Evidence evaluation report — Domestic violence

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Prepared by Ampersand Health Science Writing for the Australian Government Department of Health
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PROCESS OF THE REVIEW

Research questions

Screening and enquiry
1. What do health professionals need to do to identify women at risk from domestic violence?
2. Should specific questions be asked as part of the process of routine enquiry?
3. Are there validated screening tests for domestic violence that would be applicable to Australian maternity practice?
4. Is routine enquiry about domestic violence acceptable to women?
5. Is routine enquiry about domestic violence acceptable to health professionals?
6. What do health professionals need to do to identify Aboriginal and Torres Strait Islander women experiencing domestic violence?
7. Is routine enquiry about domestic violence acceptable to Aboriginal and Torres Strait Islander women?
8. Is routine enquiry about domestic violence acceptable to health professionals caring for Aboriginal and Torres Strait Islander women?

Interventions
9. What interventions in a health care setting are effective for assisting women affected by domestic violence?
10. What interventions in a health care setting are effective for assisting Aboriginal and Torres Strait Islander women affected by domestic violence?
11. What interventions can be used to reduce the further incidence and impact of domestic violence for a woman who has disclosed she is in a violent relationship or has recently left a violent relationship?
12. How can antenatal care providers enhance the immediate safety of women in or at risk of violence?

Additional considerations
13. What are the additional considerations for Aboriginal and Torres Strait Islander women?
14. What are the additional considerations for women from culturally and linguistically diverse groups?

Search strategy

Databases searched:
- EMBASE (OVID) and MEDLINE (OVID) and PSYCHINFO (OVID) = 2178
- COCHRANE LIBRARY = 54
- CINAHL = 776
- AUSTRALIAN INDIGENOUS HEALTHINFONET = 46

Date of searches: 05/07/2016

Dates searched: 2008 to present

MEDLINE AND EMBASE AND PSYCHINFO (OVID)
1. Domestic violence/ or Spouse abuse/ or Intimate partner violence/ or Battered women/
2. ((abus$ or batter$ or violen$) adj3 (domestic or partner$ spous$ or wife or wives)).tw.
3. exp Pregnancy/
4. exp Perinatal Care/
5. exp Prenatal Care/
6. (pregnan$ or antepart$ or prenatal$ or antenatal$ or perinatal$ or obstetric$ or maternal$).tw.
7. 1 or 2
8. 3 or 4 or 5 or 6
9. 7 and 8
10. limit 9 to yr="2008 -Current"
11. remove duplicates from 10
COCHRANE LIBRARY
1. MeSH descriptor: [Domestic Violence] this term only
2. MeSH descriptor: [Spouse Abuse] this term only
3. MeSH descriptor: [Intimate Partner Violence] explode all trees
4. MeSH descriptor: [Battered Women] this term only
5. ((abus* or batter* or violen*) near/3 (domestic or partner* spous* or wife or wives)):ti,ab,kw
6. MeSH descriptor: [Pregnancy] explode all trees
7. MeSH descriptor: [Perinatal Care] explode all trees
8. MeSH descriptor: [Prenatal Care] explode all trees
9. (pregnan* or antepart* or prenatal* or antenatal* or perinatal* or obstetric* or maternal*):ti,ab,kw
10. #1 or #2 or #3 or #4 or #5
11. #6 or #7 or #8 or #9
12. #10 and #11
13. #12: Publication Year from 2008 to 2016

CINAHL
1. (MH “Domestic Violence”)
2. (MH “Spouse Abuse”)
3. (MH “Intimate Partner Violence”)
4. (MH “Battered Women”)
5. ((abus* or batter* or violen*) N3 (domestic or partner* spous* or wife or wives))
6. (MH “Pregnancy”)
7. (MH “Perinatal Care”)
8. (MH “Prenatal Care”)
9. (pregnan* or antepart* or prenatal* or antenatal* or perinatal* or obstetric* or maternal*)
10. S1 or S2 or S3 or S4 or S5
11. S6 or S7 or S8 or S9
12. S10 and S11
13. S12: 2008 to current

AUSTRALIAN INDIGENOUS HEALTHINFONET
Title: domestic violence
2008 to current
Exclusion criteria

Full texts of were reviewed and the exclusion criteria outlined below applied.

<table>
<thead>
<tr>
<th>Reason for exclusion</th>
<th>Number of exclusions</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening</td>
<td>Intervention</td>
<td>Additional considerations</td>
</tr>
<tr>
<td>Systematic review of low quality or overlapping with high-quality systematic review</td>
<td>2</td>
<td>2</td>
<td>—</td>
</tr>
<tr>
<td>Study included in high-quality systematic review included in this review</td>
<td>5</td>
<td>12</td>
<td>—</td>
</tr>
<tr>
<td>Background information</td>
<td>30</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Level IV evidence</td>
<td>1</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Duplicate</td>
<td>8</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Not specific to target population (eg specific to non-pregnant women or high-risk women) or health care setting</td>
<td>7</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Does not answer research question</td>
<td>17</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Does not meet criteria for grading (eg no outcomes reported or reporting too limited to establish risk of bias, conference abstract, study protocol)</td>
<td>1</td>
<td>4</td>
<td>—</td>
</tr>
<tr>
<td>Narrative review or opinion paper (editorial, letter, summary, comment, interview)</td>
<td>48</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Not in English</td>
<td>3</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td><strong>Total exclusions</strong></td>
<td><strong>122</strong></td>
<td><strong>33</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

Of 207 studies identified, 157 were excluded and the analysis included 50 studies — 39 for screening, 9 for intervention and 2 for additional considerations. In addition, an Australian Institute of Welfare report on screening was included as specified in the research brief.

Assigning level of evidence

Levels of evidence were assigned using the NHMRC levels and the following definitions.

<table>
<thead>
<tr>
<th>Level</th>
<th>Screening</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>A systematic review of level II studies</td>
<td>Systematic review of level II studies</td>
</tr>
<tr>
<td>II</td>
<td>A randomised controlled trial</td>
<td>A randomised controlled trial</td>
</tr>
<tr>
<td>III-1</td>
<td>Pseudo-randomised controlled trial (ie alternate allocation or some other method)</td>
<td>Pseudo-randomised trial</td>
</tr>
</tbody>
</table>
| III-2 | A comparative study with concurrent controls:  
- Non-randomised, experimental trial  
- Cohort study  
- Case-control study | A comparative study with concurrent controls:  
- Non-randomised experimental trial  
- Cohort study  
- Case-control study  
- Interrupted time series with control group |
| III-3 | A comparative study without concurrent controls:  
- Historical control study  
- Two or more single arm study | A comparative study without concurrent controls:  
- Historical control study  
- Two or more single arm study  
- Interrupted time series without parallel control |
| IV    | Case series | Case series with either post-test or pre-test/post-test outcomes |
Study design definitions

• **All or none** — all or none of a series of people (case series) with the risk factor(s) experience the outcome. The data should relate to an unselected or representative case series, which provides an unbiased representation of the prognostic effect. For example, no smallpox develops in the absence of the specific virus; and clear proof of the causal link has come from the disappearance of smallpox after large-scale vaccination. This is a rare situation.

• **Case series** — a single group of people exposed to the intervention (factor under study). **Post-test** — only outcomes after the intervention (factor under study) are recorded in the series of people, so no comparisons can be made. **Pre-test/post-test** — measures on an outcome are taken before and after the intervention is introduced to a series of people and are then compared (also known as a ‘before-and-after study’).

• **Case-control study** — people with the outcome or disease (cases) and an appropriate group of controls without the outcome or disease (controls) are selected and information obtained about their previous exposure/non-exposure to the intervention or factor under study.

• **Cross-sectional study** — a group of people are assessed at a particular point (or cross-section) in time and the data collected on outcomes relate to that point in time ie proportion of people with asthma in October 2004. This type of study is useful for hypothesis-generation, to identify whether a risk factor is associated with a certain type of outcome, but more often than not (except when the exposure and outcome are stable eg. genetic mutation and certain clinical symptoms) the causal link cannot be proven unless a time dimension is included.

• **Historical control study** — outcomes for a prospectively collected group of people exposed to the intervention (factor under study) are compared with either (1) the outcomes of people treated at the same institution prior to the introduction of the intervention (ie. control group/usual care), or (2) the outcomes of a previously published series of people undergoing the alternate or control intervention.

• **Interrupted time series with a control group** — trends in an outcome or disease are measured over multiple time points before and after the intervention (factor under study) is introduced to a group of people, and then compared to the outcomes at the same time points for a group of people that do not receive the intervention (factor under study).

• **Interrupted time series without a parallel control group** — trends in an outcome or disease are measured over multiple time points before and after the intervention (factor under study) is introduced to a group of people, and compared (as opposed to being compared to an external control group).

• **Non-randomised, experimental trial** — the unit of experimentation (eg. people, a cluster of people) is allocated to either an intervention group or a control group, using a non-random method (such as patient or clinician preference/availability) and the outcomes from each group are compared. This can include:
  — a **controlled before-and-after study**, where outcome measurements are taken before and after the intervention is introduced, and compared at the same time point to outcome measures in the (control) group.
  — an **adjusted indirect comparison**, where two randomised controlled trials compare different interventions to the same comparator ie. the placebo or control condition. The outcomes from the two interventions are then compared indirectly.

• **Prospective cohort study** — where groups of people (cohorts) are observed at a point in time to be exposed or not exposed to an intervention (or the factor under study) and then are followed prospectively with further outcomes recorded as they happen.

• **Pseudo-randomised controlled trial** — the unit of experimentation (eg. people, a cluster of people) is allocated to either an intervention (the factor under study) group or a control group, using a pseudo-random method (such as alternate allocation, allocation by days of the week or odd-even study numbers) and the outcomes from each group are compared.
• **Randomised controlled trial** — the unit of experimentation (eg. people, or a cluster of people) is allocated to either an intervention (the factor under study) group or a control group, using a random mechanism (such as a coin toss, random number table, computer-generated random numbers) and the outcomes from each group are compared.

• **Retrospective cohort study** — where the cohorts (groups of people exposed and not exposed) are defined at a point of time in the past and information collected on subsequent outcomes, eg. the use of medical records to identify a group of women using oral contraceptives five years ago, and a group of women not using oral contraceptives, and then contacting these women or identifying in subsequent medical records the development of deep vein thrombosis.

• **Systematic literature review** — systematic location, appraisal and synthesis of evidence from scientific studies.

• **Two or more single arm study** – the outcomes of a single series of people receiving an intervention (case series) from two or more studies are compared.

Source: NHMRC (2009) NHMRC levels of evidence and grades of recommendations for developers of guidelines.

### Selection of outcomes for GRADE analysis

Outcomes considered for inclusion comprised conditions thought to be associated with family violence in pregnancy. Six outcomes were selected on the basis of clinical impact.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Importance</th>
<th>Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of domestic violence</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Referral</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Sexual abuse and coercion</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Safety planning</td>
<td>9</td>
<td>✔</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>8</td>
<td>✔</td>
</tr>
</tbody>
</table>

**Key:** 1 – 3 less important; 4 – 6 important but not critical for making a decision; 7 – 9 critical for making a decision
Evidence tables

1. Screening

Evidence summary

Results of previous review

Module I of the Guidelines (Australian Health Ministers’ Advisory Council 2012) included:

- a Grade B recommendation — At the first antenatal visit, explain to all women that asking about domestic violence is a routine part of antenatal care and enquire about each woman’s exposure to domestic violence
- and two consensus-based recommendations:
  - Ask about domestic violence when alone with the woman, tailoring the approach to her individual situation and your own skills and experience (e.g. use open-ended questions about her perception of safety at home or use an assessment tool).
  - Be aware that training programs improve the confidence and competency of health professionals in identifying and caring for women experiencing domestic violence.

Results of current review

Definition

Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. The central element is a pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent or by threatening any act that might cause harm or suffering. Domestic violence can include physical, sexual, emotional or psychological abuse. Domestic violence is also referred to as intimate partner violence and family violence.

Note that this review uses the terminology used in individual studies.

Effectiveness of screening for domestic violence

In a Cochrane review assessing the effectiveness of screening for domestic violence in health care settings (O’Doherty et al 2015), analysis suggested increases in identification in antenatal care with screening compared with usual care (OR 4.53, 95% CI 1.82 to 11.27, two RCTs, n=663, moderate quality evidence) but no evidence of an effect for other outcomes (referral, re-exposure to violence, health measures, harm arising from screening).

Face-to-face versus written/computer-based screening

Studies were inconclusive about which method of screening identified more women. The Cochrane review (O’Doherty et al 2015) found that face-to-face screening was not clearly more effective than written/computer-based techniques in identifying women experiencing domestic violence (OR 1.12, 95% CI 0.53 to 2.36, 4 RCTs, n=2,765; moderate quality).

Repeat screening

Two studies found that women acknowledged additional psychosocial risk factors (including domestic violence) if psychosocial screening was repeated (Harrison et al 2011; Kiely et al 2013).

Questions versus validated screening tools

The AIHW review (AIHW 2015) identified the screening questions in use in Australia by state/territory and collated screening questions common to jurisdictions. It also assessed existing screening tools tested in the perinatal context and validated.

The AIHW Screening for Domestic Violence Working Party advised that the preferred approach was to encourage health professionals involved in antenatal care to use a validated screening tool. However, it noted that, for a topic as sensitive and complex as domestic violence, there are reasons to consider other approaches, including whether a flexible approach to screening — as recommended in the consensus-based recommendation in Module I (Australian Health Ministers’ Advisory Council 2012) — could be maintained. Further, the Working Party noted that the reason Module I recommended a flexible approach was that, at the time of writing, evidence that using a screening tool was fundamentally better than having a discussion with a woman was not strong enough (AIHW 2015).
Given a number of issues around data quality, including indirect questioning which may sometimes be ambiguous and lead to vague or unclear responses, the AIHW Working Party did not favour a flexible approach (AIHW 2015).

However, the current review for this module update has not identified any new evidence that would strengthen support for the use of either screening questions or validated tools.

**Acceptability of screening for women**

Studies on the acceptability of screening among women found that they were largely supportive of routine enquiry — being asked was considered acceptable (Roelens et al 2008; Roelens 2010; Spangaro et al 2011b; Lutgendorf et al 2012; Baird et al 2013; Stockl et al 2013; Salmon et al 2015), was considered an important domain of enquiry for health professionals (Rietveld et al 2010; Ben Natan et al 2011; Salmon et al 2015) and women would be willing to disclose if asked (Decker et al 2013). However, women did not always feel able to disclose immediately (Salmon et al 2015). Reasons for not disclosing included not considering the abuse serious enough, fear of the offender finding out and not feeling comfortable with the health professional (Spangaro et al 2010). Beneficial encounters were characterised by familiarity with the clinician, acknowledgement of the abuse, respect and relevant referrals (Liebschutz et al 2008) and direct asking and care (defined as showing interest and a non-judgemental attitude) (Spangaro et al 2016). In one study, women who had experienced child sexual abuse, were younger, less educated, single or divorced and who smoked in pregnancy were less accepting of enquiry (Stockl et al 2013). One study reported that women who had previous contact with statutory agencies valued screening less (Spangaro et al 2011b).

**Acceptability of screening for health professionals**

While studies reported that many health professionals think that screening is important (DeBoer et al 2013), some are reluctant to screen women (Ben Natan et al 2011; Shamu et al 2013). Some studies reported differences in attitudes to screening between different health professional groups — family medicine physicians were less likely to screen women for domestic violence than obstetric/gynaecologic physicians (Pagels et al 2015), sexual health professionals were more confident about routine enquiry than maternity staff (Torres-Vitolas et al 2010) and staff in an obstetrics and gynaecology setting felt more comfortable with screening than those in a general medicine setting (Chang et al 2009).

Factors increasing a health professional’s likelihood of screening women for domestic violence included having previously screened women (Ben Natan et al 2011), having a therapeutic relationship with the woman (LoGiudice 2015), knowledge of a history of prior abuse (Lutgendorf et al 2010), recognising silent cues from women experiencing domestic violence (LoGiudice 2015), having scripted questions (Spangaro et al 2011a), interdisciplinary collaboration (Chang et al 2009; Kulkarni et al 2011; Mauri et al 2015) and access to resources (Chang et al 2009) and referral services (Spangaro et al 2011a).

The most commonly recognised barrier to screening was lack of training (Garcia & Fisher 2008; Chang et al 2009; Lazenbatt et al 2009; Lutgendorf et al 2010; Roelens 2010; Kulkarni et al 2011; Spangaro et al 2011a; DeBoer et al 2013; Shamu et al 2013; Salcedo-Barrientos et al 2014; Baird et al 2015; Infanti et al 2015; Mauri et al 2015). Other barriers identified included:

- variations in timing and the manner in which screening takes place (LoGiudice 2015)
- lack of peer support (Garcia & Fisher 2008), confidence (Lazenbatt et al 2009) or continuity of care (Lauti & Miller 2008)
- presence of the woman’s partner (LoGiudice 2015)
- women’s unwillingness to disclose (Mauri et al 2015)
- time constraints (Chang et al 2009; Lutgendorf et al 2010; Roelens 2010)
- cultural taboos (Mauri et al 2015)
- health professional attitudes to violence (Ben Natan et al 2011; Salcedo-Barrientos et al 2014)
- concerns about privacy and confidentiality (Lauti & Miller 2008)
- uncertainty regarding management and referral options (Lutgendorf et al 2010; LoGiudice 2015)
- need for debriefing (Lauti & Miller 2008), guidelines and employer support (Finnbogadottir & Dykes 2012).
Additional information

Prevalence

Based on the 2012 Personal Safety Survey, the ABS estimates that 17% (1,479,900) of all women (aged 18 and over) had experienced partner violence (that is, either physical or sexual assault or threat from either a current or previous partner) since the age of 15 (ABS 2013).

The 2012 Personal Safety Survey provides the following statistics for previous partner violence and current partner violence in relation to pregnancy status (ABS 2013):

• In terms of previous partner violence, approximately 768,800 (of the 1,267,200 women who experienced violence by a previous partner) were pregnant at some time during the relationship with their most recently violent previous partner. Of these, 54% (414,600) of women were pregnant at the time of the violence. Twenty-five per cent (25%) (195,500) reported that violence occurred for the first time during the pregnancy.

• In terms of current partner violence, approximately 180,600 (of the 237,100 women who experienced violence by a current partner) were pregnant at some time during the relationship. Of these, 22% (39,100) of women were pregnant at the time of the violence. Thirteen per cent (13%) (24,000) reported that violence occurred for the first time during pregnancy (these data have a relative standard error of between 25% and 50% and should be used with caution).

Based on data derived from the 2012 PSS, a prevalence rate for women (aged 18 and over) experiencing violence during pregnancy from their previous or current partner is estimated to be in the order of 5%, though, as indicated above, the data are based on self-report and may not represent true prevalence.

Few data are available on domestic violence during pregnancy in Indigenous populations. However, the NSW Bureau of Crime Statistics and Research reported that Indigenous women are vastly over-represented as victims of domestic violence, with the rate of domestic violence for Indigenous women (3,275 per 100,000) being almost 6 times higher than that for non-Indigenous women (544 per 100,000) between 2001 and 2010 (Grech K & Burgess M 2011). Further, the Aboriginal Families Study (a population-based survey of mothers of Aboriginal babies giving birth in South Australia between July 2011 and June 2013) identified that of the 344 mothers participating in the study 27% had left their home during pregnancy because of a family argument or fight and 16% reported that they had been pushed, shoved or assaulted during pregnancy (Brown et al 2015).

Advice to EWG

The recommendation on universal screening included in Module I remains current.

The evidence remains inconclusive on the way in which to screen. The EWG could elect to make a consensus-based recommendation allowing flexibility (as per Module I) or follow the preferences of the AIHW Screening for Domestic Violence Working Party and include a consensus-based recommendation that suggests that all health professionals involved in antenatal care use either a set of questions (eg those common to jurisdictions; see page 22) or a validated tool (eg HARK or HITS; see page 24).

The consensus-based recommendation on training for health professionals remains current.

Evidence statements

Universal screening for domestic violence versus usual care

• Identification of domestic violence in any health care setting and in antenatal clinics was higher when women were universally screened than with usual care (moderate quality evidence).

• There was no evidence for an effect on referrals (low quality evidence).

Face-to-face screening versus written/computer-based screening for domestic violence

• There was no significant difference in identification of domestic violence between the two approaches (moderate quality evidence).

Draft recommendation

At the first antenatal visit, explain to all women that asking about domestic violence is a routine part of antenatal care and, in private, enquire about each woman’s exposure to domestic violence.
**Consensus-based recommendations**

Ask about domestic violence when alone with the woman, utilising the tool used in your state/territory, the questions listed above or a validated screening tool (e.g., HARK, HITS).

Be aware that training programs improve the confidence and competency of health professionals in identifying and caring for women experiencing domestic violence.
**Summary of findings**

**Screening for intimate partner violence (IPV) versus usual care**

**Patient or population:** women attending healthcare for any health-related reason  
**Setting:** Health care  
**Intervention:** face-to-face screening or written/computerised screening  
**Comparison:** usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Anticipated absolute effects* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>% of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Identification of IPV by health professionals (assessed immediately or up to 1 month) | Identification with usual care: 17 per 1,000  
Identification with universal screening: 48 per 1,000 (30 to 78) | OR 2.95 (1.79 to 4.87) | 10,074 (8 RCTs) | ⊗⊗⊗◯ | MODERATE ¹ |
| Identification in antenatal clinics | 17 per 1,000  
74 per 1,000 (31 to 166) | OR 4.53 (1.82 to 11.27) | 663 (2 RCTs) | ⊗⊗⊗◯ | MODERATE ² |
| Referrals (assessed immediately) | 5 per 1,000  
12 per 1,000 (3 to 41) | OR 2.24 (0.64 to 7.86) | 1,298 (2 RCTs) | ⊗⊗◯◯ | LOW ³ |

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; IPV: intimate partner violence; OR: Odds ratio

**GRADE Working Group grades of evidence**

**High quality:** We are very confident that the true effect lies close to that of the estimate of the effect

**Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

**Low quality:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

**Very low quality:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

¹ Downgraded due to heterogeneity.

⁻ Downgraded due to imprecision.

³ Downgraded due to imprecision and risk of bias.

Source: Adapted from (O’Dohearty et al. 2015).
### Face-to-face screening versus written/computer-based screening for IPV

**Patient or population:** women attending healthcare for any health-related reason  
**Setting:** health care  
**Intervention:** face-to-face screening  
**Comparison:** written/computerised screening

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Anticipated absolute effects* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>% of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of IPV (non-clinically based, assessed immediately)</td>
<td></td>
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</tr>
<tr>
<td>Written/computer-based screening</td>
<td>126 per 1,000 (71 to 254)</td>
<td>OR 1.12 (0.53 to 2.36)</td>
<td>2.765 (4 studies)</td>
<td>⬤⬤⬤◯</td>
<td>MODERATE ¹</td>
</tr>
<tr>
<td>Face-to-face screening</td>
<td>139 per 1,000</td>
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</tbody>
</table>

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).  
CI: Confidence interval; IPV: intimate partner violence; OR: Odds ratio

**GRADE Working Group grades of evidence**  
**High quality:** We are very confident that the true effect lies close to that of the estimate of the effect  
**Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different  
**Low quality:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect  
**Very low quality:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

¹Downgraded due to heterogeneity.

Source: Adapted from (O’Doherty et al 2015).
### 1.1 What do health professionals need to do to identify women at risk from domestic violence?

**Effectiveness of screening**

<table>
<thead>
<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
<th>Aim/setting/population/methods</th>
<th>Findings</th>
</tr>
</thead>
</table>
| [O'Doherty et al 2015]     | SLR          | I   | 13 trials: 14,959 women 2 RCTs relevant to antenatal care; 663 women | **Aim:** To assess the effectiveness of screening for intimate personal violence (IPV) conducted within healthcare settings on identification, referral, re-exposure to violence, and health outcomes for women, and to determine if screening causes any harm. | *Primary outcomes*  
Analyses suggested increases in identification in antenatal care (OR 4.53, 95% CI 1.82 to 11.27, two RCTs, n=663, moderate quality evidence).  
There was no evidence of an effect for other referral (OR 2.24, 95% CI 0.64 to 7.86; n=1,298; 2 RCTs).  
See Summary of Findings table; page 13

*Secondary outcomes*  
There was no evidence of effect for re-exposure to violence — at 3 mth OR 0.86 (95% CI 0.39 to 1.92, n=344) at 18 mth OR 0.88 (95% CI 0.43 to 1.82); health measures — physical health: (MD 1.57 [95% CI -0.59 to 3.73, n=707); depression: (MD -1.97 [95% CI -4.33 to 0.39], post-traumatic stress disorder (OR 0.63, 95%CI 0.36 to 1.10); mental health in general: mean improvement of 1.05 in SF-12 scores (95%CI -1.70 to 3.79); quality of life (WHO Quality of Life-Bref) (MD 2.29, 95%CI -1.71 to 6.28); alcohol problems (OR 1.23, 95% CI 0.62 to 2.44), drug problems (OR 0.83, 95%CI 0.41 to 1.71); harm arising from screening (ORs not reported). |
### Face-to-face screening versus written/computer-based screening

<table>
<thead>
<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
<th>Aim-setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(O’Doherty et al 2015)</td>
<td>SLR</td>
<td>I</td>
<td>4 studies relevant to approach to screening</td>
<td>We combined the two groups of women that had computer- or paper-based screening and compared them to the women who had the face-to-face screening on the Partner Violence Screen.</td>
<td>Neither face-to-face screening nor written/computer-based techniques were favoured for identifying abused women (OR 1.12, 95% CI 0.53 to 2.36, four studies, n=2765; moderate quality). See Summary of Findings table; page 14</td>
<td></td>
</tr>
<tr>
<td>(AIHW 2015)</td>
<td>SLR</td>
<td>I</td>
<td>—</td>
<td>Not described</td>
<td>Some studies find regular face-to-face screening of women by skilled health-care providers greatly increases the detection of domestic violence, whereas others show that self-administered questionnaires (written, audio or computer-based) may be superior.</td>
<td></td>
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</tbody>
</table>
| (Svavarsdottir 2010) | Cohort       | III-2 | 208         | **Aim:** To evaluate the effectiveness of two screening procedures/methods, a self-reporting questionnaire and an interview, in detecting women abuse within an emergency department (ED) and a high-risk prenatal care clinic (HRPCC).  
**Setting:** Iceland  
**Population:** Women seeking health-care services at an ED (n=101) and pregnant women in their first trimester attending a HRPCC (n=107).  
**Methods:** Two methods were used, a self-reporting instrument and a face-to-face interview with a nurse or a midwife to compare the frequency of women’s disclosure of abuse. | A variety of prior and current abuse experiences were disclosed by each method. The women however disclosed physical abuse more often in the face-to-face interview. The women at the HRPCC disclosed the same ratio of emotional and sexual abuse regardless of the method used.  
Contradictory to what has previously been reported in the literature, there were no clear-cut results found regarding which of the methods were more effective in revealing abuse; rather, for some of the women, disclosure was based on a combination of the two methods used and the type of abuse inquired about. |                                                                                                                                                                                                         |
<table>
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<tr>
<th>Study ref</th>
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<th>LoE</th>
<th>Sample size</th>
<th>Aim/setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
</table>
| (Chang et al 2012) | Cohort       | III-2 | 250 women; 52 providers | **Aim:** To compare in person versus computerized screening for intimate partner violence (IPV) in a hospital-based prenatal clinic and explore women's assessment of the screening methods.  
**Setting:** United States  
**Population:** Women in hospital-based antenatal care  
**Methods:** We compared patient IPV disclosures on a computerized questionnaire to audio-taped first obstetric visits with an obstetric care provider and performed semi-structured interviews with patient participants who reported experiencing IPV. | Ninety-one (36%) patients disclosed IPV either via computer or in person. Of those who disclosed IPV, 60 (66%) disclosed via both methods, but 31 (34%) disclosed IPV via only one of the two methods. Twenty-three women returned for interviews. They recommended using both types together. While computerized screening was felt to be non-judgmental and more anonymous, in person screening allowed for tailored questioning and more emotional connection with the provider. opportunity for interpersonal rapport. |                                                                                                                                                                                                                       |
<table>
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<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
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<th>Aim/setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
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</table>
| (Kiely et al 2013) | Cohort       | III-2 | 1,044       | **Aim**: to examine the added benefit of repeated screening over a one-time screen in identifying risks during pregnancy.  
**Setting**: United States  
**Population**: African-American pregnant women  
**Methods**: Data were collected as part of a randomized controlled trial to address intimate partner violence, depression, smoking and environmental tobacco smoke exposure. Mothers were classified by their initial response (acknowledgement of risks) and updated during pregnancy. Risks were considered new if they were not previously reported. Standard hypothesis tests and logistic regression were used to predict acknowledgment of any new risk(s) during pregnancy. | Repeated screening identified more mothers acknowledging risk over time. Reported intimate partner violence increased by 9%. The psychosocial variables collected at the baseline that were entered into the logistic regression model included relationship status, education, Medicaid, illicit drug use, and alcohol use during pregnancy. Among these, only education less than high school was associated in acknowledgement of new risk in the bivariate analyses and significantly predicted identification of new risks (OR=1.39, 95%CI, 1.01-1.90). |          |
<table>
<thead>
<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
<th>Aim/setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
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</thead>
</table>
| (Harrison et al 2011) | Cohort | III-2 | 708 | **Aim:** to assess the extent to which risk factors unreported during an intake interview were identified during a subsequent interview.  
**Setting:** United States  
**Population:** pregnant women — predominantly young (mean age 23.5 years), unmarried (75.1%) women of color (92.5%); 38.4% were foreign-born  
**Methods:** women were screened and re-screened at three urban community health care centers between July 2007 and April 2010. | For the Partner Violence and Physical/Sexual Abuse by a Non-partner domains, the proportions who answered No to the initial PRO and Yes to the second PRO were higher for all six questions for the 12-month pre-pregnancy awareness interval (range 0.6%–2.1%) than for the post-pregnancy awareness interval (range 0.4%–1.5%) although these differences were small. |          |

### 1.2 Should specific questions be asked as part of the process of routine enquiry?

<table>
<thead>
<tr>
<th>State/territory</th>
<th>Questions</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Questions currently in use in Australia (AIHW 2015)</strong></td>
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</tbody>
</table>
| NSW | 1. Within the last year, have you been hit, slapped or hurt in other ways by your partner or ex-partner?  
2. Are you frightened of your partner or ex-partner?  
3. Are you safe to go home when you leave here?  
4. Would you like some assistance with this?  
If a woman answers no to the first two questions, no further questions are asked. | New South Wales policy documents indicate that all pregnant women should be routinely screened for DV, with questions being asked at the first antenatal visit. |
<table>
<thead>
<tr>
<th>State/territory</th>
<th>Questions</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Victoria        | 1. Are you ever afraid of someone in your family or household? If so, who?  
2. Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?  
3. Has someone in your family or household ever threatened to hurt you?  
4. Has someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?  
5. Are you worried about your children or someone else in your family or your household?  
6. Would you like help with any of this now?  
| In Victoria, routine screening is not currently implemented but screening is undertaken using a risk-based approach. |
| Queensland      | 1. Are you ever afraid of your partner or ex-partner?  
2. In the last year, has anyone at home hit, kicked, punched or otherwise hurt you?  
3. In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do?  
4. In the last year, has your partner or ex-partner threatened to hurt you?  
5. Has your child/children been hurt or witnessed violence between you and your partner or ex-partner?  
7. Are you safe to go home when you leave here?  
8. Are you worried about your child’s/children’s safety?  
9. Would you like help with any of this now?  
10. This could be important information for your health-care providers. May we send a copy of this form to your doctor or primary maternity carer?  
Questions 7–10 are asked only if patients answer ‘yes’ to any of the first 6 questions.  
| While Queensland has not previously had a widely used tool that is specific to pregnancy, a Domestic Violence Risk Assessment Questionnaire for use in pregnancy has been trialled by Queensland Health at the Royal Brisbane and Women’s Hospital; it is intended for routine screening. |
| Western Australia | 1. Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?  
2. Has someone in your family or household ever hurt or threatened to hurt you?  
3. Are you worried about the safety of your children or someone else in your family or your household?  
4. Would you like help with any of this now?  
<p>| Western Australia does not have a dedicated screening tool for DV that is specific to pregnancy; however, it does have a Common Screening Tool that is recommended for use in a variety of health and other settings. |</p>
<table>
<thead>
<tr>
<th>State/territory</th>
<th>Questions</th>
<th>Comments</th>
</tr>
</thead>
</table>
| South Australia | 1. Is your relationship with your partner an emotionally supportive one?  
2. Have you had any stresses, changes or losses in the last 12 months (for example, separation, domestic violence, unemployment, bereavement)?  
3. Have you ever been sexually or physically abused?  
Women who answer ‘yes’ to the third question are considered high risk irrespective of their total ANRQ score. | South Australia does not have a dedicated screening tool for DV that is specific to pregnancy; however, for women who have a fully completed hand-held pregnancy record, there should be a score for the AnteNatal Risk Questionnaire (ANRQ), which includes some questions that are relevant to screening for domestic violence, with one component relating to a woman’s past history of physical (including DV), sexual or emotional abuse. |
| Tasmania | 1. Have you been hit, slapped or hurt by partner or ex in last 12 months?  
2. Are you ever frightened by your partner or ex-partner?  
3. Does your partner have an AVO [apprehended violence order] against them? If ‘yes’ can you provide a copy?  
If a woman responds ‘yes’ to Question 2 above, the following questions are also asked:  
1. Are you safe to go home when you leave here?  
2. Would you like some assistance with this? | Tasmania does not have a dedicated screening tool for DV that is specific to pregnancy, however there are some questions on ObstetrixTas (the computerised recording system used by public hospitals) for DV. |
| ACT | The Australian Capital Territory does not have a dedicated screening tool for DV that is specific to pregnancy. No screening tool was identified as being used in other health-care settings. | |
| NT | 1. Are you ever afraid of your partner or someone in your family?  
2. In the last year, has your partner or anyone in your family hit, kicked, punched or hurt you?  
3. In the last year, has your partner or your family often put you down, made you feel ashamed or tried to control what you do?  
4. In the last year, has your partner or anyone in your family threatened to hurt you in any way?  
5. In the last year, has your partner or anyone in your family made you have sex when you didn’t want to?  
6. Would you like help with any of this now? | The Northern Territory has implemented routine antenatal screening for DV, with data being collected at the first visit and/or second trimester visit. |
<table>
<thead>
<tr>
<th>State/territory</th>
<th>Questions</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Screening questions common to jurisdictions | 1. Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? OR (in the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?  
2. Are you (ever) afraid of your partner or ex-partner (or someone in your family)?  
3. (In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do?  
4. (In the last year), has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)?  
5. Would you like help with any of this now? |  |

**Evidence on questions from other studies**

<table>
<thead>
<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
<th>Aim/setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
</table>
| (Kataoka et al 2016) | Cross-section | IV | 84 | **Aim:** to estimate the prevalence of IPV among before and during pregnancy.  
**Setting:** Japan  
**Population:** Pregnant women  
**Methods:** A survey was conducted at a hospital’s outpatient clinic, during October through December 2011 and March through July 2012. The Violence Against Women Screen (VAWS) questionnaire was distributed to 93 eligible women and 84 (89.5%) agreed to be assessed for the occurrence of IPV before and during pregnancy. | The mean VAWS total score was 1.43 (standard deviation [SD]=1.64; range, 0–7) before pregnancy and 0.83 (SD = 1.03; range, 0–6) during pregnancy (P<0.001). In addition, more women experienced IPV before (34.9%) than during pregnancy (20.7%). All women who screened positive during pregnancy were also positive before pregnancy. Prevalence of intimate partner physical violence was 4.9% prior to pregnancy and declined to 3.7% during pregnancy.  
IPV screening questions should include IPV that had occurred a year prior. | Question regarding violence in the previous year included in Australian questions |
1.3 Are there validated screening tests for domestic violence that would be applicable to Australian maternity practice?

**HITS and HARK tools**

<table>
<thead>
<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
<th>Aim/setting/population/methods</th>
<th>Findings</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>(AIHW 2015)</td>
<td>SLR</td>
<td>I</td>
<td>—</td>
<td>A review of some existing validated tools was undertaken. While there are many tools that can screen for DV, the review undertaken for this project was limited to tools most relevant to the perinatal context that had undergone some validation. For a tool to be considered, it needed to have been tested within a health-care setting and used in a perinatal context (either in part or full). Ten tools were reviewed, as listed below: • Abuse Assessment Screen • Humiliation, Afraid, Rape, Kick (HARK) Screen • Hurt, Insult, Threaten, Scream (HITS) Screen • Ongoing Abuse Screen • Ongoing Violence Assessment Tool • Partner Violence Screen • Slapped, Thrown and Threatened Screen • Woman Abuse Screen Tool (WAST) • WAST—Short • Women’s Experience with Battering Scale.</td>
<td>The HITS and HARK tools were both considered potentially useful to recommend for routine screening of women of childbearing age by the United States Preventative Services Task Force and cover a number of domains of DV. Both can give clinicians a clear picture of whether a woman is experiencing DV or not. See table below for details on these tools. Bolded questions are either used by one or more Australian jurisdictions, or a jurisdiction asks a very similar question.</td>
<td>Note that a systematic review of intimate partner violence screening tools found that no single screening tool for intimate partner violence had well-established psychometric properties and that further testing and validation are critically needed.</td>
</tr>
<tr>
<td>Screening tool</td>
<td>Collection method</td>
<td>No of questions and domain assessed</td>
<td>Populations studied</td>
<td>Questions, response categories, scoring procedures and notes</td>
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</table>
| Humiliation, Afraid, Rape, Kick (HARK) Screen | Self report       | Four items assess physical, sexual and emotional abuse by a partner or ex-partner within the last year. | Woman in general practice waiting rooms in the United Kingdom | (1) Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?  
(2) Within the last year, have you been afraid of your partner or ex-partner?  
(3) Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?  
(4) Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?  
Response categories: Yes/no for all questions  
Scoring procedure: If any questions on the screen are answered affirmatively, the HARK is considered positive for abuse. |
| Hurt, Insult, Threaten, Scream (HITS) Screen | Self-report or clinician administered | Four items assess the frequency of physical or emotional abuse by a partner. | Female patients in family practice settings; male patients in healthcare settings | (1) How often does your partner physically hurt you?  
(2) How often does your partner insult you or talk down to you?  
(3) How often does your partner threaten you with harm?  
(4) How often does your partner scream or curse at you?  
Response categories: Each question is answered on a 5-point scale:  
1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently  
Scoring procedure: Responses are summed to form a total HITS score which can range from 4 to 20. For female patients, a HITS cut-off score of 10 or greater can be used to classify participants as victimised. |

Source: (AIHW 2015)
### Abuse Assessment Screen

<table>
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<tr>
<th>Study ref</th>
<th>Study design</th>
<th>LoE</th>
<th>Sample size</th>
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<th>Findings</th>
<th>Comments</th>
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</table>
| (Antoniou et al 2010) | Validation study | — | 262 | **Aim:** to translate, culturally adapt and validate a special research tool that can be used by health professionals as a diagnostic tool for violence during pregnancy.  
**Setting:** Greece  
**Population:** pregnant women  
**Methods:** The Abuse Assessment Screen (AAS) questionnaire was translated into Greek followed by the cultural adaptation of the questionnaire to the Greek reality. Specific psychometric tests were used for the validation of the questionnaire in order to assess the questionnaire’s reliability and validity, and a factor analysis was also carried out. | The internal consistency for all the parties who were questioned, as expressed by Cronbach’s alpha coefficient for the AAS, was 0.806 which is quite satisfactory and the results of our study suggest that the Greek translation of the AAS has a high correlation index compared to relevant international studies. | May be applicable to subgroups of the Australian population |
| (Escriba-Aguir et al 2016) | Validation study | — | 1,329 | **Aim:** To assess the reliability, accuracy, and construct validity of the Spanish Abuse Assessment Screen (AAS) among pregnant women using the Spanish version of Index of Spouse Abuse (ISA) as a reference standard.  
**Setting:** Spain  
**Population:** pregnant women  
**Methods:** The Spanish ISA was self-administered first, followed by the AAS, administered by the midwife. Sensitivity, specificity, and predictive values of the Spanish AAS were compared with the Spanish version of the ISA as a reference standard. | Percentage of agreement between initial and retest administration of the Spanish AAS was high, from 96.4% to 100%. Specificity was for all types of abuse above 97%, but sensitivity values were much lower (33.3%, 22.9%, 6.9%, for severe physical abuse, minor psychological abuse, and minor physical abuse, respectively). The sensitivity of severe psychological abuse was perfect. Construct validity was good. | May be applicable to subgroups of the Australian population |
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<th>Study ref</th>
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<tbody>
<tr>
<td>(Fisher et al 2014)</td>
<td>Validation study</td>
<td>—</td>
<td>783</td>
<td><strong>Aim</strong>: to examine the validity of the Intimate Bonds Measure (IBM)</td>
<td>Exploratory factor analyses revealed an identical factor structure to the one reported by the measure's developers in an Anglophone Australian population more than 20 years ago. The two factors replicate exactly the Care and Control subscales and Cronbach's alpha (from 0.68 to 0.83) indicates high internal consistency in both sub-scales. Mean scores of the Care-V and Control-V sub-scales were associated significantly and in expected directions with whether a woman could confide in, felt supported by or was frightened of her partner, or had experienced intimate partner violence and measures of mental health status.</td>
<td>May be applicable to subgroups of the Australian population</td>
</tr>
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**Intimate Bonds Measure**

- **Aim**: to examine the validity of the Intimate Bonds Measure (IBM)
- **Setting**: Vietnam
- **Population**: women who were pregnant or had recently given birth
- **Methods**: The IBM was translated and culturally verified in a step-by-step process with Vietnamese health workers, researchers and community members. The validation study was nested within two larger community-based cross-sectional investigations: the first in 2006, which recruited 199 pregnant women and 165 mothers of newborns, and the second in 2010, which recruited 419 pregnant women. Internal structure was assessed by factor analysis and Cronbach's alpha and construct validity by comparison with relevant factors.
### 1.4 Is routine enquiry about domestic violence acceptable to women?

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<tr>
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<th>Comments</th>
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</table>
| (Decker et al 2013)| Cohort       | III-2 | 32 interviews; data from 1,038 surveys | **Aim**: to describe violence-related coping and help-seeking, and preferences for health care based intervention  
**Setting**: India  
**Population**: perinatal women residing in low-income communities  
**Methods**: Indepth interviews were conducted with women who had recently given birth and self-reported recent violence from husbands, followed by survey data collection from mothers seeking immunization for their infants ages 6 months or younger at three large urban health centers. | Qualitative and quantitative findings indicated that formal help-seeking is uncommon and that informal help sources are most frequently sought.  
Quantitative results revealed that, while few (<5%) women had been screened for violence in the health care setting, most (67%) would be willing to disclose abuse if asked.  
When presented with a list of possible clinic-based violence support interventions, participants endorsed crisis counseling and safety planning as most helpful (90.9%). |----------|
| (Liebschutz et al 2008) | Cross-section | IV  | 27 | **Aim**: to understand the risks and benefits of disclosing IPV to clinicians across specialties.  
**Setting**: United States  
**Population**: English-speaking female IPV survivors  
**Methods**: In-depth interviews describing medical encounters related to abuse were analyzed for common themes. Encounters with health care clinicians were categorized by outcome (IPV disclosure by patient, discovery evidenced by discussion of IPV by clinician without patient disclosure, or non-disclosure), attribute (beneficial, unhelpful, harmful), and specialty (emergency department (ED), primary care (PC), obstetrics/gynecology (OB/GYN)). | Seven of 9 ED disclosures were characterized as unhelpful; the majority of disclosures in PC and OB/GYN were characterized as beneficial. There were no harmful disclosures in any setting.  
Unhelpful disclosures resulted in emotional distress and alienation from health care.  
Regardless of whether disclosure occurred, beneficial encounters were characterized by familiarity with the clinician, acknowledgement of the abuse, respect and relevant referrals. |----------|
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| (Lutgendorf et al 2012) | Cohort       | III-2 | 461         | **Aim**: to estimate the self-reported prevalence of domestic violence and to determine the acceptability of domestic violence screening.  
**Setting**: United States  
**Population**: a pregnant military population presenting for emergency obstetric care  
**Methods**: Women were anonymously screened for domestic violence using the Abuse Assessment Screen. | The majority of women 91.8% (95% CI=88.7-94.2) were not offended by domestic violence screening and 88.8% (95% CI=82.0-88.9) felt that patients should be routinely screened. |                                                                                                                                                                                                 |
| (Rietveld et al 2010) | Cross-section | IV    | 200 (82 pregnant) | **Aim**: to investigate the prevalence of IPV among patients of an out-patient clinic obstetrics gynecology, association with level of education, and women's opinion on asking about IPV by physicians.  
**Setting**: The Netherlands  
**Population**: women between 18 and 60 years in a waiting room of an out-patient obstetrics gynecology clinic  
**Methods**: We surveyed the women and used the Composite Abuse Scale to measure type and severity of IPV. | 78% of the respondents found it important for physicians to ask about IPV. | Prevalence of IPV:  
- Ever: 23%  
- Current: 9%  
- Current in pregnant women: 5%  
- Higher among women with a lower educated partner. |
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<th>Study ref</th>
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<tr>
<td>(Roelens et al 2008)</td>
<td>Cohort</td>
<td>III-2</td>
<td>537</td>
<td><strong>Aim:</strong> to estimate the prevalence of physical and sexual intimate partner violence (IPV) — lifetime, 1-year period before pregnancy and during the index pregnancy; to assess the rates of disclosure and help-seeking behaviour with IPV; and to determine the acceptability of screening for IPV. <strong>Setting:</strong> Belgium <strong>Population:</strong> pregnant women attending five large hospitals (mean age 29.4 years, S.D. 4.09) <strong>Methods:</strong> Data were collected through an anonymous, written questionnaire that included the AAS and additional questions on the circumstances of the most recent episode of physical or sexual violence, on disclosure and help-seeking behaviour, on reporting assault to the police, and on the acceptability of routine screening for IPV.</td>
<td>There was a significant difference in the reported lifetime prevalence of IPV between women attending with a partner and those who came to the prenatal visit unattended by their partner (6.8% versus 13.9%, p=0.010). Overall, only 19.2% (23 out of 120) and as few as 6.6% (4 out of 61) of the victims of physical and sexual abuse respectively sought medical care by consulting a general practitioner, gynaecologist, or an emergency department. Routine screening for IPV by a general practitioner or gynaecologist was found to be largely acceptable.</td>
<td>The lifetime prevalence of IPV was estimated to be 10.1% (95% CI 7.7-13.0%) and the period prevalence of IPV during pregnancy and/or in the year preceding pregnancy 3.4% (95% CI 2.1-5.4%).</td>
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<td>(Roelens 2010)</td>
<td>Cross-section</td>
<td>IV</td>
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<td><strong>Aim:</strong> To explore attitudes of women and health professionals towards screening for domestic violence <strong>Setting:</strong> Belgium <strong>Population:</strong> pregnant women <strong>Methods:</strong> a questionnaire-based surveillance study among pregnant women constituting a regional probability sample and a questionnaire based Knowledge-Practice and Attitude Survey among obstetricians/gynaecologists were conducted.</td>
<td>We estimated that IPV occurred overall with one in ten women (10.1%, 95% CI 7.7-13.0%) and with about one in 30 women (3.4%, 95% CI 2.1-5.4%) during pregnancy and/or in the year preceding pregnancy. We also revealed that women experiencing IPV rarely disclose abuse spontaneously to the widely available health care services and providers, but in general approve routine questioning by their GP or gynaecologist.</td>
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| (Salmon et al 2015) | Cohort | III-2 | 236 | **Aim**: to explore the acceptability of antenatal enquiry for domestic abuse and to understand the experiences of referral and support offered to women who had positively disclosed abuse.  
**Setting**: United Kingdom  
**Population**: women using maternity services  
**Methods**: A multimethod approach was adopted including quantitative and qualitative elements. The survey assessed women’s views of the acceptability and impact of routine enquiry for domestic abuse. Interviews aimed, to understand the views and experiences of women who had positively disclosed abuse during their contact with maternity services. | 94.4% of those surveyed felt comfortable with a midwife asking about abuse. 96.6% of the participants also believed it was appropriate for a midwife to ask and that midwives should be able to respond to positive disclosure.  
Interviewees subject to abuse during pregnancy were happy to be questioned, even though they did not always feel able to disclose immediately. | |
| (Spangaro et al 2011b) | Cross-section | IV | 20 | **Aim**: to understand the conditions under which women disclose abuse in response to routine screening for intimate partner violence and their constructions of the impact of routine screening.  
**Setting**: Australia  
**Population**: a group of women recruited from antenatal, mental health, and substance abuse services  
**Methods**: In-depth interviews with 20 women followed up 6 months after disclosing abuse in response to screening. | Most women described valued impacts from screening, though this was less common for those who had previous contact with statutory agencies. The process of asking shaped constructions of abuse, giving name to it. Health workers’ responses to disclosures often helped to create a sense of connection. | |
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| (Spangaro et al 2010) | Cohort | III-2 | 363 | **Aim:** to understand more about how women use screening programmes to disclose and access information and services.  
**Setting:** Australia  
**Population:** women screened in ten Australian health care settings — antenatal, drug and alcohol and mental health services.  
**Methods:** Two samples of women were surveyed between March 2007 and July 2008; those who reported abuse during screening 6 months previously (122) and those who did not report abuse at that time (241). Twenty-three per cent (27/120) of women who reported abuse on screening were revealing this for the first time to any other person. Of those who screened negative, 14% (34/240) had experienced recent or current abuse, but chose not to disclose this when screened. | The main reasons for not disclosing were: not considering the abuse serious enough, fear of the offender finding out and not feeling comfortable with the health worker. Just over half of both the positive and negative screened groups received written information about IPV and 35% of the positive group accessed further services. The findings highlight the fact that much abuse remains hidden and that active efforts are required to make it possible for women to talk about their experiences and seek help. Screening programmes, particularly those with established protocols for asking and referral, offer opportunities for women to disclose abuse and receive further intervention. |
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| (Spangaro et al 2016) | Cross-section | IV | 32 | **Aim:** to test a model for women's decisions to disclose IPV in response to routine enquiry as part of antenatal assessment.  
**Setting:** Australia  
**Population:** pregnant women who had previously disclosed domestic violence  
**Methods:** Qualitative configurational analysis, suited to the study of causal pathways in complex social phenomena, was used to analyse interviews with 32 women who had experienced IPV in the past 12 months and who elected, when asked, to either disclose this to the midwife (n=24) or not to do so (n=8). | Multiple pathways to disclosure were identified. While no single factor was necessary or sufficient for a decision to disclose, direct asking and care, defined as showing interest and a nonjudgemental attitude, were found to be key conditions. The absence of care was also central to decisions not to disclose, as were perceptions of relevance of the abuse at the time of assessment. | |
| (Stockl et al 2013) | Cohort | III-2 | 401 | **Aim:** to explore the acceptability of routine or case-based enquiry for intimate partner violence during antenatal care  
**Setting:** Germany  
**Population:** pregnant women.  
**Methods:** A mixed methods approach was used, utilising a self-administered survey on the acceptability of routine or case-based enquiry for intimate partner violence in a university hospital's maternity ward in Munich and in-depth interviews with seven women who experienced violence during pregnancy. | 92% of participants were in favor of routine or case-based enquiry for intimate partner violence during antenatal care. Acceptance of enquiry during antenatal care was significantly associated with women's experiences of child sexual abuse, being young, less educated, single or divorced and smoking during pregnancy.  
Open-ended survey questions and in-depth interviews stressed adequate training for screening, sufficient time and provision of referral information as important considerations. | |
### 1.5 Is routine enquiry about domestic violence acceptable to health professionals?

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| (Baird et al 2015) | Cross-section | IV  | 152         | **Aim**: to investigate midwives’ knowledge of intimate partner violence against women during pregnancy.  
**Setting**: Australia  
**Population**: midwives  
**Methods**: An online survey link was distributed through the Australian College of Midwives. The survey included personal, professional and practice details, and 25 questions that tested knowledge about intimate partner violence. | Knowledge scores ranged from 27 to 48 (out of a possible 50), with the mean total score of 42.8 (SD = 3.3). Although 60% of participants scored 48, two-thirds did not know about the risks and signs of intimate partner violence. One-third of the midwives did not know about age risks associated with intimate partner violence. Around 25% incorrectly believed that perpetrators are violent because of alcohol or drug use. Nearly 90% (88%) of participants had some education or training about intimate partner violence. Those with some training achieved higher knowledge scores than those with no formal training (p = 0.003). |                                                                                                                                 |
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| (Ben Natan et al 2011) | Cross-section | IV | 100 women; 100 providers | **Aim:** to examine the effect of knowledge, department routine, and attitudes of physicians and nurses on the identification of female victims of domestic violence in Israel, as well as the patients’ attitudes regarding the screening process.  
**Population:** physicians and nurses  
**Setting:** Israel  
**Methods:** Correlative, cross-sectional design was utilized based on a sample of 100 physicians and nurses from an obstetrics and gynaecology department in a central Israel hospital and a stratified simple random sampling to recruit 100 former female patients. **Findings:** Both medical and nursing staffs were reluctant to screen women for domestic violence, although the patients interviewed for the study claimed that screening is crucial for preventing domestic violence. Past experience with assessing violence and intention to screen were the most significant predictors of screening behaviour. Several factors impede screening by medical and nursing staff, although it is legally mandated. |
| (DeBoer et al 2013) | Cross-section | IV | 156 | **Aim:** to identify nurses’ attitudes and perceived barriers to screening.  
**Setting:** United States  
**Population:** nurses  
**Methods:** A survey was distributed to clinical nurses caring for inpatients at a level I trauma center. **Findings:** Most nurses in this study reported that screening for IPV is important, that it is their responsibility to screen their patients, and that they experience few work environment barriers to screening. Among study respondents, the most common identified barrier to screening is the lack of training. |
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| (Finnbogadottir & Dykes 2012) | Cross-section | IV  | 16          | **Aim**: to explore midwives’ awareness of and clinical experience regarding domestic violence among pregnant women  
**Population**: midwives  
**Setting**: Sweden.  
**Methods**: an inductive qualitative design, using focus group interviews. | Although midwives were aware of the need to address domestic violence during pregnancy, there appear to be a number of obstacles that need to be overcome before the introduction of routine enquiry. Currently, the midwives have no written guidelines, plans of action and have insignificant or non-existent support from the employer. | Included in (LoGiudice 2015) |
| (Garcia & Fisher 2008) | Cross-section | IV  | 27          | **Aim**: to explore obstetrics and gynaecology residents’ self-rated knowledge base, motivation to practise, skills, and practice patterns with respect to patient counselling concerning (among other areas) intimate partner violence and sexual coercion.  
**Population**: obstetrics and gynaecology residents  
**Setting**: Canada  
**Methods**: Participants completed self-reports of knowledge, motivation, skills, and practice patterns for counselling. | Significant gaps were observed in knowledge of intimate partner violence and sexual coercion and residents did not feel well-trained to provide counselling in this area. Participants consistently perceived only modest levels of support from their peers and from consultants with respect to counselling in the domain of intimate partner violence and sexual coercion. | |
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| (Infanti et al 2015) | Cross-section | IV  | 31          | **Aim**: to explore the experiences of midwives in identifying and responding to pregnant women affected by domestic violence in an underserved area.  
**Population**: midwives  
**Setting**: Sri Lanka  
**Methods**: an interdisciplinary team of social scientists and medical doctors met with the midwives for group interviews and a participatory workshop. | Assets identified by midwives included training and employment security.  
Strategies to improve practice include estate-based counselling services; basic training in family counselling and mediation for midwives; greater surveillance of abusive men’s behaviours by male community leaders; and performance evaluation and incentives for work undertaken to respond to domestic violence. |                                                                                                                                 |
| (Kulkarni et al 2011) | Cross-section | IV  | 43          | **Aim**: to learn about barriers and strategies for addressing IPV among adolescents.  
**Setting**: United States  
**Population**: service providers  
**Methods**: data from focus groups with service providers who work with pregnant and parenting adolescents were thematically analysed. | Results suggest that providers can benefit from increased training and skill development in working with IPV, as well as working in interdisciplinary, collaborative teams to increase effectiveness with challenging cases.  
Programs should consider integrating IPV prevention initiatives that target broader social norms. Future research should pilot and test the effectiveness of targeted IPV training and programmatic interventions with service providers who work with this population. |                                                                                                                                 |
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<td>(Lauti &amp; Miller 2008)</td>
<td>Cross-section</td>
<td>IV</td>
<td>39</td>
<td><strong>Aim:</strong> to investigate the opinions of midwives and obstetricians, regarding their role in identification and management of family violence. <strong>Setting:</strong> New Zealand <strong>Population:</strong> midwives and obstetricians <strong>Methods:</strong> Focus groups and semi-structured interviews with midwives and obstetricians were conducted, recorded and analysed.</td>
<td>Identification themes included concerns about privacy and confidentiality, the doctors’ lack of continuity of patient care, and the role of screening. Management themes included uncertainty regarding management and referral options, the impact of managing family violence on clinicians, and the need for debriefing.</td>
<td>Included in (LoGiudice 2015)</td>
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<td>(Lazenbatt et al 2009)</td>
<td>Cohort</td>
<td>III-2</td>
<td>488</td>
<td><strong>Aim:</strong> to compare and contrast how midwives working in either hospital- or community-based settings address domestic violence <strong>Setting:</strong> Northern Ireland <strong>Population:</strong> midwives <strong>Methods:</strong> a postal survey questionnaire sought views on: prevalence of domestic violence; their role in addressing domestic violence; the acceptability of routine enquiry; and barriers encountered in asking clients questions about violence and abuse in pregnancy. Comparisons were made using descriptive, inferential statistics and cross-tabulation.</td>
<td>Although there were significant differences between hospital- and community-based midwives in relation to domestic violence, both groups of midwives tended to underestimate its prevalence. The findings suggest that midwives per se identify and respond to a fraction of the cases of domestic abuse in pregnancy, due to lack of confidence, education and training.</td>
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| (LoGiudice 2015)          | Narrative review   | IV  | 142         | **Aim**: to glean an understanding of healthcare providers’ experience with prenatal screening for intimate partner violence (IPV).  
**Methods**: Eight research reports were identified and produced a sample of 142 experienced women’s healthcare providers from the United States, New Zealand, and Sweden. | The synthesis revealed five overarching themes: therapeutic relationship, understanding what she is not saying (silent cues), presence of partner, variations of how and when to discuss, and uncertainty regarding management and referral options. When analyzed as a whole, the five themes contribute to a lack of universal screening for IPV. |
| (Lutgendorf et al 2010)    | Cross-section      | IV  | 26          | **Aim**: to assess data regarding domestic violence screening from practitioners at one military training center.  
**Setting**: United States  
**Population**: practitioners at a military training center  
**Methods**: This study used an anonymous questionnaire for physicians, nurses and nurse midwives, which surveyed current methods, attitudes toward screening, and barriers for such assessment. Fifty-seven surveys were distributed, and 26 were returned for a response rate of 45.6%. | Only about a third (38.5%) of the practitioners screened all obstetric patients while the remainder screened selected patients for domestic violence. A history of prior abuse in the respondents led practitioners to try to identify such patients within their practice.  
Lack of education or training was the most common barrier to universal screening followed by time constraints and frustration about not being able to address adequately the problem when noted. |
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<tr>
<td>(Mauri et al 2015)</td>
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<td><strong>Aim:</strong> to explore midwives’ knowledge and clinical experience of domestic violence among pregnant women, with particular emphasis on their perceptions of their professional role.</td>
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<td><strong>Setting:</strong> Italy</td>
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<td><strong>Population:</strong> midwives</td>
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<td><strong>Methods:</strong> data were collected using semi-structured interviews, and analysed.</td>
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<td>Findings</td>
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<td>Three main themes emerged: ‘it is difficult to recognise domestic violence’ because of a limited knowledge of the most common signs and symptoms of violence, a lack of training, cultural taboos, and the women’s unwillingness to disclose abuse; ‘we have a certain number of means of identifying violence’, such as relationships with the woman, specific professional training and screening tools, which have advantages and disadvantages; ‘the professionals involved’ in identifying and managing family violence highlight the importance of a interdisciplinary approach.</td>
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<td>(Pagels et al 2015)</td>
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| (Salcedo-Barrientos et al 2014) | Cross-section | IV  | 14          | **Aim**: to determine how Family Health Strategy professionals recognize and deal with domestic violence in pregnant women.  
**Setting**: Brazil  
**Population**: Family Health Strategy professionals  
**Method**: health professionals were interviewed. Empirical data were categorized and discussed in thematic groups. | We identified low number of reported cases of domestic violence; lack of education and training of health care professionals; failure in the identification and intervention process due to bias on their personal problems, moral attitudes and prejudice against these women. |                                                                                                                                                                                                                       |
| (Shamu et al 2013)        | Cross-section | IV  | 70          | **Aim**: to explore the current environment in order to identify opportunities and obstacles for interventions aimed at identifying and responding to IPV in antenatal care  
**Setting**: Zimbabwe  
**Population**: midwives and pregnant and postpartum women  
**Methods**: six in-depth interviews with midwives and seven FGDs with 64 pregnant and postpartum women in antenatal public health facilities were conducted. Recorded interviews were transcribed verbatim and analysed using thematic content analysis. | Identifying and responding to IPV in antenatal care is hampered by inadequate human, financial and infrastructural resources as well as poor support of gender-based violence training for midwives. Midwives had divergent views of their role, with some perceiving IPV as a non-clinical, social and domestic problem that does not require their attention, while others who had been sensitised to the problem felt that it could easily overwhelm them. |                                                                                                                                                                                                                       |
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| (Spangaro et al 2011a) | Cross-section | IV | 59 (29 antenatal) | **Aim:** to understand challenges, and enablers of screening apply this to a model of how health policies become routinised in practice  
**Setting:** Australia  
**Population:** health care workers  
**Methods:** Focus groups were conducted, with health care workers at 10 health services (5 antenatal settings) within two of the eight NSW health regions | Privacy, tensions between wanting to offer trust, and limited confidentiality, as well as worker’s frustration at women who elect not to end abusive relationships, remain challenges to the continued implementation of screening in an established program. Factors facilitating uptake included brief, scripted questions embedded in assessment schedules, training, access to referral services, familiarity, and women’s favourable reactions. | |
| (Svavarsdottir & Orlygsdottir 2009) | Cross-section | IV | 232 | **Aim:** to identify the incidence of violence against women seeking healthcare services and evaluate the use of clinical guidelines to identify interpersonal violence.  
**Setting:** Iceland  
**Population:** nurses, midwives and women visiting the emergency department of high risk prenatal care clinic  
**Methods:** Data were collected over a period of 7 months in 2005 and 2006. The samples consisted of 14 nurses, 10 midwives and 208 women in Iceland (101 women visiting the Emergency Department and 107 receiving prenatal care at the High Risk Prenatal Care Clinic). | Twenty women (19.6%) who visited the Emergency Department and 21 women (19.8%) who came to the High Risk Prenatal Care Clinic had been sexually abused at some point in their lives by close family members. Within the preceding 12 months, 18 women at the Emergency Department (19.1%) and eight at the High Risk Prenatal Care Clinic (7.5%) reported physical abuse, and 22 women (22.2%) at the Emergency Department and 12 (11.5%) at the High Risk Prenatal Care Clinic reported emotional abuse. A majority of the nurses and midwives indicated that the guidelines were efficient for assessing/screening for gender violence in emergency and high risk clinical settings. | |
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| (Torres-Vitolas et al 2010) | Cross-section | IV  | 254         | **Aim:** To identify maternity and sexual healthcare professionals’ training needs regarding routine enquiry for domestic abuse.  
**Setting:** United Kingdom  
**Population:** Maternity professionals (n=228) and sexual health practitioners (n=46)  
**Methods:** Participants attended a 1-day domestic abuse training session. Pre-training questionnaires were completed by 208 respondents (80% response rate). The questionnaire elicited information about previous training experiences, dealing with cases of abuse, general knowledge, attitudes towards victims of abuse and views on routine enquiry. Bivariate and multivariate analyses were conducted to identify differences according to healthcare setting, prior training, and practitioners’ demographic and experiential traits. | Maternity and sexual health professionals reported positive attitudes towards women affected by abuse, but had limited domestic abuse training. Previously trained health professionals had good general knowledge, but failed to question attendees about abuse. Sexual health professionals were more likely to enquire about domestic abuse, and were more confident about implementing routine enquiry than maternity staff. Views on routine enquiry were influenced by health setting, demographic, attitudinal and experiential factors. |
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<td>(Chang et al 2009)</td>
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<td><strong>Methods</strong>: Health professionals from two different clinical settings were asked about their comfort level in dealing with intimate partner violence (IPV). Focus groups and semistructured interviews were used to gather information.</td>
<td>Staff in an obstetrics and gynaecology setting relatively rich in IPV resources described feeling capable dealing with IPV. The staff in a general medicine setting dedicated to women's health but without a focus on IPV and with fewer supports described discomfort and difficulty dealing with IPV. Presence of systemic prioritization of and resources for IPV were described as contributing to the confidence in addressing the issue. Other necessary elements identified included (a) on-site resources, (b) adequate time, (c) focused IPV training, and (d) a team or systemic approach.</td>
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1.6 **What do health professionals need to do to identify Aboriginal and Torres Strait Islander women experiencing domestic violence?**

No evidence identified; see Section 3.

1.7 **Is routine enquiry about domestic violence acceptable to Aboriginal and Torres Strait Islander women?**

No evidence identified; see Section 3.

1.8 **Is routine enquiry about domestic violence acceptable to health professionals caring for Aboriginal and Torres Strait Islander women?**

No evidence identified; see Section 3.
## 1.9 Excluded studies

### Systematic reviews included in AIHW report

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### Studies included in systematic reviews

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**Background papers for screening**
Background information will inform revision of the narrative.

**Guidelines and statements**

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<tr>
<th>(ACOG 2012)</th>
<th>Intimate partner violence (IPV) is a significant yet preventable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (HIV). Obstetrician/gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient/physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women’s health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women’s preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ACOG 2013)</td>
<td>Reproductive and sexual coercion involves behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. This behavior includes explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods. Obstetrician-gynecologists are in a unique position to address reproductive and sexual coercion and provide screening and clinical interventions to improve health outcomes. Because of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for intimate partner violence and reproductive and sexual coercion at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup). Interventions include education on the effect of reproductive and sexual coercion and intimate partner violence on patients’ health and choices, counseling on harm-reduction strategies, and prevention of unintended pregnancies by offering long-acting methods of contraception that are less detectable to partners.</td>
</tr>
<tr>
<td>(AWHONN 2015)</td>
<td>The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other policies that require nurses to report the results of screening for intimate partner violence (IPV) to law enforcement or other regulatory agencies without the consent of the woman who experiences the IPV. Nurses and other health care professionals, however, should become familiar with laws on mandatory reporting in their states and comply as applicable. Women should be universally screened for IPV in private, safe settings where health care is provided. Nurses are ideally positioned to screen for IPV for the purpose of initiating a referral for services and support when applicable. To protect the woman’s safety, AWHONN supports policies that require a woman’s consent before reporting occurs.</td>
</tr>
</tbody>
</table>

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46
Military service is associated with unique risks to women's reproductive health. As increasing numbers of women are serving in the military, and a greater proportion of United States Veterans are women, it is essential that obstetrician-gynecologists are aware of and well prepared to address the unique health care needs of this demographic group. Obstetrician-gynecologists should ask about women's military service, know the Veteran status of their patients, and be aware of high prevalence problems (e.g., posttraumatic stress disorder, intimate partner violence, and military sexual trauma) that can threaten the health and well-being of these women. Additional research examining the effect of military and Veteran status on reproductive health is needed to guide the care for this population. Moreover, partnerships between academic departments of obstetrics and gynecology and local branches of the Veterans Health Administration are encouraged as a means of optimizing the provision of comprehensive health care to this unique group of women.

The evidenced-based clinical guideline fosters a supportive environment for educating health-care providers on domestic violence, and to improve clinic access for at-risk perinatal women. Information on domestic violence and a negotiated midwife-client safety plan can be initiated for potential or actual victims of domestic violence, and is achieved through understanding the risks of the woman and her fetus or baby, while respecting the woman's intention.

Sixteen guidelines, developed by nine institutions from Europe, the United States, Canada and Australia, met the inclusion criteria. The majority of the guidelines recommended routine assessment, although some conflicting recommendations were found for depression, illicit drug use and violence. Our research findings suggest that screening or assessment for the analysed risk factors is advisable. However, the assigned grades of recommendation reflect that the evidence base is limited. Further research should also concentrate on evaluating different screening methods, as there was little consensus on the ideal screening test.

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services. B recommendation. This recommendation applies to women who do not have signs or symptoms of abuse.

Summary of selected intimate partner violence recommendations from the World Health Organization

**Woman-centered care**

Women who disclose any form of violence by an intimate partner (or other family member) should be offered immediate support by clinicians, at a minimum. If clinicians are unable to provide this frontline support, they should ensure that someone else (within their health care setting or another that is easily accessible) is immediately available to do so (Strong)

**Identification of survivors**

Universal screening not recommended (Conditional)

Ask about exposure to IPV when assessing conditions that may be caused or complicated by abuse (Strong)

Written information about IPV should be available in all health care settings (Conditional)

**Care for survivors**

Women with a preexisting diagnosed or IPV-related mental disorders should receive mental health care delivered by health care professionals with a good understanding of violence against women (Strong)
Cognitive behavioral therapy or eyemovement desensitization and reprocessing interventions, delivered by health care professionals with a good understanding of violence against women, should be offered to women with posttraumatic stress disorder who are no longer experiencing violence (Strong).

Women who have spent at least 1 night in a shelter, refuge, or safe house should be offered a structured program of advocacy, support, and/or empowerment (Conditional).

Pregnant women should be offered brief- to medium-duration empowerment counseling (by counsellors with specific training about IPV) and IPV advocacy/support, including a safety component (Conditional).

For children exposed to IPV at home, a psychotherapeutic intervention should be offered (Conditional).

Training of clinicians

Training at prequalification level in first-line support for women who have experienced IPV should be given to clinicians (in particular physicians, nurses, and midwife) (Strong).

Clinicians offering care to women should receive in-service training integrated with training on managing sexual assault (Strong).

Health care policy

Care for women experiencing IPV should be integrated into existing health services rather than as a stand-alone service (Strong).

Mandatory reporting

Mandatory reporting to the police by the clinicians is not recommended; clinicians should offer to report the incident to the appropriate authorities (including the police) if the woman wants this and is aware of her rights (Strong).

Other background papers

(Audi et al 2012) Domestic violence during pregnancy was associated with adverse clinical and psychological outcomes for women. These results suggest that a well-organised health-care system and trained health professionals, as well as multisectorial social support, are necessary to prevent or address the negative influence of domestic violence on women’s health in Brazil.

(Bibi et al 2014) Domestic violence was quite common among married women in Hyderabad, Sindh, however help seeking was minimal. There is need to identify and address this menace effectively.

(Brown et al 2011) Our study highlights the complexities and contradictions relating to the notion of family support, with young women respondents sometimes identifying this “support” as controlling. Our findings also show how young mothers, like older adult women, are subject to a range of violent behaviours in their intimate relationships. We conclude that any attempt to minimise the “risks” this group face needs to recognise how familial and intimate relationships can negatively impact on the health and well-being of pregnant teenagers, of young mothers and that of their child/children.
Descriptive data show diverse and dynamic constellations of family and gender relations that translate to different levels of risk of partner violence among women. Regression analyses show that immigrant women are less likely to experience abuse by an intimate than U.S. born women. Black women are more likely than White women to experience partner violence; second generation Latinas are less likely to be abused. Factors associated with partner violence are being younger, having higher levels of education, moving frequently in the past year, having low levels of partner support, and experiencing high levels of stress and a past history of trauma. The reporting of sexual coercion without physical force is a common pattern among women in each group, which may indicate that it is an underlying mechanism of control that opens the door for escalating levels of partner violence and abuse.

Prevalence of IPV from either a former or current partner was 5.3% before and 3.6% during pregnancy. Prevalence of abuse by a former partner was consistently higher than the prevalence of abuse by a current partner. The three strongest predictors of IPV during pregnancy were the woman’s partner not wanting the pregnancy (current: AOR=3.47, 95% CI=3.13, 3.85; former: AOR=3.22, 95% CI=2.90, 3.76); having had a recent divorce or separation (current: AOR=3.23, 95% CI=2.92, 3.58; former: AOR=3.54, 95% CI=3.20, 3.91); and being close to someone having a drug or alcohol problem (current: AOR=3.05, 95% CI=2.78, 3.36; former: AOR=2.97, 95% CI=2.70, 3.27). Maternal characteristics (age, education, race, marital status, woman did not want the pregnancy) were less important predictors.

Findings suggest that pregnancy is more stressful for younger, single, unemployed, less educated women with less income, women with an unintended pregnancy, and those with more pregnancy and birth experiences relative to their comparison groups. Study 2 identified three classes of women: those who experienced no IPV, predominantly sexual IPV, or physical IPV only. Presence of violence in one period increased the likelihood of violence in subsequent periods for all women. Physical violence prior to conception was more likely to continue during pregnancy among women with an unintended pregnancy than among those with an intended pregnancy. Women whose partners did not want their pregnancy were at a greater risk for initiation of physical violence during pregnancy than those with partners who wanted their pregnancy. Finally, findings from Study 3 showed that pregnancy specific stress independently contributed to fetal distress, and significantly predicted unplanned cesarean delivery controlling for medical risk.

IPV against women during the pregnancy-puerperal cycle causes negative impacts on mental health. Concrete actions shall be proposed regarding the prevention, identification and treatment of women exposed to IPV during their pregnancy period.

Recognizing the intimate partner violence as a clinically relevant and identifiable risk factor for the occurrence of anxiety disorders during pregnancy can be a first step in the prevention thereof.

Women working in early pregnancy who qualified for paid maternity leave had significantly reduced odds of reporting combined physical and emotional IPV in the first 12 months postpartum compared with women not working (Adj. OR 0.21, 95% CI 0.08-0.55). Women working but not eligible for paid leave had reduced odds compared with women not working (Adj. OR 0.49, 95% CI 0.24-1.00). Models adjusted for maternal age, relationship status, income and education level. Few first time mothers reported fear for the first time after childbirth suggesting that IPV more commonly commences prior to the first birth. Paid maternity leave may have broader social benefits beyond immediate financial benefits to women and families.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
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<tbody>
<tr>
<td>Gartland et al 2014</td>
<td>Intimate partner abuse impacted the lives of one in four children. Children of mothers reporting abuse at both time points were at most risk of emotional/behavioral difficulties. The case for early intervention to reduce the impact of intimate partner abuse on women's and children's lives is compelling.</td>
</tr>
<tr>
<td>Hill et al 2016</td>
<td>Nineteen studies met the inclusion criteria (15 LBW, 12 preterm birth, 4 IUGR). IPV was associated with LBW (OR 1.18, 95% confidence interval 1.05-1.31; $\chi^2 = 0.70, P &lt; 0.001$) and preterm birth (OR 1.42, 95% confidence interval 1.21-1.63; $\chi^2 = 0.20, P &lt; 0.001$). No statistically significant association was found for IUGR. Conclusions There are associations between IPV and LBW and preterm birth that could be causal.</td>
</tr>
<tr>
<td>Howard et al 2013</td>
<td>High levels of symptoms of perinatal depression, anxiety, and PTSD are significantly associated with having experienced domestic violence. High-quality evidence is now needed on how maternity and mental health services should address domestic violence and improve health outcomes for women and their infants in the perinatal period.</td>
</tr>
<tr>
<td>Kan &amp; Feinberg 2010</td>
<td>Among a community sample of 168 couples who were expecting their first child, couple agreement regarding the presence of violence was low, and maximum reported estimates revealed substantial IPV perpetrated by both expectant mothers and fathers. Different types of IPV scores predicted unique variance in mental health problems and couple relationship distress among both the whole sample and the subsamples who perpetrated any violence.</td>
</tr>
<tr>
<td>McCall-Hosenfeld et al 2013</td>
<td>Women exposed to IPV had greater odds of receiving safety and violence counseling (adjusted odds ratio [AOR], 2.40; 95% confidence interval [CI], 1.25-4.61), and tests for STIs (AOR, 2.46; 95% CI, 1.41-4.28) compared with women who had not been exposed to IPV. Independent of other predictors, including IPV, women who saw an obstetrician-gynecologist were more likely to receive Pap tests, STI/HIV testing and counseling, and birth control counseling, compared with women who had not seen an obstetrician-gynecologist. Conclusion: Overall rates of preventive service receipt for all women in the sample were low. Women exposed to IPV were more likely to receive safety and violence counseling and STI testing, and seeing an obstetrician-gynecologist increased the odds of receiving several preventive services.</td>
</tr>
<tr>
<td>Modiba et al 2011</td>
<td>Among pregnant women attending an antenatal clinic in a public hospital in Gauteng Province in South Africa, the overall prevalence of domestic abuse amongst pregnant women was 41%. When categorized by type of abuse, the prevalence rates were: emotional abuse, 26%; physical abuse, 17%; both physical and emotional abuse, 5%; and sexual abuse, 9%.</td>
</tr>
<tr>
<td>Morgan et al 2010</td>
<td>Domestic violence in female psychiatric patients is common but undetected. Enquiry should be routine, but would require staff training.</td>
</tr>
<tr>
<td>Reichenheim et al 2008</td>
<td>Knowledge of certain characteristics of pregnant women attending health services (in Rio de Janeiro) can alert professionals to the high probability of IPV: &lt;20 years of age, non-White, living in house with inadequate garbage disposal, previous history of abortion, reporting fear of someone, reporting lack of affective social support, and reporting drug use by woman or spouse.</td>
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<tr>
<td>Rodriguez et al 2009</td>
<td>Having a systematic approach in place to ask about IPV during pregnancy was the variable that was most associated with being screened for IPV. Having institutionalized systems in place significantly increases the likelihood that all patients are screened for IPV.</td>
</tr>
</tbody>
</table>
Compared to Whites, Native Hawaiians, Japanese, Chinese, and Koreans were significantly less likely to report receiving prenatal health care counseling in intimate partner violence, but the opposite association was observed for Samoans.

Among a sample of Thai women, 13.1% reported ever being abused, whereas 4.8% reported physical abuse during pregnancy. Women abused during pregnancy, compared to nonabused women, were more likely to be younger, unmarried, have low income, be unemployed, and report that the pregnancy was unwanted. They also reported lower levels of positive health practices and higher levels of depressive symptoms.

Pregnant women whose lives are affected by intimate partner violence and unintended pregnancy are often faced with the decision for abortion. Among adult pregnant women seeking abortion, three major themes emerged: (1) It Wasn't That Bad, (2) Then It Got Worse, and (3) If I Have the Baby He'll Come Back.

Routine pregnancy visits afford a window of opportunity for identifying and supporting women experiencing mental health problems and social adversity. Changing practice to take advantage of this opportunity will require concerted and coordinated efforts by practitioners and policy makers to build systems to support public health approaches to antenatal care.

Other exclusions

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
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<td>Study</td>
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<td>Reason for exclusion</td>
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<tr>
<td>Spyridou, A., et al. (2016). “Prenatal screening for psychosocial risks in a high risk-population in Peru using the KINDEX interview.” BMC pregnancy and childbirth 16 (1) [no pagination][13].</td>
<td>Does not answer research question</td>
</tr>
<tr>
<td>Study</td>
<td>Reason for exclusion</td>
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</table>
2 Intervention

Evidence summary

The review for Module I of the Guidelines (Australian Health Ministers’ Advisory Council 2012) identified two RCTs, which informed the narrative as follows.

Brief psycho-behavioural interventions may improve domestic violence and pregnancy outcomes. Counselling sessions and advocacy programs for women experiencing domestic violence are effective in reducing domestic violence.

Results of the current review

This review identified three systematic reviews that assessed any intervention in pregnancy (Jahanfar et al 2014), advocacy interventions within or outside the health care setting for women experiencing domestic violence (Rivas et al 2015) and home visiting interventions among families at risk (Prosman et al 2015), one RCT assessing home visiting in the perinatal period (Sharps et al 2016) and four observational studies (Bacchus et al 2010; Langhinrichsen-Rohling & Turner 2012; Krans et al 2013; Matseke & Peltzer 2013). Reported outcomes, length of follow-up and tools used to assess domestic violence were heterogeneous.

Physical abuse

- Any intervention in pregnancy — There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy outcomes (Jahanfar et al 2014) (see Summary of Findings table; page 60).
- Advocacy — Brief advocacy may provide small short-term mental health benefits and reduce abuse, particularly in pregnant women and for less severe abuse (Rivas et al 2015) (see Summary of Findings table; page 61).
- Home visiting — The three home visiting programs with a focus on abuse of the mother and child identified in the systematic review (Prosman et al 2015) showed a statistically significant reduction of IPV (adjusted difference in IPV score at 1 yr: –8.67, 95%CI: –16.2 to –1.15; physical assault at 2 yr: OR 0.46; 95%CI 0.24 to 0.89; physical assault at 3 yr: IRR 0.85; 95% CI: 0.71–1.00) (Prosman et al 2015). The RCT also found a significant decrease in IPV over time (Sharps et al 2016).

Sexual abuse

Studies failed to show benefits from advocacy for sexual abuse (Rivas et al 2015) (see Summary of Findings tables; page 61).

Emotional abuse

One antenatal care study reported in the Cochrane advocacy review (Rivas et al 2015) showed reduced emotional abuse at 12 months after intervention (see Summary of Findings tables; page 61).

Low birth weight

In the Cochrane review of any interventions (Jahanfar et al 2014), the rates of low birth weight were similar between control and intervention groups (see Summary of Findings table; page 60).

Safety planning

One study in the Cochrane review on any type of intervention (Jahanfar et al 2014) reported on safety planning, which the authors had not pre-specified as an outcome but is of relevance to this review. The study examined an empowerment intervention in pregnancy compared with usual care (Cripe et al 2010) (see Summary of Findings table; page 60).

Advice to EWG

Incorporate new evidence into the narrative.

Evidence statements

Any intervention to prevent violence versus standard care for preventing or reducing domestic violence against pregnant women

- The total number of episodes of partner abuse in pregnancy and up to 10 weeks postpartum is lower among women who receive a psychological intervention than among controls (moderate quality evidence).
• The difference in risk of having a low birthweight baby between women participating in a psychological intervention and controls did not reach significance (low quality evidence).

• The difference in risk of episodes of partner abuse during pregnancy and in the first 3 months postpartum between women participating in a psychological intervention and controls did not reach significance (very low quality evidence).

• Women who participate in an empowerment intervention are more likely to adopt safety behaviours than controls (very low quality evidence).

• The evidence on partner abuse scores was inconsistent and differences between groups did not reach significance.

Advocacy interventions for women who experience intimate partner abuse versus usual care at up to 12-month follow-up

• The difference in overall abuse immediately post-intervention between women participating in intensive advocacy interventions and controls did not reach significance (very low quality evidence).

• Brief advocacy interventions for women experiencing domestic violence have no clear effect on physical abuse, minimal effect on sexual abuse and may have a beneficial effect on emotional abuse at 16 to 34 weeks follow-up and on overall abuse at 3–4 months follow-up (low to moderate quality evidence).
**Summary of findings**

*Any intervention to prevent violence versus standard care for preventing or reducing domestic violence against pregnant women*

**Patient or population:** Pregnant women  
**Setting:** United States  
**Intervention:** Any intervention  
**Comparison:** Standard care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner abuse: episodes during pregnancy</td>
<td>182 per 1,000 (45 to 185)</td>
<td>RR 0.5 (0.25 to 1.02)</td>
<td>220 (1 study)</td>
<td>VERY LOW</td>
<td>Kiely et al 2010; psychological intervention</td>
</tr>
<tr>
<td>Partner abuse: episodes during the first 3 months postpartum</td>
<td>212 per 1,000 (74 to 220)</td>
<td>RR 0.6 (0.35 to 1.04)</td>
<td>271 (1 study)</td>
<td>VERY LOW</td>
<td>Kiely et al 2010; psychological intervention</td>
</tr>
<tr>
<td>Partner abuse: abuse score in the first 3 months postpartum (Conflict Tactics Score*)</td>
<td>Mean partner abuse score in the first 3 months postpartum was 4.2 higher (10.74 lower to 19.14 higher)</td>
<td>RR 0.62 (0.43 to 0.88)</td>
<td>306 (1 study)</td>
<td>MODERATE</td>
<td>Kiely et al 2010; psychological intervention</td>
</tr>
<tr>
<td>Partner abuse: abuse score in the first 3 months postpartum (Current Abuse Score*)</td>
<td>Mean partner abuse in the first 3 months postpartum was 0.12 lower (0.31 lower to 0.07 higher)</td>
<td>RR 0.74 (0.41 to 1.32)</td>
<td>306 (1 study)</td>
<td>LOW</td>
<td>Kiely et al 2010; psychological intervention</td>
</tr>
<tr>
<td>Partner abuse: total episodes at final study assessment (pregnancy and up to 10 weeks postpartum)</td>
<td>378 per 1,000 (163 to 333)</td>
<td>RR 2.60 (1.41 to 4.79)</td>
<td>204 (1 study)</td>
<td>VERY LOW</td>
<td>Cripe et al 2010; empowerment intervention</td>
</tr>
<tr>
<td>Safety planning</td>
<td>115 per 1,000 (163 to 553)</td>
<td>RR 2.22 (1.62 to 2.99)</td>
<td>242 (1 study)</td>
<td>LOW</td>
<td>Kiely et al 2010; psychological intervention</td>
</tr>
<tr>
<td>Number of low-birthweight (&lt;2500 g) babies</td>
<td>154 per 1,000 (163 to 233)</td>
<td>RR 2.60 (1.41 to 4.79)</td>
<td>204 (1 study)</td>
<td>VERY LOW</td>
<td>Cripe et al 2010; empowerment intervention</td>
</tr>
</tbody>
</table>

*The Abuse Assessment Screen (AAS) tool was used to for screening. Respondents who answered 'yes' to being physically or emotionally hurt by someone or forced to have sexual activities within the last year were considered abused. These women, who responded 'yes' to AAS tool, were administered the Conflict Tactics Score (CTS).

**GRADE Working Group grades of evidence**

**High quality:** We are very confident that the true effect lies close to that of the estimate of the effect  
**Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different  
**Low quality:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect  
**Very low quality:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

1. All studies contributing data had design limitations.  
2. Wide confidence interval crossing the line of no effect and small sample size.  
3. Wide confidence interval crossing the line of no difference and small sample size.  
4. All studies contributing data has serious design limitations.  
5. Estimate based on small sample size.
Intensive advocacy interventions for women who experience intimate partner abuse versus usual care at up to 12-month follow-up

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall abuse (dichotomous outcome) Follow-up: immediately postintervention</td>
<td>Control 719 per 1,000 (426 to 821) Intensive advocacy interventions 648 per 1,000 (0.29 to 1.79)</td>
<td>OR 0.72 (0.17 lower to 0.16 higher)</td>
<td>103 (1 study)</td>
<td>VERY LOW a,b</td>
<td>Taft 2011</td>
</tr>
</tbody>
</table>

* The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

** One study used a composite of two scales; the other used Composite Abuse Scale.

GRADE Working Group grades of evidence
- **High quality**: We are very confident that the true effect lies close to that of the estimate of the effect
- **Moderate quality**: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
- **Low quality**: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
- **Very low quality**: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

- **a** Total events less than 300.
- **b** Sample attrition greater than 20% and differential across groups, not intention-to-treat (ITT), and group allocation not concealed.
- **c** Wide confidence intervals around 1.

Source: Adapted from (Rivas et al 2015).

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Brief advocacy interventions for women who experience intimate partner abuse versus usual care at up to 12-month follow-up

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse: Outcomes was measured on different scales in different studies Follow-up: immediately post-intervention to 12 months</td>
<td>Control The mean physical abuse across control groups was 0.45 to 12.6 Intensive advocacy interventions Mean physical abuse was 0 standard deviations higher (0.17 lower to 0.16 higher)</td>
<td>558 (3 studies)</td>
<td>Gillum 2009; McFarlane 2006; Tiwari 2010</td>
<td>Moderate a,b</td>
<td></td>
</tr>
</tbody>
</table>
Brief advocacy interventions for women who experience intimate partner abuse versus usual care at up to 12-month follow-up

**Patient or population:** Women experiencing intimate partner abuse  
**Setting:** Healthcare settings  
**Intervention:** Brief advocacy interventions  
**Comparison:** Usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>% of participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Physical abuse — severe  
Conflict Tactics Scales mean change from baseline  
Follow-up: 16 to 34 weeks\(^2\) | The mean severe physical abuse in the control groups was 0.17  
Mean severe physical abuse was 0.08 higher (0.26 lower to 0.42 higher) | 110  
(1 study) | | Tiwari 2005 |
| Sexual abuse  
CTS and Partner Abuse Scale (PAS)\(^6\)  
Follow-up: immediately post-intervention to 12 months | The mean sexual abuse ranged across control groups from 0.10 to 0.14  
The mean sexual abuse was 0.12 standard deviations lower (0.37 lower to 0.14 higher) | 239  
(2 studies) | | Gillum 2009;  
Tiwari 2010 | |
| Sexual abuse  
CTS sexual abuse single-item mean change from baseline  
Follow-up: 16 to 34 weeks\(^2\) | The mean sexual abuse in the control groups was -0.06  
The mean sexual abuse was 0.07 lower (0.30 lower to 0.16 higher) | 110  
(1 study) | | Tiwari 2010 |
| Emotional abuse  
Outcomes was measured on different scales\(^4\)  
Follow-up: immediately post-intervention to 12 months | The mean emotional abuse ranged across control groups from 12.11 to 24.80  
Mean emotional abuse was 0.05 standard deviations lower (0.22 lower to 0.11 higher) | 558  
(3 studies) | | Gillum 2009;  
McFarlane 2006;  
Tiwari 2010 |
| Emotional abuse  
CTS mean change from baseline  
Follow-up: 16 to 34 weeks\(^2\) | The mean emotional abuse in the control groups was 1.92  
Mean emotional abuse was 4.24 lower (6.42 lower to 2.06 lower) | 110  
(1 study) | | Tiwari 2005 |
| Overall abuse**  
Index of Spouse Abuse (ISA) score. Scale from 0 to 30.  
Follow-up: 3 to 4 months | The mean overall abuse in the control groups was 23.39  
Mean overall abuse was 7.74 standard deviations lower (20.33 lower to 4.85 higher) | 53  
(1 study) | | Hyman 2001 |

* The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95%CI) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95%CI).  
CI: Confidence interval

**GRADE Working Group grades of evidence**  
**High quality:** We are very confident that the true effect lies close to that of the estimate of the effect  
**Moderate quality:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different  
**Low quality:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect  
**Very low quality:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

---

\(^a\) Partner Abuse Scale (PAS), physical subscale; 46-item Severity of Violence Against Women Scale (SVAWS), physical violence subscale; Chinese version of the 39-item Revised Conflicts Tactics Scale (CTS), psychological aggression subscale.  
\(^b\) One study has significant biases, one has moderate bias, and one no significant bias.

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c 6 weeks post-delivery, but representing 16 to 34 weeks postintervention.

d Difference from severe abuse results are consistent with abuse severity effects; in this study, advocacy is less effective when the abuse is more severe.

e Conflict Tactics Scale, sexual coercion subscale; PAS, sexual abuse subscale.

f There is moderate overlap in CIs and moderate heterogeneity.

g Sample size less than 400.

h The low effect size is consistent across studies.

i Total events greater than 300.

j Partner Abuse Scale (PAS), non-physical subscale, score range 0 to 25; 46-item SVAWS, Chinese version of the 39-item revised CTS, psychological aggression subscale.

k There is inconsistency between results, though this is partly explained by setting with one study in the community and two in healthcare settings.

l Attrition and contamination bias, also insufficient information to determine whether there was allocation concealment.

m Small sample size (less than 400), standard deviation (SD) greater than 0.5

Source: (Rivas et al 2015)
2.1 What interventions in a health care setting are effective for assisting women affected by domestic violence?

<table>
<thead>
<tr>
<th>Study ref</th>
<th>Design</th>
<th>LoE</th>
<th>N</th>
<th>Aim/setting/population/methods</th>
<th>Results</th>
<th>Comments</th>
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</table>
| (Jahanfar et al 2014) | SLR    | I   | 7 studies; 2,629 women | **Aim:** to examine the effectiveness and safety of interventions in preventing or reducing domestic violence against pregnant women.  
**Population:** women attending health care settings | There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy outcomes. There is a need for high-quality, RCTs with adequate statistical power to determine whether intervention programs prevent or reduce domestic violence episodes during pregnancy, or have any effect on maternal and neonatal mortality and morbidity outcomes.  
See Summary of Findings table; page 60 | Cochrane review  
Results for all outcomes were based on single studies. |
| (Rivas et al 2015) | SLR    | I   | 13 trials 2,141   | **Aim:** To assess the effects of advocacy interventions within or outside healthcare settings  
**Population:** women who have experienced intimate partner abuse | Results suggest some benefits from advocacy. However, most studies were underpowered. Clinical and methodological heterogeneity largely precluded pooling of trials. Therefore, there is uncertainty about the magnitude of benefit, the impact of abuse severity, and the setting.  
Brief advocacy may provide small short-term mental health benefits and reduce abuse, particularly in pregnant women and for less severe abuse.  
See Summary of Findings tables; page 61 | Cochrane review |
<table>
<thead>
<tr>
<th>Study ref</th>
<th>Design</th>
<th>LoE</th>
<th>N</th>
<th>Aim/setting/population/methods</th>
<th>Results</th>
<th>Comments</th>
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<tbody>
<tr>
<td>(Prosman et al 2015)</td>
<td>SLR</td>
<td>I</td>
<td>19 papers (6 studies)</td>
<td><strong>Aim:</strong> to assess the effectiveness of <strong>home visiting</strong> in reducing IPV experienced by mothers. <strong>Population:</strong> mothers <strong>Methods.</strong> We conducted a systematic review using the Pubmed, PsychINFO and Embase databases from inception until March 2014, with a specific search strategy for each database. Three different types of studies were identified: the primary focus of one study was on the abused mother and the secondary focus on the children (Australia); two studies (Hawaii, The Netherlands) with a primarily focus on reduction of child abuse and a secondary focus on IPV and finally three studies from the USA, which aimed at reducing child abuse by providing support to the mother.</td>
<td>The Australian study reported a significant lowering of the IPV score at 1-year follow-up (15.9 versus 21.8, adjusted difference -8.67, 95%CI: –16.2 to –1.15). The Hawaii study showed significantly lower rates of physical assault after 3 years follow-up (incidence rate ratio [IRR] 0.85; 95% CI: 0.71-1.00) and the Dutch study showed a significant decrease of mothers' physical assaults 2 years after birth (odds ratio 0.46; 95% CI 0.24-0.89). The other three studies showed no significant reduction of IPV.</td>
<td>Australian study (Taft et al 2011) reported in (Rivas et al 2015)</td>
</tr>
<tr>
<td>(Sharps et al 2016)</td>
<td>RCT</td>
<td>II</td>
<td>239</td>
<td><strong>Aim:</strong> to evaluate the effectiveness of an IPV intervention in reducing violence among abused women in perinatal <strong>home visiting</strong> programs. <strong>Setting:</strong> urban and rural settings in the United States <strong>Population:</strong> women experiencing perinatal IPV <strong>Methods:</strong> The Domestic Violence Enhanced Home Visitation Program (DOVE) intervention group (n=124) received a structured abuse assessment and six home visitor-delivered empowerment sessions integrated into home visits (provided by nurses or community health workers). All participants were screened for IPV and referred appropriately. IPV was measured by the Conflicts Tactics Scale 2 at baseline through 24 months postpartum.</td>
<td>There was a significant decrease in IPV over time (F = 114.23; p &lt; 0.001) from baseline to 1, 3, 6, 12, 18, and 24 months postpartum (all p&lt;0.001). Additional models examining change in IPV from baseline indicated a significant treatment effect (F = 6.45; p &lt; 0.01). Women in the DOVE treatment group reported a larger mean decrease in IPV scores from baseline compared to women in the usual care group (mean decline 40.82 vs. 35.87). All models accounted for age and maternal depression as covariates.</td>
<td>Low risk of bias (see Section 2.2)</td>
</tr>
<tr>
<td>Study ref</td>
<td>Design</td>
<td>LoE</td>
<td>N</td>
<td>Aim/setting/population/methods</td>
<td>Results</td>
<td>Comments</td>
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</table>
| (Bacchus et al 2010) | Narrative review        | IV  | — | **Aim:** To examine the effectiveness and safety of interventions in preventing or reducing domestic violence against pregnant women.  
**Setting:** United Kingdom  
**Methods:** evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. The intervention encompassed guidelines, staff training, inclusion of routine enquiry for domestic violence with all patients, and referral of women disclosing violence to an on-site advocacy service.  
An "assumption querying" approach was applied to evaluate the intervention. Programmatic assumptions were identified and tested using interviews with service providers and patients, review of patient records, and pre- and post-training questionnaires. | Domestic violence training resulted in changes in health professionals' knowledge and practice in the short-term, but universal routine enquiry was not achieved even in a context of organisational support, guidelines, training and advocacy.  
Potential and actual harm occurred, including breaches of confidentiality and failure to document evidence, limiting women's ability to access civil and legal remedies.  
Advocacy support led to positive outcomes for many women, as long as support to maintain positive changes, whether women stayed with or left the violent partner, continued to be given.  
Maternity and sexual health services were found to be opportune points of intervention for domestic violence services that combine routine enquiry by clinicians, support after disclosure and attention to harm reduction. |
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<tr>
<th>Study ref</th>
<th>Design</th>
<th>LoE</th>
<th>N</th>
<th>Aim/setting/population/methods</th>
<th>Results</th>
<th>Comments</th>
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</table>
| (Krans et al 2013) | Retrospective cohort | III-2 | 198,323 | **Aim**: To determine the impact of prenatal counselling regarding psychosocial risk factors on maternal behaviour.  
**Setting**: United States  
**Population**: majority of participants were non-Hispanic White, multiparous, aged 20-29 years, married or cohabiting, and had graduated from high school. Over one third of participants had their prenatal care and delivery paid for by Medicaid.  
**Methods**: We analyzed data from 198,323 women participating in the Pregnancy Risk Assessment Monitoring System (PRAMS). The [χ(2)] and logistic regression analyses assessed the relationship between psychosocial risk, prenatal counseling and maternal behavior. | No significant differences were found in the rates of intimate partner violence during pregnancy (56.1% vs 43.9%; P = .09) between women who did and did not receive counselling. |          |
| (Langhinrichsen-Rohling & Turner 2012) | Cross-sectional | IV | 72 | **Aim**: to evaluate the efficacy of a brief (four session) intimate partner violence (IPV) prevention program (Building a Lasting Love)  
**Setting**: United States  
**Population**: predominantly African American inner-city adolescent girls who were receiving teen pregnancy services.  
**Methods**: Girls were randomly assigned to the prevention program (n=39) or waitlist control (n=33) conditions. Implementation fidelity was documented. | As predicted, the 24 girls who successfully completed the program reported significant reductions in their perpetration of psychological abuse toward their baby’s father as compared to the control (n=23) participants. They also reported experiencing significantly less severe IPV victimization over the course of the program. Preliminary analyses indicated that avoidant attachment to one’s partner may be associated with less program-related change. |          |
<table>
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<tr>
<th>Study ref</th>
<th>Design</th>
<th>LoE</th>
<th>N</th>
<th>Aim/setting/population/methods</th>
<th>Results</th>
<th>Comments</th>
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</table>
| (Matseke & Peltzer 2013)  | Cross-section   | IV  | 160| **Aim:** to present findings of a brief IPV intervention  
**Setting:** South Africa  
**Population:** pregnant women attending prevention of mother-to-child transmission of HIV services.  
**Methods:** Eighteen community workers were recruited and trained in assessment of and intervention for abuse during pregnancy. Women who screened positive received a brief intervention: a 20-minute session on safety behaviours and strategies for dealing with the abuse, including referral to local support services. Eighty-four women attended a follow-up interview 3 months after the intervention. | The mean danger assessment score of 6.0 before intervention fell significantly to 2.8 after 3 months.                                                                                           |                                                                                                     |

2.2   **What interventions in a health care setting are effective for assisting Aboriginal and Torres Strait Islander women affected by domestic violence?**

No evidence identified; see Section 3.

2.3   **What interventions can be used to reduce the further incidence and impact of domestic violence for a woman who has disclosed she is in a violent relationship or has recently left a violent relationship?**

See Section 2.1.
How can antenatal care providers enhance the immediate safety of women in or at risk of violence?

**Aim:** to examine the effectiveness of an empowerment intervention versus standard care.

**Setting:** Peru

**Population:** low-income, abused pregnant women, among whom 42.2% were experiencing severe psychological abuse

**Methods:** Women in the intervention group received supportive counselling and education, and advice in the areas of safety by a trained social worker lasting about 30 minutes.

Women in the empowerment group were more likely to hide money (44.6 vs. 34.3%), establish a code with family or friends (19.6 vs. 16.2%), ask neighbours to call police if violence began (6.9 vs. 1.0%), had available bank account numbers (17.1 vs. 3.1%), had valuable jewellery (8.4 vs. 3.8%), and had available a hidden bag with extra clothing (9.0 vs. 3.1%). However, there was no statistically significant difference in health-related quality of life, adoption of safety behaviours, and use of community resources between women in the two groups.

**Cochrane analysis:** Results showed that women in the intervention group were more likely to make plans to avoid abuse by adopting safety behaviours (RR 2.60, 95% CI 1.41 to 4.79)

Unclear risk of bias as assessed in (Jahanfar et al 2014)
2.5 Evaluation of limitations of randomised controlled trials for interventions

<table>
<thead>
<tr>
<th>Study limitation</th>
<th>Judgement</th>
<th>Support for judgement</th>
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<tbody>
<tr>
<td><strong>Random sequence generation</strong></td>
<td>Low risk</td>
<td>Randomisation procedures varied by site. At the urban health department site, participants were randomised using computer-generated number assignments in blocks. Eligible participants were enrolled by the study’s research nurses and assigned to DOVE versus UC according to the next random number assignment. In the rural sites, there were 13 rural health agencies that participated. Cluster randomisation was used to assign seven health agencies to deliver the DOVE intervention and six health agencies were designated as UC. Cluster randomisation was necessary in the rural sites because each health agency was small enough that intervention drift was a plausible threat if women were the unit of randomization.</td>
</tr>
<tr>
<td><strong>Allocation concealment</strong></td>
<td>Low risk</td>
<td>The data managers, database development team, and statistical analysis team members were blinded to group assignment.</td>
</tr>
<tr>
<td><strong>Blinding</strong></td>
<td>Low risk</td>
<td>Pre-specified outcomes reported.</td>
</tr>
<tr>
<td><strong>Incomplete outcome data</strong></td>
<td>Low risk</td>
<td>There was substantial attrition from both groups with the greatest attrition occurring at the 18- and 24-month time points. In consideration of this, multiple imputation was conducted given its acceptance as the most robust method for handling missing data in a longitudinal study such as this. It has been shown to mitigate the risk of bias that would otherwise be associated with study results using list wise or complete case analyses. Examination of the results demonstrates that removal of 18- and 24-month time points (data not shown) do not change substantive findings, providing further support for study results.</td>
</tr>
<tr>
<td><strong>Selective reporting</strong></td>
<td>Low risk</td>
<td></td>
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<tr>
<td><strong>Other limitations</strong></td>
<td>Low risk</td>
<td>There was an 18.8% refusal rate, which might be related, in part, to a portion of more severely abused women not wanting an intervention delivered in their home. Anecdotally, we know that some abused women eligible for study participation did not want their home visitor to know about the abuse. It is hard to know what bias this may have introduced into the results, however, we did not find significant differences by intervention group for physical abuse scores (p = 0.93) or women who reported having the father of the baby in the home versus not (p = 0.58).</td>
</tr>
</tbody>
</table>
### 2.6 Excluded studies for interventions

Systematic reviews excluded due to low quality or overlap with high-quality systematic reviews

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
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Studies included in high-quality systematic reviews included in this review

<table>
<thead>
<tr>
<th>Study</th>
<th>Review</th>
</tr>
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<tbody>
<tr>
<td>Humphreys, J., et al. (2011) Increasing discussions of intimate partner violence in prenatal care using Video Doctor plus Provider Cueing; a randomized, controlled trial. 21, 136-144 DOI: 10.1016/j.whi.2010.09.006</td>
<td>Included in (Jahanfar et al 2014)</td>
</tr>
<tr>
<td>Study</td>
<td>Review</td>
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**Other exclusions**

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</table>
3 What are the additional considerations for Aboriginal and Torres Strait Islander women?

Evidence summary

Results of the previous review
This question was not asked in the literature review conducted to inform Module I of the guidelines (Australian Health Ministers’ Advisory Council 2012) and no evidence specific to Aboriginal and Torres Strait Islander women was identified in that review.

Results of the current review
No evidence was identified through the systematic review. However, a narrative review (Olsen & Lovett 2016) was identified through background searches and key findings are highlighted below.

Additional information

Family or domestic violence?
In general, the term family violence, rather than domestic violence, is preferred by Indigenous communities, as violence against women is conceptualised within extended families and the wider community. Family violence is understood to be the result of, and perpetuated by, a range of community and family factors, rather than one individual’s problematic behaviour within an intimate partnership.

Messages for practice

• Opinions and viewpoints from Indigenous people on “what works” to prevent violence against women should be included in programs and initiatives.
• There are important historical and cultural reasons for the differences between Indigenous and non-Indigenous approaches to family violence.
• Family and community cohesion are central to Indigenous viewpoints on how to address family violence.
• The cumulative nature of intergenerational trauma and socio-demographic disadvantage such as personal, economic and family related stressors suggests that reducing violence against Indigenous women requires a multifaceted and holistic approach.

Advice to EWG
Incorporate text on terminology and background information into narrative. Include narrative review in resources section.
3.1 Excluded papers for additional considerations for Aboriginal and Torres Strait Islander women

Background papers

(Hayes et al 2010) Among 92 indigenous women attending Townsville Aboriginal and Torres Strait Islander Health Service in the “Mums and Babies” clinic, significant, positive correlations emerged between the participants’ Edinburgh Postnatal Depression Scale (EPDS) score and the mothers’ history of child abuse and a history of exposure to domestic violence. A more conservative cutoff point for the EPDS (>9 vs. >12) led to 28 versus 17% of women being identified as “at risk” for depression. Maternal depression and stress during pregnancy and early parenthood are now recognised as having multiple negative sequelae for the fetus and infant, especially in early brain development and self-regulation of stress and emotions. Because of the cumulative cultural losses experienced by Australian indigenous women, there is a reduced buffer to psychosocial stressors during pregnancy; thus, it is important for health professionals to monitor the women’s emotional and mental well-being.

(Kildea et al 2013) Bivariate analysis revealed Indigenous women were statistically more likely to have spontaneous onset of labour and a non-instrumental vaginal birth. They were less likely to take epidurals for pain relief in labour, have assisted births, caesarean sections or perineal trauma. Despite better labour outcomes, Indigenous babies were more likely to be born preterm (< 37 weeks) and be low birth weight (< 2500 g); these differences remained significant in multivariate analysis. The trend analysis revealed relatively stable rates for teenage pregnancy, small for gestational age, low birth weight babies, and perinatal mortality for both cohorts, with the gap between cohorts consistent over time. A statistical widening of the gap in preterm birth and smoking rates was found with preterm birth demonstrating a relative increase of 51% over this period.
4 What are the additional considerations for women from culturally and linguistically diverse groups?

**Evidence summary**

**Results of the previous review**

This question was not asked in the literature review conducted to inform Module I of the Guidelines (Australian Health Ministers' Advisory Council 2012).

**Results of the current review**

Two very small observational studies provided some insight into acknowledgement of cultural differences (Wellock 2010; Byrskog et al 2015).

**Advice to the EWG**

Revise narrative to include key points from studies.
<table>
<thead>
<tr>
<th>Study ref</th>
<th>Evidence Level</th>
<th>Sample size</th>
<th>Aim/methods</th>
<th>Findings</th>
<th>Comments</th>
</tr>
</thead>
</table>
| (Wellock 2010) | IV | 6 | **Aim:** to interview bilingual (‘black and ethnic minority’) women in the community to explore: (1) how domestic abuse is viewed in their culture; and (2) who should be questioning women about this sensitive issue.  
**Methods:** a qualitative study using semi-structured interviews with non-pregnant bilingual workers within the local community. | Women’s lives were influenced by their in-laws and family, status, attitudes to marriage arrangements and gossiping in the community. All of these factors affected disclosure.  
Health-care professionals must understand that women take serious measures to hide the fact that they are victims of abuse in order to preserve family honour. Divulging information to interpreters or relatives is a problem because of lack of confidentiality and gossiping in the community. |  |
| (Byrskog et al 2015) | IV | 17 | **Aim:** to explore ways ANC midwives in Sweden work with Somali born women and the questions of exposure to violence.  
**Methods:** Qualitative individual interviews with 17 midwives working with Somali-born women in nine ANC clinics in Sweden were analysed using thematic analysis. | The midwives strived to focus on the individual woman beyond ethnicity and cultural differences. In relation to the Somali born women, they navigated between different definitions of violence, ways of handling adversities in life and social contexts, guided by experience-based knowledge and collegial support. |  |
Bibliography


