What Do Pregnant Women Experiencing Intimate Partner Violence Expect of Their Health Providers and Hospital Systems?

M Kyei-Onanjiri

The University of Melbourne

J Koziol-McLain

Auckland University of Technology

J Spangaro

University of Wollongong

J Walsh

University of Wollongong

K Hegarty (✉ k.hegarty@unimelb.edu.au)

The University of Melbourne

Research Article

Keywords: Intimate partner violence, domestic violence, routine screening, woman-centred care, antenatal care, pregnancy

Posted Date: July 15th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-669553/v1>

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Abstract

Background: Intimate partner violence is a pervasive public health and human rights problem with multidimensional effects on women's physical, mental and reproductive well-being. The World Health Organization has recommended a first-line response to disclosures of intimate partner violence. However, a strong evidence base of which interventions work best is lacking and there is a greater need to listen to the voices of survivors to tailor responses. The primary purpose of this paper was to explore what pregnant women experiencing IPV wish for from their health providers and hospital systems.

Methods: This paper is part of a broader study which included a survey of 1,067 pregnancy care patients at a large tertiary hospital in Melbourne. For this paper, we analysed an open-ended question related to victim/survivor women's needs and what they wish for from health practitioners and the healthcare system. Overall, while 571 women responded to the open-ended questions, only those relating to women who screened positive on the composite abuse scale or responded 'Yes' to screening questions ($n = 142$) or had been afraid of their partner in the previous 12 months ($n = 13$) or had experienced reproductive coercion in the last 12 months ($n = 6$) were analysed for this paper, making a total of 161 respondents.

Results: Four main themes emerged from the women in this study: 1) woman-centred care; 2) relationship and domestic violence-specific concerns; 3) male partner involvement and education; and 4) hospital system reform.

Conclusions: This study shows that women experiencing intimate partner violence value care that is supportive of them, provides tailored health information, and involves their partner, as well as a health system that is well-organized, accessible and provides continuity of care. It is important to align maternal health services with attributes of care valued by women to meet the complex health needs of pregnant women experiencing intimate partner violence.

Background

Intimate partner violence (IPV) is a pervasive public health and human rights problem with multidimensional effects on women's physical, mental and reproductive well-being (García-Moreno et al., 2015). The World Health Organization estimates that the lifetime prevalence of IPV among ever-partnered women ranges from 23.2% in higher income countries to 37.7% in South-East Asia (García-Moreno et al., 2013). Although estimates of IPV prevalence vary across studies, around 17% of all women in Australia report experiencing some form of IPV; among this group, more than half (54%) experienced IPV during pregnancy, with 25% reporting IPV as a first-time experience (Phillips & Vandenbroek, 2014).

The consequences of IPV among pregnant women may lead to substantial ill-effects on maternal and foetal health outcomes (Han & Stewart, 2014; Hill, Pallitto, McCleary-Sills, & Garcia-Moreno, 2016; Howell, Miller-Graff, Hasselle, & Scrafford, 2017). Given that most women come into contact with health services during pregnancy and the postpartum period, opportunity exists within the perinatal health system to intervene or provide support for women experiencing safety issues in their relationships. The World

Health Organization has recommended a first-line response to disclosures of IPV using a model called LIVES: 1) *Listen* to the service user, with empathy, and without judgement; 2) *Inquire* about and respond to their needs and concerns; 3) *Validate* experiences, and assure them they are not to blame; 4) *Enhance* safety, discussing a plan to protect them and their children from harm; and 5) *Support* and follow-up, helping them to connect to information, services, and social support. However, a strong evidence base of which interventions work best is lacking (Howell et al., 2017) and there is a greater need to listen to the voices of survivors to tailor responses.

A qualitative meta-synthesis exploring what survivors want from health professionals echoes the LIVES response and reinforces the need for a woman-centred and trauma-informed approach to care (Tarzia et al., 2020). This includes the need for approaches that give women choice and control, and provide advocacy, action, recognition and emotional support to women. Women experiencing IPV have a range of needs given the short and long-term ramifications of IPV. (Howell et al., 2017) Needs include physical and mental health (Wilson, Silberberg, Brown, & Yaggy, 2007) and social services (Dichter & Rhodes, 2011); as well as safety, privacy and autonomy (Chang et al., 2005). In their study, Wilson et al. (2007) report that healthcare staff's perceptions of clients' health needs differed from clients' views. In addition, it is important for health services to look for opportunities to align with the expressed needs of survivors, broadening health practitioners' knowledge on survivor women's needs beyond their biomedical needs.

Research suggest that woman-centred approaches focusing on the individual needs of women, improve health practitioners' responses to IPV, as it allows them to adapt a more holistic approach and provide specific services that are valued by women (Goicolea, Hurtig, San Sebastian, Marchal, & Vives-Cases, 2015; Goicolea et al., 2017; World Health Organization, 2017). This is important because, where women experiencing IPV have needs which do not match responses prioritised and offered by health services, women may feel less motivated to disclose IPV or take up available support services after disclosure. In addition, such an approach is critical when working with complex problems like IPV, where multiple challenges and inequities can be experienced. The primary purpose of this paper was to explore what pregnant women experiencing IPV wish for from their health providers and hospital systems. This research sought to advance knowledge on the needs of women experiencing IPV and provide some empirical basis to further improve health systems' response to IPV.

Methods

Study design and participants

This paper is part of a broader study: *Sustainability of Identification and Response to Family Violence in antenatal care (SUSTAIN Study)*, which included a survey completed by 1,067 pregnancy care patients while they attended the waiting room at a large tertiary hospital in Melbourne (Hegarty et al., 2020). Inclusion criteria for women were being at least 16 years of age and attending pregnancy care appointments at the study site, and literacy in written English, Arabic, Mandarin or Cantonese. Exclusion

criteria included being closely accompanied to the appointment by a partner and/or family member; and being too unwell to participate.

The instrument employed in the SUSTAIN study was a self-completed, written questionnaire including open- and closed-ended questions. For this paper, we analysed an open-ended questions related to victim/survivor women's needs and what they wish for from health practitioners and the healthcare system, similar to another study (Taket, O'Doherty, Valpied, & Hegarty, 2014). The specific questions analysed for this paper was:

Thinking about the issues with your partner or ex-partner, please complete the following sentences with the first words that come to your mind. There are no right or wrong answers, just write what you feel.

I wish that my health care providers...

I wish that the hospital...

Each question had ample space provided for free-text responses.

The survey included four screening items relating to partner or ex-partner behaviours: whether they were afraid of their partner, controlled their daily activities, threatened to harm them or physically hurt them. Further details about abuse experienced by participants was also collected via the Composite Abuse Scale (CAS) (Hegarty, Bush, & Sheehan, 2005) as well as questions about reproductive coercion. Overall, while 571 women responded to the open-ended questions, only those relating to women who screened positive on CAS or responded 'Yes' to screening questions (n = 142) or had been afraid of their partner in the previous 12 months (n = 13) or had experienced reproductive coercion in the last 12 months (n = 6) were analysed for this paper, making a total of 161 respondents. Of the total number of survey respondents who experienced abuse according to these criteria, 47.2 % (n = 76) provided responses to one or both of these questions. 71 responded to the first part relating to healthcare practitioners, and 63 responded to the second part, relating to the hospital.

All women approached for potential recruitment into the study were given a resource card with information on domestic violence support services and other health services information. A distress protocol was in place for women and researchers involved in the study.

Data analysis

The data was analysed using framework analysis as described in the five-step process (familiarization; identifying a thematic framework; indexing; charting; and mapping and interpretation) by Ritchie, Spencer, Bryman, and Burgess (1994). An assessment of responses was conducted for the purpose of familiarization with the data to gain an overview of its depth and range. The data was sorted/coded by MKO, KH and JK by applying labels that describe important concepts across the data. In an iterative process, we developed a framework by grouping related codes into a priori categories that offered the best fit for the data while leaving room for themes arising from the data. The analytical framework was

applied by assigning (indexing) the data to identified codes and categories and then summarizing it, in the broader context of the study, by charting it into a framework table, illustrated with a range of supporting quotations from the text. This process ensured that the interpretation of the data is grounded in the experiences or world view of study participants. The data was then reviewed by all authors to explore and make meaning of patterns or characteristics of the data.

Results

Socio-demographic data

Table 1 provides a summary of respondents' socio-demographic data. The average age of participants was 32 years with a mean gestational age of approximately 27 weeks and 80% had completed Year 12. The majority (85%) of participants had a current partner and 42% were expecting their first baby. Aboriginal or Torres Strait Islander women constituted 1.2% of the participants and 38% were born outside Australia. The most common type of antenatal care received was hospital care (51%).

Table 1
Socio-demographic and health information (N = 161)

	Mean	SD
Age in years (n = 147, min = 18, max = 48)	32.2	5.6
Weeks pregnant (n = 151, min = 7, max = 41)	26.6	8.1
	n	%
First baby	67	41.6
Has current partner	142	85.0
Married	87	56.5
Defacto (living with partner)	48	31.2
Type of care received (n = 140)		
Hospital care	72	51.4
Shared care	29	20.7
Midwifery care	14	10.0
Medical care	11	7.9
Specialist clinic	14	10.0
Community clinic	0	0
Attending first appointment	32	19.8
Aboriginal or Torres Strait Islander	2	1.2
Born outside Australia	61	37.9
English not first language	44	27.3
Finished school to Year 12	129	80.1
Completed a degree or higher degree	104	64.6
Has a Health Care Card	68	42.2
Ease of managing on current income (n = 156)		
Easily	37	23.7
Not too bad	58	37.2
Difficult some of the time	50	32.1
Difficult all of the time	10	6.4

	Mean	SD
Impossible	1	0.6

Women's needs

Four main themes emerged from the women in this study: 1) woman-centred care; 2) relationship and domestic violence-specific concerns; 3) male partner involvement and education; and 4) hospital system reform. Multiple sub-themes demonstrating a variety of needs were encompassed by each theme. Table 2 provides an overview of the main themes, sub-themes (with frequency of mentions by participants) and associated illustrative quotes.

Table 2
Main themes on women's needs from their health practitioners and hospital

Themes and sub-themes	Exemplar responses to "I wish my health care providers ..."
Woman-centred care	
Consultation time (6)	<ul style="list-style-type: none"> - <i>Would give me more time and not rush me.</i> - <i>Have more time to listen.</i> - <i>Spend more time with me in each appointment.</i>
Understanding/ supportive care (18)	<ul style="list-style-type: none"> - <i>Asked us about how we feel.</i> - <i>Were more understanding and compassionate.</i> - <i>Treated me like I wasn't their 500th patient for the day.</i> - <i>... listen, care and support during pregnancy and labour, breastfeeding.</i> - <i>Trained staff at reception to be friendlier.</i> - <i>Felt more like a community and made it less scary.</i> - <i>Being more helpful for non-English speaker pregnant women and family.</i>
Communication and information sharing (12)	<ul style="list-style-type: none"> - <i>Should give more information regarding pregnancy.</i> - <i>Would write down information for you for things that are needed especially early on in pregnancy when it's very overwhelming.</i> - <i>Had more courses, materials to read that were relevant.</i>
Relationship and domestic violence-specific concerns (7)	<ul style="list-style-type: none"> - <i>Would ask about mental health and DV/FV at every single appointment.</i> - <i>9 years ago, no midwife asked me about it.</i> - <i>Can help other women and ask these questions more often.</i> - <i>I wish that the hospital has it in place to ask women how they feel emotionally about their relationship.</i> - <i>Warned me about what domestic abuse would be like</i> - <i>Takes some interest in these areas. They look after pregnant ladies and new mums like they're a nuisance and just another job they have to do.</i> - <i>Gave more information about what can happen (bullying) in a relationship after the birth, not just before</i>

Themes and sub-themes	Exemplar responses to “I wish my health care providers ...”
Male partner involvement and education (7)	<ul style="list-style-type: none"> - Ask me about my partner. - Would see the fathers and how to help mothers with a newborn or show them how to cope. Fathers get left behind and it's a huge change for them as well. - Would educate males/partners on what is involved in caring for children/family. - Encouraged father to attend co-parenting course. - Had app[ointments] for dads so they can be offered support if they need it for their added workload i.e. If preg[nant] wife is sick etc. - Make partners compulsory to attend some appointments. - Knowing about issues for men before and after birth and where to seek help.
System changes	“I wish the hospital ...”
Timeliness (20)	<ul style="list-style-type: none"> - Would run more on time. - Has no long queue. - Should make appointments to patients accurately, they need to meet patients quickly without delay. - Stuck to the appointment times they gave you.
Access (5)	<ul style="list-style-type: none"> - Are easier to contact outside appointment times. - Were more accessible. - Were more easier to make appointments. - Were available all the time.
Improved waiting areas/environment (3)	<ul style="list-style-type: none"> - Would have more comfortable chairs to wait in the outpatient clinic. Would provide support at appointment/labour if you have toddlers. - Music in the waiting room. - Was dark and calm.
Continuity of care (9)	<ul style="list-style-type: none"> - Were the same ones at every visit. - Had more continuity of care to develop trust. - Were higher in volume so everyone was able to get continuity of care. - Didn't have such shitty midwifery care. It's stupid having 16 midwives. - Provides with the same midwife and doctors during the delivery for convenience and support. .

Themes and sub-themes	Exemplar responses to “I wish my health care providers ...”
Teamwork and communication (4)	<ul style="list-style-type: none"> - <i>Would work all together, holistic care. Team meetings would be beneficial, i.e., physio, dietician, obstetrician, physician, - see you together to plan care.</i> - <i>Were more connected and communicated via files or email.</i> - <i>Had better organisation and communication.</i> - <i>Would communicate more effectively amongst staff.</i>
Mental health support/services (9)	<ul style="list-style-type: none"> - <i>Mental support for those who need it badly.</i> - <i>Would understand/take seriously my anxiety.</i> - <i>Would have psychology outpatient.</i> - <i>Referral to psychiatrist and opportunity to see psychologist through the hospital.</i> - <i>Was referred to social services and spoke to a very kind lady, she was very understanding of my situation, and this was comforting.</i>

Discussion

This study provides some insight into what women experiencing IPV perceive as important when attending antenatal care, and wish were incorporated into their interactions with health practitioners and in hospital settings. It is expected that aligning the health system’s IPV service-related priorities with women’s expectation will facilitate better quality decisions and hence better quality and person-centre care (Tarzia et al., 2020). The findings are considered under four themes. The first three themes: woman-centred care; relationship and domestic violence-specific concerns; and male/partner involvement and education; are more closely related to what women value in healthcare practitioners and the final theme concerns the system changes.

Woman-centred care

Woman-centred care as it relates to pregnant women is care which focuses on the woman’s unique needs, expectations and aspirations; recognises her right to self-determination in terms of choice, control and continuity of care; and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations (NMBA, 2006). Sub-themes identified under woman-centred care align with this definition and include consultation time, understanding/supportive care, and provision of more/clearer information. Responses captured in these sub-themes suggest that women expect to receive care that is thorough and comprehensive, tailored to their needs and supportive in nature echoing findings elsewhere (Tarzia et al., 2020). The findings suggest that respondents wanted their appointment time to feel

unhurried and they wanted to be listened to and supported, similar to findings by Brady, Lee, Gibbons, and Bogossian (2019).

Women experiencing IPV may have additional needs to safeguard their well-being and that of their children (including unborn ones) (Ferdos, Rahman, Jesmin, Rahman, & Sasagawa, 2018; Hill et al., 2016). Respondents in this survey expressed some dissatisfaction with aspects of pregnancy-related information provided. While some women wanted more clarity, others felt they needed more information or preferred some information in written form. Healthcare providers' competence in information sharing and how information is shared or withheld can greatly influence women's ability to make appropriate healthcare decisions (Altman et al., 2019).

Relationship and domestic violence-specific concerns

In addition to issues that are broadly applicable to pregnant women, respondents provided their experiences and expectations specific to screening and identification of IPV. A prevailing sub-theme was that women want to be asked about IPV and they want this to be done often during consultations, as found previously (Spangaro, Zwi, & Poulos, 2011). This is encouraging as it reassures healthcare professionals who may be unsure about broaching the subject that it is not only alright to ask pregnant women about IPV, in fact, it is expected. Repeated inquiry about IPV may be helpful as women may choose to disclose at a later date (Feder et al., 2006).

Further, women expected to receive information about the possibility and nature of IPV as it relates to pregnancy and birthing. Given that there is an increase in the incidence of IPV in the peripartum period (Dahlen, Munoz, Schmied, & Thornton, 2018; Woolhouse et al., 2019), there have been calls for more systematic and standardised screening and for universal psychosocial education (Hegarty et al., 2020; Todahl, Nekkanti, & Schnabler, 2020). Even for women who are not disclosing or showing signs of IPV, it may be worthwhile to provide some relevant information on IPV.

Male partner involvement and education

Fathers' engagement in antenatal care has long-term positive outcomes for families (Alio, Salihu, Kornosky, Richman, & Marty, 2010), however, studies show that fathers often feel excluded and unclear about their roles due to a variety of reasons such as feeling unwelcomed or healthcare focused on the woman (Steen, Downe, Bamford, & Edozien, 2012). In the context of the participants who have experienced IPV, the fact that they shared similar views about low levels of involvement of their partners in antenatal care and urged healthcare staff to encourage male involvement was a surprising finding. Although pregnant women are the focus of attention during pre- and post- natal care, active engagement of fathers may have a positive impact on families' coping and psychosocial adjustments to pregnancy-related changes (Redshaw & Henderson, 2013), and is associated with lower likelihoods of men's use of IPV against women (Chan, Emery, Fulu, Tolman, & Ip, 2017). This could also provide healthcare professionals some insight into family dynamics or behaviours that might hint at potential IPV.

Hospital system

This theme captures factors that were attributable to how the health facility is operated, including infrastructure and policy. Women shared concerns about timeliness, access, improved waiting areas, continuity of care, teamwork, and communication, as well as mental health support. Timeliness of appointments was an important issue for women as outpatients' appointments tended to run late. Long waiting times can be a frustrating experience for patients and negatively impact their perception of quality of care (Jiang, Powers, Allison, & Vincent, 2017).

Penchansky and Thomas (1981) originally explored the concept of healthcare access and suggested five interrelated dimensions of access which are affordability, availability, accessibility (geographic), accommodation (adequacy), and acceptability. According to the authors, access reflects the fit between characteristics and expectations of the providers and the clients. In this study, access to healthcare staff outside appointment times and around-the-clock availability was important to women, however their experience was that it was not easy to make contact outside scheduled hours. This access issue is captured under "accommodation" which is how well service providers run their facilities to meet the constraints and preferences of the client, including hours of operation, telephone and other forms of communication, referral and appointment systems (McLaughlin & Wyszewianski, 2002).

Patient satisfaction, waiting experience, and perceived waiting time may be influenced by the physical setting of waiting areas (Xuan, Li, Chen, Cao, & Feng, 2021). Some participants in this study expressed dissatisfaction with the waiting areas with concerns around issues such as seating, lighting, and some support for those with toddlers. Studies have identified various positive attributes of hospital waiting areas favoured by patients such as transparent spaces with natural views (Jiang et al., 2017), low noise levels, appropriate light intensity, natural views from windows, visual arts on walls, seating, room size, signage, and rest rooms (Xuan et al., 2021).

Pregnancy and childbirth require frequent health service usage over an extended period. Depending on the health facility's model of care, service providers and users may be able to cultivate respectful, supportive, and trusting relationships over that time through continuity of care (Williams, Lago, Lainchbury, & Eagar, 2010). On the contrary, women may be frustrated if services feel fragmented or uncoordinated, as was the case in this study. Concerns included being unable to see the same midwife or doctor from pregnancy through delivery and exasperation about the sheer number of midwives one may have to see throughout the process. For women experiencing IPV, a trusting relationship is even more important as it can facilitate disclosure and have an impact on women's outcomes (Spangaro et al., 2011).

As consumers of healthcare services, women had certain expectations of how their healthcare team would be organised and work together as a team. However, observations made by participants suggest that some workplace practices did not meet these expectations. At an organisational level, participants wanted more coordination between different departments/specialties and better referrals for mental health support. Some responses also suggested concerns about interpersonal communication between

healthcare staff. A study on interprofessional care coordination in complex care clinics shows that regular interprofessional communication and care planning among team members is essential in promoting person-centred care (Brooks, Winship, & Kuzel, 2020).

Respondents were concerned about their mental health and expected more enquiries and additional support in this area. For instance, women expected that self-report of symptoms would be taken seriously and acted upon. This is particularly important as the relationship between IPV and poor mental health outcomes is widely reported in the literature (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Rogathi et al., 2017; Woolhouse et al., 2019). For women experiencing IPV, to feel unheard, dismissed or to have inadequate access to vital services may have dire implications on help-seeking, particularly on their decision to disclose, take up intervention services or follow-up. Studies have shown that healthcare interactions that include validation of women's experiences have positive impacts for women (Narula, Agarwal, & McCarthy, 2012; Spangaro, Koziol-McLain, Rutherford, & Zwi, 2020).

Strengths and limitations

This work was drawn from a broader study involving more than one thousand pregnant women, providing a large and diverse sample from which those experiencing IPV were selected. The study was however conducted in an urban hospital clinic setting and may not represent the views or needs of women in regional and remote areas. In addition, for safety reasons, only women presenting to their antenatal care visit unaccompanied were eligible to participate, thus eliminating another subset of women who may have shared different perspectives. Finally, this study included few Aboriginal or Torres Strait Islander women. Further research would be needed to explore the needs and wishes of Indigenous women.

Conclusion

The quality of maternity care as experienced by women is dependent on multiple factors. This study shows that women experiencing IPV value care that is supportive of them, provides tailored health information, and involves their partner, as well as a health system that is well-organized, accessible and provides continuity of care. Despite the distinct care that might be required for IPV-related issues, some studies of pregnant women not specifically focused on those experiencing IPV show some parallels with the needs of women in this study regarding issues such as communication and information sharing (Delaney & Singleton, 2020; Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015); continuity of care, and partner involvement (Maillefer et al., 2015). A discordance between the expectations of women experiencing IPV and health practitioners' perceptions about women's need may leave women dissatisfied and unlikely to attain the best outcomes of care. It is important to align maternal health services with attributes of care valued by women to meet the complex health needs of pregnant women experiencing IPV.

List Of Abbreviations

CAS
Composite Abuse Scale
IPV
Intimate partner violence
LIVES
Listen. Inquire, Validate, Enhance, Support
SUSTAIN
Sustainability of Identification and Response to Family Violence in antenatal care (SUSTAIN Study),

Declarations

Ethics approval and consent to participate

Ethics approval was provided by The Royal Women's Hospital Human Research Ethics Committee (Reference: Project 17/35). Informed consent was obtained from all participants. The study was guided by the National Health and Medical Research Council guidelines, as updated in 2018 (National Health Medical Research Council, 2007). All the study methods were performed in accordance with relevant regulations and guidelines as approved by the Ethics Committee.

Consent for publication

Not applicable

Availability of data and materials

The data that support the findings of this study are available from the corresponding author, but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

Funding

The authors gratefully acknowledge the funding provided by Australia's National Research Organisation for Women's Safety (ANROWS).

Authors' contributions

KH designed and led the study and wrote the first draft with MKO. JKM and JS contributed to design and analyses and write up of paper. JW assisted with the design, conduct and analyses of the study. All authors read and approved the final manuscript.

Acknowledgements

We gratefully acknowledge contributions made by all the women who so generously participated in this study by sharing their experiences with us. We appreciate contributions made by Jacqueline Kuruppu, Rhiannon McArthur, India Jones, Tanya Hoad and Karyn Smith who assisted with survey data collection at the Victorian study sites.

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