Author/s:
Lu, C;Georgousopoulou, E;Baloch, S;Walton-Sonda, D;Hegarty, K;Sethna, F;Brown, NAT

Title:
Identifying the barriers faced by obstetricians and registrars in screening or enquiry of intimate partner violence in pregnancy: A systematic review of the primary evidence.

Date:
2024-02

Citation:
Lu, C., Georgousopoulou, E., Baloch, S., Walton-Sonda, D., Hegarty, K., Sethna, F. & Brown, N. A. T. (2024). Identifying the barriers faced by obstetricians and registrars in screening or enquiry of intimate partner violence in pregnancy: A systematic review of the primary evidence.. Australian and New Zealand Journal of Obstetrics and Gynaecology, 64 (1), pp.19-27. https://doi.org/10.1111/ajo.13747.

Persistent Link:
https://hdl.handle.net/11343/340008

Lu Corrine (Orcid ID: 0000-0003-3900-7114)

11

Identifying the barriers faced by obstetricians and registrars in screening or enquiry of Intimate Partner Violence in pregnancy: a systematic review of the primary evidence.

Lu[1], Corrine. Georgousopoulou[2], Ekavi. Baloch[3], Surriya. Walton-Sonda[1], Dianne. Hegarty[4], Kelsey. Sethna[1], Farah. and Brown[1,4], Nick .A.T.

[1. Canberra Health Services; 2. ACT Health Directorate; 3. University of Melbourne, Royal Women's Hospital; 4. University of Canberra]

[May 2020-May 2023]

Corresponding Author: Dr Corrine Lu: corrine.lu@trainee.ranzcog.edu.au

Statement of Disclosure:

All authors (CL, EG, SB, DW-S, KH, FS and NB) confirm there are no conflicts of interest to declare.

Declaration

The concept of the systematic review was generated by FS and CL, following an unpublished literature review by CL and NB. The search strategy was designed and performed by DWS and CL. Screening of titles, abstracts and full-text studies was completed by CL and NB, with conflicts resolved by EG. Data extraction and was completed by CL and quality analysis independently by NB and CL. Statistical analysis and oversight of the review and processes was conducted by EG. Manuscript editing was conducted by NB, CL, EG and FS. Rerun of searches conducted by CL and SB with oversight and editiorial assistance of KH.

Special acknowledgement to Mr Brett Tweedie for assistance with preparation of figures. Ethics approval was sought but not required as the systematic review met low-risk criteria. This study was unfunded; no funds received. No conflict of interest with any author.

Abstract:

Background:
Intimate partner Violence (IPV) disproportionally affects women compared to men. In pregnancy, the impact of IPV is amplified. Screening or enquiry in the antenatal outpatient setting regarding IPV has been fraught with barriers that prevent recognition and ability to intervene.

Objectives:
The aim of this systematic review was to determine the barriers that face obstetric/gynaecology doctors in antenatal outpatient settings. The secondary objective was to determine facilitators.

Methods:
Primary evidence was searched using Ovid MEDLINE, Ovid Maternity and Infant Care (Ovid MIDIRS), PubMed, and Proquest from 1993 to May 2023. Included studies comprised empirical studies in English language targeting a population of doctors providing antenatal outpatient care. The review was PROSPERO-registered (CRD42020188994). Independent screening and review was attended by two authors. Findings were anlysed thematically.

Main Results:
Nine studies addressing barriers and two studies addressing facilitators were included: three focus-group or semi-structured interviews, six surveys and two randomised trials. Barriers for providers centred on system level (time, training), provider level (personal beliefs, cultural bias, experience), and provider-perceived patient level (fear of offending, patient readiness to disclose). Increased experience and the use of validated tools were strong facilitators.

Conclusion:
Barriers to screening reflect multi-level obstruction to the identification of women exposed to IPV. Whilst the antenatal outpatient clinic setting addresses a particular population vulnerable to IPV, the barriers to obstetric doctors are not unique. The use of validated cueing tools provides an evidence-based method to facilitate enquiry of IPV amongst antenatal women and builds capacity in providers.

Funding:
No funding sources.

Keywords:
Intimate Partner Violence, obstetrician, domestic violence, antenatal care, barriers, screening

Introduction:

Intimate Partner Violence (IPV), is any act of violence that results in, physical, sexual or psychological harm by a partner or ex-partner (1, 2). Global prevalence of IPV against women is 27%, with significant variation between high and lower income countries (3). IPV disproportionally affects women (4), and is more frequently perpetrated by men (1, 3, 5). Incidence is not altered by age, affluence or gender composition of the couple but rather societal structure, education, norms, attitudes and acceptance (3, 6).

International statements since the 1990s, demonstrate increased knowledge of the health and societal impact of IPV (2, 7). These include effects seen and unseen: physical, psychological, sexual, and reproductive health outcomes (1). Visible injury commonly includes haematoma, bruising, cuts, and fractures (1, 3, 5, 6, 8). Mental health effects include depression, anxiety, alcohol and substance misuse disorders, (9) psychosis and suicidality (5, 6). Sexual and reproductive health repercussions include sexually transmitted infection, intercourse coercion, unintended pregnancy, abortion, miscarriage, stillbirth, intrauterine haemorrhage, low birth weight infant, preterm birth, and postnatal depression (4, 10, 11).

Pregnancy is a time of increased susceptibility to IPV (12). Prevalence in pregnancy is as high as complications such as preeclampsia, and potentially just as lethal. Screening or enquiry regarding IPV is one way of identifying women experiencing harm, although screening rates in clinics are known to be low (13-15). Routine screening for IPV is recommended by the United States Preventative Services Task Force, (USPSTF) (16) and the American College of Obstetricians and Gynecologists (ACOG) (17). However, a review of primary evidence examining the outcomes of screening women in a diverse range of healthcare settings did not find significant alteration to women's health outcomes with routine screening or enquiry practices (18) This was also demonstrated in a recent follow-up outcomes of a cluster-randomised control trial testing a counselling intervention for women identified as experiencing IPV in primary care (19, 20). Importantly though, screening or enquiry practices does increase the identification of women experiencing IPV (18), creating opportunity for ongoing work toward improvement in outcomes. The Society of Obstetricians and Gynaecologists of Canada (SOGC)(21), and the World Health Organisation (WHO) support the identification of women experiencing IPV, and intervention to assist; without advocating universal screening (3, 22). The WHO furthermore identifies the antenatal clinic setting as the most optimal location for enquiry or screening of IPV.

Sprague et al (23) in 2012, examined the barriers to screening or enquiry for healthcare providers, including doctors across a variety of settings. The review categorised barriers by setting, provider and person factors (23). Most recently, two metasynthesis of personal and structural barriers examined qualitative studies of providers in a range of healthcare settings (24). Distinct to these previous reviews (23-25), this systematic review aimed to specifically focus on antenatal care doctors as the antenatal clinic context has been identified as a unique opportunity for disclosure (18). Qualitative evidence indicates women find enquiry of IPV acceptable and appropriate within care provided by the obstetrician (26, 27), a relationship distinct to that with their midwife.. The objective of this systematic review was to identify barriers faced by obstetricians, obstetric registrars and doctors working in antenatal clinics, in the identification of women exposed to IPV in antenatal clinics. The secondary objective was to identify strategies to improve recognition and screening of IPV in antenatal care.

Methods:

Information sources and search strategy

The project commenced in March 2020 with development of the search strategy (appendix S1). Searches were conducted using Ovid MEDLINE, Ovid MIDIRS, PubMed, and Proquest from 1993 to May 2023. Grey literature was searched using hand searches, reference lists of articles and grey literature including Helioblast. The strategy combined keywords and MeSH terms was first developed using MEDLINE (Ovid), then modified for other databases. Searches were limited to publications in English. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (28) guidelines were followed. Three decades captured the period following the United Nations Declaration on Violence Against Women (2) and recognition as a human rights violation (7). Submission of the review was made to the PROSPERO Register of Systematic Reviews in May 2020 and registered in July 2020 (29) (CRD42020188994). The initial search was inclusive to 1993 – November 2020 and a complete re-run of the searches was formally conducted in May 2023.

Inclusion and Exclusion Criteria

The target study population was obstetricians and doctors working in the hospital antenatal clinic context. Articles included were limited to empirical studies published in English from 1993 to May 2023. There were no restrictions on age of participants, gender or length of time in practice. Studies were excluded if they were conducted in the community primary care setting, focused on non-obstetric providers, were non-English language. Studies where the target population was blended with other practitioners in the antenatal outpatient setting were included if obstetric doctors comprised at least 50% of the study population.. Included studies are listed in the summary of findings tables (appendix S2).

Data Collection

Search results were imported into COVIDENCE (30). Two researchers (CL & NB) independently screened all titles and abstract against inclusion and exclusion criteria, then independently assessed all full-text articles for eligibility. A third independent reviewer (EG) screened any studies where there was conflict in eligibility. Studies chosen for inclusion were independently assessed for quality by reviewers (CL and NB), who also performed independent data extraction. In an update of the search, a new researcher (SB) paired with reviewer one (CL) to refresh searches to May 2023, utilising the same independent processes; an external expert (KH) provided oversight of the process.

Quality Assessment, data extraction and analysis

Included studies were categorized by study type and assessed using the CASP quality checklist (31) for risk of bias and quality. Data extraction was performed in COVIDENCE and presented in the summary of findings table (appendix S2). These included year of publication, country of study, study design, number of participants, outcome measures and findings. Outcomes were organised by theme for clarity.Thematic analysis was applied to identify common barriers.

Results

A total of 1911 papers were identified through the literature searches using the search strategy and hand searching. This is shown in the Prisma Chart (Figure1). Search results were imported into the review software and duplicates were removed. In the initial 2020 search, two reviewers screened 1783 studies using title and abstract; 40 studies were included for full-text screening, and 19 studies included.. In May 2023 a full re-run of the searches was conducted and four studies were included for full-text screening, At this time tighter criteria regarding target population was applied to ensure the target group of obstetric doctors represented at least 50% of the study group. This resulted in inclusion of a total of eleven studies: nine addressing barriers – three focus group/semi-structured interviews (32-34), six survey-questionnaire studies (14, 35-39), and two randomised controlled trials addressing tools as facilitators (40, 41). Studies included were conducted predominantly in high income countries: America, Canada, Belgium, New Zealand, and France; the inclusion of a study conducted in Pakistan (34) representing the only lower-middle income economy.

Overview of Studies

Six survey-questionnaire, quantitative studies were included, published 1995 - 2019 and conducted in USA, Belgium, Canada, Pakistan and France (14, 35-39). Predominantly the surveys were distributed by mail. Survey studies inherently include bias such as recall bias, response bias/non-response bias and sampling bias. Included studies had a high risk of bias and were assessed as low quality overall. Study size varied from 21 participants (38) to 993 participants (14).

Three qualitative studies were included, one each from USA, New Zealand and Pakistan (32-34). These were published between 2008 and 2017; all had small samples, limiting relevance, reducing quality, and increasing bias. Lauti et al (32), used a mixed study population of NZ obstetricians (n=5) and midwives (n=5). Taylor et al (33) conducted interviews with US physicians who practice primary care, inclusive of family physicians, and obstetricians; the group not differentiated further. In the semi-structured interviews, there were 8 physicians of a potential 30 participants, and in the focus groups 28 of a potential 38 physicians. The McCauley et al study (34) conducted in Pakistan, included doctors (n=25) and policymakers (n =5) using semi-structured interviews. Overall, there were 66 doctors in the studied target population across the three qualitative studies.
Thematic analysis methods were used in each study. Themes identified in all studies were considered in context of systems factors, provider factors and provider-perceived patient factors via a process of inter-reviewer discussion and documentation.

Included studies had a high risk of bias and were assessed as low quality overall.The two included RCT studies comprised one conducted in the USA and one in Canada. Each study was of moderate quality and designed with similar framework; an intervention study using a pre-visit tool, such as a questionnaire (40), or a combined education - questionnaire package (41).

System barriers:
Thematic analyses revealed that barriers relating to identification of IPV as indicated by doctors in the studies, included pressures of time, inadequate privacy, and lack of referral pathways (14, 23, 39, 42). Screening practices were influenced by the time in clinic for consultations, workload, privacy and heavily influenced by education, previous exposure to

IPV, education and knowledge of resources (35, 36). Another major barrier included lack of education or training in IPV (14, 36, 39, 42, 43).

Workload pressures and limited time were identified systems issues for doctors in interviews (33, 34). This is evident with triaging and prioritising within clinic consultation time; preferential medical screening over IPV under time pressure:

> " *there are too few doctors and too many patients, so a doctor can only give her five minutes or less than five minutes. There is no time for such stories"* [obstetrician] (34).

System issues around the provision of an appropriate environment was acknowledged by obstetric doctors as a barrier to identification of women vulnerable to IPV antenatally (32).
Privacy concerns in the clinic setting also included 'the presence of family members' and concern for 'privacy issues' around documentation of information in the patient record (33). This was "always" or "often" a barrier for nearly half of respondents (47.6%) in the most recent study by Duchesne (France, 2017) (38).

System factors such as inadequate referral pathways, and education to providers about availability of such pathways incapacitates the doctor in obstetric antenatal care and subsequently inhibits further screening (33, 34). Long (2019) identified that only about half of respondents received education in either medical school or residency (36). This study also demonstrated a paucity of written resources for women, with 77% of respondents stating that their institution did not have written information for women or an established referral pathway (42). The lack of referral pathways was common across studies

> " *a lot of times we are just stuck in this situation, we don't know how to cater for the situation…loads of doctors basically ignore the problem, even if they know it's there, because they know they can't help*" (34).
> *"referral options, but also how to deal with disclosure of it…having guidelines and algorithms that show what to do could be beneficial*" [obstetrician] (32).
>
> *"I am not familiar with what the management plan is…I am not well-armed with a flow chart..of who to go to"(32).*

System Facilitators:
Enablers or facilitators to reduce barriers to identification of IPV included well-established systems, support by other staff and institutional support with provision of training, tools support or referral networks and time (32, 34). Provider training and education in IPV was strongly associated willingness to screen; three studies suggesting a statistically significant association (Roelens et al. (p=0.001) (35), Parsons et al. (p=0.001) (14). The continuum of familiarity via exposure with education and training is also shown in lifetime exposure to IPV, through personal experience or close contact (14, 43). This personal experience or exposure to IPV in a peer, was found to be statistically significant with regard to increased likelihood of enquiry; as demonstrated by Roelens (p = 0.012) with adjusted odds ratio of 2.81 (95% CI 1.15-6.85) (35).

Obstetrician participants identified the creation of an environment receptive to disclosure of IPV as an important factor in facilitating disclosure. This included continuity of care, confidentiality and privacy (32).

"*you have to create an environment where disclosure is accepted*" (32).

Calderon et al (40) who explored the use of a "cueing sheet" as a provider-intervention following a patient online questionnaire, demonstrated that discussions of IPV occurred in the intervention group 60% above the control group. In the ALPHA RCT, women exposed to IPV were identified more using the screening questionnaire (Odds Ratio of 1.8, CI 1.1-3.0; p=0.02) (41). The longevity of the effect is uncertain though, with screening declining to 50% above the control group at one month post intervention (41).

Provider Barriers

Personal beliefs around IPV influenced decisions to screen as well as the level of perceived difficulty in the identification of women affected by IPV. Most studies identified a willing attitude in providers and awareness of the importance of screening, despite low rates of screening (36). High rates of surveyed obstetric doctors providing antenatal care indicated selective screening practices (14, 43). In the Long et al (36) study, 63% screened at the initial antenatal visit, whilst 75% of respondents in the Fikree study (37) indicated they performed screening as a result of experience or exposure to IPV.

Societal, gender and cultural disparity was evident as a bias and barrier in qualitative study responses (34, 36). Personal beliefs around prevalence, type of patient at risk or impotence in ability to create change in patient circumstance also influenced screening. Some providers indicated frustration towards survivors, judgement, and unwillingness to screen (14, 37). Fikree et al (37) found that while most respondents disagreed with statements such as "nothing doctors can do to help the victim as she won't likely leave the relationship", 17% of respondents agreed with this statement (37). Fear of offending the patient also influenced screening(14, 37).

"*..domestic violence I think is not a prime issue..*" (doctor) (34).

"*domestic violence is not that common in the group of women I see because I usually see girls from good, educated and well-off families… most of the problem, most of the women.. from the rural area..*"(34).

Some providers indicated their belief that psychosocial risk screening including enquiry of IPV, was outside their scope of practice and would subsequently evolve into a management problem beyond their control (32).

"*opening a can of worms… not being able to give a pill to make it better*"(doctor) (40).

"*…you don't know how to deal with it…it's time consuming*"(32).

Provider factor barriers inhibiting enquiry included fear of repercussions for personal safety; physical and emotional safety (42). This extended to fear of reporting, and avoidance of legal proceedings, such as providing evidence in court, due to fear of personal safety and safety of the clinician's family (34).

"*…There have been incidents where doctors have been beaten up. When they come…it can turn out really bad…*"(34)

Provider-based facilitators:

Building rapport and relationship with the patient (32) was an identified personal provider factor in creating space for disclosure. Some obstetric doctors identified a sense of professional responsibility to screen (35). Providers also demonstrated higher rates of screening if there was personal experience of IPV or through a close contact (35). Similarly, obstetricians were more likely to screen for IPV if they had received education or training (14) and became more confident with experience (34).

"once you come across and deal with a scenario then from the next time onwards you become more confident" (doctor) (34).

Provider Views of Patient Barriers:
Provider-perceived patient factors in both qualitative and quantitative analysis included the identified willingness of the patient to disclose their circumstances (32, 34). Furthermore, providers recognised privacy and inherent reluctance of the patient to disclose as influential in their own enquiry patterns (35).

" *It's just the way we are, you know we don't tend to open-up our private things in front of people*"(32).

There was a recognition that the patient would choose the time to disclose, but domestic violence as a societal or cultural taboo, posed a significant patient barrier (34).

> "*it's a point they have to get to themselves*" (32).
> *"when we tell them that we can help them if they want the help of some NGO or police then they withdraw"* (doctor)(34).

Patient facilitators:
There was recognition that along with providing a receptive environment, providing education to women through antenatal care provided empowerment to women affected by IPV (32, 33).

Discussion

This systematic review was designed to identify the barriers that prevent routine enquiry, and thereby obstruct an entry-point to referral and potential for improved perinatal outcomes. Identified barriers were found at all levels: system, provider, and provider-perceived patient.

Included studies using qualitative and quantitative methods identified barriers to IPV screening including: inadequate System factors: time, training private environment and education in IPV, Provider barriers including attitudes, perceptions, and Patient factors, such as readiness and empowerment. In support of these findings, the provision of dedicated screening resources and education for obstetricians and obstetric registrars, as seen in the RCT studies (40, 41), provides statistically significant evidence to support the use of tools to facilitate improved screening and enquiry rates.

Comparisons within Healthcare Settings:

Common healthcare entry or contact points for women experiencing IPV (44) provide a contextual comparator for IPV screening. Evidence from primary care research suggests that women are open to disclosure and referral in the antenatal hospital setting (25), supporting the recommendation by the WHO that enquiry about IPV occurs in this environment (5, 45).
Provider barriers identified in this review aligned with primary care, the emergency department and other varied healthcare settings (3, 24, 46-48). This was particularly true regarding concern around adequacy of training, knowledge of IPV, time constraints, privacy, and awareness of appropriate referral pathways.

It is evident from this review that barriers to IPV enquiry can be reduced or eliminated effectively with the use of training and tools (40). However, research is needed to measure the effect of longer-term training in providers, sustainability in implementation (44), and relationship with patient outcome measures. It is unknown whether increased training and utilisation of screening to identify women is associated with long-term improved outcomes in maternal and perinatal health (18). In the general practice setting, short-term improved mental health outcomes have been seen, but evidence for longer-term improved outcomes has not been demonstrated (19).

Active facilitation of screening or identification and removal of barriers was an identified method for providers to identify women through screening or routine enquiry. Simultaneously, attitude and confidence in ability to screen was improved, and enabled facilitation of identifying women.

Strengths and Limitations

The data in this review provides valuable insight into the current practices and behaviours that contribute and result in barriers to screening or asking about IPV, however the quality is compromised by small group size, heterogenous antenatal obstetric provider-type, lower response rates, recall bias, setting and participant characteristics. RCT data was of moderate quality, indicating reasonable confidence in the indirect study of barriers.
Inclusion criteria was deliberately broad, open to all countries but limited to publication in English language. The low number of identified studies, together with lower-than-expected diversity in country of origin and income, limited application of results. The scope of this review did not extend to outcome measures, an opportunity for prospective research.

Implications

We recommend that institutions and providers of antenatal care demonstrate training in intimate partner violence; knowledge increases enquiry and is acceptable to women. We recommend the use of a validated tool in an environment assured of confidentiality, as there is strong evidence for facilitation of screening with tools and appropriate use in a private environment assists in eliminating real and percieved barriers. In addition we recommend establishing and communicating clear referral pathways for women without expectation or judgement.

Conclusion

This objective of this systematic review was to perform a focused study of the barriers and facilitators to enquiry or screening of IPV by obstetricians and doctors in outpatient hospital antenatal care. Review findings demonstrated barriers present at system level, provider level and provider-perceived patient level, in addition to facilitators identified at system and provider level. Recognition of the vulnerability of all women exposed to IPV and the sensitivity required in caring for this population is evident in qualitative data

No difference was found in the barriers to screening for IPV in this discipline of care compared to other providers in healthcare. This concurs with findings of previous studies and highlights human and system factors, where directed effort holds potential to improve multigenerational outcomes. Successful initiatives to identify women require engagement with systems, provision of education, and resources (inclusive of screening-facilitation tools), to build capacity in providers, as well as resources to support and connect women. Four principles underpin all: Engagement, Education, Enquiry and Empowerment.

References

1. Garcia-Moreno C, Guedes, A, Knerr, W. Intimate Partner Violence. Information sheet. World Health Organization; 2012 22/10/2019.
2. United Nations General Assembly. Declaration on the Elimination of Violence Against Women. United Nations General Assembly resolution ed. New York, NY: United Nations; 1993.
3. Sardinha L, Maheu-Giroux M, Stöckl H, Meyer SR, García-Moreno C. Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. The Lancet. 2022;399(10327):803-13.
4. Shadigian EM, Bauer ST. Screening for partner violence during pregnancy. International Journal of Gynaecology & Obstetrics. 2004;84(3):273-80.
5. World Health Organisation. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Italy: World Health Organization,; 2013 2013. Contract No.: ISBN 978 92 4 156462 5 (NLM classification: HV 6625).
6. García-Moreno C, Jansen H. A.F.M, Ellsberg M, Heise L, Watts C. WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses,. Geneva,: World Health Organization,; 2005.
7. United Nations, editor Vienna Declaration and Programme of Action. World Conference on Human Rights; 1993; Vienna, 14–25 June 1993. New York, NY: United Nations,; 1993.
8. Coker LA, Garcia SL, Williams MC, Crawford NT, Clear RE, McFarlane EJ, et al. Universal Psychosocial Screening and Adverse Pregnancy Outcomes in an Academic Obstetric Clinic. Obstetrics & Gynecology. 2012;119(6):1180-9.
9. Bacchus LJ, Ranganathan M, Watts C, al. e. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies.,. BMJ Open. 2018;8(e019995.).
10. World Health Organization. World report on violence and health. Geneva: World Health Organization; 2002. Report No.: 0042-9686 Contract No.: ISBN 92 4 154561 5.
11. Miriam Lum On JA, Kim Webster, Lynelle Moon. Examination of the health outcomes of intimate partner violence against women : State of knowledge paper. Sydney: Australia's National Research Organisation for Women's Safety Limited (ANROWS); 2016.
12. Yee LM, Crisham Janik M, Dorman RM, Chong PS, Garcia PM, Miller ES. Relationship between intimate partner violence and antiretroviral adherence and viral suppression in pregnancy. Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives. 2018;17:7-11.
13. Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. JAMA. 1999;282(5):468-74.
14. Parsons LH, Zaccaro D, Wells B, et al. Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. American Journal of Obstetrics and Gynecology. 1995;173(2):381-7.
15. Stayton CD, Duncan MM. Mutable Influences on Intimate Partner Abuse Screening in Health Care Settings: A Synthesis of the Literature. Trauma, Violence, & Abuse. 2005;6(4):271-85.
16. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening [Internet]. USPSTF. 2018. Available from: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening.

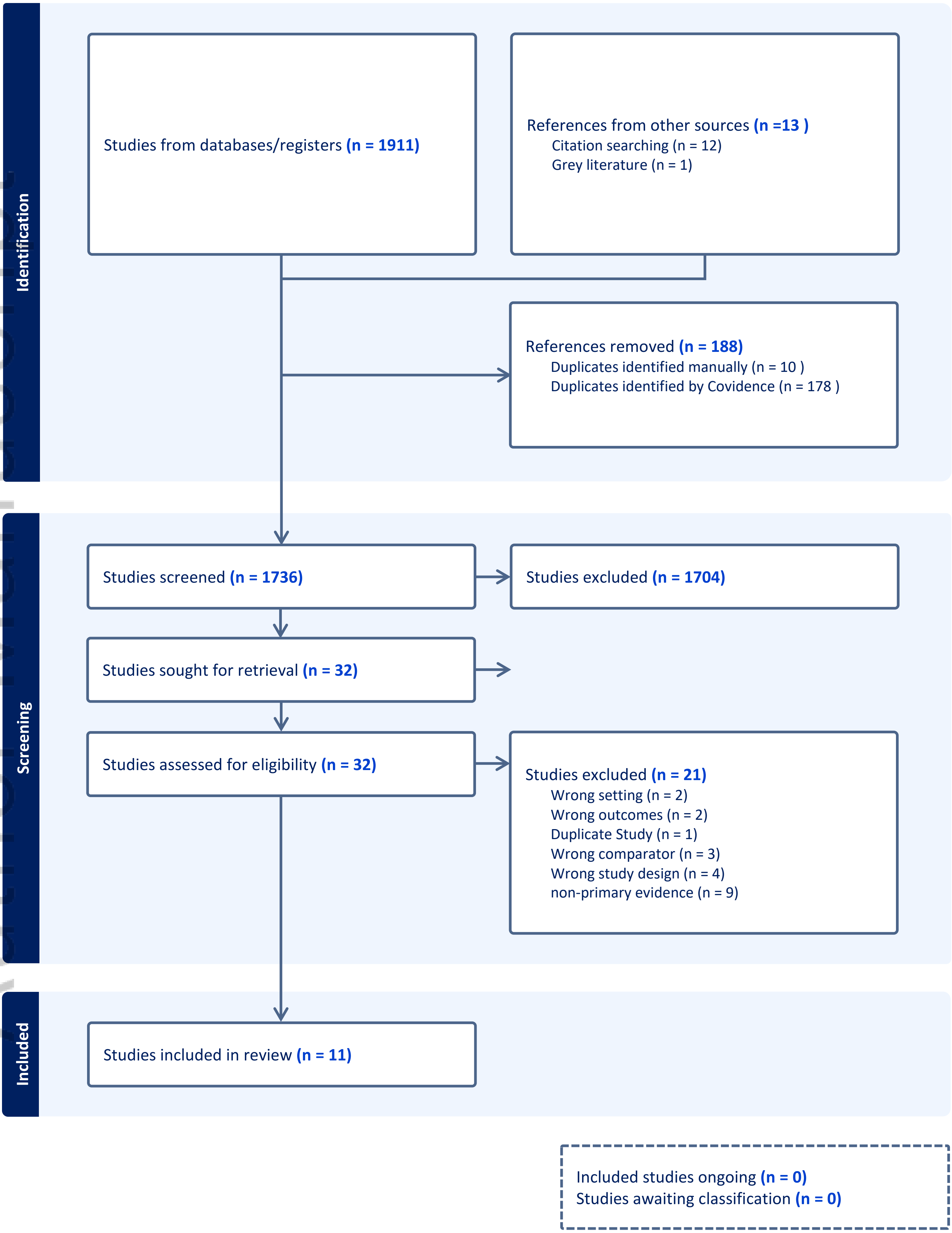
17. American College of Obstetricians and Gynecologists (ACOG). Intimate Partner Violence. American College of Obstetricians and Gynecologists; 2012, (reaffirmed 2022).
18. O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. Screening women for intimate partner violence in healthcare settings. Cochrane Database of Systematic Reviews. 2015;2015(8).
19. Hegarty K, Valpied J, Taft A, Brown SJ, Gold L, Gunn J, et al. Two-year follow up of a cluster randomised controlled trial for women experiencing intimate partner violence: effect of screening and family doctor-delivered counselling on quality of life, mental and physical health and abuse exposure. BMJ Open. 2020;10(12):e034295.
20. Hegarty KL, Gunn JM, O'Doherty LJ, Taft A, Chondros P, Feder G, et al. Women's evaluation of abuse and violence care in general practice: a cluster randomised controlled trial (weave). BMC Public Health. 2010;10(1):2.
21. SOGC. Intimate Partner Violence Consensus Statement. Journal of Obstetrics and Gynaecology Canada. 2005;27(4):365-88.
22. Organisation WWH. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non- partner sexual violence. Geneva, Switzerland: World Health Organisation; 2013.
23. Sprague S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, et al. Barriers to Screening for Intimate Partner Violence. Women & Health. 2012;52(6):587-605.
24. Tarzia L, Cameron J, Watson J, Fiolet R, Baloch S, Robertson R, et al. Personal barriers to addressing intimate partner abuse: a qualitative meta-synthesis of healthcare practitioners’ experiences. BMC Health Services Research. 2021;21(1).
25. Hegarty KL, O'Doherty LO, Astbury J, Gunn J. Identifying intimate partner violence when screening for health and lifestyle issues among women attending general practice. Aust J Prim Health. 2012;18(4):327-31.
26. Roelens K, Verstraelen H, van Egmond K, et al. Disclosure and health-seeking behaviour following intimate partner violence before and during pregnancy in Flanders, Belgium: A survey surveillance study. European Journal of Obstetrics and Gynecology and Reproductive Biology. 2008;137(1):37-42.
27. McDonnell E, Holohan M, Reilly MO, et al. Acceptability of routine enquiry regarding domestic violence in the antenatal clinic. Irish Medical Journal. 2006;99(4):123-4.
28. Moher D LA, Tetzlaff J, Altman DG, The PRISMA Group Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. . PLoS Med. 2009; 6(7): e1000097.
29. Lu C, Brown N.A.T, Georgousopoulou E, Walton-Sonda D, Sethna F. Identifying the barriers faced by obstetricians and registrars in screening or asking about intimate partner violence in pregnancy: a systematic review of the primary evidence. CRD42020188994. In: National Institute for Health Research, Centre for Reviews and Dissemination, editors. York, UK: University of York,; 2020.
30. COVIDENCE. COVIDENCE Systematic Review software,. 2017.
31. Critical Appraisal Skills Programme. CASP Checklist,. Oxford, OX2 8JQ,: Critical Appraisal Skills Programme; 2019.
32. Lauti M, Miller D. Midwives' and obstetricians' perception of their role in the identification and management of family violence. New Zealand College of Midwives Journal. 2008(38):12-6.
33. Taylor P, Zaichkin J, Pilkey D, Leconte J, Johnson BK, Peterson AC. Prenatal screening for substance use and violence: findings from physician focus groups. Maternal & Child Health Journal. 2007;11(3):241-7.
34. McCauley M, Head J, Lambert J, Zafar S, van den Broek N. "Keeping family matters behind closed doors": healthcare providers' perceptions and experiences of identifying and managing domestic violence during and after pregnancy. BMC Pregnancy & Childbirth. 2017;17(1):318.

35. Roelens K, Verstraelen H, Van Egmond K, Temmerman M. A knowledge, attitudes, and practice survey among obstetrician-gynaecologists on intimate partner violence in Flanders, Belgium. BMC Public Health. 2006;6:238.
36. Long AJ, Golfar A, Olson DM. Screening in the Prenatal Period for Intimate Partner Violence and History of Abuse: A Survey of Edmonton Obstetrician/Gynaecologists. J Obstet Gynaecol Can. 2019;41(1):38-45.
37. Fikree FF, Jafarey SN, Korejo R, Khan A, Durocher JM. Pakistani obstetricians' recognition of and attitude towards domestic violence screening. International Journal of Gynaecology & Obstetrics. 2004;87(1):59-65.
38. Duchesne SA-O, Donnadieu AC, Chariot P, Louis-Sylvestre C. Screening for domestic violence during pregnancy follow-up: evaluation of an intervention in an antenatal service. 2019(1435-1102 (Electronic)).
39. Ortiz JJ, Ford LR. Existence of staff barriers to partner violence screening and screening practices in military prenatal settings. JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing. 2005;34(1):63-9.
40. Calderon SH, Gilbert P, Jackson R, et al. Cueing prenatal providers effects on discussions of intimate partner violence. American Journal of Preventive Medicine. 2008;34(2):134-7.
41. Carroll JC, Reid AJ, Biringer A, Midmer D, Glazier RH, Wilson L, et al. Effectiveness of the Antenatal Psychosocial Health Assessment (ALPHA) form in detecting psychosocial concerns: a randomized controlled trial. CMAJ Canadian Medical Association Journal. 2005;173(3):253-9.
42. Ndimbii J, Ayon S, Abdulrahman T, Mahinda S, Jeneby F, Armstrong G, et al. Access and utilisation of reproductive, maternal, neonatal and child health services among women who inject drugs in coastal Kenya: Findings from a qualitative study. Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives. 2018;18:48-55.
43. Horan DL, Chapin J, Klein L, Schmidt LA, Schulkin J. Domestic violence screening practices of obstetrician-gynecologists. Obstetrics & Gynecology. 1998;92(5):785-9.
44. Miller CJ, Adjognon OL, Brady JE, Dichter ME, Iverson KM. Screening for intimate partner violence in healthcare settings: An implementation-oriented systematic review. Implementation Research and Practice. 2021;2:263348952110398.
45. World Health Organisation. Intimate partner violence during pregnancy. report. Geneva: The World Health Organization,; 2011.
46. Yonaka LRNMSN, Yoder MKERN, Darrow JBRNMS, Sherck JPMD. Barriers to Screening for Domestic Violence in the Emergency Department. The Journal of Continuing Education in Nursing. 2007;38(1):37-45.
47. Alotaby IY, Alkandari BA, Alshamali KA, Kamel MI, El-Shazly MK. Barriers for domestic violence screening in primary health care centers. Alexandria Journal of Medicine. 2013;49(2):175-80.
48. Hudspeth N, Cameron J, Baloch S, Tarzia L, Hegarty K. Health practitioners' perceptions of structural barriers to the identification of intimate partner abuse: a qualitative meta-synthesis. BMC Health Services Research. 2022;22(1).

Legend for Included Figures

Figure 1.	Prisma Flow Diagram for this systematic review of the barriers and facilitators for screening or enquiry of Intimate Partner Violence by Obstetric doctors in the antenatal outpatient setting.
Figure 2.	Conceptual Representation: Barriers and facilitators screening for Intimate Partner Violence.

Why don't we ask? Barriers to Screening or Enquiry Regarding Family Violence Among Obstetric Specialists and Trainees in the Hospital Setting



19th May 2023

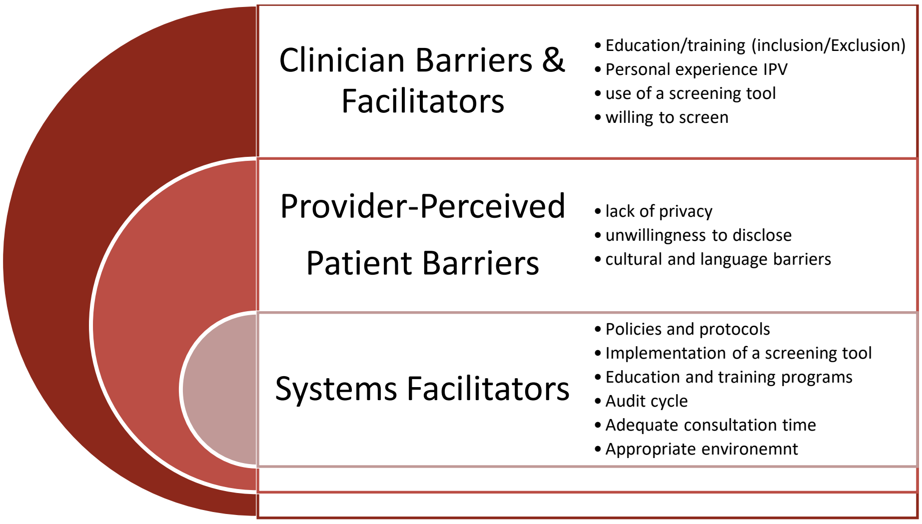


Figure 2: Conceptual Representation: Barriers and facilitating factors in enquiry or screening for Intimate Partner Violence.