GBV AoR HELPDESK

Research Query

Report Title: Review of available evidence and conditions necessary for screening for gender-based violence in antenatal healthcare settings

Author: Lara Quarterman

Overview

This report provides an overview of the available evidence on the use of screening of gender-based violence (GBV) in antenatal healthcare settings and outlines the conditions that must be present before instituting a routine screening intervention. It is a follow-up to a previous GBV AoR Helpdesk query on the evidence behind screening in healthcare settings more generally (Quarterman, 2019). The information for this report was gathered primarily through a desk review, as well as one interview with a global expert on screening.[1]

The available evidence for routine screening of GBV, specifically intimate partner violence (IPV), is rich with systematic reviews and as such, these systematic reviews were the entry point for an analysis of the evidence. Literature that focused on antenatal healthcare settings, low or middle-income countries, and/or highlighted factors in effective screening interventions were prioritised for review.[2] Notably, all of the available research on routine screening for GBV in healthcare settings focuses on IPV, which is also referred to as domestic violence or family violence in the literature. No evidence was identified for other forms of GBV (e.g. conflict-related sexual violence, child marriage, female genital mutilation/cutting (FGM/C), etc.).

The evidence does not demonstrate conclusively that there are positive effects of IPV screening in antenatal healthcare settings, including for instance, reductions in IPV or improved health outcomes for women or their babies. There are potential negative effects of IPV screening identified in the literature, but there are few studies that measure them and many calls for further investigation into both the impact of screening for IPV on women, and on healthcare providers involved in screening processes.

[1] Five five experts in the field of GBV screening were contacted and invited for key informant interviews; given the short timeframe, only one interview was completed.

[2] Documents were found using search engines such as Cochrane Collaboration and Google Scholar. Search terms included: routine screening / universal screening / antenatal care / prenatal care / gender-based violence / GBV / intimate partner violence / IPV.

There are recommendations and guidance in the literature regarding the safety and ethical considerations for designing and implementing IPV screening interventions, including how to improve detections and decrease risks of unintended negative consequences. These recommendations were supported by the key informant interviewee, who reiterated the need to ensure that certain conditions are in place prior to instituting a screening protocol.

Defining 'routine screening' for GBV

There are different types of screening for GBV that can be carried out in healthcare settings. *Universal screening* uses standardized questioning and methodology for all symptom-free women; *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; and *case finding* involves asking questions if certain indicators are present (Taft *et al*, 2013).

There is debate around the use of the term 'screening' with suggestions that 'identification' or 'detection' be used instead to broaden the conceptualisation of the activity.[3] This review borrows the definition from O'Doherty *et al* (2015, p 8):

> Screening is defined as any method that aims for every woman patient in a healthcare setting to be asked about her experiences of IPV, both past and present.

Screening can include a range of methods, including face-to-face, self-administered, or computerised surveys, or questions included in other screening processes, such as psychosocial screenings.

Rationale for IPV screening in antenatal care

Women who have experienced IPV are more likely to experience premature death and other negative effects, including injury, mental health disorders, substance use, unintended pregnancies, pregnancy termination, and adverse birth outcomes (WHO, 2013). When women experience IPV during pregnancy, they are more likely to suffer from poor nutrition, inadequate weight gain, substance use, and depression, which in turn can affect their access to antenatal healthcare, resulting in insufficient or inconsistent care. The effects of IPV on babies include low birth weight and pre-term birth, as well as neonatal death. IPV is also linked to post-natal depression for women following birth (Alhusen *et al*, 2015).

Arguments for why antenatal care may be a suitable place for IPV screening include:

- antenatal care offers the opportunity for follow up throughout pregnancy (WHO, 2013).
- the prevalence rate of IPV during pregnancy has been found to be higher than in the non-pregnant female population (Bacchus *et al*, 2004; Espinosa & Osborn, 2002).
- healthcare practitioners have an imperative to identify survivors of IPV due to its high prevalence and its harmful effects (McLellan & MacMillan, 2016).

[3] Key informant interview.

- many women have their only interaction with healthcare providers during pregnancy (Espinosa & Osborn, 2002).
- women who experience IPV during pregnancy are likely to continue to experience it following the birth (Espinosa & Osborn, 2002).
- women accessing sexual and reproductive healthcare are likely in the same age range where the risk of IPV is highest (Abma *et al,* 1997; Rennison & Welchans, 2003).
- adverse birth outcomes, including low birth rate and preterm birth, associated with IPV may be preventable (Hill *et al*, 2016).
- obstetricians/gynaecologists perceived fewer barriers to effective routine screening protocols than other physicians (Jaffee *et al*, 2015).

Evidence for positive effects of IPV screening in antenatal healthcare

Multiple systematic reviews of IPV screening in healthcare settings have found that IPV screening in these settings increases case detection, but not that subsequent interventions are effective (O'Doherty *et al*, 2005; Spangaro *et al*, 2009; WHO, 2013). The 2013 *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* outlines a research gap in both the clinical and cost effectiveness of different types of screening (e.g. case finding or universal screening) in improving outcomes in antenatal care (among other types of care) (WHO, 2013).

One systematic review of IPV screening in healthcare settings found that while screening increases identification of IPV cases, rates were still low as compared to prevalence estimates. The same review found no evidence of an effect on referrals, re-exposure to violence, or health measures for women that positively screened for IPV but also found no evidence of harm arising from screening (O'Doherty *et al*, 2015). The authors conclude that there is insufficient evidence to justify universal screening in healthcare settings and call for more research into women's long-term wellbeing linked with IPV screening.

An earlier systematic review, completed in 2010, identified limited evidence that screening led to interventions that reduced the amount of IPV experienced by pregnant women, but noted that the number of studies included in the review were small with low numbers of participants (O'Reilly *et al*, 2010). In an editorial, Jewkes (2013) highlights antenatal healthcare as an area where evidence shows potential opportunities for routine screening and where IPV recurrence has been reduced and maternal and infant outcomes have improved—though the author argues that more research into the mechanisms are needed.

Another study was identified that demonstrates a positive effect of IPV screening in antenatal care in South Africa, where measurements of danger were reduced in pregnant women following an IPV screening and voluntary intervention, which included safety planning and strategies to deal with IPV, though this was a relatively short follow up at three months (Matseke & Peltzer, 2013).

Evidence for negative effects of IPV screening in antenatal healthcare

As noted above, a systematic review found no harm to women screened for IPV in the short term (O'Doherty *et al*, 2015). Various other studies have found that women do not object to

screening, including refugee women attending an antenatal clinic in Lebanon (Hammoury & Khawaja, 2007), pregnant women screened for IPV in an antenatal care in Germany (Stöckl *et al*, 2013), and American women with lifetime history of IPV screened in healthcare settings (Swailes *et al*, 2017). However, one study found that 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 (Nelson *et al,* 2012).

Another potential challenge when introducing screening is that the perceptions of healthcare providers about IPV survivors is not always aligned with GBV advocates and best practice in responding to IPV. In one study in Zimbabwe, midwives had divergent views of their role with some perceiving IPV as a non-clinical, social, and domestic problem that they were not required to deal with (Shamu *et al*, 2013). Another study found that physicians hold negative feelings about female survivors of IPV and the majority of those surveyed reported that providing care to survivors of IPV was significant work, difficult to do, low-paying, and stressful (Garimella *et al*, 2002). This study was done in high-resource contexts and these feelings could be exacerbated in lower-resource contexts and in contexts with greater gender inequality. Bott *et al* (2010) also state that many healthcare providers have negative attitudes towards survivors of physical and sexual abuse, noting that it is a reason to take a more cautious approach to routine screening.

There are other potential negative effects of screening on women's access to and the quality of antenatal healthcare, but their effects have not been measured, including:

- reduced attendance at antenatal appointments due to avoidance of questions or IPV due to shame or stigma associated with it.
- reduction in quality or availability of other healthcare offered at antenatal facilities if resources are diverted or absorbed to support IPV screening interventions.

In addition to the issues above, another challenge to screening is that there is a lack of consensus on the types of screening methodology that should be used; Rabin *et al* (2009) carried out a systematic review of IPV screening tools and found that no single tool could be recommended and that more testing and validation of IPV screening tools is needed.

Evidence from resource-limited settings

Most studies on screening for IPV have been undertaken in high-resource settings, specifically Australia, Canada, New Zealand, the UK, and the US.[4] However, one study was identified that investigated the short-term effectiveness of screening in primary healthcare care facilities in South Africa (Matseke & Peltzer, 2013). Other studies on IPV screening have been done in low-resource settings, including Kenya, Zimbabwe, and in Palestinian refugee communities in Lebanon, but they focused on the feasibility and acceptability of screening rather than its effectiveness or the impact on women (Hammoury & Khawaja, 2007; Jhpiego, 2018b; Shamu *et al*, 2013; Undie *et al*, 2014; Vu *et al*, 2017).

[4] 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

Shamu *et al* (2013) note the complexity and difficulty of responding to IPV in antenatal and postnatal care in resource-limited settings, especially when there is inadequate human, financial, and infrastructural resources to support screening. They note specifically that most African health settings do not meet the criteria for comprehensive programmes to respond to IPV due to their weak health systems, lack of infrastructure, and human resources, as well as social norms that prevent discussing IPV.

Reflecting on this conclusion that resource-poor settings in Africa are unsuitable for IPV interventions, it is important to consider the resource implications of the conditions that are required before instituting a screening protocol in antenatal settings, both to ensure that any protocol is successful, but also that it does not displace resources from existing care. Bott *et al* (2010) note that many, if not most, developing country settings lack adequate referral systems necessary for implementing screening.

Prerequisite conditions for IPV screening in antenatal care

Liebschutz *et al* (2008) looked at routine screening from the perspective of IPV survivors and found that while no harms resulted from survivors disclosing their experience of IPV, their experience of disclosing to healthcare practitioners was shaped by the healthcare setting. WHO and International Planned Parenthood Federation (IPPF) have both issued guidance that includes minimum requirements that must be in place before asking about IPV in healthcare settings.

WHO (2013) calls for a protocol/standard operating procedure; training on how to ask and respond; a private setting; confidentiality ensured; and a system for referral in place before screening. In the IPPF guidance, Bott *et al* (2010) list conditions necessary before establishing a routine screening protocol: a clinic must ensure clients' privacy, safety, and confidentiality; healthcare providers have appropriate attitudes and skills; and there are services or referrals available to offer women.

A list of conditions that must be in place prior to establishing a screening protocol are provided below. These have been compiled from available evidence and recommendations found in the literature as well as information provided in the key informant interview. A systematic review on the effectiveness of IPV screening interventions found programmes that incorporated multiple components at multiple levels in the healthcare system tended to have more successful outcomes (O'Campo *et al*, 2001). Therefore, the conditions listed below should not be considered independently, but as composite parts of a comprehensive system.

1) Design intervention in consultation with women

Screening interventions should be designed with the input from women gathered through consultations and focus on women's previous experiences and expectations of antenatal healthcare providers (Bacchus *et al*, 2002).

2) Ensure training of antenatal healthcare providers

Training should be mandatory for those involved in IPV screening interventions (O'Campo *et al*, 2011). Training should include, at a minimum, how to ask about IPV and the response that should be provided to disclosures (Chaudoir & Quinn, 2010; Hamberger & Phelan, 2006; Shamu *et al*, 2013; Spangaro *et al*, 2016; Stöckl *et al*, 2013; WHO, 2013). An initial training

should be held at the outset of the implementation of an IPV screening protocol and be followed with ongoing capacity building for those involved in the intervention (O'Campo *et al*, 2011). Training should include information on the referral pathways and services available to IPV survivors (WHO, 2013). One suggestion is to include service-providing organisations in the training for antenatal healthcare providers (O'Campo *et al*, 2011).

Notably, training and awareness alone are not sufficient conditions for the implementation of a screening protocol (Mezey *et al*, 2003). No evidence was found about the recommended frequency or duration of training.

3) Pilot and contextualize a screening protocol or standard operating procedure

An institutional screening protocol or standard operating procedure should be in place when screening is to be carried out in antenatal healthcare setting (Hamberger & Phelan, 2006; O'Campo *et al*, 2001; WHO, 2013). Effective screening protocols were those that were standardised, included environmental prompts to initiate screening, and provided information on how to assess patient safety, review patient options, and make referrals to other support services (O'Campo *et al*, 2001). One protocol included providing referral information to all women that were screened for IPV, regardless of their answer (Spangaro *et al*, 2011).[5]

4) Allow sufficient time for screening and for follow-up

Antenatal healthcare providers should be provided with sufficient time to both carry out screening and any follow-up actions that are required, which could include making referrals (Bacchus *et al,* 2002; Gutmanis *et al*, 2007; Mezey *et al*, 2003; Stöckl *et al*, 2013). A study in a British antenatal clinic determined that routine inquiry will not be effective if women feel rushed or believe that the midwife does not have enough time to deal with disclosures of violence (Bacchus *et al*, 2002). O'Reilly *et al* (2010) found that recurrent screening throughout pregnancy increases identification rates of cases of IPV suggests that screening may be a dynamic process and involve more than a single appointment or a single screening per patient.

5) Guarantee safety, confidentiality, and privacy

Antenatal care settings that implement IPV screening protocols should ensure they can guarantee the safety of women who disclose IPV, especially from the perpetrator (Bacchus *et al*, 2002; Spangaro *et al*, 2016; WHO, 2013;). Importantly, safety should be understood to include safety from institutional control upon disclosure of IPV, specifically safety from child protective services; in other words, if women are fearful their children will be removed from their care they will not disclose IPV (Spangaro *et al*, 2016).

To ensure confidentiality, a private setting must be available for IPV screening (WHO, 2013).

6) Respect the dignity and agency of women

Women should be protected from feeling shame or stigma upon disclosure of IPV to antenatal healthcare providers (Chaudoir & Quinn, 2010; Spangaro *et al*, 2016). In addition, women should be notified that they do not need to answer questions about IPV and that all patients attending a clinic will be asked (O'Campo *et al*, 2011; key informant interview).

---

[5] An example of components of a screening protocol to be used by healthcare practitioners can be found in Jhpiego's Gender-Based Violence Quality Assurance Tool (Jhpiego, 2018a), available at http://resources.jhpiego.org/system/files/resources/GBV-Quality-Assurance-Tool--EN.pdf

7) Ensure a functioning referral system

To ensure that women experiencing IPV detected through screening are provided with support, an up-to-date referral system should exist to ensure immediate access to services (Mezey *et al*, 2003; O'Campo et al, 2011; Stöckl *et al*, 2013; WHO, 2013). Services to support women experiencing IPV can be at the antenatal clinic or involve referrals to offsite services, though one review found that clinics that had services onsite had the most effective screening programmes (O'Campo *et al*, 2011).

Service providers that should be included in the referral system include mental health services, safe shelters or transitional housing, healthcare, employment assistance, and legal support.

8) Establish institutional support for screening, including financing and leadership

Institutional support for IPV screening includes financial investment, leadership, and specialised support to staff involved in screening interventions. Support for screening protocols at higher levels within institutions promotes an overall culture of IPV awareness and can increase appropriate responses to disclosures (O'Campo *et al*, 2011).

Antenatal healthcare providers should not be expected to operate outside their area of expertise, for example by providing counselling to women who disclose IPV (O'Campo *et al*, 2011). Instead, infrastructure should exist to support frontline staff that are responsible for screening and antenatal healthcare providers should be supported to make appropriate referrals (Mezey *et al*, 2003; Shamu *et al*, 2013). One proposal is to identify a specialist midwife who can manage cases of IPV as they are identified in antenatal services (Mezey *et al*, 2003).

Importantly, sufficient financial resources are required to ensure that the institution can support a screening protocol (Shamu *et al*, 2013). Without sufficient resources, already weak institutions can be overwhelmed by the introduction of universal screening (Jhpiego, 2018a).

Further considerations for antenatal screening initiatives

In addition to the essential conditions above, there are further considerations to be addressed before establishing screening protocols in antenatal care settings.

1. Anticipate and be prepared to address the effect of screening on antenatal healthcare providers

O'Campo *et al* (2011) highlight the effect that screening for IPV can have on healthcare providers, particularly the negative effects on those detecting IPV without sufficient institutional support. One study identified that midwives who had experienced IPV themselves were particularly apprehensive about screening for IPV (Mezey *et al*, 2003), suggesting that support for those involved in screening who are also survivors should be considered in programmatic interventions. In this same study, midwives reported being fearful that they could be putting women at increased risk for violence by asking about IPV and uncomfortable with the secrecy involved in asking women about IPV when they were alone (*Ibid*).

McCormick Hadley (2009) found that healthcare providers are accustomed to providing immediate treatment upon a diagnosis and may find the inability to remedy IPV in the same way frustrating. Researchers also found that midwives became frustrated when women did not take the advice given to reduce their exposure to IPV (Mezey *et al*, 2003).

Waalan *et al* (2000) found that healthcare practitioners were concerned about offending their patients, which affected their use of screening protocols. In a study from Zimbabwe, midwives felt that including the issue of IPV in their provision of care could overwhelm them (Shamu *et al*, 2013).

Recommendations to reduce the negative effects on antenatal healthcare providers include training on how to set professional boundaries and on how to make referrals to other specialist services to prevent antenatal healthcare providers from feeling overwhelmed—or feeling that they needed to both identify and provide additional services to women experiencing IPV (Mezey *et al*, 2003).

2. Ensure a shared understanding of the purpose and value of screening

The purpose of antenatal screening needs to be articulated and understood. Many studies have shown that screening increases the number of cases that are identified, but not that subsequent interventions are effective (Spangaro *et al*, 2009). It is possible that screening itself has a therapeutic effect, but it has not been measured (Spangaro *et al*, 2009). One study in Australia found that an unclear rationale for screening was a barrier to its success (O'Campo *et al*, 2011).

3. Incorporate multiple methods for screening

As noted above, IPV screening interventions that incorporated numerous screening components at multiple levels and had institutional support tended to have more successful outcomes. If a screening protocol is to be established, the most appropriate type of screening, or combination of methods, should be considered for the context. (Examples of available screening tools for humanitarian and development settings are listed in ***Additional Resources*** at the end of this report.)

High quality studies that include randomised control groups found no effects of carrying out computerised screening for IPV alongside the provision of resource lists vs provision of resource lists alone (Klevens *et al,* 2012). Nelson *et al* (2012) found that women are more likely to report IPV through self-administered methods, including computerised screening methods, compared to face-to-face screening. On the other hand, 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. Another study found using *both* in-person and computer-based questionnaires had more success at identifying cases of IPV as opposed to use of only one or the other, potentially because computerised screening allowed disclosure without fear of shame or stigma and in-person screening allows for more flexibility and opportunity build rapport (Dado *et al,* 2012).

4. Address social norms of antenatal institutions and community

The social norms of the institution and community within which antenatal screening will take place should be considered. Institutional leadership and awareness of IPV along with appropriate responses are important to ensuring that antenatal healthcare practitioner responses to disclosures of violence are suitable and not harmful (O'Campo *et al*, 2011). This is particularly important as a positive response to a disclosure of violence may provide positive psychological benefits to the survivor of IPV (Bott *et al*, 2010; Chaudoir & Quinn, 2010).

Another important consideration is whether or not those involved with antenatal healthcare provision are themselves a previous or current perpetrator of IPV or other forms of GBV. No

evidence was found on this topic, but it was raised as a consideration in a key informant interview.

5. Anticipate and be prepared to address unintended consequences of screening

As outlined above, there are potential negative effects of implementing a screening protocol in antenatal settings. The risks of these negative consequences should be weighed and if screening is to be implemented in an antenatal healthcare setting, the risks should be mitigated.

Additional Resources: Examples of tools for GBV screening

International Rescue Committee (IRC)'s ***Screening for Gender-based Violence (GBV) in Primary Health Facilities in Humanitarian Settings: Implementation Guidelines and Recommendations for IRC Programs.*** Available at: https://gbvresponders.org/wp-content/uploads/2015/09/GBVScreening.pdf

Jhpiego's ***Gender-Based Violence Quality Assurance Tool – Minimum Care Version: Standards for the provision of high quality post-violence care in health facilities*** Available at: http://resources.jhpiego.org/system/files/resources/GBV-Quality-Assurance-Tool-Min-Care-Version-EN.pdf

Abuse Assessment Screen (AAS) Available at: http://chipts.ucla.edu/wp-content/uploads/downloads/2012/01/Abuse-Assessment-Screen-_AAS_.pdf

Hurt, insulted, Threatened with Harm and Screamed (HiTS): Domestic violence Screening Tool Available at: https://www.baylorhealth.com/PhysiciansLocations/Dallas/SpecialtiesServices/EmergencyCare/Documents/BUMCD-262_2010_HITS%20survey.pdf

Woman Abuse Screening Tool (WAST) Available at: http://womanabuse.webcanvas.ca/documents/wast.pdf

Partner Violence Screen (PVS) Available at: https://www.michigan.gov/documents/mdch/Partner_Violence_Screen_435069_7.pdf

References

Abma J, Chandra, A, Mosher WB, Peterson, LS & Piccinino LJ (1997) *Fertility, family planning, and women's health: new data from the 1995 National Survey of Family Growth*, Vital and Health Statistics, Series 23, No. 19.

Alhusen, JL, E Ray, P Sharps & L Bullock (2015) *Intimate Partner Violence During Pregnancy: Maternal and Neontal Outcomes*, Journal of Women's Health (24)1: 100-106.

Bacchus, L, G Mezey & S Bewley (2002) *Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service*, BLOG: An International Journal of Obstetrics and Gynaecology, 109(1):9-16.

Barnard M, West-Strumm D, Holmes E, Yang Y & Fisher A (2015) *The Potential for Screening for Intimate Partner Violence in Community Pharmacies: An Exploratory Study of Female Consumers*, Journal of Interpersonal Violence, 33 (6): 960-979.

Bott, S, A Guedes, MC Claramunt & A Guezmes (2010) Improving the Health Sector Response to Gender Based Violence A Resource Manual for Health Care Professionals in Developing Countries. New York: International Planned Parenthood Federation/Western Hemisphere Region.

Burge SK, Schneider FD & Catala S (2005) *Patients' advice to physicians about intervening in family conflict*, Annals of Family Medicine, 3(3):248–254.

Chang JC, Dado D, Hawker L, Cluss PA, Buranosky R, Slagel L, McNeil M & Scholle SH (2010). *Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change*, Journal of Women's Health, 19(2), 251–259.

Chaudoir SR & DM Quinn (2010) *Revealing concealable stigmatized identities: the impact of disclosure motivations and positive first-disclosure experience on fear of disclosure and well-being*, Journal of Social Issues; 66:570-584.

Chuang CH & Liebschutz JM (2005), *Screening for intimate partner violence in the primary care setting: a critical review*, Journal of Clinical Outcomes Management, 9(10):565–571.

Colarossi L, Breitbart V & Betancourt G (2010) *Barriers to Screening for Intimate Partner Violence: A Mixed-Methods Study of Providers In Family Planning Clinics*, Perspectives on Sexual and Reproductive Health, 42(10): 236-245.

Espinosa, L & K Osborne (2002) *Domestic Violence During Pregnancy: Implications for Practice,* Journal of Midwifery & Women's Health, 47(5):305-317.

Feder GS, Hutson M, Ramsay J & Taket AR (2006) *Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals—a meta-analysis of qualitative studies*, Archives of Internal Medicine, 166(1):22–37.

Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, Kuntze S, Spencer A, Bacchus L, Hague G, Warburton A, & Taket A (2009) *How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria*, Health Technology Assessments, 13(16):1– 113 & 137–347.

Garimella RN, Plichta SB, Houseman C & Garzon L (2002) How Physicians Feel about Assisting Female Victims of Intimate Partner Violence. Academic Medicine. [serial online] 77: 1262-1265.

Gutmanis I, Beynon C, Tutty L, Wathen CN & MacMillan HL (2007) *Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses*, BMC Public Health, 7(12):1–11.

Hamberger LK & Phelan MB (2006) *Domestic violence screening in medical and mental health care settings: overcoming barriers to screening, identifying, and helping partner violence victims*, Journal of Aggression, Maltreatment, and Trauma, 13(3/4):61–99.

Hammoury, N & M Khawaja (2007) *Screening for domestic violence during pregnancy in an antenatal clinic in Lebanon*, European Journal of Public Health. 17(6):605-6.

Higgins D, Manhire K & Marshall B (2015) *Prevalence of intimate partner violence disclosed during routine screening in a large general practice,* Journal of Primary Health Care, 7(2):102–108.

Hill, A, C Pallitto, J McClearly-Sills & C Garcia-Moreno (2016) *A systematic review and meta-analysis of intimate partner violence during pregnancy and selected birth outcomes*, Gynecology & Obstetrics. 133(3):269-276.

Jaffee KD, Epling JW, Grant W, Ghandour RM, & Callendar E (2005) *Physician-Identified Barriers to Intimate Partner Violence Screening*. Journal of Women's Health, 14: 713-720.

Jewkes R (2013) *Intimate partner violence: the end of routine screening*, The Lancet, pp 190-191.

Jhpiego (2018a) Gender-Based Violence Quality Assurance Tool – Minimum Care Version: Standards for the provision of high quality post-violence care in health facilities. Jhpiego: Baltimore.

Jhpiego (2018b) Lessons Learned & Results from Integrating Intimate Partner Violence Routine Enquiry into HIV Programming in Mozambique [webinar presentation]. Jhpiego: Baltimore.

Klevens J, Kee R, Trick W, Garcia D, Angula FR, Jones R & Sadowski LS (2012) *Effect of screening for partner violence on women's quality of life: a randomized controlled trial,* JAMA, 308: 681-689.

Liebschutz J, Battaglia T, Finley E & Averbuch T (2008) *Disclosing intimate partner violence to health care clinicians: what a difference the setting makes—a qualitative study*, BMC Public Health, 8(1):229–236.

Matseke, G & K Peltzer (2013) *Screening and brief intervention for intimate partner violence among antenatal care attendees at primary healthcare clinics in Mpumalanga Province, South Africa*, South African Journal of Obstetrics and Gynaecology, 19:2 (40-43).

McLennan JD & MacMillan HL (2016) *Routine primary care screening for intimate partner violence and other adverse psychosocial exposures: what's the evidence?* BMC Family Practice, 17:103

McCormick Hadley S (2009) *How to screen for intimate partner violence*, Minnesota Medicine, 8(1):41–45.

Mezey, G, L Bacchus, A Haworth & S Bewley (2003) *Midwives' perceptions and experiences of routine enquiry for domestic violence in a maternity service*. BJOG: An International Journal of Obstetrics and Gynaecology, 110:744-752.

Miller E, Decker MR, Raj A, Reed E, Marable D & Silverman JG (2010). *Intimate partner violence and health care-seeking patterns among female users of urban adolescent clinics*. Maternal and child health journal, 14(6), 910–917.

Morse DS, Lafleur R, Fogarty CT, Mittal M & Cerulli C (2012). *"They told me to leave": how health care providers address intimate partner violence,* Journal of the American Board of Family Medicine, 25(3), 333–342.

Nelson HD, Bougatsos C & Blazina I (2012) *Screening for intimate partners violence in health care settings: a systematic review to update the US Preventative Services Task Force recommendation*. Ann Intern Med, 156: 796-808.

O'Campo, P, M Kirst, C Tsamis, C Chambers & F Ahmad (2011) *Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review*, Social Science & Medicine; 72:855-866.

O'Doherty L, Hegarty K, Ramsay J, Davidson LL, Feder G, Taft A. *Screening women for intimate partner violence in healthcare settings*. Cochrane Database of Systematic Reviews 2015, Issue 7.

O'Reilly, R, B Beale & D Gillies (2010) *Screening and Intervention for Domestic Violence During Pregnancy Care: A Systematic Review*, Trauma, Violence, & Abuse. 11(4): 190-201.

Quarterman, L (2019) Review of available evidence and guidance on routine screening for gender-based violence in healthcare settings. GBV AoR Helpdesk: London.

Rabin RF, Jennings JM, Campbell JL & Bair-Merritt MH (2009) *Intimate partner violence screening tools: a systematic review*, American Journal of Preventive Medicine, 36(5):439–445.

Rennison CM & Welchans S (2003) *Intimate partner violence, 1993–2001*, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Shamu, S, N Abrahams, M Temmerman & C Zarowsky (2013) *Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe*, Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, 15(5): 511-524.

Spangaro J, Zwi AB, & Poulos R (2009) *The elusive search for definitive evidence on routine screening for intimate partner violence.* Trauma Violence & Abuse, 10(1):55-68.

Stöckl, H, L Hertlein, I Himsl, N Ditsch, C Blume, U Hasbargen, K Friese & D Stöckl (2013) *Acceptance of Routine or Case-Based Inquiry for Intimate Partner Violence: A Mixed Methods Study*, BMC Pregnancy Childbirth. 13:77.

Swailes, L, EB Lehman, JS McCall-Hosenfeld (2017) *Intimate Partner Violence Discussions in the Healthcare Setting: A Cross-Sectional Study*, Preventive Medicine Reports. 8:217-220.

Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L & Feder G (2013) *Screening women for intimate partner violence in healthcare settings*. Cochrane Database of Systematic Reviews, Issue 4.

Taft, AJ, Hooker L, Humphreys C, Hegarty K, Walter R, Adams C, Agius P & Small R (2015) *Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial*, BMC Medicine (2015) 13:150.

Undie C, Maternowska MC, Mak'anyengo M & Askew I (2014) *Is Routine Screening for Intimate Partner Violence Feasible in Public Health Care Settings in Kenya?,* J Interpers Violence, 31(2): 282 – 301.

Waalen J, Goodwin MM, Spitz AM, Petersen R & Saltzman LE (2000) *Screening for intimate partner violence by health care providers: barriers and interventions*, American Journal of Preventive Medicine, 19(4):230–237.

Walton LM, Aerts F, Burkhart H & Terry T (2015) *Intimate Partner Violence Screening and Implications for Health Care Providers*, Online Journal of Health Ethics, 11(1).

Wathen CN & MacMillan HL (2003) *Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care*, CMAJ: 582-584.

WHO (2013) Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines. Geneva: World Health Organization.

Wilson K, Silberberg M, Brown A & Yaggy S (2007) Health Needs and Barriers to Healthcare of Women Who Have Experienced Intimate Partner Violence. Journal of Women's Health; 16(10):1485-1498.

Vu, A, AL Wirtz, S Bundgaard, A Nair, G Luttah, S Ngugi & N Glass (2017) Feasibility and acceptability of a universal screening and referral protocol for gender-based violence with women seeking care in health clinics in Dadaab refugee camps in Kenya. Global Mental Health 4:e21.

Zeitler M, Paine AD, Breitbart V, Ricket VI, Olson C, Stevens L, Rottenberg L & Davidson LL (2006) *Attitudes about intimate partner violence screening among an ethnically diverse sample of young women*, Journal of Adolescent Health, 39(1).

The GBV AoR Help Desk

The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

The GBV AoR Helpdesk
You can contact the GBV AoR Helpdesk by emailing us at:
enquiries@gbviehelpdesk.org.uk
The Helpdesk is available 09.00 to 17.30 GMT Monday to Friday.
Our services are free and confidential.