of OSCCs in India by Agarwhal & Sharma (2022) identified the following barriers to effective OSCC implementation i) poor coordination between departments/authorities; ii) lack of public awareness of OSCCs; iii) provision of minimal services, described as largely counselling for matrimonial disputes; iii) survivor-blaming by service providers; and iv) problematic attitudes amongst police officers, discouraging survivor reporting (63). The study was grounded in the experiences of the authors, however, and did not offer empirical data to support these claims. A retrospective quantitative study analysing administrative data from survivors of VAWG attending an OSCC in Haryana, India reported i) the absence of a dedicated counselling room; ii) poor police response to cases; and iii) a lack of doctor referral of cases of violence to the OSCC, as barriers to an effective response (64). Given that this

study was a secondary analysis of quantitative data, it was limited in its capacity to propose possible explanations for the shortcomings identified in the study. A systematic literature review of one stop centre responses to violence against women in LMICs identified the following challenges to the response of OSCCs in the WHO South-East Asia Region i) lack of privacy within the healthcare setting (Bangladesh, Nepal); ii) lack of infrastructure (Bangladesh); and iii) lack of documentation and poor monitoring of implementation (Sri Lanka) (65). An observational case review study on sexual violence cases presenting to an OSCC in Malaysia reported delays in initial response by OSCC staff and a lengthy process from hospital admission to discharge as challenges to an effective OSCC response (66). And a case series of survivors of violence against women presenting to one stop centres in Bangladesh reported that the assistance of community members served as an enabler to survivor presentation to one stop centers (67).

The evidence suggests a heterogeneity of the conceptualisations and manifestations of the OSCC model globally, presenting a challenge to the application of the findings of global research to specific contexts, such as Thailand. Most OSCCs are hospital-based, often in tertiary centres, whereas others are located in standalone centres outside the hospital, providing basic services and onward referral (45). OSCCs are typically either government-run or led by NGOs (45). Some offer services specifically for subtypes of VAWG, such as sexual violence, whereas others offer support for survivors of various subtypes of VAWG (45). Measures required to overcome challenges to an NGO-run OSCC service, for example, may be different to measures to overcome challenges to a government-run OSCC service, such as the Thailand OSCC model.

Gaps in the global literature on OSCCs can be identified. Explorations of social norms appear to be one such gap in research conducted on the OSCC model. Existing systematic reviews

on OSCCs did not report any normative influences on the effectiveness and implementation of the OSCC model from the included studies (45,65). This may be because social norms lay outside the scope of the systematic reviews, but an examination of the individual studies included in these systematic reviews suggests a lack of research on the influence of social norms in the global OSCC literature. A further gap in the literature is that studies exploring access to OSCCs have focussed primarily on institutional barriers and facilitators to survivor access, such as OSCC operating hours, transportation and healthcare costs, and OSCC waiting times. This is in keeping with the application of an institutional lens to examine the accessibility and response of OSCCs. Studies exploring individual and community-level barriers and facilitators to OSCC access for survivors of NPSV/IPV were not identified. This study sought to help address these gaps in the global literature.

3.3. Thai literature on the challenges and opportunities of using OSCCs to help survivors of VAWG

The Thai literature on the challenges and opportunities of using OSCCs to help survivors of VAWG was found to be extremely limited, with only four published studies identified (for the search strategy see Appendix 3). The studies identified in the literature do, however, provide some valuable knowledge.

A qualitative study by Grisurapong (2002) exploring the experiences of OSCC staff of the establishment of the first OSCC in Khon Kaen Hospital, Thailand, reported several implementation successes, including i) establishing an effective referral system within the OSCC; ii) creating awareness-raising training programs and seminars; and iii) improving VAWG knowledge and attitudes of hospital staff (39). Grisurapong (2002) also identified numerous challenges in the implementation of the OSCC, primarily in terms of a need for i)

trained psychologists/psychiatrists in the hospital able to provide counselling for survivors; ii) training of obstetricians and gynaecologists in reporting violence and collecting forensic evidence; iii) refining referral procedures, particularly between healthcare providers and the police; iv) training of hospital staff on gender, decrees, and laws relevant to VAWG; v) addressing problematic attitudes/values in the Royal Thai Police (RTP); vi) specific standard operating procedures for each category of service provider; and vii) strengthening referrals to police and state attorneys.

Grisurapong conducted a further examination of the response of OSCCs to VAWG in 2004, involving a document review and key informant interviews with healthcare personnel (42). She attributed the following factors with improved OSCC performance i) training and re-training of healthcare personnel; ii) support from hospital administrators; iii) optimised service flows; iv) strong leadership and dedicated staff; and v) strong stakeholder collaboration both inside and outside the hospital (42). A common theme across many OSCC studies, Grisurapong (2004) also reported problematic attitudes of OSCC staff as a barrier to an optimal OSCC response, specifically mentioning survivor-blaming as an issue amongst OSCC staff (42).

Studies on the OSCC model in Thailand between 2004 and 2011 were not identified. Kanungbutr, Junhavat & Nintachan (2011) examined the response of a particular OSCC, at Pathum Thani Hospital, to VAWG (59) and outlined several strengths of their OSCC response, namely i) breadth of professions in the MDT; ii) good cooperation amongst members of the MDT; iii) unrestrictive referral system for patients from community hospitals; iv) confidentiality system in place; v) continuous staff development; and vi) presence of a system to prevent secondary trauma. The authors concluded that social workers were the appropriate choice for the coordinating role as chair of the MDT. The authors stated

that the OSCC was viewed as a model for responding to VAWG in Thailand, although this was provided as a description of the views of stakeholders, rather than a claim grounded in comparative evidence. The authors also identified several limitations of the OSCC response at Pathum Thani Hospital, namely i) lack of support for primary prevention; ii) insufficient staffing; iii) lack of consulting services during out-of-office hours; iv) poor visibility of the OSCC; and v) absence of a referral system for follow-up.

Studies on the OSCC model in Thailand between 2011 and 2021 were not identified. In a mixed-methods study examining the response of the 17th Somdejphrasangkharach Hospital OSCC to sexual violence, Sricharoen & Saksiri (2021) identified the following challenges i) lack of out-of-hours services; ii) lack of specialists in each field; iii) inadequate budget and management of finances; iv) MDT missing actors; and v) OSCC response not sufficiently integrated (68).

There are several limitations of the literature in Thailand on the OSCC model. Notably, all of the studies conducted were on the response of OSCCs in large hospitals, specifically regional or general hospitals. None of the studies explored the response of OSCCs based at smaller community hospitals to VAWG, thus the findings and recommendations of these studies may not be translatable to the vast majority of OSCCs that are based in community hospitals (for a breakdown of Thailand hospital size classifications see section 5.2.). Additionally, none of the studies were conducted with OSCCs located in rural settings (for a definition of 'rural' see section 5.2.), limiting the capacity of these studies to shed light on the particular challenges facing OSCCs in rural locations. A further gap is that none of the studies explored survivor access to OSCCs, but rather were focussed examinations of the response of OSCCs once survivors had attended the OSCC. Grisurapong (2002) provided a referral pathway to promote intersectoral coordination in the provision of state support to survivors of

NPSV/IPV, although the referral pathway commenced from survivor access to hospital services (39). This study seeks to address these gaps in the Thai literature on OSCCs.

Three of the four studies identified are focussed examinations of a single OSCC, two were published more than 15 years ago, and the perspectives of survivors have been consistently neglected. None of the studies were repeated, limiting the capacity to make claims about the extent to which the policy and practice recommendations of the research studies led to improvements in access to, and the response by, OSCCs.

A lack of government ownership of OSCCs by successive governments might have contributed to a lack of provision of resources for research seeking to support the development of OSCCs. Perceptions of, and attitudes towards, VAWG among policymakers could also in part explain a lack of funding for research that seeks to protect women and girls from violence and its consequences. For example, one of the OPA participants reported that one of Thailand's largest health systems and research funders, the Thai Health Promotion Foundation, perceives IPV as, primarily, a threat to the integrity of the family unit, rather than a matter of a woman's right to protection from violence or a public health issue (26). Perceiving VAWG as primarily a social issue may deter the Thai Health Promotion Foundation from supporting this issue as IPV may be perceived as lying within the scope of MSDHS, even though the service provided by OSCCs falls under the remit of the MOPH. It is noteworthy that MSDHS, rather than MOPH, has the mandate for the oversight of the coordination of the national response to VAWG (26); such structure possibly reflects a 'whole of government' perception that VAWG is primarily a social issue.

4. Chapter 4: Social norms

4.1. Introduction

Whilst the application of a social norms lens can help support a greater understanding of barriers and facilitators to the accessibility and response of health systems, social norms research has historically focussed primarily on the prevention of harmful behaviours contributing to ill health, although some research has been undertaken exploring the influence of social norms on the provision of healthcare (69–73). Employing a social norms lens in this study sought to help address this research gap. This chapter provides an overview of social norms and their relevance to research on health systems' responses to VAWG. It then presents the conceptual frameworks used in this study, which seek to support a greater understanding of the influence of social norms on the accessibility and response of OSCCs to NPSV/IPV.

4.2. What are social norms?

Social norms can be understood as "*the shared beliefs within a social unit about the appropriate ways to think, feel, and behave in a given context"* (74). Social norms differ from individual beliefs and attitudes (internally motivated judgements about something (75,76)) and can also be subdivided into "*beliefs about how others expect one to behave*" (injunctive norms) and "*beliefs about how others behave*" (descriptive norms) (77). Social norms may be 'reference group' contingent; as explained by Cislaghi & Heise (2020) "*a young man may feel reluctant to use foul language in front of his family but feel quite comfortable using coarse language when alone with his friends"* (76). Social norms can be understood as an umbrella term encompassing norms related to tradition (customary norms), religion, culture, and gender, amongst others. Cislaghi & Heise (2020) draw attention to the fact that social norms theory has emerged from social psychology literature and therefore they encourage

practitioners familiar with the social psychology literature to consider the influence of power on norms that they argue is better captured in the literature on gender norms provided by feminist scholars (76). This is emphasised by a study by Boonnate & Phaowiriya (2018) who reported that strong gender norms and patriarchal hierarchies in Thailand contribute to gender power imbalances that in turn contribute to VAWG (78).

Social norms related to VAWG can have a positive impact on the health and well-being of women and girls, for example, the norm that female family members should be respected (79). Yet, social norms related to VAWG can also negatively impact health and well-being, such as the norm that women who have experienced VAWG should remain silent to protect family honour and unity, instead of seeking medical or legal support (79). And some social norms may offer both protection and risks, such as the social norm that it is inappropriate for a man to beat his wife in front of his mother-in-law (80,81), which provides protection for women from violence when their mothers are present, yet simultaneously serves to keep violence hidden from family members who may be able to offer support. The influence of social norms on VAWG may be direct, such as the norm that it is acceptable for a man to beat his wife as a form of discipline (79), or indirect, such as the norm that it is inappropriate to interfere with another family's affairs (in cases of IPV) (82).

4.3. Relevance of social norms to research on health systems' responses to VAWG

Incorporating a social norms lens into an examination of health systems responses to VAWG may help our understanding of the influence of social norms on survivor access to healthcare and the response of healthcare providers, enabling the implementation of measures to harness or undermine these positive or negative normative influences, and thereby support a more

effective service. Colombini et al. (2022) argue that "*addressing cultural and gender norms around IPV and enhancing support and commitment from health managers was also shown to be necessary for a health system environment that enables the integration of IPV care"* (83). Several normative barriers to healthcare access and a trauma-informed response to VAWG have been reported in the literature, including the following i) it is taboo to talk about sexual violence (84–86); ii) it is appropriate for survivors to tolerate VAWG and keep it hidden as it is a private/family issue (87–90); iii) it is appropriate for male relatives to accompany women reporting VAWG (90); iv) it is inappropriate to report VAWG as it is a 'normal' part of life (79); and v) it is acceptable/appropriate for sexual violence to be settled in the community without state involvement (90–93).

4.4. Conceptual frameworks

4.4.1. Dynamic Framework for Social Change

Cislaghi & Heise's (2018) dynamic framework for social change (DF) (94) will be used in this study as the primary conceptual framework to further an understanding of the influence of social norms on the accessibility and response of OSCCs.

Several conceptual frameworks have been proposed in the literature to further an understanding of the influence of social norms on health-related behaviours (94–98). Two conceptual frameworks in particular that consider the influence of social norms on VAWG in relation to other factors could be relevant to an examination of the accessibility and response of health systems. These are Heise's (1998) socio-ecological model (96) and Cislaghi & Heise's (2018) dynamic framework for social change (94).

Heise's (1998) socio-ecological model categorizes contributors to VAWG as relating to the following i) personal history (e.g. perpetrators' experience of violence or witnessing violence in childhood); ii) microsystem (e.g. male dominance in the family or alcohol use); iii) exosystem (e.g. low socio-economic status or isolation of woman and family); and iv) macrosystem (e.g. cultural values or social norms) influences (96).

Cislaghi & Heise's (2018) dynamic framework for social change (94) builds upon Heise's socio-ecological model, positing that social norms interventions seeking to change health-related behaviours, should consider the interrelation of social norms and other factors on the behaviour in question, including i) individual: factors related to the person, such as factual beliefs, skills, and attitudes; ii) institutional: formal systems of rules and regulations, such as laws, policies, and religious ordinances; iii) material: factors including physical objects and resources, such as money, services, or land; and iv) social: factors such as the types and availability of social support, configuration of social networks, and exposure to positive deviants in a group (94). The authors argue that effective and sustainable change requires consideration of the interrelation of all of these factors rather than viewing social norms in isolation. This framework, they suggest, helps the user to identify actors working at other points of influence for possible engagement when seeking to tackle harmful behaviours through changes in social norms (94).

Whilst both models have been used most frequently to investigate factors influencing VAWG perpetration, several features of the DF support its suitability as a conceptual tool to support health systems analyses. The DF was designed to identify opportunities for change and as a consequence is arguably well suited to the development of actionable recommendations for improving health systems responses, whereas challenges highlighted by the socio-ecological model may be relatively intractable, e.g., personal history. The DF and socio-ecological

model differ slightly in their focus on human influence. The former attends more to the influence of institutions, which is central to this thesis; the latter arguably focusses more specifically on interpersonal and community influences, although these are also relevant to this thesis and captured by the DF to some extent. The DF also underscores the importance of material influences, which are integral to a health systems examination and appear to be somewhat less prominent in the socio-ecological model. Finally, the DF was developed specifically to support programming in LMICs (99), whereas the socio-ecological model is relatively context-agnostic; as such, the DF may be more readily applicable to Thailand.

The appropriateness of the DF as a conceptual tool to support a health systems examination will be critically assessed. Findings from the OPA and the literature offer preliminary support for the use of the DF as a conceptual lens to support an understanding of the interrelation of factors influencing the accessibility and response of OSCCs to NPSV/IPV in Thailand (26). For example, several participants in the OPA explained that some OSCCs have a policy, based on a misunderstanding of the law, that survivors of sexual violence require a police report before they can receive a hospital consultation, leading OSCCs to request that survivors attend the police station first and then return to the OSCC once they have obtained a police report (26). According to one OPA participant, some survivors do not return to the OSCC following the OSCC's refusal to offer a consultation without a police report (26). The decision of survivors not to return to the OSCC after initial rejection could be a consequence of the interrelation of social norms inhibiting survivor access to OSCCs, a lack of money or mode of transportation (material factors), a loss of trust in the state response (individual/institutional factor), and/or a lack of childcare support (other social factor), amongst other possible reasons.

The DF will serve two uses in this thesis. It will be used to support identification of the normative, individual, institutional, material, and other social factors impacting on the accessibility and response of OSCCs to NPSV/IPV. In addition, it will be used to further our understanding of the *interrelation* of each of these components. The DF will guide data collection. The DF will be used to inform the selection of topic guide questions (see Appendix 4). For example, the open question "*What might influence a woman's decision to attend the OSCC?*" might lead participants to divulge a social norm that it is acceptable for men to beat their wives, leading women to perceive IPV as a normal part of life and thus not an issue for which they should seek help. Participants might also explain that the presence of children in the household limits women's freedom to leave the household to seek help, as might a lack of economic empowerment. The DF will also guide data analysis by providing the initial framework for the thematic analysis (see section 5.6.), with the findings initially coded deductively as normative, individual, institutional, material, and other social factors. As the data analysis progresses to a more inductive phase, the focus of the data analysis will shift to the interrelation of these components.

This study will focus on eliciting injunctive norms, as norms prescribing or proscribing behaviour are particularly pertinent to understanding the barriers and facilitators to the accessibility and response of OSCCs to NPSV/IPV.

4.4.2. Theory of normative spectrum

To achieve greater depth of understanding of the influence of social norms on the accessibility and response of OSCCs to NPSV/IPV it is necessary to employ a further conceptual framework to supplement the DF that captures variations in the strength of social norms. Cislaghi & Heise (2018) outline a theory of normative spectrum (TNS) (100) with

four levels of influence of social norms "*i) the strongest norms make a practice obligatory; ii) strong norms make a practice appropriate; iii) weak norms make a practice acceptable; and iv) the weakest norms make a practice possible, inducing people to consider that practice as a viable course of action"* (86). In this study, upon identifying possible social norms, further analysis of the data will be undertaken in an attempt to provisionally attribute strength of influence to these norms, based on participants' responses.

5. Chapter 5: Methodology

5.1. Introduction

In the methodology chapter, I describe the study setting, research design, research methods, participant sampling, recruitment, data collection and data analysis. I then present the steps undertaken to promote the ethical conduct of the research, including measures to protect participant data. Subsequently, I discuss the importance of considering one's epistemological foundation, before reflecting on the influence of my subjectivity and biases on the research process.

5.2. Study setting

Thailand has six administrative regions (North, Northeast, East, Central, West, and South**)** (101). The Northeast region has the lowest Gross Regional Product (GRP) and the East region has the highest GRP (102). The study was conducted in all six regions of Thailand. The study was conducted in OSCCs based in both rural and urban locations. OSCCs in sub-districts (tambons) with more than 10,000 people were classified as 'urban' and OSCCs in sub-districts with fewer than 10,000 people were classified as 'rural' (103). Interviews were undertaken with OSCC staff located in public hospitals of four hospital size classifications, namely i) university-affiliated; ii) regional (>500 beds); iii) general (200-500 beds); and iv) community (10-150 beds) public hospitals.

5.3. Research design and methods

A qualitative exploratory study design was adopted to address the research questions. Qualitative methods were used as these are well-suited to exploratory research that aims to produce thick descriptions of participants' perspectives and capture human experience (104). Semi-structured interviews with OSCC staff were undertaken to address the research questions. They were selected as the primary method of data collection for several reasons.

First, semi-structured interviews enable predetermined hypotheses (e.g. those lines of enquiry revealed by the OPA) to be assessed whilst permitting the emergence of novel themes (105). Second, semi-structured interviews offer participants the freedom to share the information that they deem important (106,107). Third, this method allows flexibility to follow up participants' responses. Fourth, the semi-structured interview format has been described as promoting a reciprocal relationship between the interviewer and participant (107,108). It was considered necessary to select a method that would enable the natural, reciprocal flow of information in the form of a conversation, to prevent the participant from feeling that they were the subject of the investigation. Semi-structured interviews helped participants to feel at ease during the interviews, which in turn supported participant openness and enhanced the usefulness of participant contributions to the study. The multiple benefits of this method may in part explain why semi-structured interviews are so commonly employed in qualitative health service research (109–113).

Semi-structured interviews were selected instead of unstructured, in-depth interviews since the aim of this research is to explore a spectrum of participant experiences and perspectives while addressing various themes. Semi-structured interviews with individual participants, as opposed to focus group discussions, were sought for several reasons i) to limit social desirability bias that may be exacerbated by group interviews (114); ii) to limit the possibility

of reduced openness as a result of being in a group setting; and iii) to prevent unbalanced contributions from male and female participants, with one study reporting that women spoke 75 per cent less than men when asked to work collaboratively in a mixed-gender group (115).

5.4. Participant sampling and recruitment

A total of 36 OSCC interviews were undertaken involving 50 participants, from a total of 83 OSCCs approached for participation in this study. Table 1 provides a summary of participants, disaggregated according to profession and hospital size classification. The sample featured a large proportion of nurses and psychiatric nurses from community hospitals and social workers from general and regional hospitals. The sample had relatively fewer psychotherapists and doctors.

There were 42 female and eight male participants. Whilst most interviews were pursued with only one participant at a time, in nine interviews, more than one OSCC staff member requested to join the conversation, out of curiosity or a desire to share their experiences. Of these nine interviews, five interviews involved two participants, three interviews involved three participants, and one interview involved four participants. As a consequence of this approach, there were a greater number of participants than interviews undertaken. The same topic guides were used for the individual and group interviews.

Table 1 Number of participants by profession subdivided into hospital size classification

Profession	**Hospital size classification**				**Total**
	University	Regional (>500 beds)	General (200-500 beds)	Community (10-150 beds)	
Nurse	0	2	2	17	21 (42%)
Social worker	1	6	5	1	13 (26%)
Psychiatric nurse	0	0	2	10	12 (24%)
Psychotherapist	0	0	2	1	3 (6%)
Doctor	0	0	1	0	1 (2%)
Total	**1 (2%)**	**8 (16%)**	**12 (24%)**	**29 (58%)**	**50**

Interviews with a range of professionals represented at the OSCC were sought. The following criteria were used:

1. Participants must work at an OSCC, either full-time or part-time.
2. Participants must have worked at an OSCC for more than six months, to ensure that they have sufficient experience to provide valuable and reliable perspectives on the accessibility and response of OSCCs.

Table 2 provides a summary of recruited OSCCs, disaggregated according to region of Thailand (101) and urban versus rural setting. Population estimates for each region are also provided in Table 2 (116) to facilitate understanding of the number of interviews in each region relative to the estimated population size of the region. Disaggregating the regions according to hospital size classification was not possible given the possibility that hospitals could become identifiable; there are a limited number of university hospitals in each region in Thailand.

Table 2 Number of interviews by region subdivided into rural versus urban setting

Region of Thailand	N interviews	Population estimate (116)	N Urban	N Rural
North	4 (11%)	6,350,499	2 (50%)	2 (50%)
Northeast	16 (44%)	22,017, 248	8 (50%)	8 (50%)
East	3 (8%)	4,841,806	1 (33%)	2 (67%)
Central	3 (8%)	20,183,134	2 (67%)	1 (33%)
West	4 (11%)	3,430,314	2 (50%)	2 (50%)
South	6 (17%)	9,454,193	4 (67%)	2 (33%)
Total	**36**		**19 (53%)**	**17 (47%)**

The sample had an approximately equal proportion of OSCCs in urban and rural settings. Whilst the distribution of interviews per region appears skewed in favour of the Northeast region of Thailand in absolute numbers, the distribution is relatively even per population size, with the exception of the Central region of Thailand, which is relatively underrepresented. This is in large part attributable to challenges to the recruitment of OSCCs in Bangkok (see Appendix 1). Approximately 15.3 per cent of Thailand's population lives in Bangkok (116) and it is home to many migrants, sex workers, and tourists, amongst other population groups, thus the study was limited in its capacity to uncover particular challenges for these demographic groups. However, much of the global literature on OSCCs has focussed on urban settings, thus the fact that almost half of the OSCCs included were in rural settings helped to address this gap in the literature.

A stratified random sampling approach (117,118) to OSCC sampling was used in this study. A list of all public hospitals under MOPH categorised according to hospital size classification (strata) was identified (119). A random sequence generator (120) was applied to the list of public hospitals in each size classification. Interpreters were asked to telephone OSCCs in the list sequentially across categories i.e., university hospital 1, regional hospital 1, general hospital 1, community hospital 1, university hospital 2, regional hospital 2, etc. The full list of hospitals was

divided into smaller lists of 100 hospitals, and interpreters were presented with each list on a first-come-first-served basis. The full list had not been modified in any way by myself, so it was determined that further randomisation was unnecessary. If the OSCC staff member contacted expressed an interest in participating in the study they would be provided with the participant information sheet and consent form via email, with follow-up from the interpreter at a later date to arrange a time/date if the prospective participant was interested in participating.

Conducting interviews across different hospital size classifications supported the exploration of differences across groups in OSCC accessibility and response. It also ensured interviews with OSCCs in both urban and rural settings could be undertaken, as community hospitals are often located in rural settings, enabling differences in the accessibility and response of OSCCs in urban versus rural settings to be explored.

Including OSCCs in rural settings in the study also increased the likelihood of exposing particular challenges faced by hill tribe communities and undocumented migrants from neighbouring countries along the borders of Thailand, in addition to furthering an understanding of the challenges for women from particularly low Gross Domestic Product (GDP) areas of Thailand. OSCCs in all six regions of Thailand were sought to elicit possible regional or demographic variations in the accessibility and response of OSCCs. For example, the South of Thailand has a large Muslim population, contrasted with an otherwise predominantly Buddhist population (121).

A stratified random approach is often used when there is variation in the sample (122), as is the case with OSCCs in Thailand. Reported benefits of a stratified random approach are that it ensures that each stratum is adequately represented (122) and that it allows subgroups to be

explored in greater depth (117). This systematic, randomised approach to OSCC recruitment minimised personal selection bias; for example, approaching OSCCs through personal contacts from previous research may have biased the selection process as these OSCCs would likely have been more established and/or better supported. Two OSCCs were recruited using personal contacts from previous research, however, given that they were particularly well-placed to provide insights into the accessibility and response of OSCCs for undocumented migrant workers, the benefits of which were seen to outweigh the limitation of introducing bias into the sample as a result of this non-randomised, opportunistic approach.

5.4.1. Cessation of recruitment

The decision was made to cease recruitment of participants once 36 interviews had been undertaken. In qualitative research, there is a common misconception that sampling size is unimportant to ensuring the adequacy of the sampling strategy (123). Sandelowski (1995) argues that a sample that is too small may not produce sufficient depth and breadth, but a sample that is too large may produce "*superficial or unwieldy volumes of data"* (123). Selecting an appropriate sample size in qualitative research, however, has been described as "*an area of conceptual debate and practical uncertainty"* (124). According to Green & Thorogood (2009), 15 interviews often achieves the point of saturation in a relatively homogeneous group of participants (125). The current study sought to elicit differences across subgroups, however, requiring a larger sample. Onwuegbuzie & Leech (2007) recommend at least three cases per subgroup is necessary to facilitate comparison across subgroups (126). Thus, comparing across six regions in Thailand would require at least 18 interviews. This study also sought to elicit differences across other categories, namely participant sex, urban versus rural setting, and participant profession, requiring an even larger sample. Whilst a helpful heuristic, Onwuegbuzie and Leech's (2007) somewhat arbitrary cut-

off of three cases per subgroup should not take precedence over Sandelowski's (1995) argument that "*determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put"* (123).

The primary reason for the cessation of sampling was that sufficient breadth of data in this exploratory study had been achieved to achieve an acceptable level of data saturation to sufficiently address the research questions and objectives. Data saturation in qualitative research has been defined as the point at which "*no additional data are being found whereby the sociologist can develop properties of the category"* (127). This strict use of the term 'data saturation,' was not achieved in this study, as inevitably there will always be additional questions that can be asked in pursuit of realising this unobtainable benchmark (127,128). Instead, Mason (2010) argues that data saturation could be conceived as the "*point of diminishing return to a qualitative sample — as the study goes on more data does not necessarily lead to more information"* (127,129). And Strauss & Corbin (1998) argue that data saturation could be understood as the point at which additional data collection would be "*counter-productive*" (127,128). These two conceptualisations were used in conjunction in this study to inform the cessation of data collection. The analysis of data during data collection to inform the iterative revision of the topic guide (see section 5.6.) contributed to increasingly diminishing returns in the acquisition of valuable data as data collection progressed, leading to the decision to cease recruitment once 36 interviews had been undertaken. At least three cases were achieved for every subgroup, with the exception of the profession 'doctor' and the hospital size classification 'university-affiliated' (for the study limitations see section 7.6.2.), aligning with Onwuegbuzie & Leech's (2007) recommended minimum sample size per subgroup in a heterogenous sample (126). Once 36 interviews had

been undertaken, it was also determined that further data collection would be counter-productive as sufficient data had been collected to justify a change in study design towards more in-depth studies as a more appropriate use of participant time than the acquisition of additional data in this study.

5.5. Data collection

A total of 12 interviews were undertaken by myself in person at the OSCC (eight in the Northeast region, two in the West region, one in the North region, and one in the South region) (for a map of Thailand's regions see Appendix 5). Twenty-four interviews were conducted by myself remotely via a video conference call. The mean interview length was one hour and 15 minutes.

Interviews were conducted by me (using a Thai-English interpreter) to enhance opportunities to ask questions relevant to the research. Given that the thesis has some cross-over with the OPA, it was decided that the threat of duplication might be reduced and opportunities for addressing outstanding questions from the OPA capitalised upon if interviews were undertaken by me. As an English-speaking researcher conducting research in Thai language, there may have been inaccuracies or errors in both translation and the interpretation of translated material, both of which represent challenges and limitations of this approach (see section 7.6.2.). Limitations of my conducting the interviews also relating to my sex, gender, and my professional and cultural/religious background are presented in section 5.9.

A topic guide was developed to guide data collection with input from experts on VAWG, including a Thai researcher with expertise on VAWG and the OSCC model in Thailand (see Appendix 4). The selection of each question was informed by the research questions,

objectives and the DF. The original topic guide was translated into Thai from the English language. Revisions of the topic guide were subsequently made and revised guides disseminated to Thai interpreters.

Interviews were conducted between 5th January and 2nd July 2023. The first two semi-structured interviews formed the pilot. All interviews were conducted by me using a Thai-English interpreter. Six out of the nine interpreters recruited were female. The interpreter simultaneously translated my questions and comments in English into Thai and the participants' responses in Thai into English throughout the interview.

The selection and training of interpreters was informed by the WHO's *Ethical and safety recommendations for intervention research on violence against women* (130). Interpreters with previous experience of providing interpretation during qualitative health-related research projects, particularly on the topic of VAWG, were proactively sought. Before interviews, I met with each interpreter to assess fluency in the English language and to train interpreters on the WHO *Ethical and safety recommendations for intervention research on violence against women*. Attention was given to educating interpreters on the types of VAWG explored in this study, the OSCC model, protecting participant confidentiality, the right of participants to refuse to answer questions, and respect for participants' time, in addition to other forms of professional conduct.

It was explained to interpreters that, whilst the interviews would be conducted with OSCC staff who have experience discussing NPSV/IPV, some participants may be survivors of NPSV/IPV themselves, thus it would be important to ask questions in a step-wise, sensitive manner and proactively monitor participants for any signs of discomfort or distress. It was

made explicitly clear to interpreters that, whilst participants may offer personal experiences of VAWG, under no circumstances would participant personal experiences be actively sought in the interviews. Interpreters were asked to provide a verbatim translation of the English language questions into Thai without modifying the language, as far as possible. Interpreters were instructed not to ask their own questions and that if they wished to do so they must present the question to me first.

Participants were asked to notify me immediately if they felt that any of the questions were causing participant discomfort or distress. The body language of participants was also monitored throughout the interview. The conversation with interpreters before the interviews also provided an opportunity for interpreters to ask questions about the research, which were answered. All interpreters were asked to read the research protocol, interview topic guide, participant information sheet, and informed consent form to facilitate understanding of the research process and core principles relating to ethical research conduct. Debriefs with the interpreters were undertaken after the interviews to discuss the interview process, appropriateness and sensitivity of the questions asked, and to provide an opportunity to double-check any areas of uncertainty surrounding understanding of participant contributions.

5.6. Data analysis

After each interview, verbatim transcription of the English language content of the recorded interviews was undertaken by myself (Microsoft Word .docx format). For especially important participant contributions, interpreters were asked to double-check the quality of the transcripts to ensure that complete and accurate data was captured. Conducting the transcription myself supported familiarisation with the data. Data analysis was subsequently undertaken with the

support of qualitative data analysis software NVivo 12. Data analysis was both deductive and inductive. Data analysis was initially primarily deductive with the codes based on concepts from the DF. It then became more inductive as I progressed into the more analytical phase of the data analysis. Framework analysis adopting a thematic approach (131) was employed, using the DF as the framework. The approach to framework analysis as described in Gale et al. (2013) (132) was adopted and followed the stages below:

i) **Familiarisation.** Initial familiarisation with the data was supported by transcription. Subsequent reviews of the transcripts were undertaken to further familiarisation with the data.

ii) **Coding.** Line-by-line coding was undertaken to assign codes to any data considered relevant to the thesis research questions, such as concepts and themes. As explained by Gale et al. "*line-by-line can often alert the researcher to consider that which may ordinarily remain invisible because it is not clearly expressed or does not 'fit' with the rest of the account"* (132). Open coding was selected due to the inductive nature of the research.

iii) **Developing a working analytical framework.** After coding the first transcripts, the relationships between the codes were then examined to identify thematic categories of codes. These thematic categories formed the working analytical framework. Codes that did not easily fit into the categories were kept in an 'other category,' given the possibility that the coding of subsequent transcripts might lead to the identification of novel categories in which the codes in the 'other' category might fit.

iv) **Applying the analytical framework.** After the creation of an analytical framework, codes from subsequent interview transcripts were 'indexed' or assigned to an existing

thematic category. The working analytical framework was revised with each additional transcript analysed.

v) **Charting.** Using NVivo 12, the data was 'charted' into a matrix. Charting involved summarising the data within the categories, whilst ensuring that the meaning within the participant contributions was not lost.

vi) **Interpreting the data.** In the final stage, relationships between the themes were explored and subjected to interpretation, with characteristics, differences, connections, and other relationships identified among the various codes and themes, grounded in the research objectives.

Preliminary observations of the data made during the interviews and initial transcript review were recorded i.e., memos, which were frequently reviewed throughout the data collection and analysis process, contributing to familiarisation with the data.

In some cases, the application of the DF led to the coding of the same data into multiple categories. For example, the expectation that perpetrators of rape provide compensation to survivors could be coded as a normative barrier to accessing OSCCs, due to mediation in the community, yet it could also be coded as a material barrier to accessing OSCCs if the survivor's family (the likely recipients) perceive a need for the additional income. The DF was also used to support the identification of higher-level relationships between themes, which was important to reduce the risk of the oversimplification and siloing of complex information that can occur when implementing framework analysis.

Framework analysis tends to be used with applied research with a specific research question, a pre-determined sample population, and a limited time frame (133). The numerous strengths

of framework analysis, resulting in its selection for this study, include i) the approach is dynamic and thus open to modification throughout the analytical process (133); ii) it has the ability to manage and analyse qualitative data in a systematic way (133–135); iii) it is comprehensive, enabling a review of all data collected (133); iv) it is compatible with qualitative data analysis software (136); v) there is a clear audit trail from the original data to the ultimate themes enhancing reliability (132); vi) it is not aligned to any epistemological approach (132,137); and vii) it has previously been evidenced as a useful method to analyse qualitative data in studies on VAWG (138–140).

Alongside these strengths, challenges of framework analysis have also been described in the literature, including i) the structured approach may lead the researcher to attempt to quantify qualitative data; ii) it is time-consuming to apply; and iii) significant training is needed when using this method across a multi-disciplinary team (132). As only one primary researcher was conducting the analysis, the final limitation did not apply. The first limitation, a temptation to quantify qualitative data is valid, particularly during indexing of data, although somewhat attenuated by the fact that the research was exploratory. Regardless, awareness of this limitation helped to ensure that the research focussed on the content of the material, rather than the number of times a code appears in the data. Sufficient time was allocated for data analysis to address the second limitation.

Transcription and analysis of the first two interviews occurred before any additional data collection to enable assessment of the cultural appropriateness and sensitivity of the interviews and to ensure that the data generated was of sufficiently high quality. Data collection and analysis occurred concurrently throughout the study so that the topic guide

could be fine-tuned iteratively to ensure sensitivity and to generate more valuable information (sequential analysis) (141).

5.7. Ethics and data management

Ethical approval was provided by the LSHTM research ethics committee (Ref: 28241), Thailand's Institute for the Development of Human Research Protections (IHRP) under MOPH (Ref: IHRP 125-2565), and the Medical Service Department of the Bangkok Metropolitan Administration (BMA) (Ref: 11335) (see Appendices 6, 7 and 8 respectively).

Participant information sheets and consent forms available in both Thai and English (see Appendices 9 and 10) were provided to all participants before interviews were arranged, to ensure that participants were informed about the study and had sufficient opportunity to ask questions before deciding with respect to participation. Participant information sheets and consent forms were presented a second time to participants before the start of the interview. Written informed consent was obtained from participants before commencing interviews. Both written and verbal consent for audio recording was obtained before turning on the two recording devices (primary and backup). Participants were asked about their time availability at the beginning of each interview to ensure that interviews did not exceed the pre-agreed time or the maximum length of 90 minutes for the interview.

It was reiterated to participants before the commencement of interviews that all published reports would be de-identified and that the names of participants and their hospitals would be omitted. All participant files, or files containing participant information, duly had identifiable information removed immediately after data collection. Interview transcripts were randomly assigned an identifier code using a random number generator (120), e.g. INT3. All data

collected was stored securely in encrypted folders on two encrypted hard drives, which were kept in my possession. The WHO *Ethical and Safety Recommendations for Intervention Research on Violence Against Women* (130) and Ellsberg & Heise's *Researching Violence Against Women: A Practical Guide for Researchers and Activists* (142) informed the design and conduct of the research, including the questions in the topic guide.

5.8. Epistemological foundation

There are several theories of knowledge (epistemological theories) that underpin researchers' approaches to research. A positivist approach, for example, assumes that a stable reality exists 'out there', which research seeks to uncover (113). By contrast, a social constructivist approach rejects the notion of an objective reality and instead holds that reality is socially constructed (113). A third epistemological theory, arising from Bhaskar's (1990) rejection of the "*ideological*" positivist approach which assumes that human beings can fully comprehend the nature of reality (143,144), is critical realism. A critical realist approach holds that evidence can shed light on reality, but that it is a "*fallible, social and subjective account of reality"* (144). As such, critical realism also rejects a social constructivist approach that conflates human perception of reality with reality itself (144). There is insufficient scope in this study for a full discussion of the merits of each approach. Instead, I shall present justification for the approach taken in this study, namely critical realism.

First, it has been argued that critical realism is better equipped than social constructivism to understand the lived psychological experience of health issues (in this case NPSV/IPV); for example, a social constructivist approach is arguably less able to capture the complexity of the experience of psychological trauma following NPSV/IPV (145). It can be argued that positivism also falls short in this regard as it has a limited ability to distinguish between the

social and natural influences on psychological trauma (146). Second, a critical realist approach allows for the coexistence of sex (biological) and gender (social construct) (145), thus supporting an understanding of differences in the influence of each of these factors on the accessibility and response of OSCCs, rather than conflating them. Third, critical realism recognises the influence of "*personal, social, historical, and cultural frames*" on the observation of data (147). As a consequence, critical realism demands reflexivity, an important part of the research process (see section 5.9.).

There are also pitfalls of a critical realist approach to exploratory, qualitative health systems research on NPSV/IPV, which need to be taken into consideration and mitigated where possible. First, it has been argued that critical realism is ill-suited to an understanding of the messiness of everyday decision-making. Vincent & Mahoney (2018) claim that "…*abstract normative statements made by some critical realists often fail to capture the complex nature of dilemmas at play in people's lives"* (148). In adopting a critical realist approach, this study will be limited in understanding how survivors respond to NPSV/IPV. Whilst critical realism can shed light on some of the individual factors influencing survivors' decision-making, which the DF also seeks to elucidate, it is insufficiently equipped to understanding the complexity of decision-making, in which even the survivors' response may vary depending on her particular set of circumstances at a given moment in time.

Second, it has been argued that the capacity of critical realism to promote scientific progress (including social scientific progress) is overstated, due to the impossibility of a "*logical method of having new ideas"* (149,150). Whilst a critical realist approach was selected as the best fit for the current study, and was considered the method most suitable for supporting an understanding of the accessibility and response of OSCCs, it is prudent to note its limitations,

including that a critical realist approach cannot support the formulation of ideas that guide the research process, nor can it help generate recommendations for addressing challenges identified in the research.

5.9. Reflexivity

Olmos-Vega et al. (2023) define reflexivity as "*a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes"* (151). The authors highlight that whilst much quantitative research seeks to control for research bias to reduce its influence on the pursuit of fundamental truths, subjectivity is less easily separated from qualitative research, pointing towards the need for researcher reflexivity to uncover these subjective influences on qualitative research processes (151). 'Research processes' can be understood broadly, as including all aspects of a study, from the selection of a topic to research design, data collection methods, data analysis, selection of co-researchers or interpreters, and interpretation and dissemination of findings. Reflexivity is not intended to extract the influence of the researcher from the research, but rather to expose and address undue or unacknowledged effects and prejudices to improve the integrity and trustworthiness of the research. In this thesis, it helped to promote rigour by mandating the transparent and detailed reporting of research methods and attention to a range of different perspectives, including deviant cases (152).

Cultural, social, biological, religious, epistemological, moral, and personal factors, amongst others, may impact upon various aspects of research. This section presents a non-exhaustive list of some of the possible ways in which my subjectivity and context may have positively or negatively influenced the conduct and rigour of the research.

5.9.1. Sex and gender

To promote clarity in this section, I will adopt oversimplified definitions of sex and gender. Sex will refer to "*different biological and physiological characteristics of males and females"* (153). Gender' will refer to "*socially constructed norms, behaviours, activities, relationships and attributes that a given society considers appropriate for men and women"* (153). In adopting these definitions, it is important to highlight, at the very least, that neither sex nor gender are binary, and that sex is also a socially constructed term.

There are an infinite number of ways in which both my sex and my gender (as distinct factors) will have impacted upon this research, only some of which can be covered here. It is self-evident that as a male and a man I can only have an outsider's perspective on VAWG, given that I have not had the lived experience of being female, a girl, or a woman. In addition, I have not had personal experience of gender-based violence directed towards me. Beyond undoubtedly shaping the thesis proposal and choice of topic guide questions, my state as a male and gender as a man will both have significantly limited both the breadth and depth of my understanding of participant contributions.

Further, both my sex and my gender may have impacted on the research in more indirect ways. For example, one study reported that male researchers generally have a greater interest in conducting research for the purpose of scientific progress, whereas female researchers generally have a greater interest in societal progress (154). If this is the case, I may be more inclined to present recommendations that are aimed at promoting generalisable knowledge, rather than recommendations that are aimed at improving the situation of women and girls in Thailand. My lack of lived experience of being female, a girl, or a woman may further

contribute to this inclination, as a consequence of an empathetic divide undermining my motivation to provide practicable recommendations for addressing this problem. Other influences may to some extent limit the impact of this divide, such as memories of conversations with personal contacts who have experienced VAWG. Compounding the effects of my sex and gender, it is notable that during the development of the research proposal both of my supervisors were men, limiting opportunities for the impact of problematic beliefs and attitudes to be minimised, whilst also reducing the input of individuals with a lived experience of being female and/or a woman.

My gender, specifically, may also have impacted upon the quality of the data generated from interviews. Participants may have been less open to discussing a topic like VAWG with a man. There may have been some scepticism with regards to my motives for conducting research in this field and, as discussed above, participants may have reasonably felt that my capacity to understand the topics discussed was limited by my gender.

The influence of sex and gender on the research could only be partly addressed in this study. Efforts were made to use female interpreters in the study to help support a more complete understanding of participant contributions and to ensure that participants felt safe and comfortable in the interview, in turn promoting participant openness. Twenty-six interviews were undertaken with female interpreters and ten interviews were undertaken with male interpreters. The perspectives of female colleagues on the development of the thesis proposal, including topic guides, were proactively sought. In doing so, I was mindful to ensure that these perspectives were not being solicited as a ‘box-ticking’ exercise, but rather that these perspectives were sought with an understanding that they would improve the appropriateness and academic rigour of the research.

5.9.2. Professional background and training

My professional training and experiences may have impacted various aspects of the research. For example, previous research in VAWG and women's economic empowerment in Somalia and Uganda respectively may have positively influenced or biased the selection of questions in the topic guide. Previous experience of conducting research in Thailand may have had a positive impact on the research process, helping to inform the choice of topic, research design, methodology, and interpretation of findings. Equally, it may have had a negative impact on the research, biasing data collection and the interpretation of findings as a consequence of an understanding of the accessibility and response of OSCCs in Thailand that is neither complete nor inerrant.

Relatedly, part of the introduction in the interviews was to help build rapport and prevent participants from withholding information in the belief that I might not have experience working in a health system, so I communicated my background as a physician to research participants. It is my perception that this helped to free up participants to offer more complete and honest opinions of some of the daily challenges faced working at the OSCC. Conversely, it is possible that my background as a physician may have led participants to assume a greater understanding of working as a healthcare professional in the Thai context than I possessed, resulting in relevant details being omitted. Finally, participants' knowledge of my previous profession may have increased the threat of social desirability bias, exacerbated through the introduction of a possible additional power dynamic, namely a power divide that may exist in Thailand between physicians and other healthcare professionals.

5.9.3. Culture and religion

Cultural and religious factors may have impacted upon the research. For example, in interviews, I chose to dress smartly with a collared shirt and tie, whereas the research participants were typically less formally dressed. I chose my clothing intending to express respect for the participants. However, whilst smart attire might have engendered trust and confidence in my professionalism, it may have also increased the formality of the interview and made participants feel more nervous and less open to divulging information. Additionally, my clothing choices may have increased participants' perceptions of me as an 'outsider,' thereby increasing doubt among participants with respect to my understanding of the Thai context.

However, adopting cultural appropriation (e.g., via clothing choices) to gain more valuable data did not, in my view, align with the moral principle of respect for persons. This view in turn may have been influenced by a Presbyterian Christian upbringing. It may have been the case, however, that participants would not have seen a decision to dress similarly to them as cultural appropriation, but rather as a sign of respect. Furthermore, it cannot be assumed that what I might have labelled cultural appropriation (for example, dressing with similarity to participants) would have represented a deviation from the moral frameworks of my participants, which may have been influenced by participants' religious backgrounds, with Buddhism and Islam as the dominant religions in Thailand.

In summary, likely, differences in intersecting cultural, moral, and religious backgrounds and frameworks may have impacted both positively and negatively on data collection, in addition to other aspects of the research, such as data analysis and interpretation of findings. A complete and correct reflection of all possible personal influences, biases, and interactions

would be impossible; I have sought to engage with a range of influences whilst acknowledging that reflexivity demands an appreciation of the limits of reflexivity.

6. Chapter 6: Results

6.1. Introduction

The thesis findings are presented in three sections. The first section, corresponding to the first objective (and research question 1), presents participants' views on the help-seeking and disclosure preferences and behaviours of survivors of NPSV/IPV and the factors influencing survivors' responses. The second section, corresponding to the second objective (and research questions 2 and 3), presents participants' views on NPSV/IPV and the influence of social norms on the OSCC response. The third and final section, corresponding to the third objective (and research question 4), presents institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV. A summary of how the results are structured in relation to the research questions and objectives can be seen in Table 3.

Table 3: Structure of results section

Results section	Research objective	Research question
Section 1: Participants' views on survivors' help-seeking and disclosure preferences and behaviours and the factors that influence survivor responses to NPSV/IPV	**Objective 1:** To explore the help-seeking and disclosure preferences and behaviours of survivors of NPSV/IPV and the factors influencing survivors' responses.	**RQ1:** What are the views of OSCC staff on survivors' help-seeking and disclosure preferences and behaviours and the factors that influence survivors' responses to NPSV/IPV?
Section 2: Participants' views on NPSV/IPV and the influence of social norms on the OSCC response	**Objective 2:** To examine the views of OSCC staff on NPSV/IPV and explore the influence of social norms on the OSCC response	**RQ2:** What are the views of OSCC staff on NPSV/IPV? **RQ3.** Do social norms influence the response of OSCC staff to NPSV/IPV?
Section 3: Institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV	**Objective 3:** To investigate the institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV	**RQ4:** What are the institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV?

A summary of participants, disaggregated by sex, profession, hospital classification, region, and rural versus urban setting, can be seen in Table 4.

Table 4: Study participants

Participant	Sex	Profession	Hospital classification	Region	Rural or Urban
INT1	1F; 2M	3 nurses	Community hospital	Northeast	Rural
INT2	1M	1 social worker	University hospital	Unable to disclose as risk of re-identification of participant	Urban
INT3	1M	1 nurse	Community hospital	Northeast	Rural
INT4	2F	1 nurse; 1 social worker	Regional hospital	Northeast	Urban
INT5	1F	1 psychiatric nurse	Community hospital	South	Rural
INT6	1F	1 psychiatric nurse	Community hospital	Northeast	Urban
INT7	1F	1 social worker	General hospital	West	Urban
INT8	1F	1 social worker	Regional hospital	Central	Urban
INT9	1F	1 psychotherapist	Community hospital	South	Urban
INT10	1F	1 psychiatric nurse	Community hospital	Central	Urban
INT11	1F	1 social worker	Regional hospital	South	Urban
INT12	1F	1 social worker	General hospital	South	Urban
INT13	1F	1 social worker	Regional hospital	Northeast	Urban
INT14	1F	1 social worker	General hospital	South	Urban
INT15	1F	1 nurse	Community hospital	Northeast	Rural
INT16	2F	2 nurses	Community hospital	Northeast	Rural
INT17	1F	1 nurse	Community hospital	West	Rural
INT18	2F	2 social workers	Regional hospital	Northeast	Urban

INT19	3F	3 psychiatric nurses	Community hospital	Northeast	Urban
INT20	1F	1 nurse	Community hospital	Northeast	Rural
INT21	1F	1 nurse	Community hospital	North	Rural
INT22	1F	1 psychiatric nurse	Community hospital	East	Rural
INT23	1M	1 social worker	Community hospital	Northeast	Urban
INT24	1F; 3M	2 psychiatric nurses; 1 nurse; 1 social worker	General hospital	Northeast	Urban
INT25	1F	1 psychiatric nurse	Community hospital	South	Rural
INT26	1F	1 nurse	Community hospital	Central	Rural
INT27	1F	1 nurse	Community hospital	Northeast	Rural
INT28	2F	1 psychiatric nurse; 1 nurse	Community hospital	North	Urban
INT29	2F	1 doctor; 1 nurse	General hospital	West	Urban
INT30	1F	1 nurse	Regional hospital	East	Urban
INT31	1F	1 nurse	Community hospital	Northeast	Rural
INT32	3F	2 psychotherapists; 1 social worker	General hospital	East	Rural
INT33	1F	1 nurse	Community hospital	Northeast	Urban
INT34	1F	1 nurse	Community hospital	West	Rural
INT35	1F	1 nurse	Community hospital	Northeast	Rural
INT36	1F	1 psychiatric nurse	Community hospital	North	Rural

6.2. Section 1 – Participants' views on survivors' help-seeking and disclosure preferences and behaviours and the factors that influence survivor responses to NPSV/IPV

This section presents participants' views on survivors' help-seeking and disclosure preferences and behaviours. It then presents participants' views on factors influencing survivor disclosure and access to OSCCs. It presents possible social norms influencing survivor disclosure and access to OSCCs and their interrelation with other components of the DF, namely individual, institutional, material, and other social factors. This section seeks to address the first objective of the study.

6.2.1. Participants' views on survivor help-seeking and disclosure preferences and behaviours

Participants were asked what survivors would do after experiencing violence. Many participants reported that survivors would inform and seek help from their parents or other family members, or friends, but also seek more formal services like the police and the hospital (but not OSCC specifically). Some participants reported that some survivors would also inform village leaders and the OSCC unit. A few participants reported that survivors would contact the OSCC 1300 hotline[2] or NGOs. And one participant reported that survivors would inform health volunteers. Many participants also reported that survivors may choose to stay silent and not disclose NPSV/IPV.

> *"…usually the wife will not do anything, [she] will not tell the police or anything"*
>
> (INT12, F, social worker, urban general hospital, South region).

[2] In addition to OSCCs located in public hospitals, there is a hotline associated with the OSCC model with the number 1300, which offers survivors of NPSV/IPV initial counselling, advice, and referral onto state and non-state services

Some participants indicated a 'severity of violence threshold,' where some survivors will only disclose violence when its impact on their health and wellbeing exceeds their personal threshold.

> *"…let's say she get[s]s abused like ten times, they [survivors] would not come from between 1 to 9, they only come when [it's] the last minute, when they['re] really hurt… some cases they don't know how to do that [escape a violent home] and it cost [them] their life, some of them, you know, passed away"* (INT13, F, social worker, urban regional hospital, Northeast region).

A few participants described a particular reluctance of survivors to report to the police, explaining that survivors may resist the requests of OSCC staff to report to the police in cases of severe injury, rather than opt for legal recourse.

> *"…in the case of liver injury and spleen injury the lady doesn't want to inform the police, but the social worker and nurse will take her to go to the police"* (INT10, F, psychiatric nurse, urban community hospital, Central region).

A few participants reported that, as a result of lack of disclosure, some violence is identified by medical staff as an incidental finding when survivors are presenting to the hospital for other reasons or if it becomes apparent as a result of pregnancy. This suggests that some complications of NPSV/IPV might facilitate support, even without the intent of disclosure. Recounting a case of rape, one participant reported:

"…she got like a physically sickness so [the survivor] come to the hospital and they just kind of get checked and found out that she got raped" (INT3, M, nurse, rural community hospital, Northeast region).

6.2.2. Participants' views on factors influencing survivor disclosure and access to OSCCs

Lack of awareness of OSCCs

Some participants reported a lack of awareness about OSCCs amongst survivors. A few participants from urban university and general hospitals expressed the view that migrant and rural populations, and individuals with limited education, were less likely to know about OSCCs. Even in a region with a large migrant population, visibility of OSCCs amongst migrants was considered limited.

"For Thais they would come in and get examined. But if it's foreigners, or let's say, migrant workers, they wouldn't know where to go to receive the service" (INT2, M, social worker, urban university hospital).

A further participant offered corroboration for this view:

"Some people know, but usually it's Thai people that will know about the OSCC… usually the [migrant population] don't just walk into the OSCC" (INT7, F, social worker, urban general hospital, West region).

A lack of awareness could in part account for the fact that many participants reported that if a survivor experiences NPSV/IPV and chooses to attend the hospital they will typically go to the hospital rather than the OSCC specifically.

A few participants explained that hospital attendance may ultimately lead to their referral to OSCCs, so a lack of knowledge about OSCCs may not necessarily be a barrier to OSCC access, provided that they disclose violence at a hospital.

> *"…in the community [they] don't really know that they have OSCC. Let's say they get hurt, they go to the public health or the community hospital and they will send to the OSCC"* (INT13, F, social worker, urban regional hospital, Northeast region).

Fear of repercussions

Once at the hospital, some participants reported that survivors may not disclose violence due to fear of repercussions from the perpetrator. Some participants reported that some perpetrators threaten survivors with further violence to ensure their silence.

> *"…the abuser [may] threaten the victim: 'If you speak of it, if you say something, [there's] going to be consequences'"* (INT30, nurse, urban regional hospital, East region).

One participant reported that survivors may be especially reluctant to disclose NPSV/IPV if the perpetrator is of "*the highest status*" as the repercussions could be greater (INT25, psychiatric nurse, rural community hospital, South region).

Many participants reported that survivors may not disclose also out of fear of repercussions from their parents. Many participants reported that survivors' parents may respond by blaming or shaming the survivor, or expressing anger or verbal abuse toward the survivor. A few participants reported that parents may respond by physically abusing the survivor, adding to the survivor's previous experience(s) of violence. One participant reported that some survivors may be *"afraid that her parents will be angry and everybody will find faults on her"* (INT5, F, psychiatric nurse, rural community hospital, South region).

Asked about responses of parents upon finding out that their daughter had been raped, one participant reported *"there's parents that are very physical that way, so in any case they [survivors] might get beat"* (INT2, M, social worker, urban university hospital).

Participants indicated that repercussions from parents may be cumulative. For example, a few participants explained that parents might beat their daughter upon finding out about rape due to the belief that the rape was their daughter's fault (survivor-blaming). Reporting from experience, one participant explained that parents of survivors who run away from home after being raped might:

> *"…scold them, teach them, get angry at them, hit them, discipline them first at home, and then [they] would go to the police or the hospital"* (INT26, F, nurse, rural community hospital, Central region).

One participant explained that parents may also blame survivors for not telling them sooner, indicating that survivors may face repercussions regardless of when they choose to inform their parents.

> *"…parents blame[d] the girl, not because it's the girl's fault, but blame[d] her for not telling the parents soon enough"* (INT5, F, psychiatric nurse, rural community hospital, South region).

A further participant suggested that how parents respond depends on the personalities of the parents, in addition to the behaviour of the survivor.

> *"…it really depends on the lifestyle of the girl, maybe she like to go out, maybe she like to party, maybe you know she do something to draw the attention that she get raped…some of the family they have that different kind of dynamic, they tend to blame their own child, but not all of them"* (INT24, urban general hospital, Northeast region).

The possible loss of financial support but also accommodation was also provided by a few participants as a reason why survivors do not report IPV or sexual violence within the family.

Other participants suggested that survivors may not disclose due to fear of stigma also from the community.

> *"… embarrassment from the society, that prevent[s] them to come to get help"* (INT28, psychiatric nurse, urban community hospital, North region).

Participants indicated that this fear may not be unwarranted, with many participants from every region of Thailand reporting that if the community found out that a woman had

experienced NPSV/IPV the survivor would face stigma. Some participants reported that members of the community would be judgemental and blame the survivor.

> *"…sometimes she might get some look from some people in the community…judging her"* (INT20, nurse, rural community hospital, Northeast region).

Yet some participants reported the deviant view that members of the community would show empathy and recommend the survivor to go and seek help from the hospital. The same participant reported:

> *"…[some members of the community] would have empathy or sympathy towards her [survivor of rape] and try and tell her that she need to go to the hospital, get yourself checked"* (INT20, nurse, rural community hospital, Northeast region).

Some participants reported that community shame added to personal feelings of shame and survivors' belief that they are at fault.

> "*…sometimes it's not their fault that that's happened but…they feel ashamed for people to know about it"* (INT7, F, social worker, urban general hospital, West region).

This concern may in part be a consequence of, and magnified by, a belief expressed by some participants that members of the community would gossip if they heard about a case of NPSV/IPV. Referring to a case of rape, one participant explained "*everybody going to talk about it in town"* (INT24, urban general hospital, Northeast region).

A few participants reported that the shame and stigma following rape may affect a girl's education, with one participant from an urban general hospital in Northeast Thailand reporting that if this happened in their location they would recommend transferring the survivor to a school for children with mental illness and social disadvantage given the lack of available alternatives in her area. One participant reported fear of loss of marriage prospects in rape cases, with survivors perceiving that potential suitors in their community may consider them less desirable if they have lost their virginity.

> *"…if the girl's a virgin she think that other people won't want to marry her anymore"* (INT7, F, social worker, urban general hospital, West region).

A few participants reported that survivors may not disclose out of fear of repercussions from state actors, such as receiving a compromised professional record affecting employment or fear of deportation or jail in the case of undocumented migrants. The participants reported that survivors' concerns about deportation or jail may not be unwarranted, given the lack of a firewall protecting undocumented migrants from prosecution in cases of NPSV/IPV.

> *"Especially in [participant's location] but also in other places as well there are a lot of immigrant workers and people without ID cards, and a lot of them are afraid to go to the police station and do a report…They don't have any ID card, she bring them to the police station… but they really not going to help so much because they need to arrest her for being illegal, they need to arrest the husband for being illegal"* (INT7, F, social worker, urban general hospital, West region).

Adding nuance to these findings, the participant explained that there is a memorandum of understanding (MOU) in Thailand stating that the illegal status of undocumented migrants must be reported to authorities. However, she explained that hospitals do not do this. The reason provided by the participant was that if they did there would simply be too many people to report.

Fear of loss of confidentiality

Some participants identified fear of loss of confidentiality as a reason why survivors do not disclose NPSV/IPV. Participants indicated that this concern may not be unwarranted.

> *"…they might think that, you know, to come out to the hospital, the information might leak"* (INT35, F, nurse, rural community hospital, Northeast region).

One participant reported that survivors of rape do not to disclose to subdistrict hospitals due to concern about the capacity of subdistrict hospitals to protect survivor confidentiality and as a consequence their OSCC elects not to involve the subdistrict hospital in cases of rape.

> *"…the rape case they taking care of it themself because they don't think that they have all of the help over there [at the subdistrict hospital] and plus because it's a rape case the patient do not want to share this information with the subdistrict [hospital], so they just handle it"* (INT16, F, nurse, rural community hospital, Northeast region).

One participant reported that survivors may not have confidence in the capacity of the police to protect confidentiality.

"…when they will go to the police station and the police station refer them to come to the hospital to get the examination, they freak out and then they don't go… they feel that everybody [is] going to know about it" (INT13, F, social worker, urban regional hospital, Northeast region).

6.2.3. Social norms influencing survivor disclosure and access to OSCCs

This section presents possible injunctive norms (beliefs about how others expect one to behave) indicated by the findings that influence survivor disclosure and access to OSCCs. Table 5 presents a summary of possible injunctive norms and their interrelation with other components of the DF.

It is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors as it should be handled within the family

Some participants indicated a possible injunctive norm impacting survivor disclosure and help-seeking behaviour explaining that it is inappropriate for NPSV/IPV to be disclosed to state or non-state actors as it should be handled within the family. However, a participant offered a more nuanced explanation of the difference between norms around IPV and NPSV:

"…they [community] feel like they have to support [rape cases]…but it's different with the domestic violence. Domestic violence they tend to ignore it because they think that that topic is inside the family and they don't want to get involved" (INT30, F, nurse, urban regional hospital, East region).

A further participant reported:

> *"…the perspective of Thai people that think about the domestic abuse is it's a private matter and they don't want to get involved"* (INT13, F, social worker, urban regional hospital, Northeast region).

Some participants reported that parents would avoid disclosing NPSV/IPV to avoid stigma from members of the community. The participant from the regional hospital in East Thailand reported that parents of high social standing may be particularly keen to prevent members of the community from finding out that their daughter had experienced NPSV/IPV.

> *"…depends on the social status, like if someone [is] well known in the community, they don't want anybody to come visit or make a scene or now other people will know about it as well"* (INT30, F, nurse, urban regional hospital, East region).

Yet, one participant offered a different perspective. In a case of IPV, the survivor's parents would not stop their daughter from reporting to the police and may offer sympathy and accommodation for their daughter to help them escape the violent environment.

> *"…they would be worried for her and then they would ask her like does she want to come out of the house [and live] with them"* (INT12, F, social worker, urban general hospital, South region).

A few participants expressed the view that parents may recommend separation or divorce in cases of IPV, with both clarifying that it depends on the parents.

"…some family probably going to tell them to get a divorce or separated or some family might tell her to negotiate or try to find a better solution or to stay together but find another solution, it really depends on the factor of that family and how severe of the domestic violence" (INT20, F, nurse, rural community hospital, Northeast region).

It is obligatory for survivors of IPV to protect the family unit

Many participants expressed the view that survivors may not disclose IPV due to their desire to protect the family unit. Some participants indicated the presence of a possible injunctive norm that it is obligatory to keep the family unit together.

"…[in cases of] domestic violence, especially the women, they want to keep the family together because the ideal of a family is father, children and mother" (INT13, F, social worker, urban regional hospital, Northeast region).

A few other participants reported that survivors do not disclose IPV as they seek to preserve the ideal of the 'perfect family.' Asked why a survivor of IPV might not report to the OSCC, one participant explained:

"…belief of the image of a perfect family. They don't want anybody to know that there's something going on. They want to make sure that they keep it [secret]. They try not to stir anything to make other people expect that they have something going on in the household" (INT20, F, nurse, rural community hospital, Northeast region).

Some participants reported that the presence of children in the household helps sustain this possible injunctive norm. Setting an example for children of the importance of preserving the family unit was provided as preventing women from leaving violent relationships.

> *"..the ideal of the Thai Society, they want to keep the family together, father, mother, and children, and it show[s] the example to the kid[s], like they [members of the community] would rather [children] see the parents fighting each other than just show them that they can be separate and they can be co-parenting"* (INT8, F, social worker, urban regional hospital, Central region).

A few participants also reported that survivors may seek to protect children from the financial and social consequences of separation from their husbands.

One participant in the South of Thailand indicated that Islam may have an influence on the possible injunctive norm that it is obligatory to keep the family unit together, reporting that when Imams learn about IPV the approach often adopted is to help the couple to *"work it out"* (INT25, F, psychiatric nurse, rural community hospital, South region). The participant also highlighted that this possible injunctive norm may have high saliency amongst Muslim populations, with the participant adding that the survivor will experience further violence because *"she can't get divorced"* (INT25, F, psychiatric nurse, rural community hospital, South region).

It is appropriate for men to control family finances

A lack of survivor's financial independence from their partner was identified by some participants as preventing women from disclosing IPV. Some participants indicated the

presence of a possible umbrella norm that men are the 'heads of the household,' contributing to a further norm that it is appropriate for men to control family finances. This in turn results in a lack of women's economic independence, making it more challenging for survivors to leave violent relationships.

> *"[referring to IPV] It's a family affair and sometimes they have kids. Okay, because sometimes they [survivors] let it go because they consider the husband or man to be the breadwinner of the family. So if there's anything [that] happen[s] to their husband then there's nobody to provide for them"* (INT12, F, social worker, urban general hospital, South region).

One participant offered the similar view that survivors of IPV may not disclose to the OSCC because if it leads to prosecution "*then nobody will [be] taking care of her financially"* (INT28, F, urban community hospital, North region).

A further participant reported:

> *"Sometimes they just need our help but don't want to go through the process of the law. For example, there's a couple and her husband [is] addicted to drug[s] and beat her as a routine, so if she report[s] this to us and the police [go] through the process of [the] law her husband would go to jail for sure, so she doesn't want that just because her husband is the one who work and pay all the bill in the house"* (INT18, F, social worker, urban regional hospital, Northeast region).

When asked why survivors with dependents do not disclose IPV, one participant reported *"For the child. She [the survivor] doesn't have money"* (INT22, F, psychiatric nurse, rural community hospital, East region).

It is acceptable for men to beat their wives

One female participant expressed the existence of a possible injunctive norm impeding survivor disclosure of IPV that it is acceptable for men to beat their wives, which the participant indicated is grounded in patriarchal male dominance. Asked why a survivor of IPV might not report to the police, the participant explained "*The norm in Thailand…the man is the master of the house"* (INT10, F, psychiatric nurse, urban community hospital, Central region).

Some participants reported that IPV is considered 'normal' by survivors and the wider community. One participant explained that survivors typically think of physical intimate partner violence as *"normal fighting in the family"* (INT23, M, social worker, urban community hospital, Northeast region).

Some participants reported that some survivors do not consider violence perpetrated against them as violence or underappreciate the extent of the offence that they have experienced.

> *"…the main problem still, women here in Thailand they don't understand what is the violence in the family"* (INT23, M, social worker, urban community hospital, Northeast region).

A few participants reported that some survivors and members of the community do not know that IPV is illegal. One participant expressed her wish that she could *"let all the people know, like okay, this is illegal in Thailand"* (INT7, F, social worker, urban general hospital, West region). Only one participant said that members of the community are aware that IPV is illegal, raising the question of whether there is geographical variation in awareness of the law.

> *"…they [community members] see husband and wife fighting…they know that it's against the law"* (INT30, F, nurse, urban regional hospital, East region).

It is acceptable for men to have sexual intercourse with their wives without their wives' consent

Some participants indicated a possible injunctive norm serving as a barrier to survivor disclosure through the normalisation and acceptance of violence by women, namely that it is acceptable for men to have sexual intercourse with their wives without their wives' consent.

> *"…the local [community] would favour the male, in the sense that 'ok, you are married, so you should have a lifelong consent given to your husband*'" (INT5, F, psychiatric nurse, rural community hospital, South region).

One male social worker from a university hospital reported that the possible injunctive norm that it is acceptable for men to have sexual intercourse with their wives whenever they want exists despite legal clarity that marital rape is illegal in Thailand.

> *"According to Thai law, if the woman doesn't agree to the sexual act it's still rape, even though they're husband and wife, it's still against the law… [referring to the views of community members] for the most part they're not going to accept it [the law]"* (INT2, M, social worker, urban university hospital).

A few participants expressed their view that in marital rape cases, rather than scrutinising the behaviour of the perpetrator, the survivor's behaviour would instead be scrutinised by parents or members of the community, with participants reporting that survivors would be questioned as to why they did not want to have sexual intercourse with their husband.

> *"…first he said they [members of the community] will ask the wife, why don't you give him consent?"* (INT23, M, social worker, urban community hospital, Northeast region).

The same participant reported that whilst the survivor's behaviour would be scrutinised, the husband would also be asked why he proceeded without consent and encouraged to reflect on why his wife did not want to have sexual intercourse with him, indicating that even when perpetrators are challenged on their behaviour in marital rape cases the focus may still be on the 'problem' of the survivor's lack of interest in sexual intercourse.

A few participants indicated that how survivors *perceive* violence may possibly be contingent on their financial and social circumstances, thus the influence of these factors may extend beyond shaping how survivors respond to IPV. The participant from the university hospital noted that whether a woman would perceive non-consensual sexual intercourse within a marriage as rape depends on her economic independence. If financially dependent on her

husband she may not perceive it as rape, but if she is financially independent she may perceive it as rape.

> *"…if it's a woman that's totally reliant on her husband for everything she might not say it's rape, but if it's a woman who has her own job, has her own income, has her own wealth, she may say it is. It's like the status, how reliant is the woman on the husband whether they would view it as rape or not"* (INT2, M, social worker, urban university hospital).

A further participant reported that a survivor's perception of the *severity* of IPV may be impacted by her socio-economic circumstances, which could include sexual violence, although this was not explicitly reported by the participant.

> *"…sometimes it's about financial [circumstances], the man, the abuser [is] actually taking care of the family, so she will hold it in and think it is no big deal and that's why they don't come out and get help"* (INT33, F, nurse, urban community hospital, Northeast region).

It is inappropriate to discuss sexual violence as it is taboo

Some participants reported that it is inappropriate to discuss sexual violence as it is taboo.

> "*Thai people [are] very embarrassed when it come to that [sexual violence]. That's why nobody really help"* (INT27, F, nurse, rural community hospital, Northeast region).

A further participant reported:

> "*…in the Thai society, rape is very sensitive subject. It's very delicate topic to share with somebody"* (INT8, F, social worker, urban regional hospital, Central region).

One participant reported that sexual violence within the family is especially taboo (and a family matter).

> *"…the rape case from the family or somebody in the household it's more like a taboo to talk about it, they going to keep it very secret in their own family and they not going to talk about it, so the community not really know anything about that because they keep it really quiet"* (INT4, F, urban regional hospital, Northeast region).

It is acceptable/appropriate for cases of NPSV/IPV to be settled in the community without state involvement

The findings indicated a possible injunctive norm reported primarily by participants from community hospitals that it is acceptable/appropriate for cases of NPSV/IPV to be settled in the community without state involvement. Participants indicated that this possible injunctive norm presents a barrier to survivor disclosure to state services as resolution in the community is selected as an alternative to state support. One participant explained that village leaders seek marriage between the survivor and perpetrator in rape cases, but if it is not possible to reach an agreement they will refer the survivor to the police. The participant reported "*…[the village leaders are] going to have an agreement for them to marry each other, but if not, they [are] going to have to take [them] over to [the] police department and press charge"* (INT19, F, psychiatric nurse, urban community hospital, Northeast region).

One participant from an urban community hospital in Central Thailand expressed the view that 98 per cent of cases of rape are handled in the community and 2 per cent of cases of rape are disclosed to state actors, namely those in which an agreement between the survivor and perpetrator cannot be reached. One participant from an urban community hospital in Northeast Thailand estimated that 70 per cent of cases of IPV would be mediated in the community, with 30 per cent of cases disclosed to the OSCC. A participant from a rural community hospital in Northeast Thailand expressed the view that roughly 50 per cent of cases of rape are mediated in the community and 50 per cent of cases are reported to the police or a public hospital. And one participant from a different rural community hospital in Northeast Thailand reported that in four years working in the OSCC, there had not been any cases of IPV perpetrated towards women or girls in which the couple had separated, with cases typically mediated in the community. These descriptive normative findings provide support for the claim of an underlying injunctive norm prescribing mediation of NPSV/IPV in the community without state involvement.

Mediation as a solution to sex out of wedlock was reported by participants as a reason for mediation in cases of rape, possibly reflecting the confluence of two additional possible injunctive norms indicated in this study, namely i) it is inappropriate to have sexual intercourse out of wedlock; and ii) women who have sexual intercourse out of wedlock must get married, for example, to the individual with whom they had consensual or non-consensual sexual intercourse. One participant explained that the latter possible injunctive norm persists despite universal rejection of the benefit of the norm.

> *"…once the women have sexual intercourse then they have to marry. It's not like anybody want to settle this way, it's like it's already done so they have to do it"* (INT21, F, nurse, rural community hospital, North region).

Referring to the views of members of the community in a case of non-partner rape, a further participant explained "*later they have to live together, later they have to…"* (INT31, F, nurse, rural community hospital, Northeast region).

A few participants explained that marriage following rape is a cultural or religious obligation. Asked why the parents of a survivor of rape may encourage the survivor to marry the perpetrator, one female participant explained *"culture, religion, tradition"* (INT11, F, social worker, urban regional hospital, South region). When asked what a typical response in hill tribe communities would be to rape perpetrated by a stranger, a further participant explained:

> *"…the cultural way to settle, so they would tell the guy to come and marry, marry the girl, and if they can stay together, that's fine"* (INT21, F, nurse, rural community hospital, North region).

A further participant indicated that pregnancy contributes to adherence to this norm.

> *"…they [community] just think that, when the [woman] get pregnant, okay, the father of the baby should be the husband"* (INT11, F, social worker, urban regional hospital, South region).

The findings indicate that the pursuit of mediation in cases of NPSV/IPV may be advanced by family members in conjunction with community representatives, rather than survivors themselves, who may provide assent (rather than consent) for mediation. Many participants reported that family members of survivors would proactively advocate for mediation of cases of NPSV/IPV, even in rape cases. Referring to cases of rape, one participant reported that it's "*the parents that usually come to [the hospital to] get the mediation"* (INT35, F, nurse, rural community hospital, Northeast region).

A few participants explained that parents seek mediation through village leaders rather than seeking prosecution through the police because it leads to resolution more quickly.

> *"…[if parents] go to the police it's more time-consuming and the case will take years and years to solve. So for them [parents] going this way, marrying is faster. It's fast and it's done"* (INT31, F, nurse, rural community hospital, Northeast region).

A few participants explained that village leaders sometimes ask the survivor and perpetrator in an intimate relationship to sign an agreement in which the perpetrator declares that he will no longer perpetrate violence towards his partner.

> *"…the leader of the community will make a note, or a report that 'OK, this is the first time that you abuse her or this violence has happened, next time you're not going to do it'… then everybody have the signature…it's like an agreement"* (INT33, F, nurse, urban community hospital, Northeast region).

Some participants reported that in most cases village leaders are male.

One participant explained that in Phu Thai tribe culture, when a couple get married they nominate another couple in their tribe to serve as "*second parents*" to provide objective marital advice over the course of their lives (INT23, M, social worker, urban community hospital, Northeast region). The second parents are typically identified as role models for marriage in their community. The parents of the couple typically accept the authority of these 'second parents' in helping to resolve marital disputes. The participant explained that in cases of IPV, survivors may opt to refer to the guidance of their 'second parents,' who help to mediate cases of IPV, including marital rape. The participant also expressed the view that 'second parents' help to prevent violence from occurring by providing guidance at an early stage when the couple are experiencing marital difficulties.

A further participant explained that survivors of rape from hill tribe communities may themselves opt for mediation in the community for the purpose of achieving marriage. Asked what a woman would do if she was raped by her boyfriend, the participant explained *"she would probably ask the guy to come and marry her"* (INT21, F, nurse, rural community hospital, North region).

One nurse from a rural community hospital in Northeast Thailand explained that mediation in cases of NPSV/IPV only occurs if the perpetrator and survivor are from the same village, stating that prosecution involving state actors would occur if the perpetrator is from a different village, indicating that geography may impact upon the influence of the possible injunctive norm that it is acceptable/appropriate for cases of NPSV/IPV to be mediated in the community.

And one participant offered the nuanced view that some survivors would prefer state support over mediation in the community but survivors lose confidence in the police response if the police pursue mediation, lowering their interest in reporting to the police.

> *"…often times the police even tell the women to like talk it out with their husband, talk it out within the family, because they are not taking these cases seriously, so it actually has a negative impact on the women because in the end they kind of like, give up or even run away, they didn't start talking to the police to begin with"* (INT32, F, rural general hospital, East region).

6.3. Section 2 – Participants' views on NPSV/IPV and the influence of social norms on the OSCC response

This section presents participants' views on NPSV/IPV. It then presents social norms influencing the response of OSCC staff to NPSV/IPV and explores their interrelation with other components of the DF, namely individual, institutional, material, and other social factors. Whereas section one sought to explore the views of survivors and factors affecting how survivors respond to NPSV/IPV, section two focusses on the views of OSCC staff on NPSV/IPV and social norms influencing how OSCC staff respond to NPSV/IPV. This section seeks to address the second objective of the study.

6.3.1. Views of OSCC staff on NPSV/IPV

NPSV and IPV are family matters

Some participants expressed the view that NPSV and IPV are 'family matters.' One participant stated that a case of rape in which both the survivor and perpetrator are underage is a *"problem within the family"* (INT23, M, social worker, urban community hospital, Northeast region). The same participant added that it's better if there can be an agreement "*between the two family and don't need to go to the police"* (INT23, M, social worker, urban community hospital, Northeast region). And a participant explained that survivors of IPV should seek to resolve the violence with their husband or involve family members, but *"probably not [the] OSCC"* (INT21, F, nurse, rural community hospital, North region).

Marital rape

A few female participants from general and community hospitals expressed disagreement that non-consensual sexual intercourse within marriage is rape. One participant explained that non-consensual sexual intercourse between a husband and wife is *"not rape… abuse more than rape"* (INT22, F, psychiatric nurse, rural community hospital, East region). The same participant explained that non-consensual sexual intercourse in a couple who are engaged would be rape, explaining that it would be rape if they're unmarried and abuse if they're married. One female participant expressed the view that non-consensual sexual intercourse between a husband and wife is not rape, but rather an *"emotional issue*," adding that she would ask the survivor why she did not want to have sexual intercourse with her husband (INT12, F, social worker, urban general hospital, South region).

A few participants (both male and female) disagreed with the concept of lifelong consent.

> *"…for all the cases, even the husband and wife, or just boyfriend and girlfriend, or the young woman, if the woman didn't give the consent, it's all called rape cases"* (INT3, M, nurse, rural community hospital, Northeast region).

Survivor-blaming

A few female participants from general and community hospitals expressed the view that survivors may be partly at fault for experiencing rape (two social workers and one psychiatric nurse). One participant reported that if a woman is dancing with a stranger in a nightclub under the influence of alcohol, whilst wearing revealing clothing, and she is subsequently raped, then fault is shared "*50:50*" between the survivor and the perpetrator (INT22, F,

psychiatric nurse, rural community hospital, East region). The participant added that the survivor should have protected herself better from rape in this scenario:

> *"…the woman is at fault because she has put herself at risk in this situation for the rape"* (INT22, F, psychiatric nurse, rural community hospital, East region).

Presented with the same scenario, one female participant explained that both the survivor and perpetrator are at fault, but that the perpetrator is "*a bit more*" at fault (INT12, F, social worker, urban general hospital, South region). In contrast, a few female participants from community hospitals expressed the view that the survivor in this scenario is not to blame as survivors are never to blame for rape. One participant simply stated "*the girl should never be blamed"* (INT36, F, psychiatric nurse, rural community hospital, North region).

Mediation of NPSV/IPV in the community without state involvement

Many participants expressed their approval of the mediation of NPSV/IPV in the community without state involvement. One participant explained that it is appropriate for 'minor' cases of NPSV/IPV to be mediated in the community, but that it is appropriate for severe cases of NPSV/IPV to come to the OSCC.

> *"…she is happy with the minor cases being handled in the community but she wants the major cases to come to the OSCC"* (INT33, F, nurse, urban community hospital, Northeast region).

Elaborating on what constitutes a 'minor' case, the participant explained "*something that don't need to go to the hospital,*" raising the possibility of whether some OSCC staff adopt a

medicalised view of NPSV/IPV severity focussed on physical health. The participant also explained that minor cases are those in which "*compromise"* is possible "*so they can both stay in the community*."

Some participants even expressed support for the mediation of rape in the community without state involvement.

> *"…definitely better if they [rape cases] can be settled by the community leaders without having to go to the police because otherwise it's going to be a big deal"* (INT36, F, psychiatric nurse, rural community hospital, North region).

One participant expressed the opinion that it's most appropriate in cases of marital rape for the survivor and perpetrator to talk within the family first, rather than attend the OSCC.

> *"…firstly [the] wife and husband should talk within the family first, but if they don't understand each other they can come to the center to consult"* (INT23, M, social worker, urban community hospital, Northeast region).

A female participant explained that village leaders have a right to mediate cases of rape in which survivors are over the age of majority.

> *"…they have [the] right to negotiate this type of problem…it's okay for them to do that"* (INT8, F, social worker, urban regional hospital, Central region).

One female participant expressed the view that it is better for adolescent survivors of rape perpetrated by an intimate partner to get married and receive financial compensation than for the survivor to go through the court process, which may result in the relationship ending, the survivor remaining unmarried, and a lack of financial compensation.

> *"…if they can negotiate and then for 100,000 Thai baht they can get married together...if the issue go[es] to the court they break [up], relationship [is] not quite good, [they do] not get married"* (INT10, F, psychiatric nurse, urban community hospital, Central region).

Conversely, a few participants expressed disapproval of the marriage of survivors to the perpetrators in rape cases as it is unlikely to lead to a secure long-term relationship.

> *"…it is unfair to the woman because the man sometime do this just to get away from going to jail, which means they don't love the woman, so in the future she's going to be treated very badly"* (INT21, F, nurse, rural community hospital, North region).

A few participants expressed the view that it is better in cases of IPV in which women have dependents for women to be separated from their partner, to demonstrate to their children that they can coparent and remain cordial whilst separated and reveal to children that they can get out of abusive relationships. One female participant expressed the wish that survivors could:

> *"…set the foot down and be the example for the children to be able to get out from the situation"* (INT13, F, social worker, urban regional hospital, Northeast region).

6.3.2. Social norms influencing the response of OSCC staff to NPSV/IPV

This sub-section presents possible injunctive norms indicated by the findings that influence the response of OSCC staff to NPSV/IPV. As mentioned previously, Table 5 presents a summary of possible injunctive norms and their interrelation with other components of the DF, as indicated by the findings of the study.

It is acceptable/appropriate to seek verification of survivors' accounts

Some participants from every hospital size classification explained that OSCCs may seek verification of survivor reports of NPSV/IPV rather than take them for granted, suggesting a possible injunctive norm held by OSCC staff that it is acceptable/appropriate to seek verification of survivors' accounts.

> *"…the most difficult thing is the cooperation of the girls, the teenager, and the cooperation of the family sometimes, because sometimes they [the OSCC] try to interrogate right and they can never get the truth, the real story"* (INT12, F, social worker, urban general hospital, South region).

Some participants reported that OSCC staff may seek validation of survivor accounts from family members, schoolteachers, and health volunteers, with the latter selected as they are typically embedded within the survivor's local community.

> *"…the volunteers who live in the community, sometimes they're neighbours, they are closer to the community, to the patient, so they['re] actually monitoring what is going*

on in the community sometimes, you know, they can help out with the truth" (INT8, F, social worker, urban regional hospital, Central region).

One participant mentioned that in their OSCC providers can seek survivors' permission to talk to relatives to verify their account. However, it was not established if OSCC staff explain to survivors that part of the purpose of the discussion with relatives is to seek to verify their account. Nor is it clear if there is a formal policy about that.

"…the hospital unit will also call the OSCC therapist to talk to her, and after talking to the woman themselves, then they move on to ask the woman whether we could talk to her relatives, and when they invited their relatives to the hospital and could finally talk to them, they will see whether the story aligns" (INT32, F, rural general hospital, East region).

Justifying the need to verify survivors' accounts, the same participant explained:

"…there have been cases where you know the patient is like mentally ill and they misunderstood that they have been assaulted, that they have been raped when they weren't… [the] hospital has to validate whether this is a real rape case" (INT32, F, rural general hospital, East region).

The participant further explained that whilst it may be necessary to validate a survivor's story it should not be done in such a way that survivors feel as though their honesty is being questioned, regardless of whether it is the hospital or the police doing the questioning, adding

that when survivors' accounts are questioned, they feel *"anxious and panicky"* (INT32, F, rural general hospital, East region).

It is acceptable/appropriate to support the mediation of cases of NPSV/IPV

The findings indicated a possible injunctive norm held amongst OSCC staff in some locations that it is acceptable/appropriate to support the mediation of cases of NPSV/IPV. Some participants reported that OSCCs actively participate in the mediation of cases of NPSV/IPV. Asked if the OSCC is ever involved in cases of mediation of rape, one participant explained that she would:

> *"…invite the parents of the lady who was raped… [and ask if] the lady want get married with the man"* (INT10, F, psychiatric nurse, urban community hospital, Central region).

The participant added that it is ultimately the survivor's decision. A participant explained that in cases of IPV the OSCC would *"try to negotiate"* (INT35, F, nurse, rural community hospital, Northeast region). One participant explained that the OSCC would direct the mediation of rape cases and liaise with the community.

> *"…they [OSCC] will ask for help [from the village leader] to go down to the patient's house… and get help from the head of the village that they have to get married"* (INT20, F, nurse, rural community hospital, Northeast region).

One participant explained that whilst it is common for mediation to occur without the involvement of OSCCs "*it's much better if we, [the] OSCC, is involved"* (INT36, F,

psychiatric nurse, rural community hospital, North region). One participant who acknowledged the concept of marital rape explained that in marital rape cases the best course of action for survivors is to attend the OSCC so that the OSCC staff can help the married couple stay together, if possible, adding that they would support them *"if they really need to divorce"* (INT21, F, nurse, rural community hospital, North region).

Conversely, a few participants explained that their OSCCs do not actively participate in the mediation of rape cases, but instead offer support and guidance on referrals and support services to survivors. One participant reported that she *"never had to be the mediator to make the settlement, but [the] OSCC would take the response and would contribute in giving consultations, where to go next, legal actions, psychological treatment"* (INT36, F, psychiatric nurse, rural community hospital, North region).

And one participant said that the OSCC should not help mediate cases of IPV as *"it's not really her job,"* adding that the role of OSCC staff is to provide psychological support (INT26, F, nurse, rural community hospital, Central region). A further participant explained that "*it's not a good practice*" for OSCC staff to support mediation in cases of rape (INT15, F, nurse, rural community hospital, Northeast region).

It is acceptable/appropriate to involve non-state actors in the response to NPSV/IPV

The findings indicate a possible injunctive norm held by OSCC staff that is acceptable/appropriate to involve non-state actors, such as village leaders and health volunteers, in the response to NPSV/IPV. Many participants reported that they proactively collaborate with village leaders and health volunteers in cases of NPSV/IPV. A few

participants explained that village leaders and health volunteers are invited to participate in MDT meetings and training sessions.

Participants reported that the involvement of community representatives is helpful for several reasons. A few participants reported that OSCC staff involve community representatives so that they can monitor survivors and the community.

> *"…they depend on the village leader to help out in the community…or the volunteer in the community, to keep an eye on [the community] and monitor what is happening"* (INT30, F, nurse, urban regional hospital, East region).

Others reported that OSCC staff involve community representatives as they have good understanding of the community including social networks and geography.

> *"…it's very helpful because sometimes the volunteer know[a] the geography, where the house is and everything because if they [are] short on staff of the nurses they might not get time to go the local [community], to go out and see the house"* (INT20, F, nurse, rural community hospital, Northeast region).

One participant reported that OSCC staff involve community representatives as they can provide comfort and security for the survivor.

> *"So they would help in providing safety while they [are] calling the police, right, so Thai police, they respond very slow…while they're waiting so the head of village will*

provide some kind of a comfort and safety" (INT17, F, nurse, rural community hospital, West region).

The same participant reported that OSCC staff involve community representatives as they can provide transportation to survivors. Referring to cases of rape in which the village leaders are involved *"the head of village would provide the car to the hospital"* (INT17, F, nurse, rural community hospital, West region).

One participant reported that the OSCC works with village leaders to "*make sure the community is ready*" for when survivors return to the community (INT4, F, urban regional hospital, Northeast region). The participant explained that in rape cases, the OSCC would conduct a consultation with members of the community and village leaders to enquire as to *"what they think of the patient coming back to the society,"* which involves undertaking an "*evaluation of the people that live in the community toward rape victim*," specifically with respect to their "*attitude*." The participant added "*so it's like a two-way street, so with the patient themselves, and with the community, that work together*."

One participant reported that OSCC staff involve community representatives as they can *"help [provide a] connect[ion] between the hospital and the community"* (INT20, F, nurse, rural community hospital, Northeast region). The same participant reported that OSCC staff involve community representatives as they can help out with home visits with survivors:

> *"…sometimes they get help when they go outside the hospital, let's say they want to go visit the patient's home, they get help from the community leader as well"* (INT20, F, nurse, rural community hospital, Northeast region).

One participant from a regional hospital explained that because their hospital is less immersed in the community they do not collaborate with representatives from the community.

> *"…because it's a regional hospital…she's not really involved with the village or the community"* (INT30, F, nurse, urban regional hospital, East region).

And one nurse from a rural community hospital in Northeast Thailand explained that their OSCC seeks to restrict the involvement of actors in cases of NPSV/IPV to hospital staff, explaining that they do not involve volunteers or social workers outside the hospital, for example, to help ensure confidentiality is maintained.

A few participants reported that they never work with NGOs, with another participant responding *"rarely,"* because *"they don't have them in [participant's province]"* (INT8, F, social worker, urban regional hospital, Central region). One participant from a general hospital in West Thailand did report collaborating with NGOs.

It is acceptable to breach survivor confidentiality in the interest of the survivor or others

Whilst some participants expressed an understanding of the importance of protecting confidentiality, other participants indicated the existence of a possible injunctive norm that it is acceptable to breach survivor confidentiality in the interest of the survivor or others. One participant explained that the interests of the community are more important than protecting survivor confidentiality.

> *"…a better community, better village, is better than keeping a secret [survivor confidentiality]"* (INT17, F, nurse, rural community hospital, West region).

Referring to a rape case, one participant explained:

> *"If she feels that something is fishy, yes they would interrogate more and then they would contact like her local area to find out the truth more… they will find the information by themselves, they won't ask they will find first, to see if the story match[es] what she said"* (INT26, F, nurse, rural community hospital, Central region).

And one participant expressed support for community members breaching confidentiality and referring survivors of rape to the police without the survivor's consent, for the purpose of facilitating survivor access to state support, adding *"it's the right thing to do"* (INT30, F, nurse, urban regional hospital, East region).

Table 5: Summary of possible injunctive social norms emerging from the findings in chapters 1 and 2

Key (theory of normative spectrum): Obligatory ■ Appropriate ■ Acceptable ■ Possible ■

Theme	Injunctive social norm	Groups holding norm	Intersections with other components of the dynamic framework
NPSV/IPV is a 'family matter'	It is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors as it should be handled within the family ■	Police; OSCC staff; Community	Individual/social/material: one participant reported that parents of high social standing may be particularly keen to prevent members of the community from finding out that their daughter has experienced NPSV/IPV. It may also be the case that parents of high social standing are more affluent than those of lower social standing, thus there may be a further intersection with family wealth. Material/social: the possible loss of financial support but also accommodation was also provided by a few participants as a reason why survivors do not report IPV or sexual violence within the family. Social: some participants reported that parents would avoid disclosing NPSV/IPV to avoid stigma from members of the community. *Deviant perspectives:* Individual: one participant offered the deviant perspective that, in a case of IPV, the survivor's parents would not stop their daughter from reporting to the police and may offer sympathy and accommodation for their daughter to help them escape the violent environment. Individual: a few participants expressed the view that parents may recommend separation or divorce in cases of IPV, with both clarifying that it depends on the parents.

	It is obligatory for survivors of IPV to protect the family unit ■	Community; Survivors; Religious leaders (Imams)	Individual/social: one participant reported that survivors may not leave violent relationships to set an example for children that preserving the family unit is important. Material/social: a few participants also reported that survivors may seek to protect children from the financial and social consequences of separation from their husbands. *Deviant perspectives:* Individual: a few participants expressed the view that it is better in cases of IPV in which women have dependents for women to be separated from their partner, to demonstrate to their children that they can coparent and remain cordial whilst separated and reveal to children that they can get out of abusive relationships.
Male dominance	It is appropriate for men to control family finances ■	Community	Material/institutional/social: a lack of available financial and social support for survivors seeking to leave violent relationships serves as a barrier to pursing prosecution, helping to sustain this norm. Financial and social costs may include the need for childcare arrangements and loss of earnings associated with the consequential time commitment.
	It is acceptable for men to beat their wives ■	Community; Survivors	Individual/social: a few participants reported that some survivors and members of the community do not know that IPV is illegal. Institutional: IPV is illegal in Thailand. *Deviant perspectives:* Individual/social: one participant said that members of the community are aware that IPV is illegal.
	It is acceptable for men to have sexual intercourse with their wives without their wives' consent ■	Community; Parents; Survivors; OSCC staff	Institutional: marital rape is illegal in Thailand. Material/social: one participant noted that whether a woman would perceive non-consensual sexual intercourse within a marriage as rape depends on her social and economic circumstances.
NPSV/IPV is taboo	It is inappropriate to discuss sexual violence as it is taboo ■	Community; Family	Social: one participant reported that sexual violence within the family is especially taboo.

Mediation	It is acceptable/appropriate for cases of NPSV/IPV to be settled in the community without state involvement ■■	Community; OSCC staff; Village leaders; Parents	Institutional: a few participants explained that parents seek mediation through village leaders rather than seeking prosecution through the police because it leads to resolution more quickly. Social: one participant explained that mediation in cases of NPSV/IPV only occurs if the perpetrator and survivor are from the same village, stating that prosecution involving state actors would occur if the perpetrator is from a different village.
	It is acceptable/appropriate in rape cases for the survivor to marry the perpetrator ■■	Community; OSCC staff; Survivors ; Village leaders	Individual: one participant explained that some perpetrators accept marriage to avoid jail and that this is a problem as they do not love the survivor and may not treat her well in the future. Material/institutional/social: one participant expressed the view that it is better for adolescent survivors of rape perpetrated by an intimate partner to get married and receive financial compensation than for the survivor to go through the court process, which may result in the relationship ending, the survivor remaining unmarried, and a lack of financial compensation. Social: one participant explained that if there is a connection between the survivor and the perpetrator, then marriage is the likely outcome of rape, whereas if there is no connection the outcome is most likely that the survivor would report to the police. *Deviant perspectives:* Individual: a few participants expressed disapproval of the marriage of the survivor to the perpetrator in rape cases as it is unlikely to lead to a good outcome for the survivor in the long-term.
Verification of survivor accounts	It is acceptable/appropriate to seek verification of survivors' accounts ■■	OSCC staff; police	Institutional: some participants reported that the police and hospital are required to validate survivors' accounts. Social: some participants reported that OSCC staff may seek validation of survivor accounts from health volunteers as they are typically embedded within the survivor's local community.
Confidentiality	It is acceptable to breach survivor confidentiality in the interest of the survivor or others ■	Community; OSCC staff	Individual/social: one participant expressed the view that the interests of the community are more important than protecting survivor confidentiality. Social: one participant explained that it is acceptable for community members to breach survivor confidentiality for the purpose of facilitating survivor access to state support.

Collaboration with non-state actors	It is acceptable/appropriate to involve non-state actors, such as village leaders and health volunteers, in the response to NPSV/IPV	OSCC staff	Social: a few participants reported that the involvement of community representatives, such as village leaders and health volunteers, is helpful as they have good understanding of the community including social networks and geography, they can provide security for survivors, and they can locate safe accommodation for survivors. *Deviant perspectives:* Individual: one participant explained that their OSCC seeks to restrict the involvement of actors in cases of NPSV/IPV to hospital staff, explaining that they do not involve volunteers or social workers outside the hospital, for example, to help ensure confidentiality is maintained.

6.4. Section 3 - Institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV

This section presents institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV. As such, this section is a more focussed examination of one of the components of the DF, namely institutional factors. This section seeks to address the third objective of the study.

6.4.1. Inconsistent case management

The findings of the study indicate significant variability in Thailand with respect to the actors responsible for NPSV/IPV case management and the extent to which case management is undertaken. A definition for case management is presented in the glossary of terms. A wide range of actors were reported as carrying out a case management role. Many participants reported that social workers or nurses undertake case management. Some participants reported that village leaders, MSDHS officers, or the family of the survivor undertake case management. Doctors, teachers, community volunteers, and NGOs were also listed among the people responsible for case management. One participant suggested that the case manager is often the survivor's first entry point, with case management undertaken by the "*unit that [has] already taken up the case"* (INT29, F, urban general hospital, West region).

Some participants reported that their OSCC does not have a formal case management role, but that it varies on a case-by-case basis. Asked which actors are usually responsible for case management, one participant responded:

> *"It can be a social worker. Usually it's a social worker. But it can be anybody you know? It's whoever can go and visit them and take care of the case"* (INT7, F, social worker, urban general hospital, West region).

One female participant reported that lack of time was a barrier to optimal case management as other responsibilities impinged on the amount of time needed to oversee and coordinate cases, expressing frustration that she "*doesn't have enough time as well because as a case manager she's so busy"* (INT14, F, social worker, urban general hospital, South region).

6.4.2. Limited training and induction

Many participants reported that both national and regional/provincial training is offered for OSCC staff each year. A few participants reported that OSCC staff participate in provincial multidisciplinary case conferences once or twice per year, which many participants reported concurrently serve as training sessions. Although one participant explained that these meetings are typically "*focussed more on prevention*" than response (INT2, M, social worker, urban university hospital). One participant said that the national training in Bangkok is very informative, adding that there is no need for the training to be modified because there's "*a lot of information already during the training"* (INT14, F, social worker, urban general hospital, South region).

However, many participants expressed the view that the training that they receive to conduct their roles is insufficient.

> *"…they don't really have any training especially for the OSCC, maybe because they're a small hospital, there are not so many cases, so they don't really pay*

attention [to the] training [of] the staff" (INT28, F, urban community hospital, North region).

One participant explained that she would appreciate practical training on how to manage cases.

"…she would like to have the dummy or the case study so they can really get hands on" (INT27, F, nurse, rural community hospital, Northeast region).

A lack of OSCC staff was reported as a barrier to attendance at training sessions by one participant due to the lack of cover to ensure that survivors receive support when staff are attending training.

"…they're short on people so they don't have the opportunity to go to Bangkok and learn more" (INT27, F, nurse, rural community hospital, Northeast region).

A few participants reported that OSCC staff receive induction training from resident OSCC staff. One participant explained that OSCC case managers offer on-the-job training to staff.

"…once they [new staff] have a patient, she go[es] with them, actually go[es] in with them side-by-side, so they can show her everything, and after that she can do it all by herself" (INT27, F, nurse, rural community hospital, Northeast region).

Conversely, one participant reported that new staff members do not receive any induction in their OSCC, but are simply presented with a guideline to follow.

"…there's no training so they just follow the guideline" (INT28, F, urban community hospital, North region).

6.4.3. Variability in the existence, content, and adherence to guidelines

The findings indicated variation in the existence, content, and adherence to guidelines across OSCCs. Many participants reported being aware of MOPH's OSCC manual, which provides guidance to OSCCs in the response to NPSV/IPV. Many participants though reported that they created their own guidelines, adapted from the MOPH OSCC manual, and some said that MOPH do not review these adaptations of the OSCC manual by individual OSCCs.

Various reasons for adapting the OSCC manual were provided by participants. Some participants explained that the OSCC manual is too generic.

"…[they add] some more details because the guideline [OSCC manual] is still too neutral, so they adapt, like add more details to it" (INT3, M, nurse, rural community hospital, Northeast region).

Some participants explained that each survivor's situation is different requiring an individualised response, not accounted for by the OSCC manual.

"…it's [OSCC manual] not really helpful, it really depends on [the] case, so right now they're developing [guidelines] for everybody who have the same standard" (INT30, F, nurse, urban regional hospital, East region).

A further participant said that it was necessary to adapt the OSCC manual as it did not account for their hospital size and its limited resources.

> *"…[the OSCC] had to adapt it to make it work for the hospital, because it's a small hospital, they don't have all the equipment, the lab work, so they have to do the examination to get the sample and then send it out to the lab outside the hospital. That may take a couple days to get back the result"* (INT16, F, nurse, rural community hospital, Northeast region).

A few participants reported that clear guidance on performance indicators for NPSV and IPV would be helpful as the lack of measurable goals and key performance indicators for OSCC staff limits staff motivation to provide a high-quality service.

> *"…right now there's no like measurable goals, there's no KPIs [key performance indicators], you know, that this staff or workers in each department have to follow and achieve, so things are not being taken seriously"* (INT32, F, rural general hospital, East region).

6.4.4. Variability in availability of infrastructure and services

The findings revealed variation across OSCCs in the location of the OSCC services within the hospital and facilities available to OSCC staff. Some participants reported that the OSCC was located in the psychiatry department. A few participants reported that the OSCC was located in the outpatient department or in the emergency room (ER). One participant reported

that the OSCC was located in the forensic department and a further participant reported that the OSCC was located in the social work department.

A few participants reported that forensic examinations in rape cases occur in the outpatient department. A few participants reported that forensic examinations occur in the labour ward. And a few participants reported that forensic examinations occur in the ER. One participant explained that forensic examinations happen in the main ER bay area, with curtains pulled around the bay during the examination, presenting a threat to the protection of privacy and confidentiality.

> *"...for the rape patient, the doctor will come to the same spot, to the ER [bays] that have [a] curtain… they['re] going to call the forensic doctor [to] come in and do an examination after the general examination"* (INT13, F, social worker, urban regional hospital, Northeast region).

With the exception of the university hospital, many participants from all hospital sizes reported that the OSCC share the room in which they conduct consultations. Most of the participants that reported that their OSCC shares a room were from community hospitals, although it should be noted that the sample had proportionately more community hospitals than hospitals in other size classifications. Some participants reported sharing a room with the psychiatry department, primary care unit, hospital administration department, outpatient department, forensic department, and general medical department. A few participants explained that they use whichever room in the hospital is available. Participants have reported challenges associated with room sharing, noting that if a room is already occupied, finding an alternative space within the hospital becomes necessary. This not only reduces the

capacity of staff to ensure survivor privacy and confidentiality but also causes delays in providing support. Additionally, it results in inconvenience and frustration for OSCC staff.

> *"…the OSCC in her hospital don't have their own department or room, they have to go and use whichever room is available at that time from other departments"* (INT31, F, nurse, rural community hospital, Northeast region).

With the exception of the university hospital, some participants from all hospital sizes reported that the OSCC does have its own private room. Most of the participants that reported that their OSCC has its own private room were from community hospitals. It is not apparent from the findings that OSCCs in larger hospitals are more likely to have their own private room.

Many participants reported that the OSCC does not provide a 24/7 service as intended, but rather only during normal working hours from Monday to Friday.

> *"…this office [OSCC] is open from 8:30 to 4…as far as our center is concerned, we're not open 24 hours"* (INT2, M, social worker, urban university hospital).

A few participants explained that survivors that arrive at the OSCC outside normal working hours may be asked to return the next day.

> *"…[if] it is after the working hour, after 4 p.m.… they [survivors] have to wait until the next day to get all the doctor report and everything"* (INT12, F, social worker, urban general hospital, South region).

A further participant from a general hospital in South Thailand explained that survivors of rape that attend the hospital during the weekend will be asked to return on Monday for the forensic examination, indicating that if a survivor attends on Friday at 4:30 p.m. they would not receive a forensic examination at that location until Monday morning. Referring to rape cases, one participant explained:

> *"…if the patient go to ER on the weekends they will tell the patient to come back again,…come back again on Monday"* (INT14, F, social worker, urban general hospital, South region).

One participant reported the availability of forensic examinations 24/7, with an obstetrician/gynaecologist performing the examinations during working hours and ER doctors conducting the examinations out of hours:

> "*If it's like at midnight… [it] will be the ER doctor, but in the daytime it would be the women's doctor"* (INT32, F, rural general hospital, East region).

One participant explained that survivors of IPV presenting over the weekend "*would be asked to come back on the Monday"* (INT9, F, psychotherapist, urban community hospital, South region) rather than be kept in the hospital, with the possibility that these survivors will return to a violent relationship in the meantime.

Conversely, one participant explained that survivors that attend the hospital outside working hours are provided with some initial support and temporary accommodation, typically in the

ER, and transfer to the OSCC when it opens, rather than risk letting them return to a violent home:

> *"They will make them [survivors of NPSV/IPV] sleep in [the] hospital and then in the morning they will send someone. They won't let them go back [home]"* (INT7, F, social worker, urban general hospital, West region).

6.4.5. Limited financial and human resources

Limited financial resources

Types of funding

The findings suggested variability in the amount and structure of OSCC funding, which was specifically reported by a few participants.

> *"…the Ministry of Public Health provide funding for hospitals, but the small hospitals also get local health funding"* (INT14, F, social worker, urban general hospital, South region).

Another participant reported that their OSCC undertook fundraising activities, such as requesting financial support from NGOs to supplement minimum earmarked MOPH funding, reported as approximately 20,000-30,000 Baht per year (£456-684 GBP at the time of writing).

> "*There's only like 20-30 thousand per year, given by the government to the OSCC*" (INT7, F, social worker, urban general hospital, West region).

The participant explained that the OSCC is eligible to apply for funding from a hospital fund, but that the application process is complicated and typically involves a lot of paperwork, thus it is generally quicker and easier to ask for money from NGOs.

Participants indicated variability in the amount of MOPH funding according to hospital size classification. A few participants from community hospitals in Northeast Thailand reported that they receive funding from the MOPH of 250 Baht (£5 GBP at the time of writing) per survivor, which goes to the general hospital fund rather than to the OSCC. One participant at a general hospital in West Thailand explained that their OSCC receives 500 Baht per case (£11 GBP at the time of writing) from the MOPH, paid out biannually. One participant noted:

> *"The department of public health send[s] them the fund and then the fund fluctuate[s] by the patients, by the report that they send out to the department, so they give them the fund, let's say the general hospital, they have more patients so they get bigger [amount of funding], you know, or the community hospital they don't have a lot of patients so they get les*s" (INT27, F, nurse, rural community hospital, Northeast region).

Another participant from a regional hospital in Northeast Thailand explained that OSCCs receive financial support indirectly through MOPH's funding of training courses. One participant from a rural community hospital in East Thailand reported that the OSCC receives funding from the general hospital fund and a participant from a university hospital reported that their OSCC falls under the governance of the Ministry of Education (MOE) so they do not receive any MOPH funding, nor do they receive funding from the MOE, thus they are

required to source all funding from external sources. As an example, the participant reported that a previous OSCC director with a particular interest in addressing the lack of funding for their OSCC donated a significant sum to the OSCC upon retirement.

The findings also suggest variation in the use of funds. One participant reported that their OSCC uses its funds for prevention activities.

> *"…we use the funds for doing activities for prevention, like the 20th [25th] November every year is end violence against women [day], so we do activities*" (INT2, M, social worker, urban university hospital).

And one participant reported that their OSCC uses their funds for training of OSCC staff.

> *"…money is paid to the OSCC, to the hospital, to be used to develop, or like, improve the knowledge of the officers*" (INT29, F, urban general hospital, West region).

Challenges associated with a lack of funding

Many participants expressed the view that the funding their OSCC receives is insufficient. Participants reported that a lack of funding presented various challenges. A few participants reported that a lack of funding resulted in a lack of training. One participant reported that if she received more funding she would *"get more knowledge*" (INT27, F, nurse, rural community hospital, Northeast region).

A few participants reported that a lack of OSCC staff was a consequence of a lack of funding. One participant reported a lack of incentive to work for the OSCC as the staff are not paid extra for working at the OSCC.

> *"…the OSCC doesn't have specific budget assigned to it…you will see that staff only are working in the OSCC for like maybe a few months or just one year max, and it's not sustainable because there is no profession in terms of career or any incentive that make people want to like volunteer, to work here*" (INT29, F, urban general hospital, West region).

One participant expressed a lack of a sense of belonging as a consequence of the lack of allocated funding, explaining that it was as if they needed to ask *"permission to be in this hospital*" (INT29, F, urban general hospital, West region). A further participant indicated that a lack of payment of OSCC staff reflects an underappreciation of the importance of their work.

> *"…everyone feels like OSCC is kind of like voluntary work more than important work*" (INT31, F, nurse, rural community hospital, Northeast region).

A few participants expressed the view that a lack of funding for OSCCs was in part a consequence of a lack of OSCC visibility, suggesting that enhancing OSCC visibility would lead to greater resources for OSCCs.

> *"…the information about us [OSCC] haven't been shared throughout the whole country so people never know that we're existing here, so when people don't know*

> *about us it means less info, and less info means less budget to improve our department…everything is to be solved by money*" (INT18, F, social worker, urban regional hospital, Northeast region).

Conversely, some participants reported that there are some OSCC advertisements to increase visibility, such as billboard and poster advertisements, radio advertisements, and an MSDHS bus decorated with an OSCC advertisement. A few participants in university and general hospitals also reported that their OSCCs undertake public awareness campaigns in their community, including offering training sessions on NPSV/IPV for health volunteers and other members of the community.

Limited human resources

Relating to lack of funding, many participants across all hospital size classifications reported a lack of OSCC staff as hindering the OSCC response to NPSV/IPV. Some participants from predominantly community hospitals reported a lack of staff in core disciplines, such as social workers or forensic examiners.

> *"…[we] don't have the forensic [examiner]… the child psychiatrist, [we] don't have that one too. So it's not enough, not enough people that work in this field*" (INT14, F, social worker, urban general hospital, South region).

In contrast, one participant from a university hospital and one participant from a regional hospital reported that the OSCC had access to a broad range of staff, including a variety of specialist doctors. One participant reported "*we have experts in every aspect*" (INT2, M, social worker, urban university hospital). Whilst these findings suggest that OSCCs in larger

hospitals are more likely to have access to staff in core disciplines, one participant from a regional hospital in Northeast Thailand reported that they do not have a specialist forensic examiner, suggesting that even some larger hospitals might not have a full cohort of staff.

Challenges associated with a lack of staff

Participants described various challenges associated with a lack of staff. A lack of staff time as a consequence of a shortage of OSCC staff was reported as impacting upon comprehensiveness of care by a few participants. One participant reported that the OSCC staff were:

> *"…short on staff and they['re] burned out, so they don't give a good treatment for the patient*" (INT13, F, social worker, urban regional hospital, Northeast region).

A few participants from urban community hospitals reported that some staff work in roles that do not map onto their training due to a lack of staff. One participant explained, "*the psychologist will be the social worker and the nurse*" (INT9, F, psychotherapist, urban community hospital, South region).

Many participants reported that due to lack of staff, male doctors may undertake forensic examinations in rape cases, including internal forensic examinations. One participant stated that this was because they *"don't have[a] forensic doctor that's female at the hospital*" (INT30, F, nurse, urban regional hospital, East region). One participant explained that the hospital rota is relevant to the likelihood that a survivor will receive a forensic examination from a male doctor, explaining that cases that come in during the weekend that require a forensic examination will be seen by a male doctor because *"the doctor who is responsible*

for Monday is the male [doctor]" (INT14, F, social worker, urban general hospital, South region).

One participant explained that during normal working hours forensic examinations are typically undertaken by a female doctor, but outside working hours it may vary.

> *"…during the normal working hours they tend to have the female doctor handle this case, but even out of hours that can't really have an option so they going to have whoever in charge at that moment*" (INT28, F, urban community hospital, North region).

Some participants reported that the doctors performing forensic examinations at their hospital are general medicine or ER doctors rather than specialists in forensic medicine or gynaecology. One participant explained that forensic examinations are undertaken by *"the general doctor who's on duty at that moment*" (INT31, F, nurse, rural community hospital, Northeast region). A few participants from community hospitals stated that the general medicine or ER doctors do not have training in conducting forensic examinations and that they follow a guideline for performing forensic examinations. Asked whether non-specialist doctors conducting forensic examinations receive any training, one participant replied *"they didn't get the training, they just follow the guideline*" (INT1, nurse, rural community hospital, Northeast region).

The lack of social workers was also reported as a common problem in community hospitals by a few participants. One participant expressed disagreement with asking hospital staff to take on the social worker role without appropriate training.

> *"…if they are a social worker, they should have the licence, like [a] social worker licence. That is very important*" (INT14, F, social worker, urban general hospital, South region).

A few participants also explained that a lack of interpreters at their hospital presented a challenge (one university hospital, one general hospital, and one community hospital). One participant explained that in the absence of an interpreter, relatives of other patients or patients themselves may be asked to provide interpretation if they speak the required language.

> *"…firstly it will be the staff, some of the staff can speak [the required language], but if they're not there then they would ask the patient's relatives or even the patient at the hospital, sometimes they can speak [the required language]*" (INT21, F, nurse, rural community hospital, North region).

Despite staff shortages, one participant explained that the OSCC staff in her hospital endeavour to ensure that every case is seen, even if there is an increase in number of cases, adding that they *"don't really have an option… [we] have to treat everybody*" (INT13, F, social worker, urban regional hospital, Northeast region).

6.4.6. Inconsistent coordination within the hospital and with actors based outside the hospital

Participants indicated inconsistent coordination within the hospital and with actors based outside the hospital. One participant explained that coordination within their hospital works well because everyone uses a guideline and they understand each other's roles well.

> *"… everything is perfect because they have the guideline so everybody have responsibilities, and [participant] is the one that cooperate [coordinates] everything…everybody know[s] their role*" (INT24, urban general hospital, Northeast region).

One participant from a rural community hospital in North Thailand reported that representatives of the various departments of the hospital sit on the OSCC committee that meets to discuss the operationalisation of the OSCC model, supporting understanding across disciplines. A further participant from a general hospital in Northeast Thailand explained that non-OSCC hospital staff take over the patients of OSCC staff whilst OSCC staff attend to a new case of NPSV/IPV, indicating a level of understanding and constructive internal coordination. A few participants reported that internal multidisciplinary case conferences are held in the hospital to discuss cases, in addition to separate MDT meetings with various actors outside the hospital. A few participants explained that the OSCC manual has separate sections for the doctor, nurse, and social worker in the hospital, so each actor has to record information in the notes, facilitating coordination between these professions.

A challenge to coordination within the hospital reported by one participant from a general hospital in South Thailand was that some hospital staff may not be aware of the OSCC situated within their own hospital. A nurse working at the hospital was reported as only

recently discovering that her hospital had an OSCC, despite working in the hospital for over 10 years (the OSCC was >5 years old).

Participants reported various challenges to coordination between the OSCC and organisations based outside the hospital, such as the police, public prosecutors, schoolteachers, amongst others. One participant reported that the various sectors need to "*have the same goal*" in cases of NPSV/IPV, adding that a challenge is "*how to cooperate*" (INT20, F, nurse, rural community hospital, Northeast region).

Many participants reported that there are MDT meetings to support multisectoral coordination. Some participants explained that whilst MDT meetings do occur they are infrequent. One participant explained "*every three months they'll have [the MDT] meeting"* (INT7, F, social worker, urban general hospital, West region). One participant explained that the high turnover of staff attending MDT meetings inhibits multisectoral coordination.

> *"…there's a change of the responsible persons very often. So this is a challenge"* (INT15, F, nurse, rural community hospital, Northeast region).

A few participants reported that the guidelines that the various state sectors use when responding to NPSV/IPV differ across organisations. One participant stated that "*everybody use[s] different guideline[s]*" (INT13, F, social worker, urban regional hospital, Northeast region).

The findings indicated that, whilst there are challenges to multisectoral coordination between the OSCC and various sectors, coordination with the police is especially challenging. One

participant reported conflict between the OSCC and police with respect to the understanding of their roles and responsibilities, elaborating that the police want the OSCC to pursue confirmation of the veracity of events whereas OSCC staff want to focus on providing psychological support.

> *"…the police themselves also expect the hospital to be the ones who interrogate the patients… at the same time the hospital also want[s] to support the women to…heal them mentally and physically... it's like two conflicting things that they have to do*" (INT32, F, rural general hospital, East region).

A lack of MOUs to support multisectoral coordination was reported by a few participants. A few participants reported the presence of an MOU between the OSCC and the police to promote a coordinated response to NPSV/IPV, although participants reported that it is not always observed by the police.

> *"They do have the understanding that, that they [the police] should come here [to the OSCC]…many times they called and the police cannot come here... the police had said you know, it's too, too many [cases], they're not able to do it*" (INT7, F, social worker, urban general hospital, West region).

One participant reported that the police are more likely to respond to the law than an MOU that is not legally binding.

> *"…if it's a law it might [be followed]… but if [it's] an MOU, they might have some excuses*" (INT25, F, psychiatric nurse, rural community hospital, South region).

One participant explained that the police would not even attend the OSCC in a severe case, although may be motivated to attend if the case has media attention.

> *"But as far as the police [is concerned], they generally don't come here even if it's like a stabbing. If it's like on the news or something they will come here, but usually if it's a big, even if it's a big very bad injury, they won't come here*" (INT7, F, social worker, urban general hospital, West region).

One participant expressed the view that this was partly due to overburdening of the police and partly because police believe that the procedure is for survivors to go to the police station.

> *"So it's very difficult for the police to come here. The police will always say that usual procedure is for the person who is injured to go to the police and file a report*" (INT7, F, social worker, urban general hospital, West region).

Conversely, one participant explained that the *"police come every time when they [OSCC staff] ask for them to come"* (INT3, M, nurse, rural community hospital, Northeast region). A further participant reported that the police would only attend the OSCC if the survivor did not attend the police station first.

> *"So if the patient doesn't do the report at the police station yet the police will come to the hospital"* (INT9, F, psychotherapist, urban community hospital, South region).

Some participants reported that the police often do not refer cases of NPSV/IPV to the OSCC. One participant expressed the view that the police only refer a minority of cases of NPSV/IPV to the OSCC, adding that *"people come in [to the police] because they needed help, but [they're] just denied it"* (INT13, F, social worker, urban regional hospital, Northeast region). One participant from a community hospital in North Thailand even simply stated that the police do not refer *any* cases of NPSV/IPV to the OSCC.

A few participants offered a more nuanced view that the police will definitely refer cases of sexual violence to the OSCC, but they do not typically refer IPV to the OSCC. Conversely, one participant from a general hospital in South Thailand expressed the view that the police referred 100 per cent of cases of rape to the OSCC. A further participant from a general hospital in West Thailand, however, expressed doubt that the police referred all cases of sexual violence to the OSCC.

Problematic understandings, beliefs, and attitudes of the police were reported by participants, possibly in part accounting for a lack of referral by police of cases of NPSV/IPV. Many participants reported that the police under prioritise NPSV/IPV. One participant indicated that the police may perceive IPV as less serious than theft.

> *"They [police] need to go and arrest thieves and other people, domestic violence is a small matter for them"* (INT7, F, social worker, urban general hospital, West region).

In one interview at a general hospital in West Thailand in which the participants were asked if the police send 100 per cent of cases of IPV to the OSCC, both participants responded with laughter before explaining that the police are likely to tell survivors that it's a personal issue

that they should solve by themselves. One participant described a long and complex process for survivors after OSCC referral to the police which could influence the withdrawal of a case.

> *"…the police they will come to pick up that document to see whether, OK everything has been validated in terms of like, mental health. But actually the police will not come every day. You know, they just come maybe once or twice a week as they like, they're not like, trying to do everything immediately for the patient. And the procedure will then be even more delayed because, you know, when it comes to like Thai police procedure, they basically, once they have all the documents it's not like they start the procedure right away, they will wait for a few weeks and then maybe call the patients in to talk and like I said, there is the phase where they try to get the women to like talk things out to see whether this, whether it has to be a case, you know, [they] have that phase. And then at that point, the patient will feel like quite like exhausted, you know, with every procedure that they have to go through, and that's where they drop the case"* (INT32, F, rural general hospital, East region).

This participant's contribution again highlights that police may seek to verify survivor accounts to see if there is a 'case.' The participant reported that their OSCC does not chase the police as they are overburdened with their own responsibilities.

6.4.7. OSCCs are not truly 'one stop'

Despite the fact that OSCCs were introduced in Thailand in part to reduce the number of times survivors are required to present to state services, some participants across all hospital size classifications held the view that, even if survivors overcome the numerous and

substantial barriers to OSCC attendance, subsequent processes still involve too many steps and referrals. Many participants reported that OSCCs are not truly one stop.

> *"…they [the survivors] have to go to all the different places to do all the paperworks, different things, because if it's really a one stop service, then, you know, then everything will be done in one place"* (INT7, F, social worker, urban general hospital, West region).

The findings indicate that a consequence of the lack of police attendance at the OSCC is that when there is a case the OSCC staff may refer survivors to the police station. Some participants reported that survivors of sexual violence presenting to the OSCC without a police report would be turned away from the OSCC and told to return to the OSCC once they have acquired a police report (two regional and two general hospitals), although one participant from a regional hospital in Central Thailand added that in serious cases they would receive medical treatment including a forensic examination first before being sent to the police. Referring to a survivor of rape, one participant explained:

> *"…the only way is they [the OSCC] will advise her to go to the police first because without the police documents form the doctor will not do anything"* (INT12, F, social worker, urban general hospital, South region).

One participant from a different general hospital in South Thailand explained that one reason for refusing to examine survivors of rape without a police report is to protect the doctor.

> *"So for the patient that didn't go to the police station, the doctor [at] the hospital will tell the patient to go to the police station first to get the report and everything. So it's not going to be a problem to the doctor later when the doctor has to go to the court"* (INT14, F, social worker, urban general hospital, South region).

One participant from a community hospital in South Thailand explained that part of the rationale for requesting a police report first was out of concern for the cost to the government of the lab work required as part of a forensic examination of 3000-4000 baht (£68-£91 GBP at time of writing). Other participants from university, regional, and community hospitals, however, reported that survivors of sexual violence would be attended to at the OSCC and receive a forensic examination if they did not have a police report. Asked whether survivors typically return to the OSCC after being sent to the police station by OSCC staff, one participant responded that all return and a few others responded that the majority return.

Some participants explained that they refer survivors to MSDHS upon discharge from the hospital. One participant explained that once a survivor has been discharged from the hospital they pass on responsibility to MSDHS.

> *"…she would be involved with the medical [issues], everything in the hospital, and everything outside the hospital would be the Ministry of Social Development"* (INT17, F, nurse, rural community hospital, West region).

A few participants reported that OSCC staff may also refer survivors to OSCCs located in larger hospitals, with greater availability of resources and expertise. One psychiatric nurse from a rural community hospital in North Thailand reported that the requirement of referral

of select cases of NPSV/IPV, including rape, from her community hospital to a regional OSCC is embedded within a shared SOP, created by a joint committee of various ministries at a central level. The participant reported that the provision of transportation from the community hospital to the regional hospital was embedded in the SOP. However, a nurse from a rural community hospital in Northeast Thailand reported that their OSCC was unsuccessful in their attempt to gain support from the hospital director of their community hospital for the provision of transportation for survivors from the community OSCC to the provincial OSCC. And a nurse from a regional hospital in East Thailand highlighted that a consequence of the insufficient capacity of community OSCCs is that survivors are required to travel large distances to receive support from the regional OSCC.

6.4.8. Limited formal follow-up

Many participants reported that survivors of NPSV/IPV receive follow-up from the OSCC, although participants reported that OSCC follow-up of cases of NPSV/IPV is limited. A few participants reported that insufficient human and financial resources was a barrier to follow-up due to a lack of staff time and transportation to conduct home visits.

> *"This is a weak point of ours. Because we're social workers, we're working for the whole hospital, so following up the case is difficult for us… if we had our own vehicle we could use, on Saturday and Sunday, we would as a team drive out and visit these people and see how they're doing, follow-up"* (INT2, M, social worker, urban university hospital).

Similar to case management, a few participants reported that follow-up is fractured, with multiple sectors undertaking partial follow-up and each sector following their own follow-up procedure i.e., there is a lack of comprehensive, consolidated follow-up across sectors.

> *"…when we talk about the cases that is like, with the police… it's for the police to follow-up by themselves"* (INT32, F, rural general hospital, East region).

A few participants explained that their OSCC does not have a formal follow-up procedure, but that follow-up occurs on an ad hoc, case-by-case basis; this approach was described by a few participants as better suited to a tailored follow-up approach that accounts for variability in survivor needs and interests. One participant reported "*the best thing that we can do is just reach out to them once in a while and ask them about usual life and if they need us, they know how to catch us"* (INT18, F, social worker, urban regional hospital, Northeast region).

Some participants explained that there is a formal follow-up procedure, with a few participants expressing the belief that their follow-up procedure was created by the MOPH and a further participant reporting that the follow-up procedure came from their hospital. One participant expressed the view that their follow-up procedure is "*not [useful] in practice, you must really look at the case"* (INT7, F, social worker, urban general hospital, West region).

One participant explained that if a survivor is referred to the OSCC by a village leader, the OSCC staff will ask the village leader to follow-up upon discharge.

> *"…when the head of village send[s] them to the hospital the nurse would just let him be the guy to follow-up"* (INT17, F, nurse, rural community hospital, West region).

A few participants reported that community volunteers are mobilised to help follow-up of cases. One participant explained that their OSCC is content with subdistrict hospitals providing follow-up for cases of IPV, although they reported that rape cases are sensitive and thus they do not hand over responsibility for follow-up of rape cases to subdistrict hospitals.

> *"…if the rape case come in they will handle it themselves because they don't want a lot of people to know about it, it is a sensitive subject so they [are] not going to have the subdistrict hospital handle it"* (INT16, F, nurse, rural community hospital, Northeast region).

Some participants reported that follow-up may involve a home visit or a phone call. A few participants reported that follow-up may involve a text message on the LINE app[3] and one participant explained that follow-up may involve an opportunistic meeting when the patient returns to the hospital.

6.4.9. Variable monitoring and assessment of OSCC performance

Various mechanisms for monitoring and assessment of OSCC performance were reported by participants, although participants also noted some shortcomings of these mechanisms. A few participants from hospitals in South Thailand reported that OSCCs are assessed in every hospital twice per year as part of the national Healthcare Accreditation (HA) hospital-wide assessments. The participants explained that whilst these HA assessments do not have a

[3] LINE is a commonly used messaging platform in Southeast Asia, similar to WhatsApp

specific focus on OSCCs, they do examine the response of OSCCs as a component of their hospital assessment, with one participant reporting that the outcome of one of these assessments had been the appointment of another member of staff to the OSCC.

One participant from a regional hospital in South Thailand reported that performance is discussed in OSCC committee meetings approximately every year, and that their OSCC also helps assess the response of neighbouring OSCCs. One participant from a rural community hospital in Northeast Thailand explained that their hospital conducts an annual OSCC review to discuss cases and review guidelines. And one participant reported that the OSCC does self-assessments every month where the staff discuss the strengths and weaknesses of their response.

> *"So, primarily we just talk amongst ourselves in the team, we have a meeting every, monthly meeting and we talk about things like this, you know what our strengths and weaknesses are"* (INT2, M, social worker, urban university hospital).

A few participants explained that the provincial MOPH office visits OSCCs to undertake evaluations of the OSCCs in the province once per year. Conversely, when asked if there are any evaluations of their OSCC one participant simply stated "*no"* (INT21, F, nurse, rural community hospital, North region).

The findings indicated that oversight of OSCCs may fall under different ministries, which could present a challenge to efforts to achieve standardisation of oversight across OSCCs. The participant from a university hospital explained that their OSCC falls under the governance of the Ministry of Education, not MOPH.

7. Chapter 7: Discussion

7.1. Introduction

This chapter discusses cross-cutting and important themes that emerged from the findings of our research. Section one discusses findings pertaining primarily to objective one. Section one presents and discusses considerations for the design of referral pathways for streamlining survivor access to appropriate trauma-informed support. Our findings indicated that multiple actors may be involved in the response to NPSV/IPV, pointing towards the need for referral pathways involving both state and non-state actors to enhance survivor access to OSCCs. The lack of referral pathways has been identified as a common barrier to the effective implementation of OSCCs globally (45).

Section two discusses findings pertaining to objectives one and two. Section two discusses the benefits and challenges of employing a social norms lens when conducting an examination of the accessibility and response of OSCCs to NPSV/IPV, before critically assessing the application of the conceptual frameworks used in our study, namely the DF and the TNS. The findings exposed social norms of variable strength intersecting with individual, institutional, material, and other social factors, that influence survivor help-seeking and disclosure and the response of OSCC staff to NSPV/IPV. To my knowledge, this study is one of the first applications of a social norms lens to an examination of the accessibility and response of a health system to VAWG.

Section three discusses findings pertaining to objectives two and three. Section three presents and discusses considerations for standardisation of the response of OSCCs to NPSV/IPV in

Thailand. Our findings indicated the existence of measures to improve standardisation of the response of OSCCs to NPSV/IPV in Thailand, including SOPs within hospitals, intersectoral MOUs at regional, provincial, and local levels, and a national OSCC manual. Yet, our findings indicate that standardisation mechanisms currently in operation are insufficient to ensure that a high level of trauma-informed support (50,155,156) is consistently provided across locations.

Section four presents and discusses strengths and limitations of the research. Sections five and six present recommendations for policy and practice, as informed by our findings. Finally, section seven presents opportunities for further research.

7.2. Summary of key findings

Objective one sought to examine the help-seeking and disclosure preferences and behaviours of survivors of NPSV/IPV and the factors influencing survivors' responses. Participants in our study reported a variety of survivor help-seeking and disclosure preferences and behaviours, with survivor silence (non-disclosure) identified as a common response, adding to previous concerns of underreporting of NPSV/IPV in Thailand (39,40). Our findings indicated several possible social norms influencing survivor disclosure and access to OSCCs, such as the norm that it is inappropriate for NPSV/IPV to be disclosed to state or non-state actors as it should be handled within the family and the norm that it is obligatory to keep the family unit together. The social norms findings were identified as intersecting with other individual, institutional, material, and social factors impacting survivor disclosure, including survivors' 'personal thresholds' for disclosure, low visibility of OSCCs in the community, lack of women's economic empowerment, and the presence of dependents.

Objective two sought to examine the views of OSCC staff on NPSV/IPV and explore the influence of social norms on the OSCC response. Our findings exposed problematic views held by some (but not all) OSCC staff impacting their response to NPSV/IPV, such as the view that NPSV and IPV are family matters, disagreement that non-consensual sexual intercourse within marriage is rape, the view that survivors are (partly) at fault in rape cases, and the approval of the mediation of NPSV/IPV in the community without state involvement. Our findings also exposed possible social norms influencing the response of OSCC staff to NPSV/IPV, including the injunctive norm that it is acceptable/appropriate to seek verification of survivors' accounts and the injunctive norm that it is acceptable to breach survivor confidentiality in the interest of the survivor or others.

Objective three sought to investigate the institutional factors impacting upon the accessibility and response of OSCCs to NPSV/IPV. Among the findings were limitations and variation across OSCCs in i) number, professions, and specialist knowledge of OSCC staff; ii) extent and types of training of OSCC staff; iii) actors responsible for case management; vi) structure, amount, and use of funding; and vi) formulation of, and adherence to, guidelines promoting standardisation. As a consequence of this variation, the findings indicate that the extent to which survivors receive trauma-informed support is contingent on their geographical location. The findings suggest that OSCCs are not currently serving as a single site for one stop support.

The exploratory study design was somewhat limited in the strength of claims that could be made about differences across groups. However, some minor differences across groups did

emerge. Comparing the findings across rural and urban locations revealed that for some survivors located in rural locations the most accessible OSCCs are community ones, due to geographical distance. The findings also indicate that regional OSCCs typically have a larger cohort of staff than general and community hospitals, suggesting that general and community hospitals may suffer from similar human and financial resource constraints. One participant from an urban general hospital reported a lack of forensic examiners, child psychiatrist, female doctors, and trained social workers as negatively impacting trauma-informed care.

The similarities in the challenges between general and community OSCCs raise the question of whether the greatest difference in provision of support by OSCCs in Thailand is between regional and general OSCCs. Supporting the referral of rape cases from community OSCCs to urban general OSCCs, therefore, may not necessarily be sufficient to ensure that survivors receive high quality support, but rather referral to regional OSCCs may be the most appropriate option. That said, participants in regional hospitals reported that overburdening of staff limited their capacity to provide the highest quality of support. There may be a trade-off, therefore, between survivor access to a breadth of core staff and timely, sensitive, and diligent support. The findings also suggest that variations across hospital size classification may not impact upon all subtypes of violence in the same way. Survivors of sexual violence may require a forensic examination from a specialist, female forensic examiner, which the findings suggest are typically only available at regional OSCCs. Similarly, social support services for survivors of physical IPV are unlikely to be offered in community OSCCs given that psychiatric nurses may concurrently operate as social workers, despite lacking any specialist training.

Disaggregating the findings by region helped to elicit factors affecting access and quality of care that are relatively unique to certain settings. For example, an examination of OSCCs in the Northeast region enabled insights into Phu Thai tribe culture, revealing the use of 'second parents' as social support for survivors of IPV (although this could concurrently prevent or delay access to formal service provision in favour of mediation). Concurrently, recruiting participants from South Thailand facilitated exploration of the influence of Islam on the response to IPV, which reinforced the social norm of protection of the family unit in Muslim communities in South Thailand.

Comparing participant responses across sex revealed informative similarities between female and male participants. Both female and male participants expressed similar views on NPSV and IPV (as being 'family matters') and on their support for mediation of violence cases in the community (without state involvement). A lack of recognition of marital rape and survivor-blaming were only articulated by female participants, although deviant perspectives were also offered. Whilst more female participants expressed problematic views than male participants, the majority of participants were female and more female participants offered deviant perspectives than male participants. Further exploration is needed, therefore, to establish whether or not there are sex differences in the views of OSCC staff towards NPSV/IPV. No other patterns in deviant perspectives were identified in the study. Disaggregating participants by sex helpfully illustrated that both female and male OSCC staff may have views about NPSV/IPV that conflict with core principles of gender equality, thus in addition to specialist training in NPSV/IPV, both female and male OSCC staff may benefit from general training in gender equality.

7.3. Section 1 – Considerations for the design of referral pathways

7.3.1. Empowering survivors to realise the fulfilment of their needs

Our findings indicated that mediation of NPSV/IPV presents a barrier to survivors receiving appropriate medical, psychological, social, or legal support. Yet, participants in this study reported that some survivors choose mediation in the community over state support, highlighting that a 'best interests' approach to the provision of support may further undermine survivor autonomy, which has been violated in cases of NPSV/IPV. Conversely, one study reported that more than half of survivors of IPV simply wanted a diagnosis of injury severity and medical treatment and did not want counselling or referral (138), indicating that supporting access to OSCCs where this medical support can be offered may, for many survivors, align with respect for autonomy. Central to empowering survivors to realise the fulfilment of their needs, therefore, is the provision of information about possible risks, in addition to available solutions for circumventing or mitigating these risks.

In a review of the OSCC model in Thailand, Grisurapong (2004) explained "*At the village level, volunteers can work with community leaders, women's groups and adolescent groups in giving information on VAW [violence against women]"* (42). However, it is not clear from our findings that these community actors are best placed to provide comprehensive and appropriate information to survivors to make an informed judgement as to whether and what kind of support is needed, not least given problematic attitudes and social norms found in the community surrounding NPSV/IPV.

Application of principles of informed consent in clinical medicine, in particular, the 'reasonable patient standard' which requires the provision of information that patients themselves would consider pertinent if cognisant of this information (157,158), may support the ethical implementation of referral pathways that seek to help survivors realise the fulfilment of their needs. Spatz, Krumholz & Moulton (2016) elaborate that "*at the heart of a*

reasonable-patient standard is respect for patients' informational needs; preferences, values, and goals; safety; and autonomy" (157). The reasonable patient standard has most commonly been applied to the provision of information once patients have accessed healthcare services. Yet, our findings highlight that survivors of NPSV/IPV presenting to state or non-state actors in Thailand have the same informational needs as those outlined by Spatz, Krumholz & Moulton (2016). Adopting a broad health systems lens that includes access to healthcare therefore supports the incorporation of the 'reasonable patient standard' within referral pathways to help guide the provision of information to survivors.

Empowering survivors to realise the fulfilment of their needs requires consideration of the *content* of information provided and the particular information needs of the survivor. The provision of generic information could even disempower survivors if they are led to make a decision that is further from the decision they would make if optimally informed (159). Given a cultural propensity towards protection of the family unit in Thailand, our findings raise the question of whether undertaking a risk assessment with survivors of IPV (160), for example, might help generate valuable, individualised information so that survivors can make a more informed decision on whether a shelter may be a good option for them (and their dependents). The impracticality of training each node in the referral network to competently undertake a risk assessment supports the institution of referral pathways to streamline survivor access to actors proficient in conducting risk assessments.

The *delivery* of information is also critical to empowering survivors to realise their needs. In a study on healthcare access for indigenous groups in the North of Thailand, indigenous participants reported a lack of trust in non-indigenous healthcare providers (161), which might impact how the information is received. Optimising the provision of information can

help redress a power imbalance between survivors and providers as a consequence of a discrepancy in knowledge.

Respecting survivors' preferences also requires consideration of barriers to survivors realising their preferred, informed choice. For example, geographical distance to services was identified in this study and the wider literature (162) as a challenge for survivors in accepting referrals.

7.3.2. Foregrounding local context

Our findings revealed geographical variations in the availability of both state and non-state actors, in addition to variations in the services provided by these actors. A referral pathway for communities located between a community OSCC and a provincial OSCC, for example, might prescribe the referral of survivors to the provincial OSCC given greater availability of services at the provincial OSCC, whereas a referral pathway for communities located in a location more distant from the provincial OSCC might prescribe referral to the more proximally located community OSCC. Referral to NGOs has been described as beneficial if they are available (138,163), offering support for mapping of existing services (164). The CARE-GBV report on building, strengthening, and maintaining gender-based referral networks explained that a mapping exercise can help avoid unnecessary duplication or confusion in the creation of referral pathways (164). The authors of the report add that a mapping exercise should explore i) the level of coordination and trust between formal and informal actors in referral networks; ii) community awareness and perceptions of services; and iii) available funding, time, and staff capacity of each actor (164).

Supporting the use of these criteria, our findings indicated that for some actors, overburdening can result in delays in the provision of support, which in turn might undermine trust. Identifying bottlenecks can facilitate the implementation of referral solutions to mitigate or circumvent these bottlenecks (164). Our findings indicate that village leaders and the police present particular bottlenecks for survivors of some forms of NPSV/IPV. It should be noted, however, that the police in particular may be important if survivors seek to pursue prosecution or legal protections. Yet, referral pathways that circumvent certain actors in the initial response do not necessarily preclude these actors from later involvement. Adding nuance, the findings of the OPA revealed that some police stations have female police officers with specialist expertise in NPSV/IPV, thus in these locations it may be appropriate for survivors to receive some initial support from the police, before referral to the OSCC (26).

7.3.3. Streamlining access to support

Participants in the study reported many steps for survivors seeking to access OSCCs, with each additional step that survivors take increasing the risk of attrition (165). Importantly, some survivors may have time-sensitive needs, for example, the provision of emergency contraception, antibiotics, or a forensic examination. In addition, the data highlighted significant time pressures on a number of actors who may be involved in the response to NPSV/IPV, thus reducing the number of actors involved in the initial response to NPSV/IPV may not simply be of benefit to survivors, but may help free up time and resources for those actors to attend to other matters.

Achieving a reduction, rather than an increase, in overall work burden, increases the likelihood that the referral pathway will persist after the initial roll-out i.e., the pathway

becomes self-reinforcing. A reduction in overall work burden will however, result in an increase in work burden for some actors in the referral network, such as OSCC staff, potentially undermining the benefit of the referral pathway if the limited capacity of the particular node in the network results in the introduction or exacerbation of a bottleneck. Therefore, in redistributing the work burden it is necessary to consider the contingency capacity of nodes in the network. Our findings indicated that many OSCC staff are currently overburdened, which may in some cases result in a delay in the support that survivors receive at the OSCC. One participant expressed the view, however, that a consequence of an increase in number of survivors attending OSCCs could be an increase in funding to help OSCCs meet the increase in demand, indicating that some contingency might exist, although a time delay to the investment of additional resources, assuming that this would occur, could limit the response of OSCCs in the short-term. This study supports Kanungbutr, Junhavat & Nintachan's (2011) claim that evaluations of OSCC effectiveness in Thailand could help support funding for OSCCs (59), if it is the case that evaluations reveal a large number of survivors using the service. The provision of timelines for referral might also enhance the efficiency of referral pathways (164), for example, as provided in the VAWG referral pathways for criminal matters produced by the Malawian Ministry of Gender, Children, Disability and Social Welfare (166).

7.3.4. Co-design of referral pathways

The findings indicated a lack of clarity across sectors with respect to the roles and responsibilities of other actors. Participants explained that this may result in conflict between sectors, with the example given of conflict between the police and OSCC staff with respect to the prioritisation of survivors' psychological versus legal needs. Clarifying the roles and responsibilities of non-state actors is also critical in the creation of referral pathways, not

least given that survivors may access a variety of entry points, including non-state actors, as reported by participants in our study. As explained in the CARE-GBV report:

> *"Survivors often first disclose their experience of [gender-based violence] to informal sources of support, such as trusted friends, family, or community and religious leaders, and those who receive a supportive, affirming response are more likely to seek help in the future. It is, therefore, crucial that informal sources of support are equipped to respond to survivors and connect them with formal services they may wish to access"* (164).

Several national referral pathways, however, start from survivor access to state services (167–169). This assumes that survivors will access these services, which our findings indicate cannot necessarily be taken for granted.

The co-design of referral pathways with input from all stakeholders (164) could be one solution to ensuring that the referral pathway appropriately fits with the perceived roles and responsibilities of the various sectors, providing an opportunity for discussion of any uncertainty or disagreements concerning roles and responsibilities. Grisurapong (2002) explains "*In order to establish an effective referral system among health care providers and police, a seminar or workshop to discuss together and agree a protocol is needed* (39)*."*

This approach also helps to safeguard against gaps arising in the referral pathway. For example, our findings indicated a lack of clarity with respect to the actors responsible for case management and follow-up, possibly in part accounting for the further findings of limited case management and follow-up. The co-design of a referral pathway might also

increase the likelihood of adherence to the pathway as a consequence of increasing stakeholder buy-in. Contradicting this hypothesis, however, is our finding of low adherence of actors to co-designed MOUs. This highlights the importance of eliciting the perspectives of various stakeholders in the creation of a referral pathway on possible barriers to implementation, going beyond discussions on the content and configuration of the referral pathway. The co-design of a referral pathway might also help ensure that the perspectives of various stakeholders on survivors' needs, including survivors, are elicited and that the pathway is clear to all actors.

7.3.5. Provision of information

Our findings indicate that communication of the following non-exhaustive list of key principles to all actors could be particularly beneficial in Thailand: i) survivor privacy and confidentiality should be strictly maintained; ii) survivors should not be questioned on the veracity of their accounts; iii) survivors are not at fault for experiencing NPSV/IPV; iv) non-consensual sexual intercourse in marriage is rape; v) survivors should be empowered to make the decision that is right for them; vi) the rights of women are not secondary to the interests of the family unit and community; and vii) ongoing risks to survivors should be investigated and addressed (e.g., formal risk assessment).

Various referral pathways for VAWG published in the literature have incorporated key principles of trauma-informed care into their pathways disseminated to actors in the referral network (166–169). Information provided to actors could help address erroneous understandings of legal, ethical, and regulatory requirements revealed in our study, such as highlighting that marital rape is illegal in Thailand or that the acquisition of a police report is neither a legal nor ethical requirement prior to referral to an OSCC. That said, participants in

the OPA reported the existence of local policies mandating that survivors receive a police report before they can be seen at the OSCC (26). This highlights that the creation of a referral pathway provides an opportunity to uncover, and potentially challenge, pre-existing policies that may be problematic. Documents that outline referral pathways might also include contact information about key services (168), the lack of which was identified as a barrier to referral pathway implementation in OSCCs in Kenya and Zambia (170). This could help address the lack of visibility of OSCCs, as evidenced by this study, amongst actors in the referral network. In addition, it could potentially facilitate and expedite referral. Training of actors in the referral pathway could be considered to support the appropriate use of, and adherence to, the pathway (164,171).

7.3.6. Evaluating referral pathways

The study revealed limited oversight of the OSCC response in Thailand, which might include oversight of guidelines that direct referrals of cases of NPSV/IPV. An advantage of undertaking evaluations of referral pathways is that it could help keep actors accountable to the pathway. One participant in the OPA reported that whilst the police have an MOU for the coordinated response to NPSV/IPV, they do not adhere to the MOU as it is not legally binding (26). Periodic assessments could support adherence to referral pathways and may also facilitate the identification of weaknesses with the pathway, to inform future revisions of the pathway or the institution of novel measures for supporting its implementation. The CARE-GBV report encourages stakeholders to "*periodically evaluate the efficacy, relevance, accessibility, and use of the existing referral networks"* (164). The authors argue that this could "*include anonymous and confidential mechanisms for referral network partners, survivors, or other individuals to offer feedback on gaps and areas for improvement for the referral network*" (164).

7.4. Section 2 – Did the application of a social norms lens support an examination of the accessibility and response of OSCCs to NPSV/IPV?

Incorporating a social norms lens into a broad health systems examination of OSCCs exposed significant normative barriers to access. This raises the question of whether there is currently optimal distribution of efforts in Thailand towards improving survivor access to OSCCs, as compared with enhancing the response of OSCCs once survivors have accessed OSCCs. Whilst participants in the study reported that limited financial and human resource investment presents a significant barrier to the OSCC response to cases of NPSV/IPV, our findings suggest that the allocation of resources to enhance the visibility and accessibility of OSCCs is especially limited. These appear to be restricted primarily to minimal advertisement and some community outreach events. Furthermore, one participant indicated a degree of plasticity within the OSCC model, postulating that an increase in number of survivors accessing OSCCs could result in greater investment of resources to improve the response of the OSCC. This suggests that greater allocation of resources towards accessibility might not necessarily result in a reduction in available resources to support an improved OSCC response i.e., a zero-sum game cannot be assumed.

The application of a social norms lens in our study also appears to promote more informed decision-making with respect to how health systems can be improved. A lack of referral of cases of NPSV/IPV by the police to the OSCC could be attributed to the overburdening of the police, thus simplifying the police response to cases of NPSV/IPV could be considered among possible approaches to improving police referral to OSCCs. However, a social norm amongst the police that it is acceptable/appropriate to support the mediation of cases of NPSV/IPV, suggests that some cases of NPSV/IPV may not be referred by police officers despite the implementation of an intervention to undermine the influence of overburdening of

the police. The study also revealed that some advertising activities are undertaken to increase the visibility of OSCCs, although given the substantial normative barriers to survivor access, increasing the visibility of OSCCs alone may be insufficient to promote access to OSCCs for many survivors.

Our findings suggest that efforts to improve the accessibility and response of OSCCs to NPSV/IPV are more likely to be successful if they consider the interrelation of social norms with other individual, material, institutional, and other social factors. For example, the social norm that it is acceptable/appropriate for cases of NPSV/IPV to be mediated in the community without state involvement supports the design of a social norms intervention that seeks to directly undermine this barrier to OSCC access, such as magnifying the voice of community advocates, which may include survivors, encouraging referral to OSCCs. Yet, our findings indicated that mediation may be sought through village leaders rather than seeking prosecution through state actors because it leads to resolution more quickly. By failing to tackle concurrently the institutional factor of slow and bureaucratic legal processes that help this social norm to thrive, then the social norms approach adopted may not achieve its desired outcome of enhancing access to OSCCs. Given institutional inertia and the relative intractability of improving judicial processes for survivors, the application of the DF has the additional benefit of helping to direct efforts towards designing social norms interventions that undermine harmful social norms or harness positive social norms that may be understood to be more readily subject to influence given the nature of their interrelation with other components of the DF. For example, tackling the social norm that it is acceptable for men to have sexual intercourse with their wives without their wives' consent (marital rape), which can be understood as a barrier to survivor access if the normalisation of marital rape means that survivors (and others) do not perceive it as a problem, is supported by the finding that

marital rape is illegal in Thailand (institutional factor). Thus, a social norms intervention seeking to educate members of the community about the harms associated with marital rape would likely benefit from incorporating reference to the law in Thailand prohibiting marital rape.

Understanding intersectionality also has implications for the choice of target within an intersectional relationship. For example, seeking to promote women's economic empowerment with a view to enhancing survivor access to OSCCs, amongst other benefits, without consideration of the intersectionality of this factor with the norm that men are the heads of the household could result in an increase in women's economic empowerment, although the impact of this intervention might be inhibited if it fails to tackle the overarching patriarchal norm that men are the heads of the household. Targeting the norm that men are the heads of the household, however, could yield both a reduction in the influence of this norm and as a consequence, greater women's economic empowerment.

The DF was originally conceived to support the design of interventions seeking to prevent harmful behaviours, thus its use as a conceptual lens to shed light on the factors influencing the accessibility and response of OSCCs represented a development from its original conception. Despite this, the application of the DF in this study helped further an understanding of the influence and interrelation of social norms and individual, institutional, material, and other social factors on the accessibility and response of OSCCs to NPSV/IPV.

Application of the TNS in this study aided understanding of variations in the strength of influence of social norms on behaviour. For example, our findings indicated that the injunctive norm that it is acceptable/appropriate for OSCC staff to involve non-state actors,

such as village leaders and community health volunteers, in the response to NPSV/IPV, is weaker than the injunctive norm that it is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors as it should be handled within the family. Differentiating between different strengths of influence has implications for the selection of social norms interventions insofar as priority might be given to 'low-hanging fruit.' Social norms that have a weaker influence on harmful behaviours may be more amenable to the effect of interventions that seek to undermine the influence of these norms on harmful behaviour.

7.4.1. Challenges of using a social norms lens

Our findings also exposed challenges in using a social norms lens to further an understanding of the accessibility and response of OSCCs to NPSV/IPV. In particular, our findings indicated the need for greater conceptual clarity with regard to how subtypes of social norms are differentiated. For example, our findings indicated that the injunctive norm that it is obligatory for survivors of IPV to protect the family unit is particularly salient amongst Muslim populations, raising the question of whether this norm is a cultural norm, a religious norm, or both. A further participant expressed a lack of clarity as to whether the possible injunctive norm that it is acceptable/appropriate in rape cases for the survivor to marry the perpetrator is attributable to culture or religion.

Various definitions of subtypes of social norms have been provided in the literature, however, our findings suggest that defining social norms requires a typology of norms that accounts for definitional boundaries. The production of definitions for subtypes of social norms in isolation, without delineating between subtypes, could result in definitions that fail to account for the complexity and interrelatedness of subtypes of social norms. Specifically, our findings highlight the need for greater clarity with respect to the distinction between religious and

cultural norms. One way to differentiate between cultural and religious norms that has been presented in the literature is the extent to which the behaviour of the group holding the norm is influenced by their shared beliefs (or misbeliefs) about religious endorsement of the behaviour in question (172). If the origin of a norm is the critical element in distinguishing a religious norm from a cultural norm (173), then even if individuals would not proceed with the behaviour if they understood that it was *not* endorsed by religion, the social norm supporting this behaviour, according to this conception, would still be that of a religious norm.

The pursuit of greater clarity with respect to how subtypes of social norms are differentiated would not only promote clarity and consistency in language for stakeholders working in this space, but it might lead to further helpful differentiation of social norms. For example, pursuing a definition of religious norms might lead to other ways to conceive of a religious norm, such as the shared belief in the dignity of all people or the legalistic adherence to scripture. It is necessary to highlight here that not all religious norms are problematic. It is widely acknowledged that opposition by Methodists was instrumental in the signing of the Women's Suffrage Petition in New Zealand in 1893 (174), although it has been argued that women's suffrage in Thailand has had an "*independent indigenous trajectory in the face of colonial pressures"* (175), thus the influence of Christianity may not have been a key contributor to women's suffrage in Thailand. This raises a further question of how 'indigenous norms' can be understood in relation to cultural norms, furthering the argument for clarity vis-à-vis distinctions between subtypes of social norms.

A benefit of greater differentiation of subtypes of social norms could be that policymakers and practitioners seeking to undermine harmful social norms or harness beneficial social

norms might be more empowered to design targeted interventions. A social norms intervention that seeks to undermine the influence of a harmful religious norm on behaviour that distinguishes a religious norm from a cultural norm as a shared belief in the endorsement by religion of a particular behaviour might consider working with religious leaders to educate followers of the religion in question that the behaviour is not in fact endorsed by religion (if this is the case). Yet, such an intervention may do little to prevent the continuation of this practice by individuals or groups of individuals that do not have a shared belief in the endorsement of religion of the behaviour in question, even if religion has been the major driver of this behaviour, regardless of whether these individuals or groups of individuals are aware that this is the case.

7.4.2. Limitations of the applications of the conceptual frameworks in the study

Dynamic framework

Whilst this does not represent a limitation of the DF per se, a limitation of the *application* of the DF might be a failure to recognise the dynamic nature of influences. It should be noted here that the use of the word 'dynamic' in the DF refers to the recommendation of a dynamic process of application of the framework rather than the dynamic nature of the interrelated components (94). Application of the DF supports a 'snapshot' of factors influencing behaviour at a particular moment in time, however, some of these influences on behaviour may be transient, whereas others may be more fixed. For example, the social norm that it is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors as it should be handled within the family might intersect with the social factor of necessity to arrange childcare as a barrier to reporting, although the influence of this factor may vary on a daily

basis. If children are being looked after by their grandparents for a period of time, for example, then this social factor might not apply for that particular period.

Whilst possibly implied, the DF does not explicitly underline the importance of considering the interrelation of social norms (176). Our findings suggest that other norms are interrelated with the injunctive norm that it is inappropriate to discuss sexual violence as it is taboo, for example, the injunctive norm that it is obligatory for survivors to protect the family unit, both of which sustain survivor silence. Interventions seeking to change behaviour may not be successful if other social norms positively or negatively impacting upon the behaviour in question are not considered in the design of the intervention, or if a foundational norm (e.g., protecting the family unit) contributing to an umbrella norm (e.g., survivor silence) is not targeted by the intervention.

Exploring the interrelation of norms also supports the identification of self-reinforcing systems of norms. It has been argued that norms may be self-reinforcing insofar as social reward for adhering to a norm helps to sustain the norm in question (177). Our findings even indicate that some social norms may be quasi-tautological, thus inherently self-reinforcing. For example, the social norm that it is inappropriate to discuss sexual violence as it is taboo could be interpreted as a self-reinforcing quasi-tautology if the inappropriateness of discussing sexual violence is a consequence of the fact that this topic is taboo. In other words, this social norm could be rephrased as it is inappropriate to discuss sexual violence as it is inappropriate to discuss sexual violence. The underlying logical error is the naturalistic fallacy (178), invalidly deriving an ought from an is – 'it is taboo to discuss X, therefore it is inappropriate to discuss X i.e., one *ought* not to discuss X.' Yet, going beyond self-reinforcing individual norms, our findings indicate that there may also be self-reinforcing

systems of norms. For example, our findings indicate that the norm of setting a good example for children leads parents to teach children about the importance of protecting the family unit, reinforcing the norm of the importance of protecting the family unit. Yet, setting a good example for children might also entail implicitly (subliminally) or explicitly (focally) communicating to children that reporting NPSV/IPV could threaten the integrity of the family unit, thus reinforcing the norm that it is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors. This cycle might then repeat with the next generation. In other words, in addition to self-reinforcing norms, it can be hypothesised from our findings that self-reinforcing systems of norms might exist and that these self-reinforcing systems might themselves be generationally self-reinforcing.

Finally, it is noteworthy that the DF itself is not 'dynamic,' but rather Cislaghi & Heise (2019) recommend that the processes for employing the framework should be dynamic. Cislaghi & Heise (2019) provide the example of the application of the framework in an intervention design workshop, describing a dynamic participatory process in the generation of recommendations as a consequence of the use of the framework, but in this scenario, the DF did not evolve per se, but rather the discussions grounded in the framework evolved over the course of the workshop. In this regard, the DF does not circumvent a limitation of Heise's (1998) socio-ecological model posited in Cislaghi & Heise (2019) that "*its initial aim was to offer a model for understanding the interaction of factors*" as opposed to a "*practical tool that NGO practitioners can use when planning social norm interventions*." Employing Heise's (1998) socio-ecological model in a similar participatory manner could also yield the generation of social norms interventions, even if Heise did not offer this recommendation in her original paper (96). Cislaghi & Heise (2019) do helpfully illustrate, however, that frameworks that support the generation of knowledge, such as the DF or Heise's (1998)

socio-ecological model, can support the identification of interventions when employed during a dynamic process.

The application of the DF in the current study was limited to the identification of units of interest to the study (the components of the DF) and furthering an understanding of the interrelation of social norms and individual, material, institutional, and other social factors. A myriad of other conceptual frameworks could have been employed to further an understanding of aspects of the research not fully captured by the DF. For example, application of a health system performance assessment framework (179) might have supported greater understanding of the sustainability of OSCC financial structures. Our study highlights that conceptual frameworks employed to support health systems examinations should not seek to retrospectively fit the data as a whole to the conceptual framework i.e., the data should not be forced into the 'procrustean bed' of the framework, but rather additional complementary frameworks can be selected to shed light on aspects of the research that lie outside the scope of the particular conceptual framework in question.

Theory of normative spectrum

A limitation of the application of the TNS in this study is that it only explicitly provides a framework for assessing the strength of social norms *prescribing* behaviour (positive norms), but not social norms *proscribing* behaviour (negative norms). To address this challenge, one might propose applying direct antonyms of positive norms to negative norms, for example, the equivalent of a positive norm that makes a behaviour acceptable might have a negative norm that makes a behaviour unacceptable. However, a problem with this approach is that the strength of direct antonyms may not necessarily match that of the synonymous expressions of

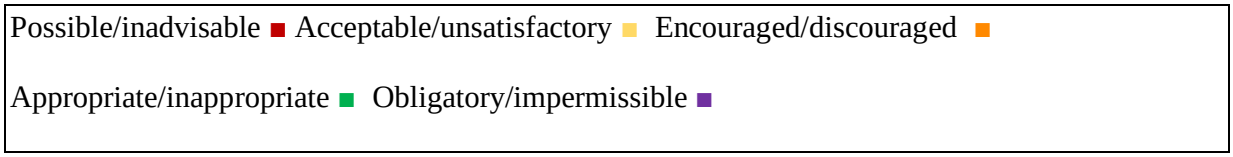
positive norms. For example, it could be argued that a norm that prescribes an *acceptable* behaviour is of a weaker strength than a norm that proscribes an *unacceptable* behaviour. A direct antonym might also simply be inappropriate. For example, the direct antonym of a positive norm that makes a behaviour *possible* would be a negative norm that makes a behaviour *impossible,* which would require some clarification on the meaning of the term *impossible.* To overcome this linguistic hurdle, one could reword *possible* as *permissible* so that the direct antonym would be impermissible, rather than impossible, but this would not address the problem of the difference in strength between these terms as *permissible* is arguably weaker than *impermissible*.

Given these limitations of direct antonyms, it may be necessary to provide novel, disassociated language for corresponding negative norms, although this would, unfortunately, introduce subjective elements that mean the corresponding language of negative norms may not directly map onto the language used for negative norms. Regardless, such an approach could yield the following i) the equivalent of a positive norm that makes a behaviour *obligatory,* might be a negative norm that makes a behaviour *impermissible;* ii) the equivalent of a positive norm that makes a behaviour *appropriate,* might be a negative norm that makes a behaviour *inappropriate;* iii) the equivalent of a positive norm that makes a behaviour *acceptable,* might be a negative norm that makes a behaviour *unsatisfactory;* and iv) the equivalent of a positive norm that makes a behaviour *possible,* might be a negative norm that makes a behaviour *inadvisable.* These examples are not intended to represent definitive alternatives, but rather seek to illustrate that disassociated language may be needed in the pursuit of a revised framework that seeks to encompass negative norms. An alternative approach might be the introduction of a ‘not’ function for equivalent negative norms, for

example, it is *not* appropriate for survivors to disclose NPSV/IPV to state or non-state actors as it should be handled within the family.

A further limitation of the application of the TNS in this study is that some social norms appeared to fall between two categories, raising the question of whether additional categories might facilitate allocation of strength. For example, the injunctive norm that non-state actors, such as village leaders and community health volunteers, should be involved in the response to NPSV/IPV might be appropriately labelled as a weakly directive norm that 'encourages' the involvement of non-state actors, as opposed to prescribing acceptable or appropriate behaviour (see Figure 1).

Figure 1: possible revised TNS from weakest to strongest influence on behaviour



Our findings raise the question of whether the TNS is best employed in a quantitative study, rather than a qualitative study. Given variations in the language used by participants when articulating the strength of norms, it was at times difficult to identify the appropriate TNS category to attribute participant responses. A quantitative study could standardise the language used and thus ensure greater consistency. That said, the application of the TNS in an inductive qualitative study may be more likely to lead to revisions in the number and language of the categories than a deductive quantitative study, furthering an argument for its use in qualitative research alone until the framework has reached an acceptable level of maturation.

Alternative understandings of normative strength

The study findings also suggest that there may be multiple ways to conceive of normative strength. This is not a limitation of the TNS per se, but rather if a consequence of the TNS is that it limits an understanding of normative strength to strength of influence then other means of conceiving of the strength of norms may be side-lined. The detectability of a norm has been identified as a further way to conceive of the strength of a norm, that is if a norm exists prescribing a particular behaviour, but that behaviour is undetectable, then the norm might have less influence on compliance with the particular behaviour (82,100). Supporting this hypothesis, our findings indicate that lack of detectability of *deviation* from a social norm *proscribing* a particular behaviour is also a sign of the weakness of the norm. To provide an example from the current study, the social norm that it is inappropriate for survivors to disclose NPSV/IPV to state or non-state actors might lead to sanctions imposed on the survivor for reporting, helping to sustain the norm. However, if the survivor's confidentiality is observed when a survivor elects to deviate from this norm, then this negative feedback loop is rendered impotent.

Normative strength could also be understood as its temporal sustainability. For example, one possible injunctive norm identified in the study was reported as persisting despite almost universal rejection of the benefit of the norm, namely that women who have sex out of wedlock must get married to the individual with whom they had sexual intercourse, even in cases of rape. This could be understood as a further example of a quasi-tautological self-reinforcing norm, as discussed previously. Conversely, a self-reinforcing feedback loop could yield an exponential increase in the benefit of undermining this norm, thus this norm could also be considered weak in strength if normative strength is understood as the immunity of a norm to intervention. This might have implications for social norms programming insofar as

a sustained approach that accounts for expected initial inertia could yield significant long-term benefits.

The breadth of reach of a norm has been identified as a further means of conceiving of normative strength, although Cislaghi & Heise (2018) caution against conflating the prevalence of a norm with its influence on behaviour (82). Clarity is also needed with respect to whether the 'prevalence' of a norm refers to its acceptance, adherence, visibility, or something else. The extent of adherence (numerator) to a norm relative to its acceptance (denominator), however, could be a further way to conceive of normative strength. The findings of both the OPA and the thesis indicate that the injunctive norm that it is acceptable for men to have sexual intercourse with their wives without their wives' consent (marital rape) is widely accepted, although it cannot be assumed that adherence is equally widespread.

Considering different ways to conceive of normative strength may support more tailored social norms programming designed to alter the influence of social norms on the accessibility and response of health systems, or support greater understanding of threats to implementation. Some norms may be 'strong' across categories, whereas others may simply be strong within a single category, possibly making the former less tractable.

7.5. Section 3 – Considerations for standardisation of the response of OSCCs to NPSV/IPV

7.5.1. Standardisation may not always be achievable or appropriate

Our findings indicated that standardisation of the response to NPSV/IPV across OSCC levels may not be achievable, let alone appropriate. Whilst it may be reasonable to incorporate trained psychological counsellors and social workers into the response to NPSV/IPV at the regional or provincial level, some community OSCCs have neither counsellors nor social workers resident in the hospital, with psychological nurses shouldering the combined responsibility of providing medical, psychological, and social support, amongst other responsibilities. Beyond practical implementation challenges, Fuller & Arnold (2021) argued that failure to account for differences that cannot be standardised can lead to confusion (180). Mandating all forensic examinations to be undertaken by trained, female, specialist forensic examiners, for example, might be met with confusion, or even frustration, from staff working in community OSCCs that only have male general doctors on site.

A consequence of unachievable standardisation, which Fuller & Arnold (2021) identify as a further risk of standardisation (180), might be that OSCC staff ignore standardised guidelines as they are deemed inapplicable or inappropriate to their context. Findings of the thesis indicated that this may already be a problem in Thailand with several participants reporting that the OSCC manual was too generic to be useful in their particular circumstances. Methods of standardisation can address this variation by incorporating a degree of flexibility to account for differences that cannot be overcome (181), challenging the thesis that standardisation and customisation are at polar opposite ends of a continuum.

Our findings also appear to support Sinsky et al.'s (2021) assertion that some variation may reflect appropriate customisation (182). As mentioned earlier, the OPA indicated the active involvement of NGOs in the response to NPSV/IPV in Bangkok (26), although some participants in the thesis reported that they did not collaborate with NGOs, with one participant explaining that this was because they were not active in their area. Thus, standardised guidelines that incorporate the involvement of NGOs in the response to NPSV/IPV, may not be appropriate for community OSCCs located in areas with limited NGO presence.

7.5.2. Standardisation requires consideration of the process of standardisation

Our findings suggesting that some variation in the response of OSCCs to NPSV/IPV in Thailand may be either appropriate or unavoidable raises the question of whether a bottom-up approach to standardisation, informed by local needs and context, is best suited to the Thai context. Our findings indicate that some degree of bottom-up standardisation is currently occurring in Thailand. Many participants reported that their OSCCs create their own guidelines, others have MOUs at the local level, and others reportedly undertake internal evaluations of OSCC performance in the form of periodic discussions amongst OSCC staff.

This narrowing of the focus of standardisation to individual OSCCs may support OSCC responses tailored to the needs of survivors and communities in the local area. However, the benefits of a top-down approach might not be achieved with this approach. The opportunities to learn from challenges experienced at other OSCCs may be limited in a bottom-up model. In addition, there may be efficiency savings with a top-down approach as the pooling of expertise for dissemination to individual OSCCs can occur, supporting the training of staff (180,182) and obviating the need to expend substantial resources to achieve the necessary

expertise in all OSCCs. In addition, a bottom-up approach to standardisation may not address the 'postcode lottery' concern, in which the support that survivors receive is contingent on their location (181). A top-down approach is also better equipped arguably to envisioning the role of individual OSCCs within the wider network of OSCCs, not achievable in a bottom-up model.

The benefits and challenges of both top-down and bottom-up approaches to standardisation point towards the need for a combination of these two approaches in Thailand. A hybrid approach in which the MOPH set clear criteria for achieving core minimum standards (156), whilst providing individual OSCCs with the flexibility to devise locally informed solutions to achieving the highest level of trauma-informed support, would be one approach to realising the benefits of both top-down and bottom-up approaches.

7.5.3. Standardisation requires consideration of the threat of 'regression to the mean'

Fuller & Arnold (2021) argued that standardisation can result in the regression of high-performing centres and innovative local solutions to a standardised mean (180). The validity of this concern is contingent, however, on the assumption that standardisation reduces the performance of hitherto high-performing centres. In other words, where the 'bar' is set is relevant. One approach to achieving standardisation that reduces the threat of the regression of high-performing OSCCs is to pursue the scaling up of 'best practices.'

One participant reported the existence of a shared SOP between the participant's community OSCC, regional OSCC, and other sectors, requiring the referral of cases of rape from the community OSCC to the regional OSCC, circumventing some of the significant limitations to an optimal, trauma-informed response at community OSCCs, as reported by participants in

our study. If this is to be understood as a 'best practice' example, it might be possible to scale up this approach. It could be argued that this would represent the standardisation of a customised approach, given that it accounts for the particular challenges of community OSCCs to some forms of NPSV/IPV, whereas other forms of violence, such as some forms of IPV, may be best managed at the community OSCC to reduce temporal and financial costs to survivors, in addition to other risks. It is important to highlight here that standardisation of 'best practices' may be limited by aspects of the response that cannot easily be standardised. For example, the same participant reported that a component of this MOU was the provision of transport to survivors by the provincial OSCC. However, a further participant reported that they were unsuccessful in their attempt to gain support from the hospital director of their community hospital for the provision of transportation for survivors from the community OSCC to the provincial OSCC. Given that participants reported a lack of financial empowerment and access to transportation as barriers to OSCC access in this study, the lack of transportation for survivors to the provincial OSCC may mean that, for some survivors, access to support at the provincial OSCC may not be achievable. That said, the *pursuit* of standardisation of this 'best practice' highlights an advantage of standardisation reported by Sinsky et al., (2021) namely that the identification of variation aids the identification of areas for improvement (182), in this case highlighting that it might be possible for transportation to be provided by provincial OSCCs rather than community OSCCs to overcome the barrier in the latter case, as successfully achieved in the former case.

Even if the limitation of the lack of transportation for survivors of rape from community OSCCs to provincial OSCCs is not overcome, the identification of this limitation provides useful information to those advocating for improvements in the response of OSCCs to NPSV/IPV, providing support for Sinsky et al.'s (2021) argument that the pursuit of

standardisation can yield valuable knowledge (182). In sum, pursuing standardisation of a high bar of trauma-informed support might reduce the threat of regression of high-performing OSCCs to the mean, and by exposing implementation challenges to achieving this higher standard, solutions can be explored.

7.5.4. Standardisation requires considered application of a community lens

Our findings also support consideration of a community lens when pursuing standardisation (180), rather than viewing survivors as isolated individuals. For example, the thesis findings suggest that there may be differences between tribes in Thailand with respect to the response to NPSV/IPV. Survivors who are members of the Phu Thai tribe reportedly involve 'second parents' in the response to NPSV/IPV. Survivors may choose to discuss IPV with these second parents rather than accessing state services. Given that second parents may pursue mediation of cases of NPSV/IPV, including marital rape, an approach to standardisation that seeks to support access to the OSCC for all survivors within the region of the OSCC might benefit from considering the role of second parents in the Phu Thai tribe, which may not be captured if the embeddedness of survivors in their community is not considered. Adopting a community lens may also support the identification of variations in social norms and other societal factors that might impact the effectiveness of efforts to achieve standardisation. The pursuit of standardisation that seeks to consider the survivor as a member of the community, however, might on the one hand lead to greater consideration of the influence of social norms and other societal factors found in the community on survivors' responses to NPSV/IPV, but it could simultaneously serve to exacerbate further problematic norms in Thailand reported by participants in this study that impinge on the rights of survivors as individuals. This underlines the importance of pursuing standardisation as a means of engendering greater patient confidence in care (182,183).

7.5.5. Standardisation might result in a redistribution, rather than reduction, of work

The study findings encourage consideration of Fuller & Arnold's (2021) concern that standardisation may simply result in the redistribution, rather than reduction, of the work burden of the response to NPSV/IPV in Thailand (180). For example, if upscaling of the referral model mentioned earlier in which survivors of rape are referred from the community OSCC to the provincial OSCC is pursued, then a redistribution, rather than reduction, in work burden might be the consequence. Indeed, in this case, the community OSCC would still retain some responsibilities in its initial response to cases of rape, not least with respect to initial medical and psychological support, and so this approach may result in an overall *increase* in work for OSCC staff, in addition to the risk of re-traumatisation for survivors and attrition as a consequence of increasing the number of steps survivors are required to take.

Yet, the importance of a trauma-informed response to rape, which demands that forensic examinations are undertaken by female specialist forensic examiners, might justify a greater overall work burden. The possibility of a greater overall work burden may also be justifiable if the additional work burden as a consequence of standardisation yields cost-effective improvements in outcomes. This highlights the importance of considering the benefits of standardisation alongside the challenges and risks. And once again, the implementation of standardisation is also relevant to the appropriateness of standardisation. Centralising the involvement of the OSCC 1300 hotline in the response to NPSV/IPV could circumvent the need for survivors of rape to present to community OSCCs in addition to provincial OSCCs as hotline staff can present survivors with the option of directly attending the provincial OSCC. Effective communication of information from the community OSCC to the provincial

OSCC in this case could help reduce duplication of work and prevent re-traumatisation, which would require appropriate data protection mechanisms.

7.5.6. Standardisation requires oversight

Our findings indicate a lack of oversight of current standardisation mechanisms. For example, participants reported a lack of oversight of the adaptation of the OSCC manual produced by the MOPH. Given that oversight could be conceived as a means of standardising the implementation of mechanisms for standardisation, this lack of oversight might negate the possibility of addressing problematic variation in the content of guidelines for standardisation across locations. In a retrospective descriptive study of programmatic data collected at an OSCC in Zimbabwe, Harrison et al. (2007) noted that the standardised response did not fully meet the needs of all survivors, particularly individuals who consented to sex as minors (184). Our findings highlighted that survivors attending OSCCs may have different needs. Some OSCCs were identified as requesting that survivors return to the OSCC the next day, or even several days later, if there are no staff available. This approach presents different risks for survivors of IPV and NPSV, with the former at risk of returning to a violent home and the latter at risk of not receiving time-sensitive medical attention. A policy for standardisation that does not account for differences in groups of survivors attending the OSCC may address the needs of one group more so than another, thus the concern expressed in Harrison et al.'s (2007) study could also apply to the response of OSCCs in Thailand. Oversight of standardisation mechanisms provides one means of ensuring that all groups benefit from measures to promote standardisation.

A lack of oversight might also contribute to a lack of adherence by providers to measures to promote standardisation, thus it could limit standardisation within a defined location, in

addition to standardisation across locations. If providers are not accountable to measures promoting standardisation, the various challenges to the provision of a trauma-informed response, as reported by participants in this study and captured by the DF, may present an insurmountable barrier to the realisation of standardisation.

Our findings of this study revealed that some evaluations of OSCC performance do occur, ranging from local assessments by the OSCC committee to the incorporation of the assessment of OSCCs as a component of national periodic Hospital Accreditation assessments. This raises the question of whether evaluations of the effectiveness of measures to enhance standardisation could be incorporated within current evaluation mechanisms, to avoid the introduction of conflict between novel and pre-existing standardisation mechanisms, leading to confusion (180).

Critically, any evaluations of measures seeking to achieve standardisation should seek to measure outcomes (182) rather than outputs as outputs may not only fail to produce improvements in outcomes but might even result in worse outcomes (185). A retrospective review of the provision of healthcare to female survivors of sexual violence at an OSCC in Kenya reported a high degree of adherence to SOPs amongst healthcare providers (output), although the impact of this SOP at improving the care that survivors receive (outcome) was not assessed in this study (186). One study evaluating the comprehensiveness of care and HIV prophylaxis for survivors of sexual violence in South Africa did identify improvements in the provision of healthcare (outcome-level) as a consequence of the institution of a five-part intervention model (187). Whilst the institution of a combined intervention approach may be a more efficient means of achieving standardisation, a disadvantage of this approach is the difficulty in attributing improved outcomes to each of the components of the intervention, which was a challenge in this particular study.

Our study also revealed variation in evaluations of OSCC performance across OSCCs. Thus, it could be argued that standardisation of the *oversight* of standardisation is needed, to ensure consistency in evaluations of standardisation across settings, in turn supporting the achievement of greater standardisation across OSCCs.

7.6. Section 4 - Strengths and limitations of the study

7.6.1. Strengths

There were some strengths of this study. First, a sufficient sample size enabled a broad range of findings to be elicited related to the objectives of this study and corroboration of important participant contributions.

Second, the iterative development of the topic guide allowed for greater nuance to be achieved as the research progressed and for deviant perspectives to be elicited. It also supported the efficient use of participant time.

Third, the study furthered an understanding of the accessibility and response of OSCCs in community hospitals. To my knowledge, this is the first study in Thailand that has examined OSCCs at this level and amongst a minority of studies exploring government-led OSCCs in non-tertiary public hospitals globally.

Fourth, including a range of hospital classification sizes in the study enabled differences in the accessibility and response of OSCCs across hospital size classification to be elicited, such as the availability of a breadth of healthcare professionals, access to specialists, and delivery of core services, such as forensic examinations. To my knowledge, this is one of the first studies in the global literature that has compared the accessibility and response of OSCCs across hospital classification sizes within a government system.

7.6.2. Limitations

There were also several limitations of our study. First, the inability to gain the perspectives of survivors on the accessibility and response of OSCCs to NPSV/IPV was a significant gap. Whilst some second-hand perspectives from participants on how survivors respond to NPSV/IPV and their reporting preferences could be elicited, clearly this cannot serve as a surrogate for the views of survivors themselves. Data from secondary sources may have been unreliable due to recall bias amongst OSCC staff and participants may have selectively chosen to report some information and neglect other information, either intentionally (e.g., social desirability bias) or unintentionally. This research did, however, highlight key learnings to overcome the challenges to survivor recruitment experienced in this study, helping to inform future approaches to survivor recruitment in Thailand and other settings (see Appendix 1).

Second, the sample size achieved the recommended sample size for a heterogenous sample (126) for all subgroups in each category, with the exception of 'doctors' in the 'profession' category and 'university-affiliated' hospitals in the 'hospital size classification' category. As such, the research was limited in its capacity to shed light on the views of doctors and the accessibility and response of OSCCs based in university-affiliated hospitals. The lack of doctors interviewed restricted understanding of factors impacting the provision of physical and forensic examinations and medical treatment, amongst other core responsibilities of doctors involved in the OSCC response. Targeting university-affiliated hospitals and larger OSCCs that are more likely to have doctors available might have overcome this limitation, although deviating from the primarily systematic sampling approach would have risked introducing further selection bias into the sample. This may have resulted in fewer OSCCs based in community hospitals from being recruited, which were of interest to the study in part given the lack of literature on OSCCs based in smaller public hospitals. Future targeted studies eliciting the views of doctors and the unique

challenges and opportunities faced by university-affiliated hospitals could help address these gaps.

Third, a further limitation of the sample was its distribution. Some regions were overrepresented in the sample in proportion to the size of their populations (e.g., Northeast and West), while others were conversely underrepresented (e.g., Central and South). An unintended advantage of this skewed distribution is that the sample favoured representation of regions with lower Gross Regional Product (GRP) (102). Given that some exploratory interviews have been conducted in each region in our study, future more in-depth studies in each region could be considered to overcome this limitation.

Fourth, participants may have been less open to discussing the sensitive topic of NPSV/IPV perpetrated against women with a male interviewer. A possible norm identified in the study that it is taboo to discuss sexual violence, in addition to the fact that most participants were female, may have magnified this possibility. And as an unknown, foreign interviewer, participants may have been more selective in their responses due to a lack of clarity with regard to my intentions in conducting the research or doubt with respect to my cultural competency. In an attempt to mitigate these concerns, space at the beginning of the discussion was devoted to building rapport and it was explained to participants that the purpose of the research was not to judge their institution but rather to generate knowledge to help inform recommendations for improving the accessibility and response of OSCCs in all locations in Thailand. It was also my experience that the Thai interpreters supporting the research helped to overcome this limitation by behaving professionally and helping to build rapport. In future research, I will seek to conduct research projects on NPSV/IPV in

collaboration with experienced female co-researchers with sufficient availability to conduct interviews.

Fifth, all interviews were audio recorded, with consent provided by all participants. Whilst audio recording helped to support familiarisation with the data, verification of translation, and enabled double-checking of transcripts with the original data, it may have also reduced participant openness. To mitigate this threat, it was made clear to all participants at the beginning of each interview that the audio recordings would not be shared with anyone outside the research team, that they would be deleted immediately following verification of the accuracy of translation, and that any contributions included in the report would be de-identified. It was explicitly explained that neither participant names nor the name of the hospital would be included in the report.

Sixth, all interviews were conducted in Thai language and translated into English, thus there may have been inaccuracies or errors in both translation and the interpretation of translated material. For quality control of translation, cross-checking of samples of audio recordings from each interpreter were undertaken with a second interpreter.

7.7. Section 5 - Recommendations for policy

A number of policy recommendations can be presented in light of our findings. Given that OSCCs fall under the governance of MOPH, with the exception of university-affiliated OSCCs, these recommendations are tailored towards the MOPH.

7.7.1. Enhancing oversight

Our findings indicated shortfalls in formal oversight of OSCCs in Thailand. In a conversation with Thailand's MOPH during the OPA, senior staff at the MOPH highlighted the need to create a performance appraisal framework (PAF) for assessing the OSCC model in Thailand. It was explained that the MOPH would be able to acquire funding to implement a PAF nationwide if a PAF could be produced. Our findings support this recommendation as a possible means of enhancing and standardising oversight, although our findings also indicate the need to incorporate within a PAF flexibility to account for differences between OSCCs, including across regional, provincial, and community hospitals. Research on OSCCs both in Thailand and globally could help support the co-design of a provisional PAF, with input from various stakeholders, including survivors, OSCC staff, MOPH, NGOs, and Thai academic institutions, amongst others. A consensus-building method could be used to support the co-design of the performance appraisal framework. A discussion of consensus-building methods that could be used is provided in Appendix 11. The co-design process could also help generate valuable learnings about the OSCC model and health policy implementation in Thailand more generally. Our findings indicate that achieving minimum standards should be central in the creation of a PAF. Subsequent evaluations of the appropriateness and implementation of the PAFs could help support the iterative optimisation of the framework and yield additional learnings about the various factors influencing the accessibility and

response of OSCCs to NPSV/IPV. Clearly, support from MOPH for the institution of a PAF increases the feasibility of this recommendation. Effective implementation is likely to be aided by the legitimacy of this government institution.

7.7.2. Referral pathways

The lack of, or problematic, referral of cases of NPSV/IPV by both state and non-state actors to OSCCs was identified as a significant barrier to survivor access to OSCCs. Problematic understandings, beliefs, and attitudes, and a cultural propensity towards mediation of NPSV/IPV including rape, appear to limit referrals, amongst other factors described in our study. The study findings suggest that referral pathways should be i) designed to empower survivors to realise their needs; ii) grounded in local context; iii) efficient; iv) co-designed; v) informative; and vi) evaluated. Whilst the involvement of various local stakeholders in the creation of referral pathways is important, the top-down provision of model referral pathways for adaptation at the local level might support the generation of evidence-based referral pathways that are concurrently tailored to local needs.

It is possible that evaluations of referral pathways could be incorporated as a component of PAFs. To avoid duplication, it may be possible to incorporate referral pathways into pre-existing multisectoral MOUs. Again, the MOPH could oversee the co-design of exemplar referral pathways with the input of an array of stakeholders, for dissemination to, and subsequent adaptation by, OSCCs with follow-up examining the appropriateness and effectiveness of adaptations of referral pathways at the local level, as discussed above.

Given that the OSCC 1300 hotline could serve as a valuable resource for directing survivors to an appropriate OSCC, helping to circumvent in the all-important ‘first contact’ phase

actors who may not respond sensitively or take their case seriously, consideration could be given to whether the involvement of the OSCC 1300 hotline in the response to NPSV/IPV could be magnified. The OSCC 1300 hotline is arguably more accessible than attending an OSCC in person in the initial phase and could present a lower risk for survivors as they can make a discrete call at an appropriate moment without having to justify their whereabouts to social contacts for the period of time that would be required if they chose to attend an OSCC in person, which our study indicated may in some cases be several hours. Yet, the findings of the OPA revealed that, at the time of the research, the OSCC 1300 hotline did not have an SOP directing their response to VAWG and that call operators used their personal judgement, grounded in minimal training (26). A carefully conceived SOP for OSCC 1300 hotline staff, informed by research and global standards, could help promote a trauma-informed state response to NPSV/IPV. If a survivor of rape contacted the OSCC 1300 hotline, for example, survivors could be provided with the option of going directly to the provincial OSCC to receive a forensic examination from a female specialist forensic examination, rather than attending the community OSCC only to be referred on to the provincial OSCC.

7.7.3. Improving knowledge

The study unearthed learnings which could be disseminated to OSCCs and other service providers to support a higher standard of trauma-informed response. In addition to applying these learnings to the design and implementation of referral pathways and oversight mechanisms, they could also be incorporated more directly into current and future induction and training programmes. To improve the knowledge of actors involved in the OSCC response in light of a finding of the study that many actors do not attend training sessions in Bangkok due to limited time and resources, the MOPH could consider creating a concise, visually appealing document or poster summarising core principles in the response to

NPSV/IPV to be presented to OSCC staff, for dissemination to other actors at MDT meetings. This could serve to complement, rather than replace, the OSCC manual. This might also promote standardisation, identified as a key challenge in this study. Future iterations of the OSCC manual could also incorporate some of the learnings of this research.

7.8. Section 6 - Recommendations for practice

A number of recommendations for practice can be presented in light of our findings to help OSCC staff meet survivors' needs. This section presents a non-exhaustive list of practical implications of the research for OSCC staff.

First, in recognition of the finding that OSCCs only operate during normal working hours, OSCC staff could consider providing training to ER staff to ensure that survivors who attend the OSCC outside normal working hours, representing a significant proportion of survivors, receive the highest standard of support. This approach may be supplemented by fostering a close relationship with government shelters or NGOs to ensure the availability of accommodation for survivors who attend the hospital outside normal working hours. Efforts to ensure that survivors do not return to a violent home after presenting to the hospital outside working hours are critical in the short-term response to NPSV/IPV, not least given that the decision by survivors to attend the hospital may increase the risk of repercussions from abusive partners upon returning home.

Second, OSCC staff could be encouraged to provide survivors of rape with comprehensive medical and psychosocial support before pursuing the acquisition of a police report, which may involve challenging local policies mandating a police report before survivors can receive OSCC support.

Third, OSCC staff could consider pursuing a formal agreement with community representatives, outlining their roles and responsibilities, and the limits of these roles and responsibilities, in the response to NPSV/IPV. An agreement might highlight the valuable advocacy role that community representatives can play in the community, helping raise

awareness of the grave and multifaceted consequences of NPSV/IPV and disseminating information about available services and support. In collaborating with community representatives, OSCC staff could encourage these actors to refer cases of NPSV/IPV to the OSCC in preference to independent mediation of cases in the community.

Fourth, OSCC staff could provide training to the various sectors at MDT meetings in key principles of a trauma-informed response, and engage in constructive, open discussions on ingrained social norms impacting upon the OSCC response to NPSV/IPV.

Finally, OSCC staff working in hospitals with limited capacity to provide a high standard of trauma-informed response to NPSV/IPV might consider the pursuit of an MOU with a regional hospital mandating referral of cases requiring greater resources and expertise.

7.9. Section 7 - Recommendations for further research

Our findings highlighted several possible avenues for further research. Justification for the selection and prioritisation of further research projects could help to reduce the threat of an opportunity cost as a consequence of favouring one project over another. Imperfect prioritisation of further research is arguably better than the arbitrary selection of further research projects. The following further research possibilities will be presented in order of priority, centralising the pursuit of the perspectives of Thai citizens with the goal of achieving practical and policy implications for improving the accessibility and response of OSCCs to NPSV/IPV.

First, research exploring the perspectives of survivors of NPSV/IPV on the accessibility and response of OSCCs would be invaluable. It may be the case that some of the challenges identified in this study are of less concern for survivors than other challenges, which may or may not have been elicited by interviews with OSCC staff. A lack of the perspectives of survivors on the OSCC model is also a lacuna in the global literature on OSCCs, thus research seeking the perspectives of survivors in Thailand could help shape research, policy, and practice priorities in other settings. Learning from the difficulties faced in recruiting survivors in this study might increase the likelihood of successful survivor recruitment in future studies (see Appendix 1). Recruitment of survivors who proactively participate in online support groups and forums may warrant consideration, in addition to efforts to recruit survivors through OSCCs and NGOs. Survivor diaries and surveys could be methods used to support the acquisition of the perspectives of survivors who use online platforms. Whilst these methods may not yield the same depth of information as in-person interviews, the necessity and urgency of gaining survivors perspectives on the response of OSCCs may justify these methods in the first instance, not least given that certain challenges and risks

associated with in-person interviews might be circumvented to a degree, including loss of employment hours and greater difficulty hiding participation from perpetrators, family, and members of the community.

Second, research conducted by Grisurapong (39,42) approximately 20 years ago exposed numerous challenges impacting the accessibility and response of OSCCs in Thailand, almost all of which were identified in this study as still presenting a challenge, raising the question of how best research on NPSV/IPV and OSCCs in Thailand can be translated into policy and practice. Implementation research exploring the barriers and facilitators to the translation of research on the accessibility and response of OSCCs in Thailand might guide the selection and design of further research studies, in addition to potentially aiding the implementation of the recommendations of the research. Included within the various objectives of an implementation study might be the identification of the research needs and policy priorities of the various state actors involved in the response of OSCCs to NPSV/IPV. It should be noted that findings of the OPA indicated that the Office of Policy and Strategy under MSDHS has an overarching mandate for the governance of coordination of the multisectoral response to VAWG, whereas OSCCs based in hospitals fall under the governance of MOPH (26), thus collaboration between these bodies could be explored in an implementation research study.

Third, given the lack of research on the OSCC model in Thailand, a broad exploratory qualitative study was considered most useful for identifying a breadth of challenges and opportunities of using OSCCs to address NPSV/IPV, in addition to priority areas for further research. More in-depth research could explore i) the knowledge, beliefs, and attitudes of state and non-state actors involved in the response to NPSV/IPV, including OSCC staff, non-OSCC hospital staff, police, MSDHS officers, village leaders, community health volunteers,

religious leaders, amongst others; ii) the effectiveness of current training programmes offered to OSCC staff; iii) the efficacy of MOUs between survivors and perpetrators of IPV at preventing further violence; iv) the barriers and facilitators to the accessibility and response of OSCCs for particularly vulnerable populations, such as hill tribe communities, undocumented migrants, sexual minorities, religious minorities, individuals lacking decision-making capacity, amongst others; and v) the roles that community representatives are currently playing in the response to NPSV/IPV and the perspectives of stakeholders on how their roles should be conceived.

8. Conclusion

This thesis helped to further our knowledge and understanding of the challenges and opportunities of using the OSCC model to help survivors of NPSV/IPV in Thailand, in accordance with the aim of our study. Our findings indicated a wide range of survivor help-seeking and disclosure preferences and behaviours, although numerous, substantial barriers were identified as contributing to survivor silence. The study exposed problematic views and social norms impacting the response of OSCC staff to NPSV/IPV, including an acceptance of marital rape, survivor-blaming, support for the mediation of cases in the community, and interrogation of survivor accounts. Our findings also revealed considerable institutional challenges to a trauma-informed OSCC response, including inconsistent case management, a lack of financial and human resources, and limited coordination and follow-up.

Some of these institutional challenges would benefit from urgent attention, such as the use of untrained, non-specialised male doctors to perform forensic examinations in rape cases and the lack of capacity of OSCCs to provide support for survivors attending the hospital outside normal working hours. The study underlined the importance of foregrounding efforts to enhance access when seeking to improve health systems' responses to NPSV/IPV. Efforts to improve the response of OSCCs once survivors have accessed OSCCs may simply represent the ‘tip of the iceberg’ (11). Application of Cislaghi & Heise’s (2018) Dynamic Framework for Social Change supported a greater understanding of the influence and interrelation of social norms and individual, material, institutional, and other social factors on the accessibility and response of OSCCs to NPSV/IPV in Thailand.

Despite limitations of the study, our findings supported the generation of evidence-informed policy and practice recommendations for promoting survivor access to consistent, trauma-informed support at OSCCs in Thailand. Our findings also supported the identification of opportunities for further research that could help facilitate improvements in the support offered by OSCCs to survivors of NPSV/IPV in Thailand.

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Appendix 1: Challenges faced in survivor recruitment

There were several challenges faced in survivor recruitment. It was deemed necessary to recruit a female Thai co-researcher with first-hand experience of conducting qualitative research with survivors of VAWG and on the OSCC model in Thailand, which was successfully achieved. Khun Kasina Limsmarnphun (Mahidol University) was considered optimally placed for this role having previously interviewed female survivors of domestic violence in the South of Thailand; however, due to limited time and flexibility, Khun Kasina was only available for interviews in Bangkok. The OSCCs in Bangkok fall under the Medical Service Department of the Bangkok Metropolitan Administration (BMA) requiring a further application for research ethics approval from the BMA before it would be possible to approach OSCCs for recruitment, in addition to ethical approval from the Thai Ministry of Public Health, which was acquired prior to arrival. This additional ethical requirement was not disclosed in discussions with Thai researchers prior to my arrival in Thailand.

Consequently, research ethics approval from the BMA was acquired after a lengthy process involving the submission of hard copies of completed forms, which were delivered in person to expedite the process of approval.[4] The BMA also required hospital director approval to be sent to them for final approval before OSCCs could be approached for recruitment to the study.

[4] An appointment in person with the Research Director of the Medical Services Department (BMA) was also undertaken to communicate the urgency of the research

Hospital directors' offices were therefore contacted for all nine public hospitals in Bangkok. All requested a cover letter and various accompanying documents to be sent by paper mail. In all cases, interpreters in this study asked if it would be permissible to submit these documents to the hospital directors' offices via email, communicating the limited time for data collection. In all cases the hospital directors' offices required paper copies to be sent, to be processed using routine hospital procedures for any paper mail. Further, hospital directors' offices communicated that expediting hospital procedures in light of the time-sensitivity of the research would not be possible.

In the end, three hospital directors did provide their approval during the available data collection period. However, by the time such approvals were granted, there was insufficient time to achieve the final approval from the BMA, recruit the OSCCs, and then ask OSCC staff if they would be willing to support survivor recruitment before the data collection period ended. In sum, given that Khun Kasina was only available for interviews in Bangkok and the thesis proposal was restricted to recruitment of survivors through OSCCs, the inability to recruit OSCCs in Bangkok prevented the recruitment of survivors to the study.

Key learnings for survivor recruitment in future studies

A number of key learnings arose from the inability to recruit survivors to the study. First and foremost, a greater allocation in the original timeline for the acquisition of all approvals with the support of research assistants in Thailand, could have ensured that these approvals would have been in place on my arrival in Thailand at the start of the data collection period. This strategy was utilised for gaining ethical approval through LSHTM and Thailand's IHRP, with support from interpreters in Thailand in the latter case; due to a lack of awareness of the

prerequisite of BMA ethical approval for interviews in public hospitals in Bangkok, this was not the case for these interviews. Whilst discussions with Thai researchers were undertaken, including discussions about the practical implementation of the research, more regular communication might have helped reveal this requirement earlier, which was explained by one of the Thai researchers I had been in discussion with, albeit too late in the research process to enable timely acquisition of BMA approval. Future researchers seeking to include OSCCs in Bangkok are encouraged to seek approval with significant lead time, especially given the requirement of using paper copies and the postal service when applying.

A second key learning relates to the benefit of a broader recruitment approach. Given the lack of visibility of OSCCs in Thailand, it seemed prudent to recruit survivors through OSCCs directly as it was suspected that the majority of survivors recruited by other means would not have attended an OSCC. A broader recruitment approach might have included recruiting survivors using approaches such as recruitment through community organisations (188–190) or online advertising (188,191). The possibility of the latter was considered during data collection in light of the challenges to recruitment, but because it would have required the submission of a research ethics amendment to all three research ethics committees, this was not feasible within the available timeframe. Restricting survivor recruitment to participants able to provide input on *all* the research questions – as opposed to including the opinions and insights of survivors who had not attended an OSCC and who therefore could not answer all the research questions – was in hindsight misguided, particularly given the extant literature on the prevailing challenges of survivor recruitment (192).

Third, a possible solution to overcoming the geographical limitation of undertaking in-person interviews with survivors in Bangkok, could have been to recruit OSCCs or NGOs to ask

survivors to independently fill out and submit a 'survivor diary,' which survivors may also find less demanding and intimidating than an in-person interview. Solicited diaries as a research method for exploring the perspectives of survivors of VAWG have been evidenced to support an understanding of survivors' home environments, facilitate understanding of complex and personal matters, and, importantly, to empower survivors (193). In future research, survivors could be presented with prompts to ensure that the aims, objectives, and research questions of the particular study are addressed. Such an approach would present its own challenges with respect to survivor safety, data management, and depth of data collection, amongst other considerations.

Finally, whilst it did not present a barrier to survivor recruitment in the present study, one of the interpreters, a Thai citizen, expressed concern about the ethical appropriateness of recruiting survivors to the study. This interpreter explained that, particularly in light of the gravity of NPSV/IPV and the demands of the research, including transportation to the interview location, a considerable time commitment, and risks to the survivor (e.g., intimate partner discovering participation), not providing payment beyond travel expenses to participating survivors was unethical. The interpreter recommended the provision of a gift voucher to compensate survivors. I explained that payment to research participants was not possible given undue inducement concerns and that it would violate the study's ethics approvals.

Appendix 2: OPA Participants

Interview type	Sex; Profession; Organisation
KII	Female; Gender equality & VAWG expert; INGO
KII	Male; Government official; Department of Children and Youth
KII	Female; Public prosecutor; Office of the Attorney General
KII	Female; VAWG specialist; CSO (gender equality)
KII	Female; Police officer; Royal Thai Police (Regional Level)
KII	Male; Police officer; Royal Thai Police (Provincial Level)
KII	Female; Government official; Department of Women's Affairs and Family Development
KII	Female; Shelter employee; Government shelter (Department of Children and Youth)
KII	Male; Physician/Government official; Ministry of Public Health
KII	Female; Public prosecutor; Office of the Attorney General
KII	Male; Anti-Trafficking expert; International organisation
KII	Male; Public prosecutor; Office of the Attorney General
KII	Female; Gender equality & VAWG expert; CSO (gender equality)
KII	Female; Public prosecutor; Government organisation
KII	Female; Indigenous peoples expert; CSO (global health & development)
KII	Female; Government official; Department of Probation
KII	Female; Gender equality & VAWG expert; CSO (global health & development)
KII	Female; Social worker/government official; Ministry of Public Health
KII	Female; Gender equality & VAWG expert; CSO (gender equality)
KII	Female; VAWG & migration expert; INGO
KII	Female; VAWG & migration expert; CSO (gender equality)
KII	Female; Social worker; Hospital/government organisation
KII	Female; Child protection specialist; CSO (anti-trafficking)
KII	Female; Researcher; Academic institution
KII	Male; Physician/government official; Ministry of Public Health
KII	Male; Researcher; Academic institution
KII	Female; Gender equality & VAWG expert; CSO (global health & development)
KII	Female; Gender equality & VAWG expert; INGO
FGD	2 Female, 1 male; CSO (indigenous peoples)
FGD	2 Female; CSO (sex workers)
FGD	4 Female, 2 male; Department of Local Administration
FGD	2 Female, 2 male; Royal Thai Police
FGD	3 Female; Social Assistance Centre/1300 hotline
FGD	1 Female, 1 male; Office of the Attorney General
FGD	2 Female; OSCC, Provincial hospital
FGD	1 Female, 1 male; CSO (gender equality)
FGD	2 Female, 1 male; Gender studies centre, Academic Institution

Appendix 3: Literature search strategy and methods

Given that a systematic literature review of barriers and enablers to the implementation and effectiveness of the one stop model for intimate partner and sexual violence in LMICs was recently undertaken (45), the decision was made not to undertake a further systematic literature review, but instead to focus on primary data collection in this study. A narrative literature review was undertaken to identify any articles not included in Olson, García-Moreno, & Colombini's (2020) systematic literature review on the challenges and opportunities of using OSCCs to help survivors of VAWG, such as articles published after 2020.

An English language search of five online databases, namely Embase, Cinahl Complete, Scopus, PsychINFO, and Thai Journals Online (ThaiJO), was undertaken to identify peer-reviewed articles relevant to this study. These databases were chosen as their scope matches the topic of inquiry and collectively enable sufficient breadth for a comprehensive search of the academic literature. The search strategy used was as follows:

"Sexual violence" OR "rape" OR "domestic violence" OR "intimate partner violence" OR "intimate-partner violence" OR IPV OR "non-partner sexual violence" or "NPSV" OR "abuse" OR "violence against women" OR "violence against women and girls" OR "VAW" OR "VAWG" OR "gender-based violence" OR GBV OR "sexual and gender based violence" OR "sexual and gender-based violence" OR SGBV OR "sexual assault" or "physical assault"

AND

“One stop crisis center” OR “one-stop crisis center” OR “one stop crisis centre” OR “one-step crisis centre” OR “OSCC” OR “one stop center” OR “one-stop center” OR “one stop centre” OR one-stop centre” OR “OSC” OR “rape crisis center” OR “rape crisis centre”

NOT

“oral squamous cell carcinoma”

A date restriction was not applied to the search results, to maximize the number of results generated. Searches were conducted within the title, abstract, and keyword lists of each database. In addition, a Google search was undertaken to identify relevant material published out with academic journals i.e., in the grey literature, such as conference proceedings, technical reports, and policy statements, amongst others. The Google search used a variety of combinations of the search terms used. Articles were initially assessed based on their title and abstract to screen their relevance for this study. Following this, full-text copies of studies for possible inclusion in the review were sought to enable a more thorough evaluation of their relevance.

The search terms were translated into Thai language using Google Translate and applied to the Thai research database ThaiJO and Google. Studies published in the Thai language were assessed for relevance using Google Translate, with a view to commissioning a full translation of relevant studies; however, the few studies identified in Thai that were relevant to this thesis had also been translated into English. Olson, García-Moreno, & Colombini’s (2020) systematic literature review on the implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in LMICs identified Grisurapong’s

(2002) study as the sole study from Thailand, even though its search had included papers in French and Spanish, in addition to English.

There were several limitations of the narrative literature search. First, other studies may have been undertaken that were not identified due to being published in paper form rather than online, given that many government and academic institutions in Thailand continue to rely heavily on a paper-based system. Second, restricting the literature search to English and Thai languages is likely to have excluded research studies on OSCCs published in other languages. Third, errors in using Google Translate to produce Thai search terms, which was necessary given limited funding for this study, may have resulted in the omission of relevant studies. Fourth, a further consequence of limited funding was that it was not possible to employ a second independent researcher to enable cross-checking of the literature search. Fifth, a few research papers could not be accessed due to gaps in institutional subscriptions, some of which may have been relevant to the study. Finally, despite the selection of a broad range of search terms, it is possible that the search terms used did not fully capture the entirety of literature on this topic and so there may be relevant studies that were not included in this review as they were not identified by the search strategy.

Appendix 4: Topic guide

Item	Prompts	Research objective	DF component (SN = social norm; I = individual; M = material; Ins = institutional; S = other social
- Present participant(s) with participant information sheet and consent form before the interview. Do not proceed with interview if the consent form has not been signed. - Ask participant how much time they have and do not go over time. Check timing with the participant if you are unsure. - If participants do not want the interview to be recorded, reassure the participants that it is their decision and that we would not record the interview without their permission. Ask the participants if they are happy to share their concerns about the recording. If there is a solution to the participants' concerns, present the solution as a possibility. If there is no solution, or the participants do not accept the proposed solution, then record the participants' responses manually. - Record the **location of the OSCC** and **sex, profession, and length of time working at OSCC** for each participant on the top of the interview form.			
Introduction			
"Hello. Thank you so much for showing an interest in this research study. Have you had a chance to read the participant information sheet?" [If not, present participant with information sheet and give them time to read it.] "Do you have any questions about the study?" [Pause for answer.] "I would like to be clear that if you decide that you would like to participate in the study, you are welcome to ask for the interview to be paused or stopped at any time and your request will be granted. If at any point you decide that you do not want some or all of your comments to be included in the study, let me know and any comments that you do not wish to be included in the study will be removed. If you are happy for your comments to be included in the report, key identifiable information will be removed, for example, your name or initials will not be included in the report. You can answer the questions in any way you like. If you would prefer not to answer a question just let me know and I will move to another question. Are you happy to participate in the study?" [If so] "Are you ready to begin?" [If so] "Are you happy for me to turn on the recording devices?" [If so, turn on recording devices and commence interview].			
Opening questions			
Preamble: "I'd like to start by asking you a little bit about yourself." [Try to build rapport. Opening questions below simply suggestions, feel free to ask questions that you feel may help the participant relax and build rapport.]			

1. Are you from [interview location]?		N/A	N/A
2. Have you lived in [interview location] for a long time?		N/A	N/A
3. For how long have you been working at the OSCC?		N/A	N/A
Thesis questions			
Preamble: "Thank you. If it is OK with you, I'd now like to ask some questions about your experience of attending the OSCC. Again, please feel free to pass on any questions that I ask and at any time you can ask me to pause or stop the interview."			
4. What do women do after experiencing violence?	a. What do they do next? b. [Repeat question until participant finished or further inquiry inappropriate]	1	SN; I; M; Ins; S
5. How do women respond to sexual violence caused by a non-partner?	a. How do you think women *should* respond to sexual violence caused by a non-partner?	1; 2	SN; I; M; Ins; S
6. How do women respond to intimate partner violence?	a. How do you think women *should* respond to intimate partner violence?	1; 2	SN; I; M; Ins; S
7. How do women find out about OSCCs?	a. Which actors commonly and uncommonly refer women to the OSCC?	1; 3	Ins; S
8. What might influence a woman's decision to attend the OSCC?	a. Are there any barriers that may prevent women from accessing OSCCs?	1	SN; I; M; Ins; S

	b. Are there any facilitators that help women to access OSCCs?		
9. When a woman arrives at the OSCC after experiencing IPV/NPSV, could you tell me how the OSCC responds from start to finish?	a. Does the response in practice differ from how OSCCs are *expected* to respond? b. [If so] How?	2; 3	SN; I; M; Ins; S
10. What factors influence the OSCC's response to NPSV/IPV?	a. NB: What do you think are the strengths of the OSCC response to violence? b. NB: What do you think are the challenges affecting the OSCC response?	2; 3	SN; I; M; Ins; S
11. Who is responsible for coordination of the support that women receive at the OSCC?	a. Do you think that [actor] is appropriate for this role? b. Who takes over this role when [actor] is unavailable e.g., on annual leave?	3	Ins
12. Do women receive follow-up after discharge from the OSCC?	a. [If so] a. What follow-up do they typically receive? i. Does the follow-up in practice differ from the follow-up OSCCs are *expected* to provide? b. Who is responsible for coordination of follow-up?	2; 3	SN; I; M; Ins; S

13. Do OSCC staff receive any formal or informal training/guidelines to help them in their response or follow-up?	a. [If so] a. What training/guidelines do OSCC staff receive?	3	M; Ins; S
14. Are there any assessments or evaluations of the OSCC response?	a. Which actors undertake assessments or evaluations of the OSCC response? b. What do these assessments or evaluations involve?	3	M; Ins

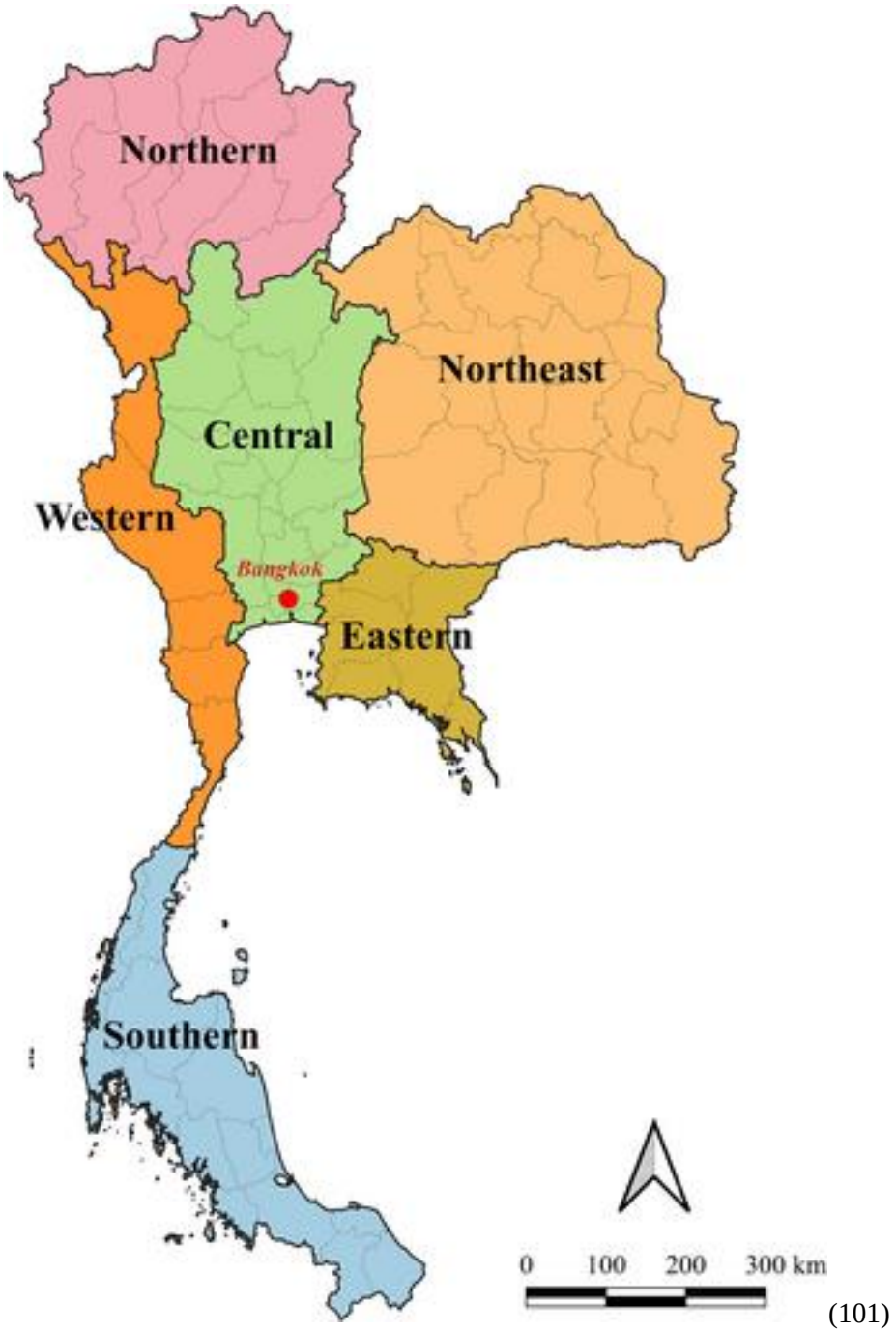
15. Which actors are in the multi-disciplinary team in this OSCC?	a. Do all actors in the multi-disciplinary team attend the OSCC when there is a case?
	b. [If not]
	  a. Which actors do not attend the OSCC?
	  i. Why do they not attend?
	  ii. How do they collaborate with other actors?
		2; 3	Ins

16. Do you believe that the OSCC has sufficient resources to achieve its objectives?	a. [If not]
	  a. What resources does the OSCC receive [human, financial. technical etc.]?
	  b. From whom?
	  i. What resources do you think the OSCC is lacking?
		3	M; Ins

17. Are there any referral systems in place?	a. [If so] i. What referral systems are in place? ii. Do you think these referral systems are effective? iii. Do you think these referral systems could be improved in any way? 1. [If so] how?	2; 3	M; Ins
18. Have any women provided positive or negative feedback about the support that they received at the OSCC?	a. [If so] i. What feedback have they provided?	1; 2; 3	I; M; Ins
Final questions			
"Thank you very much. The interview is nearly over. I just have 3 more questions if that is OK?"			
19. If there was one big thing that you could do to improve the OSCC's response to NPSV/IPV, what would it be?		1; 2; 3	SN; I; M; Ins; S
20. Is there anything else that you'd like to add that you haven't mentioned already?		1; 2; 3	SN; I; M; Ins; S
21. Do you have any questions for me [the interviewer]?		N/A	

Wrap up
[Stop recording device. Explain that the interview is over. Reiterate that all responses will be kept strictly confidential. Ask participant(s) if there are any concerns or further questions. Explain to the participant(s) that if they know of anyone else who may be interested in participating in the study, they are welcome to pass on my contact information as listed on the participant information sheet. Thank the participant(s).]

Appendix 5: Map of Thailand's regions



(101)

Appendix 6: LSHTM Research Ethics Approval

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT
United Kingdom
Switchboard: +44 (0)20 7636 8636

www.lshtm.ac.uk

Observational / Interventions Research Ethics Committee

Dr Robert Torrance
LSHTM

3 January 2023

Dear Dr Robert Torrance

Study Title: Challenges and Opportunities of using One-stop Crisis Centres to Help Survivors of Violence Against Women: the Case of Thailand

LSHTM Ethics Ref: 28241

Thank you for responding to the Observational Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Investigator CV	CV Robert Torrance	29/09/2022	1
Investigator CV	CV Kasina Limsmamphun	29/09/2022	1
Investigator CV	CV Ben Cislaghi	29/09/2022	1
Other	Research_Ethics_online_training_certificate	29/09/2022	1
Other	KL Ethics Certificate - CITI Program Certificates 2	29/09/2022	1
Advertisements	PAF recruitment email	29/09/2022	1
Advertisements	OSCC Recruitment Email	29/09/2022	1
Local Approval	image2	23/11/2022	1
Information Sheet	Consent Form V3 docx	08/12/2022	3
Information Sheet	Survivor Participant Information Sheet V5	08/12/2022	5
Information Sheet	PAF Participant Information Sheet V5	08/12/2022	5
Information Sheet	OSCC Participant Information Sheet V5	08/12/2022	5
Protocol / Proposal	Robert Torrance DrPH Thesis Proposal V10	08/12/2022	10
Covering Letter	LSHTM REC Thesis Submission - Cover Letter	14/12/2022	1

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

An annual report should be submitted to the committee using an Annual Report form on the anniversary of the approval of the study during the lifetime of the study.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

All aforementioned forms are available on the ethics online applications website and can only be submitted to the committee via the website at: http://leo.lshtm.ac.uk

Additional information is available at: www.lshtm.ac.uk/ethics

Yours sincerely,

Professor David Leon and Professor Clare Gilbert
Co-Chairs

ethics@lshtm.ac.uk
http://www.lshtm.ac.uk/ethics/

Appendix 7: Research Ethics Approval from the Thailand Institute for the Development of Human Research Protections

สำนักพัฒนาการคุ้มครองการวิจัยในมนุษย์ (สคม.) สถาบันวิจัยระบบสาธารณสุข

Institute for the Development of Human Research Protections (IHRP),

Health Systems Research Institute (HSRI)

ที่ สคม. 874 /2565

23 พฤศจิกายน 2565

เรื่อง อนุมัติให้ดำเนินการศึกษาวิจัยได้

เรียน Dr.Robert James Torrance

สิ่งที่ส่งมาด้วย หนังสืออนุมัติดำเนินโครงการวิจัย

ตามที่ท่านได้เสนอโครงการวิจัยเรื่อง "ความท้าทายและโอกาสของการใช้ศูนย์วิกฤตแบบครบวงจรเพื่อช่วยเหลือผู้รอดชีวิตจากความรุนแรงต่อสตรี: กรณีของประเทศไทย (Challenges and Opportunities of using One-stop Crisis Centres to Help Survivors of Violence Against Women: the Case of Thailand)" ต่อคณะกรรมการจริยธรรมการวิจัยในมนุษย์ฯ เพื่อพิจารณาด้านจริยธรรม และคณะกรรมการฯ ได้มีการประชุมพิจารณาเมื่อวันที่ 10 พฤศจิกายน พ.ศ. 2565 นั้น

ในการนี้ คณะกรรมการจริยธรรมการวิจัยในมนุษย์ฯ มีมติอนุมัติให้ดำเนินการศึกษาวิจัยได้ อนึ่ง คณะกรรมการฯ ขอแจ้งเกี่ยวกับความรับผิดชอบของผู้วิจัยภายหลังได้รับการอนุมัติ คือ ต้องรายงานความก้าวหน้าของการวิจัยประจำปีให้คณะกรรมการฯ ทราบทุก 6 เดือน และเมื่อเกิดเหตุการณ์ต่อไปนี้ทุกครั้ง ได้แก่

1) เมื่อมีเหตุการณ์ไม่พึงประสงค์เกิดขึ้นในโครงการวิจัย หากเป็นเหตุการณ์ไม่พึงประสงค์ที่ร้ายแรง ต้องรายงานให้คณะกรรมการฯ ทราบโดยเร็ว และให้ผู้วิจัยวิเคราะห์สถานการณ์การเกิดเหตุการณ์ไม่พึงประสงค์ว่า เกี่ยวข้องกับโครงการวิจัยที่ท่านรับผิดชอบหรือไม่ อย่างไร และในระดับใด รวมทั้งการดูแลรักษาและป้องกันอาสาสมัครด้วย
2) เมื่อมีการเปลี่ยนแปลงในโครงการวิจัย ต้องระบุให้ชัดเจนว่า มีการเปลี่ยนแปลงอะไร อย่างไร พร้อมทั้งเหตุผลที่เปลี่ยนแปลง เพื่อขอความเห็นชอบจากคณะกรรมการฯ ก่อน
3) เมื่อมีการเปลี่ยนแปลงหัวหน้าโครงการวิจัย หรือเพิ่มเติมคณะผู้วิจัย ต้องส่งประวัติของคนที่เปลี่ยนแปลงพร้อมเหตุผล ให้คณะกรรมการฯ พิจารณาให้ความเห็นชอบก่อน
4) เมื่อโครงการวิจัยยุติลง ซึ่งอาจจะเป็นการดำเนินการวิจัยเสร็จสิ้นสมบูรณ์ หรืออาจจะไม่สามารถดำเนินการวิจัยต่อไปได้ พร้อมทั้งแจ้งสาเหตุของการยุติโครงการวิจัยให้ทราบด้วย

จึงเรียนมาเพื่อโปรดทราบ

ขอแสดงความนับถือ

[redacted]

(นายแพทย์วิชัย โชควิวัฒน)

ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์ ฯ

สถาบันพัฒนาการคุ้มครองการวิจัยในมนุษย์

โทรศัพท์.0-2591-3876, 0-2591-3517, 0-2591-3541 โทรสาร.0-2591-4125 website: www.ihrp.or.th

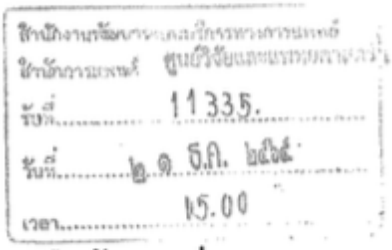
อาคาร 8 ชั้น 7 กรมวิทยาศาสตร์การแพทย์ กระทรวงสาธารณสุข นนทบุรี 11000

Building 8 Floor 7, Department of Medical Science, Ministry of Public Health, Nonthaburi 11000 Thailand

Appendix 8: Research ethics approval from the Bangkok Metropolitan Authority

สพบ.

กรมอนามัยโลกและการพัฒนา
โรงเรียนสุขอนามัยและเวชศาสตร์เขตร้อนแห่งลอนดอน
15-17 ทาวิสต็อค เพลส
ลอนดอน
17 ธันวาคม 2565
robert.torrance@lshtm.ac.uk



ผู้อำนวยการ
สำนักการแพทย์ กรุงเทพมหานคร
514 ถ. มหาจักร แขวง
ป้อมปราบ
เขตป้อมปราบศัตรูพ่าย
กรุงเทพมหานคร 10100

ความท้าทายและโอกาสของการใช้ศูนย์ช่วยเหลือสังคมเพื่อช่วยเหลือผู้รอดชีวิตจากความรุนแรงต่อสตรี: คดีในประเทศไทย

ถึง ผู้อำนวยการ

สวัสดีครับ ฉันชื่อ ดร.โรเบิร์ต ทอร์แรนซ์ ฉันเป็นนักวิจัยหลักในโครงการวิจัย "ความท้าทายและโอกาสของการใช้ศูนย์ช่วยเหลือสังคมเพื่อช่วยเหลือผู้รอดชีวิตจากความรุนแรงต่อสตรี: คดีในประเทศไทย" จุดมุ่งหมายของการศึกษานี้คือเพื่อทำความเข้าใจปัจจัยที่ส่งผลต่อการตอบสนองของศูนย์ช่วยเหลือสังคม (One-stop Crisis Center : OSCCs) ในประเทศไทยเกี่ยวกับความรุนแรงต่อสตรี

กระทรวงสาธารณสุขของไทยได้ขอให้จัดทำกรอบการประเมินผลการปฏิบัติงานเพื่อช่วยให้คำแนะนำแก่ OSCC เพื่อให้มั่นใจว่าผู้หญิงที่เคยประสบกับความรุนแรงจะได้รับการดูแลและการสนับสนุนที่มีมาตรฐานสูงสุด การวิจัยนี้

ที่ กท ๐๖๐๒.๔/ ๑๐๙

เรียน ผู้อำนวยการสำนักการแพทย์

ด้วยกรมอนามัยโลกและการพัฒนา โรงเรียนสุขอนามัยและเวชศาสตร์เขตร้อนแห่งลอนดอน ได้ขอความอนุเคราะห์ขอข้อมูลเรื่อง "ความท้าทายและโอกาสของการใช้ศูนย์ช่วยเหลือสังคมเพื่อช่วยเหลือผู้รอดชีวิตจากความรุนแรงต่อสตรี: คดีในประเทศไทย" รายละเอียดดังแนบ

ทั้งนี้ ผู้วิจัยจะมีหนังสือขออนุญาตเก็บข้อมูลไปยังโรงพยาบาลทั้ง ๘ แห่ง ได้แก่ รพก.รพต.รพจ.รพท.รพว.รพล. รพร.รพส.หากโรงพยาบาลดังกล่าวยินดีให้ข้อมูล ศูนย์วิจัยฯ จะนำโครงการนี้เสนอต่อคณะกรรมการจริยธรรมการวิจัยในคนกรุงเทพมหานคร ต่อไป

จึงเรียนมาเพื่อโปรดพิจารณา

[redacted]

(นายสมเกียรติ อัศวโรจน์พงษ์)
ผู้อำนวยการสำนักงานพัฒนาระบบบริการทางการแพทย์
สำนักการแพทย์
- ๙ ม.ค. ๒๕๖๖

[redacted]

(นายเทชรพงษ์ กำจรกิจการ)
รองผู้อำนวยการสำนักการแพทย์
- ๙ ม.ค. ๒๕๖๖

ที่ กท ๐๖๐๒/[illegible]
สนบ. [illegible]

[redacted]

(นางเลิศลักษณ์ ลีลาเรืองแสง)
รองผู้อำนวยการสำนักการแพทย์
ปฏิบัติราชการแทนผู้อำนวยการสำนักการแพทย์
๑๑ ม.ค. ๒๕๖๖

นา

Appendix 9: Participant information sheet (English version)

Participant Information Sheet

Study title:	"Challenges and Opportunities of using One-stop Crisis Centres to Help Survivors of Violence Against Women: the Case of Thailand"	
Principal investigator:	**Name:** Dr Robert Torrance London School of Hygiene and Tropical Medicine **Department:** Global Health and Development, London School of Hygiene and Tropical Medicine **Position:** DrPH (Doctor of Public Health) Student	Contact details: Tel: [redacted] Email: [redacted]

Introduction

Thank you for showing an interest in participating in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with others, before deciding whether or not to participate. If you decide to participate, we thank you. If you decide not to take part, there will be no disadvantage to you, and we thank you for considering our request.

What are the aims of the research?

The aim of the study is to understand the factors that affect the capacity of one-stop crisis centres in Thailand to meet the needs of women who have experienced violence. The research will focus specifically on intimate partner violence and non-partner sexual violence. The research will seek to answer the following questions: i) What are the needs of women who have experienced violence? ii) How do women report violence? iii) What are the experiences and perspectives of women and one-stop crisis staff on the support offered women at one-stop crisis centres?

If you participate, what will you be asked to do?

If you choose to participate in the study, the interviewer will start by asking some questions about yourself and you will be given the opportunity to ask questions to the interviewer. You will then be asked some questions about the factors that influence whether women attend OSCCs after experiencing violence. You will then be asked some questions about the services

and support provided at OSCCs to women who have experienced violence. If you would prefer not to answer a question just let the interviewer know and they will move to another question. If at any point you would like to pause or stop the interview, let the interviewer know and your request will be granted. You can answer the questions in any way you like. If at any point you decide that you do not want some or all of your comments to be included in the study, let the interviewer know and all comments that you do not wish to be included in the study will be removed. If you are happy for your comments to be included in the report, key identifiable information will be removed, for example, your name or initials will not be included in the report. The interview should take approximately 60-90 minutes.

Who are we seeking to participate in the project?

We are seeking interviews with a range of OSCC staff to enable a diverse number of perspectives to be obtained on the challenges and opportunities to an effective response to violence against women at OSCCs. Participants must have worked at an OSCC for more than 6 months, to ensure that they have had sufficient experience to provide valuable perspectives.

Is there any risk of discomfort or harm from participation?

If you agree to participate in the interview, you will be asked questions about the response of OSCCs to violence against women. It is possible that the conversation could lead to discussions about the nature, types, and consequences of violence against women, which participants may find distressing. If at any stage you would like to pause or stop the interview, please let the interviewer know and your request will be granted.

Are there any benefits of taking part?

We do not offer money or anything else for participation in this research. All participants will receive travel expenses. We do not expect the research to benefit participants, however, participants may be interested in the findings. Research results will be provided to all participants.

What data or information will be collected, and how will it be used?

We will ask your permission for audio recording of the interviews and to write down your responses during or after the interviews. Some of your responses may be included in the report, although any information that could lead to the identification of a participant will be withheld from inclusion in the report. All participant data, including audio recordings, transcribed documents, and signed consent forms will be securely stored electronically in encrypted folders on encrypted hard drives. Signed consent forms will be uploaded in electronic form to the encrypted folders and paper copies will be inserted into a shredder immediately after upload to the encrypted folders. Audio recordings will be destroyed immediately after verification of transcription has occurred. Two years after completion of the principal investigator's degree programme, all remaining participant data will be

destroyed (hard drives will be erased). Whilst participant data will be destroyed 2 years after completion of the principal investigator's degree programme, de-identified data included in reports of the research may be kept for much longer or possibly indefinitely.

Research results will be presented to the Thai Ministry of Public Health, which may later be disseminated more widely e.g., to OSCCs. The findings will also be presented to the London School of Hygiene and Tropical Medicine as part of the Principal Investigator's degree programme and UN Women Regional Office for Asia/Pacific. The findings may be submitted to a research journal or conference. Personally identifiable information will not be included in any oral or written reports.

If you agree to participate, can you withdraw later?

You may withdraw from participation in the project at any time and without any disadvantage to yourself. If you ask to withdraw from the study, your contributions will not be included in the research and any files containing information that you have provided will be permanently deleted.

Any questions?

If you have any questions now or in the future, please feel free to ask the principal investigator (the main interviewer) who is responsible for the research, or contact:

Name Prof Beniamino Cislaghi **Position** Co-investigator **Department** Global Health and Development, London School of Hygiene and Tropical Medicine	Contact details: Tel: [redacted] Email: [redacted]
Name Kasina Limsamarnphun **Position** Co-investigator **Department** Institute for Population and Social Research, Mahidol University	Contact details: Email: [redacted]

This study was approved by the Institute for the Development of Human Research Protections (Thailand) on 23rd December 2023 and the London School of Hygiene and Tropical Medicine Research Ethics Committee (UK) on 3rd January 2023 If you have any concerns about the research, you can contact the Institute for the Development of Human Research Protections via email at tikumporn@hsri.or.th or the London School of Hygiene and Tropical Medicine Research Ethics Committee via email at Ethics@lshtm.ac.uk or patricia.henley@lshtm.ac.uk. Any issues you raise will be treated confidentially and investigated and you will be notified of the outcome.

Appendix 10: Participant consent form

ใบยินยอมสำหรับผู้เข้าร่วมวิจัย

Participant Consent Form

ความท้าทายและโอกาสของการใช้ศูนย์วิกฤตแบบครบวงจรเพื่อช่วยเหลือผู้รอดชีวิตจากความรุนแรงต่อสตรี: กรณีของประเทศไทย

Challenges and Opportunities of using One-stop Crisis Centres to Help Survivors of Violence Against Women: the Case of Thailand

	กรุณาลงชื่อ Please initial
ข้าพเจ้าได้อ่านเอกสารข้อมูลสำหรับผู้เข้าร่วมวิจัยและเข้าใจวัตถุประสงค์ของโครงการวิจัยนี้แล้ว I have read the Information Sheet concerning this study and understand the aims of this research project.	-------
ข้าพเจ้ามีเวลาเพียงพอที่จะพูดคุยกับคนอื่น ๆ เกี่ยวกับการมีส่วนร่วมในการศึกษานี้ I have had sufficient time to talk with other people of my choice about participating in the study.	-------
ข้าพเจ้ายืนยันว่าข้าพเจ้ามีคุณสมบัติที่จะเข้าร่วมโครงการวิจัยนี้ดังที่ได้มีการชี้แจงในเอกสารข้อมูลสำหรับผู้เข้าร่วมวิจัย I confirm that I meet the criteria for participation which are explained in the Information Sheet.	-------
ข้าพเจ้าได้มีโอกาสถามคำถามต่อนักวิจัยหลัก และได้รับคำตอบที่น่าพอใจ ข้าพเจ้าเข้าใจว่าข้าพเจ้าสามารถขอข้อมูลเพิ่มเติมอีกเมื่อใดก็ได้ I have had the opportunity to ask the principal investigator questions, and I am satisfied with the answers that I received. I understand that I am free to request further information at any stage.	-------
ข้าพเจ้าทราบว่าการเข้าร่วมโครงการวิจัยของข้าพเจ้าเป็นไปด้วยความสมัครใจ และข้าพเจ้าสามารถถอนตัวจากการเข้าร่วมงานวิจัยเมื่อใดก็ได้โดยจะไม่ส่งผลเสียใดๆต่อข้าพเจ้า I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage to myself.	-------

ข้าพเจ้าเข้าใจว่าผลการวิจัยจะถูกตีพิมพ์ในภาพรวม แต่ข้อมูลส่วนบุคคลจะถูกเก็บเป็นความลับระหว่างข้าพเจ้าและนักวิจัยในระหว่างทำการวิจัย และจะไม่ถูกอ้างถึงในรายงานวิจัยทั้งที่เป็นลายลักษณ์อักษรและทางวาจา

I understand that the results of the project may be published in aggregate, but that any personal identifying information will remain confidential between myself and the researchers during the study and will not appear in any spoken or written report of the study. -------

ข้าพเจ้าทราบว่าไม่มีค่าตอบแทนในการเข้าร่วมงานวิจัยนี้ และข้อมูลของงานวิจัยนี้จะไม่ถูกนำไปใช้ในเชิงพาณิชย์

I know that there is no payment offered for this study, and that no commercial use will be made of the data.

ฉันตกลงที่จะเข้าร่วมการศึกษา

I consent to participate in the study

ชื่อผู้เข้าร่วมวิจัย (ตัวบรรจง):

Participant name (print):

ลายเซ็น วันที่

Signature: ---------- Date: ----------

ชื่อผู้รับคำยินยอมจากผู้เข้าร่วมวิจัย (ตัวบรรจง):

Name of person taking consent (print):

ลายเซ็น วันที่

Signature: ---------- Date: ----------

Appendix 11: Consensus building methods

The Delphi technique and Nominal Group Technique (NGT) are two of the most commonly used methods for achieving consensus amongst experts on a topic. The former is a structured method in which panellists are asked to offer their perspectives on items on a questionnaire e.g., using a Likert scale, and to provide further feedback on updated questionnaires displaying the feedback provided by panellists on previous rounds of questionnaires (194). The Delphi technique has been used extensively in health services research e.g., gaining consensus on indicators for medical treatment (194–196). Numerous benefits have been reported i) a large number of experts can be consulted (194); ii) all experts have an equal voice, avoiding a 'halo effect' in which the views of certain group members have greater influence over the outcome of the process than others (195,197); iii) the measurement of the importance of questionnaire items to panellists can be captured (195); and iv) the burden of the research on participants is low as questionnaires can be completed remotely (194), which also serves to reduce the environmental impact of the research. A significant weakness of the Delphi method, however, is the limited capacity of panellists to engage in discussion with one another to facilitate the emergence of social knowledge, although panellists are provided with the feedback from other group members. Other weaknesses of the Delphi method that have been reported include i) a 'bandwagon' effect, in which panellists change their perspectives upon receipt of feedback from other group members (197); ii) interpreting consensus from quantitative data requires determination of a cut-off for consensus, requiring justification in the absence of accepted criteria; and iii) a long process of data collection, with prompting of participants sometimes required and loss of participants possible (197).

The NGT is also a structured process of achieving group consensus, although contrary to the Delphi method, which is implemented remotely, the NGT involves multiple rounds of face-

to-face meetings (194,195). Like the Delphi method, there are variations of the NGT, although most forms of the NGT broadly follow four steps i) initial generation of ideas; ii) ranking of ideas; iii) group discussion; and iv) re-ranking of ideas by panellists in light of the group discussion (194). Like the Delphi method, the NGT is commonly used in health services research (194,195). The NGT offers greater scope for discussion between actors than the Delphi method and thus is better suited to achieving agreements between actors, thus could facilitate implementation of a framework like the PAF. Additional benefits of the NGT are that a large number of ideas/comments can be generated (195), consensus can be achieved more rapidly than the Delphi method (194), and it can promote stakeholder ownership and increase the likelihood of the generation of solutions to address the identified issue (198,199). However, the NGT is more suited to exploration of ideas rather than the pursuit of agreement on a co-developed framework which has many items requiring deliberation, given the length of time that group discussions require. The National Institutes for Health Consensus Development Conferences (200) and Glaser's State of the Art Approach (201) are further methods of consensus building (202), although these approaches have significant administrative burdens that exceed the capacity of the thesis. The former requires the convening of multiple conferences involving presentations from experts and the latter involves the identification and recruitment of experts followed by the identification of additional experts by those experts.