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Research Query

Report Title: Review of available evidence and guidance on routine screening for gender-based violence in healthcare settings

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Overview

This report provides an overview of the available evidence on the routine use of screening of gender-based violence (GBV) in healthcare settings.

Most of the available research on routine screening for GBV in healthcare settings focuses on intimate partner violence (IPV), domestic violence, or family violence and has been carried out in high resource contexts in Australia, Canada, New Zealand, the UK, and the US.[1]

The evidence overwhelming demonstrates there has been little positive effect to IPV survivors' health or wellbeing through the implementation of routine screening protocols by healthcare providers. The majority of institutional guidance published reflects this lack of evidence though there are notably some exceptions, mainly from American institutions. One institutional guidance document, from International Planned Parenthood Foundation (IPPF), is unique in that it provides details on both the conditions for establishing a routine screening protocol as well as steps on how to do so.

In addition to the effectiveness of routine screening for IPV, this report summaries the evidence on:

- Perceptions of routine screening for IPV by health care providers and survivors within the healthcare setting
- The role of different types of healthcare providers in routine screening protocols
- Tools and methodologies used in routine screening interventions
- Experiences of IPV survivors interacting with healthcare practitioners

[1] See see Barnard *et al*, 2015; Burge *et al*, 2005; Colarossi *et al*, 2010; Chang *et al*, 2010; Chuang & Liebschutz, 2005; Feder *et al*, 2006; Feder *et al*, 2009; Garimella, 2002; Higgins *et al*, 2015; Liebschutz *et al*, 2008; Miller, 2010; Morse *et al*, 2012; Nelson *et al*, 2012; Rabin *et al*, 2009; Taft *et al*, 2015; Walton *et al*, 2015; Wathen & MacMillan, 2003; Wilson *et al*, 2007; Zeitler *et al*, 2006.

One study that reviews the available evidence in support of routine screening for IPV puts it succinctly: "While we must prioritize how best to support and intervene with patients who have experienced IPV and other adverse psychosocial exposures, we should not be lulled into a false sense of security that our routine use of 'screeners' results in better health outcomes or less violence without evidence for such" (McLellan & MacMillan, 2016).

Defining 'routine screening' to detect GBV

There are different types of screening for GBV that can be carried out in healthcare settings. *Universal screening* uses a standardised question for all symptom-free women according to a procedure that does not vary from place to place. *Selective screening* targets high-risk groups, such as pregnant women or those seeking abortions. *Routine enquiry* involves asking all women accessing a facility about GBV but the methods vary according to the provider or woman's situation. *Case finding* is the use of indicators to lead to questions about experiences of violence (Taft *et al*, 2013).

All of the available evidence that focuses on the effectiveness of routine screening in health facilities for GBV focuses on screening for intimate partner violence (IPV), which can also be referred to as domestic or family violence in the literature. Typically, interventions focus on routine screening women or adolescent girls accessing healthcare for IPV and not other forms of GBV, such as sexual violence, early or forced marriage, trafficking for sexual exploitation.

For this review, 'routine screening' is defined as any method that aims to ask every woman patient in a healthcare setting about their experiences of IPV, both past and present.

Methodology

The evidence base for routine screening of GBV, specifically, IPV, is rich with systematic reviews, primarily from Western countries, and have been used to inform government-issued guidance. As such, these systematic reviews were the entry point for an analysis of the evidence and were found using search engines such as Cochrane Collaboration and Google Scholar. Where bibliographies included literature relevant to this query, it was included in the review to provide nuance and additional context to the consolidated findings.

Search terms included: routine screening / health screening / gender-based violence / GBV / intimate partner violence/ IPV / violence against women / VAW.

Some of the literature specifically reviewed the effectiveness of routine screening interventions and others looked at the feasibility and/or barriers of establishing routine screening protocols, the perceptions of routine screening by both female patients and healthcare practitioners, and the skills required to carry out routine screening.

In response to the continued recommendation by certain institutions of routine screening despite weak evidence that it is effective in improving the health and wellbeing of survivors of violence, the literature also includes editorials by academics discussing this phenomenon.[2] Editorials have also been included in this report.

[2] The term 'survivor' is used throughout this report to identify anyone that has experienced GBV at any time in their life.

Guidance for implementing routine screening for IPV has been issued by different government institutions, the World Health Organization (WHO), and non-governmental organisations (NGOs) and has been included in this report.

Theories of change regarding routine screening for IPV

Arguments for routine screening for IPV are outlined by Bott *et al*, 2010 and include:

- GBV is a major public health problem
- Routine screening may improve sexual and reproductive health-related diagnosis, treatment and counselling
- Routine screening may help providers identify victims early before violence escalates further
- Routine screening may reduce women's need for health services
- Depending on disclosures of violence may lead to women being overlooked if they are living with violence.
- Screening can be a transforming and therapeutic experience.
- Health care providers are often the only professionals who interact with most adult women

There are a number of assumptions made in the theories of change underpinning routine health screening for IPV. The first is that if women who have experienced IPV are identified in a healthcare setting, their health and wellbeing can be improved through provision of specialised services and support. Secondly, that survivors of IPV, especially adolescents, are likely to have contact with healthcare practitioners, who could be instrumental in identifying and referring survivors of IPV (Daugherty & Houry, 2008; Miller *et al*, 2010). And thirdly, that IPV may not be raised spontaneously if not prompted by a healthcare professional (McLellan & MacMillan, 2016).

The theory of change is contingent on the belief that healthcare practitioners have an imperative to identify survivors of IPV due to its high prevalence and its harmful effects (McLellan & MacMillan, 2016).

Bott *et al* (2010) also outline the arguments for taking a more cautious approach to routine screening, including:

- Unclear if screening meets accepted standards of reliability and effectiveness
- Many health centres lack the resources to protect women's privacy and confidentiality
- Many providers have negative attitudes toward victims of physical and sexual abuse
- Many, if not most, developing country settings lack adequate referral services
- Unclear what constitutes an effective response to a disclosure of violence
- Addressing GBV includes potential risks and unintended consequences

Weak evidence on effectiveness of routine screening for IPV

Despite continued calls for routine screening to be a central part of healthcare provision (see Alvarez *et al*, 2006; Barnard *et al*, 2015; Chuang & Liebshutz, 2005; Kaur & Herbert, 2005; Kiely *et al*, 2010; ; Miller *et al*, 2010; Undie *et al*, 2014; Walton *et al*, 2015), there is little evidence that demonstrates the effectiveness of routine screening, especially in positive outcomes for women that have experienced IPV (MacMillan *et al*, 2009; Taket *et al*, 2004; Spangaro *et al*, 2009).

This finding is supported in multiple systematic reviews, that conclude that IPV screening is not correlated with improved health outcomes of women that screened positively (see Alvarez *et al*, 2006; Feder *et al*, 2006; Feder *et al*, 2009; Rabin *et al* 2009; Wathen & MacMillan, 2003; Walton *et al*, 2015). While there was one systematic review that found sufficient evidence for routine screening for IPV in healthcare settings (Felter et al, 2018), a similar review done was also reviewed by the Canadian Task Force on Preventative Healthcare and found to be insufficient (Canadian Task Force on Preventative Healthcare, 2013).

A systematic review conducted in 2013 by Taft *et al* and provides a comprehensive overview of the evidence and finds that while screening is likely to increase identification of IPV, there is little evidence of the accuracy of identifications, and referrals to support services are low. Taft et al (2013) also find that the numbers of identified survivors were low and screening did not improve women's health and wellbeing in 3 – 18 months following the screening. In terms of "do no harm", a single study showed that there was no harm to survivors that were identified through routine screening however many studies did not measure potential negative effects of routine screening. The authors conclude that in absence of long-term benefits for women, there is no value in investing in universal screening programmes.

A systematic review in 2015 by O'Doherty *et al* also showed that screening in healthcare settings may increase the identification of women experiencing IPV, but the number of survivors identified were low compared to best estimates available of prevalence of IPV. The effective of routine screening has not been compared against other forms of screening, including selective screening and case finding.

Another systematic review from 2015 by Walton *et al* summarised the barriers within IPV screening interventions in American health care settings and identified lack of knowledge, cultural barriers, time constraints and negative perceptions of healthcare providers. The authors conclude that routine screening has merit, but recommend more specialised training, including on screening tools, for healthcare practitioners to improve routine screening outcomes.[3] Similarly, Colarossi *et al* (2010) call for improved training methods for healthcare practitioners on IPV, including how to respond to disclosures of violence (including role playing scenarios, scripts) and how to provide referrals, to improve the effectiveness of routine screening.

In other settings, Feder *et al* (2009) focused on studies relevant to the UK National Screening Committee and found there is insufficient evidence to support the implementation of routine screening programmes for IPV against women in general health services or clinical settings in the UK.

[3] Walton et al (2015) suggest the following tools should be used to train health care practitioners: PREMIS tool, the Hurt, Insult, Threaten, Scream (HITS), Ongoing Violence Assessment Tool (OVAT), Woman Abuse Screening Tool (WAST), and Partner Violence Screen (PVS)

Similarly, a 2003 review of routine screening efforts found insufficient evidence to recommend for or against routine screening of pregnant and non-pregnant women for IPV nor of screening men as potential perpetrators of IPV in Canada (Wathen & MacMillan, 2003). Specifically, there was insufficient evidence that found positive outcomes of the following interventions for women: primary care counselling, referrals to shelters, or referrals to personal or vocational counselling. There was conflicting evidence regarding effectiveness of interventions targeting perpetrators of IPV in reducing the rate of future violence.

Recently published academic editorials by organisations such as the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American College of Emergency Physicians, American Academy of Nurse Practitioners have been critical of continued recommendations of routine screening as evidence does not demonstrate improved health outcomes for women (Jewkes, 2013; Moracco & Cole 2009; Walton et al, 2015).[4] Moracco & Cole (2009) cite the methodological weakness of available evaluations on the effectiveness of routine screening, while Jewkes (2013) suggests that wide-scale trials confirm that activities intended to identify asymptomatic women to offer them specialised services and support has not improved women's health.

However, Jewkes (2013) recognises the negative health impacts of IPV on women's health and calls for more research into appropriate responses of the health sector and highlights that routine screening in ante-natal healthcare has reduced IPV recurrence and maternal and infant outcomes have improved but calls for more research.

Routine screening in antenatal care

The most promising area to conduct routine screening was in ante-natal care where pregnant women appeared more likely to disclose IPV. The potential for routine screening in ante-natal healthcare is based on the premise that pregnant women are more likely to come into contact with healthcare providers during routine antenatal care and may be an opportunity for ante-natal healthcare providers to identify cases of IPV and provide appropriate referrals and information. This supports work by Abma *et al* (1997) and Rennison & Welchans (2003) who focus on the role of ante-natal healthcare providers in the identification of IPV and emphasise that women accessing family planning services are likely in the same age range where the risk of IPV is highest.

Institutional guidance on routine screening for IPV

Most institutions have recommended against routine screening for IPV.

The exceptions are the Institute of Medicine (IOM) of the US National Academy of Sciences and the US Preventative Services Taskforce. IOM issued guidance on routine screening of IPV recommending it for all women and adolescent girls (Institute of Medicine, 2011). They based this recommendation on both peer-review studies and existing policies and professional guidelines from organisations such as the American Medical Association (AMA) and the

[4] For more information on recommendations of routine screening, see Institute of Medicine (2002); American Medical Association (1992); and American College of Obstetrics and Gynecologists Committee on Health Care for Underserved Women (2006).

American College of Obstetricians and Gynecologists (ACOG). The US Preventative Services Taskforce also calls for routine screening by clinicians of all women of reproductive age in *Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening* (based on Feltner *et al*, 2018).

An earlier version of this recommendation was subsequently reviewed by the Canadian Task Force on Preventative Healthcare and found to be insufficiently evidence-based for recommending routine screening for IPV in Canada (Canadian Task Force on Preventative Healthcare, 2013). In its commentary on their decision not to accept the US Preventative Services Taskforce recommendation, they state:

> "It is important to note that the guideline included data from only one study that directly addressed the benefit of screening, and that study found no effect of screening on outcomes. The recommendation for screening is based on indirect evidence with considerable limitations."

The WHO also came to the same conclusion in the publication of their 2013 *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* (WHO, 2013) and recommends focusing on a case finding approach rather than routine screening. WHO's 2013 cites the low quality of the available evidence on the impact on the health of survivors. WHO does recommend that healthcare providers ask about IPV when assessing conditions that may be caused or complicated by IPV, which could improve diagnosis/identification and subsequent care (WHO 2013).[5]

In the UK, the quality standard used is the National Institute for Health and Care Excellence (NICE) *Domestic violence and Abuse Quality Standard* which covers domestic violence and abuse in adults and young people (aged 16 and over) and it does not include routine screening (NICE, 2016). Instead, the NICE guidelines provide recommendations for identification of IPV through case finding, using a similar list of clinical conditions that may present in interactions with women in healthcare settings.[6] The NICE guidelines also provide a list of professionals to which these recommendations apply.[7]

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[5] The list of clinical conditions that could instigate a conversation about IPV, adapted from Black (2011), include: symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders; suicidality or self-harm; alcohol and other substance use; unexplained chronic gastrointestinal symptoms; unexplained reproductive symptoms, including pelvic pain, sexual dysfunction; adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes; unexplained genitourinary symptoms, including frequent bladder or kidney infection; repeated vaginal bleeding and sexually transmitted infections; chronic pain (unexplained); traumatic injury, particularly if repeated and with vague or implausible explanations; problems with the central nervous system: headaches, cognitive problems, hearing loss; repeated health consultations with no clear diagnosis; intrusive partner or husband in consultations

[6] The list used in the NICE guidelines is: symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders; suicidal tendencies or self-harming; alcohol or other substance misuse; unexplained chronic gastrointestinal symptoms; unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction; adverse reproductive outcomes, including multiple unintended pregnancies or terminations; delayed pregnancy care, miscarriage, premature labour and stillbirth; genitourinary symptoms, including frequent bladder or kidney infections; vaginal bleeding or sexually transmitted infections; chronic unexplained pain; traumatic injury, particularly if repeated and with vague or implausible explanations; problems with the central nervous system – headaches, cognitive problems, hearing loss; repeated health consultations with no clear diagnosis; intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse).

[7] Including nurses, accident and emergency doctors, adult social care staff, ambulance staff, children's centre staff, children and family social care staff, GPs, mental health professionals, midwives, health visitors, paediatricians, obstetricians and

The IPPF Western Hemisphere Region (WHR) released their *Improving the Health Sector Response to Gender Based Violence A Resource Manual for Health Care Professionals in Developing Countries* by Bott *et al* in 2010, which includes guidance on when and how to establish routine screening for GBV. Notably, this guidance is the only one identified focused on developing country contexts and recognising the complexity of establishing a routine screening protocol.

Bott *et al* (2010) provide a thorough outline of the arguments for and against routine screening for GBV as well the conditions necessary before establishing a routine screening protocol. The conditions required before routine screening can be put in place include:

- A clinic can ensure clients' privacy, safety, and confidentiality
- A clinic can ensure that providers have appropriate attitudes and skills
- A clinic can ensure that providers have something to offer women.

IPPF WHR's guidance provides detailed directions on how to establish protocols and systems, documentation of information relating to screening, referrals, monitoring and evaluation, and risks and mitigating factors of routine screening interventions as well as useful lessons that were captured in the evaluation of IPPF WHR programming (*Ibid*).

Perceptions of IPV survivors and health care providers to routine screening for IPV

An analysis was done in the UK of qualitative studies examining IPV survivors' perceptions of healthcare practitioners' responses if they disclose IPV (Feder *et al*, 2006). Women's perceptions of appropriate responses of healthcare practitioners were affected by the context of the interaction, their own readiness to address the violence, and the nature of the relationship between the woman and her healthcare practitioner.

Another study looked at the barriers to effective routine screening and found that inadequate education and insufficient experience of healthcare providers paired with competing demands of the healthcare setting impeded healthcare providers from making routine inquiries into IPV (Gutmanis *et al*, 2007). Waalan *et al* (2000) identified these same barriers and found that healthcare practitioners were concerned about offending their patients, which affected their use of screening protocols. Hamberger & Phelan (2006) also examined the barriers to routine screening and suggest implementing healthcare practitioner training, establishing protocols, and enhancing environmental cues for discussion of IPV in the healthcare setting to increase routine screening effectiveness.

When women and adolescent girls were asked about routine screening, they overwhelmingly were supportive (over 90%) and felt that their healthcare provider is an appropriate person to ask about their experiences of violence (Zeitler *et al*, 2006). However, survivors of childhood sexual abuse or those who had experienced violence in the last year were less supportive of screening (over 70%) (Zeitler *et al*, 2006). The authors suggest that the

gynaecologists, health and social care practitioners in education (including school nurses), prison staff, alcohol and drug misuse workers, youth workers

characteristics of the healthcare professional, the guarantee of confidentiality, and a common understanding of what constitutes IPV are likely to affect routine screening.

IPPF WHR report similar experiences and state "…both providers and survivors reported that routine screening was an important way to identify women at risk, to offer more appropriate medical care to women, and to help survivors understand their rights, the risks that they face, and any services that may be available in the community" (Bott *et al,* 2010).

Similarly, Burge *et al* (2005) found that patients were open to discussions about domestic violence with their physicians and that the skills required to have these discussions were within the realm of training of family medicine.

Healthcare practitioners' role in routine screening for IPV

One study in the US examined the differences between screening by licensed health care professionals (eg. clinicians and social workers) and unlicensed healthcare professionals (eg. health care assistants) in family planning clinics with institutional screening protocols (Colarossi *et al*, 2010). The study found that while participants considered IPV screening an important part of healthcare provision, routine screening alone is insufficient to improve health outcomes for survivors.

In a study on barriers to routine screening, Jaffee *et al* (2005) looked at the characteristics of healthcare practitioners. They found that the physician's gender, medical specialty, and years of experience affected their perception of the barriers to effective routine screening. Specifically, male practitioners and those in private practice perceived more barriers to carrying out routine screening for IPV and those in obstetric/gynaecological practice or who had 5-10 years of experience perceived fewer barriers. This suggests that the profiles of those involved in screening are important in determining how confident the healthcare provider will feel in identifying survivors of IPV. It indicates that some healthcare practitioners will be better placed and more appropriate to screen for IPV.

One study found that physicians hold negative feelings about female survivors of IPV. The majority of physicians surveyed reported that providing care to survivors of IPV was a significant amount work, difficult to do, low-paying, and stressful (Garimella *et al*, 2002).

Colarossi *et al* (2010) also found that healthcare practitioners had negative attitudes towards patients who screened positively for IPV but who did not follow their advice or access referrals. It is important to note that these negative feelings in service providers could be exacerbated in low resource contexts, such as humanitarian emergencies, and where greater gender inequality exists and is maintained through social norms.

Colarossi *et al* also reported that practitioners felt that if they had better understanding of the linkages between IPV and sexual and reproductive healthcare, it might improve the effect of routine screening. This is similar to McCormick Hadley (2009) finding that healthcare providers, who are accustomed to providing immediate treatment upon a diagnosis, may find the inability to remedy IPV in the same way frustrating.

Hegarty *et al*, 2013 also supported this finding and determined that IPV survivors who received counselling from family doctors trained to respond to women who have experienced IPV saw no effect on their quality of life, safety planning and behaviours, or their mental health.

Some of the evidence reviewed distinguished between the types of healthcare providers who were involved in routine screening for IPV. The relationship that a woman has with her general practitioner or family doctor could be used to identify cases of IPV (Burge et al, 2005), but there were no effects found when routine screening in a family practice was measured for effectiveness (Hegarty et al, 2013).

Obstetricians/gynaecologists perceived fewer barriers to effective routine screening protocols than other physicians (Jaffee et al, 2015). Another study focused on nurses' role in routine screening, but did not find any change in the rates of violence experienced by women even though safety planning was done more frequently (Taft et al, 2015).

Barnard et al (2005), found that women in the US felt positively towards screening when done by pharmacists.

One hypothesis for the poor results of routine screening interventions proposed by Hegarty *et al* (2008) is that multiple factors influence women's decision to disclose their abuse (including fear or readiness to act) and these factors will affect measurement of accurate screening rates.

Evidence on tools and methodologies used in routine screening for IPV

In a systematic review of IPV screening tools, Rabin *et al* (2009) found that no single tool could be recommended as there were too few studies of their effectiveness, concluding that more testing and validation of IPV screening tools is needed.

One high quality study using randomised control groups found no effects of carrying out computerised screening for IPV alongside provision of resource lists vs provision of resource lists alone; women screened positively for IPV had no perceivable difference in quality of life, mental health, missed days of work, or healthcare visits and notably, no difference in accessing IPV support services or recurrence of IPV as compared to a control group (Klevens *et al,* 2012).

Nelson *et al* (2012) found that screening instruments can be accurate in identifying women experiencing IPV and the authors assess different screening tools, finding that of 15 screening tools, only five were considered to be diagnostically accurate. In addition, the authors find that there was minimal harm done to survivors, though there were reports of increased discomfort, loss of privacy, feelings of depression, concerns about stigma from the provider, and concerns about increase in violence due to the screening. These authors also found that women are more likely to report IPV through self-administered methods, including computerised screening methods, compared to face-to-face screening.

However, another study contradicts these findings: Wilson *et al* (2007) found that women were more likely to report poor health, especially mental health concerns, in face-to-face interactions with healthcare practitioners as opposed to a written survey. This study calls for qualitative methods to be incorporated into IPV screening initiatives.

The guidance issued by IPPF WHR on the establishment of routine screening protocols includes discussion of the importance of field testing and evaluating tools in the establishment of routine screening in health care facilities and provides examples of tools for screening as well as for monitoring routine screening programming (Bott *et al*, 2010).

Evidence on the experiences of survivors of IPV disclosing to healthcare providers

Liebschutz *et al* (2008) looked at routine screening from the perspective of IPV survivors and found that while no harm resulted from survivors disclosing their experience of IPV, their experience of disclosing to healthcare practitioners was shaped by the healthcare setting. The authors recommend that clinicians build a therapeutic relationship with IPV survivors that empowers and educates their patients and does not demand disclosure.

Morse *et al* (2012) interviewed low-income IPV survivors to measure the response they received upon disclosure. Half of the women disclosed IPV to their healthcare provider and of those that did, most reported receiving advice to leave the relationship yet only 31% received safety planning to mitigate risks of leaving.

Therefore, the response that IPV survivors receive from healthcare providers following screening is important to avoid doing harm and support positive actions to reduce violence.

Evidence on routine screening for IPV focuses on Western contexts

Much of the research on routine screening for GBV in healthcare settings has been carried out in high resource contexts in Australia, Canada, New Zealand, the UK, and the US (see Barnard *et al*, 2015; Burge *et al*, 2005; Colarossi *et al*, 2010; Chang *et al*, 2010; Chuang & Liebschutz, 2005; Feder *et al*, 2006; Feder *et al*, 2009; Garimella, 2002; Higgins *et al*, 2015; Liebschutz *et al*, 2008; Miller, 2010; Morse *et al*, 2012; Nelson *et al*, 2012; Rabin *et al*, 2009; Taft *et al*, 2015; Walton *et al*, 2015; Wathen & MacMillan, 2003; Wilson *et al*, 2007; Zeitler *et al*, 2006).

A crude distinction between studies done in the US vs the other countries listed above was that there was an underlying assumption made in many of the US articles that there was an inherent value in establishing routine screening protocols.

Of the institutional guidance reviewed, one focused on routine screening for GBV in developing countries in Latin America and the Caribbean (Bott *et al*, 2010) and one peer-reviewed study was identified from Kenya (Undie *et al*, 2014), but it looked at the feasibility of instituting a routine screening intervention based on the assumption that it would have positive impacts.

The guidance from professional bodies follows a similar pattern, with the US Preventative Services Taskforce standing alone in making the recommendation for routine screening (Feltner et al, 2018) and the Canadian Task Force on Preventative Healthcare, the UK's National Institute for Health and Care Excellence, and the WHO recommending against instituting routine screening in healthcare settings (Canadian Task Force on Preventative Healthcare, 2013; NICE, 2016; WHO, 2013).

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