






REVIEW ARTICLE

Integrative review of the literature on screening for gender-based violence during pregnancy: Barriers, facilitators, and tools

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Abstract

An integrative review of the literature has been developed to explore barriers and facilitators in screening for gender-based violence in pregnant women and identify available tools for this screening. Studies were identified via a systematic search on the PubMed, CINAHL Plus (Cumulative Index of Nursing and Allied Health Literature Complete), Scopus, and LILACS (Latin American and Caribbean Health Sciences Literature) databases and a manual reverse reference search to obtain literature published between 2015 and 2020. The methodology followed the recommendations made by Whittemore & Knafel. The quality of studies was evaluated using the Critical Skills Appraisal Program tool. Twenty-three of the 4202 articles fulfilled the inclusion criteria. The principal barriers identified were lack of training for professionals (mainly nurses and midwives), lack of support policies, and lack of human and material resources. The main facilitators were to increase professional training programs on case detection, availability of effective instruments, and greater investment in resources to guarantee safety and referral of cases. With regard to the available tools, the Abuse Assessment Screen (AAS) continues to be the most widely used, although others such as the Humiliation, Afraid, Rape, and Kick questionnaire (HARK) could be suitable for antenatal care settings.

KEYWORDS

barriers, facilitators, gender-based violence, intimate partner violence, pregnancy, nursing, screening tools

Key points

- Gender-based violence during pregnancy is a serious health problem for women around the world. It also has severe physical and psychological effects in the short and long term.

All authors approve the final version of the manuscript for publication and guarantee that all parts of the manuscript have been reviewed and discussed among the entire research team in order to be presented with the highest accuracy and completeness.

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Screening mechanisms should be implemented in the antenatal care setting of the public health systems.

- The study presents an up-to-date review of the main barriers and facilitators of screening for gender-based violence in relation to health systems, professionals, and women themselves and provides information on available instruments.
- The research reveals the current state of screening of gender-based violence during pregnancy, emphasizing the role of nurses and midwives and the lack of investment in training of healthcare professionals and resources for implementation in the antenatal care setting.

1 | INTRODUCTION

The United Nations defined gender-based violence (GBV) as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (UN General Assembly, 1993). More recently, the Council of Europe Convention on preventing and combating violence against women and domestic violence defined GBV as “all acts of gender-based violence that involve or are likely to involve harm or suffering of a physical, sexual, psychological or economic nature to women, including threats of such acts, coercion or arbitrary deprivation of liberty, in public or private life” (Council of Europe, 2011). Often, the scientific literature refers to intimate partner violence when its investigation is confined to the perinatal period of the woman; however, as observed in other studies (e.g., Naismith et al., 2021) it may be interesting to use a broader perspective of the term, in which GBV is defined as violent acts perpetrated against women in different contexts (family, community, society at large), including intimate partner violence.

For centuries, the issue of GBV has been overlooked and ignored and health systems have not responded effectively to detect and address it (García-Moreno et al., 2015). From the 1990s onwards, however, international organizations such as the World Health Organization (WHO) have acknowledged GBV as a serious public health issue and a violation of women's human rights (García-Moreno et al., 2015).

Women who experience GBV are extremely vulnerable, and the risk of violence increases due to pregnancy. The antenatal period entails major physiological, psychological, and social changes (Glazier et al., 2004), which can lead to heightened vulnerability because of emotional disturbances (Guardino & Dunkel Schetter, 2014). Factors such as serious relationship difficulties, financial problems, and traditional gender roles could exacerbate this vulnerability and contribute to the occurrence of GBV during pregnancy. Evidence suggests that a prior history of GBV and a low education level may be predictors of experiencing GBV during pregnancy (James et al., 2013). Some guidelines suggest that there are complex social factors to consider in relation to GBV during pregnancy, such as mental health disorders, women with no social support, human trafficking, or female genital mutilation (National Institute for Clinical Excellence, 2010).

It is difficult to provide accurate statistics on the prevalence of GBV during pregnancy, as the methodologies used in studies on the topic vary greatly (e.g., different types of methodology and different types of violence across populations) (Román-Gálvez et al., 2021). However, several meta-analyses have identified a mean global prevalence of 28.4% for emotional violence, 13.8% for physical violence, and 8.0% for sexual abuse (James et al., 2013). More recent review studies refer to wider prevalence rates reporting that during pregnancy physical violence ranges between 1.6% and 78%, and psychological violence between 1.8% and 67.4% (Román-Gálvez et al., 2021).

Women who experience GBV during pregnancy may be at risk for experiencing psychological (Biaggi et al., 2016) and physical health consequences (Black, 2011; Chisholm et al., 2017), including death by homicide (Black, 2011). During this period, physical health effects may include problems such as premature membrane rupture, genital bleeding, reduced fetal movement, premature birth, and even miscarriage (Black, 2011). The most common psychological health effects reported by women who experience GBV during pregnancy include depression and anxiety disorders in the antenatal (Biaggi et al., 2016) and postpartum period (Chisholm et al., 2017) including post-traumatic stress disorder (McFarlane et al., 2014). GBV during pregnancy can also have serious repercussions for the health of the fetus. These include developmental and growth problems such as low birth weight, prematurity, and fetal death (Black, 2011; Chisholm et al., 2017), and severe long-term impacts on mental, cognitive, and physical health during childhood (Hahn et al., 2018).

1.1 | Background

Despite its high prevalence rates and serious consequences for the health of the mother-child dyad, GBV has been viewed as a social or legal issue rather than the public health issue that it has proven to be (García-Moreno et al., 2015). Because of the complexity involved in tackling GBV, the WHO (2021) recommends establishing guidelines for its prevention and treatment by implementing screening mechanisms in all healthcare settings and ensuring that these screening measures have considerable public health benefits (Moyer, 2013). Also, the WHO recommends that every professional involved in the care of women victims of violence should be trained in domestic violence screening (WHO, 2010). The lack of training on the gender perspective in the health sciences is a fact (Rrustemi et al., 2020). Therefore,

policies must be adopted to allow public health systems to effectively address violence against women by coordinating with other key sectors (social services, education, and the justice system) to guarantee holistic, uninterrupted care (García-Moreno et al., 2015).

The public health system is a gateway for women experiencing GBV (Colombini et al., 2017). This means that healthcare professionals who care for women in the antenatal period have an exceptional opportunity to detect GBV due to their access and direct, ongoing contact with these women (O'Reilly et al., 2010). Nurses, because of their role in the health system, are ideally positioned to provide support to women exposed to GBV (Briones-Vozmediano et al., 2021) because through their work (routine checkups, care for chronic health problems, etc.) they have the opportunity to detect and respond to GBV (e.g. Alshammari et al., 2018).

1.2 | Aims

This study aims to (1) explore barriers and facilitators of GBV screening in pregnant women in healthcare settings and (2) identify and describe the available tools for screening for GBV in pregnant women in antenatal care settings.

2 | METHOD

2.1 | Design

An integrative review of the literature was carried out to obtain an up-to-date overview of the topic in question. This design was chosen to reconceptualize the vision of the proposed problem and to facilitate an effective response. The methodology followed the recommendations made by Whittemore and Knafel (2005) for reviewing and analyzing research, as well as for reducing bias and ensuring the reliability of the results. The method consists of data reduction, data display, data comparison (noting patterns and themes, seeing plausibility, clustering, counting, making contrasts and comparisons, discerning common and unusual patterns, subsuming particular data into more general data, ascertaining the relationships between variants, finding intervening factors, building a logical chain of evidence), the drawing of conclusions, and verification.

2.2 | Search methods

A search for recent literature was conducted using the PubMed, CINAHL Plus (Cumulative Index of Nursing and Allied Health Literature Complete), Scopus, and LILACS (Latin American and Caribbean Health Sciences Literature) databases, and a manual reverse reference search using the snowball technique was carried out with references from the articles identified. The search was limited to studies written in English and published between January 2015 and December 2020.

The search was performed by the authors in December 2020. It was conducted in English using Medical Subject Headings (MeSH) terms and free text with Boolean operators AND and OR for the following keywords: pregnancy, pregnant, prenatal care, antenatal care, intimate partner violence, gender-based violence, domestic violence, screening, screening tools, barriers, facilitators, nursing, nurse.

2.3 | Search outcomes

The title and abstract of each article were examined to assess their relevance according to the proposed inclusion/exclusion criteria (Table 1). Studies based on all kinds of methodological design were considered, following the recommendations of Whittemore and Knafel (2005). The full text of the articles was then reviewed to determine whether or not they met the eligibility criteria. Six additional studies were identified via the snowball technique, using references from the articles found in the search.

The selection process is described in Figure 1.

2.4 | Quality appraisal

To evaluate the methodological quality of the articles, the CASPe (Critical Appraisal Skills Programme Español) critical appraisal tool was used (Cabello-López, 2015). CASPe has different versions for assessing reviews, clinical trials, and qualitative studies. The questionnaires in the tool comprise 10 (for reviews and qualitative studies) or 11 questions (for clinical trials), the first 2 (for reviews and qualitative studies) or three (for clinical trials) of which are eliminatory, that is, if the answer to one of these questions is "no", then the study is excluded. The subsequent questions allow the study to be analyzed in greater depth.

In the case of reviews and clinical trials, the first eight questions must be answered "yes," "no," or "I don't know." The answer "yes"

TABLE 1 Selection criteria for articles

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> Articles written in English Articles published in scientific journals, with a publication date between 2015 and 2020 Studies on instruments for screening for gender-based violence during pregnancy Studies on barriers and/or facilitators of screening for gender-based violence during pregnancy in antenatal care settings Articles that meet methodological quality criteria (Critical Appraisal Skills Programme Español [CASPe] ≥ 7) 	<ul style="list-style-type: none"> Duplicate entries Articles not available in full text Articles that are unrelated to the study objective Articles of low methodological quality

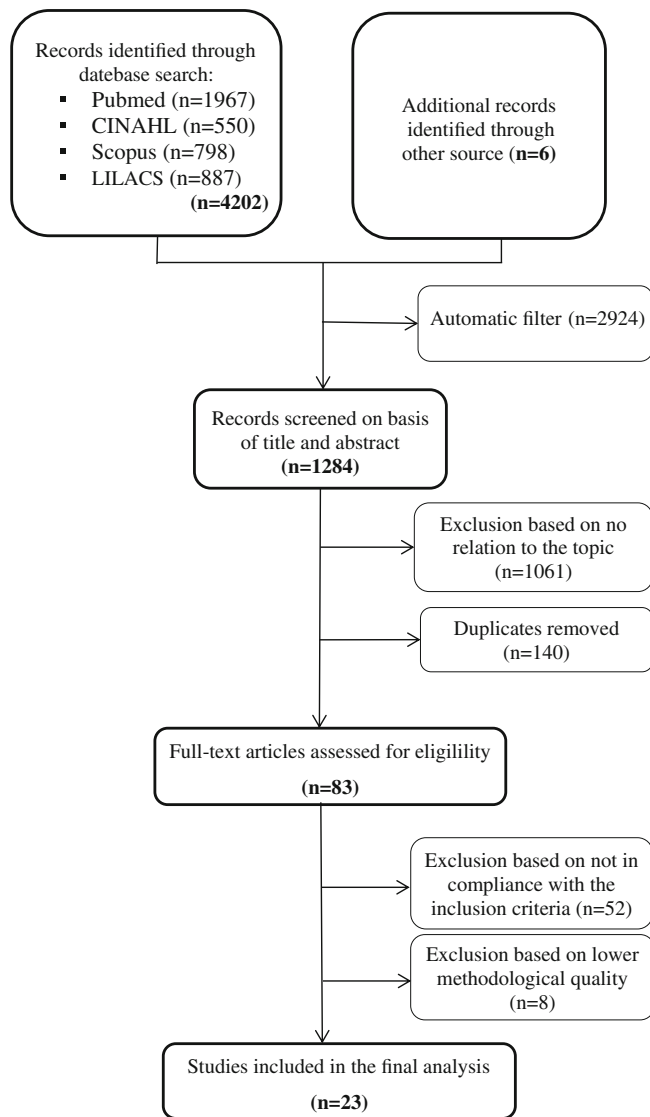


FIGURE 1 Flow chart of article identification.

scores 1 point, and “no” or “I do not know” score 0. The scoring range in both cases is from 0–8, as the last two additional questions refer to the overall result of the study and invite the reviewer to express their personal opinion. In the case of qualitative studies, the dynamic is the same but only the final question refers to the reviewer's personal opinion, so the scoring range is 0–9.

In this review, the methodological quality of the articles was evaluated using this tool and only articles scoring 7 or more points were included.

To evaluate the methodological quality of cross-sectional studies, the template developed by Berra et al. (2008) was used. It comprises 27 questions with four response options: “Very good,” “Good,” “Average,” and “Poor.” The methodological quality of a study may be considered to be high if the majority of the responses are “Very good” or “Good.”

A total of 23 studies met the inclusion criteria and were included in this review (Table 3).

2.5 | Data abstraction

The 23 selected articles were read closely to extract information that was relevant to the objectives of this review. Any discrepancies were resolved by consensus between all the authors. The data extracted included the following aspects: authors, year of publication, study design, barriers and facilitators associated with screening for GBV during pregnancy, and characteristics of the screening instruments used.

2.6 | Data synthesis

Once the data had been extracted, the results were classified and organized to enable them to be analyzed and compared to fulfill the objectives of the review (Whittemore & Knafl, 2005). The authors agreed to present the main findings by classifying the results on barriers and facilitators of GBV screening during pregnancy according to whether they were related to healthcare personnel, the health system, or women. Meanwhile, the information obtained on screening instruments (construct and characteristics, psychometric properties, and availability of validation study) was organized.

3 | RESULTS

Once the selection criteria had been applied to the 4202 articles found in the initial database search, 23 articles were included in this review (Bacchus et al., 2016; Baird et al., 2015; Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Damra et al., 2015; Duchesne et al., 2020; Escribà-Agüir et al., 2016; Eustace et al., 2016; Fletcher et al., 2016; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017; Hahn et al., 2018; Halpern-Meeke et al., 2019; Hegarty et al., 2020; Kataoka & Imazeki, 2018; Marques et al., 2017; Mauri et al., 2015; O'Doherty et al., 2015; Reinsperger et al., 2015; Spangaro et al., 2016; Wild et al., 2019). (Figure 1).

3.1 | Characteristics of included studies

Of the 23 included studies, $n = 14$ (60.9%) (Baird et al., 2015; Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Damra et al., 2015; Duchesne et al., 2020; Eustace et al., 2016; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017; Halpern-Meeke et al., 2019; Marques et al., 2017; Mauri et al., 2015; Wild et al., 2019) presented findings on barriers and facilitators related to screening for GBV during pregnancy and $n = 8$ (34.8%) (Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Escribà-Agüir et al., 2016; Fletcher et al., 2016; Kataoka & Imazeki, 2018; O'Doherty et al., 2015; Reinsperger et al., 2015) reported information on screening instruments. A total of

TABLE 2 Screening instruments for detecting gender-based violence during pregnancy

Instrument	Author/s	Construct and characteristics	Psychometric properties	Validation studies with a sample of pregnant women
Abuse Assessment Screen (AAS)	McFarlane et al. (1992)	<ul style="list-style-type: none"> • Contains five items • Format: yes/no • Administered by a professional • Evaluates the presence or absence of abuse over a specific time period, the frequency and perpetrator of the physical, sexual, or emotional abuse, and the location of injuries on the body • Includes a specific question about pregnancy • Setting: antenatal care 	Sensitivity: 93% Specificity: 55%–99%	McFarlane et al. (1998) Norton et al. (1995) Reichenheim and Moraes (2004) Escribà-Agüir et al. (2016)
Partner Violence Screen (PVS)	Feldhaus et al. (1997)	<ul style="list-style-type: none"> • Contains three items • Format: yes/no • Administered by a professional • Evaluates physical violence and perceptions of safety • Does not include a specific question about pregnancy • Settings: emergency department, primary care (pediatrics) 	Sensitivity: 64.5%–71.4% Specificity: 80.3%–84.4%	—
Ongoing Abuse Screen (OAS)	Weiss et al. (2003)	<ul style="list-style-type: none"> • Contains five items. Adapted from the AAS • Format: yes/no • Self-reported • Evaluates fear, physical and sexual abuse, and mistreatment • Includes a specific question about pregnancy • Setting: emergency department 	Sensitivity: 30%–60% Specificity: 90%–100%	—
Ongoing Violence Assessment Tool (OVAT)	Ernst et al. (2004)	<ul style="list-style-type: none"> • Contains four items • Format: true/false responses and a 5-point Likert scale (from 1 = never to 5 = very frequently) • Self-reported • Evaluates physical and emotional gender-based violence occurring in the past month • Does not include a specific question about pregnancy • Settings: emergency department, primary care 	Sensitivity: 86% Specificity: 83%	—
Slapped, Threatened or Thrown (STaT) scale	Paranjape and Liebschutz (2003)	<ul style="list-style-type: none"> • Contains three items • Format: yes/no • Administered by a professional • Evaluates whether a woman has suffered physical or psychological gender-based violence over the course of her life, whether she has been struck or threatened with violence by her partner, and whether her partner has exerted violence against objects • Does not include a specific question about pregnancy • Setting: emergency department 	Sensitivity: 94.4%–96% Specificity: 3.6%–75%	—

TABLE 2 (Continued)

Instrument	Author/s	Construct and characteristics	Psychometric properties	Validation studies with a sample of pregnant women
Humiliation, Afraid, Kick (HARK)	Sohal et al. (2007)	<ul style="list-style-type: none"> • Contains four items • Format: yes/no. Adapted from the AAS • Administered by a professional • Evaluates emotional and physical violence suffered over the past 12 months • Does not include a specific question about pregnancy • Setting: primary care 	Sensitivity: 81% Specificity: 95%	—
Hurt, Insult, Threaten, Scream (HITS)	Sherin et al. (1998)	<ul style="list-style-type: none"> • Contains four items • Format: 5-point Likert scale (from 1 = never to 5 = frequently) • Self-reported or administered by a professional • Evaluates the frequency with which a woman's partner has physically attacked, insulted or talked down to, threatened to harm, shouted or cursed at the woman over the past 12 months • Does not include a specific question about pregnancy • Settings: emergency department, primary care 	Sensitivity: 30%–88% Specificity: 88%–99%	—
Women Abuse Screening Tool (WAST)	Brown et al. (1996)	<ul style="list-style-type: none"> • Contains eight items • Format: The items on tension and conflict are scored from 0–1 (from 0 = no tension/few difficulties to 1 = serious tension/many difficulties). Other items: 3-point Likert scale (from 1 = often to 3 = never) • Self-reported • Evaluates the degree of tension and fear of the partner, and the existence of emotional, physical and sexual abuse • Does not include a specific question about pregnancy • Settings: primary care, shelters for abused women 	Sensitivity: 47%–88% Specificity: 89%–96%	—
Women Abuse Screening Tool (WAST) Short Form	Brown et al. (2000)	<ul style="list-style-type: none"> • Contains two items • Format: scores from 0–1 (from 0 = no tension, few difficulties to 1 = serious tension, many difficulties) • Self-reported • Evaluates tension within a couple's relationship and difficulties in resolving conflict • Does not include a specific question about pregnancy • Settings: primary care, shelters for abused women 	Sensitivity: 92% Specificity: 100%	—

$n = 7$ (30.4%) articles were review studies (Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Fletcher et al., 2016; Hahn et al., 2018; O'Doherty et al., 2015; Reinsperger et al., 2015), and $n = 10$ (43.5%) were qualitative studies (Bacchus et al., 2016; Damra et al., 2015; Eustace et al., 2016; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017; Kataoka & Imazeki, 2018; Marques et al., 2017; Mauri et al., 2015; Spangaro et al., 2016; Wild et al., 2019). Information on the type of design of the included studies can be found in Table 3.

3.2 | Barriers and facilitators of screening for gender-based violence in pregnant women in the antenatal care setting

An analysis of the 23 articles included in the study revealed a wide range of barriers/facilitators of screening for GBV during pregnancy, which can be grouped into three categories relating to (1) healthcare personnel; (2) the health system, and (3) women's *features, attitudes, and perceptions* of GBV screening.

Detailed information on the topics of each of the studies included in the review can be found in Table 3.

3.2.1 | Barriers relating to healthcare personnel

The most frequent barriers were lack of knowledge of approaches to GBV (Baird et al., 2015; Bermele et al., 2018; Colombini et al., 2017; Eustace et al., 2016; Mauri et al., 2015) and lack of training programs (e.g., to improve professionals' skills for identifying clinical signs and symptoms, conducting evaluations and using screening tools, and accessing available resources) (Bianchi et al., 2016; Colombini et al., 2017; Eustace et al., 2016; Mauri et al., 2015). Other barriers were linked to feelings of discomfort when addressing GBV (Duchesne et al., 2020; Kataoka & Imazeki, 2018), and a lack of self-confidence and ability to conduct screening tasks among healthcare personnel (Bermele et al., 2018; Duchesne et al., 2020), including negative attitudes and skepticism as to the efficacy of these tasks (Colombini et al., 2017).

3.2.2 | Barriers relating to the health system

At the organizational and structural level, one of the main barriers was a lack of time to carry out effective screening (Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Damra et al., 2015; Eustace et al., 2016; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017; Wild et al., 2019), an acute lack of resources (Bianchi et al., 2016; Gómez Fernández et al., 2017; Halpern-Meekin et al., 2019) including material resources and trained healthcare personnel for screening (Colombini et al., 2017), and a lack of spaces where privacy during consultations could be guaranteed (Bianchi

et al., 2016; Damra et al., 2015; Gómez Fernández et al., 2017; Wild et al., 2019).

In addition, studies reported other barriers such as a lack of reliable referral resources for cases of violence detected (Colombini et al., 2017; Eustace et al., 2016; Halpern-Meekin et al., 2019), a lack of supportive environments (e.g., spaces for exchanging good practices between colleagues; support and leadership from managers) (Colombini et al., 2017; Eustace et al., 2016; Gómez Fernández et al., 2017; Wild et al., 2019), a lack of policies to provide support for screening tasks (Bianchi et al., 2016; Colombini et al., 2017), and a lack of care continuity to monitor detected cases over the long term (Colombini et al., 2017; Damra et al., 2015).

3.2.3 | Barriers relating to women's features, attitudes, and perceptions

Some of the most prominent barriers were related to women's sociodemographic profiles (e.g., education level, ethnicity) (Halpern-Meekin et al., 2019); their partner's presence at the consultation (the pregnant woman may experience fear of reprisals and the consequences of disclosing that her partner is the perpetrator of the violence she suffers, i.e., suffer a greater degree of violence as punishment) (Duchesne et al., 2020; Eustace et al., 2016; O'Doherty et al., 2015), unwillingness among women to reveal the violence in their relationships (Mauri et al., 2015), and feelings of shame and fear of the consequences or of stigmatization (Colombini et al., 2017; Gómez Fernández et al., 2017; Marques et al., 2017). The perception of a poor therapeutic relationship (not feeling understood, feeling embarrassed) with healthcare professionals (Marques et al., 2017), cultural taboos (Gómez Fernández et al., 2017; Mauri et al., 2015), language barriers (Colombini et al., 2017; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017), and a perceived lack of material or structural resources and healthcare professionals to screen for GBV in the antenatal care setting (Bianchi et al., 2016; Colombini et al., 2017; Gómez Fernández et al., 2017; Halpern-Meekin et al., 2019) were also identified as barriers.

3.2.4 | Facilitators relating to healthcare personnel

One key facilitator was improved training on all aspects of GBV for healthcare personnel in the antenatal setting (Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Duchesne et al., 2020; Halpern-Meekin et al., 2019; Hegarty et al., 2020), especially midwives (Baird et al., 2015; Gómez Fernández et al., 2017; Mauri et al., 2015; Wild et al., 2019), and inclusion of training on this issue on university syllabuses (Baird et al., 2015; Duchesne et al., 2020). The establishment of a positive therapeutic relationship (Gómez Fernández et al., 2017; Mauri et al., 2015) and an attitude of acceptance and empathy from healthcare professionals (Chisholm et al., 2017; Colombini et al., 2017; Marques et al., 2017) were also identified as facilitators of GBV screening.

TABLE 3 Articles included in the review

Author/s (year) and country	Topic	Design	Results
Baird et al. (2015) Australia	Barriers and facilitators of GBV detection	Quantitative cross-sectional	<i>Barriers:</i> Lack of knowledge of risks and characteristics of abusers among midwives <i>Facilitators:</i> Adequate training for midwives would enhance their knowledge of ways to tackle GBV
Damra et al. (2015) Jordan	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Lack of privacy, lack of care continuity, time constraints in medical care <i>Facilitators:</i> Feeling safe and trusting professionals
O'Doherty et al. (2015)	Barriers to GBV detection Screening instruments	Systematic review	<i>Barriers:</i> Presence of the partner (abuser) during antenatal care <i>Instruments:</i> The most widely used tools in the trials included in the review were WAST, AAS, PVS, VAWS, CTS-SF, ALPHA
Reinsperger et al. (2015)	Screening instruments	Review	Discrepancies in the screening tools recommended for evaluating GBV during pregnancy: USPSTF (2013) propose HITS, OAS/OVAT, STaT, HARK, CTQ-SF, WAST AHMAC (2012) propose direct or indirect questions VA/DoD (2009) propose three simple direct questions*
Mauri et al. (2015) Italy	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Limited knowledge among midwives of the most common signs and symptoms of GBV, lack of training on responding to GBV, cultural taboos, and unwillingness to disclose abuse among women <i>Facilitators:</i> The therapeutic relationship with the woman, specific training for professionals, initiating training during university courses, use of detection tools, and an interdisciplinary focus on managing GBV
Escribà-Agüir et al. (2016) Spain	Screening instruments	Quantitative cross-sectional	The Spanish version of the AAS displays good test-retest reliability, specificity, and construct validity The sensitivity was good for detecting severe psychological abuse, and moderate for detecting severe physical abuse
Spangaro et al. (2016) Australia	Facilitators of GBV detection	Qualitative	<i>Facilitators:</i> Perception among pregnant women of high levels of interest and lack of prejudice from healthcare professionals
Eustace et al. (2016) Australia	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Perception of a lack of institutional support, lack of training or knowledge to address GBV, lack of referral resources, time constraints, and presence of partner at consultations <i>Facilitators:</i> The use of direct questions, follow-up consultations, and perception of high levels of interest and lack of prejudice from midwives among affected women
Bacchus et al. (2016) United States	Facilitators of GBV detection	Qualitative	<i>Facilitators:</i> Use of technology (tablet) in antenatal home care by healthcare professionals (reduces stigma and improves the therapeutic relationship)
Bianchi et al. (2016)	Barriers and facilitators of GBV detection Screening instruments	Review	<i>Barriers:</i> Discomfort among healthcare personnel and lack of time, privacy, support policies, knowledge of resources, and training <i>Facilitators:</i> Education and training for healthcare personnel, as well as policies and resources to guarantee detection and referral of women where necessary. Measures to address time constraints, provision of safe, private areas for evaluating GBV, and use of reliable, validated tools <i>Instruments:</i> recommendations from Centers for Disease Control and Prevention: AAS, HITS, OAS, PVS, WAST, Screening Tools–Domestic Violence (ACOG)
Fletcher et al. (2016)	Screening instruments	Review	<i>Instruments:</i> The screening tools available are imprecise: HITS and WAST: offer greater sensitivity, evaluate physical and nonphysical forms of GBV, have been used in different populations and settings, and are promising for use in pregnant women and in antenatal care settings

(Continues)

TABLE 3 (Continued)

Author/s (year) and country	Topic	Design	Results
			AAS: the most widely used tool during pregnancy. It is not currently recommended due to variations in sensitivity and the wording used HARK: focuses on efficacy, ease, and speed of scoring in a balanced manner. It evaluates all types of GBV and has frequently been used in antenatal care settings
Colombini et al. (2017)	Barriers and facilitators of GBV detection	Systematic review	<i>Barriers:</i> Lack of support and leadership from management, lack of referral and follow-up strategies linked to justice systems. Lack of information, lack of knowledge and skills to handle the issue, negative attitude and skepticism toward screening among healthcare personnel (perception of GBV as a social rather than a biomedical issue), and time constraints due to excessive workload <i>Perception among women of a lack of resources in the health system and a shortage of personnel to address the issue, as well as the risk of consequences from their abuser if they disclose the violence they are suffering</i> <i>Facilitators:</i> Availability of clear guidelines, policies, and protocols; support from management level; interdisciplinary coordination with clear, accessible referral options within and beyond the specific facility; suitable, trained personnel who show acceptance and empathy toward women suffering violence; initial and ongoing training of healthcare personnel
Silva Marques et al. (2017) Brazil	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Perception among pregnant women of a poor relationship with healthcare personnel, fear, shame, and economic and emotional dependence on the abuser <i>Facilitators:</i> Active listening by nursing professionals in antenatal care, development of a protocol specifying individual and collective responsibilities, provision of spaces for pregnant women and healthcare personnel to share uncertainties and fears, and implementation of interdisciplinary measures to ensure compliance with policies to address violence against women
Chisholm et al. (2017)	Barriers and facilitators of GBV detection Screening instruments	Review	<i>Barriers:</i> Time constraints among medical personnel <i>Facilitators:</i> Healthcare professionals with active listening skills and sensitivity, who do not judge women. Availability of appropriate screening tools (focus on technology-based screening to relieve time constraints). Committed leadership, more resources for potential referrals to specialists or lawyers, and regular training for all professionals <i>Instruments:</i> Ongoing lack of consensus as to optimal screening tool USPSTF recommends the use of WAST The AAS ^c proved useful for pregnant women, and could be adapted for use with technology The HARK is a robust tool based on the AAS that could be applied in the antenatal care setting
Kataoka and Imazeki (2018) Japan	Facilitators of GBV detection Screening instruments	Qualitative	<i>Facilitators:</i> Inform women of the benefits of screening for GBV Level of acceptability related to convenience, speed, and difficulty of the screening method. Optimization (screening during pregnancy is a convenient time for women) <i>Instruments:</i> VAWS
Hahn et al. (2018)	Facilitators of GBV detection	Review	<i>Facilitators:</i> Availability of guidelines on detecting cases, planning to ensure safety, and awareness of referral mechanisms
Bermele et al. (2018) United States	Barriers and facilitators of GBV detection Screening instruments	Quasi-experimental	<i>Barriers:</i> Lack of confidence and ability among healthcare personnel to detect and assist pregnant women suffering GBV due to lack of knowledge <i>Facilitators:</i> Improve knowledge of GBV and of the use of screening tools

TABLE 3 (Continued)

Author/s (year) and country	Topic	Design	Results
			<i>Instruments:</i> The protocol covers screening of pregnant women to detect GBV using the AAS and the DA5 to determine the risk of homicide
Wild et al. (2019) Timor (Asia)	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Lack of time among midwives, lack of privacy, and lack of supportive environments in the antenatal care setting <i>Facilitators:</i> Improved training for midwives in responding to cases of violence; support from colleagues and managers of healthcare facilities. Shift to multidisciplinary approach involving all personnel, including management bodies, and linking healthcare resources to community resources more generally
Gómez-Fernández et al. (2017) Spain	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Structural conditions for care (lack of privacy in consultations, lack of time due to high caseloads and excessive bureaucracy); women's circumstances (language barriers, cultural differences, and stigmatization); complexity of screening (fear of raising the topic due to lack of support and resources for managing the issue) <i>Facilitators:</i> The role of the midwife in monitoring the pregnancy and postpartum period and the relationship established with the woman during these visits. The presence of the woman's partner at appointments allowed attitudes and behaviors relating to GBV to be observed. Increasing training and approving an internal protocol including effective screening tools, coordination with other departments, and the most appropriate ethical and legal manner of recording the situation in clinical records
Halpern-Meekin et al. (2019) United States	Barriers and facilitators of GBV detection	Quantitative cross-sectional	<i>Barriers:</i> The sociodemographic characteristics of pregnant women and limited resources for responding adequately to GBV (referral) <i>Facilitators:</i> Improve training of healthcare personnel in the antenatal care setting, develop protocols within electronic health records and reinforce their application (incentives or penalties for noncompliance), and incorporate referral mechanisms. Adopt alternative methods to inform and support women during pregnancy
Duchesne et al. (2020) France	Barriers and facilitators of GBV detection	Quasi-experimental	<i>Barriers:</i> Presence of the partner, lack of awareness of the need for screening, discomfort among healthcare personnel when addressing GBV, and difficulty in identifying victims <i>Facilitators:</i> Deliver more holistic interventions, include training on GBV in university courses, promote training among healthcare personnel, and develop support policies to facilitate screening for GBV during pregnancy
Garnweidner-Holme et al. (2020) Norway	Barriers and facilitators of GBV detection	Qualitative	<i>Barriers:</i> Lack of time during consultations with midwives and ethnic barriers (e.g., language barriers) <i>Facilitators:</i> Use of technology (tablets) by midwives during antenatal care to provide information about GBV and promote safe behaviors
Hegarty et al. (2020)	Facilitators of GBV detection	Qualitative metasynthesis	<i>Facilitators:</i> Improve training for healthcare professionals in five areas: making a personal commitment; adopting an empathetic, unprejudiced attitude; establishing a relationship of trust with women; working with a multidisciplinary team; and receiving support from the health system

Abbreviations: AAS, Abuse Assessment Screen; ACOG, American College of Obstetricians and Gynecologists; AHMAC, Australian Health Ministers' Advisory Council; ALPHA, Antenatal Psychosocial Health Assessment; CTQ-SF, Childhood Trauma Questionnaire–Short Form; CTS-SF, Conflict Tactics Scale–Short Form; DA5, Danger Assessment–5; GBV, gender-based violence; HARK, Humiliation, Afraid, Rape, Kick; HITS, Hurt, Insult, Threaten, Scream; OAS, Ongoing Abuse Screen; OVAT, Ongoing Violence Assessment Tool; PVS, Partner Violence Screen; STAT, Slapped, Threatened, and Thrown; USPSTF, United States Preventive Services Task Force; VA/DoD, Department of Veterans Affairs/Department of Defense; VAWS, Violence Against Women Scale; WAST, Woman Abuse Screening Tool.

*“In the last year, has anyone hit, slapped, kicked or physically hurt you in any way? Since you became pregnant, has anyone hit, slapped, kicked or physically hurt you in any way? In the last year, has anyone forced you to engage in sexual activity?”

3.2.5 | Facilitators relating to the health system

The facilitators in this category were the availability of guidelines, protocols, and policies to support screening (Bianchi et al., 2016; Colombini et al., 2017; Duchesne et al., 2020; Gómez Fernández et al., 2017; Hahn et al., 2018; Halpern-Meekin et al., 2019; Marques et al., 2017; Wild et al., 2019) and efficient screening tools (Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Hahn et al., 2018; Kataoka & Imazeki, 2018; Mauri et al., 2015); the use of simple, direct screening questions (Reinsperger et al., 2015); and the use of technology to facilitate screening (Bacchus et al., 2016; Chisholm et al., 2017; Garnweidner-Holme et al., 2020).

Other facilitators included providing referral mechanisms to guarantee support and safety for women (Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Hahn et al., 2018; Halpern-Meekin et al., 2019) and linking healthcare resources to community resources for improved coverage (Chisholm et al., 2017; Wild et al., 2019), providing environments where women's privacy can be guaranteed (Bianchi et al., 2016) and communication between victims and healthcare personnel can be facilitated to allow them to share their experiences of GBV (Marques et al., 2017), adopting organizational measures to mitigate limited consultation times (Bianchi et al., 2016), implementing long-term monitoring of cases (Eustace et al., 2016), and encouraging a multidisciplinary approach (Mauri et al., 2015; Wild et al., 2019).

3.2.6 | Facilitators relating to women

Perceiving interest from healthcare personnel, not feeling judged (Eustace et al., 2016; Spangaro et al., 2016), and feeling safe and trusting in healthcare settings (Damra et al., 2015) were identified as facilitators. Other facilitators included the presence of women's partners at consultations (i.e., allowing behaviors associated with GBV to be assessed) (Gómez Fernández et al., 2017), promotion of the benefits of screening among pregnant women (i.e., offering opportunities for support) (Kataoka & Imazeki, 2018), and provision of spaces for information and support outside the antenatal care setting (Halpern-Meekin et al., 2019).

3.3 | Instruments for GBV screening during pregnancy

3.3.1 | Screening instruments included in the studies

The review by Reinsperger et al. (2015) includes the Hurt, Insult, Threaten, Scream tool (HITS; Sherin et al., 1998); the Ongoing Abuse Screen (OAS; Weiss et al., 2003), the Ongoing Violence Assessment Tool (OVAT; Ernst et al., 2004); the Slapped, Threatened or Thrown Scale (STaT; Paranjape & Liebschutz, 2003); the Humiliation, Afraid, Rape, and Kick questionnaire (HARK; Sohal et al., 2007); the

Childhood Trauma Questionnaire–Short Form (CTQ-SF; Bernstein et al., 2003); and the Women Abuse Screening Tool (WAST; Brown et al., 1996) and adds the use of direct and indirect questions. Meanwhile, Chisholm et al. (2017) cover the use of the HITS (Sherin et al., 1998), the OAS (Weiss et al., 2003), the OVAT (Ernst et al., 2004), the STaT (Paranjape & Liebschutz, 2003), the CTQ-SF (Bernstein et al., 2003), the WAST (Brown et al., 1996), and the Abuse Assessment Screen (AAS; McFarlane et al., 1992), identifying the HARK (Sohal et al., 2007) as the most robust instrument. The review by Bianchi et al. (2016) draws on recommendations from the Centers for Disease Control and Prevention (Gerberding et al., 2007) and covers the use of the AAS (McFarlane et al., 1992), the HITS (Sherin et al., 1998), the OAS (Weiss et al., 2003), the Partner Violence Screen (PVS; Feldhaus et al., 1997), the WAST (Brown et al., 1996), and the Screening Tools–Domestic Violence (proposed by the American College of Obstetricians and Gynecologists).

On the other hand, in their review, Fletcher et al. (2016) discuss the psychometric properties of all available instruments for GBV screening in antenatal care settings and recommend the use of the HITS (Sherin et al., 1998), the WAST (Brown et al., 1996), the AAS (McFarlane et al., 1992), and the HARK (Sohal et al., 2007). The systematic review by O'Doherty et al. (2015) reports on the screening tools used in some of the studies included in the review, such as the WAST (Brown et al., 1996), the PVS (Feldhaus et al., 1997), the AAS (McFarlane et al., 1992), the Violence Against Women Scale (VAWS; Kataoka, 2005), the Conflict Tactics Scale–Short Form (CTS-SF; Straus & Douglas, 2004), and the Antenatal Psychosocial Health Assessment (ALPHA; Carroll et al., 2005). The studies by Bermele et al. (2018) and Kataoka and Imazeki (2018) offer information on the instruments used in their research: the AAS (McFarlane et al., 1992), the Danger Assessment-5 (DA5; Snider et al., 2009), and the VAWS (Kataoka, 2005) respectively. Escribà-Agüir et al. (2016) report on the results of a validation of the AAS (McFarlane et al., 1992) in a group of pregnant women in Spain.

Table 2 contains a summary of the characteristics of the most commonly used screening instruments according to the studies reviewed.

All of the results obtained in the articles included in the review can be found in Table 3.

4 | DISCUSSION

Screening is the first step towards identifying cases and taking action to break the vicious circle of GBV (Chisholm et al., 2017). Evidence suggests that implementing screening mechanisms in the antenatal care setting is a key component of GBV screening, offering pregnant women the opportunity to disclose the violence they are experiencing and allowing healthcare personnel to carry out monitoring, intervention, and referral to other services (Kataoka & Imazeki, 2018). Nurses play a key role in identifying and responding to these situations

because they are the healthcare professionals who are in the closest and most continuous contact with the woman during the perinatal period (Williams et al., 2017).

However, the results appear to show that numerous barriers continue to hinder effective screening in the antenatal care setting. These barriers relate to different factors, depending on whether they are considered from the more global perspective of the health system or from more focal perspectives, such as those of healthcare personnel or women experiencing GBV during pregnancy. Nevertheless, these different sets of barriers appear to be interlinked. For example, inadequate investment in specific policies for tackling GBV during pregnancy (Bianchi et al., 2016; Colombini et al., 2017) and a lack of support and leadership from managers within health systems (Colombini et al., 2017; Eustace et al., 2016; Gómez Fernández et al., 2017; Wild et al., 2019) contribute to a lack of available training programs (Baird et al., 2015; Bermele et al., 2018; Bianchi et al., 2016; Colombini et al., 2017; Eustace et al., 2016; Mauri et al., 2015), which is the main barrier relating to healthcare personnel. Limited knowledge and skills among healthcare professionals can lead to issues such as low self-confidence or discomfort and skepticism with regard to measures to screen for GBV during pregnancy (Bermele et al., 2018; Colombini et al., 2017; Duchesne et al., 2020). In turn, this can have a negative impact on the therapeutic relationship between professionals and users (Marques et al., 2017) or even perpetuate factors affecting many women, such as cultural taboos (Gómez Fernández et al., 2017; Mauri et al., 2015), fear, and stigmatization (Colombini et al., 2017; Gómez Fernández et al., 2017; Marques et al., 2017). In addition, a lack of resources (Bianchi et al., 2016; Gómez Fernández et al., 2017; Halpern-Meekin et al., 2019), such as areas where privacy can be guaranteed (Bianchi et al., 2016; Damra et al., 2015; Gómez Fernández et al., 2017; Wild et al., 2019) and referral mechanisms (Colombini et al., 2017; Eustace et al., 2016; Halpern-Meekin et al., 2019), and a shortage of trained personnel (Colombini et al., 2017) can negatively affect women's perceptions of the health system's capacity to screen for GBV during pregnancy (Bianchi et al., 2016; Colombini et al., 2017; Gómez Fernández et al., 2017; Halpern-Meekin et al., 2019).

However, there are multiple factors that facilitate the implementation of screening interventions to detect GBV in antenatal care settings. For example, adopting policies to support screening in health systems and providing recommendations in the form of clinical guidelines and protocols (Bianchi et al., 2016; Colombini et al., 2017; Duchesne et al., 2020; Gómez Fernández et al., 2017; Hahn et al., 2018; Halpern-Meekin et al., 2019; Marques et al., 2017; Wild et al., 2019) play a role in achieving other facilitators, such as longer consultation times and long-term monitoring of cases (Eustace et al., 2016). Additionally, investment in material resources within health systems, as well as the provision of safe, private spaces for care (Bianchi et al., 2016), the availability of referral mechanisms (Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Hahn et al., 2018; Halpern-Meekin et al., 2019; Wild et al., 2019) linked to relevant community services (Chisholm et al., 2017; Wild et al., 2019), and human resources to provide a multidisciplinary response to the issue

(Bermele et al., 2018; Mauri et al., 2015) can help healthcare personnel implement measures to screen for GBV during pregnancy, improving women's mental health (Jahanfar et al., 2014) as part of a holistic approach to care (Woltmann et al., 2012). One of the most widely evidenced facilitators is improved training on screening and responding to GBV for healthcare personnel in the antenatal setting (Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Colombini et al., 2017; Duchesne et al., 2020; Halpern-Meekin et al., 2019; Hegarty et al., 2020), especially midwives (Baird et al., 2015; Gómez Fernández et al., 2017; Mauri et al., 2015; Wild et al., 2019), and inclusion of training on this issue on university syllabuses (Duchesne et al., 2020; Mauri et al., 2015). This objective echoes recommendations from the WHO (2013), which state that all professionals who provide care for women who are victims of violence must receive the training required to detect this violence. Research has shown that some effective programs are already in place to improve healthcare personnel's training on detecting GBV during pregnancy (Bermele et al., 2018). This appears to be one of the key strategies for ensuring that healthcare personnel develop their interpersonal skills and show greater acceptance and a more positive, empathetic stance to tackling GBV (Chisholm et al., 2017; Colombini et al., 2017; Eustace et al., 2016; Marques et al., 2017; Spangaro et al., 2016), resulting in a better therapeutic relationship (Gómez Fernández et al., 2017; Mauri et al., 2015) where women experience a sense of safety and trust (Damra et al., 2015) allowing them to disclose and report their circumstances.

Another of the most prominent facilitators is the availability of efficient screening instruments to detect GBV (Bermele et al., 2018; Bianchi et al., 2016; Chisholm et al., 2017; Gómez Fernández et al., 2017; Hahn et al., 2018; Kataoka & Imazeki, 2018; Mauri et al., 2015), using technology (Bacchus et al., 2016; Chisholm et al., 2017; Garnweidner-Holme et al., 2020) to overcome some of the barriers to face to face detection by addressing the lack of time for screening during consultations (Chisholm et al., 2017) and the language barrier (Colombini et al., 2017; Garnweidner-Holme et al., 2020; Gómez Fernández et al., 2017), enhancing rates of disclosure among women by using self-administered methods, and helping to standardize the way in which evaluations and interventions are implemented (Hussain et al., 2013). In recent decades, a wide range of instruments designed to detect different aspects of GBV in different groups has emerged (Haggerty et al., 2011); however, no consensus has yet been reached to detect GBV among pregnant women. Most of the studies consulted in this review (Bianchi et al., 2016; Chisholm et al., 2017; Fletcher et al., 2016; O'Doherty et al., 2015; Reinsperger et al., 2015) agree on the use of instruments such as the WAST (Brown et al., 1996), the OAS (Weiss et al., 2003), the OVAT (Ernst et al., 2004), and the HITS (Sherin et al., 1998), but they were not designed for use in antenatal care (e.g., the WAST was validated for the general population by Pichiule Castañeda et al., 2020). Although the AAS (McFarlane et al., 1992) remains the most widely used instrument (Fletcher et al., 2016) and has been validated in different languages for pregnant women (e.g. Escribà-Agüir et al., 2016), it displays certain methodological shortcomings that limit its efficacy (Fletcher et al., 2016). Some of the studies reviewed (Chisholm et al., 2017; Fletcher et al., 2016; Reinsperger et al., 2015) point to the HARK (Sohal et al., 2007) as a valid alternative, as it

evaluates all types of GBV and covers efficacy, ease, and speed of administration in a balanced manner (Fletcher et al., 2016). However, there is a lack of validation studies in pregnant women of different origins and in different settings.

4.1 | Limitations

This review has several limitations, including possible biases due to the search strategy used, as well as the range of years and the language of publication of the articles determined in the inclusion/exclusion criteria, which may have affected the quantity and type of studies identified. However, the search for references cited in the selected articles increased the probability of identifying relevant studies. The studies reviewed also displayed methodological limitations that may have influenced the results. Future research should focus on developing strategies for screening for GBV during pregnancy and confirming their efficacy with better quality controlled studies.

5 | CONCLUSION

Much of the evidence reviewed indicates that antenatal care settings are the most appropriate for detecting GBV during pregnancy (Colombini et al., 2017; Hahn et al., 2018; O'Doherty et al., 2015) and that nurses and midwives play a crucial role in identifying and managing GBV, although they continue to experience significant difficulties (Reinsperger et al., 2015). This study casts light on the current situation in screening for GBV in pregnant women in antenatal care settings and the need to work to overcome barriers to detection. It paves the way for future research to demonstrate how strategies such as developing training programs, providing clinical guidelines and protocols, applying validated evaluation instruments, and using technology can help to overcome these barriers, improving professionals' ability and willingness to implement effective measures to detect GBV in pregnant women in antenatal care settings in public health systems.

AUTHOR CONTRIBUTIONS

Study conception and design: LAP, VMGC; search strategy design: LAP; search, screening, review and selection of articles: LAP, VMGC, MJVC, DMT, ACG; interpretation of data: LAP, MJVC. Article writing: LAP; manuscript review: VMGC, MJVC, DMT, ACG.

DATA AVAILABILITY STATEMENT

Data are available upon reasonable request. All necessary data are supplied and available in the manuscript; however, the corresponding author will provide the dataset upon request. All data relevant to the study are included in the article.

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How to cite this article: Andreu-Pejó, L., Valero-Chillerón, M. J., González-Chordá, V. M., Mena Tudela, D., & Cervera Gasch, A. (2022). Integrative review of the literature on screening for gender-based violence during pregnancy: Barriers, facilitators, and tools. *Nursing & Health Sciences, 24*(3), 564–578. <https://doi.org/10.1111/nhs.12967>