

The Experiences of Women and Healthcare Providers in Assessing the History of Gender-Based Violence During Perinatal Care

Violence Against Women
1–20

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Abstract

Despite its prevalence and consequences, perinatal healthcare providers' identification of gender-based violence (GBV) remains controversial in British Columbia. This study investigated women and healthcare providers' perspectives regarding their experiences with and views of inquiring about GBV during perinatal care. Twelve in-depth interviews were conducted with women with a history of GBV and 16 perinatal healthcare providers. Data were analyzed thematically. Three themes, including "barriers to disclosure," "healthcare providers hesitate to open Pandora's Box," and "how to ask in a culturally safe way," emerged from the data. Study participants support inquiry about GBV during perinatal healthcare.

Keywords

gender-based violence, perinatal period, women, healthcare provider, screening

Introduction

Gender-based violence (GBV) refers to any physical, sexual, psychological, cultural, spiritual, social, mental, or economic violence perpetrated by an intimate partner,

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family member, or any other person (nonpartner violence) as a result of gender identity or gender expression. Unfortunately, pregnancy does not prevent the occurrence of GBV by a partner (Baird et al., 2013; World Health Organization, 2011). Perinatal care includes antenatal, intrapartum, and postpartum care (Hahn et al., 2018). GBV during the perinatal period affects many women and their unborn infants worldwide (O'Reilly et al., 2010). A multi-country survey reported that violence prevalence during this vulnerable time ranges between 4% and 32%. It has been reported that in low-income countries, the prevalence of GBV is even higher (14%–32%) (Mutisya et al., 2018). In another study, the prevalence of violence during pregnancy in economically advanced and disadvantaged countries was reported, and rates were found to range from 0.9% to 30.0% and 1.3% to 12.6%, respectively (Baird et al., 2013).

GBV during the perinatal period is one of the leading causes of maternal death (Taillieu & Brownridge, 2010). Furthermore, violence during this time not only jeopardizes a woman's current health status, but it is also a strong predictor of postpartum violence (Taillieu et al., 2016).

According to Status of Women Canada, addressing GBV is one of Canadians' most critical human rights issues (Government of Canada, S. of W. C., n.d.-a). Although data on GBV are difficult to collect, one estimate suggests that 51% of women older than 16 years report having experienced physical or sexual abuse ("We Fund Programs Working Towards Gender Equality | Gender-Based Violence in Canada," n.d.). Annually the economic cost of violence against Canadian women is estimated to be \$4.8 billion (Government of Canada, S. of W. C., n.d.-b). It is estimated that more than one in 10 female spousal victims in Canada is pregnant at the time of the abuse (Care, 2014). Rates of GBV are challenging to estimate in Canada; whether based on police reports and/or self-reports, most published data are likely to underestimate true rates. According to available evidence, out of all women who report experiencing violence, 10.5% experienced sexual and/or physical violence during pregnancy (Taillieu et al., 2016).

Impact of Perinatal GBV on Maternal and Infant Outcomes

The perinatal period is a very sensitive time for both the mother and child. Women, children, and families who experience violence during this period face more detrimental effects to their physical and mental health than those who have experienced violence at other times throughout the life course (Deshpande & Lewis-O'Connor, 2013; Van Parys et al., 2014). Violence during the perinatal period is associated with varied and significant health-related consequences, including sexually transmitted infection, miscarriage, premature birth, low birth weight baby, and unsafe abortion (Alhusen et al., 2015). Moreover, psychological distress related to violence during the perinatal period is associated with long-term psychological, physical, social, and economic consequences (Mutisya et al., 2018; World Health Organization, 2011). Violence can also weaken a mother's capability to parent effectively during the postpartum period, which may compromise maternal-child bonding (Taillieu et al., 2016). It even can

compromise a child's development (Taillieu et al., 2016). The destructive effects of violence on maternal, fetal, and infant well-being during the perinatal period make this a critical time to detect violence and offer a potential window to intervene (Velonis et al., 2017).

Assessment of Perinatal GBV

Despite the prevalence of GBV and its known consequences during the perinatal period, the assessment and identification of GBV during healthcare visits is a controversial issue (World Health Organization, 2013). Some healthcare providers report not wanting to engage with GBV assessment (Edin & Högberg, 2002), arguing it is not part of their role (O'Reilly & Peters, 2018), and they do not have enough time. Some of them do not know how to manage disclosure and mention the lack of instruction on how to ask questions (Guillery et al., 2012). Some provider organizations have made recommendations for screening for GBV (Alshammari et al., 2018; Edin & Högberg, 2002; Knox, 2018; Van Parys et al., 2014); others, however, consider it conditional and argue that asking about GBV is only beneficial if accompanied by interventions, such as counselling to increase safety behaviors, or housing that can support the survivor of the violence (O'Reilly & Peters, 2018). WHO has concluded that there is insufficient evidence supporting the idea that screening reduces GBV or improves the quality of life or health outcomes (MacMillan et al., 2009). However, it has been noted that screening programs that also offer post-screening action may lead to improved health-related outcomes for women (MacMillan et al., 2009; O'Reilly & Peters, 2018), increase the rate of referral to local advocacy programs, and can enable support from a healthcare professional. Screening for violence is supported by some health professional bodies such as the Registered Nurses' Association of Ontario (Registered Nurses' Association of Ontario, 2005) and the American College of Obstetrics and Gynecology (Deshpande & Lewis-O'Connor, 2013). In New South Wales (NSW), Australia, routine violence screening in prenatal clinics commenced in 2001 (Chaves et al., 2019) and has documented benefits. However, the WHO stipulates that healthcare providers require appropriate training and must be able to speak to women privately; therefore, its application is difficult in some clinical settings with low resources and lack of training. It has also been suggested that some women may feel offended if they are asked about GBV or receive no support after disclosure; therefore, implementation of any processes related to GBV needs careful management and evaluation (Bacchus et al., 2010).

Questions have been raised about nurses, midwives, and physicians' roles in detecting and identifying violence during perinatal care. Should women be asked about any history of violence during their perinatal care? There are different schools of thought about these questions, and there is still no consensus on an accepted approach.

In British Columbia, pregnant women are able to receive perinatal care from family physicians, registered midwives, and obstetrician-gynecologists. Perinatal care may include as many as a dozen contacts throughout pregnancy to postpartum, providing both women and healthcare providers (HCPs) numerous opportunities to establish a

trusting relationship, which might offer greater opportunities to disclose GBV. Indeed, research suggests that HCPs are among the professionals to whom GBV survivors report being most willing to disclose their experiences (O'Reilly & Peters, 2018).

Given the equivocal views and the particular context of perinatal care, more research is needed as to whether to perform GBV assessment in the context of perinatal care (Wathen & MacMillan, 2003). To respond to these questions, this study was designed to investigate women and HCPs' views on assessing the history of GBV during perinatal care.

Methods

Participants

Two distinct groups were recruited for this qualitative study: women with a self-reported history of GBV and HCPs providing perinatal healthcare. After data analysis, we decided to combine the findings from both groups. The analysis revealed that both patients and HCPs shared a number of similar perspectives. Inclusion criteria for the women were: being between the ages of 18 and 49 years, having been pregnant during the last 5 years, having a self-reported history of GBV in the same period, and being able to communicate and speak conversational English. Women self-reporting current alcohol or drug abuse and those reporting current untreated major mental health problems were excluded.

The HCPs' inclusion criteria were: having experience providing care for women during the perinatal period and having experience in providing care for women with a history of GBV.

Participants with diverse identities (including those identified as Indigenous and new immigrants) were recruited to create maximum variety within the sample.

Procedures

The researchers used flyers and advertisements in settings such as hospitals and public places such as community centers, gyms, shopping malls, shelters, family services, and courts for participant recruitment. Social media advertisements (i.e., Facebook and Instagram) and snowball sampling were also used to recruit. An office telephone number and email were provided in the advertisement for potential participants to contact the researcher. HCPs were recruited through posters placed in common areas such as streets around the hospitals, shelters, hospital boards, emails through an internal hospital newsletter, social media, and snowball sampling.

UBC and the C&W Research Ethics Board approved this study. Before interviews, comprehensive information about the study was provided by telephone. Inclusion and exclusion criteria were assessed. Participation in the study was voluntary, and prior to the interview, consent was obtained from each participant; they were assured that their personal information, transcripts, and recorded files would be anonymized.

Interview questions are provided in Tables 1 and 2. Both sets of interviews began with questions related to the definition of GBV from the participants' point of view and then continued with questions pertaining to their experiences of violence. Women were asked about their experience regarding violence and the responses they received from the healthcare system. Both groups were asked about any barriers to disclosing GBV and their suggestions for improving the existing context of identifying GBV within the healthcare system. Participants were asked whether they felt a HCP should address GBV during perinatal healthcare and how it should be assessed.

Data Analysis

A qualitative approach was used to explore participants' thoughts, experiences, and recommendations regarding inquiring into a patient's history of GBV during perinatal care. Immediately after each interview, the interview audio files were transcribed verbatim and analyzed. A thematic, inductive approach was used to analyze the data (Nowell et al., 2017) using NVivo. This approach allows themes and categories to emerge directly from the data while avoiding the use of predetermined categories. The interview recordings were transcribed verbatim into Word documents. The first author of the study and an external researcher (both were experts in qualitative research) did the analysis separately and then discussed their sense of the data. Themes and subthemes were discussed with the rest of the research team, and they came to a consensus about the final results.

Table 1. Semi-Structured Questions in Interviews With Survivors.

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1. How do you define GBV?
 2. You have mentioned that you have experienced GBV during the last 5 years, could you please explain more about it?
 3. Who was/were the first person/s that you decided to talk about this experience with? What was/were his/her/their reaction?
 4. Have you ever had the experience of asking for help from a health-related organization/healthcare provider? If yes, please explain their reaction and the quality of support you have received. And if you did not approach them, is it possible to explain why you didn't talk to them?
 5. Over the course of pregnancy and after that, did anyone in the healthcare system ask you about your history of abuse or violence?
 6. Would you have wanted your Dr., Nurse, or Midwife to ask you about your history of GBV?
 7. Did you disclose the history of GBV yourself or did your care provider start the dialogue? Would you please explain more about the questions they asked and the response and support you received?
 8. What are the barriers to disclosing violence based on your experience?
 9. During the appointment with your healthcare provider, based on your experience and opinion, what kinds of questions would be more appropriate for the investigation of GBV?
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Table 2. Semi-Structured Questions in Interviews With Healthcare Providers.

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1. How do you define GBV?
 2. Have you ever come in contact with cases of GBV among your clients? Please explain how did you notice that and what was your response?
 3. Over the course of pregnancy and after that, do you usually assess your clients for a history of violence/abuse?
 4. Based on your experience, what are the best ways of GBV identification?
 5. Based on your experience, why are some healthcare providers not interested in asking questions regarding GBV while assessing women during their perinatal care?
 6. Based on your experience, why do some women not disclose the experience of GBV to the healthcare providers?
 7. While assessing the history of violence during perinatal care, what kind of questions would be more appropriate to be asked from women?
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To familiarize ourselves with the depth and breadth of the content and obtain a general understanding, the entire text was read several times; this helped us identify meanings or possible patterns. Data were organized into meaningful groups, and initial codes were identified. Then different codes were sorted into potential themes and subthemes. The themes and subthemes were reviewed in terms of internal and external consistency. If necessary, the themes were modified, and a short and concise name was chosen so that the readers would understand each theme.

Lincoln and Guba's proposed criteria were considered to support the trustworthiness of the findings: credibility, confirmability, dependability, and transformability (Nowell et al., 2017). Strategies used to support trustworthiness included prolonged engagement with the data and repeated readings of the transcripts. Themes and subthemes were reviewed with team members. For the prevention of insider bias, the researcher practiced reflexivity and documented personal reflections in a project diary. Furthermore, a complete description of participants, process, and context increased the transferability (Tables 3 and 4).

Results

Twenty-eight interviews were conducted (10 face-to-face and 18 by phone), with each interview lasting 30–60 min. Twelve interviews were with women who had experienced GBV and were pregnant within the last 5 years, and 16 were with healthcare professionals who had provided care for women with a history of GBV (five midwives, five nurses, and six physicians).

Overview of Main Themes

Three main themes, 10 subthemes and 2 sub-subthemes were generated (see Table 5) through the analysis and research group discussions: "Barriers to disclosure,"

Table 3. Demographic Characteristics of Healthcare Providers.

Profession	Age range	Years of experience as a healthcare provider
Physicians	35–54	8–28
Nurses	29–50	8–20
Midwives	34–59	2–20

“Healthcare providers hesitate to open Pandora’s Box,” and “How to ask in a culturally safe way.” We illustrate these themes with sample quotes from participants and denote whether they were from the sample of women with a history of GBV (survivors) or the sample of HCPs.

Barriers to Disclosure. The majority of both sets of participants advocated for asking questions about the history of GBV; however, they mentioned that there was no guarantee that all women would share their experiences. Women spoke out about their fear and denial related to GBV and mentioned that they were hesitant to admit that they were in an abusive relationship. Participants in both groups expressed concerns about stigmatization and security issues, partners’ presence, and information in medical charts being disclosed to a partner or the family. Lack of awareness regarding available resources among women was another barrier to disclosure. Some women did not know that they could receive support from HCPs and were not sure if disclosure would benefit them. Based on the participants’ stories, five subthemes expand on barriers to disclosure.

a) Lack of awareness: Some survivors were not aware of different types of violence. Also, some thought that social determinants of health, including GBV, are

Table 4. Demographic Characteristics of Survivors.

	Age	Number of children	Job position	Education level
1	21	1 child	Student	Undergraduate student
2	35	1 abortion	Work for a company	Master’s degree
3	41	3 children	Unemployed	Elementary
4	40	2 children	Unemployed	High school
5	27	1 child	Student	Undergraduate student
6	38	2 children, 1 miscarriage	Social Worker	Master’s degree
7	37	2 children, 1 abortion	Engineer	Bachelor degree
8	39	1 child, 1 abortion	Self-employed	College
9	40	2 children, 1 abortion	Self-employed	College
10	35	2 children	Casual work	Bachelor degree
11	27	Pregnant, 1 abortion	Unemployed	Bachelor degree
12	42	2 children	Works for a company	University (not finished)

Table 5. Overview of 3 Major Themes, 10 subthemes, and 2 sub-subthemes.

Barriers to disclosure	(a) Lack of awareness (b) Feeling judged and stigmatized (c) Not being sure that disclosing would benefit them (d) Fear and denial (e) It's not healthcare providers' concern
Healthcare providers hesitate to open the Pandora's Box	(a) Stepping onto an unfamiliar path (b) Concerns about the next step (c) The paradox of whether to ask or not to ask - Use normalizing questions to break the ice - Ask in a way that no one feels singled out and bombarded
How to ask in a culturally safe way	(a) Lack of a single definition of GBV (b) Diverse ways of asking questions regarding GBV

not in the realm of healthcare workers; therefore, they did not talk about these experiences with their care providers. For example:

I just think a lot of women don't even know what abuse is. I think most women just think it's being hit or beaten ... women need to know about that, and once they know, I think they will speak up and ask. (40-year-old survivor)

I think because that's not their job ... they just help the baby, like delivering the baby. (37-year-old survivor)

b) Feeling judged and stigmatized: Women with experiences of GBV said that HCPs' verbal and nonverbal communication made them feel judged and stigmatized. They shared that HCPs' comments and gestures had negative effects on their willingness to speak up; some also mentioned that they were concerned about the way they were treated in healthcare settings:

Because a lot of couple times, what they were saying to me was judgmental. I can just tell by their face. They just need to be very careful about how they go about asking the questions and also be very careful about judgments because even if you're not directly speaking judgments, your body language says a lot. Every time I came into the clinic, the nurse was very short with me and just giving me attitude. (40-year-old survivor)

c) Not being sure that disclosing would benefit them: Some women expressed doubt that their HCPs could adequately support them because they did not have the knowledge and skills to deal with this issue and did not have the necessary resources to help women.

I think that a lot of them wouldn't know what to do with that information. And so it is less awkward or easier maybe to just avoid the question, rather than to ask it and that finding information that you can't do anything with or you don't know what to do with it. Bring up these horrible memories to women, and then they don't have the tools or the knowledge to know how to help this person or do anything. (27-year-old survivor/1)

d) Fear and denial: The presence of partners or in-laws at healthcare appointments was among the factors that prevented women from disclosing their experiences of GBV. They also worried about legal problems regarding child custody and housing. Some of the women also pointed out that it was difficult for them to admit that they were in an abusive relationship, or they believed that things might get better in the future:

I think a big part of mine was denial, and I did not want to admit that I was under an abusive relationship, and I hoped that it was going to change. I was afraid of being alone, afraid of what he was going to do to me if he found out, and I was also afraid of what was going to happen to my child if they found out that I was in an abusive relationship. (40-year-old survivor)

HCPs had similar views regarding why women might be reluctant to disclose experiences of GBV:

I think women are uncomfortable to talk about gender-based violence maybe for fear of further violence, for fear of being outed, for lack of resources and a lack of like next step, if they do disclose. Probably fear of financial abuse from husband or partner. I think pregnancy is a scary time in general. I think it's normal to want to be with another person, even if that person is someone who isn't kind. (34-year-old HCP)

e) It's not HCPs' concern: Women's previous experiences with regard to violence and the response they received from the healthcare system sometimes made them feel that GBV was not a concern for HCPs; instead, their focus was mainly on the woman's and infant's health.

I went to a walk-in clinic, and this time the doctor was a woman, and she said you have anxiety and just asked medical questions. Nothing like "Would you like me to refer you to a counsellor or a therapist?" I had to ask myself and said, "Can you refer me to a counsellor or therapist?" They [doctors] only handle medication. They don't pay attention. Why would I talk about it? (21-year-old survivor)

HCPs Hesitate to Open Pandora's Box. HCPs mentioned that asking questions is like opening Pandora's Box—once opened, evil is released to the world while hope is trapped.

It's a Pandora's Box and that I'm gonna ask and then what do I do next? Where do I refer to this woman? I don't know any of the resources, so that's one of the gaps. (45-year-old HCP)

HCPs were concerned about the outcomes of a patient disclosing current GBV and how to manage it appropriately. Three subthemes emerged under this theme:

a) Stepping onto an unfamiliar path: Healthcare professionals were concerned about how to start the conversation and what to ask, and they were uncertain about how to open up a discussion on GBV. They also had doubts regarding the questions they should ask women that would not cause harm or offense. However, women mentioned that asking questions in a private situation while making them sure about confidentiality would not make them feel offended; most participants from both groups advocated asking questions about the experience of violence.

I think it's a very tough area ... the first part of this strategy would be how to ask questions, and what kinds of questions should we ask? (36-year-old HCP)

I think if I had a question template to start with, and maybe recommendations of when to consider asking, then I think I would try it out. I think because I haven't done it before, there's this hesitation and worry that I'm going to offend any people or that sort of thing. (45-year-old HCP)

b) Concerns about the next step: The HCPs were worried about their lack of time and believed that entering this space would increase their workload. Some mentioned that they did not know enough about the available resources and were not sure if they could help women. Some pointed out that they did not know where they would end up if they entered this area of discussion.

I think that the next steps are really challenging. Like if gender-based violence is disclosed, I think that what to do after that is really challenging and confusing, and sometimes it may be easier in low-resource settings to not ask because the next step is so unknown and time-consuming. (34-year-old HCP)

Some women also mentioned that their HCP did not ask questions regarding GBV, and they wondered if perhaps some healthcare workers do not know what to do with the information and how to help:

I went to the doctor almost a year ago, right after the relationship that I explained; I was so depressed and went to my doctor and said that I felt so bad, I couldn't even breath. It was so bad, and I felt pressure on my chest. The doctor didn't ask me anything! He didn't even ask me why! He was like, "Oh, so you feel you are depressed? Do you have any violent thoughts about harming yourself or killing yourself?" The doctor said, "Ok, I will give you some prescription." He knew that I was a single mom; I went there with my kid. He didn't even ask me anything about the history of violence. (21-year-old survivor)

c) The paradox of whether to ask or not to ask: The HCPs in this study acknowledged the importance of asking questions regarding GBV. However, they did not consider themselves adequately prepared to detect GBV and take the necessary actions.

The participants mentioned that many women would not talk about their history of GBV and do not feel comfortable bringing it up unless asked by an HCP in a safe context. Some participants suggested that such questions should be asked of all women during their perinatal care so that no one would feel singled out. Others complained that HCPs mainly paid attention to their baby and health-related issues. Participants expected HCPs to have a more holistic approach in their assessments of their health and well-being. This subtheme had two sub-subthemes:

- Using normalizing questions to break the ice: The majority of the participants believed that asking questions about the history of violence against women during perinatal care should be part of their health assessment.

I think it is necessary to find a way to do that. I think asking the question is kind of creating the atmosphere for disclosure. I think asking questions is a really good and important first step in opening up that door for disclosure. (27-year-old survivor/2)

Asking questions definitely wouldn't offend me. I would feel that they were more understanding in their approach, and I could have greater trust in them. (27-year-old survivor/1)

- Ask in a way that no one feels singled out and bombarded: Participants in the study had some useful suggestions on how to ask questions. They also pointed out that one could start asking questions so that women do not feel singled out, pressured, or offended.

I think if we ask everybody, women wouldn't feel singled out. What if we tell them that "I'm going to ask some questions that we ask from all of the women," and so this way we are somehow not attacking them. We explain that these are among the routine questions that we ask from all of the women. Yeah, I think that might like lower people's guard so that they're more willing to answer the questions. (36-year-old HCP)

Moreover, the participants noted that women have the right to answer questions or to refuse to answer.

They should definitely be asking those questions without potentially triggering people who don't want to be asked the question over and over again, but I think that it should definitely be expressed at each visit that the door is open to talking about these experiences. (27-year-old survivor/1)

How to Ask in a Culturally Safe Way. Participants had different opinions about the types of questions that should be asked; however, in general, they favored open-ended questions, and some suggested a mix of different types of questions would be the most helpful. They mentioned that living in a multicultural society increases the complexity of asking about GBV. For example, participants expressed that people with different backgrounds and ethnicities may have different definitions of GBV. From this these, two subthemes were evident.

a) Lack of a single definition of GBV: The participants mentioned that GBV is a complex phenomenon, and people's understanding of it can differ based on their background and culture.

Every individual probably describes gender-based violence differently. This is like a hard question because, you know, we are multicultural here in Canada. (47-year-old HCP)

They also shared their experience on how to ask questions while considering cultural humility and without offending people.

Because it's been a problem in Canada for many decades. So I try to make it like this is not just a problem in your country. And I'm not asking you because you might be from somewhere else or that your community isn't any different than anywhere else. I'm not just asking because of your particular skin or that because you are part of a certain community. (59-year-old HCP)

b) Diverse ways of asking questions regarding GBV: Most participants believed that the nature of the phenomenon is complex; therefore, using open-ended questions would be more appropriate for this situation and give women more opportunities to express their experiences. Nevertheless, some also had ideas about how to supplement open-ended questions.

I think open-ended questions are better because multiple-choice questions don't give the option to express their experiences and be more open to healthcare providers. (27-year-old survivor/2)

I like the idea of every healthcare provider asking the same question. So that should people change from one care provider to another care provider, so we know that its standardized questions and that they get the same support from different care providers. I think that open-ended questions make the dialogue much easier. (34-year-old survivor)

Discussion

In recent years, more attention has focused on violence during the perinatal period due to its negative health consequences and the potential for intervention (World Health Organization, 2011). During perinatal care, HCPs are unique in detecting and identifying violence and offering support to women experiencing GBV. While the use of brief questioning by HCPs is known to lead to higher disclosure rates, there continues to be reluctance among some health professionals to embrace inquiring into GBV (Baird et al., 2013). This study aimed to use a qualitative approach to examine the issue of GBV assessment in perinatal care directly with women themselves and with a group of HCPs.

"Barriers to disclosure" was one of the main themes in this study. Barriers were rooted in lack of awareness, feeling stigmatized and judged, fear, denial, and feeling

that support and benefits would not follow disclosure. These findings confirm previous research that explains how only one-third of abused women disclose a history of violence to their family physicians (Baird et al., 2015; Cherniak et al., 2005). In a study conducted in Africa, 69.9% of nurses agreed that many survivors still would live with the abuser; therefore, they prefer to remain silent. Moreover, 66.7% of them expressed that stigmatizing attitudes towards the survivors from the community prevented disclosure. Around 65.3% of the nurses agreed that, to some extent, survivors viewed the occurrence of violence in the family as normal, and they were not aware of their rights concerning disclosure and reporting (Githui et al., 2018, p.).

Also, the involvement of police may contribute to lower disclosure, so many survivors are reluctant to take this step without serious consideration. They think disclosure and reporting may trigger processes that can have both positive and negative impacts on survivors' lives and have doubt that disclosure and reporting will benefit them (Zweig et al., 2021). For example, one study assessed Australian midwives' knowledge of intimate partner violence against women during pregnancy. The researchers suggested that 95% of women considered a partner's presence to be the main barrier to disclosure. In this study, concern and frustration were expressed by midwives about their inability to enquire into GBV when partners are present, especially if they attended all appointments. In this study, the authors mentioned that despite the reluctance of HCPs to screen for GBV, women readily accept being asked by HCPs about violence (Baird et al., 2015).

In research conducted in India, participants expressed embarrassment or shame and felt that HCPs might not believe them, which prevented them from disclosing their history of GBV. Furthermore, women reported fear of threats and more violence from a husband or mother-in-law as reasons for withholding disclosure. Notably, some participants in this study did not talk about their experience because they did not define their experience as violence; they defined violence as solely physical. As they experienced mostly emotional violence and had no physical violence injuries, some participants failed to define their own experiences as violence (Vranda et al., 2018). It has been noted that there was a lack of knowledge surrounding the different kinds of violence among pregnant women from different cultures in Norway, and women needed to be better informed about it (Garnweidner-Holme et al., 2017).

Our study participants felt that their experiences with violence were not a concern for HCPs. This finding corroborates several studies focusing on violence against women. According to evidence, HCPs are not interested in inquiring about GBV. The main reasons for this could be a lack of knowledge, skills, and training regarding the identification of violence and the proper interventions. One study's results point out a consistent relationship between higher knowledge levels about GBV and the frequency of asking women about violence (Baird et al., 2013; Crombie et al., 2017). The need to provide effective GBV training for HCPs is acknowledged by the World Health Organization (World Health Organization, 2013).

Some HCPs, especially in a hospital setting, may be reluctant to conceptualize GBV as a health issue. Many are unaware of available guidelines and believe that not having access to standardized questions and resources prevents them from being involved in

this area (Edin & Högberg, 2002; O'Reilly & Peters, 2018). In a qualitative study, the participants mentioned that HCPs were powerless when they met a woman who had experienced violence during pregnancy and pointed out that they should ask questions to provide support, not ask because it was required by guidelines (Garnweidner-Holme et al., 2017).

Although there are many opportunities for disclosure of violence in the clinical setting, few women with a current or past history of violence are identified by health-care professionals; therefore, many women suffer from the experience of abuse in silence, without receiving appropriate help and support (Feder et al., 2006). For instance, in a qualitative study conducted in Norway, pregnant women in crisis shelters illustrated how they desired to talk about their experiences of violence with their HCPs; however, they were not asked any questions about the violence. Participants in that study, regardless of their ethnic background, perceived perinatal care as an opportune time to disclose violence (Garnweidner-Holme et al., 2017).

The majority of HCPs mentioned that they were unsure how to start a dialogue surrounding GBV with their patients. They were concerned about the unfamiliar path and the steps they should take after inquiring as well as their ability to support women. Others have also found that a lack of instruction on how to ask questions about abuse was one of the main barriers to screening (Guillery et al., 2012). Therefore, not having enough knowledge and skills, as well as a lack of access to resources, may foster doubts in deciding whether or not women should be questioned about the experience of violence. Concerns regarding responding effectively to a positive disclosure of violence, especially in relation to lack of time and training, and their emotional capacity to deal with a positive disclosure were considered reasons for their unwillingness to assess GBV (Baird et al., 2013, 2015). Not knowing what to do in the event of disclosure is consistently reported as one of the main barriers to asking questions about violence (Guillery et al., 2012). Some HCPs believe if they ask about GBV, they will require extra time to listen to the woman and then respond and take action. They argued that with a heavy workload and a fast-paced environment, there is no need to look for new problems (Beynon et al., 2012). Moreover, while some studies recommend screening for violence during pregnancy and the perinatal period, they recognize that the lack of clear recommendations for the assessment impact HCPs' ability to carry out a routine inquiry of violence (Alhusen et al., 2015; Bailey, 2010).

Just like the participants of our research, in Paterno's study, many HCPs were ambivalent about whether or not to ask about violence. However, through appropriate training and the development of a systematic screening protocol, many of these barriers can be addressed (Paterno & Draughon, 2016). Looking more specifically at women's feelings of satisfaction towards HCPs, one study found that women felt satisfied when their provider gave practical advice and referral to specialist support (Feder et al., 2006). Both women and HCPs in our study suggested using normalizing questions to break the ice: "These are questions that we ask every pregnant person at this point in their pregnancy," for example. According to our participants, women should be asked in such a way that they do not feel singled out or bombarded by

questions. Normalization is one of the most useful techniques for decreasing a patient's sense of embarrassment about a sensitive topic (Carlat, 2005). This finding is in line with the recommendation of the Ontario Nursing Best Practice Guideline, which insists on the importance of using standard assessment tools in the normalization of asking questions about GBV (Registered Nurses' Association of Ontario, 2005).

Furthermore, in a study conducted by Paterno and Draughon in the United States, the authors mention that starting the conversation with a normalizing statement would be beneficial. They believe that this approach would legitimize the need for a conversation about violence. They also recommend that the way women are asked about violence should demonstrate that they are not alone in their experience. They explain that some women may not recognize themselves as victims of violence, therefore using value-laden terms such as "victims of abuse" that decrease their ability to define experiences as abusive or violent can negatively impact their willingness to disclose their history of violence (Paterno & Draughon, 2016). It has been mentioned that by asking all women, no individual would feel singled out, which prevents stigmatization (Baird et al., 2013).

Women are not likely to disclose abuse unless directly asked (Beynon et al., 2012). Although recent studies show that the rates of identification of violence against women are higher than the statistics reported in previous studies, the results continue to reflect a deficiency in asking female patients about GBV in health-care settings (Hamberger et al., 2015). Creating environments that foster disclosure would be helpful and may encourage women to disclose (e.g., posters and pamphlets in the waiting area). Moreover, electronic medical records that can guide care providers on how to assess and respond to GBV could be helpful. Also, on-site personnel who can provide further support to identified survivors would be beneficial (Alvarez et al., 2018).

One final theme that arose from the interviews pertained to how to ask in a culturally safe way. The participants repeatedly mentioned the complexity of the phenomenon and the different understandings of the definition of GBV. Each participant expressed their suggestions regarding the types of questions that would be the most suitable in this situation. They provided many examples of questions that can be asked to inquire about GBV. Most participants believed that open-ended questions would be the most appropriate; however, some mentioned that a mixed bag of questions would be more effective. Evidence suggests that women may have different perceptions of abuse. For some cultures, talking about the experience of violence is not acceptable, and there is some evidence that the situation may be even more complicated for some pregnant immigrant women (Garnweidner-Holme et al., 2017).

The social context is likely a determining factor in deciding which approach to questioning is used. Prior studies note that self-administered questionnaires are not very useful in detecting cases of GBV. These studies explain that screening would be most effective if conducted using open-ended questions in a face-to-face format (O'Reilly & Peters, 2018; Registered Nurses' Association of Ontario, 2005). The results of a study conducted in Japan do not support the findings of our study. In the Japanese study of pregnant women, a self-administered questionnaire was more

effective in detecting GBV than a face-to-face interview. This difference could be related to the context of the study. Contrary to Canada, Japan has a homogenous population where culturally, it may be difficult for Japanese women to talk about family issues. Feelings such as shame and guilt regarding GBV are extreme among Japanese women; therefore, disclosing such information through face-to-face interviews and open-ended questions would be more difficult, while privately completing a questionnaire might be considered more comfortable and more secure. This study also mentioned that face-to-face interviews require training and extra time (Kataoka et al., 2010). In other studies, researchers advocate using a computer-based abuse assessment screening tool and explain that this type of screening may identify more pregnant women who have experienced violence than face-to-face screening (Hussain et al., 2015; WHO Recommendation on Clinical Diagnosis of Intimate Partner Violence in Pregnancy | RHL, n.d.).

Should women's vulnerability to violence during pregnancy be considered the same as at other times in their lives? And should we take the same approach to assess both groups? Some health organizations and experts recommend screening all women for domestic violence. Others argue that screening should be targeted to high-risk groups, such as women in perinatal care and, in particular, pregnant women (O'Doherty et al., 2014). According to the WHO recommendations on the clinical diagnosis of intimate partner violence during pregnancy, routine inquiry can be implemented in perinatal care if HCPs are well trained and certain minimum requirements are met. The WHO defines the minimum requirements as having access to a protocol/standard operating procedure; training on how to ask about the history of abuse and on how to provide the minimum response or support; having access to a private setting; considering confidentiality; a system for referral in place; and time to allow for appropriate disclosure (WHO Recommendation on Clinical Diagnosis of Intimate Partner Violence in Pregnancy | RHL, n.d.).

There were several limitations to the study reported in this article. Due to the COVID-19 pandemic, most interviews were conducted by phone; therefore, the researcher did not write observational field notes for those telephone-based interviews. Before the pandemic, such field notes had been taken by considering the participants' nonverbal communication and appearance, as well as the atmosphere in which the interview was taking place. The researcher paid attention to tone of voice, silence, or any anger or emotion in the participants' voice quality while doing telephone interviews. In this study, we explored women's experience with a history of GBV; however, it seems that evaluating the perspective of women who had not experienced violence during their perinatal period regarding the need to assess GBV would add valuable information to the existing findings.

The deleterious ramifications of GBV on maternal, fetal, and infant health and well-being make the perinatal period a critical time for the detection and identification of violence; therefore, a standardized approach to discussing GBV in perinatal care should be considered. To improve HCPs' engagement in GBV identification, more training is needed, and local resources made available to patients experiencing GBV would need to be identified.

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References

- Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during pregnancy: Maternal and neonatal outcomes. *Journal of Women's Health, 24*(1), 100–106. <https://doi.org/10.1089/jwh.2014.4872>
- Alshammari, K. F., McGarry, J., & Higginbottom, G. M. A. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open, 5*(3), 237–253. <https://doi.org/10.1002/nop.2.133>
- Alvarez, C., Debnam, K., Clough, A., Alexander, K., & Glass, N. E. (2018). Responding to intimate partner violence: Healthcare providers' current practices and views on integrating a safety decision aid into primary care settings. *Research in Nursing & Health, 41*(2), 145–155. <https://doi.org/10.1002/nur.21853>
- Bacchus, L. J., Bewley, S., Vitolas, C. T., Aston, G., Jordan, P., & Murray, S. F. (2010). Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. *Reproductive Health Matters, 18*(36), 147–157. [https://doi.org/10.1016/S0968-8080\(10\)36526-8](https://doi.org/10.1016/S0968-8080(10)36526-8)
- Bailey, B. A. (2010). Partner violence during pregnancy: Prevalence, effects, screening, and management. *International Journal of Women's Health, 2*(2), 183–197. <https://doi.org/10.2147/ijwh.s8632>
- Baird, K., Salmon, D., & White, P. (2013). A five year follow-up study of the Bristol pregnancy domestic violence programme to promote routine enquiry. *Midwifery, 29*(8), 1003–1010. <https://doi.org/10.1016/j.midw.2013.01.007>
- Baird, K. M., Saito, A. S., Eustace, J., & Creedy, D. K. (2015). An exploration of Australian midwives' knowledge of intimate partner violence against women during pregnancy. *Women and Birth, 28*(3), 215–220. <https://doi.org/10.1016/j.wombi.2015.01.009>
- Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, C. N., & MacMillan, H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health, 12*(1), 473. <https://doi.org/10.1186/1471-2458-12-473>

- Care, W.-C. (2014). Perinatal Services BC Provincial Perinatal Guidelines Population and Public Health Prenatal Care Pathway.
- Carlat, D. J. (2005). *The psychiatric interview: A practical guide*. Lippincott Williams & Wilkins.
- Chaves, K., Eastwood, J., Ogbo, F. A., Hendry, A., Jalaludin, B., Khanlari, S., & Page, A. (2019). Intimate partner violence identified through routine antenatal screening and maternal and perinatal health outcomes. *BMC Pregnancy and Childbirth*, *19*(1), 357. <https://doi.org/10.1186/s12884-019-2527-9>
- Cherniak, D., Grant, L., Mason, R., Moore, B., & Pellizzari, R., IPV Working Group, & Society of Obstetricians and Gynaecologists of Canada (2005). Intimate partner violence consensus statement. *Journal of Obstetrics and Gynaecology Canada: JOGC/Journal d'obstetrique et Gynecologie Du Canada: JOGC*, *27*(4), 365. [https://doi.org/10.1016/s1701-2163\(16\)30465-0](https://doi.org/10.1016/s1701-2163(16)30465-0)
- Crombie, N., Hooker, L., & Reisenhofer, S. (2017). Nurse and midwifery education and intimate partner violence: A scoping review. *Journal of Clinical Nursing*, *26*(15–16), 2100–2125. [https://doi.org/10.1016/s1701-2163\(16\)30465-0](https://doi.org/10.1016/s1701-2163(16)30465-0)
- Deshpande, N. A., & Lewis-O'Connor, A. (2013). Screening for intimate partner violence during pregnancy. *Reviews in Obstetrics and Gynecology*, *6*(3–4), 141. PMC4002190.
- Edin, K. E., & Högberg, U. (2002). Violence against pregnant women will remain hidden as long as no direct questions are asked. *Midwifery*, *18*(4), 268–278. <https://doi.org/10.1054/midw.2002.0318>
- Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine*, *166*(1), 22–37. <https://doi.org/10.1001/archinte.166.1.22>
- Garnweidner-Holme, L. M., Lukasse, M., Solheim, M., & Henriksen, L. (2017). Talking about intimate partner violence in multi-cultural antenatal care: A qualitative study of pregnant women's advice for better communication in South-East Norway. *BMC Pregnancy and Childbirth*, *17*(1), 123. <https://doi.org/10.1186/s12884-017-1308-6>
- Githui, S., Chege, M., Wagoro, M., & Mwaura, J. (2018). Nurse's perception on non-disclosure of intimate partner violence by pregnant women: A cross-sectional study. *International Journal of Contemporary Research and Reviews*, *9*(1), 20198–20203. <https://doi.org/10.15520/ijcrr/2018/9/01/403>
- Government of Canada, S. of W. C. (n.d.-a). Issue Brief: Sexual Violence Against Women in Canada—Status of Women Canada. <https://cfc-swc.gc.ca/svawc-vcsfc/index-en.html>
- Government of Canada, S. of W. C. (n.d.-b). Breaking the Silence—Gender-based Violence—Status of Women Canada. <https://cfc-swc.gc.ca/violence/strategy-strategie/breaking-briser-en.html>
- Guillery, M. E., Benzies, K. M., Mannion, C., & Evans, S. (2012). Postpartum nurses' perceptions of barriers to screening for intimate partner violence: A cross-sectional survey. *BMC Nursing*, *11*(12), 2. <https://doi.org/10.1186/1472-6955-11-2>
- Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal intimate partner violence. *Obstetrics and Gynecology Clinics*, *45*(3), 535–547. <https://doi.org/10.1016/j.ogc.2018.04.008>
- Hamberger, L. K., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *Journal of Women's Health*, *24*(1), 86–91. <https://doi.org/10.1089/jwh.2014.4861>. Epub 2014 Nov 20.

- Hussain, N., Sprague, S., Madden, K., Hussain, F. N., Pindiprolu, B., & Bhandari, M. (2015). A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 16*(1), 60–69. <https://doi.org/10.1177/1524838013515759>
- Kataoka, Y., Yaju, Y., Eto, H., & Horiuchi, S. (2010). Self-administered questionnaire versus interview as a screening method for intimate partner violence in the prenatal setting in Japan: A randomised controlled trial. *BMC Pregnancy and Childbirth, 10*(1), 84. <https://doi.org/10.1186/1471-2393-10-84>
- Knox, B. (2018). Screening women for intimate partner violence: Creating proper practice habits. *The Nurse Practitioner, 43*(5), 14–20. <https://doi.org/10.1097/01.NPR.0000531918.92139.ca>
- MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M., Worster, A., Lent, B., Coben, J. H., & Campbell, J. C. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *Journal of the American Medical Association, 302*(5), 493–501. <https://doi.org/10.1001/jama.2009.1089>
- Mutisya, R. K., Ngure, K., & Mwachari, C. (2018). A psychosocial intervention to reduce gender-based violence and antepartum depressive symptoms in pregnant women in Kisumu County, Kenya: A quasi-experimental study. *Pan African Medical Journal, 29*(1), 1–9. <https://doi.org/10.11604/pamj.2018.29.11.13596>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1–13. <https://doi.org/10.1177/1609406917733847>
- O'Doherty, L. J., Taft, A., Hegarty, K., Ramsay, J., Davidson, L. L., & Feder, G. (2014). Screening women for intimate partner violence in healthcare settings: Abridged Cochrane systematic review and meta-analysis. *BMJ, 348*, g2913. <https://doi.org/10.1136/bmj.g2913>
- O'Reilly, R., Beale, B., & Gillies, D. (2010). Screening and intervention for domestic violence during pregnancy care: A systematic review. *Trauma, Violence, & Abuse, 11*(4), 190–201. <https://doi.org/10.1177/1524838010378298>
- O'Reilly, R., & Peters, K. (2018). Opportunistic domestic violence screening for pregnant and post-partum women by community based health care providers. *BMC Women's Health, 18*(1), 128. <https://doi.org/10.1186/s12905-018-0620-2>
- Paterno, M. T., & Draughon, J. E. (2016). Screening for intimate partner violence. *Journal of Midwifery & Women's Health, 61*(3), 370–375. <https://doi.org/10.1111/jmwh.12443>
- Registered Nurses' Association of Ontario (2005). *Woman abuse: Screening, identification and initial response*. Retrieved from https://mao.ca/sites/mao-ca/files/Woman_Abuse_Screening_Identification_and_Initial_Response.pdf
- Taillieu, T. L., & Brownridge, D. A. (2010). Violence against pregnant women: Prevalence, patterns, risk factors, theories, and directions for future research. *Aggression and Violent Behavior, 15*(1), 14–35. <https://doi.org/10.1016/j.avb.2009.07.013>
- Taillieu, T. L., Brownridge, D. A., Tyler, K. A., Chan, K. L., Tiwari, A., & Santos, S. C. (2016). Pregnancy and intimate partner violence in Canada: A comparison of victims who were and were not abused during pregnancy. *Journal of Family Violence, 31*(5), 567–579. <https://doi.org/10.1007/s10896-015-9789-4>
- Van Parys, A.-S., Verhamme, A., Temmerman, M., & Verstraelen, H. (2014). Intimate partner violence and pregnancy: A systematic review of interventions. *PloS One, 9*(1), 1–10. <https://doi.org/10.1371/journal.pone.0085084>

- Velonis, A. J., O'Campo, P., Kaufman-Shriqui, V., Kenny, K., Schafer, P., Vance, M., Dunkel Schetter, C., Hillemeier, M. M., Lanzi, R., & Chinchilli, V. M. (2017). The impact of prenatal and postpartum partner violence on maternal mental health: Results from the community child health network multisite study. *Journal of Women's Health, 26*(10), 1053–1061. <https://doi.org/10.1089/jwh.2016.6129>
- Vranda, M. N., Kumar, C. N., Muralidhar, D., Janardhana, N., & Sivakumar, P. T. (2018). Barriers to disclosure of intimate partner violence among female patients availing services at tertiary care psychiatric hospitals: A qualitative study. *Journal of Neurosciences in Rural Practice, 9*(3), 326–330. https://doi.org/10.4103/jnrp.jnrp_14_18
- Wathen, C. N., & MacMillan, H. L. (2003). Prevention of violence against women: recommendation statement from the Canadian task force on preventive health care. *Canadian Medical Association Journal, 169*(6), 582–584.
- We Fund Programs Working Towards Gender Equality (Gender Based Violence in Canada) (n.d.). Canadian Women's Foundation. <https://canadianwomen.org/the-facts/gender-based-violence/>.
- WHO Recommendation on Clinical Diagnosis of Intimate Partner Violence in Pregnancy (RHL) (n.d.). Retrieved May 7, 2020, from <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/antenatal-care/whorecommendation-clinical-diagnosis-intimate-partner-violence-pregnancy>.
- World Health Organization. (2011). *Intimate partner violence during pregnancy: Information sheet*. World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/70764/WHO_RHR_11.35_eng.pdf
- World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf
- Zweig, J., Farrell, L., Walsh, K., & Yu, L. (2021). Community approaches to sexual assault: VAWA's role and survivors' experiences. *Violence Against Women, 27*(1), 30–51. <https://doi.org/10.1177/1077801220949696>

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