



# Feasibility of Utilizing Abuse Assessment Tool by Midwives to Screen Pregnant Women for Intimate Partner Violence in Northern Nigeria: A Qualitative Study

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## Abstract

*Intimate partner violence among pregnant women in low-income countries continue to be on the increase and endanger the life of both mothers and their unborn child. As such it is necessary to prevent the occurrence of the incident of intimate partner violence among pregnant women. The objective of the study was to determine the feasibility and challenges of using the AAS tool by midwives to screen pregnant women for intimate partner violence in northern Nigerian.*

*A case study qualitative design was used. Non-participant observation and focus group discussions were used to collect data from ten midwives who were purposefully selected to conduct screening of pregnant women. About 90 pregnant women were screened using the Abuse Assessment Screening tool in a tertiary hospital in northern Nigeria. Thematic data analysis revealed three themes, problematic question in AAS tool, timing of screening for IPV and pregnant women discomfort with answering IPV screening questions.*

**Conclusion:** *The feasibility of using the original Abuse Assessment Screening tool is poor. A screening tool is important for screening pregnant women for IPV. For the AAS tool to be used, there is need for modification of it to suit the socio-cultural context of pregnant women in northern Nigeria.*

**Keywords:** *Feasibility, Intimate Partner Violence, Abuse Assessment Screen Tool, Pregnant Women, Screening.*

## INTRODUCTION

Intimate partner violence among pregnant women continue to be on the increase in low income countries including Nigeria (Coll et al., 2020). The Violence Against Person Prohibition (VAPP) Act of Nigeria defines intimate partner violence (domestic violence) as any act perpetrated on any person in a domestic relationship, where such act (physical, sexual, psychological, verbal, emotional or economic violence) causes harm or may cause imminent harm to the safety, health or well-being of any person (VAPP, 2015). The law went further to explain domestic relationship as married couple according to law, custom and religion, or was married or engaged or dating or living together or has lived together (VAPP, 2015). This shows, violence is recognised in Nigeria constitution and appropriate punishment will be meted on the perpetrators if identified. IPV screening is crucial in identifying women who are experiencing or have experienced

abused in-order to provide immediate treatment and prevent future reoccurrences.

The prevalence of IPV in pregnant women globally is 20% (Lencha et al., 2019). The detrimental effect of IPV during pregnancy on both mother and her foetus makes it important to screen every pregnant women for IPV during pregnancy in order to identify those who might be experiencing or have experienced IPV and are more likely to be helped than harmed (Feder et al., 2009; O'Doherty et al., 2015).

Abuse assessment screening tool has been used to screen pregnant women for IPV in United States, Canada, Spain and China (Escribà-Aguir et al., 2016; Laughon et al., 2008; Soeken et al., 1998) They found that, it yielded good validity and internal reliability of 0.97 (Cronbach's alpha), consistent with other screening tools such as the Conflict Tactics Scale, the Index of Spouse Scale, and the Danger Assessment. Soeken

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et al. (1998) reported that the tool was able to identify pregnant women who were abused and concluded that the AAS tool was reliable and valid for screening for abuse. Reichenheim and Moraes (2004) went further to test the tool with pregnant women in Brazil, they found that the tool was able to identify pregnant women who were abused, with a specificity of 97% and sensitivity of 32%. They agreed the AAS tool was reliable to identify IPV among pregnant women but advised an additional tool to be used alongside it, in order not to miss any victim. Escribà-Agüir et al. (2016) used the Spanish translated version to screen pregnant women in Spain, and they found that there was high probability of the AAS tool not to capture pregnant women who did not experience IPV but the sensitivity was low that is women who experienced IPV may be missed.

The AAS has also been semantically and transculturally validated with pregnant women for intimate partner violence in Portuguese, Spanish and Chinese and it ceded good validity and reliability of 0.96 (Escribà-Agüir et al., 2016; Laughon et al., 2008; Tiwari et al., 2007). This tool has never been used in northern Nigeria so it was important to determine the feasibility and challenges associated in using it in northern Nigeria. The AAS tool was chosen for this study because it has good reliability and validity, asked questions specifically about abuse in pregnancy, it also has short questions that maybe easy to understand and time effective in screening.

## **MATERIALS AND METHODS**

### **Research Setting**

The study was conducted at the Antenatal clinic (ANC) in a tertiary hospital in northern Nigeria. The predominant tribe and religion is Hausa and Islam respectively. The ANC has an average attendance of 230 pregnant women per week. This setting was selected because it has high attendees of pregnant women.

### **Study Design**

A case study qualitative design was used to explore and determine the feasibility and challenges of using the Abuse Assessment Screening (AAS) tool by midwives to screen pregnant women for IPV. This design allowed collection of data from multiple sources about the phenomenon. Yin (2014) suggested that case study design should be bounded to guide the research on the boundaries of the study. In bounding the case, the phenomenon was feasibility and challenges of using abuse assessment screening tool, the real life context was midwives screening of pregnant women for IPV, and the case was antenatal unit of the tertiary hospital and the time frame for data collection was 3rd April to 30th June 2018 (Yin, 2014).

### **Sampling Technique and Sample Size**

A purposive sample of ten midwives working in the ANC of a tertiary hospital in northern Nigeria were recruited to

participate in this study. These midwives have experience in rendering care to pregnant women and have experience of screening pregnant women for other conditions. This sample size though small was determined to be adequate to enable the researchers with extensive and detailed information about the participant and phenomenon under study. About 90 pregnant women were screened with AAS tool by the midwives.

### **Inclusion Criteria**

These were midwives who worked in the ANC, have minimum of three years practiced in the ANC, have experienced in screening for other condition and available for the duration of the study.

### **Exclusion Criteria**

These were midwives who were on annual leaves.

## **DATA COLLECTION**

Pilot study: this commenced 3rd April 2018. The objective was to identify any practical issues that may arise during the screening process. Two research participants were recruited for the study. The first author trained then on how to use the AAS tool to screen pregnant women for IPV and observed them as they screen pregnant women for IPV. Lesson learnt. (1) I noticed, I was not able to observe two participants at the same time, we agreed that when one participant was screening pregnant women for IPV the other will be conducting vital signs of pregnant women. Then when observing the second participant, the first participant was distributing pregnant women's files to doctors. (2) the first participants screened seven pregnant women and she complained of the process and how her daily duties were still pending. The second participant screened six pregnant women and complained same. We decided to limit the screening to five pregnant women per participant per day. (3) it was observed during the screening process; some pregnant women were reluctant to answer some questions. After the screening I approached the pregnant women and inquired about what I observed. They were in disagreement with me on my present influencing their behaviours rather the questions were somehow.

The data generated during the pilot study were included with the data of the main study since the method of data collection and analysis were same (van Teijlingen & Hundley, 2002).

Data collection for the main study was collected from the April 17th – 30th June 2018. The midwives were given two hours training by the first author on how to use the AAS tool to screen pregnant women for IPV.

Non-participant observation was applied to observe midwives screening pregnant women during their initial ANC visit by the first author. The original AAS tool was used for this process for a period of two months. The author used

checklist specifically designed to record all observations of the screening process. The author sat at the same cubicle with the midwife who was responsible for screening of pregnant women and obtained permission from every pregnant woman to be observed during the screening process. After the screening process, the observations were entered in the checklist outside the cubicle and later elaborated as field notes as advised by Creswell (2013). At least two different midwives were observed, each screening about four to five pregnant women a day for a period of two months.

At the end of the two months, the first author conducted focus group discussion with only seven out of ten participants who had been observed screening pregnant women for IPV. Three midwives went on unplanned sick leave and were not available for the FGD. The FGD was conducted in English language and audio recorded. Brief summary of the activities of participants in the past months were explained and the participants were asked to respond to the question 'what is the feasibility of using AAS tool to screen pregnant women and What challenges did you experience when using the abuse assessment screen tool to screen pregnant women for IPV?' Probing questions were asked in between the discussions to elicit more responses from participants. The first author served as the moderator of the FGD and directed the flow of the discussion (Krueger & Casey, 2009). At the end of the FGD the participants were given refreshment, incentive and thanked.

### **Data Analysis**

Yin's five stages of data analysis was used to conduct thematic analysis (Yin, 2016). we read and re-read the transcript to familiarise with the contents. Data ideas from the transcript were written down. The data were broken down into smaller pieces and codes were allocated to each of the pieces. Patterns were searched from the coded pieces and these were rearranged into themes. This was carried out several times until the coded data were subsumed under the appropriate themes and subthemes through deeper interpretation of the meaning of analysed data. The analysed data from the checklist of the non-participant observation was revisited to confirm the development of themes. The triangulated analysed data from the non-participant observation and FGD was then shared with all participants to verify the interpretation of the data as member checking (Holloway & Wheeler, 2010). The research participants were all satisfied with the interpretation.

### **Trustworthiness**

The raw data were shared with the second author who was a qualified qualitative researcher and she was satisfied with the interpretation of the data. The non-participant observation field notes and the focus group discussion data were triangulated to achieve credibility. This data was also shared with the seven participants to verify the interpretation of the data as member checking. They were all satisfied with the

interpretation of the data. There was detailed description of the data collection process to enable transferability of the findings to similar settings and participants. The step-by-step process of data analysis and interpretation that lead to the development of themes were stated. The coded data were also shared with the second author for peer debriefing verification of the interpreted data to achieved dependability and confirmability (Guba & Lincoln, 1989; Holloway & Wheeler, 2010).

### **Ethical Consideration**

Ethical clearance (NHREC/10/12/2015) was obtained from the Research Ethics Committee of the hospital where the study was conducted. Other ethical principles including obtaining informed consent from each midwife that participated in the study. Confidentiality, privacy and justice were adhered to. In addition, informed consent was obtained privately from pregnant women that indicated interest before commencement of the screening. About 90 pregnant women were approached but only 86 pregnant women agreed to be screened (World Medical Association, 2013). A token of appreciation in monetary form (3000 naira) was given to the midwives as compensation for participants' time, inconvenience and sharing of their expertise, as supported by (Department of Health, 2015) Assurance was also given that participants will be trained further on IPV and IPV screening by the researcher at the end of the research. The rationale for the training was to give something back to the research participants and not to bias the findings of the research.

### **Findings**

The sample comprised of ten midwives who screened pregnant women for IPV and later drop to seven midwives due to unscheduled sick leave. These seven midwives were all females, married, ages were between 35-58years old and had practice midwifery for 10-33years. Five out of seven had bachelor degrees in nursing and the remaining two had diploma qualification. The implication is that the sample were agile, educated and versed experienced to communicate with pregnant women who may have experienced or experiencing IPV.

Data sources from both phases (non-participant observation and FGD) were triangulated and revealed three themes associated with the use of the AAS tool:

- Problematic questions in AAS
- Timing of screening for IPV
- Pregnant women's discomfort with answering IPV screening questions.

### **PROBLEMATIC QUESTIONS IN AAS**

This theme emerged from data related to the challenges with the questions on the original AAS tool addressing abuse and not IPV. Participants highlighted the problematic questions

and wording of certain question and made recommendation on how such questions should be changed, as demonstrated in the extracts below.

*"The Question number 4 [of the original AAS Tool] asks: Has anyone forced you to have sexual activities? It is not clear whether the question relates to the pregnant woman's own husband or anyone in general. The way it is being asked, every one of them said no. This is because they interpreted anyone to mean a stranger. Perhaps the question should be direct and replace 'anyone' by 'husband.'" [Caroline, 35 years old with 10 years in practice].*

Another participant went further to explained that the word 'anyone' in question 4 should not be in IPV questions, because the tool is meant for couples who are in intimate relationship, and especially married women. The word 'anyone' may be interpreted by the women to insinuate that they could be having affairs outside of marriage, an issue that is a taboo in the northern region of Nigeria:

*"... this screening tool is particularly referring to pregnant women. If you say 'anyone', it suggests extramarital affair and it is not allowed in our culture and should not even be hinted at, in a tool." [Ivy, 58 years old with 33 years in practice]*

Another Participant [Elizabeth, 52 years old with 17 years in practice] suggested that the word 'anyone' or 'someone' be replaced with 'partner' and 'husband' to reflect the intimate relationship without reducing the usefulness of the tool:

*"Instead of putting 'anyone', there should be 'partner' or 'husband' there because the pregnant women were reluctant to answer those questions with 'anyone' or 'someone'."*

All the participants shared the view that some words in the tools can be removed or rephrased to make the tool more precise, without reducing its ability to assess IPV.

This was confirmed by field notes during non-participant observation where some pregnant women were observed to be startled at some of the screening questions and even exclaimed "What kind of question is this?". It was obvious to the first author that pregnant women have never been asked such questions before and nor did they expect to be asked such questions.

The observation's data further revealed that both the participants and the pregnant women were not comfortable with asking or responding to certain questions. This was confirmed by pregnant woman's facial expressions in the course of being screened, and their reluctances and or half-hearted answers as the screening progressed.

### TIMING OF SCREENING FOR IPV

This theme emerged from data related to the best days to screening for IPV and feasibility, as illustrated in the extract:

*"It is feasible to screen for IPV on the booking day, it is still better, all things considered, so as to avoid repetition. This is because it is the day that we have new patients." [ Gladys, 48 years old with 23 years in practice].*

Caroline [35 years old with 10 years in practice] explained why the midwives should screen on booking day:

*"Booking day is a day when we are opportune to have one on one interaction with the pregnant women more than any other days. So, I will have time to discuss any personal issues with the pregnant women"*

*"We might have seen some pregnant women in the previous ANC visit and instead of repeating the screening on her again it is better we screen pregnant women visiting for the first time during booking." [Felicia, 52 years old with 27 years in practice]*

The researcher observed that screening of pregnant women for IPV on the first ANC visit (booking day) to be more organised than on any other days. However, it was also observed that there were more women who came for the first ANC visit (booking day) than any other days, thus making this day to be the busiest day for midwives.

### PREGNANT WOMEN'S DISCOMFORT WITH ANSWERING IPV SCREENING QUESTIONS

This theme emerged from data related to the personality and attributes expressed by the pregnant women during screening for IPV. It was observed that pregnant women seemed not to trust the screening process nor the intention of the midwives, despite the purpose for screening was well explained to them, as illustrated in this extract

*"... I noticed that whenever I used the screening questions, some women became scared ... They think it is something that will be recorded. In this part of the country people are afraid of recording of their words. Even after I had explained why I was screening everyone for IPV, they remained scared." [ Beatrice, 36 years old with 13 years in practice]*

Elizabeth [52 years old with 17 years in practice] highlighted the uncooperativeness and unwillingness of pregnant women to answer the screening questions, and went on to narrate her own personal experiences. She particularly mentioned the issue of pregnant women who become tense, afraid and clam up once they see the screening tool or once the midwives begin to ask questions on IPV. She opined that such fear was probably due to anticipated consequences that may follow if the disclosure became public or whether it was just out of shame and embarrassment. She added:

*"... it is a fact that most of them were scared to open up. This may not automatically mean that they have been victims and are afraid of the consequence of disclosure, but it sure suggests something like that."*

Jenifer [52 years old with 23 years in practice] explained why pregnant women might be scared to open up



*It's very difficult even if the person does not have cultural inhibitions against disclosure to just open up to somebody she is just meeting for the first time whether midwife or not. There must be a relationship you have established with the person for the person to say what she is going through.... it will have to take a relationship or something for her to say that.*

## **DISCUSSION**

This study revealed that, midwives and pregnant women were not comfortable with some of the questions in the AAS tool. Their discomfort came from Question 4 of the original AAS tool which states “within the last year, has anyone forced you to have sexual activities? Yes/no, by whom and total number of times”. They went further to indicate that the question appears suggestive of the pregnant women having extra-marital affairs and this was considered as an insult to Hausa married women. This is unique to the current study because it is forbidden for a married Hausa woman to have intimate relationship with any man apart her husband and a single Hausa woman are not allowed to have intimate relationship with her husband to be. The question “anyone” is indicative of the woman having intimate relationship with another man apart her husband. Previous studies have not highlighted problems with the identified question in the AAS tool as a handicap. Zapata-Calvente et al. (2022) reported that the AAS tool was not perfect to be used in its present form due to its varied results on its sensitivity and other tools may be considered in screening in pregnancy. This shows the pressing need to modify the tool to suit screening for pregnant women. Arkins et al. (2016) suggested that majority of IPV screening tools do not capture the cultural sensitivity of low-income countries since they were developed in high income countries. It will be good to have one that captures these peculiarities in LIC.

The current study also indicated that the midwives have some challenges on timing of screening for IPV on days apart from booking day (first ANC visits). The findings suggested that screening should be done on booking day, since this is a day when they have more interactions with pregnant women and activities are more organised. Similar findings were reported by Eustace et al. (2016), that screening for IPV on booking days was easier because that was the day midwives have the opportunity to become more acquainted with their patients. Drexler et al. (2022) confirmed that screenings were mostly initiated at the first booking visit and repeated once every trimester of pregnant women as recommended by American college of obstetricians and gynaecologist. Hegarty et al. (2021) reported that more than a quarter of their respondents were of the opinion that screening for IPV should be repeated during pregnancy. This is contrary to the present findings where the midwives prefer once off screening. However, a once off screening during the first ANC visit (booking) is convenient and easier, it may mean that further IPV may be missed. Evidence suggests that

IPV may begin anytime during pregnancy as shown in the studies of Spangaro et al. (2011) and . They argued that pregnant women may not divulge abuse to midwives at the first contact, and therefore a repeated screening is necessary to allow pregnant women time to become at ease with the midwives so as to disclose abuse. Moreover, the cycle of abuse tends to increase with time (Walker, 1980).

In the present study, pregnant women were reluctant and sometimes even scared to disclose abuse. This finding is supported by Laisser et al. (2011), who reported that women were reluctant and appeared disturbed to be screened. Spangaro et al. (2020) and Williams et al. (2017) in their studies showed that pregnant women will not disclose abuse when screened. This may be due to shame or embarrassment to admit abuse, because of the stigma around abuse, and therefore they will be reluctant to be screened. Also, lack of trust of the midwives' intention for screening, uncertainty about confidentiality of the disclosure and being associated with violence further scared some pregnant women about being screened for IPV in other studies (Anguzu et al., 2022; Shamu et al., 2013). The midwives in northern Nigeria and low-income countries should clarify their intentions to conduct screening for IPV, and reassure pregnant women of the confidentiality of what may be disclosed over and over again.

## **Implications**

This study is important to pregnant women, it identifies those that were abused or experiencing abuse and prompt management was ensured to prevent the consequences of IPV and intrauterine death of the foetus. For midwifery practice, the feasibility of utilizing the original AAS tool is poor. The original AAS tool cannot be used in its present form in ANC in low-income country especially northern Nigeria because of the problematic question (question 4) in it. If used, it will not generate adequate information on pregnant women experiencing IPV, therefore there is need for modification of the AAS tool. The timing of screening was paramount to midwives and pregnant women too. The indication was that screening for IPV should be conducted on the first visit (booking) of pregnant women to ANC. The midwives felt this day gave them the opportunity to interact and develop rapport with pregnant women. A repeated screening will be helpful to pregnant women because IPV might escalate as pregnancy progresses. Pregnant women were not comfortable with the screening tool. This may be due to the questions or the fear of confidentiality of their discussion. Huge responsibilities are on the midwives to reassure pregnant women of the screening, conducting the screening in private areas and ensuring confidentiality strictly.

## **Limitations**

The findings from this study cannot be generalized to other settings other than northern Nigeria context due to the small sample sizes.

## CONCLUSION AND RECOMMENDATION

The study set out to investigate the feasibility and challenges of screening pregnant women with the AAS tool in northern Nigeria by the midwives and found that it is not feasible to use the original AAS tool, because it is problematic, timing of screening and pregnant women discomfort with screening. Midwives should be aware of cultural issues common in their practice and their discretion in how to address things like marital status when asking certain questions. While our findings suggest that the first ANC visit (booking) seems ideal for one-on-one interaction with the pregnant women and screening, it should not be a once off activity because IPV can start any time during pregnancy. This study recommends that policy on the appropriate day and time of screening should be developed in consultation with the midwives.

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