**Responding to Domestic & Family Violence in Pregnancy - How Can Midwives Help?**

Midwives have an important role in addressing domestic and family violence as a history of violence before pregnancy is one of the strongest predictors of pregnancy violence. For some women, the frequency and intensity of violence often increases during pregnancy. (Baird & Creedy, 2015). A World Health Organisation study involving over 26,000 women across ten low- and middle-income countries concluded that if domestic violence could be reduced by 50%, rates of unintended pregnancy could be reduced by up to 18% and abortion rates by 40% (WHO, 2013).

Closer to home, the Australian Bureau of Statistics (ABS) found that pregnant women are at greater risk. The 2016 Personal Safety Survey (PSS) asked women who had experienced violence from a partner whether they were pregnant at any stage during their relationship, and whether they experienced violence at any point during that pregnancy (ABS 2017b). An estimated two-thirds (68%, or 188,000) of women who experienced violence from a current cohabiting partner were pregnant at some stage during the relationship (Figure 4.4). Of those women, just over 1 in 6 (18%, or 34,500) experienced violence during the pregnancy. One in 20 (5.2%, or 9,800) said that the violence occurred for the first time during pregnancy, although this finding has a high relative standard error and should be interpreted with caution\*. A much higher number of women experienced violence from a previous cohabiting partner during pregnancy. More than 686,000 women who experienced violence from a previous cohabiting partner were pregnant at some stage of their relationship with the perpetrator. Of these women, nearly half (47%, or 326,000) experienced violence during their pregnancy and about one-quarter (24%, or 166,000) experienced violence for the first time during their pregnancy (ABS 2017b). The period following birth is also a time of increased women of domestic violence for women, as parental stress increases while caring for a newborn infant (Baird& Creedy, 2015). However, it not just about pregnancy, worldwide, high levels of fear, control and sexual violence in intimate relationships result in women being unable to negotiate the use of contraception and prevent pregnancies. A study from the United Kingdom by Hall et al, (2014) found women in violent relationships were more likely than other women to terminate a pregnancy and were three times as likely to conceal a termination from their partner.

**Screening during the antenatal period for Domestic and Family Violence**

A Cochrane review (O’Doherty et al., 2015) found that screening by health professionals increased identification of women experiencing intimate partner violence (OR 2.95, 95% CI 1.79 to 4.87, moderate quality evidence) but did not have a clear effect on increasing referrals (low quality evidence). Face-to-face screening was not clearly more effective in women disclosing than written/computer-based techniques (OR 1.12, 95% CI 0.53 to 2.36, moderate quality evidence).

There is now a considerable amount of research regarding the universal screening for domestic and family violence in health settings and in particular the antenatal period during pregnancy (Baird et al., 2015; O’Doherty, 2015). *The Cochrane review on Screening women for intimate partner violence in healthcare settings* aimed to assess the effectiveness of screening within health care settings and to assess if screening causes any harms (O’Doherty et al., 2015). The review concluded that screening does increase the identification of women with experience of IPV within health settings and that pregnant women are more likely to disclose abuse when they are screened. Indeed, routine screening can inform patients that a health care professional or service is ready and willing to discuss domestic violence. It also shifts the onus of responsibility on the woman to disclose by incorporating questions about domestic violence into routine ante-natal or health care. It also reduces barriers to disclosure of abuse such as stigma and offers women access to information and support.

 Although, routine screening has been found to increases disclosures, to date there has been little evidence to suggest that this in turn has led to an increase in referrals to community agencies, or actually reduce the violence which may explain why the uptake of routine screening in the antenatal has been poor (Baird, et al, 2015). In 2015 the Queensland Domestic Violence Task Force (Queensland Government ,2015) recommended improving services for pregnant women and their families, by ensuring that all midwives receive appropriate training and support. It also recommended asking all women attending ante-natal clinics about their exposure to domestic and family violence and providing appropriate referrals if domestic violence is disclosed, however, up to now, this recommendation has not been enacted in every public or private hospital throughout Queensland. In many hospitals, there is a lack of staff training and education, protocols and polices to support universal screening. As a result, responses to a positive disclosure may be responded to in an insensitive and dangerous manner (Baird, et al, 2015).

**How can midwives make a difference?**

Enquiring about domestic and family violence in the antenatal period can still be beneficial, however, if midwives are really to facilitate change in this area, we need to develop better training, screening tools and practice protocols to assist midwives – not just in Queensland, but Australia-wide. This must include an awareness of the needs of ethnic and other minority groups and the development of appropriate inter-agency pathways (Baird & Creedy, 2015).

Maternity services that offer care by the same midwife allow women to form a trusting relationship with their midwife throughout pregnancy, labour and after her child is born. This relationship allows midwives to routinely enquire about the nature of a woman’s relationship, her sense of safety, available support and health education needs. A five-year follow up study of community based midwives in Bristol, United Kingdom, identified that robust and ongoing training and support to use sensitive questioning leads to an increase in knowledge and willingness to screen for domestic violence. All the midwives surveyed reported that enquiring about domestic violence was now a fundamental part of their role. They women they care for are now more likely to disclose they’re in violent relationships (Baird, Salmon & White, 2015).

The development of a reciprocal trusting relationship has been recognised as part of the foundation for enquiry by midwives and other health professionals. Women have identified the importance of the client-health professional relationship when disclosing a history of previous or current abuse. The provision of continuity of care throughout the perinatal period by a known midwife enhances the likelihood of effective routine enquiry across time; and provides opportunities to link women with support services and to bolster their social support network (Eustace et al., 2016).  A lack of continuity of midwifery care has been identified as a barrier to disclosure thereby impacting on the effectiveness and practicable of routine enquiry for domestic violence in pregnancy. A recent study by Spangaro and colleagues suggests how women who elect not to disclose and/or who remain with abusive partners can be assisted through screening interventions, particularly through provision of written information and continuity of care (Spangaro, 2019).

**Summary**

In summary, domestic violence is implicated in poorer maternity and perinatal outcomes, poorer mental and physical health outcomes. Health care professionals including midwives have an important role in screening for and responding to domestic violence. Interventions in the maternity care in both public and private settings to support women in disclosing abuse and seeking help include screening, creating a disclosure friendly environment by the visibility and availability of information and resources. Research evidence indicates that women are receptive to and positive about being screened in health care settings. Some groups of women, including migrant, minority ethnic, and those with no local language skills, require additional provisions to support disclosure and seek help and safety.

The principal policy recommendation is to implement uniform, repeated universal routine screening for domestic violence in all maternity health care settings throughout Queensland, meaning that women will get asked, or screened, on more than one occasion and in at least one setting. This will require a commitment for a systems level change across all maternity hospital settings where the screening can be audited and anonymised data collection can occur in order to begin to collect domestic violence and pregnancy prevalence data. In addition to support the implementation of routine screening, midwifery continuity of care models must be introduced for **all women**, the evidence clearly indicates that women value the opportunity to develop a lasting trusting relationship with a known midwife. The concept of women-centred care has been identified by the World Health Organisation as best practice and an underlying principle to guide the health care response for women who experience domestic violence. This change in practice in many areas of the health services must also be measurable and auditable, with potential for women led input and suggestions. Furthermore, early pregnancy loss, or miscarriages in the care settings of maternity hospitals appears to have no screening for, or protocols in responding to, domestic violence currently: this needs to change with screening, identification and referral procedures put in place.

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Note: \* Should be interpreted with caution due to high relative standard error. Note: A current partner is a person with whom the respondent is married to or lives with in a de facto relationship. A previous partner is a person with whom the respondent was married to or lived with in a de facto relationship in the past. Data about experiences of violence during pregnancy are limited to incidents that occurred while the respondent was living with their previous partner. Source: ABS 2017b.