University of Cape Town

Department of Social Work

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Criminal Justice Social Work Dissertation:

Engagement/involvement of Staff from Public medical Institutions with pregnant women experiencing intimate partner violence - A systematic review of African & South African literature

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PLAGIARISM DECLARATION

I, *Faseegah Adams*, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

Signature: F. Adams   Date: 23.11.2024

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ABSTRACT

This study explores how staff at public health care institutions respond to intimate partner violence (IPV) experienced by pregnant women living in South Africa and Africa. This study aimed to investigate what protocols/pathways staff at public health care institutions (PHCI) use to identify, screen, report, record and refer instances of IPV. The motivation for this study was to bring awareness of IPV during pregnancy. Since learning the high statistics of IPV during pregnancy, the researcher was prompted to investigate what PHCI are doing to identify, screen, report, record and refer cases of IPV. In addition, the researcher hopes that this research can facilitate policy development for staff at PHCI on how best to respond to pregnant women experiencing IPV. The methodology used in this study was a systematic literature review, that reviewed 14 qualitative journal articles. PICo was used to identify the study participants, the Cochrane systematic review methodology was used and the PRISMA flow diagram. Using thematic analysis, the researcher used Dey and Tesch to analyse the data.

The findings indicate that there are no pathways/protocols for identifying, screening, reporting recording and refereeing instances of IPV in South Africa or Africa. There were also no direct policies or frameworks established at PHCI to manage intimate violence during pregnancy. The research identifies some of the main barriers/challenges to IPV enquiry which are lack of privacy at public health care institutions, training and awareness of IPV during pregnancy, staff agency, staff safety and cultural beliefs. These results contribute to the research regarding how PHCI in South Africa and Africa respond to IPV. Thus shifting focus away from the criminal justice system and more toward PHCI as IPV during pregnancy has grave health implications. This study provides new insights on how to build and improve protocol/pathways at PHCI. This study highlights the daily challenges that staff at PHCI face when enquiring about IPV. It concludes by discussing how The National Council on Gender-Based Violence Femicide can use information on the challenges/barriers to enquiry to achieve the goals and aims set out in The National Strategy Plan addressing gender-based violence and femicide in South Africa and Africa.

Key words

Midwives, nurses, doctors, pathways, protocols, screening, IPV, pregnancy, Africa and South Africa

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter introduces and explains the statement of the problem its rationale, the significance of the study and the research topic. It provides context and background to the study whilst outline the research topic, its 4 main research questions and objects. The researcher then highlights the main assumptions according to the research, clarifys terms and address the ethical considerations before ending the chapter with the conclusion.

1.2 Problem statement

South Africa experiences high rates of GBV affecting women mainly 1 in every 3 women are victims to physical abuse (Enaifoghe et al, 2021: 131). Pregnant women being especially vulnerable to violence during pregnancy, Studies suggest that more than 80,000 women and pregnant women experienced IPV in South Africa (Enaifoghe et al, 2021: 131). These include physical, sexual and psychological forms of abuse gravely impacting the women's maternal health equating to psychological distress, contracting sexually transmitted infections (STI's) and experiencing symptoms of depression (Enaifoghe et al, 2021: 131).

The contributing factors and risks to pregnant women experiencing IPV are increased complications during pregnancy and psychosocial stressors including but not limited to unexpected pregnancies, substance misuse and socioeconomic status (Enaifoghe et al, 2021: 131). The evidence suggest that violence against women in South Africa is a huge issue having serious health implications during pregnancy however standardised screening protocol and interventions remain limited therefore research needs to be conducted. Specifically looking at how PHCI screen and respond to pregnant women experiencing IPV, what the barriers are to screening for IPV and what are the best ways to support women experiencing IPV in the South African context. Since IPV is a global issue during pregnancy and has shown to be a significant risk for complications during pregnancy and childbirth (Aboagye et al., 2022: 2). Therefore IPV should be screened for and identified during antenatal check-ups (Aboagye et al., 2022: 2). Aboagye et al. (2022) argue that violence or IPV can have a negative influence on a women's mental and physical health, making it difficult to seek appropriate maternal health

care, therefore emphasizing the need for health care professionals to provide counselling and trauma management services to pregnant women experiencing IPV. Furthermore IPV during pregnancy negatively impacts the unborn contributing to low birth weight, preterm labour and still births. IPV during pregnancy often constitutes neglect as the pregnant women would skip or delay prenatal care increasing the health risks to the unborn (Enaifoghe et al, 2021: 131).

The researcher found that statistics on violence against pregnant women in Africa and South Africa are similar with 29% of Nigerian pregnant women experiencing IPV and 20%-35% of pregnant women experiencing IPV in South Africa (Hatcher et al., 2019:1333; Akaba & Abdullahi, 2020: 1). This was useful as the researcher used journal articles from other African countries as the data on this topic is limited in South Africa. Furthermore substanciating the need for this kind of research to be completed in South Africa.

In South Africa before 1994 there were no comprehensive reproductive health policies, like most of the world at that time women's health services consisted of mainly maternal and child health care services (Cooper et al., 2004: 71). The public health system was fragmented and characterized by racial and geographical inequalities as well as unevenly distribution of resources (Cooper et al., 2004: 75). In addition to this the staff at Black, Coloured and Indian public health care institutions were not adequately trained to support and attend to the women regularly (Cooper et al., 2004: 75). Maternal health services during this time were often overcrowded, understaffed, lacked privacy and women frequently experienced issues regarding access to services (Cooper et al., 2004: 71). The severity of domestic violence was not recognized or dealt with effectively, and services for sexual violence was fragmented, with no comprehensive plan for collaboration between relevant government departments (Cooper et al., 2004: 71). Apartheid negatively impacted the maternal health care of black, coloured and Indian women whilst violence grew between the state and its people subsequently so did the violence between men and women of colour (Enaifoghe et al, 2021: 126).

Post 1994 South African legislation and policy relating to maternal health was restructured by introducing a single system with equitable distribution of resources and expanded service delivery (Cooper et al., 2004: 74). In 1994 the Department of Health adopted the Primary Health Care approach which emphasized health as a human right, equity in resource distribution, expanded access, decentralized service aimed at promoting local health needs and

community involvement (Cooper et al., 2004: 72). The Department of Health in South Africa are responsible for antenatal care, in 2005 they adopted the focused antenatal care (FANC) model also referred to as basic antenatal care (BANC) approach (Mlotshwa & Sibiya, 2023: 2). The BANC approach was implemented as a quality improvement strategy to be used in all public health care institutions in South Africa (Mlotshwa & Sibiya, 2023: 2). The BANC approach/strategy is intended to support pregnant women with their antenatal care and ensuring that they have a healthy pregnancy. The researcher is interested into whether the BANC approach account for the screening of IPV as it is such a salient issue concerning pregnant women in South Africa.

The BANC provides antenatal care services and is the recommend minimum level of antenatal care that every pregnant woman should receive (Mlotshwa & Sibiya, 2023: 2). Mlotshwa and Sibiya (2023) add that every health care institution that pregnant women make contact at should provide BANC after pregnancy has been confirmed. Despite this it has been reported that around 60% of all maternal deaths in South Africa between 2014 and 2016 were attributed to poor quality of care and were preventable (Mlotshwa & Sibiya, 2023: 2). This gives us insights into how PHCI are struggling to ensure that women have healthy pregnancies without considering the impact of IPV on pregnancy. Suggesting that IPV during pregnancy would further strain the already overwhelmed maternal health care system in South Africa. Therefore, making it challenging for South Africa to achieve the SDGs in the reduction of maternal mortality (Mlotshwa & Sibiya, 2023: 2).

A study conducted in Cape Town reports that 15% of the pregnant women interviewed experienced IPV which is high as this was a study conducted at one PHCI (Field et al, 2018; 3). The data showed the prevalence to be much higher in countries from lower socioeconomic backgrounds emphasizing the importance of this kind of research. This study focuses on whether staff at hospitals and/or antenatal clinics record, report and assist pregnant women experiencing IPV. It sought to explore if any reporting, recording, identifying, and referring protocols are used by antenatal staff like nurses or midwives in public health care settings. WHO mentions that the prevalence of IPV during pregnancy varies between 1%-28%, and IPV during pregnancy can cause immediate and long-term consequences (Pastor-Moreno, Ruiz-Perez, I., Henares-Montiel, J, & Petrova, 2020: 123). Pastor-Moreno et al (2020) mention that socioeconomic factors could influence the risk of foetal and infant death, approximately 98%

of stillbirths and neonatal deaths occur in low to middle-income countries and 77% occur in sub-Saharan Africa and South Asia.

The results of the Nyemgah, Ranganathan and Stockl (2023) study state that partners and community members have been found to encourage and reinforce IPV during adolescent pregnancy by not taking appropriate action to deal with complaints. The lack of action from community members or stakeholders and the adolescent's inability to decide on their reproductive health appear to increase their chances of experiencing IPV during pregnancy (Nyemgah, Ranganathan & Stockl, 2023: 180). Sprague, Woollett and Hatcher (2020) provide context to what Nyemgah, Ranganathan and Stockl (2023) mention as a lack of action among community members and stakeholders in low socioeconomic settings. They state that nurses remain the backbone of health service delivery, however, South African nurses are a complex group who maintain both social status and marginalization (Sprague, Woollett & Hatcher, 2020: 1821). They go on further to explain that nurses have a higher educational attainment, employment security and higher socioeconomic status compared to their patients, yet most nurses in South Africa are black and hail from the same communities as the patients that they treat (Sprague, Woollett & Hatcher, 2020: 1821). Therefore, nurses have a shared understanding of the social-cultural norms that influence the agency of their women patients who experience IPV (Sprague, Woollett & Hatcher, 2020: 1821).

Suggesting that nurses in South Africa can be regarded as agents of change at primary health care clinics and could be viewed as key locations of intervention for women who experience IPV. However, the opposite could also be true resulting in nurses actively upholding the societal norms and values over addressing the issue of IPV during pregnancy (Sprague, Woollett & Hatcher, 2020: 1821). Furthermore, Gashaw, Schei, Solbraekke & Mangus (2020) comment that the personal perceptions of healthcare workers regarding IPV in pregnancy can serve as a facilitator or barrier when integrating IPV prevention programmes. This suggests that some healthcare workers are willing to address IPV in their clinical activities , while others do not support IPV screening tools in their perinatal reports (Gashaw et al., 2020: 2).

There are recent journal articles that mention pregnant women experiencing IPV and antenatal screening, but these studies were conducted in other African contexts (Jatta, Baru, Fawole & Ojengbede, 2021), (Ayodapo, Sekoni & Asuzu, 2017: 12), (Akaba & Abdullahi, 2020: 2) and

(Aurna et al., 2020:5). These studies offer perspectives on why IPV occurs, what kinds of IPV is the most prevalent and how culture affects patterns of disclosure among pregnant women. Providing context is important but these articles do not go beyond providing context however, the Akaba and Abdullahi (2020) article mentions that legislation around routine screening needs to be adopted by the Nigerian government to decrease instances of IPV experienced by pregnant women. This acknowledgment is useful but further exploration needs to be done regarding the topic of IPV and pregnant women in South Africa.

Other barriers that the researcher encountered were midwives and nurses not having time to participate in the study due to short staffing and high demand at public healthcare institutions. What the researcher found interesting during the recruitment process was that they underestimated the sensitivity of this research topic for nurses and midwives. This topic could potentially put their job and career as a midwife/nurse at risk as they would be asked to talk about their quality of practice the fear of this could be the reason for the midwives/nurse's unwillingness to participate in the study.

Similarly, Namageyo-Funa et al. (2014) speak of participants hesitance to being asked questions and or having difficulty verbalizing their sentiments and experience on the topic. It could be that the nurse and midwife's reluctance is linked to the integrity of the job, not enquiring about IPV with pregnant women might mean that they could be labelled as 'bad' midwives/nurses. This speaks to the inner conflict that Sprague, Woollett and Hatcher (2020) mention that nurses/midwives have when being educated but holding the same cultural norms and values of the community that they live in as well as being black women themselves. This was something that the researcher did not consider when developing the research question Namageyo-Funa et al. (2014) mention ways in which this could be overcome with strategies like cash incentives and the researcher fostering relationships with the participants these strategies clash with the ethical considerations of research studies. However if done sensitively it could be something that the researcher should consider when completing their PhD study.

The knowledge that exists on pregnant women experiencing IPV in South Africa is narrow (Hoque, Hoque & Kader, 2009: 25; Devreis et al., 2010: 2). This literature focuses more on the effects of IPV, and the risk factors associated with it, rather than looking at how healthcare facilities respond to pregnant women experiencing IPV (Shamu, et al., 2011:6). Other authors

focus on mental health, emotional distress and IPV and how it affects pregnant women (Groves et al., 2012: 4; Tsai et al., 2016: 2). Most of the literature found pertains to HIV infected pregnant women experiencing IPV (Bernstein et al., 2016: 6; Hatcher et al., 2014: 5). Tsai et al. (2016) found that pregnant women that tested positive for HIV have a higher chance of experiencing IPV. There is a gap in the literature regarding medical institutions identifying, recording, and responding to pregnant women experiencing IPV in South Africa. The gap in this knowledge relates to screening tools, recording, reporting and referral pathways at antenatal clinics for pregnant women experiencing IPV. Authors Malan, Spedding and Sordahl (2018) and Hatcher et al. (2019) acknowledge this gap and mention that an emphasis needs to be put on South African policy to address the huge issue of pregnant women experiencing IPV and how to respond to it.

The motivation for conducting this study is to explore how PHCI support pregnant women experiences IPV, thus bringing awareness to violence during pregnancy. Initially this study was empirical focusing on interviewing nurses and midwives about protocols used to identify, report, record, address and refer pregnant women who experience IPV. However, the researcher found it challenging to gain access to these participants. Despite obtaining ethical clearance from the University of Cape Town, the public healthcare institutions that the researcher approached required their own ethical clearance which was difficult to obtain having time constraints. Thus delaying and stunting the participant recruitment process forcing the researcher to pivot to systematic literature methodology.

The purpose of the study was to identify protocol if any exists at public healthcare institutions like antenatal clinics regarding the reporting, recording, referring, and identifying of IPV experienced by pregnant women in South Africa and Africa. This study explored South Africa's and Africa's public health care systems and their protocols at hospitals and antenatal clinics regarding pregnant women experiencing IPV by reviewing journals on the topic. It looked at the tools, procedures, staff competence and ways of recording and reporting instances of IPV at public hospitals/antenatal clinics in South Africa and Africa

1.3 Rationale and significance of the study

The rationale of the study is to understand how PHCI respond to pregnant women experiencing IPV. Considering the amendment of the Domestic Violence Act, of 2021 the researcher was

interested in how staff at PHCI respond to pregnant women experiencing IPV. The significance of the study is to explore how staff at PHCI respond to IPV and contribute to the identified knowledge gap highlighted in this chapter and the one that precedes it. This study provided recommendations for policy and programme interventions on how best to respond and support pregnant women experiencing IPV in South Africa. When the researcher explained the statement of the problem it was clear that although the MDGs and SDGs exist, the South African Health Departments are yet to implement standardized protocol and interventions to address the issue of IPV during pregnancy. This systematic literature review aims to identify, appraise and synthesize all relevant studies to answer the main research questions (Petticrew & Roberts, 2005: 9). Petticrew and Roberts (2005) add that a systematic literature review is useful for policymakers as it provides robust, reliable summaries wherein policymakers can draw from, this would be something which this study would endeavour to do.

1.4 Research topic

To explore how staff use the protocol/pathways that are in place for identifying, reporting, recording, and referring instances/cases of IPV experienced by pregnant women at PHCI in South Africa and Africa.

1.4.1 Main research questions

- Are there protocols/procedures in place at PHCI that screen for IPV among pregnant women in South Africa and Africa?
- Are there policies/frameworks that speak to or address the issue of IPV among pregnant women and why is there a lack thereof?
- Are the staff at PHCI identifying, reporting, recording, and referring instances of IPV?
- Are staff at PHCI competent enough to identify, facilitate, record and report instances of IPV among pregnant women?

1.4.2 Research objectives

- To explore if there are any protocols/procedures in place at PHCI that screen for IPV among pregnant women in South Africa and Africa;
- To investigate if there are any policies/frameworks in South Africa and Africa that speak to or address the issue of IPV among pregnant women or the lack thereof;

- To explore if staff at PHCI are reporting, recording, and referring instances of IPV; and
- To explore if staff at PHCI are competent enough to identify, facilitate, record and report instances of IPV among pregnant women.

1.4.3 Main research assumptions

- Pregnant women in South Africa and Africa do not experience IPV;
- The staff at PHCI are trained to assist pregnant women who experience IPV;
- The staff at PHCI do not experience IPV themselves;
- South Africa has policies that address IPV among pregnant women; and
- Pregnant women do not wish to disclose IPV to adequately trained staff at PHCI in South Africa and Africa.

1.5 Clarification of concepts

- **Intimate Partner Violence (IPV)** defined by (World Health Organization [WHO], 2012) refers to the behaviour within an intimate relationship or ex-partner that causes physical, psychological, or sexual harm to those in the relationship. These behaviours include acts of physical violence such as slapping, hitting, biting, kicking, and beating (WHO, 2012: 1). Sexual violence includes forced sexual intercourse and other forms of sexual coercion (WHO, 2012: 1). Emotional/psychological abuse such as insults, belittling, constant humiliation, intimidation, threats of harm, and threats to take away children (WHO, 2012: 1). Controlling behaviours include isolating a person from family and friends, monitoring their movements and restricting access to financial resources, employment, education, or medical care (WHO, 2012: 1).
- **Pregnancy** is a term used to describe the period in which a fetus develops inside a woman's womb or uterus (Spong, 2013).
- **Woman** only refers to sex and not gender, meaning that individuals who are biologically female refer to the reproductive capacity or potential of the person (Meyer, 2013: 55).

1.6 Ethical considerations

This study is a systematic literature review and therefore does not have any human participants, ethical considerations are used to prevent or reduce the harm that could be experienced by

human participants before during and after the research process (Laryeafio & Ogbewe, 2023: 95). The researcher obtained ethical clearance on the 02/08/2023 from the University of Cape Town for this study. The journal articles used in the systematic literature review were accessed through the University of Cape Town's online library, here the researcher used databases PubMed and EBSCO Host to gather data.

1.7 Conclusion

This chapter introduced the issue of pregnancy and IPV in Africa and South Africa and provided some background to pregnant women experiencing IPV by highlighting the lack of literature and the researcher's change in methodologies. The introduction chapter went on to state the main research question and mentioned three review objectives. The chapter ended by clarifying the concepts of IPV, pregnancy and women.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers literature that exists regarding the protocols/pathways of staff at PHCI responding to IPV during pregnancy. It also explores the feminist, phenomenological and systems theoretical framework models, the researcher uses these theories to understand what barriers stop staff from enquiring about IPV during pregnancy. Legislation and policy were used to understand what local and national governments are doing to address the issue of IPV during pregnancy in South Africa, lastly, this chapter ends with a conclusion, summarizing all key points made in the chapter.

2.2 Literature review

Pregnant women experiencing IPV are at a higher risk of miscarriages, stillbirths, preterm births and babies with low birth weight, some research supports that babies born to mothers who experienced IPV are at risk of neurological development delays (Wong et al., 2024: 1). In countries like New Zealand and the United States routine screening and enquiry about IPV among pregnant women are promoted, though it is being promoted this does not ensure that routine screen is consistently taking place (Wong et al., 2024: 1). Joyner and Mash (2012) mention that universal screening for IPV although recommended in the South African protocol is challenging to implement. They added that staff at PHCI viewed IPV as a social issue and therefore avoided enquirying about it (Joyner & Mash, 2012: 4).

The United Kingdom National Screening Committee and the Canadian Task Force on Preventative Health Care do not recommend routine screening for IPV within antenatal services as they cite insufficient evidence that screening for IPV during pregnancy reduces the occurrence of IPV (Wong et al., 2024: 1). Artz, Meer & Aschman, (2018) report similar findings in South Africa with emergency medical health care providers not being in favour of implementing the IPV screening protocol. This protocol was introduced during the 16 days of activism, where members of The Health Care Professional Counsel of South Africa were critical of the protocol and added that caseloads are already extremely high with 2 million admissions annually (Artz, Meer & Aschman, 2018: 2). This is important insights as it

demonstrates that PHCI's in South Africa attempted introduce screen protocols however realistically it was not feasible.

Akinyugha et al. (2022) found that research on the effectiveness of screening for IPV has been in some instances proven to be effective and others ineffective, due to this there has been no consensus among professional health bodies regarding the standardisation and implementation of screening for IPV. These disparities underscore the need for further exploration into this topic as much of it is unclear, thus emphasizing the significances of this study. Screening for IPV/domestic abuse at PHCI has been a contested issue among healthcare professionals worldwide, and studies have shown that PHCI is largely unresponsive to women seeking support at PHCI for IPV (Garimella, Plichta, Houseman & Garzon, 2000: 406). Other studies conducted suggest that women perceive health professionals as being less effective than other professionals in addressing their abuse (Garimella et al., 2000: 406). Women reported that healthcare professionals had poor communication, punitive responses, victim-blamed and gave misinformed advice (Garimella et al., 2000: 406). The mixed views that PHCI's have on screening protocol make it challenging to provide a substantive evidence to argue for pr against IPV screening at PHCI's, despite gender-based violent being a grave concern in South Africa.

In addition to how patients perceive healthcare professionals, healthcare professionals themselves hold backward attitudes towards PHCI's role in responding and addressing IPV stating that abuse and violence is not a health concern but rather a social issue (Garimella et al., 2000: 406). The Garimella et al. (2000) study sought to explore physicians' views on responding to abuse, the findings suggested that physicians perceive that they should be supporting victims of domestic abuse and the majority do not hold victim-blaming attitudes. However, physicians felt that they did not receive training and/or resources to assist victims of domestic violence, physicians further explained that they did not receive any domestic violence training at medical school or a postgraduate level (Garimella et al., 2000: 409). Therefore presenting a gap in the manner they respond hence the importance of this study.

In 2020 a study conducted in Britain , had findings similar to the Garimella et al. (2000) study, staff at PHCI felt that they lacked adequate training and education on IPV. Staff felt unsupported, unprepared and unconfident regarding positive disclosures of IPV. The lack of confidence stemmed from and the lack of knowledge of services or referrals available to assist

patients (Kirk & Bezzant, 2020: 757). Highlighting that barriers that occur between the individual, community and society, thus making it challenging for staff at PHCI to appropriately enquire about IPV. It could be argued that perhaps a combination of barriers to staff enquiry and lack of standardized guidelines around PHCI make it difficult to bridge this gap. Systems theory can be used to understand how the health care staff (individual) engage with policies and protocols/frameworks at PHCI in addressing IPV during pregnancy (community) and South Africa and Africa (society) (Friedman & Neuman Allan, n.d: 10).

Surprisingly WHO does not endorse universal screening or routine enquiry for violence among women attending healthcare institutions instead it encourages healthcare providers to address the issue with women who present injuries or conditions suggestive of violence (Wong et al., 2024: 1). Indicating that screening is not something that would be open and accessible to all pregnant women, only ones that have visible injuries, suggesting that IPV is only of the physical kind which is a very narrow definition of IPV as IPV encompasses a range of abuse (Decker et al., 2023: 376). This implies that staff at PHCI are trained on how to identity screen, report, record and refer instances of IPV, which is not the case and discussed by Kirk and Bezzant (2020).

It would be more fitting for all women who come in contact with PHCI that screening should take place as part of the admission process and more so pregnant women due to their vulnerability. Decker et al. (2023) add to this discourse by conducting a study and found lots of diversity in the group of patients that screened positive for experiencing IPV thus reinforcing the need for universal screening for IPV in patients admitted. It could be said that the broadness of IPV and the diversity within the group of individuals who experience IPV is reason enough to have IPV screening available to all individuals who engage with PHCI.

WHO's stance does not contradict the MDGs or SDGs, but it can be argued that WHO could be doing more around universal documents/policies and frameworks to emphasize the global issue of IPV during pregnancy. This could explain why some country's national and local governments vary in how their PHCI respond to IPV, in Australia the National Antenatal Care Guidelines allow flexibility for jurisdictions to implement screening methods for different populations (Wong et al., 2024: 1). An example of this is in parts of Australia like New South

Wales supporting routine enquiry for family violence while other states like Victoria have adopted targeted screening for family violence (Wong et al., 2024: 1).

WHO's blasé approach to IPV during pregnancy has Influenced PHCI around the world not to prioritize policies and guidelines/frameworks for how PHCI should respond to IPV during pregnancy (Warren-Gash et al, 2016: 2). WHO supports targeted IPV screening services opposed to it being a universal service offered to all pregnant women presenting at. This is particularly worrisome as countries like South Africa have not developed standardized protocols and procedures for addressing IPV, despite being in desperate need of it. Artz, Meer and Aschman (2018) attribute this to the lack of clear policies, guidelines, protocols, and procedures at PHCI in South Africa.

Wong et al. (2024) note that it can be challenging to address IPV during pregnancy on a policy level, like attending to structural barriers due to a lack of policy reminder systems, insufficient resources and inadequate privacy settings for screening. The absence of support, policies, and referral mechanisms and the lack of monitoring of the continuity of care, are identified as obstacles in policy development of addressing IPV during pregnancy (Wong et al., 2024: 1). Wong et al. (2024) the barriers in policy development, Akinyugha et al. (2022) build on this and identify barriers that staff at PHCI have regarding screening for IPV they do not feel adequality trained in handling cases of IPV, that IPV is more of a social than a medical issue, they believe that affected women may not want to disclose their experience to a doctor. Staff assume that women experiencing IPV do not feel comfortable disclosing to medical staff, and they feel that asking about IPV is intrusive (Akinyugha et al., 2022: 5). Structural barriers that staff at PHCI encounter are a lack of resources and staff, insufficient time for staff to conduct IPV and issues around confidentiality/private places (Artz, Meer & Aschman, 2018: 4).

Sprague, Woollett and Hatcher (2020) add another dimension to the barriers mentioned above they argue staff agency is important, and they recognize that agency is tethered to specific social contexts that restrict, limit or enable what women can do, be and their capabilities. Agency literature has started to consider women's expression of thought, silence and choice including their decision to stay in abusive relationships (Sprague, Woollett & Hatcher, 2020: 1822). Agency is informed by political economy, intersectional identities and determinants including race, ethnicity, socioeconomic status, and sociocultural norms (Sprague, Woollett &

Hatcher, 2020: 1822). The agency of staff at PHCI is determined by the factors mentioned above and influences how they respond to pregnant women experiencing IPV. Sprague, Woollett and Hatcher (2020) introduction of agency provides another level of complexities that needs to be understood when talking about IPV protocols at PHCI in South Africa. Sprague, Woollett & Hatcher speak of the individual within the system and mention how difficult it can be for them to respond to IPV and the internal battle that they are experiencing trying to support pregnant women being abused.

They add that staff at PHCI can be agents of change, or they could uphold community and societal norms that negatively impact pregnant women and their unborn children (Sprague, Woollett & Hatcher, 2020: 1822). Through observing both viewpoints it could be argued that one cannot effectively function without the other, meaning that only addressing IPV during pregnancy through policy change, screening tools, and referral systems and not supporting staff at PHCI through unlearning and relearning their societal and cultural beliefs regarding IPV, would not solve the current crisis. Looking towards interventions that address both would bring about meaningful positive change for pregnant women experiencing IPV in South Africa.

2.3 Theoretical framework

Theories are used to explain, understand, and predict the existing body of knowledge around a subject and a framework (Rocco & Plakhotnik, 2009). A Framework is a structure used to bolster a theory in research as it is a useful tool to outline theories (Rocco & Plakhotnik, 2009). Theoretical frameworks are used as a lens through which the researcher analyses and understands certain phenomena (Rocco & Plakhotnik, 2009). The theories used in a study need to be informed by a critical theoretical stance (Bartlett & Vavrus, 2017: 9). The critical theory approach is guided by concerns and assumptions regarding power and inequality (Bartlett & Vavrus, 2017: 9). Critical theory aims to critique inequality and change society, it studies the cultural production of structures, processes and practices of power exploitation and agency (Bartlett & Vavrus, 2017: 9). The researcher will use this approach when analysing the data including using theoretical frameworks like feminist theory, phenomenological theory, and systems theory to explore the experiences of staff at PHCI.

2.3.1 Feminist theory

Is a theory that aims to highlight social problems and issues that are experienced by women, it focuses on discrimination based on sex, gender, objectification, economic inequality, power, gender roles and stereotypes (Guy-Evans, 2023). There are many kinds of feminist theory, but all have core concepts which are gender sensitive (The Social Work Graduate, 2022). Feminism seeks to understand the structural and social factors that shape women's experience and lead to gender inequality (The Social Work Graduate, 2022). Feminism is a women-centred approach that addresses policies and structures like violence, power and patriarchy that disadvantage women (The Social Work Graduate, 2022). In South Africa, the abuse of women has been normalized as in other patriarchal societies (Sprague, Woollett and Hatcher, 2020: 1822). The agency of girls, adolescents and women is informed by dominant social constructions of gender norms and accepted gender roles in South Africa, including being submissive to male partners, being sexually available and affording men to take power regarding decision-making related to sex (Sprague, Woollett and Hatcher, 2020: 1822).

Social determinants and structural factors of poverty, unemployment, lack of financial security and independence are recognized as contributing to IPV and HIV (Sprague, Woollett and Hatcher, 2020: 1822). Scholars have emphasized that sexual health, vulnerability to HIV/other sexually transmitted infections and HIV risk behaviours cannot be understood or addressed unless attention is paid to constructs of gender, sexuality and how women perceive and express agency in the South African socio-cultural context (Sprague, Woollett and Hatcher, 2020: 1822). The high levels of violence in South Africa occur within a context of multiple contributing social dynamics which include prominent patriarchal norms where masculinity is associated with the defence of honour, harshness and risk-taking (Field et al., 2018: 2). Poverty and gender inequalities contribute to the structural determinants of violence (Field et al., 2018: 2). Feminism theory was used as it offers a comprehensive framework for understanding the root causes, ramifications and social dynamic of IPV and how gender and power facilitate violence against women. Particularly looking at how staff respond to pregnant women experiencing IPV attending PHCI.

Therefore, it is important to use feminist theory to help us understand what causes the difference between staff at PHCI acknowledging and/or not acknowledging pregnant women are experiencing IPV. This theory assists the researcher in teasing out the nuanced dilemmas that staff experience when responding to pregnant women facing IPV.

2.3.2 Phenomenological theory

This theory seeks to understand a phenomenon's universal nature by exploring the views of those who have experienced it (Delve & Limpaecher, 2022). This theory is used to study lived experience, gain a deeper understanding of how human beings think and expand knowledge about a phenomenon (Delve & Limpaecher, 2022). The phenomenological approach was termed by Hussrl as having a natural attitude (Pula, 2022: 413). The mode of analysis was not aimed at taking a reductionist view of reality but rather based it on the premise that the mundane world of our daily, taken-for-granted activities harbour the most complex philosophical commitments and that the naïve life we live as common sense possess an infinite rich logic upon which the whole of reality is founded (Pula, 2022: 413). The essence of phenomenological theory is capturing the lived experiences of individuals albeit mundane as this allows for a richer understanding of what their daily lives consist of and how that impacts the decisions they make. Phenomenological theory is descriptive and aims to accurately describe the structure and phenomenon, it also tries to uncover experiences, what they mean and how they experience them (Delve & Limpaecher, 2022). This approach requires the researcher to remain objective and only focus on the immediate experiences of the participants (Delve & Limpaecher, 2022). Phenomenological theory was used to describe the lived experiences objectively and reflect on the description concerning existing theories about the phenomenon (Delve & Limpaecher, 2022). The reason this theory was used is to understand how nurses/midwives or staff respond to pregnant women experiencing IPV, without having structured guidelines protocols and screening tools. This theory allows for staff at PHCI's voices to be heard objectively and understood as is and then reflected upon. Using phenomenological theory, allows the researcher to explain why staff at PHCI chose or chose not to screen, record, report, refer or identify instances of IPV experienced by pregnant women.

2.3.3 Systems theory

Systems theory is an interdisciplinary study of systems as they relate to one another within a larger, more complex system (Warren, Franklin & Streeter, 1998: 359). The key concept of systems theory, regardless of which discipline it's being applied to, is that the whole is greater than the sum of its parts (Warren, Franklin & Streeter, 1998: 359). Thus, examining how smaller systems come together to affect the greater complex system or certain characteristics of the whole complex system (Warren, Franklin & Streeter, 1998: 359). Systems theory seeks to explain and develop hypotheses around characteristics that arise within complex systems that seemingly could not have arisen in any single system within the whole (Warren, Franklin & Streeter, 1998: 359). Systems theory will look at how IPV impacts the individual, community, and society by looking at how staff at PHCI respond to IPV. The researcher will look at how healthcare staff (the individual) engage or dismiss policies and protocols/frameworks considering PHCI and how they should respond to addressing IPV during pregnancy (the community) in South Africa and Africa (the society). Systems theory is useful for identifying where the issue might be and developing targeted interventions to solve the issue (Friedman & Neuman Allan, n.d: 10).

2.4 Policy and legislation

The State of the Nations Address (SONA) held on the 24 of May 2024 on Gender-Based Violence and Femicide (GBVF) sought to outline how the government will intensify its efforts in fighting against GBVF (State of the Nation [SON], 2024). New legislation was introduced at the SONA, and it is called The National Council on Gender-Based Violence and Femicide Act (SON, 2024). This Act facilitates the establishment of the council, a statutory body charged with providing strategic leadership in the fight against GBVF in South Africa (SON, 2024). Some of the main purposes and responsibilities of the Act are to co-ordinate a multisectoral and inter-sectoral approach towards the implementation of the National Strategy Plan (NSP) in addressing GBVF at national, provincial, and local levels and community and other forums (National Council on Gender-Based Violence and Femicide Act, No, 09 of 2024). The NSP seeks to affirm a national commitment to building a society that is free from all forms of GBVF and to provide reporting mechanisms to facilitate the effective performance monitoring,

evaluation, and corrective action in the prevention of, and response to GBVF in South Africa (National Council on Gender-Based Violence and Femicide Act, No, 09 of 2024).

The NSP for GBVF is the government's comprehensive strategy for tackling all forms of violence and abuse towards women and children (SON, 2024). There are 4 main strategies in the NSP the first is aimed at strengthening state and societal accountability, at all levels, driven by bold leadership and high-level political commitment, driving prevention, addressing harmful social and gender norms, facilitating healing, and rebuilding social cohesion [Department of Women, Youth and Persons with Disabilities (DWYPD, 2020: 19]. The other NSP strategies include locating a response to GBVF as integral to responding to violence, poverty and inequality and lastly widening the lens, deepening the understanding, and rooting the response in communities (DWYPD, 2020: 19). The council members are the custodians of the NSP and are responsible for implementing preventative projects regarding GBVF, suggesting that protocol and screening for IPV should be implemented at PHCI. These protocols should be monitored to make sure that it is effective and work for the staff at PHCI and the pregnant women receiving the service.

The NSP and National Council on GBVF Act addresses the intersection of IPV and health care however there is no explicit mention of how PHCI should respond to IPV nevertheless this acts as starting point for PHCI to take responsibility and action in addressing IPV during pregnancy. Sprague et al. (2017) adds that historically GBVF was only the responsibility of the Department of Criminal Justice with acts like The Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill, The Criminal Law (Forensic Procedures) Amendment Bill, The Criminal and related Matters Amendment Bill and to an extent The Domestic Violence Amendment Bill (SON, 2024). All these have a slant towards the criminal justice system and how they deal with the perpetrators of the violence, however, it does not explicitly mention preventative measures like screening for IPV at PHCI.

Artz, Meer and Aschman (2018) mentioned that there are Acts within the healthcare sector that call for screening of IPV or imply IPV screening, however, there are ones with a focus on violence prevention including The Domestic Violence Act [No. 16 of 1998], The Children’s Act [No. 38 of 2005], The Sexual Offences Act (and Related Matters) Amendment Act [No. 32 of 2007] and The Revised White Paper on Families in South Africa of 2021. The points in

the Children's Act that pertain to this research are regarding the care and protection of children and parental responsibilities and rights (Republic of South Africa, 2005). The Act goes on to explain that all organs of the state nationally, provincially, and locally should be involved in the care protection and well-being of children (Republic of South Africa, 2005). Suggesting that PHCI have a duty of care to explore and screen for IPV during pregnancy to ensure that the unborn child does not suffer significant harm. The PHCI have a duty to implement these protocols according to the Act notionally provincially and locally PHCI's should prioritise screening for IPV.

Institutions must co-operate in the development of a uniform approach aimed at coordinating and integrating the services delivered to children (Republic of South Africa, 2005). Suggesting that PHCI have a responsibility to children to make sure that mothers have a successful and positive pregnancy and delivery. The Sexual Offences Act (and Related Matters) Amendment Act [No. 32 of 2007] mentions that government and departments should ensure that healthcare practitioners should support law enforcement agencies and national prosecuting authorities in making sure that perpetrators of sexual offences are held accountable and that victims/survivors are protected (Republic of South Africa, 2007). This, suggests that staff at PHCI should work with other agencies in identifying, reporting and recording instances of IPV so that this can be shared across agencies and authorities.

The Revised White Paper on Families views the family as a key development imperative and seeks to mainstream family issues into government-wide, policy making initiatives to foster positive family well-being and overall socio-economic development in the country (Department of Social Development [DSD], 2021: 8). The objectives of the Revised White Paper are to ensure that families have access to basic resources, assets and services that require to promote family well-being, empower families to access socio-economic opportunities, resources and services and to leverage social networks and resources to improve their well-being (DSD, 2021: 8). The White paper objectives are to promotes strong and equitable intra-family relationships with in safe supportive and nurturing communities and to support families in need or characterized by sever conflict or neglect of vulnerable family members, to regain their dignity and dissolve in an amicable way (DSD, 2021: 8). These objectives suggest that resources and services like screening for and identifying IPV at PHCI should be put in place to

avoid maternal mortality and unborn children being exposed to violence as it influences the well-being of the mother and to an extent the unborn child (DSD, 2021: 25).

The 2021 amendment of the Domestic Violence Act [No. 14 of 2021] mentions the obligations of the functionaries, these functionaries are medical practitioners, health care personnel, social workers, employees at public health establishments, educators or caregivers (Republic of South Africa, 2021). These functionaries have a duty to without delay complete a report if they suspect a unborn/child, a person with a disability or an older person is suspected to be experiencing domestic violence (Republic of South Africa, 2021). When completed, this report must be submitted to a social worker or police officer a risk assessment will be conducted by them and the complainant will then be referred to further services (Republic of South Africa, 2021). The Act also places the duty on an adult person to report if they suspect that an act of domestic violence has been committed against a child, disabled or older person to a social worker or police officer thus triggering a risk assessment to be done and further services to be rendered to the complainant (Republic of South Africa, 2021).

The Amendment also allows for immediate intervention by a peace officer who attends the scene of the incident of domestic violence, and they may arrest the perpetrator without a warrant (Republic of South Africa, 2021). The peace officer should ensure that the complainant receives medical attention, the peace officer should also provide the complainant with a list of safe spaces like shelters and public health establishments as well as make sure that they understand their rights and assist them with lodging criminal charges against the perpetrator (Republic of South Africa, 2021). This amendment is forward-thinking and emphasizes the responsibility of healthcare professionals to make sure that children, disabled individuals, and the elderly are protected against domestic violence. The introduction and responsibility of the peace officer are needed and allow for a rapid response and intervention to instances of domestic violence occurring in the community. It also promotes the sharing of responsibility amongst police, health care workers and social workers to act in the best interest of the child or unborn. This amendment is linked to the research as it identifies pathways of reporting and support for individulas experiencing IPV within the community. Direct referals can be made to social services through this method of reporting.

2.5 Conclusion

The literature review sought to paint a picture of PHCI's response to IPV by looking at the issue globally and narrowing it down to what it looks like in the South African context. It looked at feminist, phenomenal and systems theories to help explain and understand how staff at PHCI repose to IPV during pregnancy and addressed what might happening with the different systems. Lastly, it used policy and legislation to understand how PHCI are responsible for responding to IPV during pregnancy.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains and discusses the research design, population and sampling, data collection, data analysis, data verification, limitations of the study, and reflexivity and ends in by concluding the key point of this chapter. A systematic literature review was chosen as the methodology of this research. A systematic literature review collates all empirical evidence that fits the pre-specified eligibility criteria to answer the research topic (Lasserson, Thomas & Higgins, 2023). Systematic literature reviews are useful for policymakers as they look for solutions to policy problems and justify programs by referencing the knowledge base (Petticrew & Roberts, 2005: 11). Cochrane's (Cochrane South Africa, 2021) systematic review methodology was used as well as Preferred Reporting Items for Systematic Reviews and Meta-Analyses also known as PRISMA (Moher, Liberati, Tetzlaff & Altman, 2024). The PRISMA flow diagram was used for summarising the screening process (Moher et al., 2024).

3.2 Research design

The research design is a qualitative systematic literature review, the research questions sought to explore how staff use protocols/pathways for identifying, reporting, recording, and referring instances of IPV experienced by pregnant women at PHCI in South Africa and Africa. The researcher encountered challenges regarding recruiting participants for this study, due to time constraints related to the master's degree programme at UCT and accessibility/availability of participants the researcher had to pivot conducting a systematic literature review instead of a qualitative study. The motivation for conducting a systematic literature review was it collated all the literature on how staff at PHCI in South Africa and Africa respond to pregnant women experiencing IPV. Thus, identifying gaps in literature whilst aiming to provide an up-to-date summary of the state of research knowledge on an intervention, diagnostic test, prognosis factors or in the case of this study health or healthcare topics (Lasserson, Thomas & Higgins, 2023, Petticrew & Roberts, 2005: 11). The use of a systematic literature review is further motivated by of need to ensure that decisions affecting people's lives can be informed by an up-to-date and complete understanding of the relevant research evidence (Lasserson, Thomas

& Higgins, 2023). The researcher thought that this study would be useful and relevant because of the amendment to the Domestic Violence Act [No. 14 of 2021] and PHCI's role in addressing and responding to abuse. Another reason for choosing a qualitative systematic literature review was to understand the nuanced experiences of staff at PHCI, this was best explained and understood by using qualitative data. Bengtsson (2016) mentions that qualitative research contributes to an understanding of the human condition in different contexts or a perceived situation. The researcher sought to capture this by reviewing qualitative journal articles where staff at PHCI explain their experience with pregnant women facing IPV.

The researcher was interested in what protocols/pathways are in place for identifying, reporting, recording, and referring instances of IPV. Lastly, the reason for changing methodologies was due to the multiple failed attempts at recruiting participants for the initial qualitative study. The researcher and supervisors thought that it would be best to change methodologies to ensure that the researcher graduates within the academic year. The researcher has organized all correspondents from managers/matrons, nurses/midwives and other shareholders during the participant recruiting process into a table listed under Appendix B. The table was further discussed in the limitations section of this chapter.

3.3 Population and sampling

3.3.1 Study population

PICo was used to identify the study population, PICo is a framework used as a search strategy for systematic reviews however, it can be useful for identifying study participants as well (Ericksen & Frandsen, 2018; Thomas et al., 2023). The PICo mnemonic is an acronym for Population, Intervention, Comparison/Context and Outcome (Ericksen & Frandsen, 2018, Thomas et al., 2023). The outcome in PICo is not relevant to this study as the researcher is not interested in looking at specific outcomes McKenzie et al. (2023) echo this by stating that studying outcomes are usually reserved for randomized trial reviews. The researcher in this instance was focusing on the experience of staff at PHCI and their thick descriptive narrations rather than looking at specific outcomes (McKenzie et al., 2023). The population refers to a group of participants that have specific demographic characteristics like job type, age, and gender (Ericksen & Frandsen, 2018, Thomas et al., 2023). The population in this study are staff members at PHCI including but not limited to nurses, midwives, and doctors. The intervention

refers to the therapy, test or strategy to be investigated, the interest in this study is the protocols/pathways that are used to explore if pregnant women are experiencing IPV, specific examples that the researcher looked at are identifying, screening, recording, reporting and referring instances/cases of IPV amongst pregnant women (Ericksen & Frandsen, 2018, Thomas et al., 2023). The context is the setting/location of the study; therefore, the researcher will only be reviewing literature from South Africa, Africa, and countries of similar socio-economic backgrounds (Ericksen & Frandsen, 2018, Thomas et al., 2023).

3.3.2 Sample characteristics

Eligibility criteria is a pre-specific, unambiguous basis that determines the scope of studies to be synthesised (McKenzie et al., 2023). The eligibility criteria are based on the PICo elements of the research question (McKenzie et al., 2023). This criterion is important as helps produce more accurate, objective, and meaningful results (McKenzie et al., 2023). The criteria included in studies in a review should be sufficiently broad to encompass the likely diversity but remain sufficiently narrow to ensure that the research question is answered, and the study can be replicated (McKenzie et al., 2023). McKenzie et al. (2023) mention the three considerations for determining eligibility criteria they are that the diseases or condition of interest should be clearly defined, the broad population and setting of interest should be defined and lastly the population characteristic that might be expected to modify the size of the intervention effects.

3.3.2.1 Criteria for inclusion

The condition of interest in this study is looking at the experience of staff at PHCI responding to pregnant women facing IPV, qualitative literature would be the best methodology to describe the experience of staff at PHCI. The type of publications that will be reviewed are journal articles written in English only. The broad population and setting of interest in this study is staff working at PHCI including but not limited to midwives/nurses/doctors that engage directly with pregnant women. The researcher is only interested in reviewing journal articles conducted in South Africa, Africa and other countries that have similar socio-economic status as they have similar contexts. The researcher included a journal article that was conducted in Jamaica due to its similar socio-economic context. The consideration of population characteristics that might modify the size of the intervention has not been identified as the

researcher is including all staff at PHCI that engage directly with pregnant women as the participant population.

3.3.2.2 Criteria for exclusion

Studies that were excluded from this review were journal articles published earlier than 2014 as these articles are more than 10 years old and therefore deemed to be no longer relevant. However, during data collection, the researcher found that the amount of eligible journal articles had significantly reduced when only considering articles from 2014. Therefore, the researcher had to widen the search to include articles published from year 2012. The researcher excluded all journal articles that were not conducted in South Africa, Africa or countries that do not have similar socio-economic status to Africa.

3.3.3 Sampling procedure

Lefebvre et al. (2023) mention that researchers conducting systematic literature reviews should consult an experienced librarian as they would provide specialist input on how to proceed with searching for the data. The first step involved the researcher consulting two librarians one with experience in searching for literature on EBSCOhost a humanities database and the other had expertise in the health sciences databases and used PubMed (table 3.1). PICo was used to identify key search terms to facilitate a more efficient search and to document search strategies/terms for future updates, either in the same or similar topics (Lefebvre et al., 2023). The purpose of a search strategy is to detail how and where primary sources were found, this review used the PICo search strategy. This search strategy is used to formulate the research topic while simultaneously clarifying the questions (Lefebvre et al., 2023). The search strategy allowed the researcher to label concepts and build search terms, a comprehensive search strategy compromises "free text" which uses keywords determined by the reviewer (Lefebvre et al., 2023). Below are the keywords used by the researcher to construct the search strings, since the databases differed so did the language used which is why the researcher used different keywords for the searchers.

Both librarians assisted the researcher in building search strings by using Boolean operators using synonyms for words like women, pregnancy, IPV, hospitals, South Africa, Africa and nurses, this was done so that a wider search could be done. Boolean operators are codes used

to connect search words together to either narrow or broaden the set of results, the Boolean operators used were “, AND, OR, (), and * (Dinet, Favart & Passerault, 2004). The health science librarian introduced Mesh terms to the researcher as this was an important element of constructing search strings on PubMed. The researcher spent time trying different combinations of words and Boolean operators in conducting a wider search to maximise the number of journal articles retrieved during each search. Lefebvre et al. (2023) support this by mentioning that searchers for systematic reviews should be extensive to ensure that as many of the relevant journal articles are included, however, they argue that this should be tempered with comprehensiveness and maintaining relevance. Below are the keywords used by the researcher to construct the search strategies.

Table 3.1: The keywords used for the systematic literature review search for PubMed

P (population): midwives/nurses/doctors OR • Midwives OR nurses OR doctors OR “healthcare professionals” OR “medical personnel” OR “clinical staff” OR “nursing staff” OR “hospital staff” OR “nurse practitioners” OR “physician” OR “nurse midwives” [Mesh] OR (nurses [Mesh]) OR “physicians” [Mesh]
I (interest): pathways and protocols identifying instances/cases **OR** • Protocol OR program OR programme OR intervention OR guidelines OR recommendations • screening OR tools OR indicators OR enquiry OR investigation OR identify OR identification OR assess OR assessment OR detect OR detection **AND** Intimate Partner Violence **OR** • IPV OR "domestic abuse" OR "domestic violence" OR “spousal abuse” OR “partner abuse” OR “domestic aggression” OR (“intimate partner violence” [Mesh]) **AND** pregnant women **OR** • Pregnant OR Pregnancy OR Gestation
C (context): Africa **OR** South Africa

Search string: (((screening OR tools OR indicators OR enquiry OR investigation OR protocols OR identify OR identification OR assess OR assessment OR detect OR detection OR test OR tests OR questions OR questioning OR predictors) AND (((pregnant OR pregnancy OR gestation OR pregnant women)) OR ("Pregnant Women"[Mesh]))) AND ((IPV OR "intimate partner violence" OR "domestic abuse" OR "domestic violence") OR ("Intimate Partner Violence"[Mesh]))) AND (qualitative research OR qualitative study OR survey OR interview)

Table 3.2: The keywords used for the systematic literature review search for EBSCO host

P(Population): "Pregnant* women" OR pregnancy OR "expectant mothers" OR gestation And: Nurses OR midwives OR
I (interest):" Intimate partner violence" OR IPV OR "Domestic abuse" • Spousal abuse • Partner abuse • Domestic aggression • Domestic violence AND: procedures OR protocol OR intervention OR programme OR program
C (context): hospitals OR clinics OR "public hospitals" OR "public clinics" AND: South Africa" OR Africa

Search string: "pregnant* women" OR pregnancy OR "expectant mothers" OR gestation AND "intermate partner violence" OR IPV OR "domestic abuse" OR "spousal abuse" OR "partner abuse" OR "domestic aggression" OR "domestic violence" AND procedures OR protocol OR intervention OR programme OR program AND hospitals OR clinics OR "public hospitals" OR "public clinics" AND South Africa OR Africa

3.4 Data collection

The search stings allowed the researcher to search for the journal articles in PubMed and EBSCO HOST, once this was completed the data collection process started. The researcher exported the data from EBSCOhost and PubMed by downloading it into a CVS (Comma Separated Values) format, according to Li, Higgins and Deeks (2019) the CVS file is a data collection tool used to facilitate automatic imports of extracted data. The researcher then took the CVS files and uploaded them into Rayyan to start the screening process. The data collection process was particularly tedious because the researcher had to screen all articles individually, the screening and data extraction was done using the Rayyan software. The software is designed to allow the researcher to create and publish data extraction by including and excluding articles, the functions of the software are that it labels and justifies the reasons for exclusions, resolves conflicts, removes duplicates, has a display mode that lists all references in the review and populates a graph that visually displays relevant citations and groups them.

The researcher went through all data using the eligibility criteria mentioned earlier in this chapter to determine if the journal articles will be used. Li, Higgins and Deeks (2019) established a checklist of items to consider during the data collection process, which is like the

eligibility criteria that the researcher used to comb through the data. The researcher used a check list based of the inclusion an exclusion criteria to determine eligible journal articles.

The screening process was implemented thrice, first wherein duplicates were detected by Rayyan. The researcher excluded and removed articles that were published before 2012. The initial number of articles was 1503 after duplicates and articles published before 2012 were removed the number of articles dropped to 1462. The second screening was more specific and used the PICo framework and eligibility criteria to further exclude journal articles, this significantly decreased to number of usable journal articles to 20. During the second screening, the researcher looked at the abstracts of the articles only, if the PICo was not clearly defined in the abstract then the researcher skimmed through the article and from there determined whether it met the eligibility criteria.

The third screening process involved the researcher downloading the articles and going through them to identify if they were addressing the research questions. Thus, narrowing the number of articles to 20 which spoke to the research question. The researcher then read through all 20 articles and found that 9 of them needed to be excluded due to having the wrong participants, thus leaving the researcher with 11 viable articles. 1 of the 11 articles used was conducted in Jamaica, the rationale for including this article was that Jamaica and Africa have similar socio-economic and historic contexts. Conducting the screening process in this way permitted the researcher to simplify both searchers resulting in a more comprehensive and robust screening process.

Li, Higgins and Deeks (2019) mention that the individual extracting the data should have a good understanding of the research question because errors that occur during data extraction are rarely detected by peer reviewers or editors. For these reasons, the researcher chose to be the one completing the data extraction. It is advised by Li, Higgins and Deeks (2019) that more than one person should complete the extraction again to minimise error and reduce biases. The researcher did not have help completing extraction as this study is a minor dissertation and there was no budget however the researcher decided that screening the data in phases ensures that errors and biases were reduced.

The PRISMA flow diagram was used to present the number of articles retrieved from both

databases EBSCOhost and PubMed, The rationale for using the PRISMA flow diagram in this study was that it allowed the researcher to depict the flow of information through the different phases of the systematic review (TRSRMA, 2024). The PRISMA flow chart maps out the number of articles identified, included, excluded and reasons for exclusion. The diagram is useful in that it summarizes the screening process and how the researcher arrived at the 11 journal articles from the initial 1503 journal articles. The PRISMA flow chart is presented below in diagram 1.

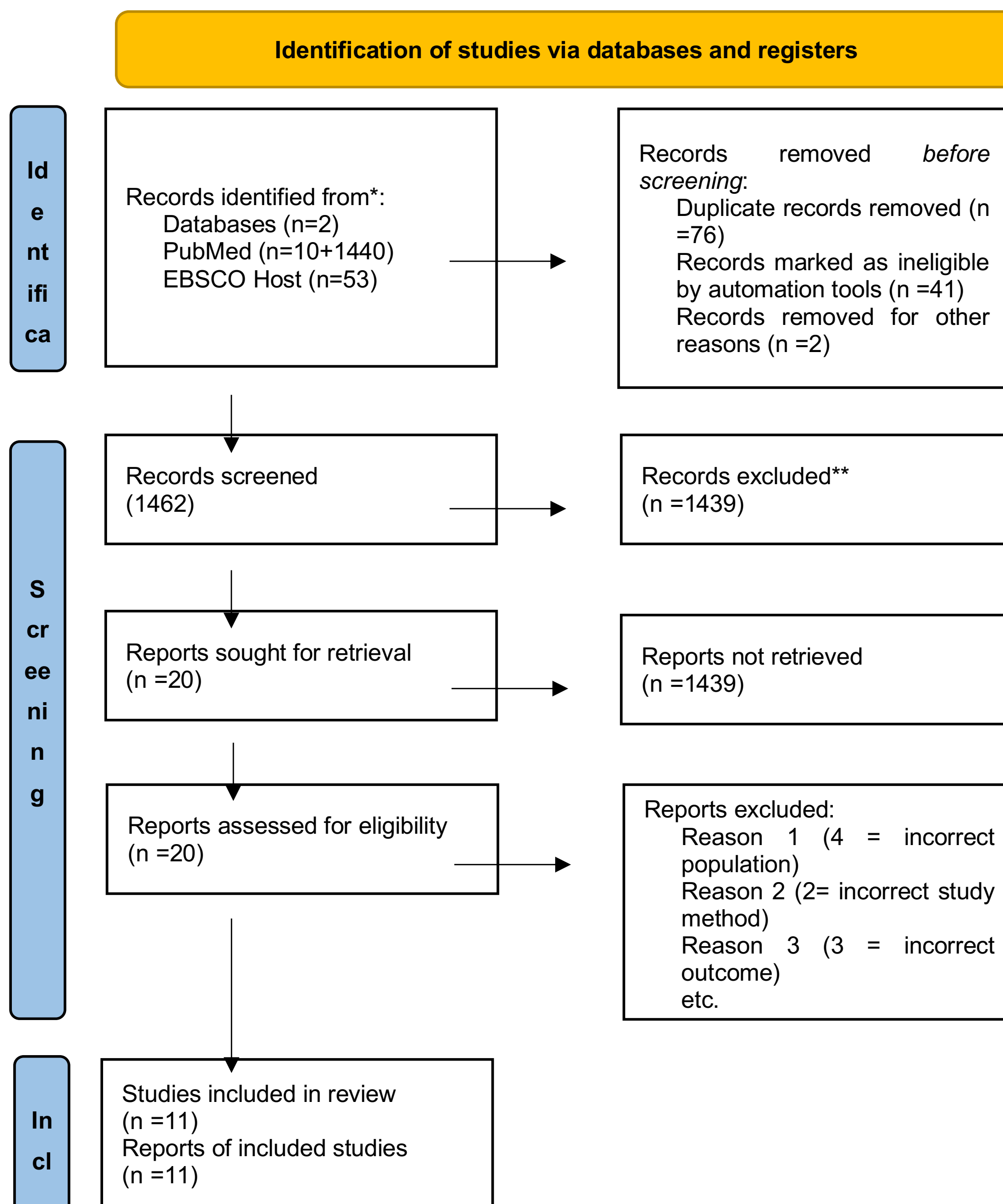

Diagram 3.1: PRISMA flow diagram for systematic review which included searchers of databases and registers only

3.5 Data analysis and synthesis

The 11 eligible articles have been extracted and are now ready to be analysed in this section the researcher discussed the data analysis and synthesis process. Inductive reasoning was used in analysing the data, and the themes and categories that emerged constituted how the data was organized (Dey, 1993: 7). Dey (1993) and Tesch (2013) were used to analyse the qualitative data as they have clear and thorough steps to analysing qualitative data. Dey (1993) explains the steps involved in qualitative data analysis, are finding a focus, managing the data, reading, and annotating, categorizing data, linking data, connecting categories, corroborating evidence, and producing an account. The researcher followed these steps when analysing the data. Creswell (2014) adds that data analysis is a process used to make sense of the raw data that has been extracted and consists of describing information and developing themes (Creswell, 2014: 345).

Using the steps mentioned above the researcher analysed the data. Step 1: finding focus alludes to reflecting on the data that has been read, looking at what kind of data the research has produced (Dey, 1993: 66). The researcher achieved this by reading over all the data once to get an understanding of each study, Tesch (2013) describes this as getting a sense of the whole. It is advised that during this step the researcher suspends any assumptions and beliefs to examine the data in a new and critical way (Dey, 1993: 66). The researcher's reflections during this stage were "why protocols/pathways or identifying IPV at PHCI were not standardized practice" which is central to the research question as it sought to explore these protocols at PHCI , initially the researcher thought that it was due to lack of resources and money, however, this started to change after reading and reflecting on the data.

Resources that help find focus are personal experiences, general culture and academic literature, the researcher reflected on theories like the systems theory, feminist theory and phenomenological theory after reading the data (Dey, 1993: 71). The holistic approach of systems theory helped the researcher study the individual, community and society's interconnectedness, thus explaining that IPV is not caused by one factor but rather multiple interacting factors. Feminist theory provided the researcher with a lens to understand the

patriarchal power structures, cultural norms and gender inequality that are evident when looking at how staff at PHCI respond to pregnant women experiencing IPV. Since this study is rooted in the experience of staff at PHCI phenomenological theory was used to focus on their lived experience and how that informs their practice as staff. These theories helped the researcher understand what might be happening for the staff members at PHCI. Step 2: Managing the data is the storing and filing of data in an organised and systematic way, Dey (1993) mentions that good analysis requires the efficient management of data. After the screening process the researcher was able to find 11 journal articles that fit the eligibility criteria, these articles were then printed off. The researcher then cut all the quotations out of the articles once this was done, the data was then stored in a clear plastic sleeve ready for the next step which is reading and annotating (Dey, 1993: 87). Step 3: Reading and annotating is a process which aid in the digestion of data, it is a process of absorbing data and interpreting what the data means (Dey, 1993: 87). The researcher read the cut-out quotations to comprehend it and to get a sense of what the participants were saying or trying to convey. The aim of reading the data was to prepare for analysis. The researcher annotated the data by noting down all the observations and thoughts on what the participant was saying and feeling, Dey (1993) adds that making notes is a thorough road to the description.

Step 4: Creating categories Dey (1993) describes this as creating conceptual tools to classify and compare the important or essential features of phenomena that we are studying. Like in Tesch (2013), the researcher developed themes, categories, and sub-categories so that similar data can be grouped. The process of creating categories was tedious and time-consuming as the researcher had to constantly alter the piles of data by adding or removing quotations based on their content. The process of sorting the quotations into piles that had similar themes and categories resulted in multiple piles of quotations.

The next stage was to allocate the piles into categories, themes and sub-categories with meaningful titles/headings. The annotating in step three helped the researcher sort through the quotations grouping them into different themes, categories and sub-categories. This process was challenging for the researcher as the themes, categories and subcategories had to be descriptive enough so to differentiate from other themes, categories and subcategories, this is called splitting and spicing categories (Dey, 1993: 139). The researcher split the themes into categories and the categories into subcategories. Throughout creating categories, assigning

categories and splitting and splicing the themes and categories were changed, rearranged and reorganised. After the splitting and slicing stage, the researcher was left with 4 main themes and multiple categories and subcategories.

Step 5: involves linking data and connecting categories Dey (1993) mentions that categorising data allows us to compare observations in terms of relations of similarity and difference. Dey (1993) adds that categories are the conceptual building blocks from which we can construct theories. Linking data and connecting categories refers to recognising substantive relations, which focuses on how things interact rather than how they relate in terms of their similarities or differences (Dey, 1993: 161). In this study the researcher looked at how the staff interact with pregnant women who experience IPV when they present at PHCI, this interaction is what linked the data to the research question. The links, connections and evidence in the different themes, categories and subcategories are all related to the staff interactions with pregnant women, the first theme was created as it looked at the challenges and concerns that staff at PHCI face. The second theme relates to the enquiry that staff make with regards to pregnant women experiencing IPV, the third theme is all about staff ideas about the improvement of protocols/pathways for screening and identifying instances of IPV at PHCI and the last theme talks about training on IPV with staff at PHCI. Below is a table of main themes, categories and sub-categories that emerged out of the data during the analysing process.

Table 3.3: Presenting the main themes, categories and subcategories that emerged from the research

Main themes	Categories	Sub-categories
4.4.1 Theme 1: Public health care system challenges, concerns and progresses	4.4.1.1 Staff experiences	4.4.1.1.1 Pathways to Reporting 4.4.1.1.2 Issues around human resource capacity 4.4.1.1.3 Privacy 4.4.1.1.4 What's working well

	4.4.1.2 Staff views on IPV and pregnancy	4.4.1.2.1 Attitudes and beliefs of staff towards IPV and pregnancy 4.4.1.2.2 Staff thoughts on improvements to public health care systems regarding IPV
4.4.2 Theme 2: Staff at PHCI enquiry	4.4.2.1 Physical enquiry	
	4.4.2.1 Verbal enquiry	4.4.2.2.1 Negative verbal enquiry 4.4.2.2.2 Positive verbal enquiry
	4.4.2.3 Effects of enquiry	4.4.2.3.1 Emotional effects of enquiry 4.4.2.3.2 How enquiry affects staff safety
4.4.3 Theme 3: Ways to improve identification, detection, and screening of IPV among pregnant women	4.4.3.1Advocacy and awareness of IPV during pregnancy	
	4.4.3.2 Screening processes	4.4.3.2.1 Effective screening methods 4.4.3.2.2 Importance of screening for IPV
	4.4.3.3 Pregnancy Complications Related to IPV	
4.4.4 Theme 4: **Training for staff at PHCI on IPV during pregnancy**	4.4.4.1 Benefits of training on IPV for staff at PHCI 4.4.4.2 Importance of staff having counselling skills	
	4.4.4.1 Staff empowerment	
	4.4.4.3 Knowledge gap in tertiary education on IPV during pregnancy 4.4.4.4 Staff view on training	

Step 7: is producing an account, this means the researcher should report on the results found during the analysis process (Dey, 1993: 245). Reporting on the results is done when the researcher introduces and explains a theme, category or sub-category and substantiates it with quotation evidence. After every theme and category, the researcher discusses the quotations by drawing from literature to support the themes and categories. The results were discussed and explored in chapter 5, the results of this study help us unpack and understand the experience of staff at PHCI that respond to pregnant women who experience IPV.

3.6 Data verification

Step 6: Corroborating evidence alludes to data verification, Dey (1993) compared this with looking at evidence in a criminal trial he mentions that this is done to make sure that the data used is credible and reliable. There are three common ways of verifying data namely triangulation, negative case (or "deviant") analysis and having a reflexive journal (Burnard et al., 2008: 431). The researcher used triangulation for the data verification process, this was done by reading and reflecting on other journal articles that looked at staff at PHCI responses to pregnant women experiencing IPV. This process involved comparing and contrasting the data found in other journal articles (Burnard et al., 2008: 431).

3.7 Limitations of the study

Limitations are matters or occurrences that arise in the study which are out of the researcher's control (Simon & Goes, 2013). They limit the extensity to which a study can go and could affect the outcome of the study (Simon & Goes, 2013). Simon and Goes (2013) explain the limitations of qualitative studies are their validity and reliability due to the nature of qualitative research, however, the researcher struggled with other limitations like lack of literature on the topic and accessibility/availability of participants for the initial qualitative study.

One of the limitations of the study was the lack of recent journal articles on the topic of IPV during pregnancy in Africa and countries that have similar socio-economic status. This was noted by the researcher and motivated the researcher to conduct the initial qualitative study. These limitations were noted in Chapter 2, as explained before the researcher planned to conduct empirical research and the researcher sought to conduct in-depth interviews with staff at PHCI who work with pregnant women. However, this was not possible due to time

constraints and the lack of availability/accessibility of staff members. After 5 months of trying to recruit participants the researcher together with supervisors decided to move to a systematic literature review.

The researcher gathered all the correspondence from managers, participants and other stakeholders as evidence of this limitation and organised it into a table which can be found under Appendix B. The table presents all the contacts that the researcher made and their correspondence. Hoyland, Hollund and Olsen (2015) speak of the challenges researchers face when conducting research in the medical field, their study found that certain considerations need to be put in place for access to be granted.

These considerations were conducting continuous negotiations to ensure the agreement and consent of participants and gatekeepers, demonstrating transparency regarding the researcher's identity, the nature of the study and its findings (Hoyland, Hollund & Olsen, 2015: 229). Although the researcher attempted these considerations and gained access via nurse/midwife managers (gatekeepers), the other limitation that the researcher faced was participant availability. The stretched maternity services at PHCI were made apparent during the participant recruitment process. The responses that the researcher would get from managers and nurses/midwives were that they do not have time to take part in the study due to being short-staffed whilst having a high workload. The researcher hypothesises that the lack of availability could be due to the workload but could also be linked to the ethical practice of the nurse/midwife and their anxieties around disclosing whether they support pregnant women who experience IPV. This could explain why it was so challenging for the researcher to access participants Traynor and Buus (2016) mentioned this phenomenon in their study.

This highlights the reality of conducting research in the medical arena and the limitations that researchers face when trying to gain access to participants in the medical field. Tertiary education institutions should look into facilitating partnerships with PHCI to make this process a lot more seamless.

In relation to the systematic literature review that was conducted after no progress was made with the empirical study, the researcher struggled to get recent journal articles for the review. This resulted in the researcher moving the year to 2012 which was much later than the initial year 2014 making the studies used in the review older than 10 years. This was done in response

to the limited number of journal articles conducted in Africa and other countries with similar socioeconomic backgrounds. This might affect the results of the study but also speaks to the lack of research on this topic in the African context.

An interesting observation during the screening and data analysing process was that the Western or developed countries had established processes and pathways of enquiry and reporting instances of IPV experienced by pregnant women. In contrast, the African or developing countries did not have an established and standardised system for identifying, reporting, recording and referring instances of IPV experienced by pregnant women at public institutions. This observation would lead one to believe that more research would be done in African or developing countries given the lack of systems in place for identifying, reporting, recording and referring instances of IPV experienced by pregnant women, but the opposite is true. Another observation that the researcher had was that when the articles in the Western and developed countries spoke about the issue of IPV and pregnancy alone, however when the researcher read the articles from African and developing countries they spoke about IPV and pregnancy with other issues like HIV/AIDS or TB which was not mentioned in the articles from western or developed contexts.

3.8 Reflexivity

Palaganas, Sanchez and Caricativa (2017) mention that reflectivity in qualitative research is how researchers acknowledge the changes brought about in themselves because of the research process and how these changes have affected the research process. The reflexivity that the researcher experienced through conducting the research was understanding that women are not exempt from holding and maintaining oppressive values due to the society they were socialized. The researcher also understood how nuanced the staff's response is to IPV and that it is not as clear cut as it seems, staff chose not to enquire for various reasons. The researcher also felt that it was strange that WHO, South Africa and other Western countries do not enforce strict guidelines regarding screening for violence at PHCI again this could be another means of maintaining and upholding oppressive values in society. This research has changed the researcher's way of understanding how PHCI respond to IPV experienced by pregnant women as it provides a clear picture of what staff experience when responding to IPV in South Africa, Africa and the like.

3.9 Conclusion

This chapter examined the methodology and mentioned that a qualitative systematic literature review would be conducted. It also expanded on the study's participants and study eligibility criteria, PICo was the search strategy that guided the researcher regarding the journal articles selected for the review. The data collection, verification and analysis were described as well and the limitations and the reflexivity of the study were explained drawing the chapter to a close.

CHAPTER FOUR

FINDINGS

4.1 Introduction

This chapter presents the profile of the participants and discusses the findings of the systematic literature review. It introduced the themes, categories, and sub-categories after each theme the researcher will unpack the findings and draw conclusions based on the quotations presented. In addition to this, the researcher will link the findings presented in each theme to other relevant studies to substantiate the evidence. The findings explore how staff use protocol/pathways at PHCI for identifying, reporting, recording, and referring instances/cases of IPV experienced by pregnant women in South Africa and Africa.

4.2 Profile of participants

The profile of the participants was diverse between studies, as all except for one study was not conducted in Africa. There was a mixture of occupations varying from nurses, midwives, OBGYNs, managers and other health care staff. The gender of staff at PHCI varied with more being female and some being male, the ages of staff were not specified but all members mentioned worked directly with pregnant women at PHCI. Pseudonyms and occupations were displayed after every quotation for articles that already had this information however this varied as not all quotations had demographic information linked to each quotation. Some of the quotations were taken from pregnant women as they commented on the service of the staff at PHCI.

4.3 Presentation and discussion of findings

4.3.1 Theme 1: Public health care system challenges, concerns and progresses

This theme identifies the current state of the public healthcare systems in South Africa and Africa. This theme is linked to the first research question which sought to understand what pathways/protocols are established at PHCI. Using the phenomenological theory the researcher was able to understand how staff respond to pregnant women who experience IPV by exploring their views and experiences (Pula, 2022: 413).

4.3.1.1 Category 1: Staff experiences

This category depicts the lived experience of staff at PHCI when interacting with pregnant women. The sub-categories look at staff experience related to pathways of reporting, issues around capacity, privacy and what's working well.

Sub-category 1: Pathways of reporting

This sub-category speaks to the pathways that staff at PHCI use to report instances of IPV experienced by pregnant women. All articles reviewed reported staff speaking on the lack of established pathways/protocols for reporting on or responding to IPV, more than half of the articles reviewed mention that there are no recognized pathways/protocols for identifying, referring, and reporting IPV cases during pregnancy:

> "The challenge is one, in rural areas, we were being overwhelmed by the number of patients. So, you just follow the assessment of the antenatal card, and the antenatal card does not include domestic violence or gender-based violence, it is not there. So…… normally we discover as I said during examination when you are one on one (with IPV survivors), that is when they tell you" (medical officer) (Anguzu et al., 2022: 8).

> "I met victims many times especially I do remember a pregnant woman whose husband is a heavy Khat (stimulant) user and she told me that he sexually abused her and made her suffer throughout the night and caused her genital trauma but because it is not indicated in the ANC card, I don't even know how to ask and help out" (nurse) (Gashaw et al., 2020: 6).

> "Many times I met victims of partner violence with obstetric complications but did not help them much, other than clinical management, I was even beaten by my husband; I think that IPV has nothing to do with ANC because it is not listed in the ANC card mainly we focus on whether the fetus is injured and check fetal movement and heart rate" (nurse) (Gashaw et al., 2020: 6).

Some staff comment on PHCI not having established pathways of referrals to other support services regarding IPV:

> "We do not have formal lines to refer intimate partner violence, we only treat visible trauma and send them back home" (midwife) (Gashaw et al., 2020: 5).

> "I had a pregnant women beaten by her husband to death, she started to have vaginal bleeding and then a dead fetus was expelled. We gave only medical care because there is no guidance to follow, we do not know how to help, and we have no skill for managing it (IPV)" (midwife) (Gashaw et al., 2020: 6).

Staff mentioned the challenges they experience when trying to refer pregnant women to services for support regarding IPV:

> "As midwives, we are exposed to pregnant women who are been abused. There are times when we want to help those persons but there are no resources such as finances and not enough medical social workers that we can refer these women to" (Cindy) (Pitter et al., 2016: 5).

> "I saw specially one woman severely beaten; I've never seen such incident in my life…. hmmmmm, and her flesh was visible. We advised her to go to the police, but she refused because she went to the police previously and the police referred her back to reconcile with her husband" (midwife) (Gashaw et al., 2020: 7)

Staff express their lack of confidence in the services that support pregnant women experiencing IPV:

> "If you know you are going to screen and find out that she is living in a violent relationship and you know you are going to leave it at that, then I would rather not screen" (Male, OBGYN) (Anguzu et al., 2022: 7).

Staff talk about the systems that are in place and how they experience difficulties with administrative tasks:

> "It's sometimes difficult as some patients give the wrong address, phone numbers don't exist or they will say they don't have a number it's not easy to trace them" (midwife) (Abrahams et al., 2024: 12).

Staff spoke positively about services that they had at PHCI; however, they mention that it was not permanent and after the organization left the staff were not able to provide that service to the pregnant women:

> "We used to have this organization…. They were after these pregnancy issues. They could see them (pregnant women) from the initial bookings and talking to them and giving them information about…. any problems at home with the husband. They were here to assist them. It's the one that looked after that. As for us, we don't….and the organization is no longer coming. I don't know what happened…. they used to come during the initial visit and…. subsequent visits…. they would also hold interviews with the mothers in the post-delivery section, especially the unbooked mothers; they would want to know the reasons why they were not booked. Some mothers would say they didn't have the money because my husband was refusing to give me the money. They would ask if he was bringing her food……the organization would pay certain amount and another amount would be paid by the city of Harare" (female midwife) (Shamu, Abrahams, Temmerman & Zarowsky, 2013: 518).

The key findings address the first research question by confirming that there are no established pathways/protocols for identifying, screening, reporting, or recording instances of IPV experienced by pregnant women. There was also no evidence to suggest that PHCI were recording the instances of IPV. Therefore, corroborating what Kirk and Bezzant (2020); Artz, Meer and Aschman (2018); and Musa-Maliki and Duma (2024) confirming that there are no established screening protocols/pathways for IPV at PHCI. There is a antenatal checklist that staff use however it does not include IPV screening, this protocol is used for clinical management only. The complications of IPV during pregnancy was mentioned however the participant remained focused on clinical management. Thus, verifies that there are no standardized and established IPV screening tools used by staff at PHCI, however, England has

an example of an effective easy to understand screening tool that is used to screen for domestic abuse, stalking and honour-based violence (DASH). This screening tool is called DASH and is used by all governmental agencies to screen for IPV in England, this could be something that South African PHCI could replicate as it is an effective way of screening for IPV.

Staff identified the challenges that they experience when referring cases of IPV alluding to the existence of referral systems but commenting on its inadequacies. Musa-Maliki and Duma (2024) state mention the absence of referral systems and resources makes it difficult for staff at PHCI to enquire about IPV. Equally through a feminist lens pathways and protocol police use should be addressed to be more victim and women centred, as this encourages disclosures and promote trust. The National Council on Gender-Based Violence and Femicide are responsible for coordinating a multisectoral and intersectoral approach guided by the NSP in combating GBVF at national, provincial, and local levels (Republic of South Africa, 2024). Strengthening collaboration with organisations and working together with pregnant women are important, there is evidence to suggest that PHCI working with organisations facilitate positive outcomes. Governments could explore this collaboration further and ensuring the longevity of this partnership. They could link staff at PHCI to police, social workers, and Social Development to make sure that referrals from PHCI are picked up by other services.

The South African government and policymakers can look to the United Kingdom (UK) for examples of this organized approach. In the UK it is called the Working Together to Safeguard Children policy of 2023, this is an example of how agencies like health, schools, police, and social care share information and work together to help protect and promote the welfare of children (Department of Education [DoE], 2015: 8). The values of the working together policy is echoed in the Revised White Paper on Families in South Africa and the Children's act justifies the need for IPV screening because it encourages that children should be born into safe, caring family environments (Republic of South Africa, 2005; DSD, 2021: 8). Thus, emphasizing the need for a coordinated approach to take place between all governmental agencies.

Sub-category 2: Issues around human resource capacity

Human resource capacity has been mentioned as a major issue with staff and presents as an obstacle when it comes to enquiring about IPV at PHCI, most articles reviewed had staff complaining about practise challenges like not having enough time to enquire about IPV:

> “When you have a queue in any kind of antenatal setting, and then the nurse asks a question…. of you open up the space you might end up having to sit with the patient to spend 20 or 30 minutes instead of 8 minutes. And so, what is that going to mean for me to be able to get through my workload? And so, there is reluctance on the part of nurses” (health manager) (Hatcher et al., 2019: 1344).

> “We have little time for patients and services are affected detecting GBV cases because if you are to detect GBV, you have to take time with this patient talking to her, counselling her, then she will come out” (female assistant nursing officer, Rural) (Anguzu et al., 2022: 6).

They mention how being short-staffed is a human resource capacity issue as they often take on more than they can handle, thus contributing to staff burnout which impacts the quality of service/support that they provide to pregnant women:

> “You know if we had more staff we would have more time to listen to people and understand what they are going through but now we are looking at the queues we want to finish and that's the problem” (health care provider) (Hatcher et al., 2019: 1345).

> “You find staff saying they are already taking more than they can manage and, in some cases, it's true, they are. There’s an element of burnout, there’s an element of not feeling rewarded and appreciated on their side, so it's like, if I don’t feel appreciated and I’m not getting rewarded for the work that I do. How am I going to provide a good service” (health manager) (Hatcher et al., 2019: 1344).

An example of staff burnout due be being overwhelmed by the workload at PHCI:

> "Sometimes I do forget to scan the referrals, especially Fridays because I am not here on Saturday and Sunday…. but my aim was to always try and push and make sure that people are being seen as soon as possible" (midwife manager) (Abrahams et al., 2024:12).

> "The reason is that we have big numbers. Sometimes you are overwhelmed with the numbers. Sometimes you have involve counsellors so instead of spending a lot of time on this mother, yet you are not going to get information you refer the mother to the counsellor because you already have a long queue to work on" (female nurse) (Anguzu et al., 2022: 7).

Sub-category 3: Privacy

For enquiries to be done staff need a private place to discuss the IPV that the pregnant women might be experiencing, most PHCI do not have such facilitates making it very difficult for enquiries to take place. Staff explain that privacy becomes a practise challenge for them as there are no private or confidential spaces at PHCI:

> "We need to get a private room. When we get a private room it will work, but unfortunately, here our space is too small and the mother will not be willing to tell you in the open because even in the examination room where we examine mothers there are two beds so there is no one-to-one privacy" (female rural midwife) (Anguzu et al., 2022: 8).

> "When we want to explore issues concerning that (IPV), we need privacy. The best time to explore is the time of booking but the booking is done where there is no privacy" (female assistant nursing officer) (Anguzu et al., 2022: 8).

> "It's only the curtains so the patients is sitting here, she can hear what is going on, on the other side (nurse) (Abrahams et al., 2024:11).

Sub-category 4: What's working well

Despite the practice challenges and concerns mentioned above, there were few instances where staff at PHCI reported on being able to respond to IPV, less than 5 articles reviewed staff reporting, identifying, and referring instances of IPV:

> “We use the Ministry of Health guidelines to screen and refer and attend to people like that” (male OBGYN) (Anguzu et al., 2022: 7).

> “When we receive these mothers, and we feel they really need help, we refer them to the gender-based violence department which is based at the ART (anti-retroviral therapy for HIV) clinic…… they put them in the GBV corner’ (female midwife) (Anguzu et al., 2022: 7).

> “Helpful to the patients, because the patients now are willing to talk to us, they (pregnant women) know where to get help if they have a problem, they know who they can talk to and that the talks should be “introduced at other clinics that see pregnant women” (health care worker) (Abrahams et al., 2024: 9).

Phenomenological theory (Delve & Limpaecher, 2022) was used to look at the structural issues of human resource capacity, privacy and the things that have been working well at PHCI. This is a snapshot of the condition in which staff at PHCI must work under. The concerns that staff have regarding privacy and human resource capacity seem to be ongoing as this has been highlighted by other studies namely in Hatcher et al. (2019: 1333); Akaba and Abdullahi (2020: 1); Musa-Maliki and Duma (2024: 7). These structural issues are so relevant to staff at PHCI that the researcher has encountered them whilst trying to recruit participants for their initial study. The researcher reported that despite staff and managers agreeing to participate in the study they did not have the time or human resource capacity to partake in the study during working hours, due to being understaffed and having an unmanageable workload.

It appears the issues around human resource capacity and privacy have always been a problem for staff however, nothing has been done about it. This would be a good starting point for The National Council on Gender-Based Violence and Femicide to advocate to governments to employ more staff and encourage the building of confidential rooms so that PHCI’s are more conducive for IPV screening and disclosures. Employing a social work team specifically

managing screening for IPV could support staff at PHCI manage their clinical caseload, by ensuring that the victims are appropriately supported and signposted. This could be facilitated by organisations or local and national governments. Similar suggestions have been made by Musa-Maliki and Duma (2024) where they implore governments and hospital authorities to attend to the structural barriers to IPV screening at PHCI. In addition to this, the researcher argues that a degree of unlearning of cultural and societal beliefs should take place as this too becomes a barrier to IPV enquiry, this has been highlighted in the Meskele, Khuzwayo and Taylor (2020) article. The structural cultural and societal beliefs should be addressed simultaneously as the researcher believes that this would be the only way impactful change will occur.

4.3.1.2 Category 2: Staff views on IPV and pregnancy

Staff views on IPV can affect how they respond to IPV, staff views are very powerful as they could determine whether the IPV gets identified or reported. All staff at PHCI used their own discretion when it came to reporting and referring instances of IPV as there were no established pathways/protocols at PHCI. Which is very subjective and not consistent thus further justifes the need for standardised IPV screen protocol. Most staff members held structural views like violence, power and patriarchy that disadvantage women concerning IPV, and they advised that pregnant women should endure IPV.

Sub-category 1: Attitudes and beliefs of staff towards IPV and pregnancy

Some staff reported advising pregnant women to reconcile with their husbands or seek strength from religion:

> "I usually advise victims to reconcile with their husbands, because children should not be brought up without a father" (midwife) (Gashaw et al., 2020: 6).

> "I met many victims, including pregnant partner violence victim women. As most of them are economically dependent on their husbands I used to tell them to reconcile with their husbands" (nurse) (Gashaw et al., 2020: 6).

Pregnant women report what they were advised to do by staff after disclosing that they are experiencing IPV:

> "Pregnant women's feedback on the advice that they received from the midwives when they spoke about the IPV that they were experiencing the women explained that the midwife had given her a book to read and said "read to forget" and advised her to speak to her pastor to "help her cope" (Abrahams et al., 2024: 14).

> "Another pregnant woman reported that a midwife "asked me to pray about the situation whenever I feel like I am alone or do not have someone to talk to. I should just talk to myself about the whole thing as if I'm with someone" (Abrahams et al., 2024: 14).

Cultural beliefs also have an impact on the views and attitudes that staff have regarding IPV, staff mention that as Africans violence/abuse should be treated as a family or personal issue therefore it should not be discussed with strangers:

> "Very much! Because most of the time, where it's very sensitive, we try to avoid it though we can see it. It (violence) is treated as if it is not there, because you always feel like you're infringing, you're getting into a person's private life. But if we have tools, we can talk about it" (health care provider) (Hatcher et al., 2019:1346).

> "Yes, African culture…. there is that saying…that the secrets for the family must remain in the family. They should not be taken to the outsiders, there is that saying" (female nurse) (Anguzu et al., 2022: 9).

> "She (the patient) needs to trust you. As Africans you should not just share (abuse)…should not discuss family matters with a stranger" (Palesa, nurse) (Sprague et al., 2020: 10).

The evidence suggests that the attitude and views that staff have on IPV impact how they respond to pregnant women experiencing IPV. These biases determine whether staff will screen reports or refer instances of IPV, Sprague et al. (2020) discuss agency and how

challenging it is for staff to use their agency when they are conditioned to have the same values and cultural beliefs as the community that they serve. This indicates how smaller systems like staff at PHCI come together to constitute the community that upholds damaging stereotypes about IPV, systems theory explains this occurrence as it argues that multiple systems enegaging with each other creating barriers to enquiry (Warren, Franklin & Streeter, 1998: 359). Lawoko et al. (2013) confirm this in their study by mentioning the complex interaction of factors at individual, organizational and societal levels that influence screening for IPV. Suggesting that a combination of individual, organizational and societal factors come together to either permit or inhibit IPV enquiry.

It could be argued that this is another barrier to staff enquiry of IPV, however, the researcher reflects that this is not as easy as employing more staff at PHCI. These values and cultural beliefs are embedded in African societies and would be much harder for The National Council on GBVF to address. Studies show that both the structural and the beliefs of the staff have been identified as barriers to the enquiry of IPV (Sprague, Woollett and Hatcher, 2020: 1821; Aboagye et al., 2022: 2; Musa-Maliki & Duma, 2024: 8). These barriers need addressing however the researcher argues that both need to be attended to simultaneously for meaningful change to occur. The National Council on GBVF should look at tackling both barriers to effect positive change, thus promoting IPV decreasing instances of IPV, increasing disclosure, and lowering maternal mortality. These are goals mentioned in the NSP on GBVF (DWYPD, 2020: 19).

Sub-category 2: Staff's thoughts on improvements to public health care systems regarding IPV

Although most staff hold unsafe beliefs and values regarding IPV they also understand that IPV is a societal issue. They comment on how IPV is part of a bigger societal issue and services that support pregnant women who experience IPV should be sustainable and implemented at a governmental level:

> "It (intervention) taught me not to be ignorant. It (IPV) seemed a bigger problem that needs to be challenged by the health department, the social department, the police, working together" (Nokuthula nurse) (Sprague et al., 2020: 13).

> "It needs to be sustainable; it needs to be owned and located somewhere within the public health care system, so that it can continue beyond this particular study, or this particular intervention. And as we know, given the lack of capacity of the health system, this is going to be a challenge" (health manager) (Hatcher et al., 2019: 1345).

> "Time and resources are limited. You're not necessarily going to get the continuity in terms of staff members. I don't think the way clinics are run and the scares resources, I'm not sure whether we are going to achieve this. So, you need to ask yourself, what would it take to establish it and how sustainable it's going to be" (health manager) (Hatcher et al., 2019: 1345).

Staff identify how the support could be streamlined to become more effective with regards to its administration:

> "And yes, you say there are options available. But they may also making the referrals easier and facilitating those referrals. Not only to say here's their name and contact number…. but to say okay I'm going to phone somebody; do you want me to do that? Do you want the help? Here's a place you can go to. I don't think just giving the contact details is enough" (health manager) (Hatcher et al., 2019: 1346).

These findings are interesting as they illustrate that staff are concerned about IPV during pregnancy. This is similar to findings in the Githui et al. (2018) article. They even comment on ways to improve the pathways/protocols and suggest that governments should be responsible for improving and investing in pathways/protocols for responding to IPV. These conflicting ideas of holding patriarchal values whilst having a higher level of education speak to the internal battle that staff constantly deal with (Sprague et al., 2020: 1822).

Staff refer to a top-down approach stating that governments should be more proactive in making sure that IPV during pregnancy is addressed. This is partly true, but it assumes that staff at PHCI are trained to respond to IPV during pregnancy, which according to the research is not a reality (Artz et al., 2018: 6). The National Council on GBVF should endorse adding IPV screening to the antenatal checks. These screening tools should be enforced and

standardized by all organs of state nationally, provincially, and locally and should be involved in the care protection and well-being of children (Republic of South Africa, 2005). Systems theory was used to locate where the issue could be stemming from, the researcher concluded that there are issues that the government need to address and issues that the staff need to address (Warren, Franklin & Streeter, 1998). Thus, locating the issue at a micro and macro level the researcher suggests that both micro and macro issues need to be tackled for the issue of IPV during pregnancy to be attended to. This signifies the dichotomy of social work practise, however it could be argued that the social work profession is best suited to address the gap between micro and macro. Social workers can work at a micro level by supporting the pregnant women through policy development, advocacy and systemic change whilst ebsureing that PHCI become more responsive and accountable for the needs of pregnant women experiencing IPV.

4.3.2 Theme 2: Staff enquiry at PHCI

This theme is specific to how staff enquire about IPV, by using the phenomenological lens to highlight how staff identify instances of IPV. This theme also looks at the effect of IPV enquiry and how this contributes to staff not enquiring about IPV among pregnant women. This theme is linked to the research question which explores whether staff are identifying, reporting, and recording instances of IPV.

4.3.2.1 Category 1: Physical enquiry

This category reports on enquiry through what staff can see like bruising, unexplained injuries and pregnant women who appear to be under emotional distress. Physical enquiry was the main way in which staff enquired, all articles reported that staff used this as a starting point for IPV screening, identifying instances of IPV.

Staff mention the instances of noticing bruising or markings on the pregnant woman's body and asking them questions about it:

> "Doctor looked at her and examined her and told her that she tell us the truth because I did not believe this story. So, forcing her, she opened up and told us that she was beaten by the husband, the reason being the husband came in

with another wife and he forced her to leave the bed and she was beaten seriously" (female nursing officer assistant) (Anguzu et al., 2022: 10).

"There was another lady of between 28-30 years (old). She came with bruises all other her body. When I was attending her why (she had been beaten by her husband), she told me that the husband discovered that she was using an implant, and she (had) never disclosed (that) to the husband. She told me that her husband was against family planning from the start. 'I have 3 children, and I cannot handle anymore, and he cannot handle any more (yet) he is insisting that I should not use family planning'" (family planning provider) (Boyce et al., 2020: 6).

Staff spoke about the physical observations that they made by assessing the pregnant woman's appearance, behaviour, partner behaviour, their emotional state and how it influenced their enquiry of IPV:

"The way I can tell that a woman's life is not okay is she's growing thin very slowly, she cries about the heart, feels pain in the heart, and also her eating reduces" (nurse) (Tol et al., 2019: 7).

"You have to make time to look…. in the eyes. If the patient doesn't make eye contact, you know there is something going on" (health care worker) (Abrahams et al., 2024: 10).

"Absenteeism from clinic, or whenever the woman comes, she might be a bit withdrawn. The woman may display abusive behaviour toward the staff or even to her children that accompany her to the clinic" (Elsa nurse) (Pitter et al., 2016: 5).

Staff observed controlling behaviour from the partner and this prompted their enquiry for IPV:

"Partners who have controlling behaviour patrol every step of their wives' movement and life. They are controlling everything including her access to money, her movement, and the need for maternal health care service utilization including antenatal care visits" (nurse)

> "A controlling partner wants to know everything and follows his spouse around. He may be controlling, and she doesn't want to say it in front of him. You might pick up on that one" (Belle Nurse) (Pitter et al., 2016: 5).

The emotional state of the pregnant woman was something that pre-empted staff from enquiring about IPV, staff mentioned that the pregnant women were also experiencing emotional abuse:

> "It was challenging (to engage IPV with patients) at first. Women may be in toxic relationship. Lots of emotional abuse. Physical violence was easier…. visible" (Thobeka Nurse) (Sprague et al., 2017: 10).

> "It was mostly emotional with one or two postnatal women. Half of the cases are unwanted pregnancies and their spouse's suggested abortion. There was constant degrading of the person, ignoring the child, and lack of financial support resulting in psychological trauma, to the point where some had suicidal thoughts and depression after the baby was born. I remembered a lady had a miscarriage shortly after her beating but I'm not sure if the miscarriage was from the beating" (Tiana midwife) (Pitter et al., 2016: 4).

Staff mention their lack of professional curiosity and screening tools for enquiry about IPV experienced by pregnant women:

> "I don't think we look for it enough, we don't ask the right questions, because if you ask, you'd be amazed. I just don't think we look for it, but there are cases. About a year ago I saw a teenager, 17 years old, who was with a much older partner, the second pregnancy and I think let me check, she had marks on her body, and so obviously been physically assaulted. But I think if we don't see the physical scars we don't ask" (health manager) (Hatcher et al., 2019: 1343).

> "There is no special tool which can help us, or one can use to identify someone who is at risk of gender-based violence. We surely do not have any tool to help us do the screening. So it is from our observations that we

develop high index of suspicion of gender-based violence" (male medical officer) (Anguzu et al., 2022: 9).

The key finding suggests that it is easier for staff to notice the physical signs/indications like bruising, change in behaviour, emotional state, and the partner's behaviour. This follows the guidance of WHO suggesting that IPV only be addressed if it is made apparent to staff at PHCI Wong et al., 2024: 1). Physical enquiry was reported as the main way staff enquire about IPV without the assistance of screening tools. Authors Musa-Maliki and Duma (2024) and Lawoko et al. (2013) mention that physical enquiry was the only way staff investigated IPV, supporting the findings in this study.

Observations and physical examinations are a good way to detect IPV however using screening tools during antenatal check-ups would be a more effective way of detecting IPV. Decker et al. (2023) argue that only relying on obvious signs of IPV is an insubstantial way of identifying IPV. The researcher supports this view and adds that WHO sets this precedent that emphasizes IPV screening primarily when IPV is apparent, despite research suggesting that most forms of IPV are not always physical (Yakely, 2022: 5). The researcher advices that this guidance be amended enabling countries like South Africa to implement IPV screening to all pregnant women. In this context The National Council on GBVF should apply pressure on policymakers for policy reform influencing them to develop and implement mandatory screening and screening tools.

Category 2: Verbal enquiry

This category explores verbal enquiries, this is usually in the form of questions that staff ask the pregnant women who attend PHCI. Almost all articles reviewed report that staff do not make verbal enquiries regarding IPV. Furthermore, it is uncommon for staff to practice professional curiosity with only a few conducting investigations once disclosures have been made.

Sub-category 1: Negative verbal enquiry

Negative enquiry was categorized as staff not enquiring about IPV, despite there being clear signs that the pregnant woman is experiencing IPV. Staff speak about not screening for IPV unless disclosures were made by pregnant women:

> “We don’t routinely screen for intimate partner violence unless a patient volunteers that information, but we don’t get into it so much” (male OBGYN) (Anguzu et al., 2022: 5).

> “Whenever we meet victims, we only treat visible trauma, stop bleeding and dress open wounds, that’s all, unless they open up, nobody will ask; as we cannot offer help if they disclose” (midwife) (Gashaw et al., 2020: 5).

> “No, unless one has disclosed to you that is when you can talk and help her…. Maybe because they don’t tell us, or maybe because we do not have a special clinic for that” (female midwife rural) (Anguzu et al., 2022: 5-6).

Staff comment on the frequency of complaints and how this can infer that the pregnant woman might be experiencing IPV:

> “You know why I am a bit hesitant? It's because usually what leads us to investigate is the frequency of the patient's complaints about that. When we don’t get the complaints usually we don’t want to get involved…. the frequency and occurrence of the problem, the magnitude of the problem. (When) we are worried about that…. (we) try to investigate. Currently to be honest I haven’t had a case of a woman being mistreated by her husband” (Diana midwife) (Shamu et al., 2013: 515).

Staff admit that they have not been probing enough when it comes to verbal enquiries of IPV:

> “No, I haven’t come across such cases (sexual and emotional violence). Maybe they are not putting it across clearly and I think the time that we have we are not probing enough as well. So, we treat may be on the surface and some of the issues go unnoticed” (Anna midwife) (Shamu et al., 2013: 515).

> “The fact is that we have not tried so much to dig into intimate partner violence because one, it is not something that people bring up so easily. So, most people find it a little disturbing to start asking” (male OBGYN) (Anguzu et al., 2022:10).

> "Whenever we meet victims, we only treat visible trauma, stop bleeding and dress open wounds, that's all, unless they open up, nobody will ask; as we cannot offer help if they disclose" (midwife) (Gashaw et al., 2020: 5).

These findings demonstrate the importance of disclosures and how this prompts staff to investigate instances of IPV, it could be argued that creating a conducive environment for disclosures to be made would increase the rate of disclosers. Thus, emphasizing the need for private confidential rooms at PHCI. Most staff mentioned not doing enough probing before disclosures are made. Again, this speaks to having screening tools that encourage disclosures so that staff are urged to enquire about the IPV that the pregnant women might be experiencing. This is useful information for The National Council on GBVF because this could be used when developing screening tools for staff at PHCI. These findings also speak to the anxieties of staff Akinyugha et al. (2022) mentioned that staff feel inadequately trained in handling cases of IPV and they do not believe that patients would disclose their abuse to them.

Feminist theory Guy-Evans (2023) can help us understand why some staff members do not make enquiries even if IPV is clear, Meskele et al. (2020) explain this by mentioning the power imbalance between men and women where in some African societies IPV is seen as part of a man's natural right in marriage. It could be that the socialization of staff members in a patriarchal society stops them from enquiry about the physical abuse that pregnant women might be experiencing. Sprague, Woollett and Hatcher (2020) mention that staff at PHCI's exist in two worlds the medical role and the individual living in their community, they have been tertiary educated because of their job but socially conditioned because of where they live. Navigating between the two worlds can be challenging resulting in cases where staff make negative verbal enquiries although physical abuse has taken place. The researcher calls for the staff at PHCI to be appropriately trained in addressing and managing IPV during pregnancy as well as unlearning societal and cultural beliefs and misconceptions of IPV. It should be made clear that both training and unlearning should be established together as if would be ineffective if addressed separately.

Sub-category 2: Positive verbal enquiry

Positive enquiry is when the staff use their skills and experience to ask questions about IPV that pregnant women might be experiencing. Although less than half of the studies reported

that staff used positive verbal enquiry it was important to recognize that there are staff members who endeavour to investigate cases of IPV. Positive verbal enquiry is rooted in staff having professional curiosity and years of experience in working with pregnant women who might be experiencing IPV.

Some of the skills that staff used were investigating and asking probing questions:

> "There are cases when someone would come with a queer complaint. It won't be looking like it's the case. You then see this person is not sick but there is something wrong. Then you sit and discuss with the person that's when she will open up. She will (then) say nurse I am not feeling well because my husband is doing this and this" (Fadzai midwife) (Shamu et al., 2013: 515).

> "They tend to hide information. Not until you really have the skills of probing, that's when you can get to know that this mother has a GBV problem" (male medical officer) (Anguzu et al., 2022: 10).

Many staff report that being non-judgmental is important when verbally enquiring about IPV:

> "At first, I was not comfortable asking women about violence. I gradually became confident. Nurses should not be judgmental. We must have (a) loving, listening attitude. We should be there as people and human beings, not as nurses" (Palesa nurse) (Sprague et al., 2020: 12).

> "Having a nonjudgmental attitude….is key to getting them to open up" (Lesidi nurse) (Sprague et al., 2020: 11).

Time was mentioned as something that staff needed when asking questions about IPV that pregnant women might be experiencing:

> "We need to give mothers time. When you give a mother time, she will always tell you what's happening to her. So maybe you need to give adequate time to a mother but that may not happen due to high numbers. Sometimes you have so many mothers around and of course, you have to do something" (female midwife) (Anguzu et al., 2022: 6).

Pregnant women comment on how impactful positive verbal enquiry is:

> “Pregnant women’s feedback “Appreciated having someone that checked on us and cared about how we are feeling” (Abrahams et al., 2024: 14).

The staff mentioned that gathering information from people around or close to the pregnant women is a good way of understanding the IPV that they might be experiencing:

> “So sometimes you end up saying to her you are not going home. You don’t discharger her. You keep her there. Then when people come to visit her, you try and find out if there are problems at home. If she is facing any problems with the husband” (Fadzai midwife) (Shamu et al., 2013: 516).

> “Maybe try and try the mother from the group (in triage and booking waiting areas), then try and ask and opens up. What’s happening? Like are you okay with your husband? What is happening at home? If you try and ask questions, someone will come and tell you what’s happening” (female assistant nursing officer) (Anguzu et al., 2022: 10).

The staff mentioned how important building rapport is and how it facilitates positive enquiry:

> “I know that as you are going to approach this mother, create a relationship with her because she will never open up to you when you are not her friend. Why? You don’t know her, and she also does not know you, but you want some important information, and when become a friend, you create a rapport with this mother and she will pour out information” (female midwife) (Anguzu et al., 2022: 10).

> “According to the relationship or rapport you have made from the beginning with these mothers, some mothers open up and tell you what’s happening at their home, how the husband is treating her. So, she may tell you that my husband is like this (abusive)….and normally people put trust in health workers. If you are really a friend, they can tell you everything because they know at times you can help” (female nursing officer) (Anguzu et al., 2022: 10).

> "Some of them don't disclose…. if you take time with that mother that's when you find out there is something wrong. That's when she will open up. Such that after being tested (for HIV) they come to me. She might not come to the clinic. She will come to my house……and then we sit down and discuss. I tell her the options and what she can do. When you are doing it out there they will be seeing it…. differently…. we will be talking about it at the same level at home…. or some of them at church" (Fadzai midwife) (Shamu et al., 2013: 516).

Once good rapport is established it is much easier for women to open up and disclose to staff that they might be experiencing IPV:

> "There are mothers who tell you everything even before we ask them if they are fine whether their husbands beat them or slap them" (male OBGYN) (Anguzu et al., 2022: 11).

> "After seeing that she has gained some confidence in you (ANC provider) …. she will come out and tell you what the real problem is" (assistant nursing officer).

The findings mention the conditions for positive enquiry, namely building rapport, being non-judgmental and gathering information about the pregnant women through other sources or professionals. The National Council on GBVF could use this information to guide them in developing training for staff at PHCI for upskilling, thus instilling confidence in staff in how to manage instances of IPV. The researcher stresses the importance of these skills by suggesting that all staff who work at PHCI should have entry-level counselling skills, as the medical space is often where difficult conversations are taking place. Meskele et al. (2020) highlight the need for nurses and midwives to be trained in how to counsel and develop safety plans as the best strategy to prevent violence. Furthermore, the researcher adds that tertiary education for healthcare staff should include courses on counselling skills, this is substantiated (Githui et al., 2018).

4.3.2.2 Category 1: Effects of enquiry

This sub-category speaks about how enquiry affects staff and how this determines whether staff enquire about IPV or not. Some of the effects of enquiry directly impact the wellbeing and safety of staff thus decreasing their motivation of enquiry for IPV. The effect of enquiry is similar to the beliefs and attitudes as it decides whether or not staff will enquire about IPV.

Sub-category 1: Emotional effects of enquiry

This alludes to the exposure to trauma that staff experience when assisting pregnant women at PHCI. Staff report on experiencing vicarious trauma that affects their emotional and mental state. Some staff mention that it is difficult for them to address or acknowledge the IPV that the pregnant women might be experiencing because this would mean that staff need to acknowledge their own experiences of IPV:

> "The health workers are affected by the same things. So, whether it's HIV or gender-based violence, maybe the starting point is to talk to the healthcare workers and sensitize them about it. But when you get them to talk about their own problem? It's true what you say, in that, you know "I don't want to talk about this because it's so close to home" (health manager) (Hatcher et al., 2019: 1346).
>
> "After you speak to the client, you sit down and reflect on that problem. It seems to leave you feeling depressed" (health promotion officer) (Abrahams et al., 2024: 9).
>
> "I struggle to shut the visuals in my mind. I couldn't sleep that night" (outreach team leader) (Abrahams et al., 2024: 13).
>
> "The patient was very emotional, and I was seeing the patient, so I also broke down" (ANC nurse) (Abrahams et al., 2024: 11).

Sub-category 2: How enquiry affects staff safety

Staff report on their safety and how enquiry of IPV puts them at risk of abuse, threats, or intimidation by the partners of the women:

> "Some persons are afraid they might get hurt…. women get hurt even if reported to the police…. not enough attention is given to it" (Belle midwife) (Pitter et al., 2016: 4).

> "Maybe challenges will be if sometimes the patient that you are busy talking then tells you about problems and you don't know how to counsel properly and maybe also you end up, you know the partner becoming violent even to you as a person. Because maybe we will be giving suggestions to this woman on what to do, then the partner ends up coming to the clinic looking for you" (health care provider) (Hatcher et al., 2019: 1343).

> "I did not deny, I told him (the husband) what I gave her. Of course, she has already told the man (husband) and there is no way you (the provider) can deny it. I told him that I gave an injection that will last for three months but after three months I will not give (it to) her again" (family planning provider) (Boyce et al., 2020: 9).

Staff also mentioned that another effect of enquiry about IPV is pregnant women hiding the abuse to protect the perpetrators:

> "There is also tendency of women protecting their husbands because of the Domestic Violence Act. The moment you try to talk and ask then they think you want to drag their husbands to the police" (Diana midwife) (Shamu et al., 2013: 519).

> "And as you know, most of the time people who are being abused sometimes they keep silent because they are afraid their abusers are the people who are providing financially, they are afraid to talk or report to the relevant departments" (health care provider) (Hatcher et al., 2019: 1341).

These findings add another layer to the barriers to enquiring suggesting that the mental and emotional wellbeing of staff are affected when they enquire about IPV. Boitet et al. (2023)

express that healthcare workers are exposed to direct and indirect trauma either by personally experiencing or witnessing stressful situations like workplace violence, disease exposure and patient suffering. This nuance provides more insights into the experience of staff at PHCI considering this finding, measures should be put in place so that staff are protected, physically and emotionally. Boitet et al. (2023) add that the emotions that staff might be feeling could be linked to burnout, moral distress, and compassionate fatigue. Governments should ensure staff at PHCI have the support they need to complete their job.

This study and the Musa-Maliki and Duma (2024) article identify mental and physical provisions that should be put in place to support staff at PHCI to enquire about IPV. These are more considerations for The National Council on GBVF should adopt guaranteeing that staff at PHCI feel safe enough to enquire about IPV. In completing this research, the researcher found that staff did not mention that they receive any type of provision from the PHCI to support them with their physical safety and emotional and mental well-being. This should be considered as staff mental and physical safety is a barrier to IPV enquiry, employing security on site and offering counselling services to staff would encourage IPV investigation.

4.3.3 Theme 3: Ways to improve identification, detection, and screening of IPV among pregnant women

This theme is about ways that staff think the identification, detection, and screening of IPV experienced by pregnant women can be improved. These are suggestions that staff have come up with through their experience in working closely with pregnant women. This theme is linked to the last research question which is the issue regarding staff competence regarding IPV during pregnancy.

4.3.3.1 Category 1: Advocacy and awareness of IPV during pregnancy

This category mentions the issues that staff have identified around advocacy and awareness of IPV during pregnancy. Most articles reported that staff commented on the lack of representation of information on IPV during pregnancy in their communities, as well as awareness about specific tools used for screening.

Staff mention that there should be awareness around screening tools and IPV during pregnancy in communities:

> "The awareness (should be) raised……in the community and we can repeat it when they come to us…. there might be those who kept silent" (health worker) (Keynejad et al., 2023: 545).

> "There should be a (research nurse) in every department or ward where there are mothers or children. Should be in ANC. In labour ward and other wards especially TOP (termination of pregnancy) because men force women to terminate" (Thobeka midwife) (Sprague et al., 2020: 8).

> "The screening tools are there but are not known much. I have seen a book of gender-based violence when I was in some health care centre III. That book (to document IPV) was there though it was not in use, but it was there. Maybe they could increase the SOP's (standard operating procedures) screening tools and even posters because I have seen the ones for family planning and people are well versed with family planning but not gender-based violence" (female midwife) (Anguzu et al., 2022: 8).

Staff mention that they lack awareness around different manifestations of abuse, they report finding it challenging to detect other forms of IPV:

> "When they speak, you know that there is some violence going on there but there is nothing you can do. And they become teary and things like that. You never know (what's happening) …. cause men are very clever- they don't usually hit women these days. Especially pregnant women, (they don't hit them) on the face and things like that. And I have realized is (the problem) is not physical as much as it is emotional" (health care provider) (Hatcher et al., 2019: 1340).

> "With pregnant mothers, at times we wouldn't even know that this (forced sex) is abuse because when we meet them they report (refusing sex)…we wouldn't be able to know whether the person is being abused or not….When we ask them they say 'the stomach is now too big and I don't want anybody on top of it" (Fadzai midwife) (Shamu et al., 2013: 517).

The findings suggest that awareness around IPV during pregnancy is not well established despite it being such a common occurrence authors like Lawoko et al. (2013) comment on the issue of awareness and relate it to societal misconceptions of IPV. There is a lack of awareness and advocacy on the topic and staff admit to not knowing how to identify other forms of abuse like sexual and emotional. Meskele, Khuzwayo and Taylor (2020) found that training on all forms of domestic abuse is something that nurses and midwives lacked, they suggested that more training and awareness would improve the detection of more forms of violence experienced by pregnant women. A study conducted by Anyango, Yost, Dobson, Nkalubo and Mckeever (2023) found a significant difference in staff who were trained on IPV during pregnancy than those who were not, suggesting that staff trained on IPV during pregnancy are more likely to screen and enquire about IPV.

Staff also explain that there are tools to screen for IPV however due to a lack of awareness and advocacy staff do not use the tools to screen for IPV. Again, this adds to the uncomfortably that staff at PHCI experience when enquiring about IPV, not having the knowledge on what other forms of IPV look like and how they can be identified need to be prioritized. Government and The National Council on GBVF should roll out awareness campaigns thus creating awareness in communities and amongst staff members. It could be argued that this can help with slowly changing how the staff and communities view IPV by demystifying the societal and cultural beliefs that they might hold regarding IPV and pregnancy. The result of spreading awareness and advocacy on IPV in communities and with staff at PHCI could help change the narrative on IPV and abuse, systems theory suggests that making a change in one system will affect all systems as they are all interlinked (Warren, Franklin & Streeter, 1998: 359). This change could start in the community through awareness campaigns at schools, hospitals and places of work, over time this would shift the communities' beliefs on IPV to more realistic and evidence-based information.

4.3.3.2 Category 2: Screening processes

This category speaks about the screening process, it highlights the effectiveness and the importance of screening from staff's point of view. It also mentions their experiences when screening pregnant women for IPV.

Sub-category 1: Effective screening methods

Some staff suggest ways that would make the screening process easier according to their experiences working at PHCI with pregnant women experiencing IPV:

> “Not too bulky. If possible, let it take less than five minutes. You ask a few questions to know whether the husband is supportive during pregnancy that will help her open. Some do not open up easily, so you may miss out on those mothers but if it is a questionnaire, this will help identify them very fast. A questionnaire that is specific to things at home, whether the husband is supportive or whether there is violence at home” (female midwife) (Anguzu et al., 2022: 8).

> “We need to come up with something very well organized and we need that information to be put in the mother's passport for antenatal. It can help us to ask such whenever you interact with pregnant mothers. If it also included there, we can try to screen each an every mother who comes since we would have where to document (IPV)” (female assistant nursing officer) (Anguzu et al., 2022: 8).

Sub-category 2: Importance of screening for IPV

Staff report on the importance of screening and how it assists staff in detecting issues that will negatively impact the health of the mother and the unborn:

> “Negative impacts on the baby’s health could be detected through screening” (Nomonde nurse) (Sprague et al., 2020: 8).

> “Something that we’ve needed for quite some time in the maternal aspect, because it’s certainly things that can be easily ignored” (health care worker) (Abrahams et al., 2024: 10).

> “It (IPV intervention) may help with HIV management and the baby will grow up in a safe environment” (Sipho nurse) (Sprague et al., 2020:8).

The findings report on staff mentioning ideas around making screening tools concise. Staff spoke about having the screening information in a document that could be added to their all their antenatal information. Experienced staff suggest effective ways for screening to be done,

study’s like Lawoko et al. (2013) describe similar findings. These findings suggest that staff are competent and understand how things should be, it could be argued that staff have the competence but are stifled due to the multiple barriers of IPV enquiry that they experience.

The National Council on GBVF should use insights to improve the screening process and adapt it so that it can be more effective to staff. The National Council on GBVF are responsible for monitoring and evaluating programmes related to GBVF, updating screening tools should be something the council investigates (Republic of South Africa, 2024). The researcher proposes quarterly meetings held by the National Council on GBVF and local governments to evaluate and update screening tools as well as pathways/protocols for identifying, reporting screening, recording and referring instances of IPV at PHCI.

Sub-category 3: Pregnancy complications related to IPV

This category explores the complications related to IPV during pregnancy, staff mention complications attributed to IPV:

> “As nurses, we did not poke enough about violence (prior to the intervention). We have a focus on physical health, such as high blood pressure. Now we know there may be an issue underlying the hypertension and we (ask), how is the home” (Busi nurse) (Sprague et al., 2020: 7).

> “IPV in South Africa is a very big problem….25% of women experience IPV. I do have mothers here: she had a bruise on the eye. She said that the partner beat her up. The other day, a women with a broken jaw. The screening that (the research nurse) did, she found a lot of (abused) women presenting with lower abdominal pain, but this has something to do with abuse” (Thobeka nurse) (Sprague et al., 2020: 7).

> “In one case I remember where women had sustained abdominal trauma, the fetus died, so those are really serious cases, Where and admission is required. But again, I think those are the tip of the iceberg cases. I suspect that there is a huge number of women who don’t have serious consequences of domestic violence, they simply either don’t complain or even of they do, I suspect that we don’t listen to them” (health manager) (Hatcher et al., 2019:1340).

Staff highlight the dangers of IPV if left unidentified thus resulting in maternal mortality or death of the unborn:

> "Partner violence during pregnancy especially physical violence is dangerous and may cause death of woman and fetus and should be considered as attacking two live simultaneously" (Nurse) (Gashaw et al., 2020: 5).
>
> "They don't open up…. because like now she could have been admitted (she referred to a woman who miscarried but after investigations, it was discovered that she was experiencing domestic violence). You sit down and try to talk…. they don't open up, but you can see clearly that there is a problem" (Fadzai midwife) (Shamu et al., 2013: 519).

This category identifies the complications connected to IPV during pregnancy. Most staff were not aware that lower abdominal pain, hypertension, and abdominal trauma are complications brought about by IPV during pregnancy, however through experience, they found that they are linked. Staff mention that severe cases of IPV result in death, one of the aims of NSP on GBVF is to decrease the maternal mortality rate. The use of preventative measures like screening for IPV during antenatal checkups could help decrease the number of maternal deaths. Although WHO and other studies suggest that adding a screening tool to antennal checkups does not add value (Wong et al., 2024:1; Artz, Meer & Aschman, 2018: 4) the researcher mentions that the early identification of IPV results in a decrease in the maternal mortality rate (Chaves et al., 2019: 3).

The National Council on GBVF should be looking to universities, governments, and training facilities to incorporate knowledge on IPV complications during pregnancy into their curriculum and training. This could be another way in which IPV could be identified by staff at PHCI's.

4.3.4 Theme 4: Training for staff at PHCI on IPV during pregnancy

This theme speaks about the benefits of training on IPV. It also mentions the impact of training and how it equips staff with the skills and tools to support pregnant women experiencing IPV. This theme is linked to competencies as well with a focus on how government can implement

certain trainings specific to the staff feedback. More than half of the articles reviewed had staff commenting on IPV training, and most of the feedback was positive.

4.3.4.1 Category 1: Benefits of training on IPV for staff at PHCI

Staff mentioned how training has benefitted them in managing instances of IPV:

> "I feel confident about my skills, dealing with any type of abuse, from any age. I can offer counselling to different age groups" (Lesedi nurse) (Sprague et al., 2020: 14).

> "I fell in love with nursing-not focusing on medical issues only. I'm (now) focusing on a person as totally…. we think psychology issues are meant for psychologists. (My) knowledge has improved" (Zama nurse) (Sprague et al., 2020: 12).

> "As you continue (in IPV training) they begin to open up. I became more sure, had a better approach….and understanding (of) how to approach women" (Lesedi nurse) (Sprague et al., 2020: 11).

Category 2: Importance of staff having counselling skills

Staff mention how important counselling skills are when enquiring about IPV with pregnant women:

> "It made me to be a comprehensive health provider. I have more empathetic…. nonjudgmental. I have increased confidence supporting a women emotionally (through) counselling" (Zama nurse) (Sprague et al., 2020: 12).

> "(We) began to go deeper-to probe into psychology, behaviours, how to dig deeper, looking at the nonverbal communication" (Lesedi nurse) (Sprague et al., 2020: 11).

> "(We) learned to give them (patients) appropriate time….(how to) be understanding….hide your shock to gain trust…(I) referred to the training

> manual often, revisiting it….developing a tool (for screening)" (Lesedi nurse) (Sprague et al., 2020: 11).

> "Because I have training, I was able to listen to the problem and listen and show them available resources. (Before) I was too sympathetic, crying with them. I learned to listen and not being judgmental. How to deal with giving them information" (Nokuthula nurse) (Sprague et al., 2020: 11).

The key findings are that training creators have more confident staff thus increasing the number of enquiries. This evidence to the findings in the Lawoko et al. (2013) study and statistically substantiated in the Anyongo et al. (2023) study. Staff comment on how using a holistic approach to understanding IPV has helped them recognize how insidious IPV is and the benefits of screening. Counselling skills are important and could be something that The National Council on GBVF should consider when implementing staff training. Research on the importance of counselling skills in PHCI settings proves that service users feel more comfortable disclosing and talking about the IPV that they experience (Meskele et al., 2020: 1055).

4.3.4.2 Category 3: Staff empowerment

This category talks about the impact of training and how this has made staff feel, most staff members felt empowered by the knowledge they received:

> "I'm taking the knowledge home. I brought (the knowledge) to my social clubs where I'm playing the educating role…. I now know that colleagues may have problems of their own (they may experience abuse, too) (Thandekile nurse) (Sprague et al., 2020: 14).

> "It instilled an urge to open my own empowerment centre female, boy girl- having family orientation (to violence)" (Lesedi nurse) (Sprague et al., 2020: 14).

4.3.4.3 Category 4: Knowledge gap in tertiary education on IPV during pregnancy

Most articles reviewed reported that staff spoke of the knowledge gap at tertiary institutions, they state that IPV and issues related to it are not spoken about enough. This leaves staff that

work at PHCI with a limited knowledge base on IPV during pregnancy and therefore impacts their confidence and willingness to enquire about IPV:

> "One of the challenges is the knowledge gap. The right way to do the assessment, you do it because you are the doctor, and you just ask your questions the way you think you should ask them. But is it the right way? So, there is that knowledge gap" (male medical officer rural) (Anguzu et al., 2022: 9).

> "The challenge is that, personally, it is just because of the knowledge that I attained from school, but I have never gone through gender-based violence training. These workshops I have never done. I just use the knowledge that I got from school, so we need training, continuous supervision and support" (male midwife) (Anguzu et al., 2022: 9).

> "Even we do not know about women's rights properly, but if we had enough knowledge about this issue, we could teach others" (nurse) (Gashaw et al., 2020: 7).

Empowerment leads to change systems theory suggests that a change in one system has an impact on all systems (Warren, Franklin & Streeter, 1998: 359). This finding suggests that staff are open to receiving training on IPV, as training had a positive impact and staff felt inspired and mentioned that they would teach the people in their community about IPV. These findings are similar to the Meskele et al. (2020) article. Empowered staff are the agents of change in their communities, thus highlighting that there are many ways to spread awareness of IPV during pregnancy in communities. Staff have identified gaps in the education taught at the tertiary institutions more could be done by tertiary institutions to emphasize learning about IPV during pregnancy, these gaps were identified in the Lawoko et al. (2013) study as well. Changing the education system would raise awareness of IPV during pregnancy especially in countries that have a higher rate of IPV like South Africa, thus resulting in more enquiries done. This could help with changing the cultural beliefs of individuals and to a larger extent the community. However, attention needs to be paid to other structural barriers to ensure sustainable change. The National Council on GBVF could facilitate tertiary institutions on unpacking IPV during pregnancy thus promoting a holistic understanding of IPV.

4.3.4.4 Category 5: Staff views on training

These are some thoughts and views staff have on training, some were positive, and some were critical of what training looked like for staff:

> "Training is a good idea… I am ready to be part of the first batch…. information is power. However, training must correlate with other relevant agencies such as the medicals social worker" (Tiana midwife) (Pitter et al., 2016: 4).

> "I think so. I think so cause maybe sometimes we miss things that if we have more training, we will pick it up. I believe if we have more experience, some of the other people go through then we will have an idea of what going on" (health provider) (Hatcher et al., 2019: 1344).

> "Yes, I think it's feasible, even though you know the staff would say 'It's extra work' but I think it would be beneficial to the women because it will be also giving information and helping them if they experience something like that. And [telling them] where to go" (health care provider) (Hatcher et al., 2019: 1342-1343).

Some of the critiques that staff had on training were:

> "Don't think that this is where they want to be to give counselling. So, we can't force them" (outreach team leader) From Abrahams et al., 2024: 13

> "When you are training (on IPV), it is better to train everyone but even if you just train some groups of people, when you are transferred, they will just go with their knowledge, The ones who remain will not do the work because they will say let those who trained do the work" (female midwife rural) (Anguzu et al., 2022: 9).

These findings emphasise the importance of training and how beneficial it is to the staff as well as the pregnant women. There needs to be a push by national and local governments facilitated by the National Council on GBVF on training on IPV during pregnancy. There is evidence to prove that most staff responded positively to training although some remain sceptical,

suggesting that training at PHCI could be implemented (Lawoko et al., 2013; Musa-Maliki & Duma, 2024). The research suggests that more competent staff results in more referring reporting identifying and reporting instances of IPV. The researcher adds that training on IPV during pregnancy should be regulated by The National Council on GBVF like the screening tools training should be updated as more research is done in this field.

4.4 Conclusion

This chapter presented and discussed the findings of the research. Quotations were presented as evidence to answer the research question and objectives. The researcher discussed the findings and grouped the barriers to enquiry as physical/practical, abstract/mental and effects of enquiry; this made it easy to explain and discuss the findings. This chapter spoke about the positives, staff suggested a better practice model regarding projects or interventions that are implemented at public healthcare institutions to address IPV and pregnancy.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter draws on all chapters to conclude its final points, each theme and its recommendations will be offered. This research explored staff at PHCI's response to IPV experienced by pregnant women in South Africa and Africa. The researcher hopes that this study will encourage South African governments and policymakers to prioritize PHCI's response to IPV during pregnancy. In addition to this, the research questions and research objectives will be addressed in this chapter.

5.2 Theme 1: Public health care system challenges, concerns and progresses

The findings highlight the challenges, concerns and progress at PHCIs in Africa and South Africa and how they respond to IPV during pregnancy. The evidence suggests that PHCIs do not have protocols/pathways for screening, identifying, reporting, recording or referring instances of IPV, which is concerning as these countries tend to have higher rates of IPV during pregnancy. The structural barriers like lack of private space, being understaffed, not having enough time and not having/adequate screening tools contribute to staff hesitation regarding IPV enquiry.

The theme also looks at staff attitudes and beliefs related to IPV, the findings suggest that cultural and societal views impact staff's decision to enquire about IPV. This presents as another barrier to IPV enquiry during pregnancy, emphasizing the internal battle that staff at PHCI face when managing IPV with pregnant women. Although there were positives some journal articles reported that staff at PHCI use screening tools, referring pregnant women to support and mention that pregnant women who are experiencing IPV know where to find help at PHCI. Lastly, the findings explore staff concern regarding IPV as they have witnessed the brutality of IPV during pregnancy, by offering ways in which IPV during pregnancy can be addressed. This theme addressed each research objective by confirming that there are no established protocols/pathways or policies that address IPV at PHCIs in Africa and South Africa. It also found that pathways/protocols for screening reporting, identifying, recording, and referring instances of IPV.

5.2.1 Recommendations: Theme 1

Based on the findings the recommendations for this theme are for the government appointed the National Council on Gender-Based Violence and Femicide (NCGBVF) which is responsible for coordinating a multisectoral and intersectoral approach guided by the NSP in combating GBVF at national, provincial, and local levels (Republic of South Africa, 2024). To address the IPV and PHCI's response to it on a policy level by introducing preventative measures during antenatal checks and establishing a standardized screening tool for all PHCI, police, organizations, social development, and social workers to use. As mentioned before a good example is the DASH screening tool used in England. An example of the recording, reporting and referral system is the working together to safeguard children policy of England as they have a good reporting, referring recording system wherein social services are immediately notified to conduct an assessment if a child born or unborn is in danger of harm. This system might be challenging to implement as South Africa does not have the infrastructure for it however the National Council should try and implement a system appropriate to the South African context.

In relation to societal views, the recommendation would be for the NCGBVF to advocate and run campaigns about IPV during pregnancy so that communities are aware of how dangerous it is. This would help change African society's view on IPV during pregnancy, understandably this is a huge undertaking as changing community and societal beliefs are challenging. However, it is important to start somewhere. Spreading awareness at schools, places of employment, hospitals and on social media would help with shifting the narrative. The feedback that staff at PHCI gave regarding how the issue of IPV could be addressed is invaluable information that could be used as a starting point for positive adjustments to be made by the NCGBVF. It has been well documented in the African context that privacy, time, and staff capacity have been ongoing, this should be something that the NCGBVF prioritizes because reducing barriers to IPV enquiry increases preventative measures thus reducing the maternity mortality rate. The way these recommendations should be addressed according to the findings is to make sure that they are attended to simultaneously so that the issue of IPV during pregnancy can be tackled holistically. The researcher hypothesizes that the reason for ineffective interventions regarding IPV during pregnancy is that they were not addressed holistically and therefore were not effective. Looking at the issue of IPV on a micro, meso and

macro level and addressing it on all levels would perhaps be a more effective way of managing IPV during pregnancy.

5.3 Theme 2: Staff at PHCI enquiry

The findings report on the types of enquiries that staff at PHCI's do, there is proof to suggest that physical enquiry through observation of bruising, unexplained injuries, emotional state and partners' behaviour is the most common. Disclosures are vital and are often needed when staff notice signs of physical abuse, staff add that even though the physical abuse is clear they still need the pregnant women to disclose their abuse this could be seen as a barrier to further investigation. The findings outline the conditions of positive enquiry which involve the staff member having elements of counselling skills, like building rapport, being non-judgmental and gathering information about the women via other professionals and members of the community. Suggesting that if staff can build rapport with pregnant women who are professionally curious, they are more likely to disclose their abuse.

Finally, this theme talks about the mental, emotional and safety concerns that staff have and experience when enquiring about IPV. This again becomes a barrier to IPV enquiry as staff did not report receiving any support from management regarding their mental and emotional state after enquiring about IPV. Staff safety at work was another barrier to the enquiry as they did not feel safe asking questions about IPV whilst living in the same community as the perpetrator. The objective that this theme addresses is the competence of the staff at PHCI suggesting that they can identify some forms of IPV however they still need the pregnant women to acknowledge the abuse. Through counselling skills staff show that they can facilitate IPV enquiry, however, due to a lack of infrastructure staff are not able to report or refer instances of IPV.

5.3.1 Recommendations: Theme 2

The recommendations for this theme would be to build on what the staff have been doing regarding the physical enquiry. Since the main way staff enquire is through what they observe, it would be good for staff to be encouraged to learn other forms of domestic abuse. The NCGBVF should be responsible for making sure that staff receive training in identifying all forms of IPV/domestic abuse. The DASH screening tool identifies all forms of IPV and could

be used in addition to staff observation skills to elicit disclosures. The NCGBVF should also consider encouraging the government to create policies that standardize routine screening for pregnant women at PHCIs. This should be followed by awareness campaigns on the introduction of the new policy, this should help with creating awareness of mandatory IPV screening at PHCI's.

The government and/or the Department of Social Development (DSD) should look into providing security on-site for staff as this was identified as one of the barriers to IPV enquiry. Perhaps this will make staff at PHCI feel safer when enquiring about IPV, thus increasing the screening rate for IPV. It could be argued that it would be more beneficial for the communities where staff live to be aware of this and have trusted people in the community to make sure that perpetrators understand that they cannot inflict any harm on staff at PHCI. However, for this to be effective a degree of unlearning needs to occur around negative assumptions regarding IPV which is something that could take years to achieve.

Midwives/nurses or any other medical staff that work with pregnant women should be trained in basic counselling skills since this has been proven useful in IPV enquiry. The burden of this should be on tertiary education institutions (TEI) as they are responsible for training most medical staff. Incorporating IPV during pregnancy into the curriculum would be beneficial, the NCGBVF could be responsible for applying pressure to TEI to implement training on IPV during pregnancy. Looking at domestic abuse and abuse TEI student/trainee medical staff needs to move away from thinking that abuse is only a social issue as abuse has medical complications.

Appropriate supervision with staff at PHCIs should be prioritized by all PHCIs, and regular check-ins with managers and counselling should be made available to staff as the findings suggest that they endure significant amounts of trauma when attending to pregnant women who experience IPV. Support for staff that might be experiencing or have experienced IPV themselves should offered and management and councillors should be supportive in helping staff deal with the abuse that they might be experiencing. The NCGBVF should hold PHCIs responsible for this by making sure that mandatory, quality supervision and support services are available to staff.

5.4 Theme 3: Ways to improve identification, detection, and screening of IPV among pregnant women

The findings report on the lack of awareness this was emphasized when staff spoke about knowledge of IPV at TEI's and at PHCI's. They mentioned the lack of awareness of the screening tools that were available as some staff stated that they had forgotten about the screening tools. The staff mentioned that this impacted their confidence which was another barrier to IPV enquiry. Through experience in working with pregnant women who experience IPV staff recommend how screening tools could be more effective, suggesting that it should be concise and part of their antenatal checks. The staff mentioned pregnancy complications related to IPV adding that lower abdominal pain and hypertension were linked to the pregnant women experiencing IPV. This theme addresses the objective related to staff competence and provides context to why no protocols/pathways for identifying IPV are in place at PHCI. The lack of advocacy and awareness on the topic makes it challenging for staff to have a holistic understanding of IPV during pregnancy.

5.4.1 Recommendations: Theme 3

Based on the findings the recommendation would be for TEI's and PHCI's to educate medical staff and students on IPV during pregnancy, as staff stated that they did not receive very little or any training on IPV during pregnancy. This would be something that PHCIs and TEIs need to add to their curriculum, with the NCGBVF overseeing and monitoring those institutions to make sure that they implement the knowledge of IPV during pregnancy into the training. Thus, boosting the confidence of staff and students and increasing the detection rate of IPV during pregnancy. Hopefully, this would impact how staff at PHCI engage with social issues in their capacity and encourage them to explore and investigate as the effects of IPV could be considered a medical issue as well.

The pregnancy complications linked to IPV are something that could be added to the screening tool, as this was found to be indicators of IPV taking place. The NCGBVF should take the feedback and insights from staff and use them to develop appropriate screening tools that could be used by all staff at PHCIs, police, organizations, and social workers. Training, advocacy, and awareness of IPV during pregnancy should be monitored by the NCGBVF, annual meetings should be held with the government, PHCI and all relevant stakeholders to discuss

how to improve screening tools, and policies and update knowledge on IPV so that it can be shared to the public. This would ensure that screening tools, policies and knowledge on IPV during pregnancy are updated, adapted, and improved upon. The role of the NCGBVF according to the Act is to be the body responsible for monitoring and evaluation of interventions that help reduce maternal mortality, suggesting that this would be an appropriate role for the NCGBVF to play.

5.5 Theme 4: Training for staff at PHCI's on IPV during pregnancy

The findings are all related to staff training leading to empowerment. The staff mentioned that training on IPV during pregnancy boosted their confidence and empowered them. Staff felt inspired and wanted to start educating their family members, friends, and community, thus showing the impact of appropriate knowledge and training on IPV. Staff commented on how important counselling skills are when working on enquiry about IPV as well as mentioning their willingness to receive training on IPV. In addition to this staff identified gaps in learning at TEI commenting on the need for a change of curriculum that includes information on IPV during pregnancy. Pregnant women voiced their thoughts on staff being educated and knowledgeable in IPV during pregnancy which was positive as well. This theme addresses objective 4 by suggesting how knowledge can help staff with their competence related to IPV during pregnancy enabling them to identify, facilitate, record and report instances of IPV.

5.5.1 Recommendations: Theme 4

Based on the findings, money and resources need to be invested in training and education at TEIs. The Department of Higher Education (DHE) need to invest in more learning and education on IPV during pregnancy, thus filling the gaps in knowledge identified by staff at PHCIs that attended TEIs. The NCGBVF should be appealing to governments and the DHE for this curriculum change, this could be part of a bigger initiative that encourages medical students to embrace supporting patients with medical issues because of social issues. Chapters 1 and 2 speak on medical staff's reluctance to acknowledge abuse/domestic violence as a medical issue despite having medical implications. The NCGBVF could be the stakeholders to tackle issues like this and hopefully change how medicine and societal issues like abuse are addressed.

5.6 Recommendations for further research

This systematic literature review is a starting point for research on IPV during pregnancy and PHCI's response in South Africa since it is such an under-researched area. The researcher hopes to inspire other academics, government and the NCGBVF to conduct further research on this topic so that the issue of IPV during pregnancy can be better managed and appropriate interventions implemented. The gaps that this study could not address was lack of recent journal articles, time constraints, lack of availability/accessibility of PHCI's staff and the sensitive nature of the topic dicussed. Future studies should consider conducting qualitative studies on this topic as well as issues related to IPV during pregnancy and the response of staff at PHCI.

5.7 Final thoughts

As the researcher conducting this study, there are a few points of reflection that I would like to mention, I found that there was a finite number of qualitative studies on IPV and the response of staff at PHCI in South Africa emphasizing the need for such research to take place. This needs to be explored through the view of staff and how they manage instances of IPV when women present at PHCI. During the reviewing stage, it was clear that quantitative studies dominated the field of IPV research in South Africa, which is not all the way bad however it does not give policy makers and other researchers a holistic understanding of how IPV is managed at PHCI in South Africa a more nuanced approach is needed, and this can only be achieved through qualitative research on the topic.

Another point of reflection is the support of PHCI for women experiencing IPV is largely unknown in the South African context, as I was researching this topic I was left with questions like what does the continuum of care look like for that pregnant women and unborn child look like once she discloses, how is this information shared with other agencies and how does local and national government make sure that safeguarding the vulnerable in society.

There are so many unanswered questions that I as a researcher am sitting with after conducting this study, which leads me to believe that there is a knowledge gap that needs to be investigated. Research needs to be done regarding partnerships with other agencies and how PHCI refer women who experience IPV for further support, as I believe that it should not stop at disclosure.

This type of research will be beneficial to government, policy makers, staff and PHCI, agencies and pregnant women experiencing IPV.

REFERENCE LIST

Aboagye, R.G., Seidu, A., Asare, B.Y., Adu, C. & Ahinkorah, B.O. 2022. Intimate partner violence and timely antenatal care visits in sub-Saharan Africa. *Archives of Public Health*, 80(124), 1-11.

Abrahams, N., Mhlongo, S., Chirwa, E., Dekel, B., Ketelo, A., Lombord, C., Shai, N., Ramsoomar, L., Mathews, S., Labschahne, G., Matzopoulos, R., Prinsloo., Martin, L.J. & Jewkes, R. 2024. Femicide, intimate partner femicide, and mnon-intimate partner femicide in South Africa: An analysis of 3 national surveys, 1999-2017. *PLOS Medicine*, 21(1), 1-21.

Akaba, G.O. & Abdullahi, H.I. 2020. Intimate partner violence among postpartum women at a teaching hospital in Nigeria's federal capital: pattern and materno-fetal outcomes. *Therapeutic Advances in Reproductive Health*, 14, 1-8.

Akinyugha, A.O., Akinyugha, A., Kareem, A.O., Ajweole, M.O., Orji, E.J., Ogedengbe, A., Babalola, F.R., Ayeodele, R.O. & Oladimeji, O.J. 2022. Perceptions of women towards screening for intimate partner violence. *African Journal of Primary Health Care & Family Medicine*, 14(1), 1-8.

Anguzu, R., Cassidy, L.D., Beyer, K.M.M. Babikako, H.M., Walker, R.J., & Dickson-Gomez, J. 2022. Facilitators and barriers to routine intimate partner violence screening in antenatal care settings in Uganda. *BMC Health Serv Res,* 22, 283 https://doi.org/10.1186/s12913-022-07669-0

Anyango, J.F., Yost, J., Dobson, A., Nkalubo, J. & Mckeever, A. 2024. Healthcare providers perceived barriers and facilitators to screening for intimate partner violence in pregnant women attending prenatal clinics. *J Adv Nurs*. doi: 10.1111/jan.16198.

Artz, L., Meer, T. & Aschman, G. 2018. Legal duties, professional obligations, or notional guidelines? Screening, treatment and referral of domestic violence cases in primary

health care settings in South Africa. *African Journal of Primary Health Care & Family Medicine*, 10(1), 1-7.

Aurna, A.G., Ayebare, E., Olwit, C., Nankabirwa, V., Ndeezi, G. & Tumwine, J.K. 2020. Intimate partner violence among pregnant teenagers in Lira district, northern Uganda: a cross-sectional study. *African Journal of Midwifery and Women's Health*, 1-10.

Ayodapo, A.O., Sekoni, O.O. & Asuzu, M.C. 2017. Pattern of intimate violence disclosure among pregnant women attending antenatal clinic in Oyo East Local Government, Nigeria. *South African Family Practice*, 59(2), 67-71.

Bartlett, L & Vavrus, F. 2017. Comparative case studies: An innovative approach. *Nordic Journal of Comparative and International Education*, 1(1), 5-17.

Bengtsson, M. 2016. How to plan and perform a qualitative study using content analysis. *Nursing Plus*, 2, 8-14.

Bernstien, M., Phillips, T., Zerbe, A., Mclntyre, J.A., Brittain, K., Petro, G., Abrams, E.J. & Myer, L. 2016. Intimate partner violence experienced by HIV-infected pregnant women on South Africa: a cross-sectional study. *BMJ Open*, 1-8, e011999. doi: 10.1136/bmjopen-2016-011999.

Boitet, L.M., Meese, K.A., Hays, M.M., Gorman, C.A., Sweeney, K.L. & Rogers, D.A. 2023. Burnout, Moral distress and compassion fatigue as correlates of posttraumatic stress symptoms in clinical and nonclinical healthcare workers. *Journal of Healthcare Management*, 68(6), 427-451.

Boyce, S.C., Uysal, J., DeLong, S.M., Carter, N., Undie, C.C., Liambila, W., Wendoh, S., & Silverman, J.G. 2020. Women's and girls' experiences of reproductive coercion and opportunities for intervention in family planning clinics in Nairobi, Kenya: A qualitative study. *Reprod Health*, 17(1), 96. doi: 10.1186/s12978-020-00942-7. PMID: 32552745; PMCID: PMC7298836.

Burnurd, P., Gill, P., Stewart, K., Treasure, E. & Chadwick, B. 2008. Analyzing and presenting qualitative data. *British Dental Journal*, 204(8), 429-432.

Chaves, K., Eastwood, J., Ogbo, F. A., Hendry, A., Jalaludin, B., Khanlari, S. & Page A. 2019. Intimate partner violence identified through routine antenatal screening and maternal and perinatal outcomes. *BMC Pregnancy and Childbirth*, 19, 357.

Cochrane South Africa. (2021) Appraising systematic literature reviews using AMSTAR 2 (ASLRUAMSTAR2), CSA, November 2021. Retrieved from https://www.youtube.com/watch?v=61dKq6RfmDI

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L. & Hoffman, M. 2004. Ten years of democracy in South Africa: Documenting transformation in reproductive health policy status. *Reproductive Health Matters*, 12(24), 70-85.

Creswell, J.W. 2014. *Research Design: qualitative, quantitative, and mixed methods.* Los Angeles: Sage Publications.

Daoud, N., Kraun, L., Sergienko, R., Batat, N., Shoham-Vardi, I., Davidovitch, N. & Cohen, A. 2020. Patterns of healthcare service utilization associated with intimate partner violence (IPV): Effects of IPV screening and receiving information on support services in a cohort of perinatal women. *PLoS*, 15(1), 1-24.

De Paula Silva, R. & Leite, F.M.C. 2020. Intimate partner violence during pregnancy: Prevalence and associated factors. *Rev Saude Publica*, 54(97), 1-11.

Decker, H., Schwab, M., Shao, S., Kaki, D., Melhado, C., Cuschieri, J. & Bongiovanni, T. 2024. Screening for intimate partner violence in trauma: Results of a Quality improvement project. *Journal of Surgical Research*, 295, 376-384.

Delve, H. L. & Limpaecher, A. 2022. *What is phenomenological research design? Essential guide to coding qualitative data*. Retrieved from https://delvetool.com/blog/phenomenology

Department of Education. 2015. *Working together policy to safeguard children policy.* United Kingdom: Department of Education.

Department of Social Development. 2021. *Revised White Paper on families in South Africa*. Pretoria: Department of Social Development. https://www.gov.za/sites/default/files/gcis_document/202107/44799gon586t.pdf

Department of Women, Youth and Persons with Disabilities. 2020. National Strategic Plan on Gender-Based Violence and Femicide. Retrieved from https://justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf

Devries, K.M., Kishor, S., Johnson, H., Stockl, H., Bacchus, L.J., Garcia-Moreno, C. & Watts, C. 2010. Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *International Journal on Sexual and Reproductive Health and Rights*, 18(36), 158-170.

Dey, I. 1993. *Qualitative data analysis: A user-friendly guide for social scientists*. London, New York: Routledge.

Dinet, J., Favart, M. & Passerault, J. 2004. Searching for information in an online public access catalogue (OPAC): The impacts of information search expertise on the use of Boolean operators. *Journal of Computer Assisted Learning*, 20, 338-346.

Enaifoghe, A., Dlelana, M., Abosede, D. A. & Dlamini, N.P. 2021. The prevalence of gender-based violence against women in South Africa: Acall for action. African Journal of Gender, Society, and development. 10 (1) 117-146.

Ericksen, M.B. & Frandsen, T.F. 2018. The impact of patient, intervention, comparison, outcome (PICO) as a search strategy tool on literature search quality: a systematic review. *Journal of the Medical Library Association*, 106(4), 420-431.

Field, S., Onah, M., van Heyningen, T. & Honikman, S. 2018. Domestic and intimate partner violence among pregnant women in low resource setting in South Africa: A faculty-based mixed methods study. *BMC Women's Health*, 18(119), 1-13.

Friedman, B.D. & Neuman Allan, K. 2019. Systems theory. Frameworks for Clinical Practice. In J. Brandell, *Theory and Practice in Clinical Social Work* (3rd ed.) (pp. 1-33). San Diego, CA: Cognella Academic Press.

Garimella, R., Plichta, S.B. Houseman, C. & Garzon, L. 2000. Physician beliefs about victims of spouse abuse and about physician role. *Journal of Women's Health & Gender-based Medicine,* 9(4), 405-411.

Gashaw, B.T., Schei, B., Solbraekke, K.N. & Mangus, J.H. 2020. Ethiopian health care workers insights into and response to intimate partner violence on pregnancy-Qualitative study. *International Journal of Environmental Research and Public Health*, 17(3745), 1-15.

Githui, S.N., Chege, M., Wagroro, M.C.A. & Mwaura, J. 2018. Barriers to screening pregnant women for domestic violence: A cross-sectional study. *J Community Public Health Nurse*, 4(1), 1-9.

Groves, A.K., Kagee, A., Maman, S., Moodely, D. & Rouse, P. 2012. Associations between intimate partner violence and emotional distress among pregnant women in Durban, South Africa. *J Interpreters Violence*, 27(7), 1341-1356.

Guy-Evans, O. 2023. *Feminist theory in sociology: Definition, types and principals*. Retrieved from https://simplysociology.com/feminist-theory-sociology.html

Hatcher, A.M., Woollett, N., Pallitto, C.C., Mokoatle, K., Stockl, H., MacPhail, C., Delany-Moretlwe, S. & Garcia-Moreno, C. 2014. Bidirectional links between HIV and intermate partner violence in pregnancy: implications for prevention of mother-to-child transmission. *Journal of the International AIDS Society*, 17(19233), 1-8.

Hatcher, A.M., Woollett, N., Pallitto, C.C., Mokoatle, K., Stöckl, H. & Garcia-Moreno, C. 2019. Willing but Not Able: Patient and Provider Receptiveness to Addressing Intimate Partner Violence in Johannesburg Antenatal Clinics. *Journal of Interpersonal Violence,* 34(7), 1331-1356.

Hoque, M.E., Hoque, M. & Kader, S.B. 2009. Prevalence and experience of domestic violence among rural pregnant women in Kwazulu-Natal, South Africa. *South African Journal Epidemiol Infect*, 24(4), 34-37.

Hoyland, S., Hollund, J.G. & Olsen, O.E. 2015. Gaining access to a research site and participants in medical and nursing reaserch: A synthesis of accounts. *Health Professional Education Research*, 49, 224-232.

Jatta, J.W., Baru, A., Fawole, O.I. & Ojengbede, O.A. 2021. Intermate partner violence among pregnant women attending antenatal care services in the rural Gambia. *PLoS ONE*, 16(8), 1-14.

Joyner, K. & Mash, R. 2012. Recognising intimate partner violence in primary care: Western Cape, South Africa. (7) 1 1-5.

Keynejad, R. C., Bitew, T., Mulushoa, A., Howard, L. M., & Hanlon, C. (2023). Pregnant women and health workers' perspectives on perinatal mental health and intimate partner violence in rural Ethiopia: A qualitative interview study. *BMC Pregnancy and Childbirth*, 23. https://doi.org/10.1186/s12884-023-05352-8

Kirk, L. & Bezzant, K. 2020. What barriers prevent health professionals screening women for domestic abuse? A literature review. British Journal of Nursing. 29 (13) 754-760.

Laryeafio, M.N. & Ogbewe, O.C. 2023. Ethical consideration dilemma: systematic review of ethics in qualitative data collection through interviews. *Journal of Ethics in Entrepreneurship and Technology*, 3(2), 94-110.

Lasserson, T.J., Thomas, J. & Higgins, J.P.T. 2023. Starting a review. In J.P.T., Higgins, J. Thomas, J. Chandler, T. Li & M.J. Page (Eds.), *Cochrane Handbook of Systematic Reviews of Interventions version 6.5 Cochrane 2024 Welch VA* (pp.3-12). Chichester (UK): John Wiley & Sons. https://training.cochrane.org/handbook/current/chapter-01

Lawoka, S., Seruwagi, G.K., Marunga, I., Mutto, M., Ochola, E., Oloya, G., Piloya, J. & Lubega, M. 2013. Health providers perceptions on screening for intimate partner violence in healthcare: A qualitative study of four health centers in Uganda. *Open Journal of Preventative Medicine*, 3(1), 1-11.

Lefebvre, C., Glanville, J., Briscoe, S., Featherston, R., Littlewood, A., Metzendorf, M.I., Noel-Storr, A., Paynter, R., Rader, T., Thomas, J. & Wieland, L.S. (2023). Searching for and selecting studies. In J.P.T., Higgins, J. Thomas, J. Chandler, T. Li & M.J. Page (Eds.), Cochrane *Handbook of Systematic Reviews of Interventions version 6.5 Cochrane 2024 Welch VA* (pp. 67-99). Chichester (UK): John Wiley & Sons. https://training.cochrane.org/handbook/current/chapter-04

Li, T., Higgins, J.P.T. & Deeks, J.J. (2019). Collecting data. In J.P.T., Higgins, J. Thomas, J. Chandler, T. Li & M.J. Page (Eds.), *Cochrane Handbook of Systematic Reviews of Interventions version 6.5 Cochrane 2024 Welch VA* (pp. 109-141). Chichester (UK): John Wiley & Sons. https://training.cochrane.org/handbook/current/chapter-05#section-5-1

Lieght, J. & Wilson, N. 2021. Intimate partner violence and maternal services utilization: Evidence from 36 national household survey. *BMC Public Health,* 21(405), 1-14.

Maclean, G. 1994. Safe motherhood in the United Kingdom. *Mod Midwife*, 4(6), 4-10.

Malan, M., Spedding, M.F. & Sorsdahl, K. 2018. The prevalence and predictors of intimate partner violence among pregnant women attending a midwife and obstetrics unit in the Western Cape. *Global Mental Health*, 5(13), 1-13.

McKenzie, J.E., Brennan, S.E., Ryan, R.E., Thomson, H.J., Johnston, R.V. & Thomas, J. 2023. Defining the criteria for including studies and how they will be grouped for the synthesis. In J.P.T., Higgins, J. Thomas, J. Chandler, T. Li & M.J. Page (Eds.), Cochrane *Handbook of Systematic Reviews of Interventions version 6.5 Cochrane 2024 Welch VA*. (pp. 33-66). Chichester (UK): John Wiley & Sons. https://training.cochrane.org/handbook/current/chapter-03

Meslekle, M., Khuzwayo, N. & Taylor, M. 2020. Health worker experience and challenges in screening for intimate partner violence among women who use antiretroviral therapy and other health services in Wolaita zone Ethiopia: A phenomenological study. *Journal of Multidisciplinary Health Care*, 13, 104-1059.

Meyer, E. 2013. Designing women: The definition of "woman" in the convention on the elimination of all forms of discrimination against women. *Chicago Journal of International Law*, 16(2), 553-590.

Mlotshwa, P.R. & Sibiya, M.N. 2023. Pregnant women's views regarding maternity facility-based delivery at primary health care facilities in the province of KwaZulu-Natal in South Africa. *International Journal of Environmental Research and Public Health*, (20)(6535), 1-12.

Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. 2009. PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med*, 6(7), e1000097. doi: 10.1371/journal.pmed.1000097.

Musa-Maliki, A.U. & Duma, S.E. 2024. Barriers to routine screening for intimate partner violence during pregnancy in Nigeria. *Heliyon*, 10, 1-11.

Namegeyo-Funa, A., Rimando, M., Brace, A.M., Christiana, R.W., Fowles, T.L., Davis, T.L., Martinez, L.M. & Sealy, D. 2014. Recruitment in qualitative public health research: Lessons learned during dissertation sample recruitment. *Qualitative Report*, 19(1), 1-17.

Nyemgah, C.A., Ranganathan, M. & Stockl, H. 2023. Intimate partner violence during pregnancy against adolescents in sub-Saharan Africa: A systematic review. *Inj Prev*, 30, 177-182.

Otsea, K. 1992. Progress and prospects: The safe motherhood initiative. *Family Care International* (pp. 1-180) March -July 1992. Washington D.C.

Palaganas, E.C., Sanchez, M.C., Molintas, M.V.P. & Caricativa, R.D. 2017. Reflexivity in qualitative research: A journey of learning. *The Qualitative Report*, 22(2), 426-238.

Pallitto, C., Garcia-Moreno, C., Stoeckl, H., Hatcher, A., MacPhail, C., Mokoatle, K. & Woollett, N. 2016. Testing a counselling intervention in antenatal care for women experiencing partner violence: a study protocol for a randomized controlled trail in Johannesburg, South Africa. *BMC Health Services Research*, 16(630), 1-10.

Pastor-Moreno, G., Ruiz-Perez, I., Henares-Montiel, J, & Petrova, D. 2020. Intimate partner violence during pregnancy and risk of fetal and neonatal death; A meta-analysis with socioeconomic context indicators. *American Journal of Obstetrics and Gynecology*, 123-133.

Petticrew, M. & Robert, H. 2005. Systematic reviews in the social sciences: A practical guide. New Jersey: Wiley-Blackwell.

Pula, B. 2022. Does phenomenology (still) matter? Three phenomenological traditions and sociological theory. *International Journal of Politics, Culture and Society*, 35, 411-431.

Republic of South Africa. 2005. *Children's Act 38 of 2005*. Retrieved from https://www.gov.za/documents/childrens-act

Republic of South Africa. 2007. *Criminal Law Sexual Offences and Related Matter Amendment Act 32 of 2007*. Retrieved from https://www.gov.za/documents/criminal-law-sexual-offences-and-related-matters-amendment-act

Republic of South Africa. 2021. *Domestic Violence Amendment Act 14 of 2021.* https://www.gov.za/documents/acts/domestic-violence-amendment-act-14-2021-english-afrikaans-28-jan-2022

Republic of South Africa. 2024. *National Council on Gender-Based Violence and Femicide Act 09 of 2024*. Retrieved from https://www.gov.za/documents/acts/national-council-gender-based-violence-and-femicide-act-9-2024-english-sepedi-27-may

Rocco, T.S. & Plakhotnik, M.S. 2009. Literature reviews, conceptual frameworks, and theoretical frameworks: Terms, functions, and distinctions. *Adult and Human Resource Development*, 8(1), 120-130.

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

Shamu, S., Abrahams, N., Temmerman, M., Musekiwa, A. & Zarowsky, C. 2011. A systematic review of African studies on intimate partner violence against pregnant women: Prevalence and risk factors. *PLoS ONE,* 6(3), 1-8.

Simon, M.K. & Goes, J. 2013. *Dissertation and scholarly research: Recipes for success.* Seattle, WA: Create Space Independent Publishing Platform.

Spong, C.Y. 2013. Defining "Term" pregnancy: Recommendations from the defining "term" pregnancy workgroup. *American Medical Association*, (23)(309), 2445-2446.

Sprague, C., Hatcher, A. B., Woollett, N. & Black, V. 2017. How nurses in Johannesburg address intimate partner violence in female patients: Understanding IVP response in low- and middle-income country health systems. *Journal of Interpersonal Violence*, 32(11), 1591-1619.

Sprague, C., Woollett, N. & Hatcher, A.M. 2020. Enhancing agency for health care providers and pregnant women experiencing intimate partner violence in South Africa. *International Journal for Research, Policy and Practice*, 15(12), 1820-1835.

State of the Nation. 2024. *Gender-based violence. (GBV)*, SON, September 2024. Retrieved from https://www.stateofthenation.gov.za/priorities/making-communities-safer/gender-based-violence#:~:text=The%20National%20Council%20on%20Gender,children%20from%20abuse%20and%20violence.

Sustainable Development Goals Fund. n.d. *Millennium Development Goals*. Retrieved from https://www.sdgfund.org/mdgs-sdgs#:~:text=In%20September%202000%2C%20leaders%20of,and%20reducing%20child%20mortality%2C%20by

Tesch, R. 2013. *Qualitative research analysis types and software tools*. New York. Routledge.

The Social Work Graduate. 2022. *Feminist social work* [Blog,1 October]. Retrieved from https://www.thesocialworkgraduate.com/post/feminist-social-work.

Thomas, J., Kneale, D., McKenzie, J.E., Brennen, S.E. & Bhaumik, S. (2023). Determining the scope of the review and the questions it will address. In J.P.T., Higgins, J. Thomas, J. Chandler, T. Li & M.J. Page (Eds.), *Cochrane Handbook of Systematic Reviews of Interventions version 6.5 Cochrane 2024 Welch VA* (pp. 13-31). Chichester (UK): Wiley-Blackwell. https://training.cochrane.org/handbook/current/chapter-02

Tol, W.A., Murray, S.M., Lund, C., Bolton, P., Murray, L.K., Davies, T., Haushofer, J., Orkin, K., Witte, M., Salama, L., Patel, V., Thornicroft, G., & Bass, J.K. 2019. Can mental health treatments help prevent or reduce intimate partner violence in lowand middle-income countries? A systematic review. *BMC Wom. Health,* 19, 34. https://doi.org/10.1186/s12905-019-0728-z.

Traynor, M. & Buus, N. 2016. Professional identity in nursing: UK students explain for poor standards of care. *Social Science and Medicine*, 166, 186-194

Tsai, A.C., Tomlinson, M., Comulada, W.S. & Rotheram-Borus, M.J. 2016. Intermate partner violence and depression symptom severity among South African women during pregnancy and postpartum: population-based prospective cohort study. *PLOS Medicine*, 1-22.

Warren, K., Franklin, C. & Streeter, C.L. 1998. New directions in systems theory: Chaos and complexity. *National Association of Social Workers,* 43(4), 357-372.

Warren-Gash, C., Bartley, A., Bayly, J., Dutey-Magni, P., Edwards, S., Madge, S., Nicholas, R., Miller, C., Radhakrishnan, S., Sathia, L., Swarbrick, Blaikie, D. & Rodger, A. 2016. Outcomes of domestic violence screening at an acute London trust: are there missed opportunities for intervention. BMJ Open. (6) 1-7.

Wong, J.Y., Zhu, S., Ma, H., Ip, P., Chan, K.L. & Leung, W.C. 2024. Intimates partner violence during pregnancy: To screen or not to screen. Best Practice and Research Clinical Obstetrics and Gynaecology. 97 1-8.

World Health Organization. 2012. *Understanding and addressing violence against women (UAVAW)*. WHO. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1&isAllowed=y

Yakeley, J. 2021. Treatment of perpetrators of intimate partner violence: What is the evidence. *Journal of Clinical Psychology*, 78, 5-14.

APPENDICES

Appendix A: Articles used in the systematic review

Title of journal article	Authors
Facilitators and barriers to routine intimate partner violence screening in antenatal care settings in Uganda	Anguzu, R., Cassidy, L.D., Beyer K.M.M., Babikako, H.M., Walker, R.J. & Dickson-Gomez, J.
Enhancing agency for health providers and pregnant women experiencing intimate partner violence in South Africa.	Sprague, C., Wollet, N., & Hatcher A.M.
Heath care provider experiences interacting with survivors of intimate partner violence: a qualitative study to inform survivor-centered approaches.	Anguzu, R., Cassidy, L.D., Nakimuli, A.O., Kansiime, J., Babikako, H.M., Beyer, K.M.M., Walker, R.J., Wandira, C., Kizito, F. & Dickson-Romez, J.
Ethiopian heath care workers insights into and responses to intimate partner violence in pregnancy-A qualitative study	Gashaw, B.T., Schei, B., Solbraekke, K.N. & Mangus, J.H.
Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe.	Shamu, S., Abgrahams, N., Temmerman, M. & Zarosky, C.
Women and girls experience of reproductive coercion and opportunities for intervention in family planning clinics in Nairobi, Kenya: a qualitative study.	Boyce, S.C., Uysal, J., DeLong, S.M., Carter, N., Undie, C.C., Liambila, W., Wendoh, S. & Silverman, J.G.

Willing but not able: Patient and provider receptiveness to addressing intimate partner violence in Johannesburg antenatal clinics.	Hatcher, A.M., Wollett, N., Pallitto, C.C., Mokoatle, K., Stockl, H. & Garcia-Moreno, C.
Maternal mental health priorities, help-seeking behaviours and resource in post-conflict settings: a qualitative study in eastern Uganda.	Tol, W.A., Ebrecht, B., Aiyo, R., Murray, S.M., Nguyen, A.J., Korhrt, B.A., Ndyanabangi, S., Alderman, S. & Nakku, J.
Implementation outcomes of a health systems strengthening intervention for perinatal women with common mental health disorders and experiences of domestic violence in South Africa: pilot feasibility and acceptability study	Abrahams, A., Jacobs, Y., Mohlamonyane, M., Boisits, S., Schneider, M., Honikman, S., Seward, N. & Lund, C.
Midwives' knowledge and attitudes when encountering gender-based violence in their practice at a maternity-hospital in Kingston, Jamaica	Pitter, C.P.
Adapting brief problem-solving therapy for pregnant women experiencing depressive symptoms and intimate partner violence in rural Ethiopia	Keynejad, R.C., Bitew, T., Sorsdahl, K., Myers, B., Honikman, S., Mulushoa, A., Demissie, M., Deyessa, N., Howard, L.M. & Hanlon, C.

Appendix B: The individuals that the researcher contacted for the in-depth interviews

Institution/person contacted	Date contacted	What they said
(midwife)	04/06/2023	Email the docs to her @westerncape.gov.za This is my email @westerncape.gov.za
(Manager of midwives)	10/06/2023	Sent an email and did not respond
used to work at maternity	27/08/2023	Slm Got unit manager U must email @westerncape.gov.uk Who will be able to adress issue. Thanks manages the MOU. But this project must go s
(Unit manager at clinic)	23/09/2023	Good day

		Please contact me on Tuesday morning via telephone or email again. Should not have a problem to accommodate you – however we need to discuss the process with the MOU staff. The OPM currently on leave. Regards
(Gynaecologist at)	13/09/2023	Nope, you apparently need to go on to the NHRD website https://nhrd.health.gov.za/
(midwife at)	14/09/2023	Slm you must come and ask the facility manager if you can come and do the project and the patient do you have consent forms
(midwife at hospital UK)		Call to I was given the email of the ward sister @nbtnhs.uk
(supervisory ward sister hospital)	11/09/2023	Hello, I am afraid this is the first email I have received from you. I apologies if you were under the impression I had not responded. The ward is under extreme pressure at the moment, with staff shortages and high acuity. I know the staff would very much like to assist in your research but currently have very little time to focus on anything outside of their clinical responsibilities. I will take a look at my working week and see if we can arrange a TEAMS meeting or similar to discuss and see how we may be able to support you with this.

		Is this open to all areas, as it maybe that community midwives may be in a better position to support you with this (They are able to manage their time more independently) If this is the case, please email details to [redacted]@nbt.nhs.uk [redacted] is the matron for [redacted]y midwifery. With thanks [redacted] [redacted] Supervisory ward sister [redacted] Mon/Tues/Thurs/Fri 7am - 5pm
[redacted] (matron for community and [redacted] birth centre)	22/09/2023	Hi, Apologies, I composed an email, which I had omitted to send! I am more than happy to support all research my concern is the capacity for the midwives to support you in giving time. The community teams are very short staffed currently and about to embrace a new maternity system digitally, which is taking up much of their time as they re-adjust to the new way of working. I will resend a request to the midwives to see if any are interested in helping you with your research. Kind Regards [redacted]

		Will wait to hear from the teams, they have your contact details so some may approach you direct. Kind Regards [redacted] 26/09/2023 Will do
[redacted] Bishop (Midwifery matron [redacted] [redacted] Trust)	09/10/2023	Dear [redacted] I am sorry, we are unable to help you at present. Perhaps a survey monkey would be appropriate to get the answers you require. We cannot facilitate 5 midwives away from there clinical duties at this time. Many Thanks. Hi [redacted] Have you spoken with our research team? I have added [redacted] (our research midwife) who may be able to assist you further. Regards,

		Hi Firstly I need to know if you have proof of NIHR ethical approval for your study and if you have contacted the R&D department at to let them know you would like to interview women at NBT? I noticed that you are studying in Cape Town. I am sorry you have been round in circles trying to get midwives to interview. There are midwives working in the research department I am sure you could interview, but they won't have the depth of knowledge you are looking for as none of them work clinically and have not done for some time. You really need midwives who would volunteer their time. If I can verify your approvals and it's OK with our Head of Midwifery (copied in) I would suggest writing a shortish email to be sent out to all midwives in the department (you could send it to me and my role share Nicky and we'll send it for you). I would choose your midwives from the responses. Kind regards,
(research facilitation officer)	10/10/2023	Hi Thank you for your email. To conduct research at , you would need to send us a copy of your research protocol and IRAS application.

		Once we receive these, we will assess our capacity and capability to do the study here. Then, we would request the full document pack, and we would have 35 days to complete our set-up from this timepoint. Best wishes, [redacted]

Appendix C: Confirmation of editing

Goodwood Estate

Cape Town

7460

04 December 2024