


“Don’t Turn a Blind Eye”: An Instruction for Supporting Meaningful Conversations About Gender-Based Violence During Perinatal Care

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Abstract

Background and purpose: Evidence suggests that Gender-based violence (GBV) is prevalent throughout the perinatal period. Women during this time have frequent contact with healthcare providers (HCPs), and there are many opportunities that HCPs can identify GBV and support women by early intervention during routine prenatal care. However, evidence shows that HCPs are still hesitant to address this issue. This study was conducted to explore the experiences of Survivors and HCPs on how to manage a meaningful conversation about GBV with survivors during perinatal care.

Methods: A thematic approach has been used in this qualitative study.

Results: Twenty-eight semi-structured interviews were conducted with survivors and HCPs. Three main themes emerged from the data analysis, including: “Knock gently on the door to enter the client’s private world”, “Show interest in clients’ stories that are beyond their physical problems” and “Gradually and cautiously cross the hidden borders.”

Conclusion: HCPs play a pivotal role in identifying GBV and providing support for survivors, particularly during their perinatal period. However, initiating a conversation around this sensitive topic needs time, skill, and enough knowledge. Validating survivors’ experiences, providing a private and safe atmosphere without judgment, and creating empathy could lead to more disclosure of GBV. To have a meaningful conversation, HCPs need to have a holistic approach toward care, show interest in clients’ stories beyond their physical problems, and support clients who have shared sensitive information.

Keywords

Women’s health, sexual abuse, qualitative approaches, pregnancy, perinatal, gender-based violence

What does this paper contribute to the wider global community?

- -Health care providers are not adequately trained to manage a meaningful conversation about gender-based violence during perinatal care.
- During perinatal care, the first appointment is not the best time for a conversation about GBV as women may feel offended, and they are less likely to disclose at this early stage when there is no rapport between them and the health care provider.
- We would have a higher probability of disclosure if perinatal healthcare providers would reveal their interest in clients’ stories that are beyond their physical problems.

Background & Purpose: Gender-based violence (GBV) affects individuals and families from different ethnic, religious, economic, and social backgrounds (Wells et al., 2012). GBV is not limited to one gender identity. Men, women, and nonbinary individuals can be subjected to

GBV. In this study, GBV refers to a range of acts that make women subordinate or dependent by isolating them from sources of support and regulating their everyday behaviour (Stark, 2018). GBV includes any violence that results in or is likely to result in sexual, physical, or psychological harm or suffering to women or gender-diverse individuals

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(Ali, 2018). It also includes threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in private or public life (Aguirre et al., 2020).

Women who have experienced GBV are more likely to have more access points with the health care system than women without this experience (Heron et al., 2021). However, many cases of GBV won't be identified by health care providers (HCPs). It is estimated that approximately a third of women worldwide have experienced GBV at some point in their lives (García-Moreno et al., 2013); nevertheless, the actual prevalence of GBV is unclear, and it is agreed that official statistics underestimate the prevalence of violence in general and during the perinatal period (pregnancy and 12 months after delivery) specifically. Evidence suggests that GBV is prevalent throughout the perinatal period, particularly in populations experiencing social inequalities, and psychological violence has been identified as the most prevalent form of violence throughout the perinatal period (Mojahed et al., 2021). According to a systematic review, the worldwide prevalence of physical, psychological, and sexual violence in pregnancy has been reported as 9.2%, 18.7%, and 5.5%, respectively (Román-Gálvez et al., 2021).

In Canada, it is suggested that one in ten women who have experienced GBV were pregnant at the time of violence. Clearly, pregnancy does not protect women from GBV (Taillieu et al., 2016).

GBV during the perinatal period has far-reaching maternal and neonatal impacts such as miscarriage, bleeding, sexually transmitted infections, premature delivery, maternal and neonatal death, depression, anxiety, self-harm, suicidal ideation, lowered self-esteem (Taillieu et al., 2016), psychosomatic complaints and substance abuse are among the harmful effects of GBV to the woman (Damra et al., 2015). Early identification and providing support including home visitation, family-based counseling, psychological care for survivors before, during, and after pregnancy, and protective shelters would prevent further harm to the mother and the baby (Alhusen et al., 2015; Mazza et al. 2021).

The perinatal period represents a critical window for diagnosing GBV (Procentese et al., 2019). The frequent health-care visits during perinatal care offer many opportunities for the identification of GBV and create opportunities to introduce effective interventions (Jahanfar et al., 2014). Short visits with HCP and not having consistent contact with the same HCP impede both disclosures of violence and healthcare providers' ability to support women experiencing it (Damra et al., 2015). Furthermore, the ongoing failure to adequately address this issue within the healthcare system is intrinsically related to medical paternalism and the dominance of the biomedical approach (Patrick & Jackson, 2021). Overloaded healthcare settings that demand more clinical productivity have afforded less time with each client, which decreases the possibility of providing intimate care for women with a history of violence. This situation can

impede effective patient–HCPs communication (Damra et al., 2015).

In British Columbia, BC Women's Hospital & Health Centre does not currently conduct screening for violence because leaders and staff lack training, and there is only limited infrastructure for GBV services. (Rossiter, 2011; Poole & Urquhart, 2009; Mirlashari et al., 2022). At present, the hospital's policy is to inquire about violence when there are signs that it may be present rather than to offer universal screening. This case-finding approach is supported by trauma- or violence-informed approaches to perinatal care (Rossiter, 2011; Wathen & Mantler, 2022). As a result of a lack of adequate training, some HCPs are not able to manage the issue of violence, and sometimes they judge women and reproduce many of the most common prejudices related to survivors of GBV; they may erroneously associate violence with oversexualized behavior on the part of the woman (Procentese et al., 2019). For instance, details such as the clothes a woman was wearing at the time of an attack, her prior number of sexual partners, her level of intoxication at the time of the attack, and prior acquaintance between the woman and her attacker become the focus of the situation instead of the assault itself (Kiebler & Stewart, 2022). Therefore, it is necessary to equip HCPs with the skills to approach GBV and communicate about this sensitive topic with women, increase their awareness and understanding of the dynamics of violence, and develop procedures for handling such cases most effectively (Ambuel et al., 2013).

The literature highlights that survivors report difficulties disclosing their experiences of GBV if HCPs fail to make time for the woman or make it obvious that they are impatient (Tarzia et al., 2020). In emergency departments, communication with violence survivors is pervasive. The current communication strategy, which is common in the emergency departments (so-called "rape-kit" and screening tools with short questions and answers), is not ideal for starting a meaningful conversation, and many survivors (including pregnant women) who are at risk for violence may not share information regarding the experience of violence and abuse with the HCPs. Therefore, evidence suggests that holding a conversation on violence in an environment like the emergency department is challenging (Rhodes et al., 2007).

It has been suggested that healthcare services need to provide a welcoming and intimate room that can offer a protective environment for women who have experienced or are living with violence (Palmieri & Valentine, 2021). Creating such a space could facilitate a more comfortable conversation between HCPs and clients and provide an opportunity to conduct a thorough assessment of the possible indicators of violence (Procentese et al., 2019). Other studies suggested using patient-centred interviewing, adopting caring communication skills, demonstrating courtesy, kindness, and sincerity, and devoting enough time with the necessary

confidentiality may improve the patient's experience and understanding of the conversation with a healthcare provider (Damra et al., 2015).

HCPs have a unique opportunity identifying GBV against women during their perinatal care, and play an important role in supporting survivors. Therefore this study aimed to explore the perspective of survivors and HCPs regarding the management of a meaningful conversation about GBV with women during perinatal care.

Methods and procedures

Study participants: We recruited two samples for this qualitative study: women with a self-reported history of GBV and pregnancy during the last five years ($n = 12$) and HCPs who were providing perinatal health care ($n = 16$). (Thirty participants contacted the researcher; however, one participant declined to participate in the study due to a busy schedule, and another one didn't have the inclusion criteria). HCPs included nurses, midwives, and physicians from five major healthcare centres in British Columbia (BC).

Inclusion criteria for survivors: Being between the ages of 18–49, having been pregnant during the last five years, having a self-reported history of GBV during perinatal period and communicating and speaking conversational English.

Exclusion criteria for survivors: Since the experience of current drug dependency and major mental health problems could influence the experience of GBV, self-reports of current alcohol or drug abuse and major mental health problems have been considered exclusion criteria. However, women who had a history of drug dependency and those involved in recreational drug abuse were not excluded from the study.

The inclusion criterion for the HCPs: The experience of providing perinatal healthcare to women with a history of gender-based violence. There were no exclusion criteria for the HCPs.

HCPs were recruited from different parts of BC. The survivors were from several various metropolitan centers in BC. While we aimed to recruit participants from diverse backgrounds, due to time constraints and budget limitations, we were hampered in the extent of our recruitment activities. However, we were fortunate that the participants who chose to take part in our study were from different ethnic groups and social backgrounds (i.e., they had different levels of education and socio-economic status, and spoke various languages). Our study sample included people who identified as Indigenous, Asian, Latina, European, and Canadian. We also had newcomer participants, a participant who identified as transgender, and two who revealed previous experience using drugs. To ensure the privacy of study participants, some potentially identifying details about the participants' backgrounds are not mentioned in the manuscript.

Table 1. Demographic characteristics of health care providers.

Profession	Age range	Healthcare practice experience
Physicians	35 – 54	8 – 28
Nurses	29 – 50	8 – 20
Midwives	34 – 59	2 – 20

Table 2. Demographic characteristics of survivors.

	Age	Ethnicity	Education Level
1	21	Latina	Undergraduate student
2	35	European	Master's degree
3	41	Indigenous	Elementary
4	40	Indigenous	High school
5	27	South Asian	Undergraduate student
6	38	Euro-Canadian	Master's degree
7	37	Latina	Bachelor degree
8	39	Euro-Canadian	College
9	40	Euro- Canadian	College
10	35	East Asian	Bachelor degree
11	27	Euro- Canadian	Diploma
12	42	Euro- Canadian	University (not finished)

After COVID –19 pandemic (March 11, 2020), interviews were conducted via phone. (Tables 1 and 2 show demographic characteristics of HCPs and survivors).

We distributed advertising posters in settings such as hospitals and public places (community centres, gyms, shopping malls, shelters, family services, and local courthouses) to recruit survivors. We also used social media (Facebook and Instagram) and snowball sampling to recruit survivor participants. An office telephone number and email were provided in all advertisements for potential participants to contact the researcher. HCPs were also recruited through posters placed in common areas such as streets around the hospitals, hospital notice boards, an internal hospital newsletter, social media, and snowball sampling.

The data were collected from December 2019 to August 2020. Both HCPs and survivors were interviewed during the same time frame. For in-person interviews, informed consent forms were signed at the location of the interview. However, participants received the consent forms before the telephone interviews. Moreover, a consent script was reviewed with the participants over the phone and before recording the interview. In the beginning of each interview, we confirmed that the participant had read the consent form and agreed to participate.

All participation was voluntary. Informed consent was obtained from all individual participants prior to the interview.

We provided information on how survivors can receive help, such as the centers for support and phones that they can call to receive help in an emergency.

Procedures: Interviews were conducted by the first author; each interview lasted between 30–60 min. The researcher conducted a short preliminary telephone interview to assess whether prospective study participants met the inclusion and exclusion criteria prior to the main interview and provided comprehensive information about the study during those encounters.

In the beginning of this study, data was collected through in-person interviews in cafeteria and their workplace. However, after the pandemic, data collection continued through phone interviews. Participants were receptive to telephone interviews because there was more flexibility in determining the date and time of telephone interviews compared to in-person interviews. Moreover, from the participants' perspective, telephone interviews made survivors feel safer and more comfortable. Participant's anonymity and confidentiality were protected. Concerning HCPs, they expressed that according to their tight schedule, time coordination would be more feasible via telephone interviews. After receiving informed consent, the researcher put the phone on the speaker and started audio recording the interview. Also, the records were secure through the use of password-protected files. An incentive was provided for the participants.

Data analysis: We were guided in this study by a qualitative approach to explore participants' thoughts, experiences, and recommendations regarding managing a meaningful conversation. We asked them questions related to situations that may support survivors in revealing their history of violence. Also, participants were asked to share their perspectives and experience concerning the initiation of a conversation about GBV. They were asked to give us their recommendation for improving this conversation. Moreover, questions were asked about their experience in the health care system concerning seeking help after exposure to violence.

We undertook data collection and analysis simultaneously and iteratively. By constantly comparing each interview's findings, we determined when we reached data saturation and were no longer learning new ideas and redundancies were apparent in the data that confirmed earlier findings.

The interview audio files were transcribed verbatim immediately following each interview. We used a thematic, inductive approach to analyze the data (Nowell et al., 2017). While avoiding the use of predetermined categories, this approach facilitates themes and subthemes to emerge directly from the data. At the first stage of the analysis, the entire manuscript was read several times as we familiarized ourselves with the depth and breadth of the content. This method helped us explore the data's implicit meanings and possible patterns. Then the data were organized into meaningful groups, and initial codes were identified. During the third step, different codes were sorted into potential themes and subthemes. Next, the whole themes

and subthemes were reviewed in terms of internal and external consistency. Finally, following discussion with the team members, concise names were chosen for the themes and subthemes.

Two expert qualitative researchers analyzed the data separately to establish trustworthiness; the initial themes were discussed with the team members. Subsequent data analysis was conducted using NVIVO. We used the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to report our research findings.

Credibility, confirmability, dependability, and transformability were considered using Lincoln and Guba's proposed criteria (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. The researcher employed reflexivity through memoing to reduce bias. A complete description of participants, process, and context increased the transferability.

Results

Three main themes and seven sub-themes emerged through the analysis of 28 interviews with 12 survivors and 16 HCPs. (Table 3)

Table 3. Study findings from interviews with GBV survivors and HCPs/.

Themes	Subthemes
Knock gently on the door to enter the client's private world	<ul style="list-style-type: none"> - Establish a meaningful relationship <ul style="list-style-type: none"> • It takes time to build a relationship • Display a non-judgmental attitude • Avoid conveying a sense of shame and blame -Build trust by holding a safe space for client to open up <ul style="list-style-type: none"> • Create a safe psychosocial space for client to open up • Create a safe physical space for client to open up
Show interest in clients' stories that are beyond their physical problems	<ul style="list-style-type: none"> -Ask about any condition/issue that may be of concern to the survivor
Gradually and cautiously cross the hidden borders	<ul style="list-style-type: none"> -Start the conversation at a general level to avoid putting the client in a difficult position <ul style="list-style-type: none"> -Apply a multicultural lens to the questions -Give the client choice about when and whether to share their experiences of GBV -Support clients who have shared sensitive information

Main theme I# knock gently on the door to enter the client's private world

Our data analysis suggested that an intrusive entry into the private world of survivors could lead them to feel insecure. Therefore, healthcare providers need to be cautious when talking about GBV. HCPs mentioned that patients' individual permission and readiness should be considered before talking about sensitive topics like GBV. Permission is more likely to be obtained if the HCP has established a meaningful relationship with the survivor and has gained her trust.

Establish a meaningful relationship

Our participants emphasized the importance of the quality of the relationship between survivors and HCPs. HCPs also discussed that relying on a questionnaire to obtain information about experiences with GBV without talking with women and creating a safe and welcoming atmosphere does not help establish a trusting relationship.

"I think even with a questionnaire; it's not something that if you don't establish that trusting atmosphere and relationship, many people would answer truthfully if it was just a questionnaire." (37yr old Physician)

One participant talked about a meaningful conversation she had with her family physician after he noticed that she was experiencing violence in her relationship.

"His reaction was to validate my experience, to offer me empathy, to make sure I wasn't in immediate danger. And to make sure I had a plan and a solution moving forward." (42yr old Survivor)

It takes time to build a relationship. Building the relationship takes time, so the topic of GBV may not arise early in the pregnancy if HCP does not have a prior relationship. This is quite common in Canada as not all family physicians provide maternity services; many pregnant patients seek a new HCP to support them on their perinatal journey. When asked about the best time for starting a conversation on GBV with women in their perinatal care, HCPs explained that the first appointment is not the best time for such a conversation as women may feel offended and they are less likely to disclose at this early stage when there is no rapport between them and the HCP.

A 34 years old Midwife expressed her experience as follows: *"That's very challenging because, at the first appointment, you really have almost no rapport, so, they usually don't talk about Violence at the very first session"*.

Another participant stated: *"They don't talk in the first appointment; it's usually after time that they feel comfortable revealing that this is going on."* (45yr old Physician)

Display a non-judgmental attitude. Participants from both groups reflected that some survivors might feel that HCPs will judge them if they talk about their history of violence. They mentioned that this attitude can prevent them from sharing their experience of violence with care providers.

"They should 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." (40yr old Survivor)

"The people who are asking those questions have to be really aware of their own judgments and biases with regards to how they're asking the questions." (28yr old Midwife)

1.1.3 Avoid instilling a sense of shame and blame. Participants from both groups explained that some women might prefer not to talk about their experience of violence because of feelings of shame or embarrassment. If you do not avoid shame and blame, you will not have a trusting relationship.

"The conversation has to be done in a way that is not shaming, so it goes back to the trauma-informed model of care. So it would have to be done so in a way that is non-punitive and non-shaming; without that in place, it's gonna do more harm than good. You're gonna completely lose the trust of your clients." (42yr old Survivor)

Build trust by holding a psychosocial and physically safe space for the client to open up

Participants spoke about women's fears and concerns regarding disclosure and its consequences and stressed the need to create a safe physical and psychosocial environment in which to have a conversation.

"Normally, I wouldn't just enter a room and say, do you feel safe? I would try to talk to the mother and establish a rapport and build trust. How are you? How are you feeling? How are you doing?" (33yr old Nurse practitioner)

"Like they don't feel emotionally safe to do so, that, you know, they either can't trust the person to do anything with the information or trust the person to believe them." (27yr old Survivor)

Moreover, many survivors will not feel safe talking about their history of violence in front of their partners or family members. To create a safe atmosphere for a conversation, provide a private environment for discussion.

A 27 years old survivor provided suggestions on how to start this conversation. She said:

"They can ask: 'Does it make you uncomfortable if we speak about you in front of your husband or in front of your mother-in-law?' and that kind of addresses different types of potential abuse that could be happening or have happened to that patient."

Main theme 2 # show interest in clients' stories that are beyond their physical problems

Survivors mentioned that it would be encouraging if they understood that HCPs are interested in their individual experiences and stories. HCPs acknowledged that when they don't show their patients that they are open to topics related to the psychosocial determinants of health, then they may give patients the impression that talking about experiences of violence is not a concern or that it does not fall within their scope of practice.

"If you're actually interested in hearing these stories and experiences and you're asking your patient, I think that's a really good and important first step in opening up that door and atmosphere. Talking about GBV definitely wouldn't offend me. For me personally feel, I would feel that they[HCPs] were being more understanding in their approach, and I could have greater trust in them to provide me health care in a way that takes into consideration the other, you know, past experiences that I've had" (27yr old Survivor)

"So if we have expressed interest in that topic, once I feel like people are more likely to disclose because they know that we're interested in that." (34yr old Midwife)

Ask about any condition/issue that may be of concern to the survivor

In many cases, the HCPs should ask the survivor about experiences that may be of concern to her. Some mothers may find the opportunity to express their concerns following such questions. For instance. A 27 year old participant expressed concerns about restrictions during the COVID pandemic, which coincided with a history of trauma related to violence and delivery.

:"I have a lot of anxieties and trepidations about going into labour and delivery right now [due to COVID], there are policies that are actually being implemented at the hospital as local to be were delivering, where I've been told that I can and cannot do certain things now in light of COVID-19, for example, that has just been very boring and very caused me a lot of stress and anxiety because of some of the trauma that I have. So, for example, you have to worry about now during labour and delivery. Which, despite all of the other restrictions that they were coming out with, that one really stood out to me and was one that I couldn't really get over. Women are just going into the hospital and then finding out that a new rule has been implemented that day, with no forewarning, which causes this kind of panic because people are panicking.

Main theme 3# gradually and cautiously cross the hidden borders

According to the participants from both groups, HCPs need to use a subtle approach to opening a conversation about GBV, and therefore HCPs need training and preparation. In the following, the conversation conditions about GBV are explained step by step based on the participants' suggestions.

Start the conversation at a general level to avoid putting the client in a difficult position

Participants suggested having an opening conversation before asking about the history of GBV. The opening could be talking about more general topics related to GBV or providing some statistics about the prevalence of GBV and its adverse effects on the mother and the baby and explaining that you ask these questions from everybody. HCPs believe that asking direct questions at the beginning of the conversation may make survivors feel that they don't have control over the flow of the conversation.

They suggest that the conversation should proceed from less direct questions and less sensitive topics such as safety and access to support at home and then, based on the survivor's response, move to more direct questions. A 35 years old survivor guided us with her suggestion as follows:

"If they start with direct questions, a lot of those questions would be answered incorrectly as a result. I think that they can be questions like: how is your energy level? How difficult it was for you to come here today? Was your partner Ok with you coming here today? Do you ever need to show your partner your phone? Does your partner have your passwords?, and Do you have to go back in a certain time?"

Also a 47 years old nurse explained that healthcare providers should remind survivors that they ask these questions from all pregnant women, therefore, no one feels singled out for asking: *"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 now not attacking them. Yeah, I think that would be helpful, and I think that that might like lower people's guard so that they're more willing to answer the question."*

Apply a multicultural lens to the questions

Participants in both groups mentioned that GBV is understood differently in different cultures and suggested that a conversation could lead to better results if HCPs applied a multicultural perspective.

"I think people have to have cultural humility, and so they really need to understand that where violence and abuse come from and what's acceptable to them may not apply to other people in their lives. And really trying to help people find what feels healthy and good for them in their

relationships and family and so working across cultural settings". (28yr old Midwife)

A 21-year-old newcomer woman was talking about the different cultures and its effect on the definition of GBV from a different point of view as follow:

"In my culture, because I am a woman, I have to do everything for my husband, and women have to raise the kids. You grow up in this culture, and you realize that men are basically trying to treat women as less than them. If you see a single dad, everyone says, Oh, Oh, he is so brave, and if you see a single mom, everyone says, oh, she is such a loser. That is her fault."

Give the client choice about when and whether to share their experience of GBV

Survivors may not feel comfortable answering questions immediately; therefore, HCPs should give women time. Survivors must have the opportunity to decide whether to expose violence or not. However, HCPs should let survivors know that they are there to support them, and this is not a closed conversation. Survivors should know that HCPs are open to talking about it whenever they feel comfortable to open up.

"I will say: You don't have to declare it right now. Because I do ask people, has it ever been your experience? We are open to talking about it. To give support around that issue." (59yr old Midwife)

"We just ask, like, 'Is there anything we need to know about your history? And, and we also tell people, if they don't want to disclose right now that it's always open for them to do so later, so it's not a closed conversation.'" (36yr old Midwife)

"I would say, I would like you to know that you can talk about this question now or other time, OK? Are you experiencing violence? Are you endangered others or yourself?" (35yr old Survivor)

Support clients who have shared sensitive information

Ensure that you, as the provider, know of resources available if someone discloses. If the patient trusts an HCP and discloses, the HCP must not ignore the issue. Turning a blind eye to the patient's problems and concentrating on physical problems can lead to a loss of trust.

"If they disclose, I don't know what resources are available that I would be able to refer them to. I just know our own social worker and psychologist, but I am sure that other resources are available for them, and I am not aware of them. I need training." (47yr old Nurse)

"I wish my midwife would have used more resources, more solutions. So, anytime you can have women supporting women, peer support, I mean, more support groups, more, or safe spaces for women only." (42yr old Survivor)

"If I had access to just a couple different resources, I might have taken a few steps differently at the beginning that might have changed the trajectory of this of the whole experience." (38yr old Survivor)

Discussion

Establishing a positive and meaningful relationship between HCPs and survivors is essential for an effective conversation about GBV. Addressing GBV and providing support for survivors are among the responsibilities of HCPs (Procentese et al., 2019). Yet, evidence shows that many HCPs do not feel equipped to discuss GBV with their clients nor report being trained adequately to start this conversation (Heron et al., 2021; Purwaningtyas et al., 2019).

There is growing evidence that many survivors are willing to discuss the experience of GBV with their HCPs. In particular, survivors are more eager to talk when a conversation is initiated by HCPs and become disappointed when HCPs show no interest in hearing their stories (Damra et al., 2015; Tarzia et al., 2020). However, some HCPs are hesitant to be involved in this area.

In many situations, HCPs do not know how to approach GBV and how to create an environment in which survivors feel comfortable enough to talk about their experience (Heron et al., 2021). Sometimes HCPs hold many of the most common prejudices related to survivors and may even interpret violence as the consequence of a provocative attitude on the part of the women (Procentese et al., 2019).

Our data analysis suggests practices that could help HCPs respond effectively to this situation. Our findings offer first-hand information on how to create an atmosphere in which both survivors and HCPs feel more comfortable participating in this sensitive dialogue. For example, survivors and HCPs agreed that HCPs should start a conversation about GBV cautiously and be careful to avoid re-traumatizing the survivors. They should "gently open the door to the client's private life" and "cautiously cross the hidden borders". Some studies encouraged HCPs to be engaged in direct questioning (Heron et al., 2021; Damra et al., 2015b). However, other evidence suggests that direct questioning should only be implemented in perinatal care if HCPs have access to a standard operating procedure, are trained and have access to supportive resources, and can provide a safe and private place for disclosure (World Health Organization, 2018). HCPs should receive awareness and skills training to establish a positive, validating, and safe environment for survivor disclosure. Also, they need to learn how to reassure survivors so that they would not be judged and stigmatized as a result of expressing their experience (Heron et al., 2021). Creation of a secure relationship with survivors serves as a key to opening up the secret box in which survivors have hidden their emotions and experiences regarding GBV (Damra et al., 2015). Health leaders and policymakers also need to address systemic barriers to service provision for survivors.

The barriers such as shortage of time, staff burnout—as well as secondary victimization by the medical systems need to be discussed and resolved. Therefore, more resources, training, and education for all different levels of care providers in the healthcare system is necessary (White et al., 2019).

In line with our findings, evidence emphasizes that this dialogue should happen in a supportive and safe environment (Heron et al., 2021). In fact, talking about trauma and sensitive subjects such as the experience of violence is not easy (Boethius & Åkerström, 2020), and survivors may not feel comfortable answering questions immediately. Likewise, care providers may not ask questions that elicit a survivor's history of violence or may struggle to address topics such as GBV effectively within the constraints of their service offerings, their healthcare setting directives, and the program's clinical orientation (Treatment (US), 2014).

Having a trusting relationship and a sense of being heard and understood are vital elements of a meaningful conversation, and together may encourage a survivor to disclose (Battaglia et al., 2003). Clients visit healthcare providers frequently during perinatal care and may have sufficient time to build trust (Sword et al., 2012).

Our study suggests that creating a psychologically and physically safe environment is essential in this conversation. Moreover, our participants emphasized that building a trustful and therapeutic relationship with survivors takes time. As a result, the first perinatal appointment may not be the best time for asking about the experiences of GBV. Literature supports our findings (Damra et al., 2015) and indicates that disclosure happens less likely during the first few appointments between HCP and survivor (Heron et al., 2021). Also, a lack of privacy in healthcare settings has been identified as hindering the creation of a safe atmosphere for disclosure (Shaheen et al., 2020; Heron et al., 2021).

HCPs should offer women time to develop rapport and feel secure in the relationship by letting them know that although they may ask about GBV at a particular appointment, the conversation is not a closed conversation, and the provider is there to support them. HCPs should ensure the clients that information will not leak (Tarzia et al., 2020b; Heron et al., 2021). During care interaction with survivor, creating safe spaces that limit the potential for further harm in is vital (Wathen & Mantler, 2022). HCPs cannot simply jump into a conversation about GBV. It seems that short, rushed appointments have a lower chance of violence disclosure (World Health Organization, 2014).

The findings of our study are in alliance with the previous research that emphasizes the importance of showing warmth and compassion while asking questions about the history of violence (Campbell et al., 2009). Importantly, our findings emphasize that HCPs should allow the survivor to exercise choice and have control over the flow of the conversation (Heron et al., 2021). Women want their care providers to do more than just listen; survivors want HCPs to be compassionate and sensitive and respond non-judgmentally (Tarzia

et al., 2020). There is emerging evidence that the quality of perinatal care may be more important than the quantity of care (Sword et al., 2012). In line with our findings, Feder and colleagues, in their study, concluded that HCPs should validate survivors' experiences, give them a choice, provide them with confidence, and respect the decisions they make (Feder et al., 2006).

Our findings suggest that clients wish for the opportunity to share more than their physical problems during healthcare appointments. Consistent with our findings, evidence indicates that survivors are uncertain whether their HCPs, however, are interested in discussing their experience of violence or supporting them and introducing them to proper resources. (Damra et al., 2015). According to the literature, survivors think that doctors are more interested in medical problems (Heron et al., 2021). Also, some care providers hesitate to include questions regarding social determinants of health in their assessment. They believe that being involved in this area is not part of their job, and the survivor should ask other professionals to help them (Damra et al., 2015). Shifting HCPs approach from a focus on a chief concern to looking at the survivor holistically has been recommended by literature (Palmieri & Valentine, 2021).

Our findings are consistent with the growing body of literature indicating that HCPs should not limit their conversation to the routine assessment of physiologic health. They should encourage women to talk about other aspects of life that might affect their well-being. Therefore, the experience of violence and safety at home needs to be included in assessments. In fact, HCPs should go beyond the traditional biomedical model (Battaglia et al., 2003). WHO emphasizes the importance of increasing awareness among HCPs and survivors that GBV is a medical problem (Krug et al., 2002).

Based on our discussions with survivors and providers, one of the main reasons leading to HCPs' hesitancy in identifying and supporting survivors is a lack of skills. HCPs need to acquire more skills to start a meaningful conversation, gain survivors' trust, and establish effective dialogue with them. Our findings reinforce the need to develop training programs in the healthcare system. Therefore, it is essential to train HCPs, increase their awareness and understanding of the dynamics of GBV and develop methods for handling such cases in the most effective way (Procentese et al., 2019).

We hope that the findings of this study can help bridge the existing knowledge gap in the health system and lead to the prevention of further harm to survivors through establishing a meaningful conversation, early detection and effective intervention.

Limitations: As this study took place over the course of the COVID-19 pandemic, this meant that in the middle of the project, our interviews switched from in-person to telephone semi-structured interviews. Although any change in the tone of participants' voices and emotions has been documented, the researcher could not write field notes.

Conclusion

HCPs play a pivotal role in identifying GBV and providing support for survivors, particularly during their perinatal period. Initiating a conversation around sensitive topics like GBV needs time, skill, and knowledge. Validating survivors' experiences, providing a private and safe atmosphere without judgment could lead to more disclosure. To have a meaningful conversation, HCPs need to show interest in clients' stories beyond their physical problems. They also should give the client choice and control over the conversation and support clients who have shared sensitive information.

Relevance to clinical practice

HCPs are still hesitant to start a meaningful conversation around GBV with mothers during their perinatal care and prefer to focus on the physical aspects of the care for the baby and the mother. HCPs should be trained on how to communicate about GBV in a meaningful way. Otherwise, many survivors will slip through the health system's cracks and suffer in silence. Decision-makers and care providers can use firsthand findings of our study to develop guidelines and practical instructions on how to initiate a meaningful conversation about GBV with survivors.

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Author's Contribution

Mirlashari J, did interviews, data gathering, analysis, writing original draft. Ann Pederson, Lori Brotto and Janet Lions had supervision role and contributed to data analysis, validation, review, and editing.

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Ethical Approval

The UBC C&W Research Ethics Board approved this study (Approval number: H19-02,409).

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