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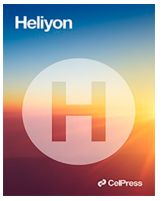

Research article

Barriers to routine screening for intimate partner violence during pregnancy in Nigeria

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ABSTRACT

Background: The benefits of routine screening for intimate partner violence (IPV) among pregnant women include early identification, prompt management, referral of IPV victims, and creating awareness about IPV. Despite these benefits, the practice of routine screening of IPV remains limited in midwifery settings in low-income countries. The purpose of this study is to identify and describe midwives' perspectives of the barriers in conducting routine screening of IPV for pregnant women in northern Nigeria.

Methods: A case study qualitative descriptive design was used to collect data from ten midwives in the antenatal clinic of a tertiary hospital. Non-participant observation and individual face-to-face semi-structured interviews were used as data collection methods. Thematic data analysis was carried out using Yin's five stage analytical cycle.

Findings: Three themes, with related subthemes, emerged from the data: (i) The theme of "Internal" barriers to IPV screening has four subthemes; midwives' personal discomfort in asking IPV- related questions, perceived mistrust of midwives by pregnant women, midwives' own perceptions of IPV as a personal matter, and midwives' lack of skills to screen for IPV. (ii) "External" barriers to IPV screening subsumes three subthemes: antenatal card related barriers, workload related barriers, and protocol barriers. (iii) "Structural" barriers to IPV screening have two subthemes: lack of space for privacy and lack of resources for managing pregnant women who have experienced IPV.

Conclusion: Knowing the barriers to midwives' screening practices is important because it may help in the development of contextually relevant and acceptable screening guidelines for midwives in Nigeria. Education and training of midwives will eliminate the internal barriers while the external barriers will need the intervention of hospital authorities and government to eliminate their effects on screening.

1. Introduction

Intimate partner violence (IPV) is physical violence, sexual violence, stalking and psychological aggression or other coercive tactics by a current or former intimate partner to their spouse or partner [1]. IPV can occur irrespective of religion, ethnicity, race, socio economic background and educational qualification of pregnant women [2]. IPV has negative impacts on pregnant women and unborn babies, when there is delay in identifying and initiating prompt management.

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The negative impacts of IPV on pregnant women include inadequate intake of nutritious food, consumption of alcohol, sexually transmitted diseases, injuries, post-traumatic stress disorder, hypertension, threatened abortion, premature labour, miscarriage, homicide and suicide [3,4]. For the babies, the negative impacts include low birth weight, respiratory distress syndrome, and perinatal death [3,4].

Midwives are in a unique position to screen pregnant women for IPV because of the frequent contacts they have during pregnancy in antenatal and post-natal visits [5,6]. Pregnant women may therefore be inclined to trust midwives and disclose IPV to them in order to get appropriate support and help [5]. Midwives will need to establish rapport to achieve this.

Routine screening for IPV among pregnant women leads to early identification [5]. This in turn prompts timely management and referral. Routine screening can mitigate the negative impacts of IPV for both the pregnant women and their children [7]. Routine screening for IPV can be used as a tool for raising awareness of IPV and reduction of the stigma that is associated with IPV in society, preventing future reoccurrence and it is cost-effective [7–9]. Despite these benefits, barriers to routine screening have been reported in many midwifery settings globally. These include lack of time due to huge workload, lack of privacy due to the presence of pregnant women's partners, lack of resources, and absence of implementable policies, protocols and guidelines [10–12].

Routine screening of IPV among pregnant women in antenatal settings occurs in high income countries such as Australia, the United States of America, United Kingdom, and Canada [13–15]. The rate of IPV screening is moderate to high in these countries, for instance the screening rate in the USA is about 49.2 %–62.9 % and 67 % in Canada [13,15,16].

In low-income countries, the rate of IPV screening is low when compared to the rates in high income countries. In Uganda, Kenya, and South Africa, health professionals do not always screen pregnant women for IPV [17–19]. Anguzu et al. [18], found that 11 out of 28 health professionals screened pregnant women for IPV. The screening rate is moderately low when compared to the total health professionals that were interviewed. In Kenya, Githui et al. [17], reported that the rate of routine screening for IPV in the antenatal setting was 16 % (20) out of 125 nurses interviewed. This rate is low when compared to the prevalence (49 %) of IPV among women in the research setting [20]. This may be due to barriers to IPV screening, such as a lack of trust in the relationship between pregnant women and midwives, culture of silence among pregnant women, deficient communication skills, and lack of knowledge on IPV screening [19,21–23].

In Nigeria, the screening rate of IPV among women is very low to non-existent [24]. John et al. [25], revealed that 7 % (35) out of 507 women interviewed had ever been screened for IPV by health professionals. Bamigboye et al. [19] argued that there is no proof that routine screening for IPV is being performed in Nigeria. This is disappointing considering efforts by IPV advocates, Civil Society Organisations (CSOs), and Non-Governmental Organisations (NGOs) to increase awareness about the negative effects of IPV on women and their children [26]. The government has been able to pass law for strict punishment of perpetrators of IPV, yet efforts have not been directed towards ensuring identification of IPV in strategic places like antenatal units [27].

The barriers to routine screening of pregnant women for IPV in northern Nigeria are largely unknown despite the increase in prevalence of IPV from 5 % in 2013 to 6 % in 2018 [28,29]. This qualitative study will enhance the understanding of midwives' perspectives of the barriers to conducting routine screening for IPV in hospitals in order to channel evidence-based interventions on mitigating IPV in pregnant women in the future. The objective is to describe the factors that influences midwives' routine IPV screening for pregnant women in a hospital in northern Nigeria.

2. Materials and methods

2.1. Research setting

The study was carried out at an antenatal clinic (ANC) in a tertiary hospital in northern Nigeria. The ANC is the busiest in the area, receiving about 230 pregnant women per week. Three to four midwives were responsible for the day-to-day management of all patients. A total of 12 midwives ran the clinic. This ANC was selected due to its high patronage of pregnant women compared to other clinics.

2.1.1. Study design

A case study qualitative descriptive design was used to identify and describe the midwives' screening practice of IPV among pregnant women attending the ANC. In bounding the case, as suggested by Yin [30], the phenomenon was the barriers to routine screening of IPV, the real life context was the midwives' perspectives of routine screening of pregnant women, the case was the antenatal unit in the tertiary hospital in northern Nigeria and the time frame for data collection was 9th January to May 22, 2017 [30]. This design was found to be the most suitable to enhance understanding of midwives' perspectives on the barriers to conducting routine screening for IPV and it remains critical in order to develop contextually relevant and acceptable screening guidelines for midwives in northern Nigeria.

Sampling Technique and Size: Purposive sampling was used to select ten midwives who had worked in the ANC for more than three years, this was important because they would have more experience with managing IPV victims. This sample size, though small, was adequate to achieve data saturation. It is also adequate since the group was homogenous that is, comprising of only midwives and working in same clinic. This was important because the study sought to understand the barriers of midwives' practice of IPV screening. Hennink and Kaiser [31] in their systematic review on sample size in qualitative research found that participant numbers of nine to 17 was enough to achieve saturation in a homogenous group for studies involving interviews. Creswell [32] advised that qualitative research is about obtaining rich and quality information about a phenomenon under study and a sample size of 10 can achieve this. The size was also guided by the rationale of the study to achieve in-depth information about the phenomenon, time frame and resources for

the research as suggested by Ref. [33]. Data saturation was reached at the ninth participant. The 10th participant was added to confirm saturation [34].

3. Data collection

Recruitment of Participants: After ethical approval was obtained, a meeting was arranged with the midwife in-charge of the ANC unit by the researcher. In the meeting, the ethical approval from the hospital and the study information sheet were presented to the midwife in-charge. They reviewed the documents and provided consent for the researcher to use the unit. The midwife in-charge gave a tour of the unit to the researcher and introduced her to the other staff working in the unit. The researcher recruited other staff that met the criteria. The midwife in-charge discussed the research with them in their offices and gave them the information sheet for 48 h to study. Thereafter, written consent was obtained from them.

During a group health talk, the researcher was introduced by the midwife in-charge of the unit to the pregnant women. The researcher explained the research to the pregnant women and the activities involved. Voluntary participation was emphasized, and assurance was given that decisions not to participate in the study will not affect the quality of treatment that participants received from the staff or clinic. Thereafter, verbal consents were obtained daily, prior to observing activities involving pregnant women. Verbal consent was used because pregnant women were not directly observed.

Pilot Study: This was conducted from 9th −30th of January 2017 using three participants. The objective was to identify any practical problem that may arise with the interview guide, venue and days of conducting the interview. The lessons learnt included: i) the raw data generated was shared with the second supervisor, who was in agreement with the data generated and satisfied with the interview guide. ii) the venue of the interview had to be changed to a more private place and the days for the interview were moved to Tuesdays which were a less busy day. Data generated during the pilot study was added to the study since data collection and analysis were interwoven [35].

Data was collected using two main data collection methods, that is non-participant observation and individual face-to-face interviews. For non-participant observation, an observation checklist developed by the researchers according to the research objective and literature was employed [23]. It was used to observe midwives' daily activities in the ANC, in order to determine the barriers to conducting routine screening for IPV. The observation checklist can be seen in appendix one. The semi-structured interview guide for individual face-to-face interviews was designed according to the study objectives by the researchers and findings from non-participant observation. The semi-structured interview guide can be seen in appendix two.

During non-participant observations, the researcher visited the ANC, moved around to observe the general activities going on, and later sat in the cubicle to observe the activities of each midwife as they interacted with patients, using the checklist, and taking field notes. The midwives and pregnant women were aware of the researcher's presence having consented to the study prior to the non-participant observation. The researcher observed all the midwives at different intervals on their routine activities in the ANC, such as checking of blood pressure, weighing, health talk and urine testing of pregnant women. The non-participant observation continued for two months (240 h in total) until all midwives have been observed. At the end of the non-participant observation period, the checklist and field notes were analysed thematically using Yin's stages of data analysis as a guide [36]. The information obtained from the analysis was used to add specific probing questions in the semi-structured interview guide. Interviews commenced at the end of non-participant observation.

The individual face-to-face interviews were conducted in English language with each of the ten participants in a private office within the ANC using the semi-structured interview guide. Each interview session lasted for 1 h and was audio-recorded with the participants' permission. A participant was interviewed each day so as not to disrupt the strict working schedule of the participants. The data were transcribed within 24 h after the interview session was over, while the information was still fresh in the researcher's memory, and preliminary data analysis was conducted. Data saturation was achieved at the ninth participant. The 10th interview was conducted to confirm data saturation [34]. Each participant's transcript was stored electronically in a file according to the pseudonym of the participant and date of the interview.

3.1. Data analysis

Thematic analysis was carried out on the data using Yin's five stages of data analysis manually [36]. Thematic analysis is the systematic method of detecting, analysing and writing out themes from a database [37]. Transcribed scripts were read and re-read to familiarise the researcher with the contents of each transcript and data ideas from each transcript were noted. The data were broken down into smaller fragments and codes assigned to each of the fragments, thereafter patterns were sought and grouped together to form a theme. This was performed repeatedly until all the codes were subsumed under the suitable themes and deeper interpretation obtained. An inter-coder, a qualitative research expert not part of the research team was given the raw data to code these smaller fragments independently. There was an inter-coder agreement of 90 % between the researcher and the inter-coder's coded data. The analysed data from the checklist of the non-participant observation was revisited to confirm the development of themes and sub-themes. The triangulated analysed data from the non-participant observation and individual interviews was shared and discussed with the second author who is an expert in qualitative research. She confirmed the interpretation of the data and naming of themes as appropriate. Thereafter, member checking was conducted with all participant to verify the interpreted data [38]. They were all satisfied with the interpretation.

3.2. Ethical considerations

Ethical clearance was obtained from the Faculty of Health Sciences Human Research Ethics Committee of University of Cape Town (HREC/101/2016) and the Nigerian hospital (ABUTHZ/HREC/VI/2016) where the research was conducted. Other ethical principles, including obtaining informed consent from each midwife as a participant, confidentiality, privacy and justice, were adhered to. In addition, pregnant women, who were to be part of the observation of midwives during routine activities of midwives, were informed of the study and asked for their verbal confirmation [39]. The researchers are female independent researchers with no relation with the research participants. The researchers were trained qualitative researchers with doctorate degrees in nursing and are presently lecturers in a Nigerian and South African University.

3.3. Trustworthiness

To achieve credibility, the raw data was shared with the second author, to verify the interpreted data and she was satisfied with it. Member check was conducted with the 10 research participants to verify the interpretation of the data and they did not request any changes in the data. Detailed explanation of the data collection process was presented to enable transferability of the findings to similar settings and population. To achieved dependability and confirmability, a thick and comprehensive report of the data collection and data analysis process were provided in this study. The researchers are independent researchers though they are in same profession with the research participants. The researcher aimed to bracket her previous beliefs and experience as a midwife, in order to avoid biases (i.e. put her beliefs and assumptions about the relationship between midwives and pregnant women aside), before embarking on the research [38].

4. Findings

Description of sample: The sample consisted of ten participants who were all registered midwives and registered nurses, as well and working in the research setting. In Nigeria, joint qualification is a common practice.

Table 1 below shows that the participants were all females, between 32 and 59 years of age and had been practicing as midwives for 7–32 years. As such, they were actively practicing health professionals and well experienced to screen pregnant women for IPV. The majority of them were Chief Nursing Officers, a high rank in the nursing profession in Nigeria. As such, they were part of the decision and policy makers in the hospital management.

4.1. Themes

The analysis from data triangulated from non-participant observation and individual face-to-face interviews revealed three main themes and nine subthemes as shown below;

1. Internal barriers to IPV screening
   i. Midwives' personal discomfort in asking IPV-related questions
   ii. Perceived mistrust of midwives by pregnant women
   iii. Midwives' own perception of IPV as a personal matter to pregnant women
   iv. Midwives' lack of skills to screen for IPV
2. External barriers to IPV screening
   i. Antenatal card related barriers
   ii. Workload related barriers
   iii. Protocol related barriers
3. Structural barriers to IPV screening
   i. Lack of space for privacy
   ii. Lack of resources for managing people who have experienced IPV

Table 1
Socio-demographic Variables of Midwives n = 10.

Participant identification	Age (years)	Sex	Educational Level	Qualification	Years in practice	Rank
1	32	Female	Diploma in Nursing	RN, RM	7	Principal Nursing Officer
2	36	Female	Diploma in Nursing	RN, RM	10	Principal Nursing Officer
3	35	Female	Diploma in Nursing	RN, RM,	7	Senior Nursing Officer
4	59	Female	Degree in Nursing	RN, RM, BNSc	32	Chief Nursing Officer
5	52	Female	Degree in Nursing	RN, RM, BNSc	17	Chief Nursing Officer
6	52	Female	Degree in Nursing	RN, RM, BNSc	27	Chief Nursing Officer
7	48	Female	MSc in Nursing	RN, RM, BNSc, MSc	23	Chief Nursing Officer
8	37	Female	Degree in Nursing	RN, RM, BNSc	14	Senior Nursing Officer
9	58	Female	Degree in Nursing	RN, RM, BNSc	32	Chief Nursing Officer
10	52	Female	Degree in Nursing	RN, RM, BNSc	23	Chief Nursing Officer

Internal Barriers to IPV Screening: This theme emerged from the data related to internal factors affecting midwives screening practice for IPV among pregnant women. It has four related subthemes. They are midwives' personal discomfort in asking IPV-related questions, perceived mistrust of midwives by pregnant women, midwives' own perceptions of IPV as a personal matter and midwives' lack of skills to screen for IPV.

Midwives' personal discomfort in asking IPV-related questions: The data revealed that midwives limit IPV questions to pregnant women whom they suspect have experienced IPV. This is because of their discomfort with discussing IPV questions, as illustrated in the following extracts:

> "Honestly speaking, for some women I will not be comfortable putting such questions in the screening tool to them because it is personal".[Participant 3].

> "I will only screen women that I suspect of being victims but not everybody. This is because some patients might not be comfortable with the kind of questions we may ask. I am not comfortable asking every women these questions."[Participant 8]

> "If I suspect the patients are going through abuse, I may ask. But I will not just see a normal pregnant woman or patient and start asking her questions of abuse. It will just be uncomfortable for me to do so, she might think … 'Ah! What does this woman want from me?" [Participant 1]

Perceived mistrust of midwives by pregnant women: The perception of mistrust by the pregnant women were noticeable in the extracts of participants. The pregnant women felt that revealing the truth about IPV in their marriage may be disclosed by the midwives to others. This made them to be untruthful or silent when asked about IPV. This is demonstrated in the extracts below:

> "Most pregnant women will not just come out to tell us, no matter how much we asked them, they will keep their abuse to themselves. They may not want to share the secret of their homes to strangers especially if they don't trust us [midwives]. Remember, some of us come from the same communities with them." [Participant 1]

> "For some of these pregnant women, no matter what we do or explain about professional confidentiality, I don't think they will accept our assurances on the confidentiality of their words. This will make it very difficult to get answers to these IPV questions." [Participant 7]

> "Some patients might not want to give you details on the actual truth and some may feel you want to interfere in their own personal life and decide not to tell you more. It's a matter of trust between us and them really." [Participant 10]

Midwives' own perceptions of IPV as a personal matter to pregnant women: The midwives' own perception of culture and religion in the northern region of Nigeria came out strongly as an internal barrier to routine screening for and disclosure of IPV in pregnant women, as illustrated in the extract below:

> "We don't go into that [screening] because some of us feel such issue [IPV], Islamically, is between husband and wife." [Participant 6]

> "In this part of the country [Northern Nigeria] we are introverts or something like that. So when things like abuse happens, we don't come out to say anything about it because it is personal, we hold it within ourselves. That is what we learnt from childhood." [Participant 5]

Participant 4 explained the cultural taboos associated with intimate or domestic relationships in the region as follows:

> "Even myself [Midwife] as a woman, can I just come and meet you [Researcher] for the first time and tell you my husband is beating me or he is sexually abusing me? I can't say it, it's not possible. So how can I ask another woman to share that with me?"

Midwives' lack of skills to screen for IPV: inadequate training of midwives affected their competencies in performing screening for IPV, as illustrated in the extracts below:

> "As a midwife, I was not trained to identify pregnant women that have been victim of intimate partner violence, we have never had such trainig. So I would not even try to do something I was never taught." [Participant 1]

> "The hospital management should provide the resources for this IPV training to hold, then I will be motivated to care more for the pregnant women because I do not have the skills to screen for IPV." [Participant 6]

> "I have attended many continuing education training on different things but not on intimate partner violence, so I do not have the skills to screen or manage IPV victims." [Participant 1]

External Barriers to IPV Screening: This theme and its related subthemes were generated from the data related to external factors affecting midwives screening practice for IPV among pregnant women. The subthemes are: antenatal card related barriers, workload related barriers, and protocol barriers.

> Antenatal card related barriers: The antenatal (ANC) card is a small hand card given to pregnant women when they visit the antenatal clinic for the first time. In every pregnancy, a new ANC card is given to pregnant women which is kept in their hospital file. This card contains pre-set questions on pregnant women's socio-demographic data such as name, address, phone number, occupation, ethnicity, religion, age, height, and weight. Medical history, obstetric history, family history, and gestational

progression of pregnancy are all in the pre-set questions which are in rows and columns. At every antenatal visit, midwives ask pregnant women about their health and any procedure carried out will be documented in the ANC card.

There were preset questions in the current antenatal card. These were used during booking to screen pregnant women for other conditions apart from violence, since there is no question on IPV. This was confirmed by the following extracts:

"Even if we want to screen for IPV, we cannot. There are no questions on the antenatal card relating to intimate partner violence to ask pregnant women, so we stick to the questions on the antenatal card." [Participant 2]

"If there was a column in the antenatal clinic card for IPV questions, we probably could do it but we do not have a routine form or anything that we have to fill on IPV, so we can't do it." [Participant 8]

"Although we see pregnant women with problems every day, we only ask what is expected of us as midwives using the antenatal card." [Participant 9]

This was also confirmed by a prior observation during the non-participant observation. It was discovered that the antenatal card used for collecting history from the pregnant women asks for socio-demographic data, medical history, and obstetric history of the pregnant women. The antenatal card was found to have no question on IPV.

Workload related barriers: Data revealed that each midwife attends to about 15–20 pregnant women per day in the ANC. Several of the midwives reported that the large number of pregnant women seen by each midwife makes it exhausting to undertake screening for IPV. This is demonstrated in the extracts below.

"Even if I am to screen, I will not be able to. Like today alone in this clinic, we saw 45 pregnant women plus 40 gynae patients and 20 postnatal patients.. There is no way I can even screen all these women for IPV as well, even if I want to". [Participant 5]

"… when I come to the clinic, I am overwhelmed with work. I don't even have time to sit and discuss one on one with my patients … so the workload is really affecting effective service in this place and that is why I don't screen even if I want to." [Participant 3]

"I am sure a lot of them [people experiencing IPV] are among these women we see here every day. But we don't pay attention to their abuse because we allow the huge workload to absorb us." [Participant 5]

The increased workload is due to insufficient staff in the ANC, this is demonstrated in the following extracts:

"There are many patients, but few midwives because we are short staffed in this hospital. Honestly, as you can see, we [staff] are not many. It's only three of us and all these pregnant women." [Participant 7]

This was also confirmed by prior observations during the non-participant observation. It was discovered that the antenatal clinic runs from Monday to Friday with only three midwives attending to about 46 pregnant women per day. These midwives attend to pregnant women, gynaecology patients, as well as postnatal patients.

Protocol related barriers: The absence of institutional permissions, approvals, directives, and policies formalising midwives' screening of pregnant women for IPV was also reported as a barrier to their screening practice of IPV. This is demonstrated in the following extracts:

"We have not been directed to ask such questions [screening for IPV]. The only thing we do is to give health education to pregnant women, even the health education that we give here [antenatal clinic] is not individualised, it is given to groups of pregnant women." [Participant 5]

"There is no policy in this hospital that requires us to ask our patients about intimate partner violence. So we have not been practising it [routine screening] in this hospital." [Participant 2]

"There is no guiding procedure manual on screening pregnant women for IPV and I have never come across any such document in all my years of practice here." [Participant 4]

Structural Barriers to IPV Screening: This theme and its related subthemes were derived from data related to inadequate infrastructure and facilities that affect midwives' screening practices for IPV. The subthemes are lack of space for privacy and lack of resources for managing IPV victims.

Lack of space for privacy: This subtheme was generated from data related to the problem of inadequate space for privacy in the ANC as highlighted in the extracts:

" …, there is no space to discuss private matters like IPV. Most of the things we do, like health education, we do them in groups, here in the same hall." [Participant 6]

"When we are doing the initial booking, this place is usually so choked up, we don't have space. Sometimes the available cubicles are not even enough for doctors to consult let alone for creating a private space for us and patient to discuss intimate issues like IPV comfortably. It is imposible." [Participant 5]

"In fact this place is so inadequate, we sometimes take some pregnant women, the new clients to Surgical Out Patient Department (SOPD) clinic to attend to them there so as to decongest this place. We cannot ask sensitive matters in this space." [Participant 7]

This was confirmed by a prior observation during non-participant observation. It was observed that pregnant women were seen in one large waiting room with a midwife checking their blood pressure while two other midwives were booking new pregnant women separately, at the same time in the large waiting room. However, there were different cubicles set aside for pregnant women who are referred to the medical doctors for further assessment and management. The set-up of the large waiting room made it difficult to conduct private discussions, thus confirming lack of space for privacy for IPV screening.

Lack of resources for managing IPV victims: Apprehensions were shown by participants on lack of resources to help pregnant women. Midwives may not be able to help pregnant women who have experienced IPV when identified because of lack of resources and this may affect their confidence to screen pregnant women for IPV.

> "What do we do for these women after we identify them as victims of abuse? Do we say – thank you for telling me and fold our arms [do nothing]? No, they will expect us to do something. There have to be solutions or benefits for patients coming out to voice their problems. Right now, there is no resources. So we cannot screen for problems we cannot solve." [Participant 6]

> "We have different resources [centre] where we refer patients with different problems, like people with HIV, but we have no where to refer cases of intimate partner violence. We don't have a centre/resources for it in this hospital. So we don't screen because if we find that someone is indeed abused in their marriage, what will we do? I think it would be irresponsible for me to raise the patient's hopes by asking and then failing to refer her appropriately." [Participant 9]

> "Even if we screen these women for IPV and we find that they are indeed abused, where do we refer them to for help? There are many victims of IPV in our society, but we can't ask them to tell us because we cannot refer them for help. At least I do not know where I can refer them to in this area." [Participant 1]

5. Discussion

Fig. 1 below shows that, both external and structural barriers are interconneted with the internal barriers.

The external barriers such as lack of protocol and increase workload may affect the motivation of midwives to improve their knowledge and skills on IPV management. This may inturn affects their screening skills. Midwives' knowledge about IPV would have ridden them of their preconceived idea about IPV been a personal matters between couples, thereby improvng identification and prompt management.

The structural barriers such as lack of privacy and resources to manage pregnant women who have experienced IPV further increase midwives discomfort to handle IPV cases if identified. With the lack of resources to manage women who have experienced IPV, pregnant women may not trust midwives to help them if IPV is identified, as such this will further affects midwives screening practice.

The main finding of this study is that there are internal and external barriers to IPV screening. Other studies [17,40,41] in high and low income countries have reported these findings too, but none have been reported in northern Nigeria. On the internal barriers, midwives were not comfortable in screening for IPV among pregnant women for a number of reasons. At personal level, midwives felt uncomfortable because IPV is still regarded as a sensitive topic that requires a trusting midwife-woman relationship to be developed first before such information can be shared. Evans et al. [42], and Portnoy et al. [11], reported that health providers were not comfortable discussing IPV without having a strong rapport with their patients. A trusting relationship is needed for effective screeening for IPV, this can be developed with repeated attendance of the midwives to the pregnant women.

Perceived mistrust of midwives by pregnant women regarding the confidentiality of their disclosure was identified as a barrier to IPV screening. A similar finding was made by Hatcher et al. [19], who reported that in South Africa, there is perceived mistrust

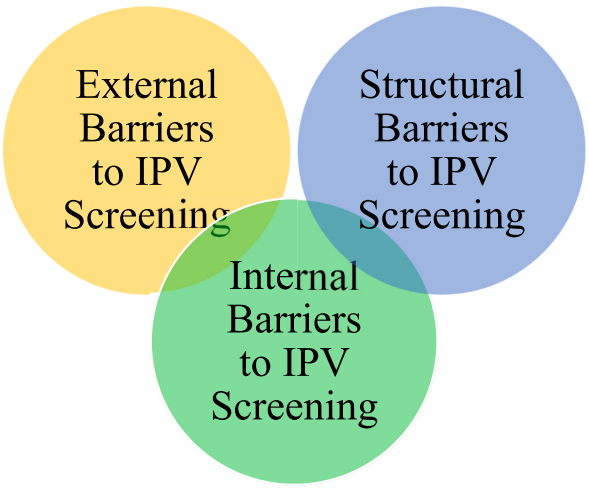

Fig. 1. Interrelation of the themes.

between midwives and pregnant women, as the latter feared that what is discussed may be discovered by the perpetrator which may lead to more IPV. This hinders IPV screening.

Midwives' own perception of IPV as a personal matter or private issues between couples was also reported by the present study to be a barrier to screening for IPV among pregnant women. This finding is supported by Arrab and Ibrahim's [43] study in Egypt, which revealed that IPV is seen as a sensitive and personal issue between couples and midwives do not want to invade their privacy. This was a preconception held by midwives due to their cultural background. With effective education on IPV screening, their belief may change and improve identification and treatment women who have experienced IPV more.

Lack of IPV screening skills serve as an internal barrier to midwives screening practice. In South Africa, it was reported that pregnant women who have experienced IPV were not screened for IPV because the midwives lack the skills and have not undergone the training to handle IPV issues [19]. A similar finding was reported in Egypt by Ibrahim et al. [40], who stated that skills of midwives improved after IPV screening training and were sustained with continuous training [12].

The internal barriers to IPV screening were mainly midwives' perception which may be changed with educating midwives on IPV. Midwives may not screen pregnant women for IPV even when they see women who have experienced IPV. Failure to identify and treat pregnant women who experience IPV may endanger her and her child. This failure may affect the maternal and foetal morbidity and mortality in Nigeria, especially when the maternal mortality rate is still high (1047 deaths per 100,000 live births) [44]. It is time to start looking at the influence of the social dimension to maternal and foetal mortality. The government need to prioritize the identification of women who have experienced IPV, especially pregnant women, to save both mother and child.

The absence of IPV-related questions in the antenatal booking card was identified as a barrier to midwives' screening practice of pregnant women for IPV. Gashaw et al. [45], reported that the absence of IPV screening questions in the antenatal card of Ethiopia was a barrier to screening for IPV. Portnoy et al. [11], reported that a clear and comprehensive procedure facilitated screening of IPV and disclosure. IPV related question should be included in a covert way in the ANC card, in order to prevent the perpetrator from finding out and prevent ANC visit.

Staff shortage and huge workload were identified as a barrier to midwives' screening practices in this study. This is common in most African countries and other international countries too. In South Africa, Hatcher et al. [19], found that due to insufficient staff, routine screening of women for IPV was not being carried out. Similar findings were reported in Australia [41]. There is need to recruit additional and supporting staff, such as midwives, psychologist and social worker to assist in the ANC unite.

Absence of institutional support for IPV screening, such as absence of institutional permissions, approvals, directives, and policies that formalised midwives' screening of pregnant women for IPV were seen as a barrier by midwives in the current study. This is consistent with the findings of Clark et al. [46], and Kosiak et al., [47]. The uncertainty of what to ask, when to ask and what to do when IPV was disclosed served as a barrier to IPV screening [47]. Screening programmes that were thriving had good policy, explicit screening protocols, and endorsement from the hospital management, as reported in a systematic review of screening programmes [48]. The external barriers to IPV screening appear easier to address but may not be in reality. Presently, there has been reduced staffing and increasing burnout of midwives in Nigeria. This is due to the increased migration of healthcare staff to high income countries for better welfare [49,50]. This further increases the workload and pressure on the staff in Nigeria. There is need to continue raising the awareness of the danger of IPV for government to prioritize IPV screening. The government need to formulate a well-rounded policy on IPV and employ more staff to cushion the shortfall occasioned by staff migration.

This study also revealed that there is inadequate space for privacy for midwives to converse with their patients on IPV matters. In USA, Williams et al. [51], reported that the emergency unit has a large waiting room which makes it difficult for health care provider to discuss IPV issues. Due to inadequate space for privacy, private discussion could be heard by other patients and their relatives. Lack of privacy as a barrier to midwives' screening practices was also reported in Brazil and Australia [42,52]. Privacy is very important in ensuring confidentiality in IPV discussion.

Absence of resources and referral centres deter midwives from screening for IPV. Portnoy et al. [11], found that patients will disclose IPV more if there are resources available and Sexual Assault Referral Centres to refer women who have experienced IPV too for effective management. The referral centres should be all inclusive centres that can provide holistic care to women who have experienced IPV. Miller et al. [13], and Wilson et al. [10], confirmed that lack of referral centres makes it futile to screen for IPV. They advised that referral centres facilitate pregnant women's access to social services, support, and safety. In low-income countries, resources are usually challenging with different competing programmes demanding resources. Funds can be drawn from the world bank loan newly approved to the Nigerian government for women [53], to provide IPV centres that strictly deal with IPV cases and management in tertiary hospitals in Nigeria.

6. Implications

This is the first study to describe the barriers to midwives screening practice of IPV in northern Nigeria, where the prevalence of IPV among pregnant women is 6 % [29]. This study is important in establishing Evidence-Based Interventions to address and prevent IPV against pregnant women in the future. Training of midwives and funding are necessary to improve management of IPV survivors. The present situation of low staff in the Nigerian healthcare system, due to mass migration of staff, creates an urgent need for the government to employ more staff to replace those that have left in-order to reduce the workload [49,50]. The feasibility of conducting routine screening of IPV in the antenatal is high when these barriers are eliminated.

6.1. Strength and limitations

The strength of the study is in the design. It gave the researcher the opportunity to explore the phenomenon up close with the participants, utilizing different approaches such as non-participant observations and individual face-to-face interviews. The prolonged stay in the site of the study by the researcher aided in gathering rich information from participants. It is of course possible that the paticipants, being conscious of being observed might be more cautious in what they do. The long period of observation helped to limit this effect. This also fostered good communication with participants during the interview session.

The transferability of this findings to other antenatal setting in other low-income countries may, however, be limited by the fact that this study was conducted in ANC of one tertiary hospital. This was so because there is only one tertiary hospital in each state in Nigeria and the high patients patronage when compared to secondary health facilities The secondary hospital has fewer midwives when compared to tertiary hospitals while the primary healthcare centres were being managed by Communities Health Extension Workers who were not part of the research participants.

The Corona Virus-19 Era affected the publication of this article on time. Despite this delay, the screening condition for IPV in the research setting has not improved. Indications from a recent follow up visit to the research setting, suggest that the situation has not change.

7. Conclusion and recommendation

The barriers to midwives' screening practice of IPV among pregnant women in northern Nigeria were found to be internal, external to the midwives, and structural. The internal barriers can be addressed through continuous education, pre-service and in-service training of midwives on IPV screening and related issues. The external and structural barriers are organisational problems which will need the involvement of the hospital authority and government to resolve. In planning for intervention to improve screening and management of women who have experienced IPV, both the external and structural barriers should be handled prior to the internal barriers. If these two barriers are well managed then the internal barriers will easily be reduced. For further study, there is need to develop interventions on the feasibility of IPV screening in low-income countries and women's perception and acceptability of IPV screening.

Data availability

Data will be made available on request.

Ethics declarations

Ethics statement: please choose all applicable statements below:

- This study was reviewed and approved by [Ahmadu Bello University Teaching Hospital Zaria Health Research Ethics Committee], with the approval number: [ABUTHZ/HREC/VI/2016].
- All participants/patients (or their proxies/legal guardians) provided informed consent to participate in the study. Yes
- All participants/patients (or their proxies/legal guardians) provided informed consent for the publication of their anonymised case details and images. Yes
- Review and/or approval by an ethics committee was not needed for this study because [please explain why]. Not applicable
- Informed consent was not required for this study because [please explain why]. N/A

CRediT authorship contribution statement

Ayishetu U. Musa-Maliki: Writing – review & editing, Writing – original draft, Resources, Methodology, Investigation, Formal analysis, Conceptualization. **Sinegugu E. Duma:** Writing – review & editing, Writing – original draft, Validation, Supervision, Resources, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix. One

OBSERVATION CHECKLIST

Objective	Category	Descriptive notes	Reflective notes
Factors influencing midwives' routine IPV screening for pregnant women in hospital	Physical activities: At Routine activities At Screening for other diseases At booking Social (interactions) Environmental		

Appendix. Two

INTERVIEW GUIDE.

Introduction: The term screening refers to the application of standardized questions according to a procedure that does not vary from place to place. Intimate partner violence is the physical, sexual, economical, psychological or other harm against a pregnant woman by her partner or spouse. To screen for IPV is therefore to apply a standardized tool to a pregnant woman with a view to determine if she has been victim of intimate partner violence.

1. In the context of what I have just explained to you about screening. After two months of observing you, I notice you have not been screening, why?
2. What do you think can help you to screen pregnant women for IPV?
3. How do you document women that have been abused by their partner?
4. What are the resources available for the women for use in the hospital and community?
5. How do the pregnant women have access to it? In other words, how was it communicated to the women?
6. How has the information on available resources in the community influence your practices?
7. As a midwife, how were you trained to identify pregnant women that have been victims of IPV?
8. How was your programme in midwifery school structured to accommodate identification of IPV in pregnant women?
9. What continuous education programme, in-service training, or self-study are in place to improve your practice? How are the hospital management and government assisted with that? Probe.
10. What has the hospital management done to assist with identifying pregnant women experiencing IPV? In terms of clear goals and policy? Please explain more please.
11. How has the physical environment influenced the screening of pregnant women? Please elaborate.
12. Apart from what you have told me, what do you think will motivate you to screen/take care of pregnant women in antenatal unit? Please explain. Probe. What will demotivate you?
13. Is there any other thing you will like to add?

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