

**The Impact of Child Protection Training on
Nurses' Self-Efficacy in Detection and Reporting
of Child Abuse in Saudi Arabia**

**A thesis presented to Trinity College Dublin, the
University of Dublin**

for the degree of Doctor in Philosophy in Nursing

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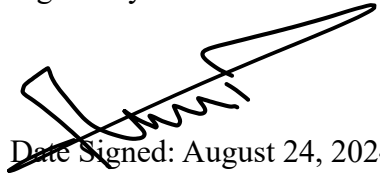
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Abstract

Background

The World Health Organisation (WHO) has reported that child abuse and neglect constitute major international health problems that cause unacceptable morbidity and mortality. These forms of maltreatment can have severe physical and psychological effects on children's development that persist into adulthood. Early detection of abuse and removing children from potentially hazardous and perilous conditions pose significant challenges. Nurses who care for children and families are uniquely positioned to identify children at risk of abuse and neglect during visits and have the opportunity to initiate interventions to prevent future harm. However, barriers such as a lack of experience, training, and confidence in handling abuse cases exist. Several training programmes have been developed to enhance nurses' abilities to recognise and report child abuse. Studies demonstrate that these training programmes effectively improve nurses' awareness, detection, and reporting of child abuse and neglect. In Saudi Arabia, The National Family Safety Program provides non-mandatory training to healthcare practitioners to support them in identifying and reporting child abuse cases through the Child Protection Multidisciplinary Training Programme (CPMTP) in multiple healthcare sites.

The concept of self-efficacy has been used to assess the outcomes of clinical training programmes in other fields, as positive effects on self-efficacy should translate to desirable practice patterns. To date, few studies have explored the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of child abuse and neglect. Furthermore, none of these studies have been conducted in Saudi Arabia.

Aim

To explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of child abuse and neglect (CAN) in Saudi Arabia.

Methods

This study was conducted across three regions of Saudi Arabia, with participation from nurses caring for children, using the Child Abuse Neglect Reporting Self-Efficacy Questionnaire (CANRSEQ). The questionnaire was administered in online and hard-copy formats across all three regions, with a completion time averaging under 20 minutes. Data were analysed using descriptive statistics and correlation analyses using Statistical Package for Social Sciences (SPSS) version 28 software.

Findings

The response rate was 77% (n = 247) among staff nurses. The majority (75.5%) had not reported any cases of child abuse or neglect in the past. The findings indicate that 73.2% (n = 164) did not receive any formal CAN cases. Additionally, 19.2% (n = 43) of the respondents had undergone formal training sessions concerning CAN, and 10.4% (n = 23) attended the CPMTP provided by NFSP. The study's findings showed a significant difference in self-efficacy expectations (EEs) on the SE-CAN scale. However, there was no significant difference in outcome expectation (OE) scores between those who attended CAN training and those who did not, as measured by the OE-CAN scale. The respondents generally reported being more confident in handling known abuse cases than in suspected abuse cases. Self-efficacy in detecting and reporting CAN differed among education groups when measuring the relationship between personal characteristics and professional self-efficacy in nurses. Those who had a postgraduate degree and attended a training programme reported a statistically significant higher self-efficacy score (i.e.,

EES, EEK, OE; mean = 3.4864 ± 0.56619) compared to those with a bachelor degree (mean 3.2337 ± 0.59468 , $p < .05$). Conversely, no significant differences were found in self-efficacy based on other personal characteristics such as age, gender, or marital status ($p > 0.05$). Regarding knowledge of the law, most of the participants, 70.7% ($n = 164$), believed they had a legal obligation to report cases where a child or young person was at risk of physical or sexual abuse. However, the lowest percentage, 42.1% ($n = 98$), was recorded for cases where a prenatal report was made, but the birth mother did not receive adequate support services.

Conclusion

This study is the first in Saudi Arabia to investigate the impact of child abuse training on nurses' ability to identify and respond to CAN. The results provide an important contribution to our understanding of nurses' self-efficacy in managing such cases, as they highlight the specific areas where nurses feel most confident and capable. Additionally, the findings shed light on potential areas for improvement and the need for targeted interventions to enhance nurses' self-efficacy in specific aspects of CAN. The underreporting of child abuse is attributed to various barriers, but training programmes can significantly improve nurses' confidence in reporting abuse cases. Notably, nurses are more confident in reporting known cases rather than suspected cases, and the ability to detect abuse is dependent on the type of abuse being investigated (physical, emotional, and sexual abuse). Therefore, training programmes must enhance nurses' confidence and provide them with clear guidelines for mandatory reporting and support in navigating these challenges.

Glossary of Abbreviation and Definition of Key Terms

1. ***Child abuse and neglect (CAN):*** “Child maltreatment that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence, and commercial or other exploitation, which results in actual or potential harm to the child’s health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power” World Health Organization (WHO, 2020, p. 4).
2. ***Self-efficacy:*** Self-efficacy is defined by Bandura (1977) as belief in one’s ability to succeed in a particular situation.
3. ***National Family Safety Programme (NFSP):*** The NFSP is a Saudi government organisation that works to reduce family violence through education, advocacy, and lobbying for change. The NFSP creates professional partnerships with professionals, government and non-government entities, and international organisations to provide a safe environment for families in Saudi Arabia (SA).
4. ***Child Protection Multidisciplinary Training (CPMTP):*** The NFSP, through its Department of Training and Development, has instituted a CPMTP aimed at increasing the knowledge and skills of professionals in identifying and managing instances of child abuse and domestic violence. This programme involves inter-agency training courses and child protection centres to enhance the knowledge, skills, and awareness of participants in dealing with CAN. It focuses on promoting a safe community, supporting victims of domestic violence, and educating professionals on effective strategies for child protection (Jalal, 2016).
5. ***Child protection:*** This broad term describes efforts aimed at keeping children safe from harm. The United Nations International Children’s Emergency Fund (UNICEF)

uses the term “child protection” to refer to preventing and responding to violence, exploitation, and abuse against children (UNICEF, 2011).

6. ***Child Protection Team (CPTs)***: This hospital-based multidisciplinary team is composed of a paediatrician or paediatric surgeon, a psychiatrist or psychologist, and a social worker. Together, they assess the kind, subtype, and urgency of injuries and sequelae resulting from child abuse and violence.
7. ***Child Protection System (CPS)***: The United Nations International Children’s Emergency Fund (UNICEF) defines a child protection system as: “Structures, functions and capacities, among other components, that have been assembled in relation to a set of child protection goals” (Unicef, 2020, p. 45).
8. ***Children/Childhood***: Focusing on the period between birth and 18 years old.

Chapter 1: Introduction to the Thesis

1.1 Background

Child abuse and neglect (CAN) are considered major global health problems, which cause unacceptable levels of child morbidity and mortality (Roje Đapić et al., 2020; Lee & Chou, 2016). A meta-analysis published in 2015 by Stoltenborgh et al. (2015), involving 244 publications and 511 prevalence rates for various types of maltreatment from January 1980 to January 2008, revealed that a substantial number of children are victims of abuse. The actual incidence is difficult to calculate and often goes unreported (Stoltenborgh et al., 2015). Globally, 1 billion children (2–17 years) have experienced sexual, physical, or emotional violence and neglect (WHO, 2022b). Studies have demonstrated a much higher proportion of children with a history of maltreatment than officially reported by Child Protection Services (CPS) (Bentley, 2017; Gilbert et al., 2009).

In SA, the first case of CAN was reported in 1990 (Al-Mugeiren & Ganelin, 1990). Retrospective studies reported that 309 cases of child neglect were diagnosed between 2015 and 2019, with the mean age of victims being 4.4 ± 4.1 years, and 51.8% were male, in a specialised children's hospital in Riyadh (Alfarhan et al., 2022). Child maltreatment encompasses any act of commission or omission by a responsible adult that results in harm, the potential for harm, or the threat of harm to a child (Smeekens et al., 2011), with the harm being unintentional in some cases (Al-Eissa et al., 2015).

Child abuse is the intentional exposure of a child to such circumstances, which results in emotional, physical, sexual, and psychological damage (Biçakçi et al., 2016). It also includes neglect by a parent or caregiver, which can inhibit a child's psychological, physical, social, or moral development (Avdibegović & Brkić, 2020; Biçakçi et al., 2016). Different forms of CAN exist, such as physical abuse, sexual abuse, psychological

maltreatment, and neglect (Robinson, 2019; Higgins & McCabe, 2001). Additionally, exposure to intimate partner violence is considered a form of child maltreatment, and affected children are often victims of targeted child abuse (Artz et al., 2014). The devastating impacts of CAN can cause short and long-lasting physical and mental health issues for children (Middlebrooks, 2007). Additionally, CAN can negatively influence a child's socialising and learning capabilities while impairing their overall development (Han et al., 2024; Fergusson et al., 2005).

The identification of CAN cases is crucial, and health professionals play a significant role in the identification process (Bragança-Souza et al., 2024). Nurses, as frontline healthcare professionals, are pivotal in identifying and responding to cases of child abuse (Lee et al., 2012c; Nayda, 2002). Among health professionals, nurses often deal with the victims of CAN by focusing primarily on saving lives and stabilising the child's condition (Emami et al., 2024). However, their ability to fulfil this responsibility hinges on their knowledge and skills, self-efficacy, and belief in their capability to perform effectively in this domain (Lee et al., 2012c; Lee & Ko, 2010). Therefore, nurses must know how to recognise and respond to symptoms of child maltreatment to protect and support vulnerable children (Fraser et al., 2010; Feng & Levine, 2005). According to Fraser et al. (2010), nurses who have knowledge and understanding of the signs and symptoms of abuse can intervene early and provide the necessary preventive measures and interventions to prevent further harm. Additionally, understanding the legal and ethical obligations surrounding child abuse reporting is obligatory to ensure proper procedural follow-up to protect the child and comply with the law (Elzamzamy et al., 2022; Chen & Scannapieco, 2006). Furthermore, nurses play a crucial role in advocating for children who may not have a voice and ensuring they receive the care and protection they deserve (Abbasinia et al., 2020; Neutzling et al., 2017).

Given the cultural and religious similarities shared by Arab Gulf states, the experiences of neighbouring countries have been instrumental in shaping discussions around child protection and abuse prevention (Marcus et al., 2017). The law differs across the Arab Gulf states. In Jordan, healthcare workers are obligated to report suspected CAN cases to the authorities, police, or national child abuse hotline (AlShalhoub et al., 2023). However, Kuwait has no legal obligation to report suspected CAN cases to law enforcement officials or social agencies (Al-Moosa et al., 2003). SA, one of the largest countries in size and population within the Arab Peninsula region, has seen most of its reported child abuse cases occurring in hospitals over the years, which have often involved severe injuries requiring medical attention (Alkathiri et al., 2021b). In SA, healthcare providers who treat potential victims are required to report suspected or confirmed cases of child maltreatment, especially when serious injuries are involved, to the Department of Social Services (Habib, 2012). The Child Protection Centres (CPC) project also includes drafting mandatory reporting laws for healthcare professionals and establishing a National CAN Registry (Al Eissa & Almuneef, 2010). These initiatives are essential in creating a safer environment for children in SA and holding perpetrators accountable for their actions.

The government cabinet in SA has developed a comprehensive policy that prioritises the protection of individuals, according to the 2014 Government policy (AlFarhan et al., 2022). To support this policy, the Saudi National Health Council (NHC) has approved a hospital-based CPT project offered by the NFSP. This initiative has resulted in the establishment of 39 CPTs in major hospitals nationwide; these teams include core multidisciplinary members such as paediatricians, social workers, psychologists, surgeons, legal service providers, nurses, and others (Almuneef & Al-Eissa, 2011). The members of CPTs underwent comprehensive training on

multidisciplinary approaches to the diagnosis and management of CAN. Additionally, they received specialised training through the CPMTP aimed at enhancing the knowledge and skills of medical professionals in identifying and managing cases of CAN (Al-Eissa & Almuneef, 2010). Furthermore, the Ministry of Labour and Social Development has recognised its role in achieving the National Transformation Programme (NTP) of Vision 2030. It has set 11 goals, including the establishment of an integrated family protection system to support this policy (Government, 2024b). This crucial component of the broader social development programmes outlined in the NTP prioritises enhancing the quality of life for all Saudi citizens through initiatives such as education, healthcare, housing, and social protection.

Nurses in SA are mandated to report cases of child abuse according to the Saudi Health Practice Bylaw. Failure to do so may lead to disciplinary action or termination (Almuneef & Al-Eissa, 2011). Nurses play a crucial role in identifying and addressing instances of CAN. They collaborate closely with other professionals, such as paediatricians, social workers, and psychologists, to ensure a comprehensive diagnosis, intervention, and support approach. However, a lack of research in SA has investigated the knowledge and awareness of paediatric nurses about child abuse. Addressing this gap is essential for improving the care and assistance provided to victims of CAN and their families. This section discusses the vital role of nurses in detecting and reporting child abuse cases.

1.2 The Role of Nurses in Detecting and Reporting Child Abuse Cases

Internationally, nurses have a professional and legal obligation to detect and report CAN cases. Identifying and preventing child abuse in its early stages is a significant challenge, particularly in hospitals (Elarousy & Abed, 2019; James & Green, 2018).

Recent literature suggests nurses should have experience with CAN detection and reporting in their usual practice settings, such as emergency departments (Raman et al., 2012; Fraser et al., 2010; Piltz & Wachtel, 2009), schools (Kraft & Eriksson, 2015), paediatric and neonatal inpatient areas (Lavigne et al., 2017), and primary health care settings (Midtsund et al., 2023). In these settings, nurses must integrate comprehensive assessments focusing on the child's physical health and consider family dynamics and environmental influences to identify and address CAN cases.

1.2.1 Training Nurses' Needs to Effectively Report Child Abuse and Neglect Cases

Nurses must have a clear process for reporting suspected CAN cases as an essential part of their professional duty, in hospitals (El-Radhi, 2015; Tingberg, 2010; Rowse, 2009; Tingberg et al., 2008). Despite their responsibility to report, many nurses feel ill-equipped to handle such situations due to a lack of preparation, support, and training (Winqust et al., 2024a; Skarsaune & Bondas, 2015). Therefore, they must be educationally prepared and provided with supportive tools to detect and report all forms of abuse (Lines et al., 2017; Schols et al., 2013). Additionally, they need keen observation and assessment skills, as they can encounter cases from any ethnic group or child with different socioeconomic statuses and genders (Overton, 2022). Therefore, the development of nurses' knowledge and self-efficacy to report child abuse is a critical objective of nursing programmes at all degree levels (Winqust et al., 2024b). To achieve this objective, hospital and community nurses must receive in-service training, such as practice simulations on how to manage conflicts that may arise when reporting suspected cases of child abuse (Flemington & Fraser, 2017; Feng & Levine, 2005). Furthermore, it is recommended that emergency department staff members are key workers for the

provision of education on child abuse and that specific screening tools are regularly used to detect abuse among children who present in those departments (Louwers et al., 2014).

1.2.2 Challenges Encountered by Nurses in Saudi Arabia

Nurses, like other healthcare professionals, may face obstacles when reporting suspected child abuse in SA. These obstacles include a lack of knowledge, fear of penalties for filing a complaint, and insufficient education (Alkathiri et al., 2021; Salami & Alhalal, 2020; Elarousy & Abed, 2019). Nurses have also expressed a lack of trust in the reporting processes and feeling unsupported by their peers and senior staff members (Salami & Alhalal, 2020). Additionally, they have felt helpless in the face of child abuse cases (Alkathiri et al., 2021b). As a result, nurses may be unable to report cases of CAN due to these obstacles.

Researchers have also highlighted deficiencies in reporting CAN cases and nurse training on CAN in SA (Elarousy & Abed, 2018; Lardhi, 2016). Healthcare professionals have reported several factors causing hesitation in reporting CAN cases, such as a lack of indicators to suspect abuse (AlShalhoub et al., 2023; Elarousy & Abed, 2019; Faraz et al., 2018; Habib, 2012). Similarly, inexperience, lack of diagnostic protocols, lack of confidence in communicating with parents about child abuse, and cultural backgrounds are also challenging factors (AlShalhoub et al., 2023). A significant number of healthcare professionals in SA were unaware of the procedures for reporting CAN cases or where to find the relevant documents to report such cases (Owaidah et al., 2022; Alkathiri et al., 2021; Elarousy & Abed, 2019; Mogaddam et al., 2016; Al-Dabaan et al., 2014). This deficit may be due to insufficient course attendance, workshops, and lectures, which leads to limited knowledge for detecting and reporting CAN cases (Alkathiri et al., 2021; Elarousy & Abed, 2019; Almutiry & Osman, 2018).

In SA, many hospitals rely on international workers, particularly nurses (Alreshidi et al., 2021; Alshehry et al., 2019), who are unfamiliar with CAN-reporting requirements in the context of SA (Elarousy & Al-Jadaani, 2013). A study conducted in SA highlighted that healthcare professionals, particularly those in emergency departments, paediatrics, and family medicine, face challenges in diagnosing and reporting child abuse, including issues related to underdiagnosis and concerns about confidentiality and privacy (AlShalhoub et al., 2023). Moreover, physicians may also have doubts about whether to report child abuse, either due to bad experiences with the families of abused children or because they fear that reporting may expose the child to additional abuse (Alkathiri et al., 2021; Elarousy & Abed, 2019; Mogaddam et al., 2016; Al-Dabaan et al., 2014). Despite the mandatory reporting law for CAN cases in all hospitals by the Ministry of Health of SA, healthcare professionals are hesitant to report due to the lack of clear legal implications for not reporting such cases in the policy and procedures of healthcare settings (Aldukhayel et al., 2020; Alsaleem et al., 2019; Elarousy & Abed, 2019; Elarousy & Abed, 2019).

This lack of reporting and attention from healthcare professionals, especially nurses, can have serious consequences for the well-being and safety of abused children. Therefore, child protection systems must address these barriers and create a supportive environment that encourages detection, reporting, and intervention in cases of child abuse. This environment must include improved learning and professional development and healthcare professionals to ensure they are equipped with the knowledge, skills, and confidence to identify and manage child abuse cases effectively. The study presented in this thesis explores the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected CAN cases in SA. Self-efficacy is crucial for nurses because it directly affects their ability to accurately identify and respond

to CAN cases. Nurses who feel confident in their skills are more likely to take action and report incidents, which ultimately leads to better protection and care for vulnerable children. The following section discusses the rationale behind the study.

1.3 Study Rationale

CAN training is not a core component of registration programmes for nurses in SA. Graduates may undertake additional training, such as the CPMTP, but such training is not mandatory. Studying how CAN training influences nurses' self-efficacy in detecting and reporting in SA is an area that requires further exploration. Limited information exists on how training provided by the NFSP in SA has supported nurses in detecting and reporting CAN cases. Research on the outcomes of CAN training programmes indicates that such training can lead to improved knowledge, better identification skills, increased confidence in reporting procedures, and greater overall effectiveness in handling child abuse cases (Walsh et al., 2022; Fraser et al., 2018; Lee et al., 2012c). These outcomes are significant because they directly impact the self-efficacy of healthcare professionals and provide insights into how such training can improve the detection and reporting of CAN cases (Walsh et al., 2022; Fraser et al., 2018). Self-efficacy, which refers to individuals' beliefs in their capability to execute behaviours necessary to produce specific performance attainments, is crucial in this context (Bandura & Walters, 1977).

The implementation of the CPMTP in SA may enhance nurses' self-efficacy in detecting and reporting instances of child abuse. Through structured training, nurses can develop a deeper understanding of the signs and symptoms associated with child abuse, which can enable them to identify cases more effectively. As a result, they may become better equipped to intervene in such situations and provide the necessary support and protection for vulnerable children. Additionally, by instilling confidence in their ability to recognise and report abuse, the objective of the training programme is to empower nurses

to overcome potential barriers, such as fear of repercussions or uncertainty about the reporting process (Mandadi et al., 2021; Raman et al., 2012), which can facilitate a more proactive approach to safeguard children (Khanjari et al., 2021; Tiyyagura et al., 2015; Bradbury-Jones & Taylor, 2013). Many international nurses working in Saudi hospitals may have undertaken CAN training in their home countries, but not all had the opportunity to undertake the CPMTP. Therefore, this study aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA.

1.4 Structure of Thesis

This thesis is structured across eight chapters. The thesis format is as follows:

Chapter 1 provides a background on child abuse, the role of nurses in detecting and reporting CAN cases, the challenges faced by nurses in SA, and the rationale for this study.

Chapter 2 offers an overview of the concept of child abuse, both internationally and in SA. It explores the immediate and future consequences of child abuse and its importance. Additionally, it delves into the legal obligations surrounding child abuse reporting, the responsibility of nurses in preventing future occurrences, and the significance of their education in detecting it. The chapter also discusses the CPS and the CPMTP in SA.

Chapter 3 discusses the theoretical framework that underpins this study. It examines how self-efficacy has evolved since Bandura, the significance of self-efficacy in

nursing sciences, the importance of education in building self-efficacy in reporting suspected cases, and how self-efficacy influences CAN reporting.

Chapter 4 presents a narrative review of empirical studies to identify approaches for evaluating CAN and synthesise the reported benefits and outcomes of the child protection programmes assessed in the included studies.

Chapter 5 provides an in-depth exploration of the methodology and philosophy that underpins the research study. It offers the context for the research approach adopted and discusses the philosophical foundations underpinning the study, which are influenced by and framed within the post-positivism paradigm. The chapter elaborates on the study design, presents the study objectives, and the rationale for why this particular methodology was chosen. Furthermore, it outlines the recruitment and sampling procedures, data collection methods, and data analysis techniques used in the study. Lastly, the ethical considerations that were considered when conducting this research are outlined.

Chapter 6 presents the findings of this study.

Chapter 7 presents a discussion of the findings concerning the published literature and outlines the strengths and limitations of the study.

Chapter 8 presents the conclusion to the thesis, provides an overview of the study's implications, and makes recommendations for practice, research, and education.

Chapter 2: An Overview of Child Abuse

This chapter outlines the prevalence of child abuse and its consequences both internationally and in SA. It explores the immediate and long-term effects of child abuse, which emphasises its importance and outlines the legal obligations surrounding its reporting. Furthermore, the chapter explores the role of nurses in preventing future occurrences of child abuse, including the significance of their education in detecting it. It also discusses CPS and the Child Protection Multidisciplinary Training Programme (CPMTP) in SA.

2.1 Introduction

Child abuse is one of the most significant issues affecting many children worldwide. A report indicated that a substantial portion of children, nearly 50% of those under 15 years of age, were exposed to various forms of abuse (Unicef, 2020a). This statement was updated by the WHO, which revealed that approximately three in four, or 300 million, children aged 2 to 4 experience physical or psychological abuse from their

parents or caregivers (WHO, 2022a). Approximately 1 billion children aged 2 to 17 globally have experienced violence, with reported prevalence rates of 58% in North America and 42% in Europe (Hillis et al., 2016). Such alarming statistics highlight the urgent need for collective action and intervention to safeguard the well-being and dignity of children, who are among the most vulnerable and precious members of the global community. Focusing on childhood abuse is also crucial because it has a massive impact on future perpetration and victimisation of violence, and it is associated with physical and mental health issues that can last a lifetime (Mohammed et al., 2024).

The WHO's (2022) report that child abuse is a widespread problem affecting children around the world is supported by findings from studies across nations (Lee et al., 2023; Sharratt et al., 2023; Radford et al., 2011). In the United States alone, millions of children are victims of abuse every year, which leads to immense suffering. Between 3.1 million and 17.8 million children in the US experience physical, sexual, or emotional abuse annually (Evans et al., 2008). Furthermore, according to Kim & Maguire-Jack (2021), recent data from the U.S. Department of Health & Human Services (2020, 2012) show an increase in the incidence of child maltreatment reports, which rose from 38.9 per 1,000 children in 2007 to 47.8 per 1,000 children in 2018 (Kim & Maguire-Jack, 2021). Additionally, over 500,000 suspected cases of neglected children were reported to CPS in 2012, constituting 75.3% of all confirmed child maltreatment cases (Australian Institute of Health and Welfare, 2021).

In the United Kingdom, 5% of children under 11 and 13.4% of 11- to 17-year-olds surveyed experienced severe maltreatment by a parent or caregiver. Additionally, 14.5% of 18- to 24-year-olds reported experiencing severe maltreatment during their childhood (Radford et al., 2011). According to the National Society for the Prevention of Cruelty to Children (NSPCC; 2022), in the UK, 500,000 children experience abuse every year. In

2022, the NSPCC helpline contacted 22,505 children for child abuse investigations, with an average of 62 children reported as victims of child abuse daily (NSPCC, 2022).

Similarly, in Europe, at least 55 million children were reported as experiencing child abuse (WHO, 2018).

According to the European Report on Preventing Child Maltreatment in 2013, 18 million children experience maltreatment, and at least 850 children younger than 15 years die due to abuse each year (Sethi et al., 2013). The incidence of different types of abuse is varied, with 29.1% for emotional abuse, followed by 22.9% and 9.6% for physical and sexual abuse, respectively (Lancet, 2013). For example, in Australia, one in 32 children aged 0–17 received CPS in 2019–2020, with emotional abuse being the most common type of abuse or neglect (Australian Institute of Health and Welfare, 2021). According to the Australian Institute of Health and Welfare reports, psychological abuse is the most common form of abuse or neglect reported in child protection notifications (40%), followed by neglect (28%) (Australian Institute of Health and Welfare, 2016).

Like other parts of the world, the Arab world is not exceptional. In some Gulf countries, child abuse is a serious problem and is rarely discussed since it is often considered a form of discipline (Habib, 2012). Many abusers go unpunished, which leads to continued and ongoing suffering for abused children (Abbas et al., 2022; Ben Natan et al., 2012; Al-Mahroos & Al-Amer, 2011). In a study conducted in Bahrain by Abbas et al. (2022), adults aged between 18 and 45 were surveyed for instances of child abuse they experienced before turning 18. The findings revealed that most cases of child abuse occurred one or two times within the age range of 5 to 13, with physical abuse being the most prevalent, accounting for 45.83% of these cases. The study identified fathers as the perpetrators in 41.67% of these cases. Approximately half of the surveyed participants

experienced physical harm, with 14% requiring medical intervention (Abbas et al., 2022). The prevalence of child abuse is not limited to Bahrain alone. A literature review conducted by Al-Mahroos (2007) reported that 27 children from Kuwait, 11 cases from SA, and five cases from Oman were identified with different forms of abuse in papers published between 1987 and 2005. In Yemen, 51–81% of children were subjected to corporal punishment, and cruelty was observed at home and school (Al-Mahroos, 2007). Similarly, in the United Arab Emirates (UAE), 47% of dentists encountered a suspicious case of child abuse during their careers. However, only 15% reported these cases to the authorities (Al-Amad et al., 2016). Moreover, between 2013 and 2015, 113 suspected cases of child abuse were reported to Tawam and Al Ain hospitals in the UAE; however, upon investigation, 72 children were confirmed to have been abused (Al Abdouli et al., 2017).

Numerous retrospective studies on CAN in SA have revealed fluctuating prevalence rates of different abuse types over time. For instance, physical abuse and neglect were most common between 2000 and 2008, but by 2014, psychological abuse had become the predominant form of child abuse (Mogaddam et al., 2015). Between 2009 and 2013, specific studies found physical abuse to be the most frequent (Almuneef et al., 2016), while research from 2015 to 2016 highlighted sexual abuse as the primary concern (Alshanawani et al., 2020). From 2015 to 2019, supervisory neglect emerged as the most prevalent form of child neglect (AlFarhan et al., 2022). These findings point to a changing landscape in the types of abuse reported over different periods. Table 1 provides a summary of the literature reviews that examined the prevalence of CAN in SA.

Table 1

Retrospective Studies on the Prevalence of Child Abuse and Neglect in Saudi Arabia

Study	Year	Studies/cases	Physical abuse (%)	Sexual (%)	Psychological (%)	
Mogaddam et al. (2015)	2000–2015	20 studies	In 2007	70	15	15
			2000–2008	Most prevalent type of CAN case	-	-
			2014	-	-	Most prevalent type of CAN case
Almuneef et al. (2016)	2009–2013	220 CAN cases	42	4	Psychological: 14 Neglect: 39	
Al-Zayed et al. (2020)	2015–2016	385 CAN cases	-	98	-	
AlFarhan et al. (2022)	2015–2019	309 CAN cases	5.5	-	Emotional: 6.8 Neglect: 3.2	

In 2013, a cross-sectional study was conducted to determine the prevalence of adverse childhood experiences (ACEs) among individuals aged 18 years and above in SA. The study involved 10,156 participants from all regions of the country who completed a self-administered Adverse Childhood Experiences – International Questionnaire (ACE-IQ) survey tool developed by the WHO. The study aimed to examine the correlations between ACEs, chronic diseases, and high-risk behaviours among the adult population residing in Riyadh. The study reported that over 50% of the participants had experienced emotional abuse, followed by physical abuse, bullying, neglect, and sexual abuse, with 42%, 39%, 29%, and 21% of participants, respectively. The study also revealed that risky behaviours ranged from 4% to 22%, and self-reported chronic diseases ranged from 6% to 17%. Furthermore, the study concluded that

individuals exposed to four or more ACEs were at an increased risk of chronic diseases and risky behaviours (Almuneef et al., 2018).

A pilot study was conducted by Al-Eissa et al. (2015) to determine the incidence of child maltreatment in a single city in SA; it involved adolescent participants and using the International Society for Prevention of Child Abuse and Neglect (ISPCAN) Child Abuse Screening Tool-Child (ICAST-CH). The investigation revealed that psychological abuse was the most frequently reported form of maltreatment, accounting for 74.9% of cases, followed by physical abuse, exposure to violence, neglect, and sexual abuse in 14% of the cases. Female participants were found to be at higher risk for psychological and physical abuse, exposure to violence, and neglect, but not for sexual abuse (Al-Eissa et al., 2015). Overall, the study shed light on the prevalence of different forms of child maltreatment in SA, highlighting the need for further research and intervention programmes to address these issues. The findings also underscored the importance of gender considerations in understanding and preventing child abuse.

Other studies have indicated that collaboration between different sectors and organisations has created a more comprehensive and effective response to child abuse, ensuring that children are not left unprotected or unheard. For example, a study conducted by Almuneef and Al-Eissa (2011) found that 70.7% of the 180 cases of child abuse from King Abdulaziz Medical City, NGH Affairs in Riyadh (KAMC-R), SA, referred to CPS between 2000 and 2008 were substantiated as child abuse cases. However, only 46.6% of these cases were referred for further legal action. The reporting rate increased tenfold during this period, attributed to various factors, including heightened awareness campaigns, enhanced training programmes for professionals, the enforcement of legal mandates for reporting, the establishment of reporting systems like the National Family Safety Registry and Child Helpline, a cultural shift towards addressing child abuse,

improved intersectoral collaboration, and ongoing research efforts (Almuneef & Al-Eissa, 2011). Previous research in the region indicated that physical abuse and neglect were the most common forms of maltreatment, with parents being the culprits in 48.9% of cases. Additionally, 8.3% of the affected children died from child abuse during this period (Al Eissa & Almuneef, 2010).

These findings highlight the changing patterns of CAN in SA over the specified periods, with variations in the prevalence of different types of abuse. Notably, the statistics represent the findings of different centres and do not determine SA's national child abuse rate. While the government and healthcare providers in SA are taking active steps to address the issue of child abuse, it remains prevalent and requires further attention (AlShalhoub et al., 2023; Alenezi et al., 2022). It is also important to acknowledge that incidents of abuse and neglect can vary in severity and type depending on the situation and source. Numerous studies have demonstrated the prevalence of child maltreatment, with certain forms being more common than others (Gama et al., 2021; Font & Maguire-Jack, 2020; da Silva Franzin et al., 2014; Al Odhayani et al., 2013; Radford et al., 2011).

These findings highlight the high prevalence rates of severe maltreatment among children and young adults. Therefore, society must address this issue, provide necessary support, and prevent further harm. Given that such abuse can be well-hidden and challenging to identify, raising public awareness for early detection and prevention is essential. Despite significant efforts made both locally and internationally, child abuse remains a serious issue that requires more attention, as it can have both short and long-term effects on the well-being of children. Focusing on prevention and early intervention strategies is vital to avoid significant consequences for children's well-being in the future.

These findings provide an understanding of the most common forms of abuse in SA and underscore the need for further research to understand the child abuse phenomenon comprehensively.

2.2 Consequences of Child Abuse

The consequences of child abuse are profound and far-reaching, and they leave indelible scars on the physical, emotional, and psychological well-being of victims (Rokach & Clayton, 2023). Beyond the immediate trauma endured, children subjected to abuse often face long-term repercussions, including developmental delays, impaired social skills, diminished self-esteem (Radford et al., 2011; Spataro et al., 2004; Banyard et al., 2001), and social health (Cooper, 2000). Additionally, child abuse has been linked to long-term health risks such as obesity, brain damage, and even death (Sebastian, 2014). These risks may not be immediately apparent but can emerge later in life. Children who have experienced two or more forms of maltreatment, with the first instance occurring after the age of 3, are particularly vulnerable, which significantly impacts various aspects of their lives (Green et al., 2018). Studies have demonstrated that individuals who have experienced childhood abuse are more likely to have weakened immune systems and experience chronic pain in adulthood (Irish et al., 2009; Springer et al., 2007; Moeller et al., 1993). Persistent alterations can occur in the inflammatory cytokines and hypothalamic-pituitary-adrenal axis due to CAN, which may contribute to disease vulnerability and a more pernicious course of disease (Elizabeth & Charles, 2020). Moreover, childhood abuse can significantly impact behavioural and mental health development (Al Odhayani et al., 2013). Behavioural changes can manifest differently across developmental stages: infant abuse can result in shaken baby syndrome; toddler-age abuse can lead to anger and difficulty expressing emotions; preschool-aged abuse can result in repression and hiding emotions through physical aggression; primary school-

aged abuse can lead to poor academic performance and social withdrawal; and adolescents who have undergone abuse are more likely to experience depression and anxiety (Prince, 2024). These impacts are due to the specific effects of abuse on brain regions and circuits involved in emotional regulation, stress response, memory, and interhemispheric integration (Samson et al., 2024).

Childhood abuse can be extended into adulthood and result in higher rates of pregnancy complications, and metabolic conditions such as diabetes (Radford et al., 2011).

Moreover, abuse can have a lasting impact on mental health, which makes it difficult to cope with everyday life while leading to issues such as posttraumatic stress disorder (PTSD), alcohol and drug abuse, eating disorders, and other mental health conditions (Lereya et al., 2015; Sigurdardottir & Halldorsdottir, 2013; Moeller et al., 1993). These conditions can affect self-esteem, emotion, and attachment regulation, impacting individuals' adult lives (Theodoropoulou et al., 2024). Additionally, these mental health increase the risk of violent behaviour (Radford et al., 2011). Adults with mental health issues often struggle to understand and express emotions and show empathy (Young & Widom, 2014). This difficulty can be due to their inability to process and regulate emotions. CAN can negatively affect children's health and academic performance, limiting their educational and skill-building opportunities, future job prospects and career development, and overall life opportunities (Nazir et al., 2023; Hardcastle et al., 2018). These negative consequences can lead to cycles of poverty and deprivation that are hard to escape. Families in this situation may experience financial hardship and struggle to provide adequate nutrition, health care, and other necessary resources for their children (Selph et al., 2013). Unfortunately, some forms of abuse or neglect can be challenging to detect, particularly neglect or emotional abuse, because children are unlikely to report them as being scary or upsetting (Gilbert et al., 2009).

Therefore, early detection and intervention are critical to address risks that may not be immediately apparent and prevent severe and life-threatening effects (Hirasawa, 2006). Physical assessments and skin examinations can reveal bruises, lacerations, burns, bites, and other signs of abuse, which can be documented in detail to facilitate early detection and intervention (Christian et al., 2015). The American Academy of Paediatrics stresses the need to consider the likely explanations for a child's skin injuries, especially when they are non-accidental and result in temporary reddening (Kellogg, 2014). For this purpose, healthcare providers' knowledge concerning intervening with abused children is crucial to their role (Tiyyagura et al., 2015). Early detection and reporting of CAN cases are essential in ensuring that children receive the necessary care and support to mitigate the long-term effects of abuse. To successfully intervene and provide appropriate care for children who have been abused, nurses must also be familiar with the reporting laws and support systems available in their jurisdiction. As discussed in the following section, ensuring accurate and appropriate CAN reporting is fundamental to effective intervention.

2.3 Child Abuse Reporting Laws

Child abuse reporting laws vary worldwide. Child abuse reporting laws play a fundamental role in safeguarding vulnerable children by establishing a legal obligation to report suspicions of abuse (Kenny et al., 2017). These laws empower professionals, such as teachers, healthcare workers, and social workers, to alert authorities, initiate investigations, and prevent further harm to the child (Ife et al., 2022).

Mandatory reporters face complex ethical and practical consideration when reporting child abuse cases. Acts of corporal punishment can have various characteristics that can be challenging to differentiate (Gershoff, 2002). Relying solely on the parents' accounts of their disciplinary practices can further obscure the distinction (Dobson, 2014). The potential consequences of reporting, such as the loss of parental authority, the

possibility of child removal, and the disruption of the family unit, can all impact the decision to report a suspected incident (Elzamzamy et al., 2022). Factors such as cultural differences, inadequate training, and the challenge of distinguishing between discipline and abuse contribute to these dilemmas (Chan et al., 2023; Elzamzamy et al., 2022; Gangoli et al., 2020). These factors can lead to further child victimisation, guilt, and regret for the reporting individual. Thus, healthcare professionals need to understand their rights, responsibilities, and options (Tufford et al., 2021) to ensure they can take the appropriate steps to address the issue.

Countries such as the US, Canada, and Australia have implemented laws mandating the reporting of suspected cases of child abuse or neglect (Rankin & Ornstein, 2009; Mathews & Kenny, 2008). The specifics of these laws vary, which impacts the number of reportable incidents and the parties responsible for reporting (Mathews & Kenny, 2008). For example, in the US, mandatory reporters are obligated to report any instances of CAN (Goldenberg, 2013). The US relies on the CPS system for the protection of children from CAN. Reporting is the foundation of this system, which brings maltreated children to the attention of CPS, who then respond to the CAN case appropriately (Sedlak et al., 2022). Furthermore, child sexual abuse (CSA) prevention policies, such as CSA prevention education in schools and mandated reporting practices, are also in place (Helpingstine et al., 2024). Similarly, all Australian states and territories have legislation requiring medical physicians to report child abuse cases to CPS (Bird, 2011). However, there is a greater focus on reporting cases of neglect or emotional (Mathews, 2014).

Currently, in England and Wales, no general statutory obligation exists to report child abuse cases; however, anyone with concerns should report to the local authorities (Government, 2024a). Previously, there was no mandatory reporting requirement for CSA

in England and Wales, but there was a professional duty to report (Mathews & Kenny, 2008). However, new measures are being evaluated to enhance child protection practices. One such measure is the Independent Inquiry into Child Sexual Abuse (IICSA), established in 2015, which is evaluating a legislative mandatory reporting duty (Mathews et al., 2020). This duty would require certain professionals, such as teachers and healthcare workers, to report suspected cases of CSA to the authorities. It is challenging to draw a definite conclusion about the impact of mandatory reporting laws on reporting because many jurisdictions have implemented these laws in various ways. They are primarily created to identify severe maltreatment cases that might otherwise remain hidden. Hence, mandatory reporting laws may be more effective in identifying and addressing non-physical forms of abuse. To ensure that these laws are followed, those responsible for reporting must be educated on their responsibilities, the signs of CAN, what should and should not be reported, the reporting process, and the entities to which reports should be made.

The Arab community faces a challenging balance between protecting children from abuse and working within cultural, traditional, and religious constraints (Al-Krenawi & Graham, 2005). Children in the Arab region experience all forms of child abuse, which are often disregarded or tolerated (Shah et al., 2021). Physical discipline is culturally accepted to raise a disciplined child (Heilmann et al., 2021; Nitsch et al., 2015). However, finding a balance between respecting cultural traditions and ensuring the safety and well-being of children is a complex challenge that requires open dialogue, education, and the promotion of alternative forms of discipline (Elarousy & Al-Jadaani, 2013). To achieve this delicate balance, a diverse range of professionals, including medical professionals, religious leaders, teachers, mass media, lawyers, and politicians, must work together effectively to ensure the well-being, safety, and rights of children while providing them

with a positive environment to thrive in (Al-Mahroos & Al-Amer, 2011). It is also critical to provide support and resources to caregivers of such victims (Moore et al., 2017). In some Arab countries, parents may view child abuse as a source of shame, so they deny or cover up such abuse (Arai et al., 2021; Delker et al., 2018; Schönbucher et al., 2012). Thus, organisations and governments have undertaken efforts to raise awareness and promote positive parenting practices in the Arab community (Baker & Dwairy, 2003). Indeed, more work is required to create lasting change and protect children from harm.

Although physical punishment is considered a form of child abuse and several Arab countries, including SA, Algeria, Morocco, and Egypt, have laws against violence, physical punishment is still used as a disciplinary measure in schools (Conte, 2014). Another study showed that although physical punishment may be prohibited, implementing this law is lacking in the Arab region (Seth & van Niekerk, 2013). This lack of enforcement means that even with laws in place to protect children in the Arab region, they remain vulnerable to abuse (Al-Saadoon et al., 2021; Almutawa & Magliveras, 2021). This lack of enforcement can lead to a cycle of abuse, with parents continuing to punish their children even in the face of the law (Shaffer et al., 2021). It can also lead to a lack of trust in the police and legal system (Shaffer et al., 2021; Martin et al., 2017), which can further exacerbate the problem.

Like other Arab countries, SA's healthcare system has not sufficiently paid attention to the role of nurses in child abuse case reporting (Salami & Alhalal, 2020). A study indicated that nurses showed a positive attitude towards reporting child abuse, which might be due to the legal obligation to report such cases in SA (Alharbi & Moussa, 2023). Many sexual and physical abuse cases were referred to law enforcement

authorities for further investigations. Only severe abuse types were prosecuted in court based on the General Criminal Bylaw (Almuneef & Al-Eissa, 2011).

2.4 The Role of Nurses in the Prevention of Further Child Abuse

Nurses play a crucial role in identifying and preventing child abuse by virtue of their close interaction with children and their ability to establish trusting relationships (Briones-Vozmediano et al., 2022; Lavigne et al., 2017; Lines et al., 2017; Nayda, 2002). Even with the involvement of CPS, nurses have a particularly effective role with families in developing safe and competent parenting skills (Jack et al., 2021). In addition to their ability to identify signs of abuse or associated health issues, nurses can effectively communicate and gather important information regarding children's well-being, advocate for their welfare, and intervene to protect them from abuse or provide necessary care (Volkman & Hillemeier, 2008). Nurses have a professional duty to safeguard children from any form of abuse (Lines et al., 2018), which enables them to identify issues before they become serious and act accordingly to protect children from abuse or provide the necessary care.

According to Yildiz and Tanrıverdi (2018), nurses can build rapport and trust with children, which makes it simpler to provide the appropriate care and support. Professional nurses have the capabilities and competencies, particularly in emergency settings, to ensure the safety and comfort of children (Liang et al., 2024). Some nurses may lack awareness of the signs of child abuse or feel unprepared to deal with this issue, which can hinder their ability to identify and report child abuse cases (Schols et al., 2013). In contrast, nurses in SA have excellent knowledge and attitudes regarding child maltreatment, yet they have a significant deficit in knowledge regarding the reporting procedures for cases of child maltreatment (Alkathiri et al., 2021).

Studies suggest that nurses face challenges when it comes to reporting CAN. Several factors contribute to them, such as a lack of knowledge related to child abuse and reporting, often due to insufficient pre-service education and in-service training regarding child abuse, as well as underreporting due to the uncertainty of the evidence (Atencion et al., 2019). Some nurses may report abuse depending on the nature of the abuse, they may consider the possible results and implications before making a complaint (Hailes et al., 2019).

Various organisational issues can also influence nurses' attitudes toward reporting child abuse and promoting child safety. These issues include communication concerns, confidence levels, and awareness of mandatory reporting requirements (Kuruppu et al., 2022; Oulton et al., 2018). In some cases, underreporting by nurses may be attributed to organisational issues such as mandatory reporting requirements (Zusman & Saporta-Sorozon, 2022; Ben Natan et al., 2012b). Healthcare professionals highlight child welfare organisations' non-professional and non-cooperative behaviour, particularly CPS (Gubbels et al., 2021a). Additionally, a lack of time for abuse identification and the perception that it is sometimes not considered a medical problem also contribute to underreporting (Alrimawi et al., 2014).

Effective communication skills are essential when managing suspected or confirmed cases of child abuse to overcome these hindering factors. Nurses may face difficulties in communicating with parents or children to detect or discuss indicators of abuse (Gubbels et al., 2021a). Establishing reliable relationships with children and their families is also essential in identifying and helping victims of abuse (Sheehan & Fealy, 2020; Kraft & Eriksson, 2015). To improve confidence in reporting suspected cases, networking, improved evaluation tools, and cooperation can all be helpful (Kraft & Eriksson, 2015). Nurses may encounter challenges when reporting CAN cases, especially in cases of

emotional abuse where they may lack the confidence in identifying the signs of abuse that require reporting (Pisimisi et al., 2022; Khanjari et al., 2021; Lines et al., 2020; Fraser et al., 2010). The reluctance of nurses to disclose suspected child abuse is influenced by their level of knowledge and comprehension of the phenomenon (Green, 2020; Lines et al., 2018).

To address underreporting, nurses require better resources and education programmes to aid in the identification and reporting of child abuse (Powers et al., 2019; Schols et al., 2013). These resources may help nurses better identify and report child abuse by boosting their knowledge, attitude, confidence, and connections with collaborative services (Gubbels et al., 2021; Barrett et al., 2017). Close collaboration between nurses and organisations that provide CPS facilitates constructive change in the lives of abused children (Lines et al., 2021). As highlighted by a Swedish study, failing to report suspected crimes against children potentially minimises or makes the occurrence of violence appear invisible (van Ufford et al., 2022). In order to address under- or non-reporting effectively, continuous multidisciplinary training is necessary to support childcare professionals in identifying and preventing child abuse (Lazenbatt & Freeman, 2006).

In conclusion, nurses play a pivotal role in detecting and reporting child abuse, although various factors influence their ability to do so. Improving their knowledge, attitude, and communication skills and facilitating collaboration with child welfare organisations can significantly enhance their effectiveness. Therefore, it is crucial to ensure that nurses possess the necessary skills and knowledge to correctly identify and report child abuse. The importance of training is discussed in the next section.

2.5 Importance of Nurse Training in Child Abuse Detection

Nurses are the largest group of health professionals and have frequent contact with children who are at increased risk of abuse and neglect (Lines et al., 2018). They are often the first point of contact for many child abuse cases and have the opportunity to identify different forms of abuse. Therefore, their observations can provide valuable information to protect children and prevent future violent incidents (Pabiś et al., 2011). Unfortunately, many nurses lack the necessary training and awareness of abuse signs and symptoms, as well as the comfort level needed to discuss these delicate topics with their colleagues (Lines et al., 2021; Skarsaune & Bondas, 2015). As a result, there is a shortage of research on paediatric nurses' attitudes and clear guidelines on their reporting role (Khanjari et al., 2021), which is due to a lack of training on the role of nurses in reporting CAN cases (Goodridge, 2021; Hashimoto & Takahashi, 2020) and a lack of awareness of abuse signs and symptoms (Parvin et al., 2023; Goodridge, 2021).

A study of Dutch nurses discovered that even though nurses understand their responsibility for child safety, they do not always take the essential steps when necessary (Louwers et al., 2012). Without an understanding of nurses' attitudes towards perpetrators, it is difficult to create effective policies and interventions that foster a safe environment for children (Buckley et al., 2023). Researchers have emphasised the importance of continuing in-service education and training programmes to improve self-confidence and competence in their role as mandated reporters of child abuse (Khanjari et al., 2021; Kim et al., 2020; Fraser et al., 2018; Lee & Chou, 2017). Therefore, nurses require enhanced support and training to ensure they feel confident in reporting child abuse and fulfilling their responsibilities in child safety. These programmes can improve nurses' comprehension of child abuse indicators, reporting protocols, self-efficacy, and

legal obligations while also offering emotional support. Nurses who report instances of child abuse should have access to continual assistance and support services.

2.5.1 Child Protection Services in Saudi Arabia

CPS in SA has evolved over the past few decades in response to the growing recognition of CAN. This section provides a structured analysis of the development and implementation of child protection initiatives in SA (Figure 1). It presents an original representation of the development of the CPS in SA based on the literature included in this chapter.

In SA, CPS is overseen by two primary agencies: the General Administration of Social Protection (GASP) and the NFSP. These agencies were established to ensure the well-being of children and provide them with a safe, secure environment free from abuse or neglect. The GASP is responsible for developing policies and regulations related to child welfare, while the NFSP focuses on developing programmes and initiatives aimed at protecting children from harm and promoting their welfare. The two organisations work collaboratively to achieve their common goal of safeguarding the rights and interests of minors in the country. The King's Royal Decree established the NFSP in 2005 to enhance the detection and management of child protection throughout the country. As a result, 41 CPCs were established (Aparicio, 2012). These centres are equipped with interdisciplinary teams comprising social workers, medics (i.e., surgeons, paediatricians, obstetricians, and forensic doctors), nurses, psychologists, and psychiatrists. The GASP coordinates 17 social protection committees (SPCs), while the NFSP integrates training activities.

The NFSP initiated the original child protection centre at a major hospital in Riyadh in 2008. This project received the full support and approval of the NHC, the health authority in the Kingdom of SA (Al Eissa & Almuneef, 2010). Since then, the

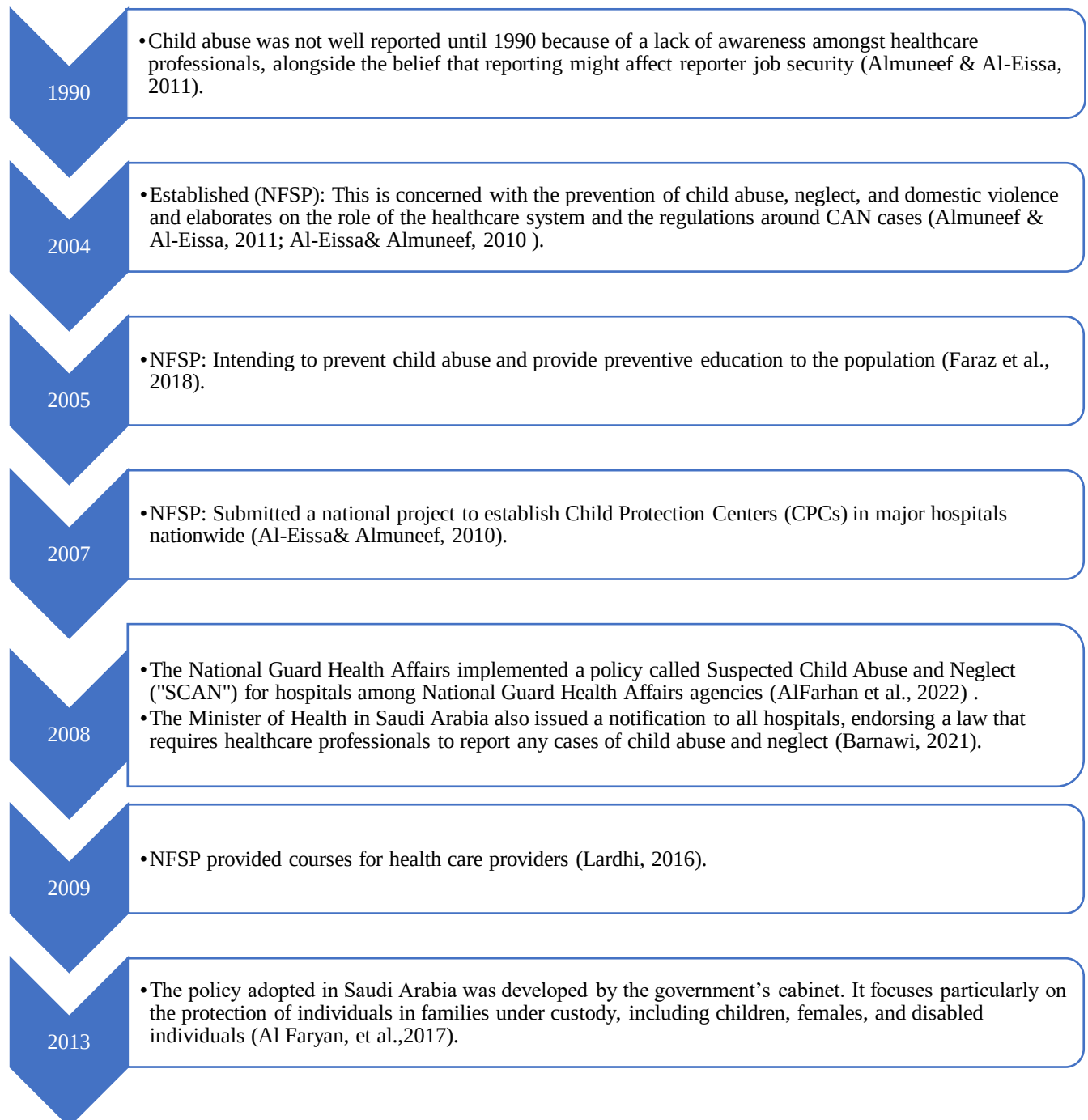
NFSP has had the primary goal of increasing professional knowledge and skills through training and development programmes focusing on child abuse and domestic violence including psychological and expanding counselling, research safety, and guidance for individuals under the age of 18 seeking social, health, and legal assistance. This programme reaches beyond the age limit to include parents and staff who deal with similar child protection issues. Generally, it is possible to report CAN cases in SA by calling the toll-free number (1919) from any fixed-line or mobile phone or talking to Social Protection Committees (SPCs) in different regions. They include the NFSP, hospitals (governmental and private), police stations, institutions for education, charities, and human rights commissions. However, in SA, services often fail to provide adequate protection for children, mainly due to unclear policies and procedures. Often, adequate support systems, including legal systems, are lacking, especially when suspected offenders threaten operators. The lack of job clarity, procedures, and treatment procedures has further hindered their position (Jalal et al., 2019). The Saudi government uses a range of policies to protect children at risk; there were some critical gaps in these policies (Al Faryan, 2014). Moreover, there is no accessible publication of clear child protection policies.

In 2008, a notification was issued by the Ministry of Health of SA to all hospitals, which endorsed the mandatory reporting law for CAN cases for healthcare providers. The law aimed to safeguard the reporter's identity and maintain the information's confidentiality. As per legal mandates, healthcare workers must report suspected CAN cases to the appropriate authorities and register them in the National Family Safety Registry (NFSR). This web-based registry helps register CAN cases by trained CPT members from all 13 provinces by assessing its prevalence, demographics, and likelihood of recurrence and providing short-term services (Alaraik et al., 2022). In 2013 and 2014,

SA approved laws for protection against abuse and child protection, respectively. These laws aim to prohibit all forms of child sexual abuse (CSA) exploitation, mandate all professionals to report any suspected cases of maltreatment, and ensure that the professionals are not negatively affected if, after a thorough investigation, it turns out not to be a case of abuse. They also state that ignorance in reporting suspected cases may result in disciplinary action against professionals and protect the identity of the reporters in all cases (Al-Saif et al., 2018). The Saudi law clearly states that non-compliance with Article 23, which mandates the reporting of CAN cases, can lead to a penalty of paying a fine of up to 100,000 Saudi riyals, imprisonment for up to two years, or both. In cases where the circumstances of the crime include a special needs victim, the incident takes place at work, school, place of care, or worship, the perpetrator is one of those entrusted with the application of the provisions of the law, or the practice of multiple forms of abuse in one case, the punishment intensifies to paying a fine between 100,000 and 500,000 Saudi riyals, imprisonment for not less than two years and not more than five, or both (Ministers, 2014).

Figure 1

Development of the Child Protection System in Saudi Arabia



2.5.2 The Child Protection Multidisciplinary Training Programme

The NFSP, through its Department of Training and Development, instituted the CPMTP aimed at increasing the knowledge and skills of professionals in identifying and managing instances of child abuse and domestic violence. This training programme was initiated by Almuneef and Al-Eissa (2011), with the first training occurring in the Central

Zone, leading to various developments by 2014. The NFSP and various partners, including the Ministry of Health, the Arab Professional Society for the Prevention of Violence Against Children, the World Health Organization, the Ministry of Education, the Ministry of Social Affairs, the Ministry of the Interior, the ISPCAN, Health Affairs at the Ministry of the National Guard, and Naif Arab University for Security Sciences conducted a total of 26 training courses. These courses engaged nearly 2,000 trainers from various disciplines across SA, representing the country's sectors (Jalal, 2016). ISPCAN created the CPMTP, and the NFSP adapted the course according to SA's culture, religion, and system norms. For instance, the training was customised to align with local legislation and procedures and covered emerging issues such as teenage pregnancy, which may not have been widely discussed in society.

The CPMTP comprises four teaching modules, with workshops to equip trainees with the necessary skills and knowledge. The first module focuses on child maltreatment, with a workshop aimed at detecting various types of CAN. The second module concerns assessment and interventions, while the third module covers the basic guidelines for working on CAN cases. The workshop for this module seeks to promote child protection, multidisciplinary teamwork, and report formulation. The final module is devoted to the formulation of prevention strategies across different levels of the healthcare and welfare systems (Jalal, 2016). The Child Maltreatment Course is a one-day face-to-face session for all healthcare professionals (e.g. paediatricians, emergency physicians, forensic medicine specialists, paediatric nurses, residents, and fellows). The course outline includes advanced skills in history taking, physical examination in CAN cases, cutaneous injuries and burns, an overview of sexual abuse, and differentiating accidents from abuse, child neglect, and emotional abuse. The last training session was conducted in November 2019 in Riyadh, prior to the onset of the COVID-19 pandemic. This course is optional for

healthcare providers, and detailed programme content is not publicly available. Access to online resources within the country is currently limited. Details of the CPMTP outlined here were sourced through verbal communications and the National Family Safety Programme website.

2.6 Conclusion

Child abuse, a pervasive and disturbing social issue, manifests in various forms, including physical, emotional, and sexual abuse, as well as neglect, and leaves a deep and lasting impact on the physical and psychological well-being of victims. Despite widespread awareness and efforts to prevent it, child abuse occurs worldwide, often perpetuated by complex family, social, and cultural dynamics. Child abuse reporting laws vary globally, but mandating CAN reporting is crucial to protect vulnerable children. Differences in law enforcement in the Arab region put children at risk despite existing laws. Similarly, the healthcare system in SA supports the role of nurses in reporting abuse, who play a critical role in the investigation. The effectiveness of nurses can be enhanced by increasing their knowledge, improving their attitudes, and fostering cooperation with child welfare agencies. Training programmes focused on research and management skills have been developed to improve reporting.

CPS in SA is overseen by agencies such as the General Authority for Statistics and Planning and the NFSP, which offer training programmes like the CPMTP to effectively address child abuse and domestic violence. However, an in-depth literature review is warranted to evaluate training, which can contribute to the body of knowledge by providing a clearer understanding of optimal training content and techniques. Additionally, it can inform decision-makers on whether current training interventions align with what is most likely to be successful.

The next chapter explores the theoretical framework that guided the research's design, implementation, and analysis. It also provides details regarding how the theoretical framework was developed.

Chapter 3. Theoretical Framework: Self-Efficacy Theory

3.1 Introduction

Child abuse is a pervasive issue that affects the well-being and development of children worldwide. Prior studies have identified social cognitive theory (SCT) as a framework for explaining the reporting of child abuse cases (Camilo et al., 2020; Heleniak & McLaughlin, 2020). At the core of SCT is the concept of self-efficacy, which refers to individuals' beliefs in their capabilities to perform specific tasks or behaviours (Bandura, 1986). This theory emphasises the significance of social influences and learning mechanisms, including self-efficacy, in shaping individuals' behaviour.

Researchers have found that self-efficacy is a crucial factor in the decision to report suspected child abuse cases (Fraser et al., 2018). By considering social cognitive and self-efficacy theories in the study of child abuse reporting, researchers can gain a more comprehensive understanding of the factors that influence individuals' decisions to report abuse. Self-efficacy theory is foundational in understanding human behaviour and motivation; it posits that individuals believe in their capabilities (Alazri & Hanna, 2020).

This chapter describes the rationale for the theoretical framework that underpins this study. It explores the evolution of the self-efficacy concept since Bandura's initial work, the relevance of self-efficacy in nursing sciences, the crucial role of education in fostering self-efficacy in reporting suspected cases, and how self-efficacy affects the reporting of CAN cases.

3.2 Social Cognitive Theory

Researchers have applied SCT to various fields, such as education, psychology, and health promotion, to understand human behaviours. SCT emphasises the importance of social influences (Greenwood, 2019), self-efficacy, and outcome expectations OEs in shaping health behaviours (McCormick, 2001; Shrauger & Schohn, 1995). By integrating

these various viewpoints, researchers and practitioners can create comprehensive interventions that address multiple factors influencing individuals' decisions. Understanding the diverse influences on health behaviours enables more personalised and effective interventions to promote positive outcomes (Bandura, 2000). Healthcare professionals need a solid understanding of these theories to assist individuals in making informed decisions about their health and clinical care (Abbasgholizadeh Rahimi et al., 2021; Aarthun et al., 2020). By combining evidence-based practice with theory-driven approaches, the field of public health can continue to make significant progress in improving population health outcomes. Additionally, SCT is the most relevant for health communication because it primarily deals with individuals' emotional and cognitive events (Mobley & Sandoval, 2008).

3.2.1 Overview

SCT is based on the belief that people learn through observation and imitation (Bandura, 2021; Rumjaun & Narod, 2020). By understanding the complex dynamics of observational learning and social influence on human behaviour, psychologists and other professionals can gain deeper insights (Rosenthal & Zimmerman, 2014). This understanding allows them to make more accurate predictions and develop effective interventions in clinical, educational, and broader social settings. Consequently, they can leverage social cognitive processes to drive positive individual, group, and societal changes (Butler & McManus, 2014).

SCT emphasises the concept of self-efficacy, which is considered “one of the most theoretically, heuristically, and practically useful concepts formulated in modern psychology” (Betz et al., 1996, p. 47). According to this theory, combined personal, behavioural, and environmental factors affect motivation (Bandura, 2001, 1999, 1986).

Bandura (1986) used the term “triadic reciprocity” to describe the interplay between behaviour, cognitive, and personal factors. Triadic reciprocity proposes that human learning results from the dynamic interplay between these three factors (Bandura, 1989, 1977; Bandura & Walters, 1977). However, within this relationship of triadic reciprocity, self-efficacy is the key factor that influences motivation and engagement (Bresó et al., 2011; Bandura, 1986). Individuals with high levels of self-efficacy tend to have greater engagement in terms of behaviour, cognition, and motivation than others (Schunk, 1996; Bandura & Walters, 1977).

According to SCT, people’s thoughts determine their motivation and actions (Bandura, 1991). This anticipatory control mechanism involves expectations, which are the outcomes of undertaking specific actions (Luszczynska & Schwarzer, 2015; Bandura, 1991). For example, people who believe in their ability to succeed are more likely to persist in facing challenges and setbacks (McMichael et al., 2022). This confidence in their skills and capabilities leads to increased effort and, ultimately, better performance outcomes (Schunk, 1996). In contrast, people with low self-efficacy are more likely to give up easily and doubt their abilities, which hinders their motivation and engagement in tasks. Therefore, educators must foster a sense of self-efficacy in their students to promote a positive learning environment and enhance overall learning outcomes (Pan, 2014).

SCT faces significant challenges that span various domains. These challenges include grappling with the complexities of diversity and culture (Schunk & DiBenedetto, 2020; Bandura, 1999), navigating methodological hurdles, and understanding the enduring impact of interventions over time (Conner & Norman, 2015; Gist & Mitchell, 1992). These critical issues underscore the need for a comprehensive examination of the

theory and nuanced approaches to address the multifaceted nature of its application (Ford et al., 2020). Mayfield and Mayfield (2012) argued that studying how people from different cultural backgrounds interact is needed in real life and theory. Similarly, other writers have argued for the need to improve methods to ensure they are valid and reliable and assess interventions' sustained effectiveness (Schunk & DiBenedetto, 2020). By considering these factors, researchers and practitioners can enhance their understanding of effectively applying the theory in various settings and contexts.

3.3 The Development of Self-Efficacy Over Time

In Bandura's (1977) theory, self-efficacy is a pivotal factor within an explanatory framework for understanding human behaviour. It is a personal belief in one's capabilities and competencies for the organisation and execution of tasks (Artino et al., 2012).

According to Bandura's (1986) description of SCT, self-efficacy is the crucial link between acquiring new knowledge and effectively applying necessary skills. Hence, self-efficacy is critical in determining whether a person will act on newly acquired knowledge and skills. Self-efficacy can be learned, improved, and enhanced by acquiring advanced knowledge (Van Der Roest et al., 2017). Despite being initially developed in the social sciences, self-efficacy theory has transcended disciplinary boundaries and found its application across various specialities, including nursing, to comprehend and predict human behaviour (Manjarres-Posada et al., 2020).

As defined by Bandura (1986), self-efficacy is "people's judgments of their capabilities to organise and execute courses of action required to attain designated types of performances" (p. 391). Self-efficacy reflects individuals' beliefs in their ability to perform a specific task, influencing their behavioural choices and persistence (Bandura et al., 1999; Schunk, 1989). Conversely, when people believe their efforts will not lead to

change, this belief reduces their efforts or even stops them from trying to complete the task (Bandura, 1982).

3.4 Central Concepts of Self-Efficacy

According to Bandura's (1977) self-efficacy theory, mastery behaviour distinguishes self-EEs from outcome expectancies. Efficacy expectations and OEs are the two central concepts of self-efficacy theory (Bandura, 1986, 1977; Bandura & Walters, 1977). Efficacy expectations signify individuals' confidence in their ability to execute the specific behaviours necessary to achieve their goals (Ozer & Bandura, 1990). This confidence level is intricately linked to assessing their ability or capability to organise and implement the actions necessary for performing these behaviours effectively (Schunk, 1986). Conversely, OEs signify individuals' strong beliefs regarding the consequences that actions will produce (Bandura, 2004; Bandura et al., 1999; Bandura & Walters, 1977). Additionally, individuals' outcomes are often based on their beliefs about what they can accomplish (Bandura, 1977). OEs also significantly impact self-efficacy directly and indirectly (Bandura, 1989).

The first central concept of self-efficacy theory is personal expectations, as proposed by Bandura in 1997, derived from four key factors: performance accomplishment, vicarious experience, verbal persuasion, and physiological information (Bandura, 1997), as detailed in Section 3.5. The second central concept of self-efficacy theory is OEs, which entail convictions regarding the outcomes resulting from one's actions. Unlike EEs, believing that a certain behaviour can produce a specific outcome does not inherently confer confidence or sufficient motivation to perform said behaviour (Bandura et al., 1999; Bandura, 1977). Instead, OEs involve judgements regarding the effectiveness of behaviour in achieving desired results (Hsu et al., 2007). In the context of CAN reporting, these expectations could involve beliefs about the potential positive

changes for the child resulting from reporting to child protection authorities or doubts about such actions' effectiveness.

When combined, self-efficacy and positive OEs serve as central drivers of behaviour change (Bandura & Walters, 1977). Therefore, OEs emerge as an influencing factor in the likelihood of reporting CAN cases (Lee et al., 2012c). However, studies have demonstrated that anticipated results directly impact self-efficacy assessments, which has led some scholars to question the validity of self-efficacy theory (Chen et al., 2018; Artino, 2012). Nevertheless, Bandura countered these assertions by arguing that self-efficacy judgements remain valid even when influenced by anticipated outcomes (Williams, 2010b). According to Bandura (1986), self-efficacy influences behavioural choices, the effort put into completing tasks, and, ultimately, the mastery of behaviour (Lent & Brown, 2006; Bandura & Wessels, 1994; Ozer & Bandura, 1990).

3.5 Sources of Self-Efficacy

In 2004, Bandura revised his theory by identifying personal mastery experiences, social persuasion, vicarious learning, and physiological and affective states as the primary sources of self-efficacy (Bandura, 2004). These sources collectively influence and shape individuals' expectations regarding the extent and strength of their self-efficacy. This revised version of Bandura's theory suggests that self-efficacy is not a fixed trait, but a construct shaped by the individual's experiences and environment.

The first source of self-efficacy, personal mastery experiences, such as direct successes and failures in pursuing goals, is emphasised as the most influential determinant of self-efficacy beliefs (Bandura, 2004). Various factors can shape individuals' perceptions of their capabilities, yet the most impactful way to cultivate robust self-assurance is through mastery experiences (Bandura et al., 1999). Achieving

success in a task bolsters people's confidence in their abilities (Bandura, 1977).

Conversely, setbacks can undermine their confidence, particularly if they occur early on before forming a solid sense of self-assurance (Pajares, 2012).

In CAN training programme settings, nurses are more likely to possess higher self-efficacy for detecting and reporting CAN cases if they have experienced successful interventions and received positive feedback on their efforts to address variable cases (Lee & Chou, 2017; Turner et al., 2017). Conversely, nurses who experience difficulties in achieving their child protection goals may harbour lower self-efficacy beliefs regarding their capability to report CAN cases in the future (Lee & Chou, 2017).

The second source of self-efficacy, vicarious learning (Bandura, 1977), refers to acquiring EEs through observing another person's success. This process offers individuals access to role models and allows them to assess and evaluate others' performances while shaping their efficacy beliefs. The degree of perceived similarity between the observer and the person observed significantly influences their EEs (Bandura, 2004). For nurses, observing the success or struggles of fellow nurses as they report CAN cases may affect the self-efficacy of the observing nurses (Lee et al., 2012; Gates, 1995). Similarly, nurses can gain confidence in their ability to handle similar situations by observing their colleagues' actions and outcomes.

The third source of self-efficacy beliefs is social persuasion, which refers to the influence others convey on an individual's self-efficacy (Bandura, 1977). For instance, encouragement can bolster one's EEs and OEs and influence the likelihood or intention to perform a specific behaviour (Bandura, 2004). Consequently, it can strengthen individuals' beliefs in their efficacy by encouraging them to believe that they can attain success. According to Bandura (1986), self-efficacy influences behavioural choices, the effort put into completing tasks, and, ultimately, the mastery of behaviour (Lent & Brown,

2006; Bandura & Wessels, 1994; Ozer & Bandura, 1990). Within the context of nursing, narratives shared among nurses about successfully reporting cases of CAN and challenges and failures may influence nurses' perceptions of their capability to effectively report CAN cases (Feng et al., 2012). Similarly, in nursing environments characterised by a culture of mutual support and encouragement, nurses may develop a strong belief in their capabilities to accomplish their goals within training programmes (Khanjari et al., 2021).

Finally, physiological and emotional states encompass the impact of physiological and affective responses on self-efficacy (Bandura, 1977). When individuals incorporate information from these states, such as anxiety, discomfort, or stress, their self-efficacy can be negatively affected (Fong & Krause, 2014; Bandura, 1977). Bandura (2004) suggested that information derived from physiological and affective states can change individuals' perceptions of their ability to manage threatening situations. The elation experienced by nurses when receiving positive feedback indicating their growth and learning from intervention or the joy, they feel seeing children thrive in a learning experience will likely shape the development of their self-efficacy beliefs. Such arousal states contribute to forming robust mental schemas regarding success in relation to the nurses' efforts and may foster strong, positive self-efficacy beliefs (Huang et al., 2024). These four sources of experience – mastery, social modelling, social persuasion, and physical and emotional states – are pertinent to examining mandatory reporting self-efficacy (Ahn et al., 2017). By understanding the various sources of self-efficacy, individuals can work towards enhancing their belief in their abilities and ultimately achieve greater success in their endeavours.

3.6 Self-Efficacy and Training

Training is another area where self-efficacy plays a crucial role in child abuse detection and reporting (Fraser et al., 2018; Lee, 2008; Kim & Cicchetti, 2003). Several studies have reported that empowering professionals with the knowledge, self-efficacy, and confidence to recognise and report abuse can create a safer environment for all children (Walls & Drape, 2021; Fraser et al., 2010, 2018; Lefevre et al., 2017). For example, a study conducted by Fraser et al. (2018) found that training programmes focusing on improving self-efficacy in healthcare professionals led to a higher detection rate of child abuse cases. This increased self-confidence resulted in more effective reporting and intervention, which led to better outcomes for the children involved. Another study by Farrell and Walsh (2010) found that healthcare professionals who received training on child abuse recognition and reporting had higher levels of self-efficacy in identifying and reporting cases of abuse compared to those who did not receive such training. Similarly, self-efficacy was significantly increased when child abuse simulation-based education (CASE) courses were introduced into the curricula for nursing students compared to the contrast group (Lee & Lee, 2022). This increased self-efficacy can lead to earlier intervention and support for the child in need (Fraser et al., 2018; Lee & Chou, 2017; Lee et al., 2012).

Self-efficacy relates to people's self-confidence in their capabilities, which can affect their performance, outcome achievement, and behavioural modification (Bandura, 1977). Therefore, the evaluation of training programmes must be developed through the evaluation of self-efficacy, as assessment improvements can translate into real-world behaviour modification (Dwyer, 2019; Schunk & Mullen, 2012; Lorenz et al., 2000). This approach can achieve more successful outcomes, as Fraser et al. (2018) and Roh et al. (2013) demonstrated.

3.7 Self-Efficacy in Nursing Science

Self-efficacy has significantly contributed to nursing science despite limited literature. Firstly, it has enhanced disciplinary knowledge in healthcare by integrating interventions for health promotion, prevention, and treatment based on an understanding of human behaviour (Pender et al., 2006; Schwarzer & Luszczynska, 2005). Secondly, it has underscored the significance of interdisciplinary knowledge within nursing education (Manjarres-Posada et al., 2020). Likewise, self-efficacy is essential because it influences students' motivation, learning strategies, and clinical performance (Artino, 2012; Pike & O'Donnell, 2010). Nursing students with high self-efficacy are more likely to approach challenging clinical situations with confidence, persistence, and resilience (Shorey & Lopez, 2021; Walsh et al., 2020). Since they believe in their capacity and capability to acquire and apply the necessary knowledge and skills to provide quality patient care (Mohamadirizi et al., 2015). This self-belief enhances their performance, which positively impacts patient outcomes and overall healthcare quality (Roh et al., 2013).

Several studies have established a correlation between the concept of self-efficacy and aspects of patient education (Benight et al., 2018; Brandao et al., 2018), resilience among nursing students (Chen et al., 2019; Terry et al., 2019; Kimhi et al., 2016; Abdal et al., 2015; Rowbotham & Owen, 2015; Townsend & Scanlan, 2011), nursing interventions (Kim et al., 2020; Ludwigson et al., 2020), and nurses performance in identifying cases of child abuse (Lee & Chou, 2017; Fraser et al., 2010; Lee, 2008a; Feng & Levine, 2005). For example, a study conducted by Kim et al. (2020) found that nurses with a high level of self-efficacy were more likely to implement nursing interventions and provide quality patient care effectively.

Nurses with higher self-efficacy were better at identifying and reporting cases of child abuse, which led to improved outcomes for at-risk children (Lee et al., 2012c). These findings imply that nurses must possess confidence in their abilities to deliver proficient patient care and feel competent to make intervention decisions. Nurses need to believe that they can achieve desired outcomes (Manojlovich, 2005) since lacking this self-efficacy may result in diminished motivation to engage in the professional behaviours essential for effective practice (Kim et al., 2022; Orgambidez et al., 2019). In SA, limited literature exists concerning self-efficacy in various areas of patient care, such as oral health (Anweigi et al., 2022), mental health (Aldosary et al., 2023; Abo-Ali et al., 2021; Siddiqui, 2018), physical activity (Al-Otaibi, 2013), and health education, including breastfeeding (Al Naseeb et al., 2023; Al-Thubaity et al., 2023; Baeisa et al., 2023; Habib et al., 2021; Khresheh & Ahmed, 2018), and medical education (Siddiqui, 2018; Demirören et al., 2016). For example, Habib et al. (2021) highlighted the inverse relationship between high breastfeeding self-efficacy and emotional challenges for mothers, while Baeisa et al. (2023) demonstrated that positive breastfeeding self-efficacy is linked to lower rates of postpartum depression. A study by Abo-Ali et al. (2021) emphasised the importance of supporting healthcare workers' mental well-being and self-efficacy, especially during challenging times like the COVID-19 pandemic. However, a scarcity of research has specifically explored self-efficacy within the context of nursing practice.

3.8 Factors Related to Self-Efficacy in Reporting Child Abuse

Factors related to self-efficacy in reporting child abuse include combined education, experiences, and training, which can significantly impact a healthcare provider's ability to report and address cases of child abuse effectively. Keane and

Chapman (2008b) suggested that mentoring and training programmes can help improve nurses' knowledge and skills in detecting and reporting child abuse and enhance their self-efficacy. Furthermore, attitudes towards professional responsibilities and the belief in protecting victimised children can also improve self-efficacy regarding reporting instances of child abuse (Guastafarro et al., 2023; Lee et al., 2012b; Fraser et al., 2010). Education fosters a supportive environment where nurses can seek guidance, collaborate with interdisciplinary teams, and access resources to address their concerns and uncertainties. By developing a comprehensive understanding of the signs and symptoms of CAN through education, nurses can confidently report suspected cases to the appropriate authorities, which can lead to the early detection and prevention of adverse impacts (Finch et al., 2021; Al-Dabaan et al., 2016; Fraser et al., 2010) and facilitate the early identification and mitigation of the deleterious consequences associated with child maltreatment (Fraser et al., 2010). Furthermore, training individuals to recognise the signs of child abuse can also help interrupt the intergenerational cycle of abuse within families by providing early intervention and support. Therefore, by bolstering nurses' self-efficacy through education, healthcare organisations can promote a culture of accountability, advocacy, and patient safety while improving outcomes for vulnerable populations.

Recent studies have shown that personal experiences can significantly impact an individual's self-efficacy in recognising and reporting the signs of abuse (Narayanan et al., 2023; Diotaiuti et al., 2022). Specifically, individuals with personal experience with child abuse are more likely to feel higher levels of self-efficacy in their ability to recognise the signs of abuse and report them (Parlak & Ozbey, 2022; Martins et al., 2015). Healthcare professionals who have attended child abuse training programmes and have experience reporting instances may feel more confident in their abilities (Fraser et al., 2018; Lee et al., 2012c). Nurses have a professional duty to prevent, detect, and

address instances of CAN (Lines et al., 2018). Continuing education, including child abuse education, has increased nurses' confidence in managing child abuse and their likelihood of reporting suspected cases (Herendeen et al., 2014). Therefore, knowledge, attitudes, individual experiences, and the environment in which professionals work all impact self-efficacy in reporting child abuse. Enhancing self-efficacy and promoting child abuse reporting can be achieved through training programmes and by fostering positive attitudes toward professional responsibilities.

3.9 Rationale for Self-Efficacy as a Theoretical Framework for This Study

Self-efficacy has been cited as an important concept in the perception of the ability to manage CAN cases (Fraser et al., 2018; Lee et al., 2012c). As explained above, healthcare organisations must address these key factors – education, attitudes, and experiences – which lead to more effective CAN reporting, intervention, and prevention. As highlighted by Al-Dabaan et al. (2016), Finch et al. (2021), and Fraser et al. (2010), this approach can facilitate the early identification and mitigation of the detrimental consequences associated with child maltreatment while simultaneously providing timely support and intervention to help break the cycle of abuse within families. This approach can also help protect children from further harm, reduce the likelihood of intergenerational transmission of maltreatment, and lead to better outcomes for children and society.

Education plays a pivotal role in enhancing nurses' self-efficacy in reporting suspected cases of abuse or neglect. Through comprehensive training and ongoing professional development, nurses gain the knowledge, skills, and confidence necessary to identify signs of abuse (Mouatadir et al., 2023), effectively communicate with patients and families, and navigate the complexities of reporting procedures (Mouatadir et al.,

2023; Crisp & Green Lister, 2006). Nurses who provide care for children and families hold a unique position to identify children at risk of abuse and neglect, and they possess the potential to initiate interventions to prevent future harm (Putnam-Hornstein et al., 2015). Studies have shown that nurses who receive continuing education, including training on child abuse, are more likely to report suspected cases and feel more confident managing them (Zalkin et al., 2011; Flaherty et al., 2008). Furthermore, in examining the influence of self-efficacy on nurses' likelihood to report child abuse Fraser et al., (2010), highlighted the crucial role of training in promoting nurses' confidence in recognising and reporting different types of abuse.

Challenges in recognising and reporting child abuse exist. Nurses may struggle with accurately assessing the extent of the harm of the abuse, as reported by Fraser et al. (2010). Additionally, nurses' responses to CAN are shaped by the organisational systems and hierarchies within which they operate and their sociocultural contexts (Lines et al., 2020). Despite these challenges, Bandura's theory provides a valuable framework for understanding and addressing CAN in nursing practice (Azar, 1986). Bandura's theory underscores the significance of self-efficacy and observational learning in shaping behaviour, which empowers nurses to effectively intervene in cases of child abuse. Nurses can strive to create a safer environment for vulnerable children by understanding the complexities of reporting CAN.

In conclusion, the selection of self-efficacy as the theoretical framework for this study is well-justified. Bandura's SCT provides a robust foundation for understanding the critical role of nurses' beliefs in effectively identifying and reporting suspected cases of CAN. By examining the impact of child abuse training on nurses' self-efficacy, the findings of this study seek to inform the development of targeted interventions that can enhance nurses' confidence, improve their reporting of suspected cases, and contribute to

the protection of vulnerable children. The exploration underpinned by this theoretical framework can offer valuable insights into the complexities of addressing CAN within the nursing profession and guide future efforts to create a safer environment for children.

3.10 Conclusion

This chapter provided an in-depth exploration of the study's theoretical framework, focusing on self-efficacy theory within the broader context of SCT. Understanding how self-efficacy influences behaviour, particularly in reporting CAN, is crucial for developing effective interventions. Self-efficacy theory offers a valuable framework for understanding human behaviour, particularly in personal growth and development. This theory builds on Bandura's belief in individuals' ability to influence actions and outcomes by emphasising the importance of self-confidence, trust in one's abilities, goal setting, motivation, and resilience. The ability to perform across various life domains guides efforts to increase self-efficacy and confidence, empowering individuals to achieve their goals.

Bandura identified four primary sources of self-efficacy: personal mastery experiences, vicarious learning, social persuasion, and physiological and emotional states. These sources shape individuals' beliefs in their capabilities and influence their behaviour. Research has shown that training and education significantly enhance nurses' self-efficacy, which leads to better detection and reporting of child abuse cases. Well-structured training programmes increase healthcare professionals' confidence and competence in managing suspected abuse cases, which results in improved intervention and support for at-risk children. Furthermore, applying self-efficacy theory in nursing education underscores its importance in fostering resilience, motivation, and effective clinical performance among nursing students and professionals.

Understanding and enhancing self-efficacy within nursing practice is crucial for promoting a culture of accountability, advocacy, and patient safety. By providing comprehensive training and supportive environments, healthcare organisations can empower nurses to fulfil their professional responsibilities with confidence, which can contribute to the early detection and prevention of child abuse and improving outcomes for vulnerable populations. The choice of self-efficacy as a theoretical framework for this study is based on Bandura's SCT, which suggests that individuals' beliefs in their ability to perform certain behaviours significantly influence their actions. As no study was found investigating nurses' self-efficacy in managing CAN cases in SA, this study explored the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA.

The next chapter involves a narrative literature review to identify approaches and methods for evaluating child protection training programmes. The narrative review aims to explore how child protection training is evaluated and summarise the reported outcomes of these programmes. Additionally, reported outcomes from the included studies are presented. Through a thorough synthesis of the findings, informed decisions are made regarding the implementation of methods to assess the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA.

Chapter 4. Narrative Literature Review

4.1 Introduction

Child protection training is critical for frontline healthcare staff to identify and respond appropriately to cases of CAN. Since this study aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of child abuse and neglect (CAN) in Saudi Arabia, a systematic narrative review of the literature was conducted to explore the evaluation of child protection programmes for healthcare workers internationally. Specifically, the approaches and methods used to evaluate child protection training for healthcare workers were explored to identify the most appropriate approach and methods for this study. A secondary aim was to synthesise the reported outcomes and the benefits and effectiveness of the training programmes in the included studies.

A narrative review using a systematic approach was selected for this literature review because the aim of this review was less restricted than that of a systematic review (Ferrari, 2015) and aligned with the purpose of a narrative review, which is to provide a comprehensive overview and synthesis of existing knowledge on a specific topic (Grant & Booth, 2009; Popay et al., 2006). Unlike systematic reviews, which follow a structured methodology (Loke et al., 2007), narrative reviews allow for flexibility in exploring diverse perspectives and viewpoints related to the topic (Sukhera, 2022). This flexibility can be beneficial in uncovering new connections and interpretations that may not be captured in a systematic review. Narrative reviews provide room for the subjective interpretation and synthesis of the literature while incorporating the author's unique insights and interpretations (Jahan et al., 2016). Ferrari (2015) suggested that narrative reviews aim to identify and summarise what has been previously published while seeking new study areas that have not yet been addressed. The researcher chose to apply a

systematic approach in this review to significantly enhance the credibility and accuracy of the resulting findings and conclusions (Aveyard, 2023).

This chapter presents the aims and objectives of the narrative review, the methods used to conduct it, and a critical summary of the findings.

4.2 Aim and Objectives of Review

This review aimed to explore how child protection training programmes are evaluated and to summarise the reported outcomes of these programmes. For the purposes of this review, a child protection training programme was defined as one that provides healthcare providers in hospital settings with the necessary tools to identify potential child abuse cases and report them using the appropriate procedures. The following objectives were addressed:

- To identify the approaches and research designs used to deliver child protection training programmes.
- To identify the methods and measures used to evaluate the child protection training programmes.

A secondary aim of this review was to synthesise the reported benefits and outcomes of the child protection programmes evaluated in the included studies.

4.3 Methodology

4.3.1 Search and Review Methodology

A literature search was performed in February 2020 in six electronic databases (MEDLINE, CINAHL, Embase, Web of Science, PsycINFO, and Social Science Index) for data published from 1 January 2010 to 5 February 2020. A subject librarian from Trinity College Dublin was consulted to assist in the development of the search strategy

and search terms used. The following keywords and their synonyms were utilised: “detection” OR “reporting” AND “programmes” OR “frameworks” AND “health professional” OR “child abuse” AND “intervention” OR “evaluation”. A combination of these keywords with Boolean operators was utilised to explore the relevant studies (Appendix A). The initial search strategy was re-run using the same databases in February 2024 to update the prior version of the review for the period between January 2020 and February 2024.

4.3.2 Eligibility Criteria

Eligibility criteria were determined using the PICO framework by grouping searches and meticulously examining each database for peer-reviewed articles, including pilot studies. The age range of the subjects was limited to 0–18 years. The participants were specifically required to be employed at hospitals. Only studies published in English were included (see Table 2).

Table 2 *Study Selection Criteria*

Criteria PICO	Inclusion Criteria	Exclusion Criteria
<i>Population</i>	Frontline healthcare workers Child Protection Team General Practitioner (GP)	Adults > 18 years old
		Foetus
		Foster care
		Adolescent mothers
		Drug and alcohol abuse
		Gun violence
		Alcohol and substance abuse
		Transgender programmes
		Disabled children
		Special needs children
<i>Intervention</i>	Child protection training evaluation	Maternity programme
		Prenatal
		Intimate partner violence from schools
		-

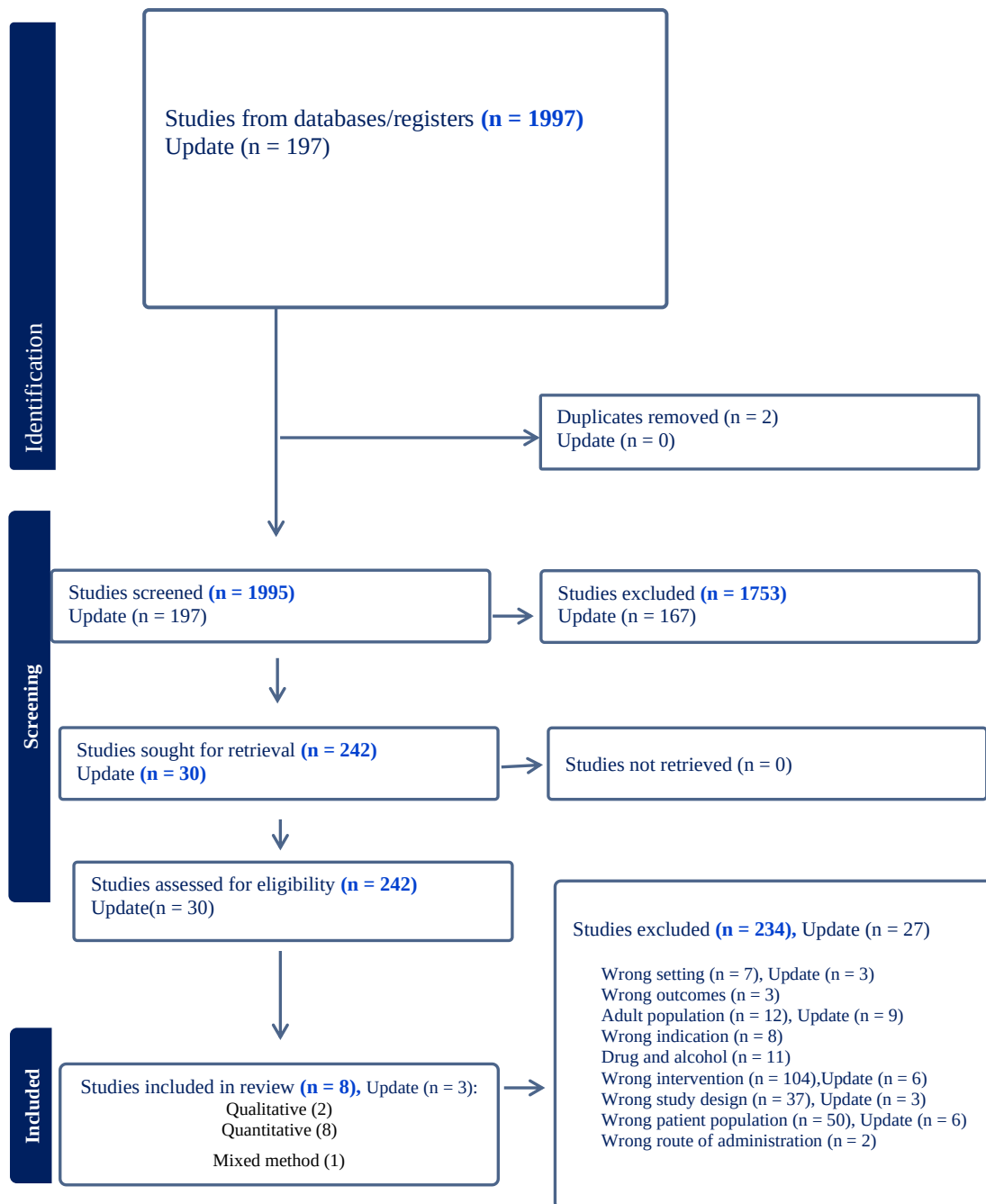
Control/Comparison	Not applicable (as this is an exploratory review)	-
Outcome	Approaches and methods used to evaluate CAN training. Reported benefits and outcomes of such training.	-

4.3.3 Search Outcomes and Screening

The results of electronic database searches were exported to Covidence, an online screening tool used by Cochrane reviewers (Kellermeyer et al., 2018). Overall, N = 2,013 records were identified through database searching; n = 1,995 were screened based on their titles and abstracts. One researcher (AA) screened the data; n = 1,753 were excluded from the irrelevant records. The remaining papers (n = 242) were assessed for eligibility. Of these, n = 234 papers that did not meet the review eligibility criteria were excluded, so n = 8 papers were included in the original review. The updated search in February 2024 resulted in n = 197 of the total articles retrieved from all databases. No duplicates were found. Following the title and abstract screening of the 197 papers, 167 papers were excluded. A total of 30 papers were sought for retrieval and assessed against the eligibility criteria. After full-text assessment, n = 27 papers were excluded for various reasons. Finally, eight papers were included in the original review, combined with three articles from the update, which comprised 11 articles selected for inclusion in this review (Figure 2).

Figure 2

PRISMA



4.3.4 Data Extraction

Data were extracted using a summary table that included the author, date, aim, intervention programme, population, sample size, approach to evaluation, key findings, and limitations (Appendix B).

4.3.5 Quality Assessment

The research design of the included studies guided the choice of the quality appraisal and risk of bias assessment tools used to evaluate the included studies. The methodological quality of qualitative studies ($n = 2$) was assessed using the Critical Appraisal Skills Programme (CASP, 2018) checklist. The Mixed Methods Appraisal Tool (MMAT) was applied to assess the quality of mixed-method ($n = 1$) and quantitative ($n = 8$) studies. It rated the quality based on the degree to which each study's methodology met predetermined criteria using the approach described by Charette et al. (2020). Studies were classified as either low (scoring ≤ 3) or high (score > 3) depending on the reviewer's response: yes = 1 point or no = 0 points (Hong et al., 2018).

Regardless of their methodological quality, studies were included in this review to minimise the risk of study selection bias (Higgins & Altman, 2008). Most of the quantitative studies were found to be of low quality (score ≤ 3) except for two studies, which had a quality score ≥ 3 (Flemington & Fraser, 2017; Lee & Chou, 2017). In addition, both qualitative studies were of good quality (Albright et al., 2019a; Maguire-Jack & Byers, 2013)(Appendices C & D).

4.3.6 Data Synthesis

The analysis involved coding the data, identifying patterns, and categorising the findings into overarching themes to address the aim and objectives of the review. Four themes emerged from the synthesis of the reviewed literature: (a) approaches adopted to evaluate CAN training courses, (b) types of training courses evaluated, (c) methods and

measures to evaluate the child protection training programmes, (d) the benefits of CAN training programmes, and (e) evaluating short and long-term outcomes of training.

4.4 Findings

4.4.1 Characteristics of the Included Studies

This review consisted of 11 studies conducted across several countries, including the US (n = 3) and one study from each of the following countries: Zimbabwe, Tanzania, Taiwan, Vietnam, South Korea, Greece, and the Netherlands. Additionally, one study was conducted across the US and the Netherlands. There were 2,205 total participants in the included studies, with sample sizes ranging from 13 (Maguire-Jack & Byers, 2013) to 77 (Albright et al., 2019b) participants in the qualitative studies and from 37 (Smeekens et al., 2011) to 663 (Paek et al., 2019) in the quantitative studies.

4.4.2 Approaches Adopted to Evaluate CAN Training Courses

The reviewed studies employed a range of quantitative, qualitative, and mixed-method research designs to assess the impact and outcomes of CAN training interventions. In evaluating the efficacy of CAN training programmes, eight studies used a quantitative approach (Giannakas et al., 2022; Paek et al., 2019; Flemington & Fraser, 2017; Lee & Chou, 2017; Abeid et al., 2016; Smeekens et al., 2011; McMahon-Howard & Reimers, 2013; Alvarez et al., 2010a), two used qualitative comparative methods and conducted face-to-face interviews (Kim & Maguire-Jack, 2021; Albright et al., 2019b), and one used a mixed-method approach (Musiwa, 2018) to evaluate CAN training programmes. In the quantitative approach, three studies evaluated training programmes using randomised control trials (RCTs; McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010a). Four studies used pre-post intervention assessments

(Giannakas et al., 2022b; Paek et al., 2019; Flemington & Fraser, 2017; McMahon-Howard & Reimers, 2013). Two studies used a quasi-experimental design (Lee & Chou, 2017; Abeid et al., 2015), and two used semi-structured surveys (Paek et al., 2019; Musiwa, 2018). One of the qualitative studies investigated how workers in CPS systems in Colorado and the Netherlands measure and perceive the effectiveness of their CPS system (Albright et al., 2019a). Meanwhile, the other sought to explore the impact of prevention programmes on CPS decisions (Maguire-Jack & Byers, 2013) (see Appendix B).

4.4.3 Types of Training Programmes Evaluated

This review studied training programmes focused on child maltreatment prevention and response. Specific programmes evaluated included the Commercial Sexual Exploitation of Children (CSEC) training programme in the US (McMahon-Howard & Reimers, 2013), the Victim-Friendly Court system (Musiwa, 2018), a clinical training programme for safe children in Vietnam (Flemington & Fraser, 2017), and the CPS system in the Netherlands and the US (Albright et al., 2019a). Additionally, a 5-day training programme using World Health Organisation (WHO)/United Nations High Commissioner for Refugees (UNHCR) guidelines was conducted in one study (Abeid et al., 2016), an e-learning programme on child abuse (Smeekens et al., 2011), various child maltreatment prevention programmes (Maguire-Jack & Byers, 2013), and a CAN training programme (Lee & Chou, 2017). Other programmes evaluated include the educational programme at 15 hospitals called the Program for the Early Reporting of Child Abuse by Healthcare Providers (CAHCP); (Paek et al., 2019) and participatory workshops in CAN (Giannakas et al., 2022a). The programmes included training for nurses to enhance their self-efficacy in reporting cases of CAN (Lee & Chou, 2017; Smeekens et al., 2011), a

workshop for professionals to effectively report suspected child maltreatment (Child Maltreatment Reporting workshop) (Alvarez et al., 2010b), and an education programme for healthcare providers and social service staff (Albright et al., 2019; Paek et al., 2019; Abeid et al., 2016; Maguire-Jack & Byers, 2013; McMahon-Howard & Reimers, 2013). One study utilised simulation-based medical education to manage CAN (Giannakas et al., 2022a). As indicated in Appendix B, a collaborative and interdisciplinary training programme for students, doctors, and nurse practitioners were also reported (Flemington & Fraser, 2017; Alvarez et al., 2010).

4.4.4 Methods and Measures to Evaluate the Child Protection Training Programmes

This review found that several studies were conducted to evaluate the effectiveness of CAN-reporting training. Different questionnaires and measures were used in these studies. Two of the eight quantitative studies focused on developing CAN training programmes (Lee & Chou, 2017; Alvarez et al., 2010b). The remaining nine studies evaluated the available training or education, which was the review's focus.

This review found various research methodologies employed to conduct the training and assess the results. For instance, a study by Abeid et al. (2016) used a quasi-experimental cross-sectional study and found that knowledge about CAN cases increased. Another study by Flemington and Fraser (2017) used a pre-post intervention with long-term follow-up, with assessments at pre-test, post-test (three weeks), and six months after the training. Similarly, in a pilot study to evaluate training effectiveness on healthcare professionals, the participants completed a survey before and after the lecture and again three months later (Paek et al., 2019). In Greece, Giannakas et al. (2022) developed and evaluated a two-hour workshop of simulation-based training methods for medical students with role-playing, using mannequins, and peer-to-peer teaching in CAN.

Questionnaires were used before, immediately after, and six months after each workshop (Giannakas et al., 2022b).

Three studies used valid instruments to measure the impact of the training (Giannakas et al., 2022; Lee & Chou, 2017; Flemington & Fraser, 2017). For instance, one of the questionnaires was the Safe Children Vietnam Child Abuse and Neglect Questionnaire (CANQ; Flemington & Fraser, 2017), a modified version developed for use in Australia (Fraser et al., 2010). The questionnaire collects baseline demographic information and data about healthcare professionals' training in child protection, knowledge of CAN presentations, intentions to report, and attitudes towards reporting. Another study used the Child Abuse Neglect Reporting Self-Efficacy (CANRSE) questionnaire developed by Lee et al. (2012) to measure efficacy and OEs for CAN reporting among Taiwanese nurses (Lee & Chou, 2017). The CANRSE questionnaire contains 32 questions measuring EEs for CAN reporting using three subscales: workload prioritisation for reporting, colleague support, and confidence to report. Twelve questions measure OEs for CAN reporting with three subscales: child benefit, family benefit, and faith in child services. The questionnaire also includes the General Self-Efficacy Scale (GSE), a 10-item scale, and the Likelihood to Report CAN (LR-CAN) scale, comprising 24 items relating to four vignettes based on true cases.

Lee and Chou (2017) used an 11-point Likert scale, with anchors ranging from 0 (completely unconfident) to 10 (completely confident). This study's Content Validity Index (CVI) was 0.89, and the test-retest reliability coefficient was 0.91. Self-assessment questions adapted from the CANRSE instrument were also used in a study by Giannakas et al. (2022). Paek et al. (2019) used a survey questionnaire with 12 questions divided into three sections to assess healthcare providers' experience, awareness, knowledge, and attitudes related to child abuse. Although this study did not explicitly mention the

validation of the questionnaire instrument, it focused on assessing specific aspects related to child abuse education and reporting among healthcare providers. Self-efficacy was measured using a 10-point Likert scale to assess healthcare providers' confidence levels when encountering suspected victims of child abuse and their willingness to report such cases (Paek et al., 2019).

Some studies have used self-administered questionnaires adapted from previous studies to measure the benefits of training. For example, Abeid et al. (2015) used a self-administered survey adapted from a study conducted in Vietnam on improving healthcare responses to gender-based violence. Another study used three measures, including knowledge of child maltreatment reporting laws, recognition and intent to report suspected child maltreatment, and clinical expertise in reporting (Alvarez et al., 2010a).

In the review, four of the 11 included studies measured changes in the number of reported cases of CAN via participant responses to vignettes (Giannakas et al., 2022a; Lee & Chou, 2017; Flemington & Fraser, 2017; Alvarez et al., 2010b). Alvarez et al. (2010) used an inventory of eight child maltreatment vignettes. Flemington and Fraser (2017) explored the recognition and reporting behaviour of child abuse cases through four vignettes, each focusing on a different type of abuse.

Giannakas et al. (2022) and Lee and Chou (2017) used vignettes to measure changes in reported child abuse and neglect cases via a validated instrument (CANRSE). These vignettes were used to measure nurses' self-efficacy in reporting CAN cases. The results from vignette scenarios in these studies helped gauge nurses' attitudes and confidence levels in reporting CAN and provided valuable insights into their self-efficacy in handling these sensitive and critical (Giannakas et al., 2022; Lee & Chou, 2017). One study used vignettes by presenting participants with scenarios depicting various types of child maltreatment, such as physical abuse, sexual abuse, neglect, and emotional abuse

(Alvarez et al., 2010a). Another study used case vignettes as part of the data collection process to assess participants' knowledge and intention to report child abuse cases (Flemington & Fraser, 2017).

Other studies used combined methods to evaluate child protection training. For example, in a study by Smeekens et al. (2011), eight simulated scenarios based on real clinical cases were used with an in vivo video-recorded assessment, which comprised six items corresponding to each of the six steps in the SPUTOVAMO-R checklist, which stands for suspected abuse, physical examination, undressing the child, talking to the child, observation, verification, action, medical care, onward referral, and registration. In another study, a questionnaire was designed to measure participants' pro-CSEC victim beliefs (McMahon-Howard & Reimers, 2013). The items on the questionnaire asked participants to indicate how familiar they are with different aspects of CSEC. Finally, a pilot study used a questionnaire containing three sections: practical knowledge regarding child abuse, confidence in reporting, and willingness to report (Paek et al., 2019). A semi-structured questionnaire and semi-structured interview were used in a mixed-methods study, but the questionnaire and the scale used were not reported (Musiwa, 2018).

The review discovered various research methodologies and measurement approaches to assess CAN training programmes. Studies employed quantitative and mixed-methods designs, including quasi-experimental, cross-sectional, and pilot studies. Combining validated psychometric tools, vignette-based assessments, and qualitative feedback provided a richer understanding of the factors influencing healthcare professionals' knowledge, attitudes, and behaviours around child protection. Therefore, future studies could build on these strengths and address their limitations to further advance the evidence base on effective strategies for enhancing the capacity of healthcare providers to identify and respond to child maltreatment.

4.4.5 Benefits of CAN Training Programmes

Several studies were conducted to assess the benefits of training programmes aimed at improving professionals' ability to recognise and report possible cases of child abuse. This review showed that professional training in child abuse and reporting policies improved participants' knowledge (Giannakas et al., 2022; Paek et al., 2019; Musiwa, 2018; Flemington & Fraser, 2017; Abeid et al., 2016; McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010), attitudes (McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010), self-efficacy and self-confidence (Giannakas et al., 2022; Lee & Chou, 2017; Smeekens et al., 2011), stakeholder cooperation (Musiwa, 2018), and willingness to report CAN cases (Paek et al., 2019; Alvarez et al., 2010a).

Self-efficacy, which was reported in some studies, is an important factor in reporting child abuse cases (Giannakas et al., 2022; Paek et al., 2019; Lee & Chou, 2017; Flemington & Fraser, 2017; Smeekens et al., 2011). The CANRSE questionnaire was used as a tool for measuring self-efficacy in two studies (Giannakasa et al., 2022; Lee & Chou, 2017). The study findings indicated that the educational intervention positively impacted healthcare providers' self-efficacy in recognising and reporting child abuse cases in their practice (Giannakas et al., 2022; Paek et al., 2019; Lee & Chou, 2017).

4.4.6 Evaluating Short- and Long-Term Outcomes of Training

The results of this review showed mixed results for short- and long-term training. When follow-up evaluations were conducted on participants of four studies, significant benefits were reported (Paek et al., 2019; Fraser et al., 2018; Lee & Chou, 2017). Two studies showed that participants exhibited significant improvement and

increased self-confidence after one month (Lee & Chou, 2017), three months (Paek et al., 2019), and six months (Giannakas et al., 2020; Flemington & Fraser, 2017). Additionally, two studies demonstrated that participants' knowledge of child abuse increased immediately after the educational programme, with a stronger willingness to report any suspected abuse three months after the programme (Paek et al., 2019; McMahon-Howard & Reimers, 2013).

Flemington and Fraser (2017) noted that six months after training, participants in the intervention group showed enhanced knowledge of CAN. In a pilot study to evaluate the effectiveness of training on healthcare professionals, knowledge among participants in the intervention group increased, with scores improving from 5.28 points before to 8.03 after the educational programme and remaining at 7.1 after three months ($p < .001$) (Paek et al., 2019). However, one study reported a slight decrease in some aspects, such as the willingness to report child abuse, three months after the programme. Similarly, in Greece, Giannakas et al. (2022) developed and evaluated a two-hour workshop of simulation-based training methods for medical students with role playing, the use of mannequins, and peer-to-peer teaching in CAN. The study conducted a comparative analysis at different time intervals to evaluate variations in knowledge and self-confidence over time. The initial two assessments, which took place immediately after the workshop and six months later, revealed a statistically significant elevation in knowledge compared to the pre-workshop period ($p < .0001$). However, the third analysis revealed a statistically significant decrease in the score six months after compared to immediately after the workshop ($p = .046$) (Giannakas et al., 2022b).

When follow-up evaluations were conducted, some studies addressed attitudinal barriers to reporting (McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010a). For example, Flemington and Fraser (2017) explored the

recognition and reporting behaviour of child abuse cases through four vignettes, each focusing on a different type of abuse. The results showed significant improvements in recognising the seriousness of child physical abuse and emotional abuse scenarios over time. While there were no significant changes in the seriousness rating of witnessed intimate partner violence, participants were more likely to identify it as abuse at six months. Participants initially considered CSA the most severe vignette, with an improved perception of its seriousness over time (Flemington & Fraser, 2017).

However, Abeid et al. (2016) suggested that additional strategies may be necessary to effectively address and modify attitudes over time. Their study indicated that attitudes towards violence among healthcare workers remained relatively stable following the training programme, with minimal changes observed in attitudes. This stability in Abeid et al., (2016) study suggested that the training intervention may not have been sufficient to produce significant and lasting shifts in attitudes towards sexual violence. The study also mentioned the challenge of assessing attitude changes after training due to the absence of validated violence scales and conflicting study findings (Abeid et al., 2015). Therefore, according to another study, promoting a culture of open communication and creating effective support systems may be a more practical approach to addressing the issue of underreporting (Musiwa, 2018).

4.5 Discussion

This review explored the approaches and methods used to evaluate child protection training programmes and summarised their outcomes. Most studies on child violence prevention included in this review were conducted in developed countries. Only four studies were conducted in developing countries, which indicated the need for further research in those areas. The reviewed articles provided evidence of the approaches used

for delivering and evaluating training on preventing CAN. While the evidence described the benefits of such training, further research was needed to fully understand its impact.

4.5.1 Approaches and Research Designs for Delivering Child Protection Training Programmes

In this review, most of the studies evaluated training programmes quantitatively by using questionnaires and surveys. The studies mostly followed a quantitative approach, which was preferred because it provided numerical data that could be easily analysed and compared across different groups (Uher, 2022). This method helped systematically assess learning outcomes and programme benefits (Nusche, 2008). It also enabled researchers to quantify the extent of knowledge acquisition, skill development, and behavioural changes among the participants, offering clear metrics for evaluation (Stockemer et al., 2019).

Quantitative data were analysed statistically, which allowed the researchers to identify patterns, correlations, and trends with high precision and reliability (Bruce et al., 2018). This approach provided a time-, effort-, and cost-efficient way for researchers to connect with a large number of people who shared common characteristics, regardless of their geographical locations (Nardi, 2018). Moreover, the emphasis on quantitative evaluation aligned with the need for objective and measurable evidence to inform decision-making processes in educational settings and enhance the credibility and validity of the study findings (Mertens, 2023). Overall, the use of quantitative research methods in educational research streamlined the data collection and analysis processes and enhanced the rigour and reliability of the study findings.

This review included trials conducted in three different countries, and the studies revealed that participants' knowledge improved. They could identify child sexual exploitation, were willing to report such cases, and recognised the effects of child abuse

on their performance during a case simulation and their self-efficacy (McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010a). Similar results were obtained by Kenny (2007), which demonstrated the effectiveness of web-based information about child maltreatment for undergraduate education and graduate counselling students. This study showed significantly higher post-test scores in relation to participants' knowledge of the signs and symptoms of abuse (Kenny, 2007). However, when a randomised control group design was used, a number of participants switched out of their assigned group due to scheduling conflicts and an error in the training registration system (Matto et al., 2021; Sullivan, 2011).

To conclude, the review findings showed that the predominant use of quantitative research methods in these studies improved the findings' rigour, reliability, and generalisability. These insights emphasise the importance of continuous professional development in this critical area to ensure that frontline practitioners are equipped to protect vulnerable children and promote their well-being.

4.5.2 Evaluating Training Programmes' Methods and Measures

The review results showed that various training programme methods were evaluated, and a range of measures was used to assess their outcomes, including various instruments to measure competencies and outcomes (e.g., surveys and questionnaires). In eight studies, the authors argued that the intervention had the most significant effect among those who achieved low scores on the pre-test (Giannakas et al., 2022; Paek et al., 2019; Lee & Chou, 2017; Flemington & Fraser, 2017; Abeid et al., 2016; McMahon-Howard & Reimers, 2013; Smeekens et al., 2011; Alvarez et al., 2010). In most of these studies, the respondents, their parents/caregivers, and teachers were informed about the sensitive nature of the research. The use of instruments allowed researchers to systematically

measure changes in participants' knowledge, skills, and behaviours, which provided a clear measure of the effectiveness of the programmes. Other examples from outside this review were used surveys to address sensitive topics such as CAN among children and young people (Lloyd & Devine, 2015; Finkelhor et al., 2014; Ellonen & Pösö, 2011). The authors argued that using instruments was helpful and crucial for gathering feedback from participants about their training experience (Phillips et al., 2013). This issue was particularly important in anonymous online surveys of children asking questions specifically about abuse and neglect, where it would not be possible for researchers to identify individual respondents (Ellonen & Pösö, 2011). Another study reported that data collection on sensitive topics required researchers to anticipate the impact of their research on participants and how it was interpreted (Albaum et al., 2014). "Topic sensitivity" refers to the intrusiveness of survey questions, the potential risks of sharing sensitive information, and the possibility of triggering social desirability concerns (Yan, 2021). However, the use of surveys and questionnaires was found effective in addressing these concerns (Ibbett et al., 2023; Tourangeau & Yan, 2007).

Researchers have focused on how survey mode affects response errors, including willingness to respond and accuracy of answers (Albaum et al., 2014). As Couper (2011) noted, self-administered web surveys can provide more privacy to respondents than interviewer-administered modes. However, ethical issues may arise from sensitive responses, so researchers need to protect participants (Mathews et al., 2022). According to Lee et al., (2012), the anonymity provided by web-based surveys is one of the benefits reported by researchers in their 10-year review of research on sensitive issues. Hence, participants in web-based surveys can feel more comfortable answering sensitive questions because their identities are kept anonymous. Additionally, open-ended questions allow participants to provide qualitative insights into areas of strength and areas

for improvement (Popping, 2015), which can lead to more comprehensive and representative data for researchers to analyse and draw conclusions from.

This review identified a growing body of literature focusing on professional self-efficacy, which indicated a burgeoning interest in the application of self-efficacy theory to professional practice and behaviours (Giannakas et al., 2022b; Lee & Chou, 2017).

Nonetheless, a gap was found in the exploration of self-efficacy in improving the identification and reporting of CAN. Furthermore, a study conducted by Colgrave et al. (2020) revealed that the CANRSE questionnaire proved reliable and valid in assessing nurses' self-efficacy in reporting CAN cases. The study recommended utilising findings from the CANRSE questionnaire to inform the development of training programmes and interventions aimed at enhancing healthcare professionals' self-efficacy in reporting CAN cases. Meanwhile, evaluating the success of the training programmes is also necessary to determine if the training programmes are effective or a waste of time and resources.

Vignette-based assessments were used in a number of studies (Lee & Chou, 2017; Flemington & Fraser, 2017; Alvarez et al., 2010a). During this process, participants were presented with realistic, standardised cases of CAN in the form of "vignettes", as reported by Lee and Chou (2017), who presented a real case in Taiwan. Indeed, researchers and trainers can gain valuable insights into participants' knowledge, decision-making skills, and overall preparedness for handling real-world child maltreatment incidents by observing how they respond to hypothetical situations (Naughton et al., 2017; Bradbury-Jones et al., 2014). Vignettes have been used to assess variations in clinical judgement and decision-making about child abuse detection and reporting (Naughton et al., 2018).

Keeping vignettes real is an important characteristic of the vignette method. In contrast to generic multiple-choice tests or abstract discussions, vignettes give participants simulated scenarios that are closely similar to the types of cases that they may

encounter in the clinical setting (Skilling & Stylianides, 2020). Therefore, healthcare professionals can bridge the gap between theoretical knowledge and practical application, enabling them to recognise child abuse and determine appropriate courses of action (Kia, 2024).

In this review, Giannakas et al. (2022) reported that vignettes effectively provide a safe environment for participants. Vignettes are very helpful in desensitising sensitive or difficult topics (Hughes & Huby, 2002). Therefore, participants are more comfortable and less threatened when discussing their situations, opinions, and actions since they perceive these scenarios as non-personal (Murphy et al., 2017; Bradbury-Jones et al., 2014; Ganong & Coleman, 2006). Vignettes have also been shown to assist healthcare professionals in preparing to handle child abuse cases more effectively. In addition to improving their skills and confidence, these tools allow professionals to practice hypothetical scenarios under low-pressure conditions (Sample et al., 2023).

The review results showed significant improvements in participants' ability to recognise and classify child abuse incidents over time using vignettes (Flemington & Fraser, 2017; Lee & Chou, 2017). These results were consistent with previous studies that utilised vignettes relevant in medical settings. For example, Flaherty et al. (2006) studied ambiguous patient histories using a survey and clinical vignettes. Their results showed that paediatricians who received recent child abuse education had a higher level of confidence in identifying and treating child abuse cases. Furthermore, the training was associated with a high degree of confidence in managing child abuse, positive attitudes toward domestic violence screening, and a strong belief in anticipatory guidance that paediatricians were more likely to suspect abuse and report the child to CPS (Flaherty et al., 2006). Vignettes help assess participants' recognition and understanding of different abuse scenarios, highlighting areas for effective training and educational programmes to

enhance professionals' ability to identify and respond to abuse cases in hospitals (Lee & Chou, 2017). These findings suggest that using vignettes has enabled researchers to measure attitudes and behaviours related to child maltreatment. This approach better prepares healthcare professionals to address the issue.

The vignette method also has limitations, one of which is validity, which is important because participants' responses to hypothetical scenarios may not always align with their actions in reality (Erfanian et al., 2020; Skilling & Stylianides, 2020). While vignettes are meant to convey the reality of child abuse cases, they cannot capture how context impacts decision-making in real-life contexts (Scott et al., 2011). Additionally, ethical considerations should be considered when presenting vignettes depicting child abuse scenarios (McInroy & Beer, 2022; Silva et al., 2019). A sensitive topic such as this can elicit strong emotions and even cause distress for some participants, which makes it important to plan and handle it carefully to ensure well-being (Erfanian et al., 2020). While vignettes offer a valuable and controlled method for training and assessing healthcare professionals in handling child abuse cases, their limitations must be acknowledged. Ensuring the validity of responses and considering ethical implications are crucial to maximising their effectiveness. Ultimately, vignettes should be used as a complementary tool, alongside real-world experience and continuous education, to prepare professionals for the complexities of child abuse cases.

In conclusion, the studies reviewed highlight the importance of using various training programme evaluation methods, including surveys and questionnaires, to measure competencies and outcomes. Using vignette-based assessments effectively measures the impact of child protection training programmes. While it has some limitations, this approach has helped researchers evaluate participants' recognition, understanding, and response to various abuse scenarios, leading to more impactful

training initiatives. The findings suggest that these tools were effective in gathering feedback from participants about their training experiences, particularly for sensitive topics like child abuse. However, the studies also acknowledge potential method limitations, such as self-selection bias and ethical considerations around sensitive responses. Future research should focus on implementing strategies to mitigate these limitations and ensure the ethical treatment of participants to enhance the validity and reliability of the research findings.

4.5.3 Synthesise the Reported Benefits and Outcomes

Given that child abuse is a complex behaviour influenced by various factors, it is essential to carefully consider the benefits of participating in CAN training. The review examined existing literature on the benefits of participating in CAN training programmes. The findings indicate that such training interventions can positively impact key outcomes, including enhancing participants' knowledge, attitudes, and self-efficacy regarding recognising and reporting potential cases of CAN immediately after the training programmes. The reviewed studies consistent with other literatures, demonstrated that CAN training programmes lead to significant improvements in participants' knowledge about child abuse and neglect (Mostovoy et al., 2024; Conners-Burrow et al., 2013; McKee & Dillenburg, 2012), as well as their understanding of reporting policies and procedures (Johnson & Christensen, 2019). This increase in knowledge is a crucial first step in empowering professionals to recognise and appropriately respond to suspected cases of child maltreatment.

Some authors have highlighted that due to a lack of knowledge, nurses may miss the signs of CAN by attributing them to natural conditions or accidental trauma (Pisimisi et al., 2022). It is a significant first step in increasing awareness among healthcare providers and trainers and a vital part of community prevention and education efforts. A

recent study confirmed that the lack of education and training in these healthcare workers can fail to protect children (Lupariello et al., 2023). Thus, nurses require consistent and ongoing training on how to identify and report cases of child maltreatment since improving knowledge is a necessary but not sufficient aspect of reporting child maltreatment.

Furthermore, the reviewed studies indicated that CAN training could lead to improved self-efficacy and self-confidence among professionals in recognising and reporting suspected child abuse cases (Giannakas et al., 2022; Lee & Chou, 2017). This critical outcome of higher levels of self-efficacy is linked to an increased likelihood of reporting suspected abuse (Chia-Jung et al., 2022; Bandura & Cervone, 1986; Betz & Hackett, 1986). This review aligned with previous studies that reported that individuals with high self-efficacy were more likely to set ambitious goals, persevere in the face of challenges, and achieve better outcomes (Maddux, 2016; Schwarzer & Luszczynska, 2008). Perceived self-efficacy has been established as a significant contributor to the decision-making process within various professions, particularly in the detection and reporting of child abuse (Maddux, 2016).

Enhancing self-efficacy through training programmes can also lead to improved job performance and job satisfaction among healthcare professionals (Nielsen et al., 2009). In addition, in dealing with sensitive and complex issues such as child abuse, individuals with higher self-efficacy are more likely to persist through challenges and setbacks (Warner & Schwarzer, 2017). This finding highlights the importance of ongoing education and training in building self-efficacy among healthcare professionals.

Notably, while the overall trend indicates that CAN training programmes can have positive impacts, some studies have also identified persistent challenges. Reporting suspected or confirmed cases of child abuse is a complex issue that requires more than

just simple awareness raising (Bunting et al., 2010). As mentioned earlier, a lack of education and training on identifying the signs of abuse and the proper reporting procedures can lead healthcare workers to miss or misattribute potential cases of maltreatment. Several studies have investigated what may contribute to professionals' inability to recognise signs of CAN, including a lack of training, personal factors, perceptions and attitudes toward CAN, and the results of child abuse reporting (Ayling, 2019; Smeekens et al., 2011; Lee, 2008).

For instance, in Taiwan, Feng and Levine (2005) found that nurses lacked the necessary knowledge and ability to handle child abuse cases, lacked feedback from child protection agencies, were burdened with time and workload pressures, and lacked confidence in the legal authority to which they were obliged to report cases. Moreover, the results of assessing the adherence of Dutch Child Health Care (CHC) professionals to seven key activities described in a national guideline on preventing CAN indicated that poor attitudes to obligatory reporting of child abuse and neglect largely impacted the capacity to identify the severity of cases. This finding corresponded with the findings from other research, in which poor attitudes were linked with poor reporting procedures (Konijnendijk et al., 2014).

Elarousy and Abed (2019) and Fraser et al. (2010) identified barriers such as lack of training and knowledge, which emphasised the need for education and training to improve recognition and reporting. On the other hand, Piltz and Watchel (2009) identified barriers such as limited education and experience, fear of consequences, and lack of emotional support that hindered nurses from reporting suspected cases.

A lack of trust in handling child abuse investigations has been noted by professionals, which leads to hesitancy in reporting, specifically with CPS (Gubbels et al., 2021; Green, 2020). Challenges such as a lack of legal support, difficulties in

communication with parents, and disagreements among professionals can hinder the effective reporting of child abuse (Maul et al., 2019). Addressing these barriers and fostering a supportive environment for child protection is crucial. Therefore, researchers must address these barriers and create a supportive environment for child protection. Professionals can navigate these challenges effectively with the help of training programmes and clear guidelines.

This review aligned with the broader literature on the benefits of CAN training, which has consistently demonstrated the potential of such interventions to improve key outcomes related to the recognition and reporting of child abuse. However, the research also underscored the need for continued efforts to address persistent challenges and ensure that all professionals are equipped and empowered to play their vital role in protecting children from abuse and neglect.

Overall, the reviewed studies provided strong evidence that well-designed CAN training programmes can positively impact healthcare and other relevant professionals' knowledge, attitudes, self-efficacy, and reporting behaviours. However, the findings also highlighted the need for more comprehensive and sustained interventions to address the complex attitudinal and systemic barriers hindering effective CAN reporting. Future research should explore the optimal design, delivery, and reinforcement of CAN training programmes to ensure lasting and impactful outcomes for professionals and better protection for children.

4.6 Strengths and Limitations

The main aim of this narrative review was to explore how child protection training programmes are evaluated and to summarise the reported outcomes of these programmes. However, the findings were limited to English-language publications. Moreover, since the

review focused on frontline workers in hospitals, the findings could not be generalised to community settings. Additionally, including studies with a heterogeneous participant group (physicians, nurses, social workers, and mental health professionals) made it challenging to compare findings. Most of the studies were of low quality and conducted in diverse settings (hospitals, online, private conference rooms) across different countries (the US, Netherlands, Georgia, Zimbabwe, Korea, Taiwan, Vietnam, and Tanzania), where child protection systems and cultural backgrounds vary significantly.

The review found that standardised questionnaires were useful for assessing changes in knowledge, attitudes, and reporting behaviours before and after the training intervention. However, due to the limitations of the studies, the findings should be interpreted with caution. Alvarez et al. (2010), Musiwa (2018), and Albright (2019) had relatively small sample sizes, which made it difficult to detect statistically significant changes in their results. These small sample sizes reduced statistical power, which made it challenging to detect meaningful effects (Hackshaw, 2008).

Flemington and Fraser (2017) observed that participants might have overestimated the positive effects of training interventions due to their alignment with perceived social norms and expectations (van de Mortel, 2008). Additionally, Smeekens et al. (2011) and Flemington and Fraser (2017) noted that previous experience or exposure to child abuse training was not consistently accounted for in the analyses. These confounding variables could independently influence outcomes and make it challenging to attribute observed changes solely to training interventions (Carlson & Morrison, 2009).

The review provided valuable insights into the factors associated with evaluating CAN training. However, further research is needed to fully understand the impact of training programmes and laws on reporting behaviour. A few limitations must be explained. Firstly, the experiences and backgrounds of the primary study researchers

could have influenced the data collection, analysis, and interpretation process and introduced unintended biases in those individual studies. Additionally, the limited information provided in the primary articles regarding the scope of the laws made it difficult to assess their relevance to the aim and objectives of the review. Therefore, further research is needed to fully understand the impact of these laws on reporting behaviour.

The review highlighted that most of the included studies were of low quality, which raised concerns about the validity and reliability of the reported outcomes. For instance, the qualitative studies included had poor methodological quality because they ignored researcher-participant interactions and accuracy-improving methods, such as triangulation, member checking, and maintaining audit trails to enhance the trustworthiness of the findings. There was a substantial risk of bias in the experimental research, with issues such as inadequate blinding of participants, researchers, or outcome assessors, as well as inadequate allocation concealment, which could introduce selection bias and undermine the internal validity of those studies. The mixed-method studies showed poor sample representativeness. As a result, the findings of these studies should be interpreted with caution.

4.7 Summary

In summary, five themes emerged from the included studies: (a) approaches adopted to evaluate CAN training courses, (b) types of training courses evaluated, (c) methods and measures to evaluate the child protection training programmes, (d) benefits of CAN training programmes, and (e) reporting on the short- and long-term outcomes. Nine studies employed quantitative methods, two were qualitative, and one used a mixed-

method approach. Among the quantitative approaches, most studies used non-randomised designs, while one study utilised a randomised approach.

The findings revealed that the CAN training was evaluated primarily through vignette techniques. The vignette-based assessments evaluated healthcare providers' ability to identify and differentiate child maltreatment and how they made decisions to report it. These measures included using valid instruments, which meant the studies reported that the instruments consistently measured what they were intended to measure (validity) in a reproducible way (reliability). Professionals benefitted from child protection training programmes via increased knowledge, attitudes, skills, confidence, and self-efficacy regarding identifying, intervening, and supporting child abuse cases. Through education programmes, healthcare workers improved their knowledge, attitudes, and clinical practices about child protection.

In addition, the findings indicated that additional interventions are likely to be necessary to overcome attitudinal barriers to reporting child abuse. These interventions include encouraging open communication and establishing effective support networks. In addition, the review found that no studies were identified that specifically examined the concept of self-efficacy and self-confidence in reporting child abuse in Saudi Arabian training. Although studies reported increased self-efficacy and self-confidence in reporting CAN, no study specifically explored the concept of CAN training in SA. Future studies should address the limitations identified in this review to provide more robust and generalisable evidence.

The next chapter presents the aims and objectives of the study, the philosophical underpinnings influencing the selected design, and the methods.

Chapter 5. Methodology

This chapter describes the methodology used to conduct this study. It begins with an overview of the philosophical beliefs and values that underpin the approach, followed by an overview of the study design, the setting and sample, and the methods and instruments selected for data collection and analysis.

5.1. Research Question

What is the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of child abuse and neglect (CAN) in Saudi Arabia?

5.2 Study Aim and Objectives

This study aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA. To achieve this aim, the objectives of the study were as follows:

- 1) Measure the impact of training on nurses' self-efficacy in detecting and reporting suspected and known CAN cases.
- 2) Assess nurses' understanding of the consequences for the child and their family in reporting suspected CAN cases.
- 3) Measure the nurses' confidence when reporting suspected and known CAN cases.
- 4) Determine the relationship between personal characteristics (e.g., gender and education level) and professional self-efficacy in nurses.
- 5) Assess nurses' knowledge of the law about CAN reporting in SA.

The following null hypotheses were tested to address these objectives:

- 1) No difference exists in nurses' self-efficacy in detecting and reporting suspected and known CAN cases between those who received CAN training in other jurisdictions or as part of their previous education or attended formal training (CPMTP) on CAN detection and reporting in SA and those who did not or could not remember.
- 2) No relationship exists between personal characteristics (e.g., gender and education level) and professional self-efficacy in nurses.

5.3 Philosophical Assumptions Underpinning this Study.

The philosophical assumptions in research can be understood by examining how researchers utilise the nature of reality and knowledge. Creswell and Poth (2016) highlighted the importance of researchers being aware of the philosophical assumptions and research paradigms that form the foundation of their work. Philosophical issues play a crucial role in research as they reveal the values, beliefs, and modes of inquiry that inform and underlie research efforts (Barton & Bishop, 2014). Understanding and articulating these philosophical underpinnings can enhance the rigour of research projects and improve overall communication within the research community (Brown & Dueñas, 2020). A research paradigm, which reflects how a researcher perceives the nature of reality and guides their engagement in research to generate knowledge, is fundamental in shaping the research process (Gretschel et al., 2023). By explicitly detailing philosophical assumptions and paradigms, researchers can provide a clear understanding of the underlying beliefs and values shaping their research endeavours (Ataro, 2020).

Researchers' ontological and epistemological positions influence the types of questions asked, the methodologies utilised, and the methods used in data collection, analysis, interpretation, and evaluation (Pope & Mays, 2020; Tamminen & Poucher,

2020; Bradbury-Jones et al., 2014; Jackson, 2013; Wahyuni, 2012). Ontology is the study of the nature of reality, while epistemology examines how we can know reality (Gray, 2009). In this context, the ontological stance is that a real world exists independently of researcher perceptions, including the actual impact of the training on nurses' self-efficacy. It also acknowledges that our understanding of this impact is imperfect and influenced by contextual factors and individual perceptions. Epistemology, however, refers to how an individual has knowledge and understands their own and others' modes of thinking (Tubbs, 2016). In other words, it addresses the following question: "How can we know (have knowledge of) reality?" (Krauss, 2005, p. 759). Thus, it studies what we know and how we know it. The epistemological stance is that knowledge should be examined using tools best suited to solve the problem (Avgousti, 2013).

According to Denzin and Lincoln (2018), epistemology explores the relationship between knowledge and the individual who possesses it in an attempt to explain the world through that knowledge. In this context, the epistemological stance is that knowledge about the impact of the training can be obtained through observation and measurement. By acknowledging and understanding the underlying philosophical assumptions of a study, researchers can better interpret and analyse their findings. This approach allows researchers to critically assess their biases and assumptions, which can lead to more robust and reliable results (Dawadi et al., 2021). In essence, the philosophical foundations of a study determine the research process and impact the interpretation and dissemination of its results.

A paradigm is a set of logically related assumptions, concepts, or propositions that guide research (Krauss, 2005). A clear understanding of a paradigm can provide a foundation for further choices. Authors differ in how paradigms are categorised. For example, Tashakkori and Teddlie (1998) categorised logical positivism, post-positivism,

pragmatism, and constructivism as paradigms, whereas Guba (1990) distinguished positivism from the other three paradigms. Philosophers have modified the three as a challenge: post-positivism, critical theory, and constructivism. These varying philosophical and theoretical perspectives on research guide researchers and result in differences in research methodologies (Al-Ababneh, 2020).

Understanding the implications of different paradigms is essential for researchers to conduct rigorous and meaningful research to advance knowledge in their field. Positivism employs experimental and quantitative techniques to test and confirm research hypotheses (Park et al., 2020). This approach encompasses using measurable data through standardised instruments, such as questionnaires. The researcher is regarded as unbiased, objective, and distinct from the study participants (Pilot & Beck, 2012). Positivists maintain a value-neutral, distant position towards the object of inquiry and emphasise generalisability (Park et al., 2020; Clark, 1998). Although quantitative research is considered deductive, some scholars argue it incorporates both deductive and inductive approaches (Yilmaz, 2013; Ochieng, 2009).

Post-positivism emerged as a reaction of educational researchers to the limitations of positivism as a paradigm (Panhwar et al., 2017). It asserts that reality is socially and culturally constructed, so achieving absolute objectivity is unattainable (Maksimović & Evtimov, 2023). Researchers who align with the constructivist paradigm believe multiple realities exist. Their epistemological stance is that knowledge needs to be interpreted to discover the underlying meanings (Dieronitou, 2014). In contrast, pragmatists believe that reality is constantly negotiated, interpreted, and changing through human action and interaction (Corbin & Strauss, 2008).

The difference between post-positivists and positivist approaches to research can be noted in the researcher's role in the process. One argument of the post-positivist

approach asserts that the researcher and the research subject cannot be independent (Malkani, 2019). However, many other arguments have been used to identify the post-positivist approach. Post-positivism is a philosophical approach that places significant emphasis on using quantitative methodologies to establish causal relationships (Furlong & Marsh, 2010). From this standpoint, quantitative approaches may offer optimal ways to achieve such aims, as they encompass the evolution of explicatory and predictive models (Fox, 2008). However, post-positivists also acknowledge the limitations of a purely quantitative approach and recognise the importance of incorporating qualitative methods to gain a deeper understanding of social phenomena.

After carefully considering various research methodologies, a quantitative approach using questionnaires was selected to address the research question. This approach and method of data collection were consistent with the post-positivist paradigm. This thesis focused on measurable variables. Therefore, the research was aligned with the post-positivist philosophical approach that considers measuring using a scale as the foundation of gathering knowledge about the real world.

5.4 Post-Positivist Philosophical

Positivism was the dominant research approach until the post-modern period (post-World War II), when philosophers such as Popper (1968) and Kuhn (1962, 1996) challenged the ontological and epistemological assumptions underpinning positivism. They asserted that scientific theories could not establish the notion of absolute truth and total objectivity (Pilot & Beck, 2012; Crotty, 1998). This argument led to the emergence of post-positivism, which acknowledges the limitations of positivism and the impossibility of total objectivity. Post-positivists use falsification to verify their research hypotheses due to recognising the complexity of real-world environments (Guba &

Lincoln, 1994). They strive for objectivity and impartiality while seeking probabilistic evidence instead of absolute truth and establishing correlations between variables rather than the direct cause and effect (Creswell, 2014).

Post-positivists strive to be impartial and unbiased and seek probabilistic evidence instead of absolute truth (Omodan, 2024; Ryan, 2006). They aim to establish relationships between variables rather than direct cause and effect (Parahoo, 2014b; Polit & Beck, 2006). However, they still believe in the importance of objectivity and generalisability (Mertens, 2023). Post-positivists also acknowledge that feelings or experiences that cannot be observed can be explored and explained through reliable and valid self-reporting tools such as surveys (Parahoo, 2014b), which were used in this study. This approach is more aligned with this study's objective to explore the experiences of research participants, as it acknowledges that absolute truth cannot be established, and total objectivity cannot be obtained.

Post-positivism is grounded in the belief that there is an objective reality. However, the researcher's understanding of it is inherently limited by human subjectivity and the constraints of the research process. In the context of this study, the ontology acknowledges that there is a reality to be studied – namely, the impact of training in self-efficacy on nursing interventions – but this reality is complex and cannot be fully understood due to various factors influencing the outcomes. As mentioned previously, post-positivism acknowledges the limitations of strict positivism.

In this study, the researcher assumed that subjectivity and complexity are involved in understanding nurses' self-efficacy and their ability to detect and report child maltreatment when assessing the impact of the training. Thus, the researcher strived for objectivity but acknowledged that complete objectivity was challenging to achieve. The author considered the research questions raised in selecting the appropriate research

design for this study. The study aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases in SA, which was not explored by previous research. This research approach aligned with post-positivism's beliefs and values to examine nurses' self-efficacy.

Quantitative research methods are consistent with post-positivism, which recognises the challenges of complete objectivity due to the influence of individual subjectivity (Routledge, 2007). While objective observation was essential in this study, the researcher acknowledged that complete objectivity was unattainable. Therefore, understanding the philosophical foundations of research methodologies was crucial to making informed decisions and contributing to advancing knowledge. The researcher used validated and reliable survey instruments to quantitatively measure different aspects of self-efficacy. The researcher's role was that of a neutral observer to minimise potential researcher bias.

5.5 Research Design

The author considered the research questions raised when selecting the appropriate research design for this study. The design of a research study is a fundamental aspect that determines the research processes and components, including research methods, strategy, and sampling (Sileyew, 2019; Richardson & Robinson, 2007). It is a comprehensive plan that outlines how the study will be conducted and how its various elements will be organised logically and coherently (Thakur, 2021; Crewell, 1994). A research study's design refers to the researcher's approach to address a specific research question (Williams, 2007).

Two principal research approaches exist: qualitative and quantitative (Creswell, 2014; Fetter et al., 2013). Qualitative research describes phenomena, while quantitative

research tests hypotheses and measures variables (Chih-Pei & Yan-Yi, 2017; Amaratunga et al., 2002). Although mixed-methods research is increasingly popular, the extent to which qualitative and quantitative research methods can be combined is still debated (Liu, 2022). Depending on the research question, one approach may be more suitable. For example, if the research question is focused on understanding an individual's experience with a particular phenomenon, a qualitative approach may be more appropriate, while if the research question is focused on the relationship between two or more variables, a quantitative approach may be more suitable.

Quantitative research designs include experimental, quasi-experimental, and non-experimental (Baker, 2017; Polit & Beck, 2010). Experimental designs involve deliberately manipulating the independent variable to observe the effect on the dependent variable (Polit & Beck, 2008). If researchers want to investigate causal relationships, quasi-experimental designs are recommended. These designs are similar to actual experiments but do not meet all the requirements, such as randomly allocating subjects to groups, control, and manipulation (Gopalan et al., 2020). Non-experimental designs involve observing the relationship between variables without manipulation (Rogers & Revesz, 2020; Baker, 2017). Researchers use experimental designs when they want to change independent variables over time (Rogers & Revesz, 2020; Flannelly et al., 2018) by introducing an intervention and randomly assigning participants to either a control or treatment group. In comparison, quasi-experimental designs are those in which an intervention is introduced, but a control group or random assignment of patients into groups is not required (Bloomfield & Fisher, 2019; Montero & León, 2007).

According to McCusker and Gunaydin (2015), the goals of a study should guide the selection of an effective research design. Therefore, in research studies aiming to test the effects of an intervention, an experimental or quasi-experimental design may be

chosen. Conversely, studies with objectives to explore relationships between variables or test variables between groups in a specific cohort typically employ non-experimental designs, such as survey research. In this thesis, the researcher did not implement an intervention, alter independent variables, or randomly assign participants to treatment groups. Hence, a non-experimental design was judged suitable to meet the study's aim and objectives.

Two broad types of non-experimental research designs are cross-sectional and longitudinal (Novosel, 2023; Polit & Beck, 2008; Johnson, 2001). To conduct a cross-sectional study, researchers only gather data from participants at a single time point (Setia, 2016; Mann, 2003); in contrast, longitudinal designs are used to collect data over time. Cross-sectional designs are used to explain the phenomena of interest, examine correlations, or assess differences between variables at a single time point (Polit & Beck, 2010). An example of a longitudinal research design is the cohort design, which tracks individuals with similar characteristics or experiences over time to assess the occurrence of an outcome of interest or report changes to the phenomenon under investigation (Andrade, 2022; Polit & Beck, 2010). A cross-sectional survey was used to collect data in this thesis, as it was less costly and allowed for efficient data collection in a short timeframe (Wang & Cheng, 2020; Fetters et al., 2013).

According to Radhakrishnan (2013), non-experimental methodologies are most suitable for conducting research studies that are descriptive, comparative, or correlational. Williams (2007) classified descriptive studies into many varieties, including comparative and correlational studies. Researchers use descriptive-comparative designs when they want to compare two or more groups on one or more variables but do not want to resort to manipulation, control, or randomisation (Siedlecki, 2020; Williams, 2007). Similarly, in descriptive-correlational designs, researchers evaluate and attempt to explain correlations

between variables (Bloomfield & Fisher, 2019). The strength of correlated variables' relationships shows how one variable's change affects another but does not prove causality (Bloomfield & Fisher, 2019; Polit & Beck, 2010). The researcher considered specific criteria to select the most suitable quantitative study design (Saxena et al., 2013; Polit & Beck, 2010). In light of the study's objectives, a cross-sectional study was the most appropriate design due to its ability to collect data at a single point, among other reasons outlined in the next section.

Each research objective in this study was developed to identify whether and to what extent a predictor variable was linked to a criterion variable due to the nature of a correlational design. The descriptive cross-sectional comparative design employed in this study provided an opportunity to compare self-efficacy outcomes between those who attended and those who did not attend CAN training (objective 1), test the relationships between personal characteristics and SE (objective 4), and assess nurses knowledge/understanding of matters relating to CAN (objectives 2, 3 and 5).

5.6 Rationale for Selecting the Study Research Design

When conducting research, selecting an appropriate study design is a critical decision that can significantly impact the quality and interpretability of the findings. In the current study, the researcher opted for a descriptive comparative cross-sectional design, which warrants a closer examination of the rationale behind this methodological choice.

One of the primary characteristics of a cross-sectional design is its ability to capture a "snapshot" of the population at a specific time. According to Wang and Chang (2020), a cross-sectional study is a type of observational study design used in medical research, and

it is often compared to taking a “snapshot” of a population. This approach is particularly well-suited to the research objectives outlined in the study, which aimed to explore the impact of training on nurses' self-efficacy in identifying and reporting cases of child abuse and neglect (CAN) and assess the relationships between various personal characteristics and self-efficacy.

An alternative design approach, like a pre-post evaluation, would have required administering assessments before and after the training intervention. While this method could have provided more direct evidence of the training's impact, it may have presented significant logistical and resource-related challenges for the researchers. The cross-sectional survey allowed them to collect all the necessary data simultaneously from three different regions, a more efficient and feasible approach given the study's context.

Moreover, the cross-sectional design enabled the researcher to capture existing differences between nurses who had received CAN training in general (either any formal training or the CPMTP) and those who had not. This comparative analysis provided valuable insights into the participants' self-efficacy, knowledge, and attitudes, even if it could not directly attribute any observed changes to the training intervention itself. By examining these associations, the researcher was able to gain a deeper understanding of the relationships between the key variables of interest.

Another crucial consideration in the researcher's decision-making process was the sensitive nature of the topic under investigation, child abuse and neglect. Collecting data on such a delicate subject matter through interviews or other direct methods may have been met with ethical and practical barriers, as individuals are often reluctant to disclose their experiences or perceptions due to fear of identification. The cross-sectional survey

approach, on the other hand, allowed participants to feel more comfortable sharing their perspectives, reducing social desire bias.

Furthermore, this study's research objectives were primarily focused on exploring the impact of training and assessing the relationships between variables. This was rather than establishing causal relationships. Cross-sectional designs are well-suited to this type of inquiry, allowing researchers to examine associations without claiming causality. This design choice was aligned with the study's goals and the researchers' intent to gain a deeper understanding of the phenomena under investigation.

In conclusion, the researcher decision to employ a descriptive comparative cross-sectional design was well-reasoned and strategically aligned with the study's objectives, practical considerations, and the topic's sensitive nature. The researcher could have explored the impact of the training pre-post, but a cross-sectional approach allowed them to capture a comprehensive snapshot of the population, examine key variables, and address unique study-specific challenges.

5.7 Advantages and Disadvantages of Cross-Sectional Survey

Researchers have a variety of methods at their disposal when conducting cross-sectional surveys. This thesis utilised a questionnaire for data collection, with both hard copy and electronic web-based options available. This approach offers several advantages, such as engaging a more diverse and remote audience to share their perspectives, which increases the number of respondents (Cope, 2014; Van der Bijl & Shortridge-Baggett, 2002). Researchers can gather a significant quantity of data from many individuals via surveys. Thus, if the sample is representative of the population, an accurate portrait of the population can be produced from a relatively small number of people (Cope, 2014). Surveys also offer anonymity, which can encourage participants to

freely express their thoughts and feelings (Vangeest & Johnson, 2011; Coughlan et al., 2009). However, surveys may suffer from response bias and rely heavily on self-reported information, which can introduce inaccuracies in the data collected (Vangeest & Johnson, 2011).

Cross-sectional surveys require careful planning and consideration to ensure that questions are clear and unbiased to achieve reliable results (Van Selm & Jankowski, 2006). Although cross-sectional designs have low costs and enable fast data collection, these characteristics also result in specific weaknesses (Wang & Cheng, 2020; Hulley et al., 2013). As data are collected at one point, the “snapshot” description cannot account for what happens before or after the data are collected. Therefore, researchers cannot know if results would differ significantly if another time point had been chosen (Beck & Katz, 1995).

However, a cross-sectional survey has not been used extensively to examine the issue of measuring nurses’ self-efficacy in Saudi Arabian hospitals for identifying and reporting cases of CAN. Nevertheless, the field requires further investigation. Therefore, an anonymous cross-sectional survey was chosen to encourage participants to provide honest and accurate responses aligned with the post-positivist research paradigm. This method allowed the researcher to gather valuable data on sensitive topics like child abuse, as individuals could feel more comfortable disclosing information without fear of judgement or repercussions. The questionnaire was administered to participants in paper form, by email, and through a web-based application like Qualtrics. Using hard copy and online surveys allowed for better sample coverage and lower non-response rates than using either method alone (Van Horn et al., 2009). In conclusion, a cross-sectional survey design was used to explore the impact of child protection training on nurses’ self-efficacy

in recognising and reporting suspected cases of child abuse, as outlined in the following section.

5.8 Method

This section describes the methods employed in the thesis based on the methodological approach and research design. The methods are described as the specific strategies utilised in implementing the research (Bryman, 2016). The decision to use this method was guided by the theoretical perspective of the study and its capacity to provide answers to the research question at hand. As mentioned in the methodology section, the post-positivist perspective views knowledge as a quantifiable and measurable construct. Therefore, the study's methods were geared towards quantifying the impact of training on nurses' self-efficacy in identifying and reporting cases of CAN, which entailed selecting a representative sample and appropriate sampling criteria, choosing suitable instruments, and ensuring reliability and validity. These essential considerations ensured that the research findings were not unduly influenced by factors not accounted for in the hypotheses.

Randomised sampling is the gold standard for obtaining an unbiased population representation. However, this study utilised a convenience sampling approach by selecting participants based on availability and accessibility rather than randomly. While this non-probability sampling method is commonly used in quantitative research, convenience sampling has implications for the generalisability of the findings that should be considered. Nonetheless, given the emphasis on objectivity and generalisability in quantitative research, this study employed statistical analysis techniques to examine the relationships between the training and nurses' self-efficacy, considering ethical considerations and expertly handling data collection challenges. Although this study did

not implement a specific training programme, as the researcher was not given access to the programme material or training teams, it sought to determine the impact of any CAN training provided to nurses working in healthcare facilities in SA; including programmes from the NFSP, such as the CPMTP. The impact of training was studied using a questionnaire with the CANRSE (Colgrave et al., 2020). A questionnaire asked the respondents to identify the training type(s) they received. The impact of the nurses' training was then determined using a cross-sectional study design. The specific data collection and analysis methods are described in the following sections.

5.8.1 Study Setting

According to the report from the NFSP, 48 CPTs are stationed in hospitals throughout all 13 provinces of SA. These teams are evenly spread across the former five regions: Central, Western, Eastern, Northern, and Southern SA, with a greater concentration of hospitals in the Central, Western, and Eastern regions due to their higher population density. The study participants were selected from the Ministry of National Guard-Health Affairs (MNG-HA) in these three primary regions. Data were gathered from the NGH in Riyadh (Central region), Dammam (Eastern region), and Jeddah (Western region; Figure 3). The data collection sites selected were King Abdulaziz Medical City in Riyadh, the Jeddah complexes, and Imam Abdulrahman bin Faisal Hospital in Dammam. These hospitals had the same training system, offered tertiary-level care, and required a CAN training programme, which was not mandatory. Most nurses in these hospitals were non-Saudi, so the effect of nurses' backgrounds and language on interpreting or reporting CAN cases could be applicable. Moreover, these hospitals were geographically diverse across the three cities. The nurses from each of the three regions were specifically chosen to enhance the generalisability of the findings.

Figure 3

Geographical Distribution of Child Protection Centres in Saudi Arabia (NFSP, 2016)



5.8.2 Population and Sample

Identifying the population and sample was crucial to ensuring that the findings and conclusions drawn from the research could be generalised to the larger target population. Researchers carefully consider demographics, geographic location, and specific traits when selecting a research population (Parahoo, 2014a). Specifically, in this context, the researcher could access and recruit the nurses working at the National Guard-Health Affairs (NGH) hospitals in the three regions of SA (Riyadh, Dammam, and Jeddah). The sample population was only different in terms of accessibility, so the sample population was comprised of participants who met the inclusion and exclusion criteria and to whom the researcher was granted access for the study (Polit & Beck, 2008). A target population is a particular group of people or objects about whom the researcher

aims to draw conclusions (Ormston et al., 2014). As this thesis aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA, the sample consisted of registered nurses who met the study inclusion criteria at the sites where research access was granted.

5.8.3 Sampling

A sample is a group of items selected to represent the population under study (Bansal, 2017). Sampling is an essential part of scientific inquiry because it allows researchers to check the reliability of their findings (Singh & Masuku, 2014). Probability sampling approaches are often used in quantitative research to generate a sample closely resembling the entire population (Graff, 2014). In contrast, convenience sampling is a non-probability technique used when time and resources are limited, which allows for a simpler and more efficient data collection process (Singh & Masuku, 2014). Notably, convenience sampling may introduce bias into the results, as the sample may not represent the entire population. It is essential to consider the potential limitations of this technique before using it in research. This study selected nurses from the three identified settings using a non-probability convenience sampling approach. This methodology involved the researcher's non-random selection of the participants (Singh & Masuku, 2014).

Convenience sampling is a non-probability technique that enables researchers to choose participants based on practical criteria such as accessibility, proximity, availability, and willingness to participate (Etikan et al., 2016; Dornyei, 2007). For this study, this technique was selected because of its simplicity, accessibility to nurses, and lower costs in comparison to alternative methods (Etikan et al., 2016; Polit & Beck, 2010). However, the method could increase the risk of selection bias and limit the generalisability of the

results since the selection of nurses was not random (Landers & Behrend, 2015). This potential selection bias could result in a sample that was not representative of the larger population of nurses and could result in limited generalisability. Furthermore, the reliance on practical criteria for participant selection could overlook crucial factors that could impact the study's results, such as experience level or specific expertise.

5.8.4 Sample Size

The sample size of any study depends on several factors, including the accepted level of significance, power of the study, expected effect size, and standard deviation of the population (Lakens, 2022; Peterson & Foley, 2021; Mascha & Vetter, 2018). In this study, the target population was nurses who worked in paediatric hospitals in three regions in SA.

The researcher consulted a statistician from the School of Nursing and Midwifery at the SPSS clinic in Trinity College Dublin to determine the required number of participants for this study. The researcher used G*Power (version 3.1.9.6; Heinrich-Heine-Universität Düsseldorf, Düsseldorf, Germany). With a significance level (α) of 0.05, median effect size (d) of 0.5, and power ($1 - \beta$) of 0.95, the analysis indicated that 176 participants were needed for this study. The power level with a significance of 0.05 was chosen to minimise the risk of type I and type II errors (Banerjee et al., 2009). A commonly used method of sampling is simple random sampling, in which each unit in the population has an equal chance of being selected for the sample. As the population was spread across three locations, the sample size was divided proportionally based on the number of nurses in each location (Table 3).

Table 3*Sample Sizes from Each Region*

Group	Population	Proportionate sample size (G*Power)	Sample size (n)
Riyadh	770	151	213
Dammam	26	5	7
Jeddah	99	19	27
Total	895	176	247

Approximately 10–20% of additional subjects are required to allow adjustment for factors such as withdrawals and missing data (Kp & Srikantiah, 2012). Hence, the final sample size = effective sample size / (1 – anticipated non-response rate). As the population was spread across three locations, the sample size was divided proportionally based on the population in each place. The minimum required number was 276, with an anticipated non-response or drop-out rate of 20% (Massey & Tourangeau, 2013). Therefore, the recommended target sample size was $276 / (1 - 0.2) = 345$ participants. With this approach, even if 20% of the participants drop out, the required sample size of 276 participants can still be reached. Out of 276 paper questionnaires, 202 were completed, and 45 responses were obtained online, resulting in a 77% overall response rate, shown in Table 5.

5.8.5 Inclusion/Exclusion Criteria

Before collecting data in cross-sectional research designs, it is crucial to establish the criteria for inclusion and exclusion (Setia, 2016). In such research, participants are chosen based on predetermined criteria for inclusion and exclusion (Wang & Cheng,

2020; Setia, 2016). For this study, individuals had to meet specific requirements to be eligible.

Inclusion Criteria:

- registered nurses.
- at least one year of experience in any paediatric setting.
- worked at National Guard Health Affairs (NGH) in Riyadh, Dammam, or Jeddah.

Exclusion Criteria:

- nurses with less than one year of experience in paediatric care.
- nursing students, trainees, interns, and non-patient interacting nurses.

5.8.6 Instrument Selection

This study utilised a questionnaire as its primary research instrument. The English version of the CANRSE scale was employed, which was validated and found to be reliable by Colgrave et al. (2020) in Australia, as explained in Chapter 3. The decision to use the English language for the questionnaire was based on the fact that English is used in healthcare facilities in SA.

5.8.7 The Development and Validation of the CANRSE Scale to Measure Nurses' Self-Efficacy in Reporting Child Abuse and Neglect

The CANRSE scale has been widely recognised as a reliable and valid measure of nurses' self-efficacy in reporting CAN. Researchers have utilised the scale to examine factors influencing self-efficacy, such as personal and professional characteristics, training experiences, and organisational support. The CANRSE scale measures professional self-EEs and OEs based on Bandura's (1977) theory, as summarised in figure

4. Lee et al. (2012) developed the CANRSE in both English and Chinese. The CANRSE scale was the first tool designed to measure the self-efficacy of nurses in reporting cases of child abuse or neglect. The scale underwent rigorous testing in Taiwan (Lee et al., 2012) to develop and validate the CANRSE scale to measure nurses' self-efficacy in reporting CAN. The questionnaire was designed to measure professional self-efficacy for reporting four types of abuse: physical, sexual, emotional, and neglect. The development process involved an extensive literature review and input from an expert panel to ensure its validity and reliability.

The CANRSE questionnaire contains 47 items divided into two scales: SE-CAN for self-EEs and OE-CAN for OEs related to reporting CAN cases. Later, Lee et al. (2012) translated the CANRSE questionnaire into Mandarin Chinese with minor adjustments for use in Taiwan. The translated version was used to examine the self-efficacy of Taiwanese nurses in reporting suspected and known cases of CAN, and it demonstrated strong validity and reliability.

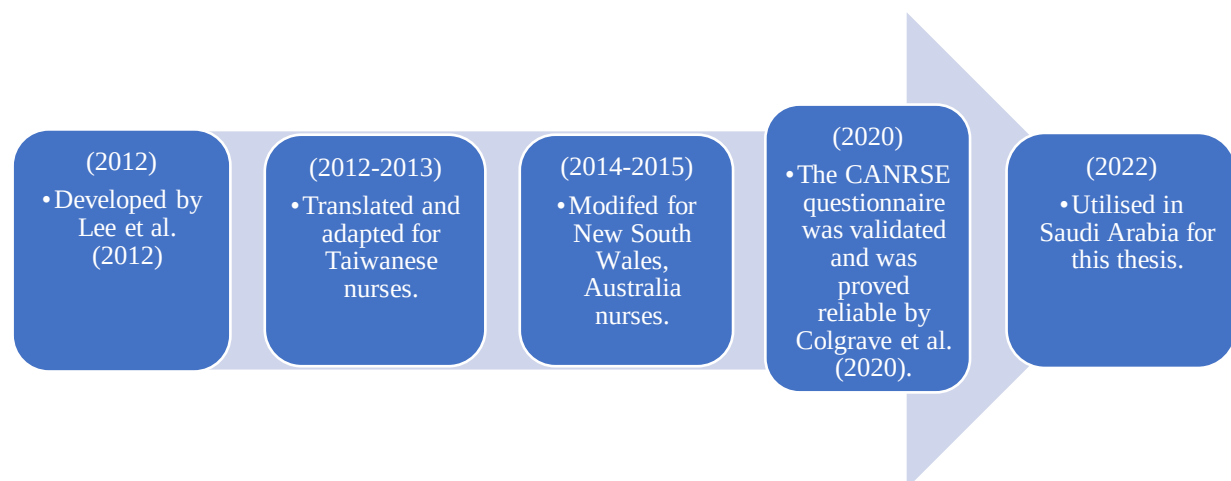
A study in Vietnam also validated the tool's reliability in detecting and responding to cases of CAN (Fraser et al., 2018). The results indicated that the CANRSE is reliable and valid. Colgrave et al. (2020) later translated the full version of the tool for use in healthcare settings in New South Wales. Overall, the CANRSE is a reliable and valid measurement tool for assessing nurses' self-efficacy in reporting cases of child abuse or neglect.

A modified English language version of the CANRSE questionnaire was developed for use in the Australian state of New South Wales by Colgrave et al. (2020). This version was tailored to align with NSW's legal obligations and reporting requirements while considering different definitions of CAN and reporting protocols. The adaptation was designed to examine the self-efficacy of healthcare professionals,

including mandatory reporters, in reporting CAN cases in a cross-cultural context. Despite the translation and adaptation process, the questionnaire demonstrated validity and reliability in measuring self-efficacy related to CAN reporting in NSW. Colgrave et al. (2020) reported that the findings from the CANRSE questionnaire could inform the development of training programmes and interventions to enhance healthcare professionals' self-efficacy in reporting CAN cases. Given the increasing evidence supporting the adequacy of self-efficacy in predicting professional behaviours, this study used the new instrument by Colgrave et al. (2020).

Figure 4

Summary of the History of the CANRSE Questionnaire



Bandura's cognitive behaviour theory frames the CANRSE questionnaire, which is comprised of six domains and encompasses three key variables. The first domain covers personal and professional information, including gender, age, nationality, marital status, education, and parental status; professional information, such as current position, work experience in the paediatric area, workplace, and years of experience; and

experience in reporting CAN, including work environment factors like support from staff, whether reports were made, and managerial support. The second domain evaluates attitudes and feelings about reporting using 15 statements on a 5-point Likert scale, while the third domain focuses on education and training experiences related to CAN and reporting.

The fourth domain assesses knowledge of the law, while the fifth domain evaluates intended reporting behaviour using ten vignettes – each represents a reportable case of CAN and is evaluated across seven items. Lastly, the sixth domain six examines self-efficacy with suspected cases of CAN (EES: 16 items comprising four subscales), self-efficacy with known cases of CAN (EEK: 16 items comprising four subscales), and outcome expectations (OE: 12 items comprising three subscales). Each item is scored on an 11-point Likert scale, from 0 to 10, with higher scores indicating higher self-efficacy (0 = not confident at all, 10 = extremely confident). Additionally, the questionnaire includes the GSE, which is a 10-item scale. Based on a study involving Taiwanese nurses, the questionnaire exhibited a CVI of 0.89, which indicated the high relevance and representativeness of the items. The test-retest reliability coefficient was 0.91, which indicated consistency in responses over time (Lee et al., 2012b). Therefore, the CANRSE questionnaire is a valid and reliable tool for evaluating self-efficacy in handling cases of child abuse and neglect.

The CANRSE scale measures various domains of efficacy, and items within the same domain should be positively correlated with each other and with the total score. Bandura (2006) advocated for domain-specific self-efficacy assessment, which highlighted the importance of closely linking the items on the scale to the construct being evaluated (Bandura, 2006; Bandura et al., 1999). A factor analysis is conducted to verify the homogeneity of the items (Pett et al., 2003). Different domains of efficacy require

different sets of scales, with item homogeneity within each domain-relevant scale.

Reliability is an important aspect to consider, as it places an upper limit on the maximum possible correlation that can be obtained between variables. Internal consistency reliabilities are recommended to be computed using Cronbach's alpha (Hajjar, 2018).

If the reliability coefficients are low, it is advisable to either discard or rewrite the items with low correlations. However, including only a few items will limit the alpha level, so it is recommended to increase the number of items to obtain a more accurate measure of efficacy (Urdan & Pajares, 2006) to help ensure that the scale measures the construct it intends to measure. It is important to carefully consider the items included in a scale to maintain its reliability and validity.

Thus, the internal consistency method was employed to assess the survey's validity (Table 4). This method uses Cronbach's coefficient alpha, a metric ranging from 0 to 1 that gauges the survey's reliability. A higher score indicates a greater level of reliability. It is used to confirm that the designed items measure the same factor, test how highly these items are correlated, and predict each other. According to Taber (2018), acceptable values of Cronbach's alpha vary depending on the scale's intended purpose. However, the minimum value should not fall below .7. George and Mallery (2019) maintained that the degree of internal consistency can be classified as excellent if values exceed .9, good if between .8 and .9, acceptable if higher than .7, questionable if above .6, poor if above .5, and unacceptable if below .5.

In this study, combining all 107 items across the various dimensions, the overall Cronbach's alpha coefficient was 0.97, which demonstrated excellent internal consistency for the entire set of measures.

Table 4*Alpha Correlation for Each Dimension*

Dimensions	Number of items	Alpha coefficient	Mean inter-item
Attitudes and feelings about reporting	15	0.918	Ranged between ($r = .73$, $p < .01$) and ($r = .56$, $p < .01$)
Intended reporting behaviour.	10 dimensions, each dimension had five items	Good results, it ranged between ($\alpha = .94$) and ($\alpha = .80$)	Ranged between ($r = .87$, $p < .01$) and ($r = .59$, $p < .01$)
Efficacy expectations for CAN	4 dimensions, each dimension had four items	Good results, it ranged between ($\alpha = .99$) and ($\alpha = .96$)	Ranged between ($r = .98$, $p < .01$) and ($r = .88$, $p < .01$)
Outcome expectations	3 dimensions, each dimension had five items	Good results, which ranged between ($\alpha = .99$) and ($\alpha = .99$)	Ranged between ($r = .98$, $p < .01$) and ($r = .92$, $p < .01$)
General perceived self-efficacy scale	11 items	Good results ($\alpha = .94$)	Between ($r = .80$, $p < .01$) and ($r = .61$, $p < .01$)
Total	107	0.97	

5.8.8 Content Validity

The validation of a questionnaire's content is crucial in ensuring its reliability and validity. In this study, the researcher obtained approval from the developer of the CANRSE scale to use the complete version of the questionnaire (see Appendix E). The content was meticulously reviewed, with each item assessed for its relevance to the research objectives, according to Yusoff (2019). Moreover, face validity and pilot testing were essential steps to ensure the questionnaire's clarity and comprehensiveness, with feedback sought from experts in the field. The content validation process was conducted with rigour and attention to detail to ensure the questionnaire's suitability and validity for use in SA.

Content Validity of the Scale. A comprehensive literature search was conducted to select a validated instrument. The selected instrument was carefully reviewed and tested to ensure its relevance and appropriateness for measuring nurses' self-efficacy in reporting CAN cases in SA. Content validity was measured at the item, domain, and whole scale levels (Polit et al., 2007). Additionally, expert opinions from healthcare professionals and researchers were sought to validate the adapted instrument's content validity.

Validity refers to how well the research methods measure what they set out to measure and whether meaningful and accurate conclusions can be drawn from the research. It is concerned with trustworthiness and whether the research is evaluating what it is supposed to (Creswell & Plano Clark, 2011). Creswell (2015) defined the content validity index (CVI) as the extent to which the questions on the instrument and the scores from these questions represent all possible questions that could be asked. It is essentially a method of evaluating how important the item is by reaching a consensus among a panel of experts. According to Yusoff (2019), there are two types of CVI: one for individual items (I-CVI) and one for the overall scale (S-CVI).

Several authors, including Lynn (1986), Grant and Davis (1997), and Polit et al. (2007), have presented varied perspectives on the calculation of the CVI, the number of experts required for consultation, and the acceptable cut-off score. Lynn (1986) proposed that at least three experts should be consulted while noting that more than ten experts were likely unnecessary. Davis (1997) recommended a minimum of two experts with an acceptable CVI value of at least 0.80. Meanwhile, Polit and Beck (2006) and Polit et al. (2007) suggested that items achieving an I-CVI of 0.78 or higher for three or more experts could demonstrate good content validity.

In this study, all questions in the questionnaire were given the same weight. Specifically, a “clear” response was assigned a value of 1, while an “unclear” response or comment was given a value of 0. The researcher used these criteria to ensure that only the most valid and reliable items were included in the questionnaire.

In research, CVIs are often utilised in one of two ways: either for individual items or for the whole scale (Yusoff, 2019; Polit et al., 2007; Polit & Beck, 2006). These methods aim to gauge how closely each item aligns with the concept being measured by polling field experts. The CVI is then calculated by dividing the number of relevant items by the total number of elements. This percentage, in conjunction with the scale-level CVI and the universal agreement approach (S-CVI/UA), is used to classify the scale into “relevant” and “not relevant” categories. Subsequently, the scale can be dichotomised, and values 3 and 4 can be combined.

Three experts were asked to rate the items to determine the CVIs for the instrument used in this study (Appendix F). The feedback received from these experts was then used to make necessary modifications to the items. In this study, the questionnaire scale achieved a satisfactory scale of S-CVI, and based on the CVI, none of the items were removed (Appendix G). hence, the questionnaire scale effectively measured the intended constructs.

In conclusion, the CVI offered a reliable methodology for assessing the relevance and clarity of individual items or the entire scale in research. In conjunction with the S-CVI/UA, the CVI provided a useful tool to ensure that the measurements accurately reflect the studied concepts. The following section describes the selection review panel.

Selecting a Review Panel of Experts. A group of experts was tasked with evaluating both the overall instrument and its components. Five distinguished university

professors—three in paediatric medicine and two in linguistics—were identified and invited to participate in the CANRSE scale content validation process. Each expert had at least five years of academic experience, with three meeting this criterion. The three experts were selected and contacted via email, which proved efficient in improving the response rate and time.

The experts were requested to examine the CANRSE survey and complete the CVI scale electronically. They were provided with pertinent information about the study and asked to assess the survey items and instructions for readability and clarity. The directives they received aided them in rating the level of difficulty of the words used and the clarity of the survey instructions, particularly those that were challenging to respond to or caused anxiety. Furthermore, the experts rated the word difficulty level used, the clarity of the survey instructions, and the concepts they believed the survey measured. Based on the findings from the expert panel review process, various modifications to the items were made, including additions, deletions, and adjustments.

Reviewing Domain and Items. Before scoring each item, the experts were tasked with thoroughly reviewing each domain and its respective content. They were encouraged to provide feedback on various aspects such as content, phrase length, sequence, sociocultural characteristics, and overall structure to ensure the items were pertinent to the targeted domain. This feedback could be delivered verbally or in written form.

Content Reliability. Various approaches have been proposed to estimate the reliability of tests that employ such items. Among them, Cronbach's alpha coefficient has been widely used to estimate a test's internal consistency, which is taken as a lower bound (Sijtsma, 2009). Cronbach's alpha is the most popular reliability estimate (Carmines,

1979; Cronbach, 1951). This study evaluated the internal consistency and reliability of the questionnaire's scales and subscales using this coefficient. In a previous study, Lee et al. (2012) used the CANRSE questionnaire on a sample of Taiwanese nurses and found a CVI of 0.89 and a test-retest reliability coefficient of 0.91. The reliability of factors was evaluated in this study using coefficient alpha, with a value of 0.97 considered an acceptable level of reliability, as shown in Table 4.

5.8.9 Pilot Survey

Pilot studies are conducted before the primary data collection for a study to ensure the effectiveness of research methods and procedures. According to Thabane et al. (2010), these small-scale experiments or test runs involve working with a smaller sample size to identify potential issues or challenges that may arise during the main study. The purpose of a pilot study is to test the reliability and validity of the questionnaire, which is an essential factor in increasing the effectiveness and quality of the main study (Hassan et al., 2006). As emphasised by Teresi et al. (2022), conducting these preliminary studies before conducting extensive research is crucial, as they provide valuable insights into the research process and increase the quality and effectiveness of the main study. This study tested the questionnaire beforehand to determine if the items included were relevant and appropriate. The researcher also assessed whether the questionnaire measured what it intended to measure. According to Thabane et al. (2010), these tests are essential for assessing the feasibility of methods, data collection procedures, and data analysis techniques. The researcher conducted this test to identify any potential flaws or limitations in the questionnaire and made the necessary adjustments and improvements.

In the pilot study, nurses were invited to participate in the survey voluntarily and anonymously. Each participant was given an envelope containing a questionnaire and a

cover letter featuring the researcher's contact information. The letter instructed recipients to indicate the time they completed the questionnaire and return the finished document to the researcher's office located at the hospital. Ample time was given for participants to answer the questionnaires; they reported spending approximately 15–20 minutes completing the provided survey tool. A pilot study with 20 participants was conducted, and 15 people responded. The response rate of 77% indicated a good level of engagement from the participants and suggested that the survey tool was well-received and easy to understand.

Researchers can correct any unforeseen problems by conducting a pilot study before the final questionnaire is administered. A successful pilot study can provide valuable insights into the research process and help ensure the main study runs smoothly (Alversia, 2011). Therefore, researchers must conduct pilot studies before embarking on large-scale research projects. For this study, a gatekeeper distributed the questionnaires to nurses in a specific department of a children's hospital in Riyadh. Notably, the pilot study department was separate from those in the main study to avoid potential data contamination.

The questionnaire items were modified based on the responses obtained during the pilot study to ensure their suitability for the study's population. For example, a question about the participants' nationality was included in the survey as it pertained to their knowledge of the law, given that the participants belonged to different nations. Moreover, the items were rephrased to integrate cultural variations and make them more understandable; for instance, the vignette of one case was changed from age 16 to 12 years old. The instrument was also revised to enhance clarity and concision based on feedback received from expert panel reviews (see Appendix H for the survey modifications). These modifications ensured the questionnaire items were appropriate,

relevant, and accessible to the study's participants. Subsequently, a final questionnaire draft was generated and submitted to the ethics department's faculty for approval before its use in the main study (Appendix K). Overall, pilot testing is an essential step in the research process that enhances the overall quality and credibility of the study. The following section elucidates the data collection methods.

5.9 Data Collection

This section outlines the process of recruiting participants and gathering data through a questionnaire. The objective was to obtain information from as many individuals as possible. The researcher collected data from participants using online and paper-based questionnaires facilitated by the survey technique. This approach enabled the researcher to reach a broader and more diverse population to enhance the generalisability of the findings. Additionally, online questionnaires offered convenience for the participant by allowing them to complete the survey swiftly at their own pace and from the comfort of their homes, as discussed in the subsequent section. Data were collected between December 2021 and February 2022.

5.9.1 Recruitment Process

Upon obtaining approval from the Research Ethics Committee of the Faculty of Health Sciences at Trinity College Dublin and the KAIMRC in Riyadh (Appendix I) and from TCD (Appendix J), the researcher liaised with the gatekeeper to establish the study setting, distribute the questionnaire, and disseminate the participant information leaflet (PIL; Appendix O)

The invitation's wording was similar for the hard-Copy (Appendix L), and digital groups, except for explaining how to access the web-based or digital questionnaire (Appendix M). The letter contained details for contacting the researcher for more

information and invited participants to volunteer to participate in the study. The research and eligibility criteria were shared with the potential participants to identify eligible participants (Padgett, 2016). Therefore, the sample criteria were outlined in the invitation letter. Furthermore, the poster included the researcher's phone number so that any nurses interested in the research could contact the researcher (Appendix N).

The head of each department in Riyadh, Dammam, and Jeddah was contacted and followed up by the gatekeeper via telephone to arrange a suitable time to meet with the staff to ensure the successful recruitment of participants in the study areas of the children's hospital. To initiate participant recruitment in each city, the researcher was present on-site. This approach facilitated access to prospective respondents, enabling them to pose questions, establish trust, and feel more comfortable participating in the survey, which may have impacted the sample response rate. Throughout recruitment, the researcher identified and resolved the issues that arose and collected completed forms before proceeding to the next city. Participants requiring further clarification on any survey aspect were encouraged to contact the researcher, and the number of hard copies distributed and collected was closely monitored.

In summary, the researcher followed a thorough recruitment process with the assistance of gatekeepers in each setting. Using posters, emails, and phone numbers facilitated communication between the researcher and prospective participants to ensure a successful recruitment process and sample collection.

5.10 Data Collection Procedure

In this study, the questionnaire was disseminated electronically (via Qualtrics) and in physical copies (printed on paper). Researchers have found that combining paper-based and online data collection methods minimises cost and workload and obtains more robust

and reliable data for their studies (van Gelder et al., 2020). Using online and hard-copy surveys helped increase the number of participants and provided flexibility for involvement in the study at any time or location. According to Tella (2015), paper surveys have a higher response rate than electronic surveys, mainly due to face-to-face interaction, researcher availability, and guidance for those who may not fully understand the questions. Furthermore, paper-based methods provide a physical record of data that can be useful for archiving purposes (Corti, 2000). Paper-based surveys also offer confidentiality and privacy to respondents (Raghupathy & Hahn-Smith, 2013), so they potentially encourage more honest and accurate answers for enhanced data accuracy. An online survey was used to cater to participant preferences, as noted by Gideon (2012). Matteson et al. (2011) reported that this method led to a higher number of responses.

The participants were allotted an estimated 15 to 20 minutes to complete the survey, based on the study conducted by Lee (2020) and the time recorded during the pilot study. A return box was sometimes provided for convenience, with information about the researcher's next availability. The returned questionnaires were sealed and either returned to the researcher or deposited in the researcher's locked box at the children's hospital.

The online version of the survey was available via a link to the complete CANRSE questionnaire, which was made available in Qualtrics (online survey). Researchers have shown that online surveys offer greater representativeness and higher response rates than hard-copy surveys (Converse et al., 2008; Beebe et al., 2007). Additionally, they are often more cost-effective and efficient than other modes of data collection, such as paper-and-pencil methods (Wilson et al., 2010). The Riyadh gatekeeper contacted each department's head to organise the advertising, and the survey link was distributed to staff via posters in nurses' break rooms. The PIL also highlighted

that the IP addresses of participants were not collected at any point, so the data provided could not be traced back to them. The online survey on the webpage was not linked to respondents' email addresses, which afforded the participants an added measure of anonymity and allowed them to more freely and honestly answer the questions (Van Selm & Jankowski, 2006).

In this study, the researcher provided a method for the respondent to track their progress while answering the questionnaire via a progress bar at the bottom or the side of the page to maximise completion rates. The online survey host was compatible across multiple platforms and devices, with the survey link remaining active for four weeks. Participation was voluntary and anonymous, as no identifying data were collected. Further, the sample criteria were listed on the front page so that participants could decide if they were eligible to participate. Participants were also assured that all responses were analysed and stored on an encrypted and password-protected computer, allowing access only to the researcher.

5.10.1 Data Collection Process

Online Survey:

1. The online survey was available via a Qualtrics link.
2. The gatekeeper was requested to promote the questionnaire link through posters in the nurses' room and circulate the questionnaire link to participants via email and distributed the invitation letters in the nurses' stations in the emergency room, outpatient clinic, medical and surgical wards, burns unit, and day surgery unit.
3. The poster included the details about the study and the researcher's contact details and was posted in the paediatric staff rooms of all hospitals involved.

4. Respondents were assured that their personal information would not be collected and that their answers would be kept confidential and anonymous to encourage all eligible individuals to contact the researcher or access the digital survey link.
5. A participant information sheet was provided as a download, and the participants clicked on the tick box to confirm they were happy to proceed and consented to participate. The PILs highlighted that IP addresses were not collected to ensure anonymity.
6. The survey link remained active for four weeks.
7. Participation was voluntary and anonymous, with no identifying data collected.
8. Participants confirmed consent by ticking a box. They received a participant information sheet and sample criteria.
9. Responses were stored on an encrypted and password-protected computer, accessible only to the researcher.

Hard-Copy Surveys:

1. Gatekeepers distributed invitation letters to participants during morning shift changes or on designated study days in each department.
2. Nurses interested in participating could contact researcher for further information or collect the questionnaire from the gatekeepers.
3. Gatekeepers delivered questionnaire packages (which included the study information sheet and questionnaire) to willing nurses in each department.
4. In the Central region, the returned questionnaires were sealed and either returned to the researcher or deposited in the principal investigator's locked box at the hospital.

5. The researcher collected envelopes from each department, answered questions, and conducted follow-ups in the Central region by visiting the departments and addressing the concerns and questions of the potential participants.
6. Return boxes were made available in different hospital departments in other regions, such as the East and West hospitals, with information about the researcher's name and the next available date. The returned questionnaires were sealed and either returned to the researcher or deposited in the box in each department.
7. Participants were not required to sign the consent form to protect their privacy. Instead, they indicated their agreement to participate in the research by checking a box on the permission form.
8. Participants were given two weeks to return the survey to the researcher.
9. The completed surveys were securely stored in a locked cabinet in a designated office at the hospital.

Due to a small number of participants from Dammam, the researcher moved to Al Ahasa Hospital in the Eastern region. At Al Ahasa Hospital, the researcher confirmed with the research centre in Riyadh KAIMRC that nurses were involved in the research and part of the data collection process. The researcher distributed letters of invitation to the nurses' stations in each department, containing details about the research and the researcher's name and contact details. Participants in a study meeting who were willing to participate requested a copy of the questionnaire package. The researcher then provided the interested nurses with the necessary materials, such as an informed consent form, the survey instrument, and instructions for completing and returning the questionnaire. Before deciding whether to participate, nurses had ample time to review

the documents and ask clarifying questions. Through the in-person meeting, the researcher addressed participants' concerns and ensured they understood the research objectives and participation requirements clearly. Return boxes were available in the nurses' stations for nurses to submit their completed questionnaires. Nurses could easily return surveys at their own pace and convenience, which allowed for a streamlined and organised data collection process.

King Abdelaziz Medical City in Jeddah was the second-largest hospital in the Western region for data collection. Invitation letters and information envelopes containing the questionnaires were given to the gatekeeper for distribution. Nurses were requested to return the completed survey instrument within two weeks of distribution. The researcher visited each department to follow up on the advertisement for the invitation to participate and collect the envelopes. Regular follow-ups were conducted to ensure that those who had not returned the questionnaires were reminded about the survey. Based on Fowler's (2009) research, one-third to one-half of the original sample may participate if a follow-up survey is conducted. The researcher visited each of the identified areas for data collection and explained to participants the importance of the survey, the benefits of the study, and how and why respondents could help by completing the survey. The researcher thanked the participants in advance.

Out of the 275 paper questionnaires distributed, 202 were filled out and returned, with an additional 45 participants responding online. Thus, the total response via online and hard copy was 247, and the response rate for the study was 77% (Table 5).

Table 5

Response Rate

Sites	Central centre (Riyadh)	East centre (Al Dammam, Al Ahasa)	West centre (Jeddah)	Online responses	TOTAL
Number of questionnaires Distributed (Paper/hard copy)	199	30	46	-	275
Number of questionnaires Collected	134	26	42	45	73.45% (247)
Response rate	67%	86%	91%		77.19% (202/275 + 45/45)

The overall percentage = (total number of questionnaires collected / total number of questionnaires distributed) $\times$ 100. The total number of questionnaires distributed was 275 (paper) + 45 (online) = 320. The total number of questionnaires collected was 202 (paper) + 45 (online) = 247. The overall response rate was = $(247/320) \times 100 \approx 77.19\%$. Thus, the response rate for this thesis was 77%, which is considered reliable for data analysis according to Mugenda's (1993) recommendation. A response rate of 50% is considered adequate for analysis and reporting, with 60% being good and 70% or higher considered excellent for generalisation (Mugenda, 1993). After comparing the quality of data and responses gathered through online surveys versus paper-based surveys in the context of this thesis, no significant differences existed in terms of how accurately individuals can communicate sensitive information in both computer-administered and paper-based surveys (Kim et al., 2008; Vereecken & Maes, 2006). However, the respondents reported that online surveys were more engaging than their paper-based counterparts (Nulty, 2008). Nonetheless, the online questionnaire administration did not yield a higher response rate.

The researcher assessed and cleaned the data to identify the integrity, logic, and consistency of the responses, patterns of missing values, and whether the missing data

would affect the analysis adversely. These analytical procedures and their results are described in the next chapter. Finally, the researcher kept a record tracking the history and justification for any changes in the number of survey distributions and collections in each department. The next section explains how the researcher managed the data and used statistical tests according to the thesis objectives.

5.10.2 Methods Adapted to Address Data Collection Challenges

When conducting research, obstacles often arise that need to be overcome. In this study, two main challenges emerged. The first was finding and meeting with an appropriate gatekeeper at KAIMRC. Since the researcher was not affiliated with NGH, finding a gatekeeper who met specific criteria. Despite providing all necessary details via email, some hospital staff had concerns about the researcher's interests and why their facility was chosen for data collection. Hence, as mentioned in the PIL, the researcher reassured them that participation was voluntary and that they could withdraw at any point without consequence. The data were anonymous, so there would be no way to link their responses back to them. The data would be secure, with access limited only to the researcher and supervisors. If participants were uncomfortable sharing deeply personal or traumatic experiences, they were provided contact information for their supervisors and a helpline at the hospital.

Another challenge during the study was the return of several incomplete surveys, as anticipated, which made it difficult to achieve the minimum sample size requirement promptly. The primary reasons for incomplete survey responses were a lack of time, survey fatigue, and a lack of interest in the research topic (Vangeest & Johnson, 2011). Thus, the researcher sent periodic reminders via the gatekeepers to the nurses, which outlined the opportunity to participate online or via paper-based methods. These

reminders were forwarded to the nurses' respective work sites and proved to be an effective strategy. These reminders were initially sent out 14 days after the start of data collection in each city.

The ability to conduct research online presents a unique opportunity to overcome geographical limitations that have hindered researchers. The researcher had limited time and aimed to cover three regions. This method offered access to a broader and more diverse range of participants, which addressed the generalisability often associated with experimental studies, as noted by Iyengar (2011, p. 84). As such, online research was ideal for gathering a more representative sample of nurses across a wider population. Moreover, conducting research online in this study eliminated potential biases that could arise from face-to-face interactions. Hence, the participants might have felt more secure expressing their genuine opinions and experiences in an anonymous online setting when discussing topics related to child abuse. Maintaining the anonymity of participants was crucial, given the subject's sensitive nature, which could lead to more accurate and reliable data collection to further enhance the validity of the study's findings.

The COVID-19 pandemic presented a host of challenges in the context of this study, including issues related to accessing study sites and recruiting potential participants. In response to the pandemic, SA established several strict public health measures, such as requiring individuals to travel to the country fully vaccinated and undergo mandatory quarantine for seven days (Alyahya, 2021). These restrictions posed a significant challenge to data collection, particularly for those who received the COVID-19 vaccine outside of SA. Therefore, the researcher was required to register their vaccination with the Saudi Ministry of Health and use the Tawaklna mobile app, the official COVID-19 application used to prevent the spread of the virus. Obtaining a vaccination certificate through this process took up to two weeks and was necessary for

quarantine-free travel. As a result, limited time was available to collect data from three cities.

Hard copy and online surveys were utilised to overcome these limitations. Moreover, the surveys were distributed in person as hard copies to guarantee a comprehensive and diverse sample from multiple hospitals. Additionally, an online survey was crafted to reach a wider audience via phones or computers, with the flexibility of allowing participants to complete it at their leisure using any device. This strategy facilitated a larger sample size and enabled data collection from individuals who could not participate in person. By combining physical and online surveys, the researcher was able to obtain comprehensive data despite the limited time available for data collection.

5.10.3 Data Management

Before analysing the data, the researcher carefully reviewed all completed questionnaires to ensure no data were missing. Quality checks on the data were crucial to assess the representativeness and reliability of the analysis results (Virdee et al., 2020). Afterwards, the gathered information was entered into SPSS version 28 and coded by the researcher. Each piece of data was matched with its corresponding questionnaire to ensure accuracy. A codebook was developed to record all data labels. Descriptive details on all variables were generated, including counts for demographic variables using frequencies and proportions. The data were analysed for missing values and outliers using various methods, such as examining frequencies, minimum and maximum values, and measures of central tendency. All testing and analysis were discussed with supervisors and a statistician to guarantee their validity.

In conclusion, the comprehensive approach to data collection indicates the researcher anticipates and proactively addresses common survey research challenges. The survey was completed, and meaningful results were obtained despite obstacles.

5.11 Data Analysis

The researcher used the Statistical Package for Social Sciences (SPSS) software version 28 to analyse the collected research data. Using SPSS enabled the researcher to handle a larger sample size, create diverse charts and graphs, and conduct appropriate statistical tests. The researcher entered the data into SPSS and assigned a unique code to each response. This coding process allowed the researcher to easily organise and categorise the data for further analysis. Figures, charts, and tables were then used to represent the demographic profile of the respondents. The data were subsequently analysed using the descriptive and inferential statistical tests outlined in section 5.11.2. Furthermore, the researcher calculated the results for each survey question based on the number of participants who provided a response. This is a common approach in quantitative research, as it allows the researcher to account for any missing data and provide a clear picture of the overall sample size for each variable (Pallant, 2020; Tabachnick et al., 2019)

5.11.1 Scoring and Analysis of Study Instruments

The thesis utilises the CANRSE questionnaire to explore the impact of CAN training on nurses' ability to detect and report child abuse and neglect. This section explains the scoring method for the questionnaire, specifically the sum scoring approach, and outlines the analysis plan for the free text sections. This scoring method provided a comprehensive strategy for analysing the quantitative and qualitative data, which needed to be correct to ensure accurate results. By consulting with a statistician with expertise in psychometric scales, researchers can ensure the scoring is correct per established guidelines (Aithal & Aithal, 2020) to maintain the integrity and reliability of the study findings, and

representative of the target population. The scoring methodology for each section is explained in Appendix Q. This includes the step-by-step process for calculating the sum scores, as well as subscale calculations. The next section discusses the statistics analysis used in this study, including descriptive analysis, and inferential analysis. For the free-text sections, a thematic analysis approach was employed to identify common themes and patterns in the responses (Braun & Clarke, 2006).

5.11.2 Statistic Test Used

The application of the CANRSE questionnaire required a careful selection of psychometric tests to interrogate the data. The tests were evaluated based on their validity, reliability, and relevance to the measured constructs. Established criteria were used to identify the most suitable tests, including their psychometric properties and theoretical alignment with Bandura's concept of self-efficacy. Experts in statistics from the School of Nursing and Midwifery, Trinity College Dublin, and external statistical experts in University College Dublin were consulted to ensure that the selected tests effectively capture the multidimensional nature of self-efficacy in reporting CAN cases. Through this comprehensive assessment, the CANRSE questionnaire accurately and reliably measured self-efficacy related to reporting child abuse and neglect, which made it a valuable tool for research and practice in the field of child protection. The table 6 below describes each research objective, the statistical test used to address the objective, and the rationale for selecting each test.

5.11.3 Descriptive Analysis

Conducting a descriptive analysis to better understand the data involves examining its characteristics and summarising its main features. It was employed for this study to analyse the demographic data and to assess nurses' knowledge of the law regarding CAN. This analysis involved tabulating, illustrating, and describing the data collected from the sample. The purpose of this test was to present a clear understanding of the data's properties and to summarise it into an easily manageable form. The descriptive analysis provided information on the fundamental features of the data, including range, minimum and maximum values, and frequency. Additionally, it included measures of central tendency, such as mean and median, which helped to understand the typical characteristics of the data. The mean provided the average value, the median provided the middle value, and the mode provided the most frequently occurring value. By analysing these measures, the researchers gained insights into the central tendency of the data. Measures of dispersion, such as standard deviation, skewness, and kurtosis, allowed the researcher to understand the data distribution.

5.11.4 Inferential Analysis

The researcher used inferential analysis to examine the relationship between variables in this study. The table below summarises the study's objectives, the appropriate statistical tests, and the reasons for choosing each test (see Table 6).

- The Mann-Whitney U test was employed to assess differences in the overall mean score of study variables, specifically those trained group who participated in (any CAN training or/and CPMTP) and those who did not. This allowed the researcher to explore the potential impact of the training program on nurses' self-efficacy (SE) to detect and report child abuse and neglect. This non-parametric

test compares differences between two independent groups when the dependent variable is ordinal or continuous but not normally distributed.

- The Kruskal-Wallis H test is a non-parametric statistical test used to determine if there are statistically significant differences between the medians of three or more independent groups. This non-parametric method is appropriate for the ordinal nature of the data, ensuring accurate and reliable results without the need for normally distributed data. In this study, it is applied to assess whether the understanding of the consequences of reporting child abuse and neglect differs significantly between different job roles among nurses. The Kruskal-Wallis test was used in this study to assess differences in professional self-efficacy across groups defined by personal characteristics.
- The chi-square test of independence is used to examine whether the distribution of individuals across various categories (e.g., have made a report of CAN in the past) is related to training experiences. This test helps identify any significant associations between these categorical variables.
- The chi-square test of independence is also used to examine whether the distribution of individuals across various categories (e.g., attended any formal training, CPMTTP) is related to demographic or professional attributes (e.g., gender, age, nationality). This test helps identify any significant associations between these categorical variables.
- The Independent Samples t-test used to compare mean self-efficacy scores between two groups for each question, self-efficacy (GSE), and job position. It determines whether the observed means differences are statistically significant. This helps to

understand the impact of specific experiences or behaviours on perceived self-efficacy.

- Regression analysis was conducted, following steps: The first step was to specify the dependent variable - the mean total score representing participants' attitudes and feelings towards CAN reporting. This was calculated by having participants complete a 10-item Likert scale survey on this topic. Then, the mean total score for the Likert scale was calculated by computing a new variable to represent the mean total score (using SPSS). Target Variable: Mean Attitude Feeling. A new variable called "MeanAttitudeFeeling" contains the mean score. Use the Function group: Statistical, then Functions and Special Variables: Mean, then in the Numeric expression: (item1 + item2 + ... + item15), then calculate.

The independent variables in the regression model were the participants' efficacy expectations for reporting suspected CAN cases. In addition, they had efficacy expectations for reporting known CAN cases and outcome expectations regarding the consequences of reporting CAN. These variables were measured using separate scales and computed as mean scores in a similar manner to the dependent variable.

- Using SPSS statistical software, the researcher set up multiple linear regression. This was done with the mean attitude/feeling score as the dependent variable and the three expectation variables as independent predictors. This allowed them to determine the extent to which each type of efficacy and outcome expectation uniquely contributed to explaining the variance in attitudes and feelings towards CAN reporting. The software produced various statistics, including unstandardized coefficients (B), standardized coefficients (Beta), t-values, and significance levels (p-values).

- The descriptive analysis provided a straightforward summary of the nurses' knowledge of the law regarding CAN reporting. This method highlighted the average knowledge level and the distribution of scores, helping to identify areas where further education or training might be needed.

To sum up, the Kruskal-Wallis H test, Mann-Whitney U test, regression analysis, and descriptive analysis are well-suited for the study's objectives and data characteristics. The Kruskal-Wallis H test handle non-parametric, ordinal data for multiple groups, while regression analysis examines relationships between variables. The Kruskal-Wallis test is a non-parametric alternative to the one-way ANOVA, and it is used to determine if there are any statistically significant differences between two or more groups when the dependent variable is ordinal or continuous, but the data does not meet the assumptions of a parametric test. Descriptive analysis provides a clear summary of knowledge levels. Together, these methods offer a comprehensive inferential analysis of the study's data, providing valuable insights into nurses' efficacy expectations, understanding of CAN consequences, confidence in reporting, and knowledge of relevant laws. These findings will be elaborated upon in Chapter 6.

Table 6
Objectives of the Study with Appropriate Statistical Tests

Objectives	Test	Reasons

Role of training on nurses' SE in detecting and reporting suspected and known CAN cases, especially when comparing groups with different training experiences	Mann-Whitney U test	Not assume a normal distribution of the data Compare two independent groups Ordinal data Small sample size
Nurses understanding of the consequences for the child and their family of reporting CAN cases	Kruskal-Wallis test	Non-parametric nature Multiple group comparisons based on the type of abuse (physical, sexual, emotional, neglect, and domestic violence) and nursing positions (Charge Nurse, Staff Nurse, Supervisor, Other) Ordinal data is based on a scale of 0–10
Confidence when reporting suspected and known CAN cases	Regression analysis	For examining the relationship between a dependent variable and one or more independent variables In the context of this study on confidence when reporting suspected and known CAN cases
Relationship between personal characteristics and professional self-efficacy in nurses	Kruskal-Wallis test, post hoc pairwise comparisons to pinpoint where the differences lie between groups	Non-parametric data Multiple independent groups Ordinal or scale data
Assess nurse's knowledge of the law about CAN reporting in Saudi Arabia	Descriptive analysis	To summarise and describe the central tendency and variability of the nurses' knowledge scores

5.11.5 Qualitative Data Analysis for the Free-text

The open-ended questions in this survey were generated when participants either selected “other” as a response option and provided additional information or answered a qualitative question. A combination of inductive and thematic analysis was used to analyse the qualitative data, based on Braun and Clarke's six-phase approach to thematic analysis (Braun & Clarke, 2006). The six phases included becoming familiar with the data, preliminary coding, searching for potential themes, assessing themes, refining and

defining themes, and finalising codes and themes. The researcher and the statistician generated preliminary codes, and illustrative quotes related to these codes were extracted.

Next, the researcher and the statistician independently coded the responses. They then collaboratively discussed codes and quotes. To systematise and code open-ended responses, they utilised Microsoft Excel, a versatile tool widely used in research. All coding discrepancies were resolved, and the two reviewers independently grouped individual codes into themes, finalising them by consensus.

Finally, a descriptive definition of each category was created. The results chapter presents a comprehensive analysis of the themes, including a detailed report on the frequency and number of codes reported within each theme. The researcher followed a rigorous and well-established approach to analysing the open-ended survey responses, involving collaboration, independent coding, theme development, and comprehensive reporting of the qualitative findings.

5.12 Ethical Considerations

This study was approved by the KAIMRC in Riyadh (Protocol Number: SP21R/204/05) and the Research Ethics Committee of the Faculty of Health Sciences at Trinity College Dublin. Prior to commencing the study, the researcher engaged in a comprehensive consultation process with various stakeholders. This collaborative effort involved some KAIMRC staff, nursing directors, and relevant NFSP members, ensuring the research was conducted ethically and with cultural sensitivity. The researcher also sought input from field experts to bolster the study's validity and reliability. This inclusive approach allowed the study to benefit from diverse perspectives, which led to more robust results. This approach involved a series of meetings over time to build relationships and facilitate the processing of the study and data collection. The study was

conducted in three regions under the Ministry of National Guard-Health Affairs (MNG-HA), which operates under KAIMRC's purview, with sub-offices established in Riyadh, Al Ahasa, Dammam, and Jeddah regions of SA.

Per MNG-HA regulations, the researcher (who was not an MNG-HA employee) had to locate and coordinate with a gatekeeper at each site. The gatekeeper was required to hold a research position as an associate scientist, consultant physician, assistant professor, or above and protect the interests of participants to ensure they were not under any pressure to participate. The researcher was also required to be qualified and have a valid International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH-GCP) certification: the Guideline for Good Clinical Practice (GCP; Appendix R). The GCP is an internationally agreed standard that ensures ethical and scientific quality in designing, recording, and reporting trials that involve human subjects. The course consisted of 12 modules and was based on the principles of the (ICH-GCP) and the Code of Federal Regulations for clinical research trials in the United States. The researcher obtained certification for completing research with integrity while conducting the study (Appendix S). This certification ensured that the researcher thoroughly understood the ethical considerations and regulatory requirements of conducting research.

When conducting research involving individuals, researchers need to consider ethical concerns, so a Code of Ethics was established to protect the well-being of participants. The present study was based on the ethical principles outlined in the Belmont Report (1979), created by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research. The Belmont guidelines rest on three core ethical principles: respect for individuals or autonomy, beneficence, and justice. The following section explores how these principles guided the conduct of this study. The

researcher had to receive training in this area from the National Institutes of Health. In the context of this research, these principles were key to ensuring that participants were treated with dignity and independence, protected from harm, and shared in the benefits of scientific inquiry.

Respect for autonomy means that participants are free to make informed choices about whether to participate in the study. In this thesis, the researcher distributed an invitation form outlining the study's goals and rationale before conducting a survey. Everyone who wanted to participate in the study was treated fairly and included. There was no coercion or manipulation used to get them to join. All inquiries were welcome, and participants were free to withhold information or drop-out of the research at any time without repercussions. Participants' privacy was protected through the anonymity of the poll. Additionally, the permission form clarified that the information participants provided would not be shared with other parties or used for any purpose other than this study. The information was de-identified so that no one respondent could be identified. Participants were not required to sign the consent form to protect the privacy of their information. Instead, there was a checkbox on the permission form for participants to indicate their agreement to participate in the research. As a result, the completed surveys provide evidence that the participants knowingly and voluntarily consented to being surveyed.

When working with human beings, it is essential to always ensure their safety. Participants' rights were protected in this study in several ways, including the researcher's training in this area, the inclusion of the researcher's contact details for any questions about the survey's content, and an informed consent form (Appendix P) that explicitly stated that participants' responses would not be used for any purpose other than this study. Data handling and storage were conducted per the Data Protection Act 2018 (Appendix O) and the university's ethical norms. Nothing of a personal nature was recorded, and all

appropriate precautions were taken to that end. Finally, the data obtained were kept secret and only utilised for the study's stated aims. The researcher will disseminate the study's results via scholarly lectures and publications, but no personal information about the participants will be shared.

Beneficence requires researchers to minimise harm to participants while maximising benefits to society. The researcher crafted respectful and non-invasive questions and ensured participants had access to help and resources if needed. Furthermore, the researcher had procedures to provide help and resources to participants who exhibited discomfort or suggested they were suffering. If they felt down or needed help, the study participants were told to call the hospital's social staff hotline. Justice requires that the benefits and risks of research be shared fairly among participants. In this study, the researcher recruited nurses with specific criteria, such as the requisite skills and experience, to provide meaningful insights into suspected cases of CAN. Exclusion criteria were carefully established to ensure the validity of the survey findings. By upholding these ethical ideals, the researcher obtained valuable insights into a critical healthcare issue while ensuring that participants were protected and treated with respect.

5.14 Conclusion

This chapter discussed the methodology and methods used in conducting the study. The first sections explained the plan for the research study, including a detailed explanation of the research design, a description of the setting, participants, and survey instruments. This section was followed by an explanation of data collection procedures and the data analysis plan. The methods employed in this study were carefully chosen to ensure reliable and valid data collection and included a survey and data analysis techniques such as regression analysis. The next chapter provides a detailed explanation of each method and how they were applied in this thesis.

Chapter 6: Results

This chapter presents the outcomes of the data analysis that assesses the impact of child protection training on nurse self-efficacy in identifying and reporting child abuse cases. The results are reported in two sections: Section 6.1 reports on the demographic responses, while section 6.2 presents the inferential statistical results.

The study variables were based on the CANRSE (Colgrave et al., 2020), which is grounded in Bandura's cognitive behaviour theory and consists of two scales: SE-CAN for measuring self-EEs and OE-CAN for measuring OE. SE- CAN is split between EEs for suspected CAN cases (EES) and EEs for known CAN cases (EEK). The CANRSE consists of six domains: demographic variables, attitudes and feelings about reporting, education and training experiences, knowledge of the law, intended reporting behaviour, and the GSE scale.

6.1 Section A: Response Rate

The study achieved an overall response rate of $n = 247$ (77%). Of the respondents, 202 completed hard-copy questionnaires, while $n = 45$ chose to respond online. The results reported below are based on the decision to include all completed questionnaires in the analysis.

6.1.1 Demographic Results

Descriptive statistics were employed to analyse the participants' answers to all the sections and questions in the questionnaire, beginning with the demographic section.

6.1.2 Section A: Demographic Characteristics

Most participants were female, comprising 96.8% (n = 239) of the total group. This gender disparity reflects the nursing staff composition in Saudi Arabia. Participants were divided into three age categories: 26–35 years old (n = 130, 52.6%), 36–45 years old (n = 54, 21.9%), and 46–55 years old (n = 42, 17%). Additionally, (n=200, 81%) of respondents identified as non-Saudi. Most participants were married (n=132, 53.4%) and a small percentage (n=19, 7.7%) had completed postgraduate studies. Of the total group, (n=126, 51%) had children, and (n=73, 57.9%) of those had only one child. Table 7 below provides more details on the demographic data.

Table 7 *Demographic Data*

Characteristic	n (%)
Gender (n = 247)	Male
	8 (3.2%)
	Female
	239 (96.8%)
Age (n = 247)	18-25
	7 (2.8%)
	26-35
	130 (52.6%)
	36-45
	54 (21.9%)
	46-55
	42 (17.0%)
	>55
	14 (5.7%)
Nationality (n = 247)	Saudi
	35 (14.2%)
	Non-Saudi
	200 (81.0%)
	Prefer not to say
	12 (4.9%)
Marital Status (n = 247)	Single/separated/widowed
	110 (44.5%)
	Married
	132 (53.4%)
	Prefer not to say
	5 (2.0%)
Education level (n = 247)	College Certificate/Diploma
	148 (59.9%)
	Undergraduate
	80 (32.4%)
	Postgraduate
	19 (7.7%)
Parental Status (n = 247)	Parent
	126 (51.0%)
	Not Parent
	121 (49.0%)
If yes, how many children do you have? (n = 126)	1
	73 (57.9%)
	2
	27 (21.4%)
	3 or more
	26 (20.6%)

6.1.3 Section B: Employment Details

Table 8 shows the employment details of the nurses participating in the study. The highest number of respondents (n = 187, 78.9%) held the job title of staff nurse. A total of (n=165,68.2%) of the respondents worked in the central region, and (n=73,30.3%) had over 10 years of experience in the nursing profession (Table 8).

Table 8

Job Details

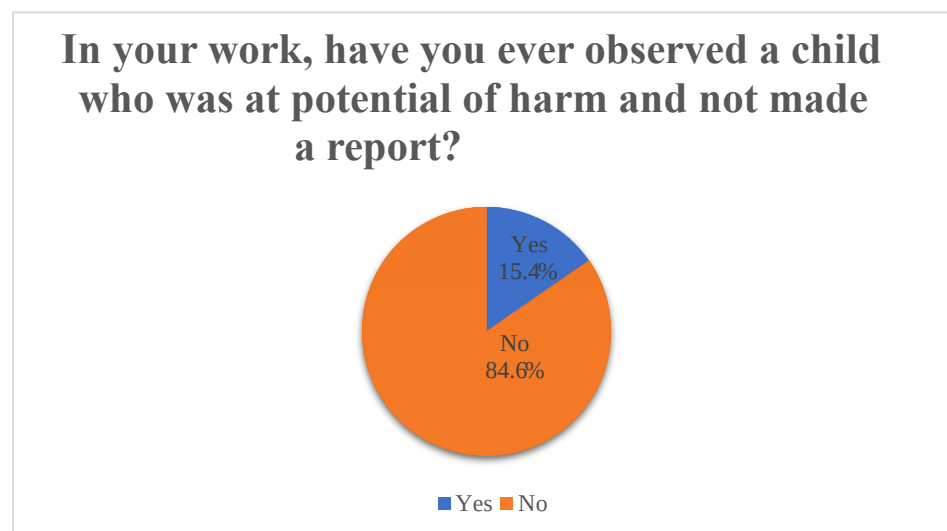
Job Details		n	%
Job title (n = 237)	Charge nurse	31	13.1
	Staff Nurse	187	78.9
	Supervisor	11	4.6
	Others	8	3.4
Are you now or have you been employed in paediatrics? (n = 241)	No	29	12.0
	Yes	212	88.0
Workplace location (n = 242)	Central region	165	68.2
	Eastern region	31	12.8
	Western region	46	19.0
Including this year, how many years have you worked in the paediatrics. Department? (n = 241)	1–3 years	52	21.6
	4–7 years	71	29.5
	8–10 years	45	18.7
	10+ years	73	30.3

6.1.4 Section C: Clinical Experience of Cases with CAN

Figure 5 shows that most respondents (n = 204, 84.6%) had never observed a child at potential risk of harm and had not made a report. Conversely, (n = 37, 15.4%) of the participants had observed an abused child and not made a report in such a situation (Figure 5).

Figure 5

Clinical Experience of the Cases



In the qualitative comments, eight respondents provided reasons for having observed an abused child and not making a report. These reasons were categorised under challenges in the reporting process, absence of abuse evidence, and other reasons, as in the following quotations:

- Challenges in the reporting process:
“Reported to Medical Records Clerk (MRC) but often in registration, they concluded it does not abuse” (Participant 108)
- Presence of abuse evidence:

“It was clearly abuse, but the parents were lying and gave a different story”(Participant 18); “uncertain fact”(Participant 11).

- Other reasons for not reporting:

“He was seen outside the clinic” (Participant 33); “The patient obeyed not to harm anybody if talk nicely”(Participant 25).

“Parent denied”(Participant 30); “cultural issues”(Participant 168); “time-consuming”(Participant 38).

6.1.5 Section D: Attitudes and Feelings Regarding the Reporting Decisions

Table 9 presents the study’s outcomes on nurses’ attitudes and feelings towards reporting cases of CAN. The researcher used a weighted mean calculation, aggregating scores, and discussed the outcomes with the supervisory team and statistical experts for evaluation and feedback. The responses ranged from 1 to 5, where 1 represented strong disagreement, and 5 indicated strong agreement. The scores were averaged to determine the overall response to the survey queries. Based on Thompson & Elmes (1998), the following equation was used to determine the degree of response of the study sample to each item in the questionnaire and establish the length of the level category for comparing the average responses: the upper limit of the response (5) – the lower limit of the response (1) / the number of levels (5) = $(5 - 1) / 5 = .8$. The categories were as follows: 1 to 1.80 for strong disagreement, 1.80 to 2.60 for disagreement, 2.60 to 3.40 for neutrality, 3.40 to 4.20 for agreement, and 4.20 to 5 for strong agreement.

The data indicated that most respondents displayed an unfavourable disposition towards all items, except for item 2, which had a neutral average score of 2.66 ± 1.193 . Conversely, item 9 obtained the most disagreement, with a score of 1.84 ± 0.884 . The collective attitudes and feelings regarding reporting yielded a mean score of 2.19 ± 0.688 ,

which indicated that the respondents generally disagreed or strongly disagreed with reporting in these situations (Table 21, Appendix U).

6.1.6 Section E: Work Environment

This survey section explored how the work environment supported staff who reported incidents involving CAN. Participants were asked if they had reported such cases and if they had supported colleagues who did. The results, presented in Table 9, indicate that a significant majority (n=144,72.4%) of the participants had never provided support to a colleague who reported child abuse or neglect, while (n=55,27.6%) had done so in such scenarios.

Similarly, (n=144,75.5%) of participants had not reported any cases of child abuse or neglect in the past, while (n=59,24.5%) had. In cases where an incident was reported, the support came from colleagues (n = 30, 85%), supervisors (n = 14, 46%), team leaders (n = 11, 36.7%), managers (n = 18, 56.3%), and other supporters (n = 3, 15.8%). Only (n = 2, 8.7%) reported receiving no support. For participants who did not report any incidents, the majority felt supported by colleagues for reporting (n = 158, 88.3%), while (n = 52, 26.9%) felt supported by their supervisor, (n = 77, 39.5%) by their team leader, and (n = 107, 55.4%) by manager. However, (n = 44, 22.8%) felt unsupported (Table 9).

Table 9 *Nurses' Responses About Work Environment*

(n = 241)		n	%
Have you ever supported a fellow staff member who reported child abuse or neglect?	Yes	55	27.6
	No	144	72.4
Have you made a report of (child abuse or neglect) in the past?	Yes	59	24.5
	No	182	75.5
A- Have reported (n = 59)			
Were you supported by your colleagues for reporting?	Yes	30	85.7
	No	5	14.3
<i>Were you supported by supervisor, team leader, or manager when reporting the suspected child abuse or neglect?</i>			
Supervisor	Yes	14	46.7
	No	16	53.3
Team leader	Yes	11	36.7
	No	19	63.3
Manager	Yes	18	56.3
	No	14	43.8
No one	Yes	2	8.7
	No	21	91.3
To others	Yes	3	15.8
	No	16	84.2
B- Not Reported (n = 182)			
Do you feel that your colleagues would support you in reporting suspected child abuse or neglect?	Yes	158	88.3
	No	21	11.7
<i>Do you feel that your supervisor, team leader, or manager would support you in reporting suspected child abuse or neglect?</i>			
Supervisor	Yes	52	26.9
	No	141	73.1
Team leader	Yes	77	39.5
	No	118	60.5
Manager	Yes	107	55.4
	No	86	44.6
no one	Yes	44	22.8
	No	149	77.2

The nurses' responses about their experiences with reporting CAN and supporting colleagues who reported such cases were in their responses about the work environment domain (Section E). For the 24.5% (n = 59) of the participants who had reported CAN (Table 9), the researcher examined the correlation between training on child abuse and neglect and the likelihood of reporting such cases.

Table 10 shows that A Chi-Square test of independence was used to analyse the relationship between having received CAN training and the reporting behaviour of participants. The Chi-Square test revealed a significant association between having CAN training and the likelihood of reporting child abuse or neglect, $\chi^2(2, N = 224) = 33.155$, $p < .001$. The contingency coefficient of .349 indicates a moderate association between the variables.

The data suggest that there is a significant association between having received CAN training and the likelihood of reporting child abuse or neglect. The majority (62.1%) of participants who had not undergone CAN training did not report abuse or neglect. This highlights the potential impact of CAN training on reporting behaviours and underscores the importance of training in enhancing reporting practices.

Table 10 Association Between Reporting Abuse and Neglect and Training

		Have you made a report of (child abuse or neglect) in the past?			N	Chi-Square	P-Value	Contingency coefficient
		YES	NO					
Have you had CAN training	Not Sure	2(.9%)	15(6.7%)	717(7.6%)	33.155	<.001		.349
	No	25(11.2%)	139(62.1%)	164(73.2%)				
	Yes	24(10.7%)	19(8.5%)	43(19.2%)				
Total		51(22.8%)	173(77.2%)	224				

Respondents reported facing barriers to reporting, as evidenced by their responses to qualitative questions. In the qualitative comments, 75 respondents provided reasons/explanations for these barriers, which were categorised under knowledge, policy, and other barriers as the following quotations:

- Knowledge: Eight respondents – Reasons related to knowledge: “*Lack of knowledge of how to report*” (Participants 15, 27, 29, 30, 109, and 130); “*No knowledge about the policy*” (Participant 29); one nurse (Participant 11) mentioned the “*Lack of evidence of the event*”.
 - Concerning Participant 25’s response: “*No training available*”.
- Policy: Nineteen respondents mentioned reasons related to the reporting policy “No support” (n = 4; Participants 17, 18, 19, and 29); “*Fear to be involved in the situation*” (n = 2; Participants 18 and 29); one participant wrote, “*Maybe for some fear of being involved in a severe matter and legal issues, but the hospital has a policy, and I believe that everyone reporting child abuse is being well protected and support*” (Participant. 220); “*Some cases have been reported to the SCAN team and from the admission office*” (Participant 120); “*Sometimes, we do not hear any follow-ups to what extent the case has gone*” (Participant 99); “*Lack of access for reporting*” (Participant 88); “*If the consultant is resistant to report the cases*” (Participant 89); “*Reporting is a long process*” (Participant 38); “*People come the make small things complicated*” (Participant 60); “*Consider legality issue*” (Participant 20); “*The attitude of the abuser toward the caregiver*” (Participant 34); “*Most parents want to avoid making a report*” (Participant 13); and “*Being the junior*” (Participant 44); “*Not in the hospital policy*” (Participant 33).
- Other barriers (n = 30):

- Communication (n = 1; Participant 7)
- Language (n = 4; Participants 27, 30, 58, and 80)
- Fear (n = 11): “Fear” (Participants 4, 10, 11, 15, 18, 22, and 23); “Fear of being victimised by family” (Participants 26, 29, 35, and 44)
- Time-consuming (n = 5); Participants 8, 19, 30, 109 and 38; “*Takes time with the workload*” (Participant 13)
- Lack of support (n = 6; Participants 17, 18, 19, 25, 26, and 133)
- Workload (n = 1; Participant 13)
- Cultural: One nurse (Participant 8) wrote, “*It’s not easy to report because of the culture that this country has . . . in some instances, we can tell the doctors what we observed or notice that patients might be abused by their families*”. Some nurses mentioned barriers related to the family. One nurse (Participant 25) wrote, “*Not reported because of the family background*”; Participant 20 noted the “*Attitude of the abuser to the care giver*”.

Responses were received from 17 participants regarding the support provided to a fellow staff member who reported a case of CAN. The following themes were identified in the analysis: providing informational support, encouraging and facilitating reporting, and raising awareness and encouraging reporting:

- Providing informational support: Six respondents mentioned reasons related to providing informational support. One nurse (Participant 8) wrote, “*They recommended that the physician consult the Suspected Child Abuse and Neglect (SCAN) team*”; Participant 11 said, “*I informed my supervisor, police, authorities, and the doctor*”; Participant 54 offered, “*I encouraged her to*

report the issue for patient safety"; Participant 212 referenced *"by guiding them to contact and report to the admission team"*; Participant 20 believed that *"the doctor will consult suspected child abuse cases to the SCAN team"*; Participant 15 noted, *"I informed them how to observe the child and gather information from the mother about the usual daily routine at home"*.

- Encouraging and facilitating reporting: Eight respondents mentioned reasons for encouraging and facilitating reporting. One participant wrote about *"Providing support to report child abuse or neglect to improve the case and prevent it from happening"* (Participant 78); *"By asking her to report to higher authority"*(Participant 56); *"Reported MRC, social worker, and SCAN team"* (Participant 83) *"With admission, inform SCAN"* (Participant 20); *"Consult the SCAN team"* (Participant 21); *"I went with her and asked the parent, and we informed the senior doctor"* (Participant 29); *"Emotional support"* (Participant 33); *"Moral support"* (Participant 98).
- Awareness and encouragement of reporting CAN cases: Three respondents mentioned providing support to a fellow staff member for awareness and encouragement of reporting: *"We are witnessing any signs that result in suspected neglect and abuse"* (Participant 9); *"We are encouraging reporting"*. (Participant 33); *"I always ask the staff to report"* (Participant 83).

6.1.7 Section F: Nurses' Training Experiences

Table 11 below displays the summary statistics for nurses' training experiences. The findings showcase that a significant portion of respondents, 73.2% (n = 164), did not receive any formal training relating to CAN cases. In contrast, 19.2% (n = 43) of

respondents participated in formal training sessions concerning CAN, with 10.4% (n = 23) attending the CPMTP dedicated to CAN cases (Table 11).

Table 11 Nurses' Training Experiences

Training Experiences		n	%
Have you had any formal training specifically related to (child abuse and neglect and/or child protection)?	Not Sure	17	7.6
	No	164	73.2
	Yes	43	19.2
Have you attended "Child Protection Multidisciplinary Training Programme (CPMTP)"?	No	199	89.6
	Yes	23	10.4

In Table 24/Appendix X, description information was provided for two groups of participants, including (trained group) those with formal training and those participating in the CPMTP, along with a group not involved in either training (untrained group). The data showed that most respondents were female, with 98% of those receiving formal training and 97% without formal training being female. Additionally, a significant percentage of respondents (72–96%) currently worked in paediatric care. The highest percentage (17%) of CAN cases was observed among those who received multidisciplinary training. The percentage of Saudis with multidisciplinary training was 22%, slightly higher than the 19% with formal training. Among the staff nurses, 77% had multidisciplinary training, considerably higher than the 14% of charge response rate nurses who had the same training.

Chi-square tests were conducted to determine if there was a statistically significant association between the demographic data and attendance at the training course (Appendix X). A statistically significant association was found between education level and CPMTP attendance ($p < 0.05$). Nurses with higher education levels (postgraduate) were less likely to attend training than those with undergraduate qualifications (Bachelors degree). These findings suggested that educational attainment may influence CPMTP attendance.

A strong association was observed between paediatric work experience and attendance at any formal training on CAN ($p < 0.001$). Nurses with paediatric work experience were significantly more likely to receive formal training than those without such experience. In light of this finding, it was clear that work experience in paediatric areas plays an important role in shaping training needs and participation in educational programmes.

The analysis revealed a significant association between workplace location and attendance at any formal training on CAN ($p < 0.003$). Nurses working in the Central region were significantly more likely to receive formal training than those in the Eastern and Western regions (Appendix X). This geographical variation in training rates warrants further investigation to understand the underlying factors. The results indicated that demographic factors such as education level, paediatric work experience, and workplace location were significantly associated with nurses' attendance at CAN training courses. These findings highlighted the importance of considering these factors when developing targeted training initiatives.

6.1.8 Section G: Knowledge of the Law

The responses relating to the participants' knowledge of the law about CAN reporting in SA are presented in (Table 23, Appendix W). Out of N = 247 participants, 164 (70.7%) responses stated that reporting abuse or mistreatment of a child or young person who is at risk of physical or sexual harm is mandatory. Additionally, most participants, 196 (86.3%), stated that they were required to report suspected abuse or neglect of a child or young person under circumstances that relate to a series of acts of abuse or omission of basic needs.

The study further explored the amount of knowledge required before one is mandated by legislation to report. Most respondents (n = 129, 55.4%) indicated that it is reasonable to suspect a child is at risk of abuse even in the absence of evidence of the abuse. Regarding the level of harm that must occur before mandatory reporting is required, many participants (n = 131, 56.7%) believed that the harm to the child or young person must be significant.

In terms of reporting cases, most respondents (n = 155, 68.9%) indicated that they would consider reporting child abuse if it were likely to occur in the future, even if it had not yet happened. Moreover, most (n = 154, 67.2%) believed that they would seek further information about harm to a child to work out a duty to report, such as consulting a colleague about the harm to a child.

When asked whom to report to if the legislative duty to report CAN were activated, the SCAN team was the most commonly reported entity (89.5%), followed by reporting the relevant details about the cases to the hospital social services department (54.6%). Additionally, a significant proportion of respondents (57.9%) believed that their identity as the reporter was usually protected from disclosure if they reported in good faith.

Table 23 reveals that a significant portion of the participants (71.9%) were uncertain about the highest penalty they could be imposed by law if they failed to fulfil their reporting obligations. Furthermore, 58.1% of those surveyed were unsure if they could face prosecution and be liable for damages if they made a good faith report that could not be substantiated. Additionally, 59% of respondents did not consider vilification liability related to mandatory reporting, while 57.3% were unsure about the connection between mandatory reporting and criminal behaviour.

6.1.9 Section H: Intended Reporting Behaviour

Table 12 shows the participants' responses towards the intended reporting behaviour through four types of abuse across ten vignettes. All items were rated on a scale from 1 (not at all serious) to 10 (extremely serious). The highest mean score for intent to report was for physical abuse (mean 8.82 ± 1.335), followed by sexual abuse (8.57 ± 1.635), neglect (8.26 ± 1.758), and emotional abuse (8.05 ± 1.695). The majority, 80.1%, indicated that they believed the law required them to report physical child abuse as the highest priority, followed by sexual abuse (71%), neglect (67.9%), and emotional abuse (63.6%). These findings are further illustrated in Table 12.

Table 12 *Intended Reporting Behaviour*

Abuse Type	Vignette	Mean ± SD	Law required to report			Overall Mean/ intent to report (Yes) %
			Yes (n) %	No (n) %	Not Sure (n) %	
Physical Abuse	1st Vignette (Q35)	8.82 ± 1.335	188 (83.2%)	11 (4.9%)	27 (11.9%)	80.1%
	2nd Vignette (Q36)		174 (77%)	11 (4.9%)	41 (18.1%)	
Sexual Abuse	1st Vignette (Q37)		169 (75.8%)	8 (3.6%)	46 (20.6%)	71%

	2nd Vignette (Q38)	8.57 ± 1.635	149 (66.2%)	15 (6.7%)	61 (27.1%)	
Emotional Abuse	1st Vignette (Q39)		138 (62.2%)	24 (10.8%)	60 (27%)	
	2nd Vignette (Q40)	8.05 ± 1.695	112 (50.2%)	46 (20.6%)	65 (29.1%)	63.6%
	3rd Vignette (Q43)		172 (78.5%)	9 (4.1%)	38 (17.4%)	
Neglect	1st Vignette (Q41)		157 (71%)	15 (6.8%)	49 (22.2%)	
	2nd Vignette (Q42)	8.26 ± 1.758	141 (63.8%)	27 (12.2%)	53 (24%)	67.9%
	3rd Vignette (Q44)		151 (68.9%)	21 (9.6%)	47 (21.5%)	

6.1.10 Measures of Efficacy Expectations for CAN – Suspected/Known

Table 13 shows the participants' responses towards the measures of EEs for CAN (Suspected/Known). There were three subscales to measure EEs for (Suspected/Known) cases: the first subscale was “prioritise workload to report”, the second subscale was “support from my colleagues”, and the third was “seek the opinion from my supervisor/manager/team leader to report”. All items were rated on a scale from 0 (not confident at all) to 10 (extremely confident).

Participants reported higher mean scores for their ability to report known child abuse than for suspected cases of child abuse, with average scores ranging from 6.91 ± 2.440 to 7.07 ± 2.209 for known child abuse cases and 6.59 ± 2.409 to 6.69 ± 2.464 for suspected child abuse cases. Participants reported more confidence in their ability to ask for support from their colleagues when reporting known child abuse (physical, sexual, and emotional) than for suspected cases, with the highest confidence reported for suspected child neglect abuse (7.08 ± 2.301). Participants were more confident that they could seek the opinion of their supervisor/manager/team leader to report suspected child abuse, with average scores ranging between 7.19 ± 2.466 and 7.27 ± 2.391 , which were

higher than for known child abuse cases, where average ranged from 7.15 ± 2.385 to 7.19 ± 2.278 . Finally, participants were more confident in their ability to report known child abuse compared to suspected child abuse (Table 13).

Table 13 Responses Towards Measures of Efficacy Expectations for CAN – Suspected/Known

	Suspected			Known		
	n	Mean	Std. Deviation	n	Mean	Std. Deviation
<i>I am confident that I can prioritise my workload to report:</i>						
Child physical abuse	215	6.59	2.409	217	7.04	2.365
Child sexual abuse	216	6.63	2.524	220	6.91	2.440
Child emotional abuse	216	6.59	2.429	220	7.04	2.220
Child neglect	216	6.69	2.464	220	7.07	2.209
<i>I am confident that I can ask for support from my colleagues when I report:</i>						
Child physical abuse	216	6.92	2.556	220	7.00	2.415
Child sexual abuse	219	6.91	2.571	219	6.93	2.487
Child emotional abuse	214	7.03	2.475	219	7.04	2.360
Child neglect	218	7.10	2.413	219	7.08	2.301
<i>I am confident that I can seek the opinion from my supervisor/manager/team leader when reporting:</i>						
Child physical abuse	220	7.25	2.506	220	7.16	2.387
Child sexual abuse	220	7.19	2.466	220	7.15	2.385

Child emotional abuse	216	7.27	2.391	220	7.19	2.278
Child neglect	216	7.27	2.398	220	7.19	2.323
<i>I am confident that I can report:</i>						
Child physical abuse	218	6.80	2.637	219	7.02	2.460
Child sexual abuse	219	6.65	2.751	220	7.00	2.498
Child emotional abuse	218	6.73	2.653	219	7.04	2.419
Child neglect	219	6.82	2.580	220	7.03	2.431

6.1.11 Outcome Expectations for CAN

Table 14 presents the participants' responses on the OE measures for CAN, which ranged from 0 (not confident at all) to 10 (extremely confident). The highest nurse confidence in reporting according to the child's and family's best interest was for child emotional abuse, with means of 7.21 ± 2.199 and 6.54 ± 2.494 , respectively. Conversely, the SCAN team received the highest confidence level from the participants regarding their ability to appropriately respond when reporting CSA, with a mean of 7.05 ± 2.373 .

Table 14 *Confidence Level in Outcome Expectations for CAN*

	n	Mean	Std. Deviation
<i>How confident are you that reporting is in the child's best interest?</i>			
Child physical abuse	220	7.12	2.287
Child sexual abuse	220	7.14	2.295
Child emotional abuse	219	7.21	2.199
Child neglect	219	7.16	2.259
Child exposure to domestic violence	217	7.20	2.265
<i>How confident are you that reporting is in the family's best interest?</i>			
Child physical abuse	219	6.48	2.531
Child sexual abuse	219	6.46	2.553
Child emotional abuse	216	6.54	2.494
Child neglect	219	6.52	2.52
Child exposure to domestic violence	217	6.51	2.537
<i>How confident are you SCAN team will respond appropriately when reports are made?</i>			

Child physical abuse	219	6.97	2.397
Child sexual abuse	220	7.05	2.373
Child emotional abuse	220	7.00	2.318
Child neglect	220	7.03	2.335
Child exposure to domestic violence	220	7.02	2.399

6.1.12 General Perceived Self-Efficacy Scale

Table 15 presents data on the general perceived self-efficacy scale. Respondents were asked to rate ten statements using a 4-point Likert scale, ranging from 1 (not at all true) to 4 (exactly true). Higher scores on the GSE scale were intended to imply higher levels of general perceived self-efficacy. The results indicated that participants scored high on five statements and moderate on the remaining five. The highest mean score was 3.31 ± 0.667 , which corresponded to a high level of perceived self-efficacy (exactly true) and was obtained for item 7, “I can remain calm when facing difficulties because I can rely on my coping abilities”, which was related to coping abilities. On the other hand, the lowest mean score (2.87 ± 0.884) was obtained for the item, “If someone opposes me, I can find the means and ways to get what I want”, which corresponded to a moderate level of perceived self-efficacy (moderately true), with $n = 99$ (45%) respondents answering it as moderately true. The overall mean score of the general perceived self-efficacy scale for the participants was 3.21 ± 0.556 , which corresponded to a moderate level of perceived self-efficacy.

Table 15 *General Perceived Self-Efficacy Scale*

Statements	Not at all true n (%)	Hardly true n (%)	Moderately true n (%)	Exactly true n (%)	Mean	Std. Deviation
Item 1: I can always manage to solve difficult problems if I try hard enough.	7 (3.2)	19 (8.6)	111 (50.2)	84 (38.0)	3.23	0.736
Item 2: If someone opposes me, I can find the means and ways to get what I want.	18 (8.2)	48 (21.8)	99 (45.0)	55 (25.0)	2.87	0.884
Item 3: It is easy for me to stick to my aims and accomplish my goals	4 (1.8)	27 (12.2)	117 (52.7)	74 (33.3)	3.18	0.706
Item 4: I am confident that I can deal efficiently with unexpected events.	- -	22 (10.1)	123 (56.7)	72 (33.2)	3.23	0.618
Item 5: Thanks to resourcefulness, I know how to handle unforeseen situations.	5 (2.3)	28 (12.7)	114 (51.6)	74 (33.5)	3.16	0.727
Item 6: I can solve most problems if I invest the necessary effort.	4 (1.8)	21 (9.5)	109 (49.1)	88 (39.6)	3.27	0.703
Item 7: I can remain calm when facing difficulties because I can rely on my coping abilities.	2 (0.9)	19 (8.7)	107 (48.9)	91 (41.6)	3.31	0.667
Item 8: When I am confronted with a problem, I can usually find several solutions.	1 (0.5)	19 (8.6)	110 (49.5)	92 (41.4)	3.32	0.646
Item 9: If I am in trouble, I can usually think of a solution.	1 (0.5)	21 (9.5)	114 (51.6)	85 (38.5)	3.28	0.649
Item 10: I can usually handle whatever comes my way.	2 (0.9)	21 (9.5)	112 (50.5)	87 (39.2)	3.28	0.668
Self-Efficacy					3.21	0.556

6.2 Section B: Inferential Analysis

6.2.1 The Role of Training on Nurses' Self-Efficacy in Detecting and Reporting

Suspected and Known CAN Cases

The analysis revealed that attending training led to significant differences in EEs for suspected or known cases of CAN nor in OEs. The study compared the efficacy and OEs between two groups of professionals: those who trained group " any CAN training including the CPMTP," and those who had no previous CAN training. The analysis included mean ranks, sum of ranks, and statistical significance as measured by the Mann-Whitney U test. The p-values exceeded the typical threshold of 0.05, which indicated that although attendees had slightly higher mean ranks in all categories, these differences were not statistically significant. Non-parametric tests like the Mann-Whitney U test are more reliable for small sample sizes than parametric tests, which can be sensitive to deviations from normality and other assumptions (Table 16).

A statistically significant difference ($p = 0.013$) was found in EEs for suspected CAN cases between participants with and without training. Individuals who attended training had a higher mean rank (113.65) than those without training (mean rank = 90.40). Hence, training positively impacts one's confidence and perceived effectiveness in identifying and responding to suspected CAN. The analysis also revealed a statistically significant difference ($p = 0.026$) in EEs for known CAN cases between the two groups. Similar to the findings for suspected CAN, individuals who attended training had a higher mean rank (111.76) than those without training (mean rank = 91.00), which indicated that training enhances one's belief in one's ability to effectively handle confirmed cases of CAN.

The significant findings on EEs for both suspected and known CAN cases highlighted the important role of training in enhancing individuals' confidence and perceived abilities to identify, report, and respond to child abuse and neglect. The results for OEs were marginally significant ($p = 0.057$), slightly above the traditional 0.05 threshold for statistical significance. Nevertheless, the trend suggested that individuals who attended training (mean rank = 109.31) might have had higher expectations about the positive outcomes of reporting CAN cases than those without training (mean rank = 91.66). This trend pointed to a potentially positive impact of training on OEs, but the evidence was not strong enough to conclude statistical significance at the 0.05 level.

Table 16 *The Self-efficacy of the trained and untrained groups*

Category		N	Mean Rank	Mean Rank Differences	Mann-Whitney U	Z	Asymp. Sig. (2-tailed)
Efficacy Expectations for CAN-Suspected	No	145	90.40	2.76	2,523.000	-2.490	.013
	Yes	46	113.65				
	Total	191					
Efficacy Expectations for CAN-Known	No	145	91.00	6.42	2,610.000	-2.228	.026
	Yes	46	111.76				
	Total	191					
Outcome Expectations for CAN	No	144	91.66	4.08	2,758.500	-1.905	.057
	Yes	47	109.31				
	Total	191					

Table 17's analysis revealed that attending the CPMTP did not lead to significant differences in EEs for suspected or known CAN cases or outcome expectations. While the p-values for the observed differences in mean ranks were not statistically significant, the findings suggested a potential positive impact of the training on participants'

expectations, with the largest mean rank difference observed for Efficacy Expectations for CAN-Known (6.42), followed by OEs for CAN (4.08), and Efficacy Expectations for CAN-Suspected (2.76). However, despite these observed differences, the p-values for all three comparisons were not statistically significant at the typical 0.05 level, so the differences could not be considered reliable or conclusive.

Table 17 Self-efficacy according to nurses' attended " Child Protection Multidisciplinary Training Programme (CPMTP)", and did not.

Category		N	Mean Rank	Mean Rank Differences	Mann-Whitney U	Z	Asymp. Sig. (2-tailed)
Efficacy Expectations for CAN-Suspected	No	193	107.72	2.76	2,068.5	-0.197	0.843
	Yes	22	110.48				
	Total	215					
Efficacy Expectations for CAN-Known	No	194	107.37	6.42	1915.5	-0.451	0.652
	Yes	21	113.79				
	Total	215					
Outcome Expectations for CAN	No	193	107.58	4.08	2042.5	-0.292	0.77
	Yes	22	111.66				
	Total	215					

6.2.2 Nurses' Understanding of the Consequences for the Child and Their Family of Reporting Child Abuse and Neglect Cases

Numerous factors were identified as key determinants influencing nurses' decision-making process regarding reporting cases of CAN. Foremost among these was their concern for the optimal outcomes of the children under their care and their families. Part 4 of the CANRSE questionnaire encompassed 12 items used to evaluate nurses' CAN-reporting OEs, as outlined in Appendix K. These items included queries aimed at gauging beliefs surrounding CAN reporting and perceived efficacy, with scores tallied on

a 0–10 scale, where 0 represented a complete lack of confidence, and 10 indicated the highest level of confidence. Each abuse type (physical, sexual, emotional, neglect, and domestic violence) was also assessed using the same methodology as previously illustrated in Table 14. Notably, there were no significant disparities in nurses' understanding of the consequences for the child and their family or professional rank when reporting cases of child abuse ($p > .05$), as indicated by a p-value exceeding .05 (Table 22, Appendix V).

6.2.3 Confidence When Reporting Suspected and Known Child Abuse and Neglect Cases

Table 18 shows a comprehensive overview of the results of the linear regression analysis (calculated as described in Chapter 5). This analysis examined how different factors (independent variables), Efficacy Expectations for Suspected CAN cases, Efficacy Expectations for Known CAN cases, and OEs for CAN Cases predicted “attitudes and feelings about reporting” (the dependent variable). Hence, the mean total score for the “attitudes and feelings about reporting” variable was calculated for each participant, which represented the average score across all the items related to the participant's attitudes and feelings about reporting CAN cases (Table 21, Appendix U). Specifically focusing on computing the mean total scores for attitudes using SPSS, the score was derived by summing the mean scores of individual statements to obtain an overall measure of the perceived barriers, which involved using the “Transform” > “Compute Variable” function. The analysis sought to measure how various efficacy and OEs influenced these attitudes and feelings.

The “Unstandardised Coefficients” (B) represented the change in the dependent variable (Attitudes and Feelings about Reporting) associated with a one-unit change in the

respective independent variable while holding the other variables constant. The “Standardised Coefficients” (Beta) represented the change in the dependent variable, measured in standard deviations, associated with a one-standard-deviation change in the respective independent variable, holding the other variables constant. The “t” statistic and “Sig.” (p-value) indicated the statistical significance of each coefficient. A p-value less than the chosen significance level (0.05) suggested the coefficient was statistically significant.

The coefficient for EEs/suspected of CAN was -0.114 . Therefore, per each unit increase in EEs for suspected cases of CAN, attitudes and feelings about reporting decreased by 0.114 units. This relationship was statistically significant ($p < 0.001$). Therefore, as participants perceived self-efficacy in dealing with suspected cases of CAN increased by 1 unit, their positive attitudes and feelings towards reporting CAN cases decreased by 0.114 units. In other words, higher self-efficacy (overconfidence) was associated with lower motivation to report suspected CAN cases.

Furthermore, the coefficient for EEs/known for CAN was -0.147 . Hence, with each unit increase in EEs for known cases of CAN, attitudes and feelings about reporting decreased by 0.147 units. Thus, as participants perceived self-efficacy in dealing with known cases of CAN increased by 1 unit, their positive attitudes and feelings towards reporting CAN cases decreased by 0.147 units. However, this relationship was not statistically significant ($p = 0.205$).

Lastly, the coefficient for OEs for CAN was -0.084 . In other words, for each unit increase in OEs for CAN, attitudes and feelings about reporting decreased by 0.084 units. Hence, as participants’ expectations about the outcomes of reporting CAN cases increased by 1 unit, their positive attitudes and feelings towards reporting CAN cases decreased by 0.084 units. However, this relationship was not statistically significant ($p = 0.300$). The

linear regression analysis revealed that EEs for suspected cases significantly negatively impacted attitudes and feelings towards reporting suspected CAN. In contrast, the relationships between EEs for known CAN cases and OEs for CAN reporting with reporting attitudes were not statistically significant (Table 18).

Table 18 *Linear Regression Result for the Self-efficacy on Attitudes and Feelings About Reporting*

	Unstandardised Coefficients		Standardised Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	2.954	.137		21.622	<.001
Efficacy Expectations for CAN – Suspected	.114	.019	-.382-	-6.065	<.001
Efficacy Expectations for CAN – Known	.147	-1.058	.291	-.072	.205
Outcome Expectations for CAN	-.084	-.726	.468	-.050	.300

F = 36.786, p < .001, R = .382, R Square = 0.148

6.2.4 The Relationship Between Personal Characteristics and Professional Self-Efficacy in Nurses

The personal characteristics of nurses, including age, gender, marital status, length of working experience, and training in CAN (from demographic questions 1–11), and Section F, with Efficacy Expectations for CAN-suspected (Q 45–48), Efficacy Expectations for CAN-known (Q 49–52), OC-E for CAN (Q 53–55), were subject to analysis to establish whether they exerted any influence on self-efficacy in CAN reporting. Table 19 outlines the test results for the difference in mean self-efficacy scores based on personal characteristics.

A statistically significant difference was observed in the mean score of self-efficacy among educational groups ($p < .05$). A Kruskal-Wallis test was conducted, and pairwise post hoc comparison revealed that participants with postgraduates qualifications had the highest mean score in self-efficacy (3.4864 ± 0.56619). In comparison, those with bachelor's degree had a mean score of (3.2337 ± 0.59468). Conversely, no significant difference in self-efficacy was found regarding other personal characteristics ($p > .05$).

Table 19 *Difference in Mean Score of Self-Efficacy According to Personal Characteristics*

Characteristic		n	Mean	SD	p-value
Gender	Male	7	3.5143	.67683	.099
	Female	215	3.2016	.55044	
Age	18-25	7	3.3952	0.68047	.572
	26-35	113	3.2467	0.52063	
	36-45	50	3.2151	0.61948	
	46-55	39	3.1373	0.58384	
	>55	13	3.0145	0.43394	
Nationality	Saudi	31	3.3316	0.57141	.544
	Non-Saudi	180	3.1971	0.54474	
	Prefer not to say	11	3.1081	0.68803	
Marital Status	Single/separated/widowed	104	3.2248	0.55257	.651
	Married	113	3.1926	.54804	
	Prefer not to say	5	3.3600	.86487	
Education level	College Certificate/Diploma	132	3.1618	.52400	.026*
	Bachelors degree	72	3.2337	.59468	
	Postgraduate	18	3.4864	.56619	
Parental Status	Parent	116	3.1905	.56658	.558
	Not Parent	106	3.2344	.54534	
If yes, how many children do you have?	1	69	3.2700	.60069	.087
	2	24	3.1126	.45925	
	3 and above	23	3.0332	.53842	
Job title	Charge nurse	30	3.1642	.61985	.135
	Staff Nurse	172	3.2112	.54214	
	Supervisor	10	3.0989	.39222	
	Others	6	3.6500	.76354	
Are you now or have you been employed in paediatrics?	No	21	3.1392	.44624	.290
	Yes	200	3.2156	.56568	
Workplace location	Central region	148	3.1958	.55810	.771
	Eastern region	31	3.2115	.64466	
	Western region	43	3.2654	.48387	
Working year	1 – 3 years	50	3.2447	.52645	.834
	4 – 7 years	63	3.2422	.55568	
	8 -10 years	41	3.1526	.61623	
	10 + years	67	3.1970	.55075	
In your work, have you ever observed a child who was at potential of harm and not made a report?	No	188	3.2290	.55283	.348
	Yes	33	3.1303	.57145	

*: $p < .05$

6.2.5 Work Environment and General Self-Efficacy

Table 20 presents a comparative analysis of the work environment and GSE for individuals who either supported a colleague who reported CAN or made such a report in the past. Participants who supported a fellow staff member in reporting child abuse or neglect had a significantly higher self-efficacy score ($M = 3.4496$, $SD = 0.59779$) than those who had not ($M = 3.1436$, $SD = 0.53721$). This difference was statistically significant: $t(193) = 3.448$, $p = 0.000$. In contrast, participants who made a report of child abuse or neglect had a slightly higher self-efficacy score ($M = 3.2428$, $SD = 0.55446$) than those who had not ($M = 3.2026$, $SD = 0.55736$). However, this difference was not statistically significant: $t(220) = 0.446$, $p = 0.656$. The findings revealed a statistically significant difference in self-efficacy between those who offered support and those who did not, with the former group exhibiting higher levels of self-efficacy. Hence, providing support to colleagues in reporting cases of child abuse or neglect is associated with higher GSE among nurses.

Table 20 Independent Sample T-Test Results of Comparing the Work Environment Section and General Perceived Self-Efficacy

Self-efficacy		n	Mean	Std. Deviation	t	df	p-value
Have you ever supported a fellow staff member who reported child abuse or neglect?	Yes	54	3.4496	0.59779	3.448	193	0.000**
	No	141	3.1436	0.53721			
Have you made a report of (child abuse or neglect) in the past?	Yes	49	3.2428	0.55446	0.446	220	0.656
	No	173	3.2026	0.55736			

** $p = .01$

6.2.6 Nurse's Knowledge of the Law About Child Abuse and Neglect Reporting in SA

This section aimed to evaluate the respondents' understanding of the laws related to reporting cases of child abuse and neglect (from the CANRSE questionnaire Section K, Q21–34). The details are presented above in the descriptive analysis (Section G).

6.3 Chapter Summary

This study aimed to explore the impact of training on nurses' self-efficacy in detecting and reporting cases of suspected and known CAN. A survey was conducted among N = 253 nurses using the CANRSE questionnaire, administered in hard copy and online. Notably, 247 nurses responded, which represented a 77% response rate. Most respondents were staff nurses (68.2%) working in the Central region. Most participants (81%) were non-Saudi, with only 14.2% being Saudi.

Furthermore, n = 182 (75.5%) of the respondents had not reported incidents of CAN, while n = 59 (24.4%) had. The main reason for not reporting was a lack of formal training and knowledge about child abuse and protection. A significant number of respondents, n = 167 (73.2%), cited barriers to reporting and had not received formal training on the subject. Only n = 43 (19.2%) had participated in formal training sessions, while n = 23 (10.4%) had attended the CPMTP.

Interestingly, only n = 5 (22%) of Saudi nurses attended the CPMTP by the NFSP, while almost half of the non-Saudi nurses, n = 32 (74%), had undergone other formal training. This research showed that n = 146 (70.7%) of nurses felt they had a legal obligation to report cases of physical or sexual abuse involving children or young people. However, there was less recognition of the need to report cases of emotional abuse. Despite this, most nurses indicated that they would report cases described in the survey. The majority recognised their legal duty to report physical and sexual abuse and neglect

(80%, 71%, and 67.9%, respectively), but only 63% identified the same obligation for emotional abuse.

Attending any training related to CAN cases did not lead to significant differences in nurses' self-EEs for reporting suspected or known cases of child abuse and neglect or in their expectations about the outcomes of reporting. However, the analysis compared nurses who received CAN-related training versus those who did not and found significant differences. Participants who attended CAN training scored significantly higher on measures of self-efficacy for reporting suspected and known cases, as well as on expectations about the reporting outcomes. These differences had small to medium effect sizes, which suggested that the training positively impacted the nurses' knowledge, confidence, and attitudes towards fulfilling CAN-reporting responsibilities.

This study also examined personal characteristics (i.e., age, gender, marital status, and length of working experience) and self-efficacy and found that individuals with postgraduate degrees exhibited the highest confidence level. Most participants working in paediatric professions had not attended the CPMTP.

Regarding reporting cases, a comprehensive overview of the legal obligations, and processes for mandatory reporting of CAN in the healthcare setting in SA, most respondents indicated they would consider reporting child abuse if it was likely to occur in the future, even if it had not yet happened. The SCAN team was the most commonly reported entity to report to, followed by the hospital's social services department, where the relevant details about the cases were reported. Additionally, some respondents did not consider defamation as a factor in mandatory reporting, while others were unsure about the link between mandatory reporting and criminal conduct. Despite this, many participants remained confident that reporting in good faith would typically result in their identity as the reporter remaining confidential.

The next chapter discusses the findings in relation to the study's aims and objectives. The researcher also unpacks the methodological approaches and discusses the limitations and implications for future research.

Chapter 7: Discussion

This study is the first in SA or neighbouring countries to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN. The study used a new instrument validated by Colgrave et al. (2020) to measure nurses' CAN-reporting self-efficacy (the CANRSE).

This chapter discusses the findings related to the study objectives within the context of previous research and relevant published works. The findings are presented per the study's aim and objectives:

This study aimed to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA. The objectives of this study were as follows:

- To measure the impact of training on nurses' self-efficacy in detecting and reporting suspected and known CAN cases.
- To assess nurses' understanding of the consequences for the child and their family in reporting suspected CAN cases.
- To measure nurses' confidence when reporting suspected and known CAN cases.
- To determine the relationship between personal characteristics (e.g., gender and education level) and professional self-efficacy in nurses.
- To assess nurses' knowledge of the law relating to CAN reporting in SA.

This chapter presents the findings under the headings of the impact of training on nurses' self-efficacy, nurses' knowledge of the consequences of reporting suspected cases of CAN, factors influencing reporting of CAN, confidence when reporting suspected and known cases of CAN, challenges in reporting child abuse, and the relationship between

personal characteristics and professional self-efficacy in reporting cases of CAN, knowledge about CAN-reporting law.

7.1 Impact of Training on Nurses' Self-Efficacy

The primary aim of this study was to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA. As described by Biçakçi et al. (2016), child abuse occurs when a child is deliberately exposed to such circumstances, resulting in emotional, physical, sexual, and psychological damage. A limited understanding of these relationships exists, particularly in non-Western cultural contexts. This study provided additional insight into this complex phenomenon by employing two scales: (1) the SE-CAN for measuring self-EEs and (2) the OE-CAN for assessing outcome expectations, consistent with Bandura's (1977) self-efficacy theory (as discussed in Chapter 3). The findings highlighted that providing comprehensive training to nurses can significantly improve their self-efficacy and confidence in identifying, reporting, and responding to suspected and known cases of CAN (Table 16). This finding is important, as nurses often play a crucial role in the detection and reporting of CAN (Ben Natan et al., 2012b; Feng & Wu, 2005), so their self-efficacy in this area can directly impact the protection and support provided to vulnerable children (Shorey & Lopez, 2021; Lee & Ko, 2010; Bandura, 1977; Bandura & Walters, 1977).

While the findings revealed a positive association between nurses' participation in any previous CAN training and their reported levels of self-efficacy in identifying and responding to child abuse, this association was not significant between the attendees of the specific CPMTP and those who did not attend this programme (Table 17). Notably, the CPMTP was voluntary, and the sample size of CPMTP attendees could have failed to detect significant differences between the groups. Despite these limitations, the findings

are important as, despite the small sample size of the CPMTP attendees, the high response rate of 77% suggests that the findings reflect the overall population. This finding contrasts with international literature, which suggests that CAN training increases nurses' self-efficacy and competence in handling these cases (Gilissen et al., 2020; Hashimoto & Takahashi, 2020; Fraser et al., 2018). Therefore, this result challenges the belief that all training programmes lead to improvements in reporting self-efficacy scores.

The study also investigated how participants who attended previous CAN training changed nurses' OEs regarding reporting incidents of CAN, which could lead to changed self-efficacy (Table 16). The findings revealed no difference in OEs between those who attended any CAN training in general and those who did not. Williams (2010) discussed the interplay between OEs and self-efficacy and indicated that OEs can influence individuals' self-efficacy judgements (Williams, 2010a). Bandura's (2021) theory of self-efficacy and OEs emphasised the importance of these factors in motivating individuals to take action (Bandura, 2012; Bandura & Walters, 1977). The essential concepts of this research are EEs and OEs from self-efficacy theory (Bandura, 1986, 1977).

While previous research uncovered significant differences between those who received CAN training in general and those who did not in factors such as EEs with suspected/known CAN cases and OEs (Fraser et al., 2018; Lee & Chou, 2017; Murphy et al., 2017), the current study did not yield similar results related to significant change in OEs regarding CAN reporting. The study conducted by Lee and Chou (2017) in a Taiwanese healthcare setting, comprising a ten-hour workshop-based child abuse and neglect training for registered nurses, resulted in improvements in both EEs for suspected and known CAN and OE cases. However, combining different types of training into a single variable and then measuring self-efficacy ensures a thorough analysis. This method considers the various training methods that participants may have undergone, which gives

a more precise indication of their confidence in reporting cases of CAN. This approach also deals with overlapping groups, ensuring that all relevant training experiences are considered in the analysis. The mixed findings across studies highlight the need for more research to understand the factors contributing to such training programmes' effectiveness and sustainability.

The low number of participants who attended the CPMTP likely influenced the results rather than the results being definitive. This study reported that only 10.4% of participants (Table 11). Hence, other factors beyond training attendance may have contributed to the low uptake rate of the CPMTP, such as the workload and insufficient CAN training. One factor highlighted in the study is that the workload of nurses hinders access to CAN training, as mentioned by 13 participants in the qualitative responses (section E). In other words, nurses' heavy workload factors may limit their ability to attend CAN training while negatively impacting their self-efficacy in reporting CAN cases. Thus, the high demands and pressures of nurses' jobs may negatively impact their capacity to engage in professional development activities related to CAN.

Research has shown that nurses' self-efficacy, or their belief in their ability to effectively identify and respond to CAN, is a key factor influencing reporting behaviours (Eisbach & Driessnack, 2010; Feng et al., 2010). When nurses feel overwhelmed by high workloads and lack the time to build their knowledge and skills, it can undermine their confidence and self-assurance in managing CAN cases. This barrier can be addressed by making the CPMTP more accessible and offering it at convenient times and locations.

The conflict between nursing work and professional development opportunities, including training in CAN, has also been identified as a challenge for nurses (Lines et al., 2020). In addition, a SA study suggested that nurses and other professionals working with children must attend a minimum number of training hours on CAN (Alkathiri et al.,

2021b). It may be possible to overcome this obstacle by offering flexible scheduling options, online learning opportunities, or dedicated training times during working hours.

Moreover, a lack of belief in the support provided by healthcare organisations can negatively impact nurses' motivation to participate in CAN training programmes (Khanjari et al., 2021; Alvarez et al., 2010a; Fraser et al., 2010). As a result, the participants' workloads and time demands may influence their self-EEs, which in turn may affect their willingness or confidence in identifying and reporting suspected abuse, even if some general CAN training has been provided to them. Offering continuing education credits, or other forms of recognition for nurses who complete the CPMTP may help increase attendance and engagement. Strategies should not only focus on enhancing training opportunities, but also address organisational factors that may undermine providers' sense of competence and ability to act on suspected maltreatment.

The low participation rate in the CPMTP observed in the present study could also reflect a broader trend of insufficient CAN training for healthcare professionals. Some participants addressed this issue in their qualitative responses (Section E). Similarly, previous studies have suggested that CAN awareness is low among nurses, so CAN training should be implemented to help them recognise and report such cases (Lee et al., 2007; Feng & Levine, 2005).

For example, a study by Feng and Levine (2005) found that 86% of Taiwanese nurses had not reported any cases of child abuse, 21% had not reported any suspected cases of child abuse, and 80% had not received education concerning child abuse. Moreover, Lee et al. (2007) concluded that more than 70% of Taiwanese nurses believed they needed CAN training as the courses were unavailable in their hospitals. Hence, Taiwanese nurses were unprepared to identify and report cases of child

abuse, likely due to a lack of training. Additionally, the lack of CAN training may also contribute to the low reporting rates, as nurses may be unaware of the proper protocols for reporting and the importance of doing so.

Consequently, this study indicated that implementing comprehensive, formal training programmes on CAN is an essential priority for healthcare organisations. This finding was consistent with other studies conducted in SA, which highlighted the importance of improving CAN training (AlFarhan et al., 2022; Elarousy & Abed, 2019; Al-Dabaan et al., 2014). These findings suggested that a lack of adequate CAN training opportunities may contribute to healthcare providers feeling underprepared to identify and report suspected child abuse cases. Therefore, the low participation rate observed in the current CPMTP study could reflect this broader issue within the healthcare system.

This study presented a picture of the relationship between nurses' training and reporting suspected CAN cases (Table 10). While formal training on CAN appeared to be associated with increased reporting of suspected cases. In other words, nurses who received formal CAN training were more likely to report suspected cases (Lee et al., 2007). The results were consistent with several studies that have demonstrated the effectiveness of targeted training programmes in improving nurses' knowledge, confidence, and reporting behaviour (Walsh et al., 2022; Lee & Chou, 2017; Letourneau et al., 2016).

In one study, Letourneau et al. (2016) demonstrated that CAN training programmes consistently increased healthcare providers' knowledge and awareness of child maltreatment, which led to a significant increase in the number of reported cases. Moreover, a significant programme in the United States on recognising and reporting CSA improved participants' knowledge and response when abuse was suspected (Rheingold et al., 2015). Following these findings, Finan et al. (2018) discovered that

nurses who received formal CAN training reported suspected CAN much more frequently than nurses who did not. In addition to providing nurses with a deeper understanding of the significance of reporting, the training enabled them to recognise CAN, which resulted in higher reporting rates than those without specialised training (Finan et al., 2018). In addition, Kim and Maguire-Jack (2021) state that data obtained through a cross-sectional survey of U.S. healthcare providers indicated that higher levels of confidence and knowledge regarding the management of child maltreatment, was associated with better recognition and reporting of cases of child maltreatment (Mandadi et al., 2021). A similar educational programme implemented in Iran demonstrated promising results in improving nurses' knowledge and skills in identifying and reporting CAN (Khanjari et al., 2021). Targeted training programmes have been shown to improve nurses' ability to identify and report suspected CAN. Initiatives like these can increase the number of cases identified and reported by nurses by enhancing their knowledge, skills, and confidence. The results of the current study emphasise the importance of training nurses to identify and report child abuse.

The study found a strong connection between nurses' educational level, work experience, workplace location, and their attendance at training related to CAN (Table 24, Appendix X). Nurses with higher qualifications, such as postgraduate degrees, were less likely to attend the CPMTTP than those with lower educational levels, like bachelors degree qualification. Hence, educational attainment could influence participation in the CPMTTP. Previous authors identified nurses' perceived knowledge and confidence as factors influencing their ability and willingness to detect and respond to child maltreatment, which may be linked to their educational background (Murphy et al., 2017; Tiyyagura et al., 2015). One possible explanation for this finding is that nurses with higher educational attainment could feel more confident in their ability to recognise and

respond to CAN and perceive less need for additional training. Alternatively, they could have more demanding work schedules or responsibilities that make it more difficult to attend training sessions.

Interestingly, another study found that nurses with higher educational qualifications were less likely to report suspected CAN, suggesting that their educational attainment could have influenced their participation in related training programmes (Çamur & Erdoğan, 2022). Therefore, the relationship between educational level, training attendance, and reporting behaviour may be complex and multifaceted. Further research is needed to explore why nurses with different educational backgrounds may vary in their participation in child protection training.

According to the study findings, another important connection was found between nurses' attendance of any general CAN training and work experience (Appendix X). The data showed a higher likelihood that nurses with previous paediatric experience were trained in CAN. Work experience shapes training needs and participation in child protection educational programmes. Prior studies found that nurses with more experience working with children were more likely to report suspected child abuse, which indicates the importance of work experience in shaping training needs and participation (Lineset al., 2020; Feng et al., 2012). This issue highlights the importance of work experience in shaping training needs and participation in educational programmes focused on child protection. These findings underscored the need for healthcare policy to address the disparities in training participation among professionals with varying educational backgrounds. Additionally, incorporating mandatory child protection training into continuing education requirements for all nurses, regardless of their level of expertise, could help bridge the gap and enhance overall competency in this critical area.

The analysis also revealed that workplace location was another factor that contributed to nurses' attendance of any general CAN training (Appendix X). In particular, the data showed that nurses working in the Central region were significantly more likely to acquire such training than those in the Eastern and Western regions. Given regional differences in training rates, it is important to consider how contextual factors may impact nurses' access to and engagement with child protection educational programmes. A previous study by Skarsaune and Bondas (2015) discussed that regional differences in resources, policies, and priorities contributed to variations in nurses' engagement with child protection training and practices.

This need for further investigation presents an opportunity for future research to help address these regional disparities. Healthcare policymakers can allocate more resources to underrepresented areas to ensure equitable access to training. Establishing partnerships with local healthcare organisations and institutions can also facilitate disseminating training programmes.

In conclusion, the study underscores the significance of considering demographic factors when developing and implementing targeted training initiatives on CAN. Organisations can enhance participation and ensure more effective capacity building in this critical practice area.

7.2 Nurses' Knowledge of the Consequences of Reporting Suspected Child Abuse and Neglect Cases

A second objective was to assess nurses' understanding of the consequences for the child and their family in reporting suspected CAN cases. The findings of this study indicated that nurses were more likely to report suspected CAN if they believed it was in the child's best interest. Moreover, nurses' perceptions of the outcome of the reporting

process, such as whether the child or family would benefit, played a significant role in their decision to report CAN cases (Table 14). This finding supported Nadya's (2002) findings that the consequences of reporting for the child and the family are a significant factor in nurses' decision-making when reporting cases of CAN. Hence, nurses recognise the potential disruptions or negative consequences of reporting on family dynamics. These findings were also consistent with previous research on reporting behaviours, which suggested that OEs can be a significant factor for nurses when deciding whether to report (Lee & Ko, 2010). Therefore, providing nurses with clear guidelines and support during the reporting process is imperative to aid in their decision to report and allay their fears about the potential consequences. For example, they may feel that reporting suspected CAN is not in the best interests of the child, that the child's family will respond negatively towards them or the child, or that reporting suspicions would harm the child's bond with the family (Ward & Hisley, 2015; Pietrantonio et al., 2013; Chihak, 2009; Flaherty et al., 2006; Alvarez et al., 2004). Hence, a safe and secure environment to voice concerns is essential if nurses are to feel empowered to report cases, improve outcomes, and prevent consequences (Flaherty et al., 2004). Encouraging nurses to report can lead to improved outcomes for the child and aid in their protection from future harm.

This study analysed whether nursing position or seniority influenced nurses' perceptions and beliefs about the potential consequences of reporting suspected CAN (Table 22, Appendix V). The finding suggested that nurses tended to have similar views and concerns about the potential outcomes of reporting suspected CAN regardless of their professional position or years of experience. This finding was in contrast to other study findings.

For example, a study by Feng and Chiu (2012) found that nurses with more experience had higher outcome expectations, which indicated they expected better results

when reporting CAN cases. According to Green (2020), limited experience can create uncertainties, which can lead to professionals deferring reporting suspected CAN to their more senior or experienced colleagues. Other studies have suggested that senior nurses may feel more empowered and comfortable when navigating the reporting process than junior nurses, who may be concerned about negative consequences (Fraser et al., 2018; Jordan et al., 2017). Moreover, research has demonstrated that nurses' perceptions of organisational systems and hierarchies significantly impact their responses to CAN, and leadership roles may provide additional support and resources for effective reporting (Lines et al., 2020). It has also been proposed that nurses play a crucial role in addressing child abuse at all levels (Keane & Chapman, 2008a). Nurses in leadership positions may have a greater understanding of child abuse, ethical reflection and interprofessional collaboration, all of which are essential for effective reporting (Skarsaune & Bondas, 2015).

Based on the contrast between the findings of the present study and those of previous research, it is evident that a deeper understanding is needed of the factors that influence nurses' perceptions and decision-making processes about reporting suspected maltreatment of children (Fraser et al., 2010). Understanding how individual and organisational characteristics shape nurses' OEs around CAN reporting is crucial for developing effective interventions and educational programmes to promote the protection of vulnerable children (Murphy et al., 2017). The current study's results suggest that interventions and educational programmes aimed at promoting reporting and ensuring the safety of vulnerable children should be designed to target all nurses, regardless of their professional position or years of experience. This inclusive approach can help create a supportive environment where nurses feel empowered to take action to protect children at risk. An inclusive approach targeting all nurses, regardless of their position or experience,

is recommended (Tiyyagura et al., 2015). The best care for vulnerable children requires a comprehensive strategy to ensure all nurses are enabled and encouraged to detect and report CAN cases.

7.3 Factors Influencing the Reporting of Child Abuse and Neglect

According to this study, participants believed they were legally required to report cases of CAN, but the type of abuse influenced their likelihood of reporting (Table 12). The study found that participants considered the following forms of abuse to be more severe – physical abuse (80.1%), sexual abuse (71%), and neglect (67.9%) – and were thus more likely to report them. Emotional abuse was ranked last at (63.9%), which could be due to its difficulty in detection and lack of immediate consequence. This finding supported Nayda's (2002) observation that Australian nurses were less likely to report suspected emotional abuse. The view was that nurses could feel uncomfortable discussing or reporting emotionally abusive behaviours due to prior training, and nurses' personal experiences influence the likelihood of reporting some types of maltreatment. Hence, these abuse cases remained unreported (Fraser et al., 2010).

However, previous researchers suggested nurses were unprepared to report child emotional abuse effectively (Camilo et al., 2021; Green, 2020; Nayda, 2002). Zellman (1990) also found that the severity of the abuse strongly influenced the mandatory reporting intention. Like other studies, this study found that the lack of clear evidence of abuse was a significant barrier to reporting (Table 21) (Stephens et al., 2021; Al-Zayed, et al., 2020). In contrast, Lee et al. (2020) found that children who had been sexually abused experience significant psychological and emotional trauma. Identifying and addressing the trauma associated with sexual abuse to reduce long-term harm to

victims is imperative (Hailes et al., 2019) since it can manifest in physical, cognitive, or behavioural symptoms (Gama et al., 2021; Hailes et al., 2019).

A study conducted by Ko and Koh (2007) on Korean nurses revealed that CSA characteristics, such as the age and gender of the victim, could impact nurses' perception of the seriousness of CAN cases. It is concerning that agencies responsible for protecting children may not take reports of emotional abuse as seriously as other types of abuse (Naughton et al., 2017). Detectability of sexual abuse is more difficult than detection of physical abuse (Chauviré-Geib & Fegert, 2024). SA is a very conservative Islamic country. Even sexual abuse is the least tolerated form of abuse in conservative countries (Alnasser et al., 2017; Alsehaimi, 2016; AlMadani et al., 2012; Newton & Vandeven, 2010). However, it is still a common occurrence in the country, with reports of sexual abuse cases increasing yearly (Almuneef, 2021; AlMadani et al., 2012). The fact that it is a somewhat hidden phenomenon in SA (Almuneef, 2021) means that many cases remain unreported. While physical and sexual abuse are viewed as more severe, emotional abuse can have long-lasting psychological effects, as discussed in Chapter 2, that are challenging to recognise and address. Awareness of the signs and impacts of emotional abuse is essential in addressing this issue effectively.

7.4. Confidence When Reporting on Suspected and Known Child Abuse and Neglect Cases

Another objective of this study was to assess nurses' confidence in reporting suspected and known cases of CAN. The regression analysis shows that self-efficacy factors, such as efficacy expectations for CAN (suspected and known) and outcome expectations for CAN, are associated with attitudes and feelings about reporting CAN (Table 18). One key finding was the negative relationship between nurses' efficacy

expectations for reporting suspected CAN cases and their attitudes/feelings about reporting. In other words, those with a higher confidence level in their ability to identify and address suspected CAN, they may still have hesitations or concerns about reporting these cases.

Previous literature has suggested that the ambiguity and uncertainty surrounding suspected abuse create a unique psychological barrier for healthcare providers (Karakachian et al., 2024). Additionally, healthcare professionals may feel uncertain about the appropriate action or lack confidence in gathering sufficient evidence to support their suspicions (Özer & İnci, 2024). They may believe it is challenging to protect vulnerable patients and prevent abuse (Karakachian et al., 2024), and reporting suspected CAN is the only way to ensure vulnerable patients are not at risk (Palmer et al., 2024; Quarles van Ufford et al., 2024). Furthermore, healthcare providers may feel a moral obligation to ensure that the healthcare system is held accountable for abuse (Quarles van Ufford et al., 2024; Sweatman et al., 2024). These findings have significant implications for efforts to protect children and strengthen reporting behaviours among healthcare professionals. Rather than simply focusing on enhancing general knowledge and skills, interventions must directly address the complex psychological factors that shape reporting tendencies.

This study reported that most participants (75.5%) did not report CAN cases in their past experiences, while 24.5% reported such incidents (Table 9) based on the descriptive analysis. The participants reported a higher ability to report known CAN cases than suspected CAN (Table 13). While participants in this study might have felt confident handling known CAN cases, their attitudes toward reporting suspected CAN were more complex and less consistent (Table 18). Similar results were reported in a previous study in SA, in which high levels of perceived competence did not necessarily translate into

active reporting (Brnawi, 2021). Responses in the qualitative comments provided reasons and explanations for these barriers (Section E), categorised under knowledge, policy, and other barriers.

Regarding knowledge-related barriers, the data suggested that some nurses lacked knowledge of how to report CAN cases, were unaware of the relevant policies, and lacked evidence to substantiate the suspected event. These sentiments were similar to those of another study in SA, which found that 78% of nurses did not report a situation when uncertain whether it constituted abuse (Elarousy & Abed, 2018). This response was due to a lack of training and knowledge about CAN, as well as a lack of confidence in their ability to identify it. Other studies have reported contrasting findings demonstrating that nurses' confidence and self-efficacy levels influence their reporting intentions regarding suspected abuse and neglect (Lee & Chou, 2017; Lee & Ko, 2010). A lack of adequate training and education can also result in nurses ignoring or failing to report instances of abuse and neglect (Öztürk, 2024). In response to suspected child abuse, nurses should raise awareness, responsibility, and courage to act (Skarsaune & Bondas, 2015).

Providing access to resources and support while knowing the signs and symptoms of child abuse can help nurses feel more confident in making the correct decision when it comes to reporting suspected cases of abuse (McCoy & Keen, 2022, Crosson-Tower, 2003). This support is essential for the protection of vulnerable children and for providing them with the necessary care and support. Nurses should also be supported to feel more confident in their roles. The findings of this study were consistent with previous evidence about inadequate nurses' confidence in reporting CAN cases (Green, 2020; Ben Natan et al., 2012b; Raman et al., 2012). Nurses should also be supported to feel more confident in their roles. According to Rolim (2014), the primary issue preventing nurses from reporting CAN is their reported lack of knowledge. Similarly, Ben Natan et al.

(2012) observed that healthcare staff felt they had not received appropriate training in identifying and managing CAN and regarded themselves as only slightly prepared to complete reporting. Therefore, better training and education are needed to provide nurses with the confidence they need to report child abuse cases.

Nurses may hesitate to report if they believe the process will be burdensome, ineffective, or potentially disruptive to the family. Based on the results of this study, participants are likely to have greater general perceived self-efficacy in their ability to report CAN when working in a supportive environment. Thus, they can assist their colleagues during challenging situations, such as reporting CAN (Table 20). The theory of SCT states that by observing others in challenging situations and supporting them, individuals may develop a sense of competence and mastery that can enhance their self-esteem (Bandura, 1986; Bandura & Walters, 1977). In addition, a supportive work environment and a culture of collegiality can contribute to a higher level of GSE (Tschannen-Moran & Hoy, 2007).

Nonetheless, it was noted that reporting personally, without support, may not necessarily lead to increased confidence in future reporting scenarios. Other research has shown that many individuals seek support from their supervisors, colleagues, and peers to manage the stress of working with families in high-conflict situations, like CAN cases (Kuruppu et al., 2020; Saini et al., 2019). Some institutional policies require that supervisory personnel be informed of CAN cases before reporting them to CPS; in other words, reporting such cases directly to CPS may not necessarily be the first action taken (Tufford & Lee, 2019). Similar to other research, the strength of the evidence for an abuse suspicion is a significant factor in whether a formal report is made (Price & Kehn, 2023).

The findings of this study were similar to those found in previous studies about nurses and CPS in reporting cases of CAN (Section E). Researchers have shown that

professionals are often hesitant to report suspected child abuse to the CPS for various reasons, including nurses' negative attitudes towards CPS due to the limited feedback from CPS after reporting CAN cases, as well as delayed investigations (Khanjari et al., 2021; Fraser et al., 2010). Hence, many cases of CAN go unreported or unaddressed, which leaves vulnerable children without the support and protection they require. However, studies have also suggested that nurses are more likely to report CAN cases when they better understand the CPS process, receive more training on CAN reporting, and have better relationships with CPS workers (Price & Kehn, 2023). Therefore, building relationships between nurses and CPS workers and providing nurses with more training and support is crucial to ensure that all professionals involved in healthcare services work together to identify and report suspected CAN to protect the health and safety of vulnerable children.

The results suggesting that the respondents perceived themselves as capable and resourceful in dealing with various life situations were encouraging since these perceptions can have positive implications for well-being and effectiveness in professional roles requiring high levels of personal efficacy. The findings presented in this study on participants' general perceived self-efficacy were consistent with the existing literature (Table 15). This study's overall moderate to high level of general perceived self-efficacy aligned with numerous other studies.

Luszczynska and Schwarzer's (2005) cross-cultural study explored self-efficacy, well-being, stress appraisals, social relations, and achievements. There were N = 8,796 participants, including school and university students, teachers, and factory workers, from five countries: Costa Rica, Germany, Poland, Turkey, and the United States. Across countries, the findings provided evidence for associations between perceived general self-efficacy (Schwarzer & Luszczynska, 2005). They indicated that GSE was connected to a

broad range of psychological constructs about various domains of human functioning, as aligned with the existing self-efficacy research. Bandura's (1997) theory of social cognition stated that people who believe they can cope with challenging situations are more likely to approach them confidently. Healthcare and social service professionals can achieve positive organisational outcomes if their cultures promote and reinforce general perceived self-efficacy. Healthcare providers who feel capable and empowered are likelier to engage in discretionary behaviours, like volunteering for extra tasks, mentoring colleagues, and advocating for their patients (Laschinger & Fida, 2015). As a result, team dynamics can be improved, job satisfaction can increase, and overall performance can increase, resulting in better services and patient outcomes.

Overall, this study's findings contribute to the existing literature by providing insights into participants' general perceived self-efficacy and highlighting the potential influence of cultural and social factors on specific aspects of self-efficacy beliefs. These findings have important implications for understanding self-efficacy development and expression in diverse cultural contexts.

In conclusion, when reporting suspected or known CAN, nurses need to address multiple barriers caused by knowledge gaps, policy limitations, and other organisational factors is essential.

7.4.1 Challenges in Reporting Child Abuse

This study found that most respondents (84.6%) acknowledged always reporting suspected cases of child harm, while most nurses reported suspected child maltreatment cases. However, a notable minority (15.4%) of participants observed CAN and chose not to report it (Figure 5). These findings suggested that barriers to reporting may also remain present and influential among nurses. The qualitative questions in this study reported several reasons for not reporting CAN cases (Section E). These obstacles included fear,

lack of support, nurses' experiences and self-efficacy, workload and resources, communication skills and resource awareness, and experience and reporting behaviour. Similar issues have been observed in many studies worldwide, where healthcare practitioners encounter obstacles while dealing with CAN cases (Khanjari et al., 2021; Elarousy & Abed, 2018; Svärd, 2017b; Louwers et al., 2012; Bunting et al., 2010; Alvarez et al., 2004). For example, nurses may be reluctant to report child abuse and neglect due to fears of potential repercussions from perpetrators or parents. Various studies have identified several factors that contribute to nurses' reluctance to report child abuse or neglect cases, including anxiety, insecurity, and uncertainty about whether they should report their suspicions (Parlak & Ozbey, 2022; Zusman & Saporta-Sorozon, 2022; Elarousy & Abed, 2018; Louwers et al., 2012; Bunting et al., 2010). Additionally, the lack of standardised protocols and training on identifying and reporting child abuse further exacerbates the problem (Louwers et al., 2012; Alvarez et al., 2004). To address this issue, healthcare institutions should provide comprehensive training programmes and establish clear reporting procedures to ensure that nurses feel supported and empowered to report suspected cases of child abuse or neglect.

The study results indicated that nurses generally felt confident in their ability to report child abuse but reported significant issues in terms of the relationship between themselves and the child or family. Previous studies found that fear of damaging the relationship between the child and the reporter was a concern (Gubbels et al., 2021b; Green, 2020; Lazenbatt & Freeman, 2006). For instance, Green (2020) found that nurses felt they were in a difficult position in terms of reporting child abuse, as they were concerned that the child would be angry if they reported the abuse and the relationship between the nurse and the child would be damaged. These findings indicate the importance of educating nurses to ensure they have the confidence to report child abuse

despite their fear of the potential conflict that may arise between them and the child or family.

Another barrier is that nurses in this study reported needing more time to report CAN cases due to their heavy workload. Nurses who attended formal training stated that caring for CAN is time-consuming. They also felt that the reporting process was too time-consuming and needed more resources and support from their supervisors to document the cases correctly (Khanjari et al., 2021). Bandura (2004) explained these results and proposed that work acknowledges that individuals interact with their environments, including hospital policy and human resources, which may influence nurses' intention to report CAN cases. In addition, Manojlovich (2005) pointed out that the current nurse shortage affects their stress and behaviour. Therefore, nurses who can prioritise their workload to document CAN cases may have higher self-efficacy in CAN reporting.

Another barrier reported was that the participants indicated a lack of communication skills to adequately communicate probable child abuse indications with the SCAN team. As a result, training in communication skills is critical for improving the identification and prevention of child abuse, as previously suggested by (van der Put et al., 2017; Schols et al., 2013). In this study, most professionals consulted and supported colleagues to recognise or respond to child abuse suspicions. Child protection helplines were not used, and some professionals might not have been aware of their existence. This issue was also found in assessment studies examining how these reporting approaches were used in SA (Al-Eissa, 2019). Therefore, including communication skills and awareness of available resources in training may improve CAN detection and reporting.

The study found that participants who observed but failed to report incidents of abuse felt that the primary responsibility for reporting CAN cases should lie with doctors or MRCs, as indicated by their qualitative responses. Participants could believe that

doctors should have primary responsibility because they are trained to recognise signs of abuse and have regular interactions with children. Additionally, doctors are often viewed as authority figures who are trusted to handle sensitive situations appropriately. The rationale is that doctors are seen as having a more authoritative role in healthcare services (Mkonyi et al., 2021). Nevertheless, this perception is concerning, as it may make nurses feel less empowered to report suspected CAN cases. Nurses often have the most direct contact with patients and families and are well-positioned to identify potential signs of abuse or neglect (James & Green, 2018). However, if nurses believe reporting responsibility falls primarily on doctors or MRC, they may be less inclined to speak up and initiate the reporting process. These dynamic highlights a potential disconnect between healthcare professionals regarding child protection. Ideally, there should be a shared understanding that all healthcare providers have an ethical and, in many cases, legal obligation to report suspected cases of abuse, regardless of their specific role or level of authority (Chan et al., 2020; Guttman et al., 2019; Tufford, 2019).

This study's qualitative findings reinforced the existing evidence that language barriers are a major communication obstacle. The respondents indicated that language differences in communication resulted in significant difficulties and hesitations in observing and failing to report incidents. Based on the findings of Magruder and Shaw (2008), language discord between service providers and families poses a crucial obstacle to identifying and assessing child abuse. Regarding cultural beliefs, values, and practices, it is unclear what specific challenges international nurses may face (Balante et al., 2021)). According to previous research, fluency in the patient's language is imperative; a translator can add to the difficulty of discussing sensitive topics such as CSA (van der Zalm et al., 2015). To overcome these language barriers, implementing comprehensive language training programmes for international-educated nurses could be beneficial.

In conclusion, nurses may be discouraged from reporting suspected cases of abuse due to several barriers identified in this study. Comprehensive training, clear reporting procedures, and strong institutional support are essential. In addition, nurses' contributions to child abuse reporting should be recognised to help nurses overcome these challenges and effectively address suspected cases of abuse. Indeed, nurses can identify, and report suspected cases of abuse if they are equipped with knowledge, skills, and resources.

7.5 Relationship Between Personal Characteristics and Professional Self-Efficacy in Reporting CAN Cases

The study investigated the association between personal qualities and professional self-efficacy in reporting cases of CAN (Table 19). The results demonstrated a significant association between self-efficacy, educational attainment, but not other demographic characteristics. Additionally, the research found that nurses who had completed postgraduate education displayed high self-efficacy when reporting CAN. This finding was consistent with Sundler et al.'s (2021) study, where paediatric nurses who obtained continuing education, including child abuse education, had more confidence in child abuse management and were more likely to report suspected CAN (Sundler et al., 2021). However, other studies have found that nurses' knowledge and awareness of child abuse can depend on the amount of training they have received, while gender may also play a role in how nurses respond to signs of child abuse. For example, a study in SA by Al-Saif et al. (2018) described that women, healthcare professionals, and those who had participated in more than five training courses were more concerned about the underreporting of abuse (high sensitivity) relative to other professionals, while men were less concerned about child abuse and showed less awareness and knowledge of how to

identify it (Al-Saif et al., 2018). This study found that nurses' interest in reporting CAN cases increases with their level of education. It should be noted, however, that few scholars have examined the impact of CAN training during university education or the pathways to certification in nurses' self-efficacy in CAN. Therefore, more research is needed to understand the impact of university CAN training on nurses' self-efficacy and reporting behaviours. In addition, pathways to CAN-reporting certification need to be explored.

The findings of this study aligned with previous research conducted among teachers in Australian schools, which showed that teachers with lower educational qualifications were less likely to report suspected child abuse (Goebbels et al., 2008). Luckey-Smith (2013) reported similar results in her studies on the self-efficacy of senior nursing students, which aligned with Albagawi et al.'s (2019) findings that high levels of self-efficacy are often attributed to the quality of the academic programme attended and the educational experiences of the nurses. In contrast, Zhang et al. (2015) found higher self-efficacy scores among male student nurses than female student nurses in China, which contradicted the present study's results. A quantitative study conducted within the four largest Swedish children's hospitals showed that the odds of being low reporters were significantly higher for nurses and nurse assistants than for physicians and hospital social workers (Svärd, 2017a). These findings suggest that personal characteristics and training quality may influence self-efficacy levels among nurses.

7.6. Knowledge About Child Abuse and Neglect Reporting Laws

This study found that most nurses in this sample were aware of their ethical and professional obligations to report suspected child abuse, even if the abuse had not yet occurred (Table 23, Appendix W). Several studies have indicated that healthcare

providers, particularly nurses, are aware of their legal obligation to report suspected child maltreatment (Goebbels et al., 2008; Alvarez et al., 2004). In a survey of nurses in the United States, 97% reported that they knew about their state's mandatory reporting laws (Alvarez et al., 2004). Another study of Australian teachers found that 85% knew their legal responsibility to report suspected child abuse (Goebbels et al., 2008). According to these findings, nurses generally comply with the law when informed of their reporting duties. However, this notion contrasts with the findings of previous research conducted in Taiwan. For example, Feng and Levine's (2005) study of over 1,000 nurses found an almost identical 21% of nurses had failed to report at least one suspected case of CAN. Similarly, Lee et al. (2007) reported a higher proportion (43.4%) of nurses who had suspected but not reported cases of CAN. In contrast to those studies, the current study showed a difference in the reporting rates that cultural, institutional, or other contextual factors could influence. Other studies have shown that child abuse tends to be underreported by nurses (Elarousy & Abed, 2018; Lee & Chou, 2017; Ben Natan et al., 2012). For example, a study conducted by Ben Natan et al. (2012) revealed that healthcare professionals, including nurses, often struggled to accurately identify signs of CAN and neglected to report their suspicions to the necessary authorities. Similarly, Louwers et al. (2012) found that nurses often failed to report suspicions of child abuse to the relevant authority due to a lack of confidence in their judgement or fear of repercussions. The literature supports the finding that while the majority of healthcare providers appear to report suspected cases of child maltreatment, continued efforts are needed to strengthen the child protection knowledge, skills, and confidence of all professionals within the healthcare system (Feng et al., 2012; Louwers et al., 2012; Bunting et al., 2010). To address this issue, training programmes for child protection

professionals should, at a minimum, help professionals identify signs of different CAN cases and address the legal parameters of what, when, and how to report maltreatment.

The survey found that most nurses who participated in this study understood their mandatory reporting duties in different situations, especially concerning potential physical or sexual abuse, domestic violence, and other forms of mistreatment. The results indicated that these nurses typically abided by their legal and ethical obligations to recognise, and report suspected cases of abuse. However, the study also found some areas of concern. There appeared to be less confidence in handling prenatal reports (Table 23, Appendix W), which included effectively engaging with support services and having the requisite knowledge before making a report. Therefore, nurses may require additional training and resources to improve their confidence and competence. Previous studies have reported that nurses should be supported in their efforts to advocate for prenatal abuse victims (McKinney et al., 2021; Abbott-Egnor, 2018; Lazenbatt & Freeman, 2006; Dunn & Oths, 2004). For example, a study by Lazenbatt and Freeman (2006) found that nurses and midwives often felt underprepared to identify and report suspected cases of prenatal abuse or substance use. Other studies have reported the critical role that prenatal care providers, especially nurses, play in recognising and reporting suspected CSA to connect victims with necessary resources and protection (Abbott-Egnor, 2018). Hence, more targeted training is needed in this area. Similarly, Yokomizo et al. (2023) found that some healthcare providers struggled to navigate the appropriate referral pathways and support services for pregnant women at risk of abuse. This finding suggests that while nurses generally understand their mandatory reporting responsibilities, there may be gaps in their training and preparedness to navigate the full scope of CAN cases, particularly those involving the pregnancy period. Addressing these concerns could lead to more effective and timely interventions.

This study's findings revealed that most nurses who reported the CAN cases provided relevant details about the case to the hospital's social services department (Table 23, Appendix W). This report indicated the importance of effective communication between healthcare providers to ensure they provide accurate and timely information to the social services department. One study reported that healthcare practitioners view child abuse issues as social workers' main role (Bunting et al., 2010), which indicates that nurses may lack the knowledge or resources to effectively report CAN cases. Nurses may also feel overwhelmed by the paperwork and bureaucracy involved in making a report, which again points to a lack of sufficient training or support to report CAN cases. Few Saudi hospitals have provided information about child abuse and/or required multidisciplinary teams to identify suspected and known CAN cases. Thus, a notable percentage of nurses from previous research in SA reported lacking confidence in correctly identifying and reporting CAN (Alhowaymel et al., 2023; Elarousy & Abed, 2019). Therefore, an emphasis must be placed on providing effective training to nurses on recognising and reporting CAN, as well as the relevant regulations for such cases.

Furthermore, 68.9% of participants in this study expressed the importance of carefully considering reporting CAN (Table 23, Appendix W). This finding was derived from the knowledge of the law domain in the questionnaire, particularly in anticipation of potential future occurrences. The study also found that nurses were unaware of the proper reporting protocol, which could lead to an inadequate response to an event of potential child abuse. This lack of knowledge of reporting laws and protocols could delay reporting, which could have serious repercussions for the child. Similar to previous studies, Paavilainen et al. (2002) and Feng and Levine (2005) found that nurses' awareness of CAN was low. They also found that nurses had difficulty identifying CAN cases due to a lack of knowledge of the reporting law. Nurses reported that they only

wanted to report cases when they were absolutely certain that the situation met the legal definition of abuse or neglect (Lee et al., 2012a). However, reporting suspected or confirmed cases of CAN is a complex issue that requires more than just awareness (Bunting et al., 2010). Nurses need a training programme to include information on screening and assessment of children to better identify and support children at risk. Finally, training should emphasise the importance of creating a safe and supportive environment for children. Reporting abuse is a legal obligation and moral responsibility to protect children's well-being. Nurses can play a crucial role in preventing and addressing child abuse by creating a safe and supportive environment for children.

Although most nurses knew that they needed to report CAN cases, many did not know the reporting laws accurately (Table 23, Appendix W). These findings aligned with previous studies that demonstrated professionals' reluctance to report child maltreatment due to a lack of knowledge about reporting regulations (Alvarez et al., 2004; Renninger et al., 2002). This sentiment can be attributed to a lack of education and training in disclosure laws. In addition, there is the fear of legal and professional repercussions for disclosing. Additionally, nurses could lack the confidence to report due to the complexities of the reporting process. The most common reasons for reporting were a belief that the situation met the legal definition of abuse or neglect, the mandatory nature of the reporting, and a desire to protect children and others (Renningeet al., 2002). Hence, nurses want to be totally sure before they report child abuse cases. This finding was somewhat surprising and indicated the need for extensive CAN education among nurses, especially on nurses' roles and legislative obligations.

In conclusion, the study's findings suggest that most nurses in SA understand their obligation to report suspected cases of CAN. However, the study also revealed gaps in nurses' knowledge and confidence, particularly in dealing with prenatal reports and

accessing appropriate support services. These issues can be addressed in several ways. First, targeted training should be provided to help nurses and other child protection professionals better understand the legal aspects of reporting and how to effectively identify, assess, and respond to different forms of CAN. Additionally, improving nurses' knowledge of mandatory reporting laws and providing more comprehensive training on screening, assessment, and referral processes may enhance their ability to engage with support services and ensure timely interventions. SA enacted such laws to ensure the identification and cessation of child victimisation (Al Eissa & Almuneef, 2010), as explained in Chapter 2. These laws seek to ensure that cases of severe maltreatment are documented and investigated, even if the victim is hesitant or unable to report the abuse. It also gives reporters a sense of safety and security in knowing they are protected by the law (Forde, 2022; Alsehaimi, 2016).

Strengthening nurses' capacity in these areas could help them better protect vulnerable children, especially during the critical prenatal period. SA's experience of reporting child abuse cases is relatively recent, so statistics on the prevalence and nature of abuse are limited (Alsehaimi et al., 2019). Establishing standardised guidelines for nurses and multidisciplinary teams may help address hospital reporting challenges (Lee & Chou, 2017). Therefore, to enhance nurses' intention to report CAN cases, this study reveals that nurses' knowledge of the CAN mandatory reporting law must be improved by introducing a standard and clear definition of CAN and mandatory reporting in the training programmes.

Study Results in the Context of Bandura's Theory on Self-Efficacy:

For this study, Bandura's Social Cognitive Theory (SCT), specifically the concept of self-efficacy, served as the theoretical foundation for exploring the impact of training

on nurses' ability to recognise and reporting child abuse and neglect (CAN). According to Bandura's theory (Bandura, 1986, 1977), individuals' beliefs about their own abilities (self-efficacy) have a profound influence on their motivation, behavior, and ultimate performance when attempting to perform in a given domain. In other word, by emphasising the interaction between personal, behavioural, and environmental factors, SCT provides a complete understanding of human behaviour.

Nurses play a crucial role in the early detection and management of child abuse and neglect (CAN). It has been stated by Biçakçi et al. (2016) that child abuse involves deliberately exposing a child to circumstances that are detrimental to their emotional, physical, sexual, and psychological development. A recent cross-sectional study in Saudi Arabia, the study's objectives were aiming to explore the impact of training on nurses' self-efficacy, assess their understanding of the consequences of reporting suspected CAN cases, gauge their confidence in reporting, explore the relationship between personal characteristics and professional self-efficacy, and evaluate their knowledge of CAN reporting laws in Saudi Arabia. This is the first study in the region using the CANRSE questionnaire, which was developed for use in the Australian by Colgrave et al. (2020).

The study's findings provided valuable insights interpreted through Bandura's SCT. Consistent with the theory, the researcher found that nurses with prior CAN training had significantly higher self-efficacy than those without such training. This aligns with Bandura's proposition that mastery experiences, such as training, can enhance individuals' self-efficacy beliefs. The researcher noted that their findings are in line with studies conducted in other cultural contexts, where studies have shown that training and self-efficacy are important factors for enhancing nurses' ability to recognise and respond

appropriately to CAN (Lee & Chou, 2017; Fraser et al.,2010). It is important to note that the researcher contextualised their findings within SaudiArabian culture and society.

Nurses' perceptions and behavior regarding CAN may be influenced by societal norms, legal frameworks, and healthcare system factors. Furthermore, the study revealed that higher self-efficacy was associated with more positive attitudes, greater CAN knowledge, and increased reporting of known cases. In the discussion, Bandura's theory was discussed in terms of how it could be used to explain how training and self-efficacy shape nurses' practices in this setting as well as how the processes differ from those observed elsewhere in the world.

This study has provided a robust and nuanced understanding of the factors which influence nurses' ability to identify and respond to child abuse and neglect in the Saudi Arabian context through the interpretation of the results in light of Bandura's social cognitive theory and the international literature on CAN. In addition to strengthening the conceptual framework, this approach enhances the transferability of the study's findings as well. As a result, this data informs public health policy, practice, and future research in this critical area of child welfare and public health, as discussed in next chapter.

In conclusion, the selection of self-efficacy as the theoretical framework for this study is well-justified. Bandura's social cognitive theory provides a robust foundation for understanding the critical role of nurses' beliefs in their ability to effectively identify and report suspected cases of child abuse and neglect. By examining the impact of child abuse training on nurses' self-efficacy, this study aims to inform the development of targeted interventions that can enhance nurses' confidence and improve their reporting of suspected cases, ultimately contributing to the protection of vulnerable children. The exploration of this theoretical framework will offer valuable insights into the complexities

of addressing child abuse and neglect within the nursing profession and guide future efforts to create a safer environment for children.

7.7 Strengths and Limitations of this Study

7.7.1 Strengths

- Cross-sectional surveys are an effective means of gathering data on sensitive topics. This method ensures participant anonymity and confidentiality and promotes a diverse sample size. Additionally, it creates a secure environment where individuals can candidly share their experiences and perspectives. The larger sample size generated by this approach results in more dependable and comprehensive findings. Moreover, removing direct interaction with interviewers helps avoid biases and social desirability effects to ensure the accuracy and integrity of the data collected.
- When collecting data through a survey, a low response rate can limit the generalisability of the findings and introduce bias. To address this issue, the researcher employed effective survey administration techniques, both hard copies and online, and followed up with the respondents.
- Using surveys for data collection can result in biased responses due to social desirability bias. A thorough analysis of the participant feedback from the pilot study was conducted to mitigate this issue and guarantee unbiased results.
- The wording of survey questions can influence responses and lead to bias. To mitigate this issue, the researcher conducted a pilot study to identify and address any issues with wording or phrasing before using the survey in the main study.
- This study adds to the body of knowledge about self-efficacy for nurses dealing with CAN cases. The findings may help inform policy decisions regarding nurses' training to detect and report child abuse in SA. It may also provide valuable insights into using the CANRSE questionnaire for assessing nurses' self-efficacy in this region.

- This study can inform the development of interventions and educational programmes to improve nurses' confidence in managing CAN cases. It can also serve as a basis for future research on this topic in other countries.
- The use of this validated instrument gives the study increased credibility. It allows researchers to better measure and compare the three sources of self-efficacy related to training. This type of comparison has not been done before in the Arab region, which makes this study valuable for further research in the area. Therefore, the results of this study can inform and guide the development of learning models tailored to nurses. Additionally, the results can inform the development of interventions that support self-efficacy development in a range of learning environments.
- This study is the first to evaluate the CANRSE questionnaire reliability and validity in an SA setting. The rigorous validation process included academic nurses and CAN experts. The study showed that the CANRSE questionnaire can be used to assess nursing self-efficacy in SA. The results indicated that nurses in SA can accurately assess nursing child abuse detection and reporting using the CANRSE questionnaire.
- This study is also the first in the Middle East to use a valid scale to explore the role of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN and measure nurses' knowledge about the law of child abuse detection and reporting in SA. Such studies are needed to generate evidence-based practices to reduce CAN in this region and assess and improve the current state of knowledge among healthcare professionals. Furthermore, this study provides important insights into the awareness and application of the region's laws and regulations surrounding child abuse detection and reporting.
- Research on subjects often faces resistance long before it reaches its target participants. Given the nature of society, conducting such a study in SA is equally problematic

(AlMadani et. al., 2012). An anonymous survey proved an effective approach for conducting a study on such a sensitive topic since it resulted in a high response rate. Ethical approval was obtained and explained to the participants. However, gaining access to research sites and the individuals that occupy these spaces can present further challenges for researchers. It was difficult for the researcher to gain access to certain hospitals since some refused to take part in the study for various reasons. Instead of collecting data from just one city as originally planned, the researcher conducted the study across three regions. Despite limited access to some research sites, the researcher obtained many participants through this adjustment. A researcher's ability to adapt to multiple research settings and collect data across regions demonstrates her flexibility and perseverance. Despite initial obstacles to obtaining participation from all the original research sites, this approach allowed the study to be conducted effectively and provide valuable insights.

7.7.2 Limitations

- Despite the small sample size, the study reported a 77% response rate, which showed high participant engagement from three regions. Additionally, this study is the first investigation in the Arab region related to national training on child protection, which makes a significant contribution to the field and lays the groundwork for future research.
- Most of the sample were female; therefore, the results may not be generalisable to males.
- The challenges presented by COVID-19 impacted the implementation of the study. Nurses at the forefront of managing the pandemic may have had limited availability due to their increased workload, which may have reduced response rates to the survey.

- This study used a cross-sectional design, which had limitations for establishing causal relationships. However, theory provided the necessary structure and logic to interpret cross-sectional relationships and guided the researcher in formulating hypotheses and making informed causal inferences despite the design constraints (Van der Stede, 2014). Therefore, the researcher believes this approach was justified and valuable for several reasons. The primary objective of the study was to explore the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN in SA. A cross-sectional design allowed the researcher to capture the current state of training, knowledge, and self-efficacy among the participating nurses, providing a snapshot of this critical issue at a specific time. Despite the limitations of cross-sectional studies in establishing causality, this design enabled the researcher to identify potential relationships and patterns that could inform future research directions and interventions. By examining the differential self-efficacy levels among nurses with varied training backgrounds, the study yielded valuable insights that can guide the development of targeted training programmes and support systems to enhance nurses' capabilities in this domain.

7.8 Conclusion

This study provides several significant contributions to the literature regarding the impact of training on nurses' self-efficacy in detecting and reporting CAN in SA. As the first study of its kind in the Arab world, the findings provide novel and valuable insights that will assist in future research and interventions in this understudied area. The CANRSE questionnaire, a newly validated instrument, can provide more credible self-efficacy assessments.

- 1) The study's results can guide nurse educators in developing training programmes and learning models to enhance their capacity to identify and report child abuse. By targeting specific sources of self-efficacy, nurses can increase their confidence and competence in this critical area.
- 2) This study provides insights into the factors influencing nurses' self-efficacy, which can inform the design of interventions to enhance their ability to detect and report child abuse effectively. This information is crucial for increasing child protection efforts in healthcare settings.
- 3) As a cross-sectional study, this study does not provide a comprehensive assessment of self-efficacy changes over time but provides the foundation for future longitudinal studies. Consequently, training and other interventions can be designed to examine nurses' self-efficacy development over the long term.

Overall, this study provides valuable insight into the limited literature on nurse self-efficacy in detecting and reporting child abuse in the Arab world. Nurses can use the insights to develop impactful interventions and inform future research to strengthen their vital role in protecting vulnerable children.

Chapter 8: Conclusion and Recommendations

This chapter concludes the thesis by making various recommendations and implications for future clinical practise, research, and education. These recommendations are offered in light of the study's findings.

8.1 Conclusion

This study explored the impact of child abuse training on nurses' self-efficacy in recognising and responding to known and suspected cases of CAN among a group of nurses (n = 247) with work experience in SA. A cross-sectional survey was employed using the CANRSE questionnaire, which was utilised to measure nurses' experiences in detecting and reporting cases of CAN in SA. The findings addressed the research aim and objectives to provide a body of knowledge on how nursing education has impacted the self-efficacy of a group of nurses in SA in detecting and reporting CAN.

The study's findings suggest that training regarding child abuse can help nurse providers feel more confident in identifying CAN and contribute to increased awareness and understanding of the issue. Hence, nurses are responsible for identifying signs of potential abuse and neglect in their patients and taking the necessary steps to address these cases. Self-efficacy research has been conducted to better equip nurses and healthcare providers with the knowledge and skills to identify and report potential cases of CAN.

Factors such as a lack of knowledge about child abuse, pertinent legal reporting guidelines, and concerns about the consequences of disclosing child abuse influence their conduct in these cases (Colgrave et al., 2020; Maguire-Jack & Byers, 2013). Child abuse training could improve healthcare providers' knowledge (Abeid et al., 2015; McMahon-Howard & Reimers, 2013), attitudes (Flemington & Fraser, 2017), and self-efficacy

(Smeekens et al., 2011) toward CAN reporting. This training could also enhance healthcare providers' ability to recognise the signs and symptoms of child abuse (Shackshaft et al., 2022) and lead to more accurate and timely reporting. Additionally, by increasing healthcare providers' understanding of the legal guidelines and their confidence in their reporting abilities, child abuse training may help alleviate their concerns about the consequences of disclosing child abuse. Ultimately, this training could result in improved outcomes for the children affected by abuse, as well as a more effective and comprehensive response from healthcare providers.

Based on the findings and comparable research, a more reasonable interpretation is that the primary reasons for non-reporting are a lack of training and policies that address healthcare providers' concerns about reporting, such as doubt regarding suspicion and confidence in the ability of child protection agencies to investigate and act. This research also highlights the importance of peer support and the need for increased communication and collaboration between nurses, CPS, and other relevant stakeholders in developing successful approaches to addressing child abuse. Additional research is needed to investigate other factors that influence reporting behaviour and assess the effectiveness of programmes to remove obstacles to reporting child abuse.

This study contributes to the body of research to enhance child protection practices in healthcare settings. The study's findings have important implications for clinical training, as they can enhance nurses' ability to detect and respond to situations involving CAN. The recommendations offered for training stakeholders and clinical staff can improve internal attributions, raise awareness, facilitate identification, and enhance nurses' management of CAN cases.

The results of this study highlight the relationship between specific attributes of nurses and their self-efficacy when it comes to reporting cases of CAN. Among these

attributes, education emerged as a significant factor. Interestingly, the study found that nurses who qualified with an undergraduate (bachelor' degree) attended the education programme CPMTTP more frequently, whereas the nurses with postgraduate qualifications exhibited higher levels of self-efficacy. Moreover, non-Saudi nurses were more inclined to attend CAN-related training than their Saudi counterparts. This study is unusual because it is the first in the Arabic area to investigate the effects of nurses' characteristics and self-efficacy on CAN reporting. Hence, it is reasonable to assume that more advanced education, according to nurses' demographic characteristics, can assist nurses in reporting CAN cases. However, additional research is needed to establish the relationship between personal characteristics and self-efficacy in nurses who attended child protection courses. For instance, nurses with more experience may have also had more exposure to adverse events or traumatic experiences, which could explain the lack of correlation between years of experience and child abuse reporting. Thus, further research is needed to better understand the relationship between experience and child abuse reporting. It has been suggested that the lack of encouragement for nursing self-efficacy in CAN reporting in SA's training courses could explain this finding. This outcome could be improved if hospitals or family safety programmes design training programmes based on an initial needs assessment and a related theoretical framework.

In summary, this study underscores the persistent issue of underreporting child abuse cases and emphasises the critical need to address this problem urgently. To effectively combat this issue, it is crucial to establish comprehensive measures and initiatives that enable nurses to report cases accurately. Equipping nurses with the necessary knowledge and skills to identify and report child abuse is an essential first step. Moreover, creating a secure and supportive environment in healthcare settings is crucial to encourage nurses to speak up and report cases without fear of retaliation. This

supportive atmosphere should prioritise healthcare professionals' self-efficacy and children's protection. Additionally, clear policies and guidelines are necessary to guide nurses in reporting cases. These protocols should provide a structured framework to ensure consistent and appropriate reporting of child abuse cases.

Based on the study's findings, a multifaceted approach, including education, support, and policy development, is necessary to promote a culture of reporting child abuse and safeguarding vulnerable children. Only by working together can we hope to reduce the underreporting of child abuse cases and create a safer future for children.

8.2 Implications

8.2.1 Implications for Research

- Additionally, future research could increase the sample size to further validate the results and ensure their generalisability to a larger population.
- In the future, researchers could interview nurses about the impact of training on reporting CAN cases. Although mixed methods can provide more data, interviews must be organised to gather detailed information on the impact of training and any barriers to reporting.
- Furthermore, longitudinal research that evaluates the difference between CAN-reporting intention and actual reporting can help clarify the link between prediction and actual behaviour. Such research could reveal whether the intention to report leads to action and, if so, what drives the behaviour change.
- Further research is needed to better understand the relationship between clinical experience and child abuse reporting. This research can also inform the development of interventions to increase the likelihood of reporting. Additionally, it can shed light on the effects of knowledge, skills, and attitudes

in decision-making. Moreover, it can provide information to support the implementation of policies and procedures to ensure effective child abuse reporting.

- Further research should be undertaken to assess the unique challenges faced by male nurses, nursing students, and other groups of paediatric nurses. These data can inform the development of targeted support programmes and interventions by considering societal perceptions, gender biases, and workplace dynamics, which may impact their experiences in the field.
- In this study, the rationale for nurses not documenting suspected and known abuse was not examined in depth. Understanding the reasons for this is important because nurses are required by law to do so. Further studies should investigate why nurses are hesitant to report CAN in accordance with the law.

8.2.2 Implications for Practice

- The findings of this study provide valuable insight into the types of abuse linked to nurses' reporting behaviour in SA. The study discovered that nurses reported incidents of physical and sexual abuse more frequently than incidents of neglect and emotional abuse. These data can be used to inform and develop effective policies for improving nurses' intervention and for preventing and responding to all forms of child abuse.
- The open-ended comments highlighted that effective communication and teamwork among healthcare professionals are critical for reporting CAN cases. Practitioners need clear guidelines, training, and institutional policies that foster a collaborative approach to identifying and responding to suspected child abuse and neglect.

- This study supports the view that developing effective approaches and strategies for training and self-efficacy must build on experienced nurses' expertise. According to this study, an effective approach and strategy for training and supporting nurses must be based on experienced nurses' expertise. Nurses need a supportive environment to report suspected CAN. As frontline child protection professionals, nurses must feel supported, validated, and empowered. If they receive the necessary resources, training, and institutional support, they will feel more confident and able to report suspected abuse and neglect. Additionally, establishing clear referral pathways and feedback loops between nurses, child protection agencies, and other key stakeholders can reinforce nurses' importance.

8.2.3 Implications for Education

- This study's findings suggest that nurses' characteristics affect how they receive training related to CAN in SA, including their education, work experience in paediatrics, and location. Nurses who have postgraduate qualifications, have limited paediatric experience, or are located in certain regions are less likely to have participated in CAN training. The integration of formal programmes into nursing curricula, as well as ongoing professional development, could facilitate improved training. Healthcare organisations must integrate CAN training into initial nursing education and continuing professional development to empower nurses to recognise, document, and report CAN. Nurses at all levels can be equipped to safeguard the well-being of children using this multifaceted approach.

- Through CAN training, nurses can better recognise when a patient exhibits signs of abuse and be better equipped to make a report. Additionally, this information can help healthcare professionals understand the laws and regulations surrounding reporting abuse and how to handle such situations appropriately, which is important to ensure that all healthcare professionals are current on the latest clinical advances in the field and the ethical, social, and legal implications of CAN. Moreover, CAN training can assist healthcare professionals in making better decisions regarding patient care. For example, workshops and continuing education programmes can be tailored to individual needs (i.e. CAN definition, when, what, how to report CAN cases, and reporting laws). Integrating CAN information throughout professional training can help nurses develop foundational knowledge concerning child abuse.
- CAN training and courses may be incorporated into nurses' training at several levels, such as undergraduate and postgraduate curricula and continuing education programmes. After the training, nurses will be better equipped to recognise the signs and symptoms of CAN and understand the legal and ethical implications of reporting such cases. This training can also help them comprehend CAN's physical, psychological, and developmental impacts and how best to respond to such cases.
- Furthermore, training programmes can focus on the significance of regular communication and collaboration among healthcare providers involved in the case, which includes the SCAN team, police, and medical personnel.

8.3 Dissemination

8.3.1 Oral Presentations

- I presented the literature review from the study at a conference: Albandari Almuatairi (2021) A Systematic review to evaluate child protection programmes for healthcare providers in the detection and reporting of child abuse in acute hospital settings, Trinity Health and Education International Research Conference 2023 (THEconf2023): ‘Transforming healthcare in a changing world: new ways of thinking and working’ March 07th-09th 2023. <https://www.nursing-midwifery.tcd.ie/events-conferences/THEconference2023/call-for-abstracts.php>.
- I presented the study at a conference: Albandari Almuatairi (2024) The impact of child protection training on nurses’ self-efficacy in the detection and reporting of child abuse, Trinity Health and Education International Research Conference 2024 (THEconf2024): ‘New Horizons in Healthcare: Global impact, Local Relevance’ March 06th-07th 2024.

<https://www.tcd.ie/nursing-midwifery/events-and-conferences/>

8.3.2. Plan for Future Dissemination

Papers:

- The researcher plans to present and disseminate the study’s findings through conferences, presentations, and peer-reviewed publications.
- The Impact of Child Protection Training on Nurse’s Self Efficacy in Saudi Arabia.
- Reliability and validity of the Arabic version of the CANRSE questionnaire
- Understanding the detection and reporting of CAN cases: nurses’ role
- Barriers to reporting CAN cases.

Future plan:

- Proposed to collaborate with local organisations to arrange campaigns at hospitals and healthcare centres to increase awareness and promote better healthcare practices.
- Plan to collaborate with international researchers to expand the global impact of our research findings.
- Collaborate with the local experts in CAN and propose a child research centre.
- These findings will be featured in local magazines that are related to family and child health.

8.4. The Reflection of the Doctoral Programme in Terms of Learning and Development as a Researcher

As a nursing faculty member, I teach paediatric nursing and serve as a clinical instructor for nursing students at various hospitals. I have had the privilege of imparting knowledge and skills to future nurses. This experience has deepened my understanding of child healthcare and honed my pedagogical skills. However, teaching child health nursing presented real-world challenges and questions that could not be addressed solely through teaching and training, igniting a passion for research. I desired to learn more about paediatric healthcare and find evidence-based solutions to enhance the lives of children and their families. My passion for child health research led me to pursue a PhD abroad. The doctoral programme would provide me with the necessary research skills and mentorship to conduct meaningful research in child nursing.

Studying abroad also offered exposure to diverse perspectives and international collaborations, enriching my research journey. Transitioning to a full-time PhD student presented challenges, such as adapting to a new learning environment and navigating

research intricacies. However, I diligently embraced these challenges, sought guidance from my supervisors, and developed effective time management strategies.

Participating in Research Support and Education Days and peer support enabled me to engage in thought-provoking discussions, collaborate with experienced researchers, and expand my knowledge and expertise in a wide range of research projects and topics. These experiences greatly enhanced my critical thinking and analytical skills and provided valuable networking opportunities. In addition to the academic benefits, I had the opportunity to present my research at a conference, where I received valuable feedback and improved my communication skills. Through the supportive and nurturing environment of the programme, I have been encouraged to explore new research ideas and push the boundaries of my capabilities. The programme has provided me with numerous networking opportunities. Through interactions with fellow researchers and professionals in the field, I have established essential connections and built valuable relationships. These connections will undoubtedly prove beneficial in my future career endeavours. Overall, I am delighted with my decision to pursue this programme, as it has equipped me with the necessary skills and experiences to excel in the field of research.

Ultimately, my goal is to contribute to the body of knowledge in child nursing through rigorous research. I see myself as a bridge between academia and clinical practice, translating research findings into practical solutions that benefit nursing, children, and their families. By collaborating with multidisciplinary teams, I aim to create evidence-based interventions that improve young patients' overall quality of care. Additionally, I am passionate about advocating for the well-being and rights of children, ensuring that their voices are heard and their needs are met. Through my dedication to scholarship and compassion for paediatric healthcare, I am committed to making a lasting impact in child nursing.

In conclusion, my doctoral programme in child nursing has been a transformative journey that has deepened my expertise and fuelled my passion for providing the best possible care to young patients. I am immensely grateful for the opportunities and support I have received. I look forward to a career dedicated to improving the health and lives of children and their families through research and practice.

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Appendix A. Literature Review Search Strategy for Different Databases

Database: Medline

Search Terms	Search Options	
S17	S10 AND S15 AND S16	(111)
S16	S13 OR S14	(7,865,115)
S15	S11 OR S12	(5,992,776)
S14	TX (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigate* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR AB (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigate* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”)	(7,855,398)
S13	“intervention” OR (MH “Child Health Services”) OR (MH “Community Health Services”) OR (MH “Early Intervention (Education)”) OR (MH “Primary Prevention”)	(637,652)
S12	TX (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment) OR AB (Evaluate* OR Outcome	(5,205,460)

	OR "Programme Evaluation methods" OR "Programme Evaluation methods" OR "Quality Improvement" OR "Programme Evaluation" OR "Systems Analysis" OR "Treatment Outcomes" OR assessment)	
S11	"evaluation" OR (MH "Outcome and Process Assessment (Health Care)") OR (MH "Programme Evaluation+") OR (MH "Quality Improvement") OR (MH "Health Care Quality, Access, and Evaluation")	(1,518,777)
S10	S3 and S6 and S9	(311)
S9	S7 OR S8	(788,690)
S8	TX (counsellor* OR counselor* OR nurse* OR "nursing staff" OR "nursing personnel" OR psychiatrist* OR socialworker* OR "social worker*" OR psychologist* OR "health* worker*" OR "medical staff*" OR "medical personnel" OR "health care professional*" OR "clinical staff*" OR paediatrician* OR "health professional*" OR "health care provider*" OR "Allied Health Personnel" OR "health care provider") OR AB (counsellor* OR counselor* OR nurse* OR "nursing staff" OR "nursing personnel" OR psychiatrist* ...	(712,462)
S7	(MH "Nurses") OR (MH "Physicians") OR (MH "Social Workers") OR (MH "Counselors") OR (MH "Medical Staff")	(125,010)
S6	S4 OR S5	(67,401)
S5	TI ("child* abus*" OR Child Molestation* OR "Sexual Abuse of Child*" OR "Child Sexual Abuse*" OR "Sexual Child Abuse" OR "Sexual Child Molestation" OR "child* sexual molest*" OR "child neglect*" OR "neglect of a child*" OR "psychological abuse of a child" OR "child maltreatment" OR "Physical Abuse* Infants" OR "Physical Abuse* child") OR AB ("child* abus*" OR Child Molestation* OR "Sexual Abuse of Child*" OR "Child Sexual Abuse*" OR "Sexual Child Abuse" OR "Sexual Child Molestation" OR "child ...	(15,995)
S4	(MH "Domestic Violence") OR (MH "Child Abuse") OR (MH "Child Abuse, Sexual") OR (MH "Violence")	(63,452)
S3	S1 OR S2	(1,196,266)
S2	TI ("detection and reporting" OR "Substance Abuse Detection methods" OR "Child Abuse diagnosis" OR "Child Abuse legislation" OR "jurisprudence" OR "Signal Detection" OR "Decision Making" OR "policy" OR "Professional Role" OR "Attitude of Health Personnel"	(1,182,796)

	OR "Primary Health Care methods" OR "Child Abuse diagnosis" OR "Case Management legislation & jurisprudence" OR "Self Report" OR "Medical Records" OR "Patient Compliance" OR "Health Behaviour" OR "Health Knowledge" OR "Attitudes" OR "Practice ...	
S1	(MH "Mandatory Reporting") OR (MH "Substance Abuse Detection") OR (MH "Signal Detection, Psychological") OR (MH "Legislation") OR (MH "Legal Case") OR (MH "Guideline") OR (MH "Government Document") OR (MH "Form") OR (MH "Technical Report")	(15,747)

Database: CINAHL

**Search Search Options
Terms**

S20	S13 AND S18 AND S19	(28)
S19	S16 OR S17	(1,031,011)
S18	S14 OR S15	(1,097,581)

S17	TI (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR AB (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”)	(1,015,999)
S16	(MH “Early Childhood Intervention”) OR (MH “Early Intervention”) OR “intervention”	(249,850)
S15	TI (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment) OR AB (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment)	(1,071,697)
S14	(MH “Evaluation”) OR (MH “Programme Evaluation”) OR (MH “Course Evaluation”)	(42,669)
S13	S7 AND S8 AND S9	(94)
S12	S7 AND S8 AND S9	(94)
S11	S7 AND S8 AND S9	(94)
S10	S7 AND S8 AND S9	(108)
S9	S5 OR S6	(499,124)
S8	S3 OR S4	(55,927)
S7	S1 OR S2	(62,514)

S6	TI (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist* OR socialworker* OR “social worker*” OR psychologist* OR “health* worker*” OR “medical staff*” OR “medical personnel” OR “health care professional*” OR “clinical staff*” OR paediatrician* OR “health professional*” OR “health care provider*” OR “Allied Health Personnel” OR “health care provider”) OR AB (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist ...	(416,386)
S5	(MH “Physicians”) OR (MH “Consultants”) OR (MH “Counselors”) OR (MH “Medical Staff”) OR (MH “Nurses”) OR (MH “Community Health Workers”)	(123,636)
S4	TI ((Child* OR teen OR teenager* OR minor* OR infant OR youth OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR posttraumatic OR injur*)) OR AB ((Child* OR teen OR teenager* OR minor* OR infant OR youth OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR posttraumatic OR injur*))	(29,323)
S3	(MH “Child Abuse, Sexual”) OR (MH “Violence”) OR (MH “Community Violence”) OR (MH “Domestic Violence”) OR (MH “Exposure to Violence”) OR (MH “Gun Violence”) OR (MH “School Violence”) OR (MH “Sibling Violence”) OR (MH “Student Abuse”)	(31,500)
S2	TI ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*)) OR AB ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*))	(60,904)
S1	(MH “Programmemr Development”)	(196)

Database: Embase

No.	Query	Results
#19	#18 AND ([adolescent]/lim OR [child]/lim OR [infant]/lim OR [newborn]/lim OR [preschool]/lim OR [school]/lim)	286
#18	#17 AND ([adolescent]/lim OR [child]/lim OR [infant]/lim OR [newborn]/lim OR [preschool]/lim OR [school]/lim)	42,213
#17	#10 AND #13 AND #16	216
#16	#14 OR #15	1,071,974
#15	(intervention:ab,ti OR 'early intervention':ab,ti OR 'early diagnosis':ab,ti OR diagnosis:ab,ti OR investigat*:ab,ti OR 'health services':ab,ti OR prevention:ab,ti) AND control:ab,ti OR 'attitude of health personnel':ab,ti	1,067,244
#14	'intervention'/exp OR 'health workforce'/exp OR 'child hospitalization'/exp OR 'child welfare'/exp	42,213
#13	#11 OR #12	7,873,272
#12	evaluate*:ab,ti OR outcome:ab,ti OR 'programme evaluation methods':ab,ti OR 'quality improvement':ab,ti OR 'programme evaluation':ab,ti OR 'systems analysis':ab,ti OR 'treatment outcomes':ab,ti OR assessment:ab,ti	5,472,668
#11	'outcome assessment'/exp OR 'programme evaluation'/exp OR 'evaluation'/exp OR 'evaluation' OR 'follow up'/exp OR 'follow up'	4,119,790
#10	#3 AND #6 AND #9	3,889
#9	#7 OR #8	93,701
#8	'child abuse'/exp OR 'child abuse' OR (('child'/exp OR child) AND ('abuse'/exp OR abuse))	71,890
#7	((('child*' OR 'teen' OR 'minor' OR 'infant' OR 'youth' OR 'school-aged' OR 'baby' OR 'babies' OR adolescen*) NEAR/3 ('abus*' OR 'trauma*' OR 'sexual* abus*' OR 'neglect*' OR 'ptsd' OR 'post traumatic stress' OR injur)):ab,ti	47,370
#6	#4 OR #5	1,976,842
#5	'counsellor*':ab,ti OR 'nurse*':ab,ti OR 'nursing staff':ab,ti OR 'nursing personnel':ab,ti OR 'psychiatrist*':ab,ti OR 'social?worker*':ab,ti OR 'psychologist*':ab,ti OR 'health* worker*':ab,ti OR 'medical staff*':ab,ti OR 'medical personnel':ab,ti OR 'health care professional*':ab,ti OR 'clinical	521,483

	staff*:ab,ti OR 'paediatrician*':ab,ti OR 'health professional*':ab,ti OR 'health?care provider*':ab,ti	
#4	'social work practice'/exp OR 'professional practice'/exp OR 'health care organization'/exp OR 'staff'/exp OR 'counselor'/exp OR 'advanced practice provider'/exp OR 'clinician'/exp OR 'health workforce'/exp OR 'school administrator'/exp	1,571,595
#3	#1 OR #2	5,101,811
#2	'programme*':ab,ti OR 'framework*':ab,ti OR 'schem*':ab,ti OR 'structur*':ab,ti OR 'plan*':ab,ti OR (('model*' NEAR/3 ('screen*' OR 'detect*' OR 'report*' OR 'identif*'))):ab,ti	4,763,162
#1	'programme development'/exp	23,271

No.	Save History / Create Alert / Open Saved History	Results
# 7	#6 AND #5 AND #4 <i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	1,624
# 6	TS=(Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR TI=(Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) <i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	8,972,000
# 5	TS=(Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR TI=(Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) <i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	8,972,000
# 4	#3 AND #2 AND #1) AND DOCUMENT TYPES: (Review) <i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	2,919
# 3	TS=(Programme* OR framework* OR schem* OR structur* OR plan* OR model* NEAR/4 screen* OR detect* OR report* OR identif*) <i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	20,763,331

# 2	TS=(Child* OR teen OR teenager* OR minor* OR infant* OR youth* OR “school-aged” OR baby OR babies OR adolescen* NEAR/4 abus* OR trauma* OR “sexual* abus*” OR neglect* OR ptsd OR posttraumatic OR injur*)	3,854,946
	<i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	

# 1	TS=(counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist* OR socialworker* OR “social worker*” OR psychologist* OR “health* worker*” OR “medical staff*” OR “medical personnel” OR “health care professional*” OR “clinical staff*” OR paediatrician* OR “health professional*” OR “health care provider*” OR “Allied Health Personnel” OR “health care provider”)	209,564
	<i>Indexes=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC Timespan=1945-2020</i>	

Database: PsycINFO

Search Terms	Search Options	
S17	S7 AND S8 AND S9 AND S14 AND S15	(35)
S16	S7 AND S8 AND S9 AND S14 AND S15	(35)
S15	S12 OR S13	(398,469)
S14	S10 OR S11	(878,098)
S13	TI (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR AB (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”)	(398,288)
S12	((DE “Intervention” OR DE “Strategic Family Therapy” OR DE “Social Casework” OR DE “Group Counseling” OR DE “Group Intervention” OR DE “Group Psychotherapy” OR DE “Support Groups”) OR (DE “Hot Line Services”)) AND (DE “Behavior Change” OR DE “Affirmative Therapy” OR DE “Digital Interventions”)	(1,473)
S11	TI (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment) OR AB (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment)	(864,616)
S10	DE “Educational Programme Evaluation” OR DE “Treatment Process and Outcome Measures” OR DE “Evaluation”	(24,955)

S9	S3 OR S4	(144,421)
S8	S2 OR S6	(305,340)
S7	S1 OR S5	(85,656)
S6	TI (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist* OR socialworker*OR “social worker*” OR psychologist* OR “health* worker*” OR “medical staff*” OR “medical personnel” OR “health care professional*” OR “clinical staff*” OR paediatrician* OR “health professional*” OR “health care provider*” OR “Allied Health Personnel” OR “health care provider”) OR AB (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist ...	(263,816)
S5	TI ((Child* OR teen OR teenager*OR minor* OR infant OR youth OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR posttraumatic OR injur*)) OR AB ((Child* OR teen OR teenager*OR minor* OR infant OR youth OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR posttraumatic OR injur*))	(56,711)
S4	TI ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*)) OR AB ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*))	(61,597)
S3	((DE “Patient Reported Outcome Measures” OR DE “Reporting Standards” OR DE “Child Abuse Reporting” OR DE “Professional Consultation” OR DE “Health Care Delivery” OR DE “Treatment Effectiveness Evaluation”) AND (DE “Health Care Psychology” OR DE “Family Relations” OR DE “Screening”)) OR (DE “Decision Making”)	(84,604)
S2	(((((DE “Health Personnel”) OR (DE “Professional Consultation”)) OR (DE “Primary Health Care”)) OR (DE “Clinicians”)) OR (DE “Paramedics”)) OR (DE “Allied Health Personnel”)	(60,391)
S1	DE “Child Abuse” OR DE “Child Neglect” OR DE “Domestic Violence” OR DE “Emotional Abuse” OR DE “Patient Abuse” OR DE “Sexual Abuse” OR DE “Verbal Abuse” OR DE “Violent Crime”	(55,916)

Database: Social Sciences

Search Terms	Search Options	
S16	S3 AND S6 AND S9 AND S12 AND S15	3
S15	S13 OR S14	(142,501)
S14	TI (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”) OR AB (Intervention Or “Early Intervention” OR “Early Diagnosis” or diagnosis or Investigat* OR “Health Services” OR “Prevention and Control” OR “Attitude of Health Personnel”)	(136,429)
S13	(((DE “Peer review (Professional performance)”) OR (DE “Child protection services”) OR (DE “Child welfare”) OR (DE “Psychometrics”) OR (DE “Evaluation of human services programmes”)	(8,151)
S12	S10 OR S11	(89,905)
S11	TI (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment) OR AB (Evaluate* OR Outcome OR “Programme Evaluation methods” OR “Programme Evaluation methods” OR “Quality Improvement” OR “Programme Evaluation” OR “Systems Analysis” OR “Treatment Outcomes” OR assessment)	(88,559)
S10	(DE “Evaluation of medical care”) OR (DE “Evaluation research (Social action programmes)”)	(2,233)
S9	S7 OR S8	(30,130)

S8	TI (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist* OR socialworker* OR “social worker*” OR psychologist* OR “health* worker*” OR “medical staff*” OR “medical personnel” OR “health care professional*” OR “clinical staff*” OR	(28,631)
	paediatrician* OR “health professional*” OR “health care provider*” OR “Allied Health Personnel” OR “health care provider”) OR AB (counsellor* OR counselor* OR nurse* OR “nursing staff” OR “nursing personnel” OR psychiatrist* ...	
S7	((DE “Medical personnel”) AND (DE “Allied health personnel” OR DE “Health care intervention (Social services)”) OR (DE “Child welfare workers”)) OR DE “Children’s rights” OR DE “Decision making in child welfare” OR DE “School safety” OR DE “Services for children”)	(1,662)
S6	S4 OR S5	(13,552)
S5	TI ((Child* OR teen OR teenager* OR minor* OR infant* OR youth* OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR ptsd OR posttraumatic OR injur*)) OR AB ((Child* OR teen OR teenager* OR minor* OR infant* OR youth* OR school-aged OR baby OR babies OR adolescen*) N4 (abus* OR trauma* OR “sexual* abus*” OR neglect* OR ptsd OR posttraumatic OR injur*))	(12,033)
S4	(DE “Child abuse”)	(3,629)
S3	S1 OR S2	(12,025)
S2	TI ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*)) OR AB ((Programme* OR framework* OR schem* OR structur* OR plan* OR model*) N4 (screen* OR detect* OR report* OR identif*))	(12,024)
S1	(((((DE “Reporting of child sexual abuse” OR DE “Theory & practice” OR DE “Reporting of family violence”) OR (DE “Social action”)) OR (DE “Programmmed instruction”)) OR (DE “Community education”)) OR (DE “School violence”)) AND (DE “Social cognition theory (Communication)” OR DE “Social case work with children”))	(111,656)

Appendix B. General Characteristics and Outcomes of Included Studies

Authors ID	Country /Sample Size	Topic/Aim	Programme	Population in the Study	Approach for Evaluation	Results/Conclusions/ Key Findings	Limitations
Alvarez et al., (2010b)	US/55	To develop a training curriculum to assist professionals in reporting suspected child maltreatment. To further develop the workshop that was favourably evaluated in the aforementioned study by Donohue et al. (2002).	A training programme to assist professionals in effectively reporting suspected child maltreatment (Child Maltreatment Reporting workshop)	Professional and student mental health practitioners	Randomised control (pre-post-test): including standardised training protocols. Random assignment of participants to control workshop (Ethnic cultural sensitivity was chosen as the comparison workshop).	Participants who were assigned to this training program improved their knowledge of State and Federal laws, were able to identify child maltreatment scenarios, and evidenced knowledge of requisite clinical skills relevant to reporting suspected child maltreatment more than participants who were randomly assigned to a control workshop focusing on ethnic and cultural sensitivity	The sample size did not permit examination of the degree to which the level of training or professional background may have influenced study results, and potential selection biases were not examined.

Smeeckens et al., (2011)	Netherlands/38	To evaluate the effectiveness of an e-learning programme in the recognition of child abuse in terms of the effect on both the performance during a case simulation and on self-efficacy in a randomised controlled trial.	E-learning programme on child abuse. The programme consists of three different modules: recognition, acting, and communication. The e-learning programme contains simulations of clinical cases, video animations, and interactive elements. Participants were instructed to complete the programme in a minimum duration of 2 h during a 2-week period either at the hospital or at home.	ED nurses	A randomised controlled trial was performed using a pre- and post-intervention design	E-learning improved the performance in case simulations and the self-efficacy of the nurses in the ED in the detection of child abuse	A drop-out rate of 36% due to participants' shift pattern. This high drop-out rate might limit the generalizability of the findings. Due to the simulated setting, the interaction between parent and child is hard to represent and this could have influenced the outcome of that particular item. The time allowed to accomplish the task was not restricted during the case simulation.

McMahon-Howard & Reimers (2013)	US/123	1) to explore child protective service (CPS) employees' beliefs and knowledge regarding commercial sexual exploitation of children (CSEC) prior to participating in the CSEC training programme. (2) to determine if participation in a CSEC webinar training programme improved CPS employees' CSEC beliefs and knowledge, and (3) to determine if participation in a CSEC webinar training programme increased referrals for specialised, CSEC services.	CSEC training programme in the United States	All social service staff	Experimental pre- and post-test design using random sampling in treatment and control groups. Method of data collection: Questionnaire (1: to measured participants' pro-CSEC victim beliefs. 2: to measure participants CSEC knowledge. 3: All participants who completed the online questionnaire were emailed again approximately three months later and were asked to complete another online questionnaire)	90-min CSEC webinar training is effective for increasing CPS employees' knowledge about CSEC. Significant improvement in participant's ability to identify the risk factors for entry into CSEC increased their knowledge of local laws and services regarding CSEC and their self-reported willingness to refer CSEC victims and children 'at risk' for CSEC to specialised services.	Sample only included CPS employees in Georgia who volunteered to participate in this study. Findings are not generalisable to all CPS employees. A number of participants switched out of their assigned group due to scheduling conflicts and an error in the training registration system. The resulting quasi-experimental design is an improvement over previous research, which used one-group designs. Use of ANCOVA models, to control for differences between the two groups enabled valid estimates of the effects of the training.

Maguire-Jack & Byers, (2013)	US/13	To understand whether the availability of maltreatment prevention programmes is an external factor affecting CPS decisions	Various child maltreatment prevention programmes are available	CPS workers and supervisors from four Wisconsin counties who make decisions regarding: (1) whether to screen in reported cases of alleged maltreatment for an investigation; (2) whether to substantiate allegations; (3) whether to move a case into ongoing services; and (4) whether to remove a child from the home.	Modified Analytic Induction methodology was applied as a means of conducting comparative analysis. A semi-structured interview guide was developed a priori and was used to conduct the interviews	(1) the availability of prevention resources matters for CPS worker decision making; (2) workers' awareness of service gaps affects the types of services they provide to families when a case is opened; and (3) prevention services were viewed as a "check" on a family's well-being; willingness to work on the identified challenges and degree of compliance with the programme factored into the worker's decisions	(1) The study was limited to four counties in the state of Wisconsin that were selected because they ranked on the extreme ends of the prevention service availability and maltreatment level continuums. (2) length of the interviews
Abeid et al., (2016)	Tanzania /320	To assess the impact of the training of health professionals	A clinical training curriculum for health care workers (HCWs) which includes gender-based violence GBV screening protocols. This was a 5-day training programme which was conducted using the	HCWs selected from the district hospital and the five health centres in the intervention area	This was an intervention study which employed pre- and post-comparison cross-sectional surveys to evaluate HCWs' knowledge, attitude, and clinical practice related to sexual violence before and after a training programme. It was a self-administered survey	A significant improvement in the care of survivors was observed in most of the items used to measure practice in the intervention but not in the comparison area. Training on the management of sexual violence is effective in improving healthcare workers' knowledge and practice but not their attitude	Higher number of doctors in the intervention than in the comparison area. This difference in HCWs could be attributed to the geographical location. The findings cannot be generalised to the entire country. Being a quasi-experimental design, this may have resulted in cluster effects

			WHO/UNHCR guidelines and the National GBV management guidelines				
Flemington & Fraser (2017)	Vietnam/ 116	Evaluation of a clinical training programme aimed at improving emergency staff knowledge, attitudes and reporting behaviours concerning child abuse presentations in the emergency care setting	Safe Children Vietnam. The programme included a take- home workbook, in- service presentations, a DVD screening, and a two-day interactive workshop	Emergency department doctors, nurses and healthcare staff were eligible for the study. Staff were invited to participate by the chief investigator with support from the medical and nursing directors	Using pre- and post- intervention design with long- term follow-up. Data collection: The Safe Children Vietnam Child Abuse and Neglect Questionnaire (CANQ). Attitudes towards reporting were explored through a series of statements replicated from the CANQ implementation in Australia. Knowledge and Intention to Report According to Vignettes: Recognition and reporting behaviour of child abuse cases were explored through four vignettes, each focusing on a different type of abuse (child physical abuse, child emotional	Staff were more likely to acknowledge the seriousness of abuse following participation in the programme. Attitudes towards reporting or likelihood to report child abuse in this study remained relatively stable over the duration of the study	The study site may not be representative of all emergency care settings in Vietnam. There is potential for subtle differences in characteristics not detectable by statistical testing. Self-selection bias. The post-test surveys does not reflect actual programme participation. Attendance was likely limited to emergency staff that were rostered on those particular days

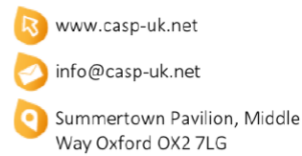
					abuse, witnessing intimate partner violence, and child sexual abuse)		
Lee & Chou, (2017)	Taiwan/80	To design a training programme for nurses and evaluate the effectiveness of the training programme in improving the nurses' self-efficacy in reporting cases of child abuse and neglect	Child abuse and neglect (CAN) training programmes	80 clinical nurses: 40 in an experimental group and 40 in a control group; the pre-test, post-test and follow-up results were compared between the groups.	A quasi-experimental research design	The results supported the hypothesis that nurse self-efficacy in reporting child abuse and neglect cases would improve after completing the Child Abuse and Neglect Training Program for Nurses	The study acknowledged that the short duration of the training programme was a limitation
Musiwa(2018)	Zimbabwe/ 38	Assessing how the presence of the Victim-Friendly Court VFC and key child protection policy and legal frame works has affected the management of Intrafamilial Child Sexual Abuse Intrafamilial Child Sexual Abuse (ICSA) in Zimbabwe	Civil Society Organizations (CSOs) and Family Support Services and Legal Aid Society of Zimbabwe	All professionals from the 13 agencies implementing the VFC initiative in Marondera: 25 VFC professionals, key informants and records of ICSA cases managed by the VFC	A mixed-methods case study, semi-structured interview guides were used to collect data from the 15 key informants via one-on-one interviews, Sem-structured questionnaires were used to collect data from the 25 VFC professionals who were given 2 weeks to fill in the questionnaires. Reviewing court records of ICSA cases managed by the VFC	The VFC system in Marondera is perceived to be effective in permeating negative sociocultural barriers which prevent people from reporting. Enhanced coordination among VFC agencies. However, the same frameworks are perceived to be fraught with gaps and inconsistencies, too prescriptive, incoherent with some key aspects of the National Constitution and international child rights standards, and poorly resourced for effective implementation. All this has negatively affected the management of ICSA	Due to the small sample size used, the study should not be taken as entirely conclusive. Circumstances may differ from one VFC to another. Thus, this study should not be taken as entirely generalisable to all VFCs, though critical relationships can be drawn

Albright et al., (2019)	US and Netherlands/77	To investigate how effectiveness is measured and perceived by workers in the CPS systems in the Netherlands and the United States, using Colorado as a representative state within the US	The CPS system in the Netherlands and in US	In-depth semi-structured interviews were conducted with national, and local level administrators and CPS workers. Interviewees included front line employees with deep knowledge of daily mechanics and processes (e.g. agency directors, social workers) as well as experts and thought leaders who possessed historical memory and perspective about their site's CPS system	Qualitative comparative case study, to compare the development, function, and effectiveness of CPS systems in Colorado, the Netherlands	Both systems in this study lack the ability to collect data on the quality of their services and the longitudinal outcomes for the children and families they serve. Need to develop measures for positive outcome	Generalizability, the sample size of this study was relatively small
Paek et al., (2019)	South Korea/663	To evaluate the effectiveness of education programme for health care providers as pilot study	The educational programme consisted of two 2-hour-long didactic lectures and was held at 15 hospitals between July and December 2016	Participants completed survey questionnaires before and after the lecture and 3 months later	846 participants completed two questionnaires before and immediately after the education and 633 participants completed the final questionnaire three months after the education	Participants' knowledge about child abuse improved significantly from 5.28 points before the educational programme to 8.03 points immediately after the programme and 7.1 points three months later. Confidence in reporting suspected cases of child abuse also increased, with scores rising from 4.76	Small Sample Size and Short Study Period. The study's cross-sectional design limits the depth of understanding of the phenomenon being studied

					before the programme to 7.59 after the programme and 6.6 three months later. The study observed an increase in the number of reported cases of child abuse in the educated areas, indicating a positive impact of the educational programme on healthcare providers' reporting behaviour	
Giannakas et al., (2022)	Greece/600	Develop a participatory educational workshop in CAN for medical students. To 20 gather, train, and establish a peer-to-peer teaching group. To assess the effectiveness of the workshop in gain of knowledge and improvement of self-confidence for participants	The programme described in the PDF file is a participatory workshop designed to educate medical students on the identification and management of child abuse and neglect (CAN). The workshop included the following components: Simulation-Based Medical Education (SBME). Peer-to-Peer Teaching Group. Recruitment and Training of Actors.	A two-hour workshop was created with role playing, the use of mannikins and peer-to-peer teaching. A 15 item knowledge and a nine item self-confidence questionnaire were used before, right after, and six months after each workshop	Participants showed statistically significant gains in knowledge immediately after the workshops ($p < .001$) and six months after the workshops ($p < .0001$). Increased self-confidence in recognising and managing child abuse and neglect cases. Feedback from participants highlighted the effectiveness of workshops compared to traditional lectures. While the initial gains in knowledge slightly decreased in the six-month follow-up evaluation, participants still performed better than before the workshops	The study did not include a control group for comparison. The study did not assess long-term outcomes beyond six months. Participants only had the opportunity to manage one case scenario during the workshop due to time constraints. This may have restricted the breadth of exposure to different types of child abuse and neglect cases

Legal Mandates
and
Communication
Tips.
Feedback and
comments from
participants
were collected
and analysed

Appendix C. Critical Appraisal: Qualitative Studies using the Critical Appraisal Skills Programme (CASP, 2018) Checklist



CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- ▶ Are the results of the study valid? (Section A)
- ▶ What are the results? (Section B)
- ▶ Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Sections:	Maguire-Jack and Byers (2013)	Albright et al. (2019)
Was there a clear statement of the aims of the research?	No	Yes
Is a qualitative methodology appropriate?	YES	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes
Was the recruitment strategy appropriate for the aims of the research?	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	No	No
Have ethical issues been taken into consideration?	No	No
Was the data analysis sufficiently rigorous?	Yes	Yes
Is there a clear statement of findings?	Yes	Yes
How valuable is the research?	Yes	Yes

Appendix D. Mixed Methods Appraisal Tool (MMAT): Mixed Methods, and Quantitative Descriptive Studies

MIXED METHODS APPRAISAL TOOL (MMAT) VERSION 2018

User guide

Prepared by

Quan Nha HONG^a, Pierre PLUYE^a, Sergi FÀBREGUES^b, Gillian BARTLETT^a, Felicity BOARDMAN^c,
Margaret CARGO^d, Pierre DAGENAIS^e, Marie-Pierre GAGNON^f, Frances GRIFFITHS^c, Belinda NICOLAU^a,
Alicia O'CATHAIN^g, Marie-Claude ROUSSEAU^h, & Isabelle VEDEL^a

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^dUniversity of Canberra, Canberra, Australia; ^eUniversité de Sherbrooke, Sherbrooke, Canada; ^fUniversité Laval, Québec, Canada;

^gUniversity of Sheffield, Sheffield, England; ^hInstitut Armand-Frappier Research Centre, Laval, Canada

Last update: August 1st, 2018



McGill

Department of Département de
Family Medicine médecine de famille
Academic excellence and innovation in care, teaching and research
Innovation et excellence académique dans les soins, l'enseignement et
la recherche

What is the MMAT?

The MMAT is a critical appraisal tool that is designed for the appraisal stage of systematic mixed studies reviews, i.e., reviews that include qualitative, quantitative and mixed methods studies. It permits to appraise the methodological quality of five categories to studies: qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies, and mixed methods studies.

How was the MMAT developed?

The MMAT was developed in 2006 (Pluye et al., 2009a) and was revised in 2011 (Pace et al., 2012). The present version 2018 was developed on the basis of findings from a literature review of critical appraisal tools, interviews with MMAT users, and an e-Delphi study with international experts (Hong, 2018). The MMAT developers are continuously seeking for improvement and testing of this tool. Users' feedback is always appreciated.

What the MMAT can be used for?

The MMAT can be used to appraise the quality of empirical studies, i.e., primary research based on experiment, observation or simulation (Abbott, 1998; Porta et al., 2014). It cannot be used for non-empirical papers such as review and theoretical papers. Also, the MMAT allows the appraisal of most common types of study methodologies and designs. However, some specific designs such as economic and diagnostic accuracy studies cannot be assessed with the MMAT. Other critical appraisal tools might be relevant for these designs.

What are the requirements?

Because critical appraisal is about judgment making, it is advised to have at least two reviewers independently involved in the appraisal process. Also, using the MMAT requires experience or training in these domains. For instance, MMAT users may be helped by a colleague with specific expertise when needed.

How to use the MMAT?

This document comprises two parts: checklist (Part I) and explanation of the criteria (Part II).

1. Respond to the two screening questions. Responding 'No' or 'Can't tell' to one or both questions might indicate that the paper is not an empirical study, and thus cannot be appraised using the MMAT. MMAT users might decide not to use these questions, especially if the selection criteria of their review are limited to empirical studies.
2. For each included study, choose the appropriate category of studies to appraise. Look at the description of the methods used in the included studies. If needed, use the algorithm at the end of this document.
3. Rate the criteria of the chosen category. For example, if the paper is a qualitative study, only rate the five criteria in the qualitative category. The 'Can't tell' response category means that the paper do not report appropriate information to answer 'Yes' or 'No', or that report unclear information related to the criterion. Rating 'Can't tell' could lead to look for companion papers, or contact authors to ask more information or clarification when needed. In Part II of this document, indicators are added for some criteria. The list is not exhaustive and not all indicators are necessary. You should agree among your team which ones are important to consider for your field and apply them uniformly across all included studies from the same category.

How to score?

It is discouraged to calculate an overall score from the ratings of each criterion. Instead, it is advised to provide a more detailed presentation of the ratings of each criterion to better inform the quality of the included studies. This may lead to perform a sensitivity analysis (i.e., to consider the quality of studies by contrasting their results). Excluding studies with low methodological quality is usually discouraged.

How to cite this document?

Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

Category of Study Designs	Methodological Quality Criteria	McMahon-Howard et al. (2013)	Abeid, et al. (2016)	Lee and Chou (2017)	Flemington and Fraser (2017)	Alvarez, et al. (2010)	Smeekens et al. (2011)	Musiwa (2018)	Paek et al., (2019)	Giannakas et al., (2022)
1. Screening questions (for all types)	S1. Are there clear research questions?	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
	S2. Do the collected data allow addressing the research questions?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?						Yes			
	2.2. Are the groups comparable at baseline?						Yes			
	2.3. Are there complete outcome data?						Yes			
	2.4. Are outcome assessors blinded to the intervention provided?						cannot tell			
	2.5 Did the participants adhere to the assigned intervention ?						cannot tell			
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?	No	Yes	Yes	Yes	No			No	Yes
	3.2. Are the measurements appropriate regarding both the outcome and intervention (or exposure)?	Yes	Yes	Yes	Yes	Yes			Yes	Yes
	3.3. Are the outcome data	Yes	Yes	Yes	Yes	yes			Yes	Yes

	comprehensive?									
	3.4. Are the confounders accounted for in the design and analysis?	cannot tell	cannot tell	No	Yes	Yes			Yes	Cannot tell
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	Cannot tell	Yes	Yes	Cannot tell	Cannot tell			Can't tell	Yes
Fixed-method	5.1. Is there an adequate rationale for using a mixed-methods design to address the research question?							Yes		
	5.2. Are the different components of the study effectively integrated to answer the research question?							Yes		
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?							Yes		
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?							Cannot tell		
	5.5. Do the different components of the study adhere to the quality criteria of each							Cannot tell		

	tradition of the methods involved?									

Appendix E. Approval from the Author to Use the CANRSE Questionnaire

June Colgrave <June.Colgrave@scu.edu.au>
To: Albandari Almutairi <almutaal@tcd.ie>
Cc: Jennifer Fraser <jennifer.fraser@sydney.edu.au>

15 July 2020 at 01:44

Good morning Albandari

I have attached the Child abuse and reporting self-efficacy questionnaire – English version for you. (CANRSE (Eng))

I have attached the article that I wrote on the psychometric properties of CANRSE.

I would ask that you please reference us if you use the article and / or CANRSE questionnaire.

I wish you well in your study and look forward to hearing about your findings.

Please contact me if I can be of any further assistance.

Kind regards

June

June Colgrave, RN, MN, MACN

Director on Board of Australian College of Children and Young People's Nurses

Lecturer, Nursing

Southern Cross University

Appendix F. Instruction for the Rating Scale for the Validation of Survey

Dear Experts

You are being invited to participate in a research study conducted by Albandari to validate a survey that will: Measure the impact of a child abuse training program on nurses' self-efficacy in recognising and responding to known and suspected cases of Child Abuse and Neglect (CAN) in Saudi Arabia.

Student Investigator: Albandari Almutairi

PhD student at School of Nursing and Midwifery

Trinity College Dublin

Contact Number: +966503252245; Email: ALMUTAAL@TCD.IE

INSTRUCTIONS FOR VALIDATING THE QUESTIONNAIRE:

This tool has eight domains:

- Demographic variables
- Attitude and feelings about reporting
- Education and training experiences
- Knowledge of the law
- Intended reporting behaviour
- Self-efficacy with suspected/Known cases of CAN (EES/K: 16 items comprising four subscales)
- Outcome expectations (OE: 12 items comprising three subscales)

- Gerernal Self-efficacy Scale which is a 10-item scale.

Kindly review this tool and provide your feedback on the following:

- The relevance of each question in the tool (how important is the question)
- The clarity of each question (how clear is the wording)
- Recommendations for the improvement of each question

Kindly be as objective and constructive as possible by following the scale below.

- “1” = not relevant
- “2” = Somewhat relevant
- “3” = quite relevant
- “4” = highly relevant and succinct

If you have any comments or correction regarding the questionnaire, please mention them on the copy provided.

Appendix G. CVI

Item	Expert A	Expert B	Expert C	Expert in Agreement	Expert in Agreement 3 or 4	I-CVI	UA (1-0)
1	4	4	4	12	3	1	1
2	4	4	4	12	3	1	1
3	4	4	4	12	3	1	1
4	4	4	4	12	3	1	1
5	4	4	4	12	3	1	1
6	4	4	4	12	3	1	1
7	4	4	4	12	3	1	1
8	4	4	4	12	3	1	1
9	2	4	4	10	2	0.6	0
10	4	4	4	12	3	1	1
11	4	3	4	11	3	1	1
12	4	4	4	12	3	1	1
13	4	4	4	12	3	1	1
14	4	4	4	12	3	1	1
15	4	4	4	12	3	1	1
16	4	4	4	12	3	1	1
17	4	4	4	12	3	1	1
18	4	4	4	12	3	1	1
19	4	4	4	12	3	1	1
20	4	4	4	12	3	1	1
21	4	4	4	12	3	1	1
22	4	4	4	12	3	1	1

23	4	4	4	12	3	1	1
24	4	4	4	12	3	1	1
25	4	4	4	12	3	1	1
26	4	4	4	12	3	1	1
27	4	4	4	12	3	1	1
28	4	4	4	12	3	1	1
29	4	4	4	12	3	1	1
30	2	4	4	10	2	0.6	0
31	3	4	4	11	3	1	1
32	3	4	4	11	3	1	1
33	3	4	4	11	3	1	1
34	4	4	4	12	3	1	1
35	4	4	4	12	3	1	1
36	4	4	4	12	3	1	1
37	4	4	4	12	3	1	1
38	4	4	4	12	3	1	1
39	4	4	4	12	3	1	1
40	4	4	4	12	3	1	1
41	4	4	4	12	3	1	1
42	4	4	4	12	3	1	1
43	4	4	4	12	3	1	1
44	4	4	4	12	3	1	1
45	4	4	4	12	3	1	1
46	4	4	4	12	3	1	1
47	4	4	4	12	3	1	1
48	4	4	4	12	3	1	1
49	4	4	4	12	3	1	1
50	4	4	4	12	3	1	1

51	4	4	4	12	3	1	1
52	4	4	4	12	3	1	1
53	4	4	4	12	3	1	1
54	4	4	4	12	3	1	1
55	4	4	4	12	3	1	1
Proportion of relevance =	0.9	1	1	S-CVI = .98 S-CVI Avg based on the proportion of relevance = .96			

Appendix H. Survey Changes

Domain	Original Questionnaire	Modified Questionnaire
Demographics:	What is your age? ☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65	Added age group: More than 75 years What is your age? ☐ 18-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 66-75 ☐ > 75.
	No question about the participants' nationality.	What is your nationality? ☐ Saudi. ☐ Non-Saudi. ☐ I prefer not to say. Others:
	What is your highest qualification? ☐ Highschool ☐ College Certificate ☐ Diploma ☐ Undergraduate Degree ☐ Post-graduate Qualification ☐ Masters ☐ Doctorate ☐ PhD ☐ Other (please specify)	What is your highest education qualification? ☐ High school ☐ College certificate ☐ Diploma ☐ Undergraduate degree ☐ Masters ☐ PhD Other (please specify)
	What is the location of your current workplace? ☐ Regional NSW ☐ Rural NSW ☐ Remote NSW	What is the location of your current workplace? ☐ Central region (Riyadh) ☐ Eastern region (Al Ahasa) ☐ Eastern region (Dammam) ☐ Western region (Jeddah) ☐ Western region (Medina)
Job details:	What is the title of your main job? ☐ Nurse ☐ Doctor ☐ Allied Health ☐ Supervisor ☐ Other (please specify)	What is your job title? ☐ Charge nurse ☐ Staff nurse ☐ Supervisor ☐ Other (please specify)
	Including this year, how many years have you worked in the Emergency Department? o1 o2 o3 o4	Including this year, how many years have you worked in the Paediatrics Department? ☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ 10+

	☐ 5 ☐ 5+	
Attitude and feeling about reporting:	I fear reprisals from reporting child abuse and neglect. Do you feel that your supervisor, team leader, or manager would support you in reporting suspected child abuse or neglect? ☐ Yes ☐ No ☐ NA	I fear revenge because of reporting child abuse and neglect. When reporting the suspected child abuse or neglect, were you supported by any one of them? ☐ Supervisor ☐ Team leader ☐ Manager ☐ No one Other: Specify the position
Education and training:	Have you had any formal training specifically related to child abuse and neglect and/or child protection? ☐ Yes ☐ No	Have you had any formal training specifically related to child abuse and neglect and/or child protection? ☐ Yes ☐ No ☐ Can't remember.
	As a Mandatory Reporter delivering healthcare in NSW, I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a series of acts or omissions. ☐ Yes ☐ No ☐ I am unsure	As a Mandatory Reporter delivering healthcare in SA, I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a single act of abuse or omission of a basic need. ☐ Yes ☐ No ☐ I am not sure. If you are not sure, why?
Knowledge of Law:	When my legislative duty to report child abuse and neglect is activated, I have to report it to (You may tick more than one box): ☐ Child Well-being Unit ☐ Child Protection Helpline ☐ NSW Department of Family and Community Services ☐ The Police ☐ I am unsure	When my legislative duty to report child abuse and neglect is activated, I have to report it to (You may tick more than one box): ☐ Suspected Child Abuse and Neglect (SCAN) team ☐ Child Protection Helpline. ☐ The Police. ☐ I am unsure.
	When my legislative duty to report child abuse and neglect is activated, I can report the relevant details about the case by: (you may tick more than one box) ☐ Making a phone call ☐ Sending a fax	When my legislative duty to report (child abuse and neglect) is activated, I can report the relevant details about the case by: (you may tick more than one box) ☐ Making a phone call

	- o Complete an online form - o I am unsure how to report	- o Making a phone call to protection helpline 1919. - o Making a phone call to child helpline 116111. - o Sending a fax - o Sending an E-mail - o Complete online form - o Consultation with nominated person in department - o Hospital social services department - o I am unsure how to report
	If I fail to make a report when my reporting duty is activated, the maximum financial penalty under legislation that can apply to me in NSW is a fine of: - o \$0 (no penalty) - o \$50 - o \$750 - o \$2,000 - o \$10,000 - o \$22,000 - o \$50,000 - o I am unsure	If I fail to make a report when my reporting duty is activated, the maximum penalty under legislation that can apply to me in SA is one of the following: - o Changing your profession - o Losing their job - o No penalty - o I am not sure.
Intended reporting behaviour:	You receive a direct disclosure that on one occasion about 6 months ago, a stepfather had sexual intercourse with his 16 year old stepdaughter. There are no obvious signs of harm to the girl, and the stepfather, the girl and her mother all assure you quite convincingly that the whole family is fine.	You receive a direct disclosure that on one occasion about 6 months ago, a stepfather had sexual intercourse with his 14-year-old stepdaughter. There are no obvious signs of harm to the girl, and the stepfather. The girl and her mother assure you quite convincingly that the whole family is fine.
	Parents often compare the school performance of their 16 year old son to that of other boys (and their own older sons), and they tell him he'll never amount to anything. They ridicule, criticise and punish him when he does not do well in exams. The boy shows signs of depression and anxiety.	Parents often compare the school performance of their 12-year-old son to that of other boys (and their own older sons). They also tell him he'll never amount to anything. They ridicule, criticise, and punish him when he does not do well in exams. The boy shows signs of depression and anxiety.
Qualitative Questions.	Please give a brief description.	Please give a brief description (The most not include any identifying information)

Appendix I. Ethical Approval King Abdullah International Medical Research Centre (KAIMRC)



Kingdom of Saudi Arabia
Ministry of National Guard - Health Affairs



King Abdullah International Medical Research Center
(KAIMRC)

المملكة العربية السعودية
وزارة الحرس الوطني - الصحة

IRB NCBE Registration No.:
H-01-R-005

IRB Office

Memo Ref.No. IRBC/1078/21

E-CTS Ref. No. 

RYD-21-419812-80225

Study Number: **SP21R/204/05**
 Study Title: **To study the impact of a training programme on nurses' self-efficacy in detecting and responding to suspected cases of child abuse and neglect**
 Study Sponsor: **Non grant**
 IRB Approval Date: **14 June 2021**
 IRB Review Type: ☒ **Expedited Review** ☐ **Full Board**
 Study site(s): **Central Region**

Dear **Dr. Hamad Al Khalaf**
 Consultant, King Abdullah Specialized Children's Hospital
 Ministry of National Guard – Health Affairs

Sub-investigator/s – Albandari Almutairi

After reviewing your submitted research proposal/protocol and related documents, the **IRB has APPROVED** the submission. The approval includes the following related documents:

Document/Title	Version	Date
Research Proposal	01	14 June 2021
Data Collection Form	01	14 June 2021
Inform Consent Form	01	14 June 2021

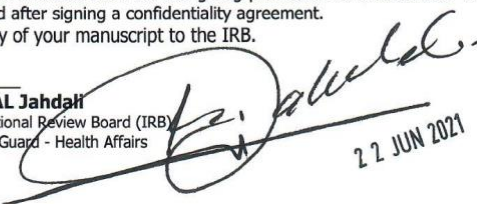
The approval of the research study is valid for **one year** from the above approval to expiration date.

Terms of Approval:

- **Annual Reports:** An Annual report must be submitted for approval to avoid termination/suspension of your research.
- **Financial report:** If your study is funded project, details financial report should be submitted with the scientific report.
- **Final Report:** After completion of the study, a final report must be forwarded to the IRB.
- **Retention of original data:** The PI is responsible for the storage and retention of original data pertaining to the project for a minimum of five years.
- **Reporting of adverse events or unanticipated problems:** The PI is responsible to report any serious or unexpected adverse events or unanticipated problems, which could involve any risk to participants or others, or any event on incidents that may have impact on the research or participants.
- **Biological samples:** No biological samples to be shipped out of the Kingdom of Saudi Arabia without prior IRB approval.
- **Participant incentives:** No financial compensation or gifts to be given to participants without prior IRB approval.
- **Storage of biological samples:** All biological samples collected for the purpose of this research must be stored in the KAIMRC related repository.
- You will need to resubmit the proposal to the IRB for review and re-approval before implementing any changes to the approved proposal.
- It is possible that the IRB may decide that the proposed new changes may exclude the proposal from being accepted for exempt review.
- It is your responsibility to safely store the data collected.
- Please note that phone based surveys are not permitted.
- If your approved proposal requires access to Bestcare, please write to the IRB informing them of the name of the designated data collector and exactly define the period requested for collecting data. Do not start the data collection until an approval memo is issued from the IRB giving permission to that collector to start accessing Bestcare for the duration of the project and after signing a confidentiality agreement.

To submit a copy of your manuscript to the IRB.

Prof. Hamdan AL Jahdali
 A/Chairman, Institutional Review Board (IRB)
 Ministry of National Guard - Health Affairs


 22 JUN 2021

HJ/AQ/AJ

Appendix J. Ethical Approval Faculty Research Ethical Committee (FREC)



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Albandari Lafi Almutairi
School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin, D02 T283

13th October 2021

Ref: 210908

Title of Study: An evaluation of the impact of a child protection training programme on nurses' self-efficacy in detection and reporting of child abuse.

Dear Albandari,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in September 2021. We are pleased to inform you that the above project has ethical approval to proceed.

This study has been ethically approved. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement'

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee

Appendix K. Child Abuse and Neglect Reporting Questionnaire

Section A: Demographics:

Q1. Are you male or female?

- ☐ Male
- ☐ Female
- ☐ Non- specified

Q2. What is your age?

- ☐ 18-25
- ☐ 26-35
- ☐ 36-45
- ☐ 46-55
- ☐ 56-65
- ☐ 66-75
- ☐ > 75.

Q3. What is your nationality?

- ☐ Saudi.
- ☐ Non-Saudi.
- ☐ I prefer not to say.
- ☐ Others:

Q4. What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Prefer not to say
- ☐ Other (please specify):

Q5. What is your highest education qualification?

- ☐ High school.
- ☐ College certificate
- ☐ Diploma
- ☐ Undergraduate degree
- ☐ Masters
- ☐ PhD
- ☐ Other (please specify) * They must not include any identifying information.

Q6. Are you a parent?

- ☐ Yes
- ☐ No

If yes, how many children do you have? * They must not include any identifying information

Section B: Job Details

Q7. What is your job title?

- ☐ Charge nurse
- ☐ Staff nurse
- ☐ Supervisor
- ☐ Other (please specify). * They must not include any identifying information.

Q8. Are you now or have you ever been: employed in paediatrics area?

- ☐ Yes
- ☐ No

If yes, please give a brief description*They must not include any identifying information.

- ☐ Central region (Riyadh)
- ☐ Eastern region (Al Ahasa)
- ☐ Eastern region (Dammam)
- ☐ Western region (Jeddah)
- ☐ Western region (Medina)

Q10. Including this year, how many years have you worked in the paediatrics Department?

- ☐ 1-3
- ☐ 4-7
- ☐ 8-10
- ☐ 10+

Section C: Experience

Q11. In your work, have you ever observed a child who was at potential of harm and not made a report?

- ☐ Yes
- ☐ No

If yes, please give your reason(s) for not making a report. * They must not include any identifying information.

Section D: Attitudes and Feelings:

Q12. In relation to reporting child abuse and neglect, to what extent do you agree or disagree with the following statements? (Indicate your response to the following statements by crossing out the number which most corresponds to your evaluation. Each item is scored on a 1 to 5 scale, where 1 = the statement is false or that you strongly disagree; 2 = the statement is mostly false or you disagree; 3 = the statement is about equally true or false, you cannot decide, or you are neutral on the statement; 4 = the statement is mostly true, or you agree; and 5 = the statement is definitely true or you strongly agree).

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
I fear revenge from reporting child abuse and neglect.	1	2	3	4	5
If I was uncertain about the evidence, I would not report a case of child abuse and neglect.	1	2	3	4	5
I fear litigation and/or legal liability from reporting child abuse and neglect.	1	2	3	4	5
I lack faith in SCAN (Suspected Child Abuse and Neglect) team to respond appropriately when reports are made.	1	2	3	4	5
Workload pressures are likely to deter me from reporting child abuse and neglect.	1	2	3	4	5
Time constraints are likely to deter me from reporting child abuse and neglect.	1	2	3	4	5
I don't think it's in the child's best interests to report child abuse and neglect.	1	2	3	4	5
I don't think it's in the family's best interests to report child abuse and neglect.	1	2	3	4	5
I think child abuse and neglect cases can be handled without involving SCAN team and the Ministry of human resource and social development.	1	2	3	4	5
Lack of support from the hospital culture is likely to deter me from reporting child abuse and neglect.	1	2	3	4	5
Poor access to the online SCAN (Suspected Child Abuse and Neglect) team or emailing and contacting the hotline (1919) is likely to deter me from reporting child abuse and neglect.	1	2	3	4	5
I think the responsibility to report should rest with senior staff only.	1	2	3	4	5
I should not be required by law to report child abuse and neglect.	1	2	3	4	5
Lack of detailed feedback on the outcome of reports made in the past deters me from reporting child abuse and neglect.	1	2	3	4	5
I worry that my report may contribute to the overloaded SCAN team and the Ministry of human resource and social development	1	2	3	4	5

Section E: Work Environment:

Q13. Have you ever supported a fellow staff member who reported child abuse or neglect?

- ☐ Yes
- ☐ No

If yes, please describe the support you gave briefly. (*They must not include any identifying information).

***Q14. Have you made a report of (child abuse or neglect) in the past?**

- ☐ Yes, proceed to part (A), skip part (B)
- ☐ No, proceed to part (B), skip part (A)

A: Have Reported:

Q15. Were you supported by your colleagues for reporting?

- ☐ Yes
- ☐ No
- ☐ NA (not applicable).

Q16. When reporting the suspected child abuse or neglect, were you supported by any one of them?

- ☐ Supervisor
- ☐ Team leader
- ☐ Manager
- ☐ No one.
- ☐ To other: Specify the position *They must not include any identifying information.

B: Not Reported:

If you have not made a report of (child abuse and neglect) in the past:

Q15. Do you feel that your colleagues would support you in reporting suspected child abuse or neglect?

- ☐ Yes
- ☐ No
- ☐ NA (not applicable).

Q16. When reporting the suspected child abuse or neglect, were you supported by any one of them?

- ☐ Supervisor
- ☐ Team leader
- ☐ Manager
- ☐ No one.
- ☐ To other: Specify the position *They must not include any identifying information.

Q17. What do you perceive as barriers to reporting? * They must not include any identifying information.

Section F: Education/Training

Q18. Have you had any formal training specifically related to (child abuse and neglect and/or child protection)?

- ☐ Yes
- ☐ No
- ☐ Can't remember.

Q19. Have you attended “Multidisciplinary Child Abuse and Neglect Cases training Course”?

- ☐ Yes
- ☐ No

Q20. Please list any other training opportunities you have taken regarding training for child abuse and neglect reporting and/or child abuse recognition (e.g. university, self-assessment tools).

Section G: Knowledge of the Law

Please select the option(s) that you believe to be the most correct by TICKING the best response for each question or statement.

Q21. As a Mandatory Reporter delivering healthcare in Saudi Arabia, you are required by law to report a child or young person at risk when:

- ☐ Their basic physical or psychological needs are not being met or at risk of not being met.
- ☐ Their parents/caregiver has not arranged or is unwilling to arrange necessary medical care.
- ☐ Their parents/caregiver has not arranged or is unwilling to arrange for a child or young person to receive an education.
- ☐ The child or young person is at risk of being physically or sexually abused or ill-treated.
- ☐ The child or young person is living in a household where there are incidents of domestic violence, and they are at risk of serious physical or psychological harm.
- ☐ The child was the subject of a pre-natal report, and the birth mother has not engaged successfully with support services.

Q22. As a Mandatory Reporter delivering healthcare in SA, I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a single act of abuse or omission of basic need.

- ☐ Yes
- ☐ No
- ☐ I am not sure.

If you are not sure, why?

Q23. As a Mandatory Reporter delivering healthcare in SA, I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a series act of abuse or omission of basic need.

- ☐ Yes
- ☐ No
- ☐ I am not sure.

If you are not sure, why?

Q24. How much knowledge of the abuse do you need to have before you are required by legislation to report?

- ☐ I need to report only when I have actual knowledge that a child has been or is being abused.
- ☐ I need to report when I have reasonable grounds to suspect that a child is at risk of being abused, even if I have no actual knowledge of the abuse.
- ☐ I am not sure.

Q25. How much harm to a child needs to have occur before you are required by legislation to report?

- ☐ I need to report child abuse or neglect only when I think the harm being caused to the child or young person is significant.
- ☐ I need to report child abuse or neglect even when I think the harm to the child is insignificant or there is no harm at all.
- ☐ I am unsure.

Q26. Are you required by legislation to report child abuse and neglect only when it has already happened, or also when you think it has not yet happened, but it is likely to occur in the future?

- ☐ I need to report child abuse and neglect only when I think it has already happened.
- ☐ I need to report child abuse and neglect only when I think it is likely to occur in the future.
- ☐ I need to report child abuse and neglect both in cases where I think it has already happened, and in cases where I think it has not happened yet but is likely to occur in the future.
- ☐ I am not sure.

Q27. Are you allowed to seek further information – e.g. consulting a colleague – about harm to a child, to work out your duty to report?

- ☐ Yes
- ☐ No
- ☐ I am not sure.

Q28. When my legislative duty to report child abuse and neglect is activated, I have to report it to (You may tick more than one box):

- ☐ Suspected Child Abuse and Neglect (SCAN) team.
- ☐ Child Protection Helpline.
- ☐ The Police.
- ☐ I am unsure.

Q29. When my legislative duty to report (child abuse and neglect) is activated, I can report the relevant details about the case by: (you may tick more than one box)

- ☐ Making a phone call
- ☐ Making a phone call to protection helpline 1919.
- ☐ Making a phone call to child helpline 116111.
- ☐ Sending a fax.
- ☐ Sending an E-mail.
- ☐ Complete online form.
- ☐ Consultation with nominated person in department
- ☐ Hospital social services department.
- ☐ I am unsure how to report.

Q30. If I make a report in good faith:

- ☐ My identity as the reporter is usually protected from disclosure.
- ☐ My identity as the reporter is not at all protected from disclosure.
- ☐ I can document in such a way as to increase my anonymity as a reporter.
- ☐ I am unsure whether my identity would be protected from disclosure.

Q31. If I fail to make a report when my reporting duty is activated the maximum penalty under legislation that can apply to me in SA is one of the following:

- ☐ Changing your profession.
- ☐ Losing their job.
- ☐ No penalty
- ☐ I am not sure

Some reports of suspected child abuse or neglect are found to be not substantiated. If I make a report in good faith which is not substantiated:

Q32. I can be sued and held liable for damages in a court of law

- ☐ True
- ☐ False
- ☐ I am not sure

Q33. I can be sued and held liable for vilification in a court of law

- ☐ True
- ☐ False
- ☐ I am not sure

Q34. I can be sued and held liable for criminal conduct in a court of law

- ☐ True
- ☐ False
- ☐ I am not sure

Section H: Intended Reporting Behaviour

Carefully read the following vignettes and respond to each of the questions. For each statement, circle the number corresponding to the degree of your agreement or disagreement. Note, there is not right or wrong answer. All that is important is that you indicate your personal feeling.

Q35. A 20-year-old woman brought her 19 months old daughter to the emergency room with facial bruises and swelling. X-rays revealed old, healing rib fractures. The mother reported that the child's father had a terrible temper and would hit the child when she was crying.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10

Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10

Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10

Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am not sure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q36. A mother who has previously brought her 2-year-old daughter to the emergency room with serious injuries caused by her abusive husband also has a one-month-old son. While she says her husband has not hit her son yet, she fears for her son's safety.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all Serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am not sure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q37. You receive a direct disclosure that on one occasion about 6 months ago, a stepfather had sexual intercourse with his 14-year-old stepdaughter. There are no obvious signs of harm to the girl, and the stepfather. The girl and her mother assure you quite convincingly that the whole family is fine.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/ or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am not sure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q38. You receive a direct disclosure from a 13-year-old boy that his father has repeatedly shown him pornographic films involving sexual violence. There are no obvious signs of harm to the boy.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am not sure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q39. Parents often compare the school performance of their 12-year-old son to that of other boys (and their own older sons). They also tell him he'll never amount to anything. They ridicule, criticise, and punish him when he does not do well in exams. The boy shows signs of depression and anxiety.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q40. A quiet and shy young boy confides that he is very sad because he accidentally broke his dad's favourite mug. He says his dad told him he was worthless, should never have been born and was nothing but trouble. When you ask, the boy says that this is how his father always talks to him and to his mother, and that it's okay because his father never really does anything to hurt them.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure.

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q41. Parents regularly leave their 9-year-old child alone inside the house after dark. Often, they do not return until midnight. On one occasion, the child started a small fire.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10

Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10

Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10

Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q42. Over some time, parents ignore the fact that their 10-month-old son was obviously ill, crying constantly and not eating. When they finally brought the child to a hospital, he was found to be seriously dehydrated.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10

Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/ or neglect?

1 2 3 4 5 6 7 8 9 10

Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10
Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure.

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting: *The must not include any identifying information.

Q43. A 34-year-old woman presents to the ED with serious injuries to her head and torso. These have resulted from a physical assault perpetrated by her husband. You find out this occurred in front of her two children, a boy aged 4 years and a girl aged 6 years.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10
Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10
Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10
Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10

Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure

Q44. A mother presents to the Emergency Department with a lacerated forehead sustained from a domestic dispute. The mother states her 15-month-old child was in her arms at the time an object was thrown and was not injured.

Based on the information provided, how serious is this incident?

1 2 3 4 5 6 7 8 9 10

Not at all serious Extremely serious

In your professional judgment, does the incident described above constitute abuse and/or neglect?

1 2 3 4 5 6 7 8 9 10

Absolutely not Absolutely yes

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on this child?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

All things considered, what overall impact would a child abuse and/or neglect report be likely to have on the rest of the family?

1 2 3 4 5 6 7 8 9 10

Highly negative impact Highly positive impact

How likely would you report this case?

1 2 3 4 5 6 7 8 9 10

Almost certainly would not report Almost certainly would report

In your view, would you be required by law to report this incident?

- ☐ Yes
- ☐ No
- ☐ I am unsure

If you think that you are required by legislation to report this case, but would not report it, please give your reason(s) for not reporting. * They must not include any identifying information.

Measures of Efficacy Expectations for CAN - Suspected:

The following questions relate to confidence when you report suspected child abuse and neglect cases.

Please select an item from the rating scale for each statement.

Q45. I am confident that I can prioritise my workload to report:

	Not confident at all				Somewhat confident				Extremely confident			
Suspected physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q46. I am confident that I can ask for support from my colleagues when I report:

	Not confident at all				Somewhat confident				Extremely confident			
Suspected physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Suspected child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q47. I am confident that I can seek the opinion from my supervisor/manager/team leader to report:

Not confident at all	Somewhat confident	Extremely confident

Suspected physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q48. I am confident that I can report:

	Not confident at all				Somewhat confident				Extremely confident			
Suspected physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suspected child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Measures of Efficacy Expectations for CAN - Known:

The following questions relate to confidence when you report known child abuse and neglect cases.

Please select an item from the rating scale for each statement.

Q49. I am confident that I can prioritise my workload to report:

	Not confident at all				Somewhat confident				Extremely confident			
Known physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Known sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q50. I am confident that I can ask for support from my colleagues when I report

Not confident at all Somewhat confident Extremely confident

Known physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q51. I am confident that I can seek the opinion from my supervisor/manager/team leader to report:

Not confident at all Somewhat confident Extremely confident

Known physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Known child exposure to	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

domestic
violence

Q52. I am confident that I can report:

	Not confident at all				Somewhat confident				Extremely confident			
Known physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Known sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Known neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Known child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Measures of Outcome Expectations for CAN:

The following questions relate to confidence when you report child abuse and neglect cases.

Please select an item on the rating scale for each statement.

Q53. How confident are you that reporting is in the child's best interest for?

	Not confident at all				Somewhat confident				Extremely confident			
Child physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Child sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Child emotional abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Child neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q54. How confident are you that reporting is in the family's best interest for?

Not confident at all	Somewhat confident	Extremely confident

Child physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child emotional abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q55. How confident are you SCAN (Suspected Child Abuse and Neglect) team will respond appropriately when reports are made for?

	Not confident at all			Somewhat confident				Extremely confident			
Child physical abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child sexual abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child emotional abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child neglect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child exposure to domestic violence	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q56. General Perceived Self-Efficacy Scale.

	Not at all True	Hardly True	Moderately True	Exactly True
I can always manage to solve difficult problems if I try hard enough.	☐	☐	☐	☐
If someone opposes me, I can find the means and ways to get what I want.	☐	☐	☐	☐
It is easy for me to stick to my aims and accomplish my goals.	☐	☐	☐	☐
I am confident that I could deal efficiently with unexpected events.	☐	☐	☐	☐

Thanks to resourcefulness, I know how to handle unforeseen situations.	☐	☐	☐	☐
I can solve most problems if I invest the necessary effort.	☐	☐	☐	☐
I can remain calm when facing difficulties because I can rely on my coping abilities.	☐	☐	☐	☐
When I am confronted with a problem, I can usually find several solutions.	☐	☐	☐	☐
If I am in trouble, I can usually think of a solution.	☐	☐	☐	☐
I can usually handle whatever comes my way.	☐	☐	☐	☐

Comments:

Do you have any other comments? * They must not include any identifying information.

Thanks.

Thank you for your participation!

Appendix L. Participation Invitation Letter

Dear Invitee,

My name is Albandari Almutairi, a PhD candidate in Nursing and Midwifery school at Trinity College Dublin under the research supervision of Dr Mary Hughes and Dr Margarita Corry.

I am contacting you to invite you to participate in a research study to explore the impact of a child abuse training on nurses' self-efficacy (self-efficacy is a personal belief in their ability to perform a specific task) in recognising and responding to known and suspected Child Abuse and Neglect (CAN) cases in Saudi Arabia.

In this study, I am conducting a survey in three hospitals in Riyadh City. I am looking for qualified nurses, charge nurses, and staff nurses with at least one year of pediatric care experience. Therefore, you have received this letter from me through (Dr Hamad, General paediatrics and complex care, consultant) as you are working in contact with children.

- Participation is voluntary and you may withdraw from the study up to the point of submitting the questionnaire. You are invited to complete a questionnaire which can be filled in at a place of convenience to you, e.g. nursing room, home, and at the time of your choice.
- The survey will take approximately 20-30 minutes to complete.
- The study is **anonymous**; this means that you are not required to provide your name or any other identifying information. Please contact me by email or phone (Email: almutaal@tcd.ie, Mobile Number: +966503252245, if you have any questions.
- After seven days the researcher (Albandari Almutairi) will visit your department to collect the survey, or they can leave them for me to collect it at

the researcher Locked a locker in the Nurses room on the First Floor labelled with (Albandari Almutairi) in the children hospital.

Thank you for your time and participation.

Sincerely,

Albandari Almutairi, PhD Student.

School of Nursing and Midwifery at Trinity Collage Dublin

Email: almutaal@tcd.ie

Mobile Number: +966503252245.

Appendix M. Invitation Letter for Online Survey

Dear Invitee,

My name is Albandari Almutairi, a PhD candidate in Nursing and Midwifery school at Trinity College Dublin under the research supervision of Dr Mary Hughes and Dr Margarita Corry's.

I am contacting you to invite you to participate in a research study to explore the impact of a child abuse training on nurses' self-efficacy (self-efficacy is a personal belief in their ability to perform a specific task) in recognising and responding to known and suspected Child Abuse and Neglect (CAN) cases in Saudi Arabia.

In this study, I am conducting a cross-sectional study in three hospitals in Riyadh City. I am looking for qualified nurses, and staff nurses with at least one year of paediatric care experience.

- Participation is voluntary, and you may withdraw from the study at any time.

You will complete the questionnaire at a place of convenience to you, e.g. nursing room, home, and at the time of your choice.

- The survey will take approximately 20-30 minutes to complete.
- The study is anonymous; this means that you are not required to provide your name or any other identifying information. IP addresses will not be collected at any point, meaning the data you provide cannot be traced back to you. Please contact me by email or phone (see details below) for further questions.

If for any reason you wish to complete the survey at a late time, you can do this by pressing **save and continue.**

This adds a cookie to your computer/tablet. To re-access the survey, you must:

Use the same device that you originally began completing the survey.

You have been given this [link after reading the participation information leaflet and agreeing to participate in this study.](#)

➤ **I wish to participate**

Feel free to share this letter with your colleagues who meet the criteria.

If you have any questions about the study, please contact me:

Albandari Almutairi

School of Nursing and Midwifery at Trinity College Dublin

Almutaal@tcd.ie

(+966503252245)

Thank you for your time and participation.

Appendix N. The Invitation Poster



CALLING FOR PARTICIPANTS

Are you:

- A qualified, registered nurse and working with children?
- Staff nurse?
- Do you have at least one year experience in a paediatric area?
- Would you be interested in participating in a research stud.

+ + Measuring nurses' self-efficacy (as the degree of one's
+ + feelings about one's ability to accomplish goals) in
+ + detecting and responding to suspected cases of child
+ + abuse and neglect?

Please contact now Albandari Almutairi,
Email: almutaal@tcd.ie / W hatsA pp: +353834328323, to
find out more.
Or visit this LINK:
https://nursingandmidwifery.fra1.qualtrics.com/jfe/form/SV_elJEx0UnHXfg9r8
Participation in this research is entirely voluntary.

Confidentiality and anonymity will be maintained at all times.

I look forward to hearing from you!



Appendix O. Participant Information Leaflet

Name of Study: The Impact of Child Protection Training on Nurses' Self-Efficacy in the Detection and Reporting of Child Abuse.

Site	King Abdullah Specialist Children's Hospital (KASCH) in King Abdulaziz medical city
Principal Investigator(s) and Co-Investigator(s) (insert names, titles and contact details)	Albandari Almutairi Dr Mary Hughes and Dr Margrita Corry
Study Organiser/Sponsor (if applicable)	N/A
Data Controllers	Trinity College Dublin (for research data)
Data Protection Officer	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2 Email: dataprotection@tcd.ie; Website: www.tcd.ie/privacy. Data Protection Officer of [hospital]: [INSERT CONTACT DETAILS HERE].

You are being invited to take part in a research study that is being done by Albandari Almutairi at King Abdulaziz Medical City in Riyadh.

Before you decide whether or not you wish to take part, please read this information sheet carefully. Contact Albandari Almutairi if you have any questions. Do not feel rushed or under pressure to make a quick decision. You should understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. You may wish to discuss it with your family, friends, or director.

This leaflet has five main parts:

Part 1 – The Study

Part 2 – Data Protection

Part 3 – Costs, Funding, and Approval

Part 4 – Future Research

Part 5 – Further Information

Why is this study being done?

To study the impact of a training on nurses' self-efficacy (the degree of one's feelings about one's ability to accomplish goals) in detecting and responding to suspected cases of child abuse and neglect.

Why have I been invited to take part?

- You are invited because you are qualified, registered nurse working with children.
- You are nurses and directors of departments.
- From both genders, any nationality, have at least one year experiences in any paediatric areas (Outpatient, emergency room, medical and surgical wards, burns units, day surgery unit).
- You can speak and write in English.

Do I have to take part? Can I withdraw?

- You don't have to take part in this study. It is entirely voluntary.
- If you decide not to take part it won't affect your current or future career.
- You can change your mind about taking part in the study and opt out at any time even if the study has started.

What happens if I change my mind?

Participation in this study is voluntary. Thus, you are free to refuse to participate or to withdraw your participation in this study at any time. There will be no penalty or unfair treatment should you choose not to be in this study.

Participation in this study is not a requirement of your employment, nor will it impact your employment. Identifying information will not be used when the data is collected or analysed. You can change your mind at any time by contacting the researcher at (+966503252245).

However, once submitted it will not be possible to destroy data already used and analysed in research the study.

How will the study be carried out?

- Your involvement in the study will be in the form of a survey conducted by Albandari Almutairi who is a research student at the Trinity Collage Dublin.
- The Child Abuse Neglect Reporting Self-Efficacy (CANRSE) survey questionnaire will be distributed to participants after meeting the researcher and the nurses directores in each department via the General paediatrics and complex care, consultant (Dr Hammad AlKhalaf) in the hospital.
- You may complete the questionnaire at a place of convenience to you e.g. nursing room, home, and at the time of your choice.
- The survey will take approximately 20-30 minutes to complete.
- Once completed, the questionnaire can be returned to the researcher in the sealed envelope provided.

- The survey responses will be anonymous.
- Participation is voluntary and you will be given the opportunity to ask questions before beginning the survey.
- Participants will be asked to return the completed questionnaire within one week to the researcher.

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

- Before you decide to volunteer to take part in a research study, you need to know as much as possible about the research study. If there are any issues that concern you, be sure to ask questions. By contacting me via (almutaal@tcd.ie / +966503252245).
- You will be asked to complete the questionnaire which we estimate will take you 20-30 minutes.
- Remember, if you do not understand the answer to any of your questions, ask again. Ask Albandari Almutairi to explain the answer in a way you can understand it.

What will happen to my data?

- It is an anonymous survey.
- Once completed the hard-copy survey will be returned and stored by the researcher in a locked cabinet in a locked office at the researcher's home.

Are there any benefits to taking part in this research?

While there are no immediate benefits to you from participating in the project, it is hoped that this work will have a beneficial impact in terms of evaluating how a training impacts on nurses in detecting and responding to suspected cases of child abuse and neglect. The impact of the findings may be long-term, so the benefits of the research finding may not be seen for several years. By participating, you are helping to advance nursing science for future generations.

Are there any risks to me or others if I take part?

There is no risk to the participants; in the unlikely event, sharing your personal experience during answering the survey should cause discomfort or distress, the following steps will be taken;

- You can stop the answering unless you wish to continue.
- You can contact the PI via (almutaal@tcd.ie / +966503252245).
- I will provide reassurance to decrease your anxiety level.
- I will offer you with the support services in place by referring you to a professional practitioner.
- I will give you an opportunity to resume the answering in another day (if you wish so) based on your convenience and availability.

Will I be told the outcome of the study? Will I be told the results of any tests or investigations performed as part of this study that relate to me?

Results of the research will be published. You will not be identified in any report or publication. Your institution will not be identified in any report or publication.

Will my personal data be kept confidential? How will my data be kept safe?

All the information that we collect during the research study is an anonymous. You and Your institution will not be able to be identified or identifiable in any reports or publications. Any data collected about you in the online questionnaire will be stored online in a form protected by passwords and other relevant security processes and technologies. These anonymised data will not allow any individuals or their institutions to be identified.

Has this study been approved by a research ethics committee?

This study will be conducted in three settings. The approval by the Research centre in setting B, Research Centre in setting C, Riyadh, SA, and by the Research Ethics Committee, Faculty Research and Ethics Committee at Trinity College Dublin, Dublin, Ireland.

Who should I contact for information or complaints?

If you have any concerns or questions, you can contact:

- PI: Albandrari Almutairi: <mailto:almutaal@tcd.ie> / +966503252245.

- Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Appendix P. Consent Form



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

STUDY NAME:

Centre ID:

Identification Number for the Study: 18345102

Consent Form

The below section should always be included in consent forms. The consents should be reviewed by the Principal Investigator and research team and amended as appropriate in line with the specific requirements and consents being sought from participants.

There are X sections in this form. Each section has a statement and asks you to initial if you agree. The end of this form is for the researchers to complete.

Please ask any questions you may have when reading each of the statements.

Thank you for participating.

Please Initial the box if you agree with the statement. Please feel free to ask questions if there is something you do not understand.

General	Tick box
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that this study is entirely voluntary, and if I decide that I do not want to take part, I can stop taking part in this study at any time without giving a reason. I understand that deciding not to take part will not affect my future career.	

I understand that all information will be kept private and confidential and that my name will not be disclosed.	
I understand that I will not be paid for taking part in this study ¹ .	
I know how to contact the research team if I so need.	
I agree to take part in this research study having been fully informed of the risks, benefits and alternatives which are set out in full in the information leaflet which I have been provided with.	
[I agree to being contacted by the researcher Albandari Almutairi by phone (+966 503252245) as part of this research study.]	
I agree to allow personal information about me to be shared with the principal investigator.	
I agree to allow personal information about me to be shared with the supervisor or principal investigator (Dr Mary Hughes/ Dr Margarita Corry) from Trinity College of Dublin for the purpose of exploring the evaluation of the effectiveness of a Child Protection for Health Care Providers in the detection and reporting of child abuse in a hospital setting in Saudi Arabia, as described in the Participant Information Leaflet.	
I understand that personal information about me, including the transfer of this personal information outside of the of Saudi Arabia, will be protected in accordance with the General Data Protection Regulation.	
I understand that there are no direct benefits to me from participating in this study.	

¹ Amend as appropriate.

I understand that the results from the analysis of my personal information will be given to me if I request such. I agree that the results from the analysis of my personal information can be published in a scientific journal and disclosed at a scientific conference/symposium.	

Staff Name (Block Capitals)

Witness Name (Block Capitals)

Staff Signature Date

Witness Signature Date

To be completed by the Principal Investigator or nominee.

I, Albandari Almutairi, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the participant information leaflet and consent form to the participant with the contacts of the study team.

Researcher Name: Albandari Almutairi

Title and Qualifications: PhD Student

Signature:

Date:

Appendix Q. Scoring and Analysis of the Research Instruments

Domain	Scoring and Analysis
Section A to C: Demographic Characteristics, Job Details, Experience:	Assign numerical codes to each response option to facilitate data entry and analysis. These codes should be unique and easy to interpret. For example, you might assign the code 1 to “Male”, 2 to “Female”, and 3 to “non-specified” for a gender-related question. If a participant selects “Male” for the gender question, enter 1 in the gender variable for that participant.
Section D: Attitude and Feeling Regarding the Reporting Decisions:	A 5-point Likert-type Scale (1, strongly agree to 5, strongly disagree) was used to measure the attitudes and feelings regarding the reporting decisions. Each item is scored on a 1 to 5 scale, where 1 = the statement is false or that strongly disagree; 2 = the statement is mostly false or disagree; 3 = the statement is about equally true or false, cannot decide, or are neutral on the statement; 4 = the statement is mostly true, or agree; and 5 = the statement is definitely true or strongly agree). The Likert scaling technique, thus, assigns a scale value to each of the five responses. The same thing is done with respect to each and every statement in the instrument. This way the instrument yields a total score for each respondent, which would then measure to what extent agree the respondents agree with the given statements. If the instrument consists of 15 statements, the following score values would be revealing. $15 \times 5 = 75$ (Strong agree response possible) $15 \times 3 = 45$ (A neutral attitude) $15 \times 1 = 15$ (Strong disagree response) The scores for any individual would fall between 15 and 75. If the score happens to be above 45, it indicates ‘strong agree’ with the given point of view; a score of below 45 would mean ‘strong disagree’ and that of exactly 45 would be suggestive of a neutral attitude.
Section E: Work Environment:	In the straightforward “dichotomous” items, a 1/2 labelling (Yes/No): Yes=1, No=2.
Section F: Education/Training:	It has three response categories consisting of yes (2), no (1), and not sure (0).
Section G: Knowledge of the Law:	One knowledge item was formatted differently: -Questions were asked, allowing for the possibility of selecting more than one answer statements, and scoring was based on the frequency of each statement. Yes=1, No=2. - Questions were asked, the option of selecting one answer statement was provided, and scoring was based on the number of each statement (1-2-3-4).
Section H: Intended Reporting Behaviour:	This section of the study involved the use of ten vignettes to assess the tendency of nurses to report Child Abuse and Neglect (CAN). These vignettes were developed based on suggestions from experts and were previously used in studies by Feng and Levine (2005) and Zellman (1990). For this study, a sample of four types of abuse

	across 10 vignettes were used to evaluate nurses' behaviour related to CAN cases. Each vignette had six questions, which helped the nurses to make judgments about the seriousness of the incident, whether it constituted abuse or neglect, the likely impact of a child abuse report on the child and the rest of the family, and the likelihood of the nurses reporting the case. The respondents rated their level of confidence in performing each item on a scale of 1 to 10, where 1 meant not serious at all and 10 meant extremely serious. Using the median split, the composite intention to report score was used to categorise the study participants into two groups: those more likely and those less likely to report suspected cases of child sexual abuse. Participants who scored above the median were categorised as being more likely to report, while those who scored below the median were categorised as less likely. The higher the score, the more likely the nurses to report the suspected case of child abuse. Finally, the nurses were asked whether they would be legally required to report the incident. The question had three response categories: yes (1), no (2), and not sure (3).
Measures of Efficacy Expectations for CAN - Suspected/ Known Measures of Outcome Expectations for CAN:	This part of the survey comprised two scales: (i) self-efficacy expectations of child abuse and neglect reporting (SE-CAN) containing 32 items focusing on nurses' confidence to manage CAN cases, and (ii) the outcome expectations of child abuse and neglect reporting (OE-CAN) containing 12 items focusing on beliefs that the reporting behaviours can produce outcomes in the child/family's best interest (Lee et al., 2010). The SE-CAN scale was structured in two parts: 16 items targeting SE of suspected CAN reporting, and 16 items targeting SE of known CAN reporting. Each item was scored on an 11-point Likert scale where scores ranged from 0 = no confidence at all to 10 = extremely confident. The OE-CAN scale comprised 15 statements of beliefs surrounding the outcomes of reporting behaviours for which the participants were required to rate their level of agreement using an 11- point Likert scale. Respondents rated the degree to which they were confident in their ability to perform each item on a scale of 0 (not confident) to 10 (completely confident).
General Perceived Self-Efficacy Scale:	The original GSE scale was a measure of self-efficacy in general that was developed in Germany by Schwarzer and Jerusalem, (1995). Bandura's (1977) social cognitive theory was used to assess general and optimistic SE to cope with a variety of difficult demands in life and to measure the strength dimension of SE. Lee (2008) and Colgrave et al. (2020) correlated the EES, EEK, and OE-CAN scales with GSE. The internal consistency applied in previous research was 0.93. In this thesis, the author followed the Schwarzer & Jerusalem (1995) scoring system: a 4-point Likert scale with options: 1 = not at all true, 2 = hardly true, 3 = moderately true, and 4 = exactly true.

Appendix R. Certificate of Completion of Good Clinical Practice



Appendix S. Calculate the Mean Score for the Attitude and Feeling Scale:

Numeric Expression:

= MEAN(Q12.1,Q12.2,Q12.3,Q12.4,Q12.5,Q12.6,Q12.7,Q12.8,Q12.9,Q12.10,Q12.11,Q12.12,Q12.13,Q12.14,Q12.15)

Function group:

- Miscellaneous
- Missing Values
- PDF & Noncentral PDF
- Random Numbers
- Search
- Significance
- Statistical
- Scoring

Functions and Special Variables:

- Cfvar
- Max
- Mean
- Median
- Min
- Sd
- Sum
- Variance

MEAN(numexpr,numexpr[,...]).
Numeric

Returns the arithmetic mean of its arguments that have valid, nonmissing values.

This function requires two or more arguments, which must be numeric

ction condition)

Cancel OK

Appendix T. Certificate of Completing the Research Integrity Course



Appendix U. Attitudes and Feelings About Reporting

Table 21

Attitudes and Feelings About Reporting

Statements:		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Mean	Std. Deviation
1. I fear revenge from reporting child abuse and neglect.	N	78	89	40	23	4	2.09	1.024
	%	33.3	38.0	17.1	9.8	1.7		
2. If I was uncertain about the evidence, I would not report a case of child abuse and neglect.	N	48	65	54	56	12	2.66	1.193
	%	20.4	27.7	23.0	23.8	5.1		
3. I fear litigation and/or legal liability from reporting child abuse and neglect.	N	61	87	43	37	4	2.29	1.077
	%	26.3	37.5	18.5	15.9	1.7		
4. I lack faith in SCAN (Suspected Child Abuse and Neglect) team to respond appropriately when reports are made	N	64	90	54	23	3	2.19	0.990
	%	27.4	38.5	23.1	9.8	1.3		
5. Workload pressures are likely to deter me from reporting child abuse and neglect.	N	56	108	39	26	4	2.20	0.986
	%	24.0	46.4	16.7	11.2	1.7		
6. Time constraints are likely to deter me from reporting child abuse and neglect.	N	55	107	34	32	4	2.24	1.019
	%	23.7	46.1	14.7	13.8	1.7		
7. I don't think it's in the child's best interests to report child abuse and neglect.	N	90	98	29	13	2	1.88	0.896
	%	38.8	42.2	12.5	5.6	0.9		
8. I don't think it's in the family's best interests to report child abuse and neglect.	N	77	93	43	15	6	2.06	1.000
	%	32.9	39.7	18.4	6.4	2.6		

9. I think child abuse and neglect cases can be handled without involving SCAN team and the Ministry of human resource and social development.	N	94	94	33	8	3	1.84	0.884
	%	40.5	40.5	14.2	3.4	1.3		
10. Lack of support from the hospital culture is likely to deter me from reporting child abuse and neglect.	N	54	82	56	29	11	2.40	1.116
	%	23.3	35.3	24.1	12.5	4.7		
11. Poor access to the online SCAN (Suspected Child Abuse and Neglect) team or emailing and contacting the hotline (1919) is likely to deter me from reporting child abuse and neglect.	N	46	80	54	41	11	2.53	1.135
	%	19.8	34.5	23.3	17.7	4.7		
12. I think the responsibility to report should rest with senior staff only.	N	80	115	25	8	3	1.87	0.834
	%	34.6	49.8	10.8	3.5	1.3		
13. I should not be required by law to report child abuse and neglect.	N	68	105	38	13	6	2.06	0.960
	%	29.6	45.7	16.5	5.7	2.6		
14. Lack of detailed feedback on the outcome of reports made in the past deters me from reporting child abuse and neglect.	N	42	72	63	49	6	2.59	1.089
	%	18.1	31.0	27.2	21.1	2.6		
15. I worry that my report may contribute to the overloaded SCAN team and the Ministry of human resource and social development	N	73	111	40	7	2	1.94	0.826
	%	31.3	47.6	17.2	3.0	0.9		
Overall Attitudes and Feelings about Reporting							2.19	0.688

Appendix V. Kruskal-Wallis H Test

Table 22

Kruskal-Wallis H Test Results for Assessing the Nurses' Understanding of the Consequences for the Child and Their Family on Reporting Child Abuse and Neglect

	Job	N	Mean	Std. Deviation	Kruskal-Wallis H	df	Asymp. Sig.
<i>How confident are you that reporting is in the child's best interest?</i>							
Child physical abuse	Charge nurse	30	7.23	1.832	2.703	2	.259
	Staff nurse	171	6.97	2.390			
	Supervisor	9	8.22	1.716			
	Other	6	9.33	.816			
Child sexual abuse	Charge nurse	30	7.07	1.911	2.017	2	.365
	Staff nurse	171	7.02	2.386			
	Supervisor	9	8.11	1.965			
	Other	6	9.33	.816			
Child emotional abuse	Charge nurse	30	7.20	1.864	2.303	2	.316
	Staff nurse	170	7.08	2.283			
	Supervisor	9	8.22	1.716			
	Other	6	9.33	.816			
Child neglect	Charge nurse	30	7.20	1.864	2.442	2	.295
	Staff nurse	170	7.01	2.348			

	Supervisor	9	8.22	1.716			
	Other	6	9.50	0.837			
Child exposure to domestic violence	Charge nurse	30	7.20	1.864	2.202	2	.333
	Staff nurse	168	7.07	2.360			
	Supervisor	9	8.22	1.716			
	Other	6	9.50	.837			
<i>How confident are you that reporting is in the family's best interest?</i>							
Child physical abuse	Charge nurse	30	6.57	2.096	.546	2	.761
	Staff nurse	170	6.37	2.595			
	Supervisor	9	6.89	2.088			
	Other	6	9.50	.837			
Child sexual abuse	Charge nurse	30	6.57	2.096	.340	2	.844
	Staff nurse	170	6.36	2.626			
	Supervisor	9	6.78	2.167			
	Other	6	9.33	.816			
Child emotional abuse	Charge nurse	30	6.53	2.097	.502	2	.778
	Staff nurse	168	6.45	2.545			
	Supervisor	8	7.00	2.204			
	Other	6	9.50	.837			
Child neglect	Charge nurse	30	6.50	2.177	.205	2	.902
	Staff nurse	170	6.44	2.569			
	Supervisor	9	6.78	2.167			
	Other	6	9.50	0.837			

Child exposure to domestic violence	Charge nurse	30	6.47	2.177	.189	2	.910
	Staff nurse	168	6.43	2.591			
	Supervisor	9	6.78	2.167			
	Other	6	9.50	.837			
<i>How confident are you SCAN team will respond appropriately when reports are made?</i>							
Child physical abuse	Charge nurse	30	7.20	2.188	.447	2	.800
	Staff nurse	170	6.85	2.461			
	Supervisor	9	7.00	1.871			
	Other	6	9.50	.837			
Child sexual abuse	Charge nurse	30	7.40	2.298	1.033	2	.597
	Staff nurse	171	6.94	2.371			
	Supervisor	9	7.11	2.261			
	Other	6	9.67	0.816			
Child emotional abuse	Charge nurse	30	7.40	2.044	1.139	2	.566
	Staff nurse	171	6.91	2.346			
	Supervisor	9	7.22	1.856			
	Other	6	8.50	2.811			
Child neglect	Charge nurse	30	7.53	2.145	1.773	2	.412
	Staff nurse	171	6.93	2.353			
	Supervisor	9	7.00	1.732			
	Other	6	8.50	2.811			
	Charge nurse	30	7.53	2.145	1.802	2	.406

Child exposure to domestic violence	Staff nurse	171	6.89	2.442
	Supervisor	9	7.11	2.028
	Other	6	8.50	2.811

Appendix W. Nurses' Knowledge of the Law About CAN Experiences

Table 23

Nurses' Knowledge of the Law about CAN Experiences

		n	%
<i>As a Mandatory Reporter delivering healthcare in Saudi Arabia, you are required by law to report a child or young person at risk when:</i>			
Their basic physical or psychological needs are not being met or at risk of not being met.	Yes	143	61.6
	No	89	38.4
Their parents/caregiver has not arranged or is unwilling to arrange necessary medical care.	Yes	141	60.8
	No	91	39.2
Their parents/caregiver has not arranged or is unwilling to arrange for a child or young person to receive an education.	Yes	124	53.4
	No	108	46.6
The child or young person is at risk of being physically or sexually abused or ill-treated.	Yes	164	70.7
	No	68	29.3
The child or young person is living in a household where there are incidents of domestic violence, and they are at risk of serious physical or psychological harm.	Yes	160	69.0
	No	72	31.0
	Yes	98	42.1

The child was the subject of a prenatal report, and the birth mother has not engaged successfully with support services.	No	135	57.9
As a Mandatory Reporter delivering healthcare in SA, I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a single act of abuse or omission of basic need.	Yes	165	71.4
	No	13	5.6
	Not Sure	53	22.9
I am required by law to report suspected abuse or neglect of a child or young person due to any circumstances that relate to a series act of abuse or omission of basic need.	Yes	196	86.3
	No	11	4.8
	Not Sure	20	8.8
How much knowledge of the abuse do you need to have before you are required by legislation to report?	only when I have actual knowledge that a child has been or is being abused.	63	27.0
	I have reasonable to suspect that a child is at risk of being abused even if I have no actual knowledge of the abuse	129	55.4
	I am not sure	41	17.6
How much harm to a child needs to have occur before you are required by legislation to report?	when I think, the harm being caused to the child or young person is significant.	131	56.7

	even when I think the harm to the child is insignificant or there is no harm at all.	60	26.0
	I am unsure	40	17.3
Are you required by legislation to report child abuse and neglect only when it has already happened, or also when you think it has not yet happened, but it is likely to occur in the future?	I need to report only when I think it has already happened	28	12.4
	only when I think it is likely to occur in the future.	20	8.9
	I need to really think it has not happened yet but is likely to occur in the future.	155	68.9
	Not Sure	22	9.8
Are you allowed to seek further information – e.g. consulting a colleague – about harm to a child, to work out your duty to report	Yes	154	67.2
	No	22	9.6
	Not Sure	53	23.1
<i>When my legislative duty to report child abuse and neglect is activated, I have to report it to</i>			
SCAN team	Yes	205	89.5
	No	24	10.5
Child protection helpline	Yes	75	32.9

	No	153	67.1
The police	Yes	72	31.4
	No	157	68.6
I am unsure	Yes	19	8.4
	No	207	91.6
<i>When my legislative duty to report child abuse and neglect is activated, I can report the relevant details about the case by:</i>			
Making a phone call	Yes	59	25.8
	No	170	74.2
Making a phone call to protection helpline 1919	Yes	45	19.7
	No	184	80.3
Making a phone call to child helpline 116111	Yes	39	17.0
	No	190	83.0
Sending a fax	Yes	14	6.1
	No	215	93.9
Sending an E-mail.	Yes	31	13.5
	No	198	86.5
Complete online form	Yes	16	7.0

	No	213	93.0
Consultation with nominated person in department	Yes	83	36.2
	No	146	63.8
Hospital social services department	Yes	125	54.6
	No	104	45.4
I am unsure how to report	Yes	38	16.6
	No	191	83.4
If I make a report in good faith:	My identity as the reporter is usually protected from disclosure.	124	57.9
	My identity as the reporter is not at all protected from disclosure.	6	2.8
	I can document in such a way as to increase my anonymity as a reporter.	14	6.5
	I am unsure whether my identity would be protected from disclosure.	70	32.7
If I fail to make a report when my reporting duty is activated the maximum penalty under legislation that can apply to me in SA is one of the following:	Changing your profession	3	1.3
	Losing their job	20	8.9

	No penalty	40	17.9
	I am not sure	161	71.9
I can be sued and held liable for damages in a court of law	I am not sure	53	23.9
	True	40	18.0
	False	129	58.1
I can be sued and held liable for vilification in a court of law	I am not sure	63	28.4
	True	28	12.6
	False	131	59.0
I can be sued and held liable for criminal conduct in a court of law	I am not sure	67	29.5
	True	30	13.2
	False	130	57.3

Appendix X. A Statistically Significant Association Between Demographic Data and Training Attendance.

Table 24

Comparison of Demographic Data and Training Attainment

Variable	Any formal training - Yes n(%)	No n(%)	Chi- Square	P-Value	(CPMTP) - Yes n(%)	No(%)	Chi- Square	P- Value	No - Any training n(%)
Gender			.575	.750			.713	.515	
Male	1 (2%)	5(3%)			0 (0%)	6 (3%)			11 (3%)
Female	42 (98%)	159(97%)			23 (100%)	193 (97%)			352 (97%)
Age			6.011	.646			4.399	.355	
26-35	22 (51%)	80(49%)			14 (61%)	96 (48%)			198 (56%)
36-45	9 (21%)	38(23%)			2 (9%)	50 (25%)			126 (35%)
Nationality			2.614	.624			2.460	.292	
Saudi	8 (19%)	19(12%)			5 (22%)	25 (13%)			41 (11%)
Non-Saudi	32 (74%)	131(80%)			15 (65%)	160 (80%)			289 (79%)
Marital			.834	.934			2.173	.337	
Single	20 (46%)	64(39%)			7 (30%)	86 (43%)			114 (31%)
Married	21 (49%)	86(52%)			14 (61%)	100 (50%)			266 (69%)
Education level			3.415	.005			7.026	0.030	
Undergraduate	37 (87%)	154 (94%)			80 (91%)	186 (94%)			494 (93%)
Postgraduate	6 (14%)	9 (6%)			5 (21%)	12 (6%)			30 (7%)
Parental status			.246	.884			.1876	.417	

Yes	22 (52%)	86(52%)		13 (56%)	102(51%)	184 (51%)
No	21 (49%)	78(48%)		10 (44%)	97(49%)	175 (49%)
Job title			8.006 .238		.310 .95	
Charge Nurse	5 (12%)	22(14%)		3 (14%)	28(14%)	50 (14%)
Staff Nurse	32 (74%)	130(81%)		17 (77%)	155(79%)	440 (86%)
Are you currently working in paediatric area			18.97 <0.001		.912 .634	
Yes	31 (72%)	154(94%)		22 (96%)	176(88%)	332 (92%)
No	12 (28%)	9(6%)		1 (4%)	22(11%)	30 (8%)
Work place			14.973 0.003		15.828 0.015	
Central Region	39 (91%)	99(60%)		16 (70%)	132 (66%)	331 (89%)
Eastern (Alhasa)	2 (5%)	22(13%)		3 (13%)	23 (12%)	67 (18%)
Eastern (Dammam)	1 (2%)	3(2%)		1 (4%)	3 (2%)	6 (2%)
Western	1 (2%)	40(24%)		3 (13%)	41(21%)	124 (33%)
Experience in paediatric area			5.409 .493		3.502 .744	
1 to 3 years	10 (23%)	37(23%)		5 (22%)	45(23%)	119 (32%)
4 to 7 years	10 (23%)	46(28%)		8 (35%)	53(27%)	145 (40%)
8 to 10 years	7 (16%)	29(18%)		3 (13%)	38(19%)	97 (26%)
More than 10 years	16 (37%)	51(31%)		7 (30%)	62(31%)	175 (47%)