PERARES Deliverable D5.1

Final report ‘Domestic Violence PER Action Plan’

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I. Introduction

a. Deliverable D5.1: This report

This final report describes all the main tasks and activities the three partners (see presentation beneath) carried out for the PERARES work package 5, “Structuring PER in Research on Domestic Violence”. To provide a clear overview, a subdivision is made between content-related tasks and evaluation of the project as a pilot study. In the content-related part (‘Studies on Domestic Violence and Pregnancy’) we report for example our scanning for international research gaps in the domain of domestic violence and pregnancy, the design of the mutual research question and research methods used in each case, comparison of study results, recommendations for policymakers on local, national and European level concerning the topic, measuring the impact and making research agenda suggestions. Moreover, this report includes evaluation and recommendations on the process of involving civil society organizations (CSOs) in research and the place of a science shop within this process.

b. PERARES

Public Engagement with Research And Research Engagement with Society - in short PERARES - is a four-year project funded by the European Community’s 7th Framework Programme, started in 2010. It aims to strengthen public engagement in research (PER) by involving researchers and CSOs in the formulation of research agendas and the research process.

PERARES uses debates on science and research to seek and develop the research requests of civil society. Those research questions are discussed between researchers, CSO representatives, science shop and public engagement staff and the resulting research questions are forwarded to research institutes. Results of research are reported via online discussion platforms, live events and the work of existing and new science shops. In this way, the results of research can feed into the ongoing public debate and need for research information connected with social issues. Thus there is the potential for the outcomes of these debates to provide ‘upstream’ influence on setting the agenda for research. For this, PERARES partners have linked existing debate formats with the science shop network and started a transnational web portal for debates. These are connected to the European reflection on the grand societal challenges for the future of the ERA. Likewise, on the topic of domestic violence, for example, an online debate was mediated by members of the WP5-team during summer 2012.

To be able to answer research requests, it is necessary to enlarge and strengthen the network of research bodies doing research for and with CSOs. Thus, through PERARES nine new science shop-like facilities throughout Europe are started, mentored by experienced partners. Science shop-like work is advanced by adding studies on good practices to the available knowledge base and organizing workshops. Guidelines to evaluate the impact of engagement activities are developed and tested.
The partners pilot and assess alternative forms of agenda-setting dialogue between researchers and CSOs, e.g. long-term periodic meetings and regular scenario workshops, and two important social sciences fields were chosen for PERARES as topics where there was increased potential for collaboration between researchers and CSOs: Roma/Travellers’ issues and domestic violence issues. The latter is discussed in this report. The partners also investigate the potential role of higher education institutes and funding councils in supporting co-operation with CSOs. PERARES is responsible for sharing its activities with the wider community through two large conferences (Bonn in May 2012, Copenhagen in May 2014) and ongoing dissemination. Thus, through increased, better structured co-operation, more researchers and CSOs engage in incorporating needs, concerns and knowledge of civil society in research agendas.

c. Work package 5

1. Partners

This work package was facilitated through and managed by two new science shops and an existing one. The new science shops are situated respectively in the Public Engagement Team of the University of Cambridge (UCAM), named ‘Community Knowledge Exchange’, and in the Department of Social Studies of the University of Stavanger (UIS), named ‘Forskningstorget’. ‘Wetenschapswinkel’, the existing science shop of the University of Brussels (VUB) is like the Cambridge unit based in the central services of the university, more specifically in the Science Communication unit of the Research & Development Department. (Hereforth these three mediating structures will be named ‘science shops’.)

Three local CSOs played substantial roles as key partners who helped to convey the views of similar organizations in their work field:

- **Cambridge Women’s Aid (UK):** offers information, advice, refuge, and ongoing practical and emotional support to women experiencing domestic abuse in strictest confidence.
- **Women’s Shelter (NO):** helps the individual woman and man experiencing domestic abuse as well as work towards changing the power structures in society that perpetuate the oppression of women.
- **Beweging tegen Geweld – vzw Zijn (B):** takes preventive action against violence and abuse within each relationship based on mutual trust, so that the spiral of violence will be broken.

The organizations shared experiences, suggested literature, identified relevant policy guidelines that exist regarding domestic violence and pregnancy, revealed gaps in research or their knowledge of research concerning the topic, had discussions with us in framing the research topic and helped the student-researchers with their research during the whole process. Women Against Violence Europe (WAVE) - informal network of European women’s NGOs working in the field of combating violence against women and children - was consulted at the preparation of the WP5 part of the PERARES proposal and provided European-wide basic information on the prevalence of domestic violence.

Also, some local experts in the domain of domestic violence and pregnancy, who are doing research or have done research in the past about the topic were involved too, by being invited to comment.
on the online debate platform, for example, and their research was consulted through literature reviews.

2. Main tasks & efforts

PERARES’ work package 5 “Structuring PER in Research on Domestic Violence” aims to enact a pilot Public Engaged Research (PER) action plan with the following objectives:

- Actively engage CSOs from different countries with research bodies and vice versa, facilitated through and managed by science shops.
- Gathering information from and for CSOs to improve the well-being of a particular group of people within Europe, including public and CSO aspirations for a research agenda, by gathering useful information through a comparative study on domestic violence in three different European countries. Within this topic, we focused on particularly vulnerable groups, specifically pregnant women, and even more specifically immigrants within this group. Special attention on this aspect is also policy-relevant.
- Obtaining relevant European-wide data and recommendations on research on domestic violence and cooperation with CSOs, for policymakers regarding research agendas on a national and European level (providing study results and making requests for future research agenda), described in a multi-annual PER action plan which can be used to prolong the PERARES project.
- Evaluating/monitoring the process of engagement between CSOs and researchers, to obtain recommendations for good practice for this kind of engagement, and gain important information on the involvement and influence of CSOs in research (and research agendas).
- Laying a foundation for new science shops through the pilot case of studying the issue of domestic violence during pregnancy and exchange of experience (science shops of Brussels, Stavanger and Cambridge).

3. Process

The first tasks after the start of PERARES in May 2010 concerned preparation and exchanging information and experience on the topic of domestic violence against pregnant women and related immigration issues, both on a local and transnational level. The aim was to get a clearer view on what was needed and on research gaps for those CSOs working in the field of domestic violence and pregnancy. Cambridge Women’s Aid, Women’s Shelter Stavanger and Beweging tegen Geweld – vzw Zijn were consulted regarding their participation in this PERARES project, and invited to become involved in this exchange of experiences and literature. Subsequently, more researchers were recruited and first round tables were held with stakeholders (researchers, supervisors, CSOs, science shops) to determine roles and tasks.

As for international information, the WAVE-network provided European-wide information on the prevalence of domestic violence and service provision in different countries. As for local/national information, researchers were consulted, literature and scientific information was assembled and experiences from CSOs were shared. These actions were facilitated through the science shop at the 3 research institutions. This facilitation made it possible to bring CSOs, experts and researchers within one location together to combine different aspects of information, experiences and interests.
During a **first transnational workshop** in Brussels (February 2011) experts, CSOs and researchers were brought together to discuss good practices and social needs, as well as to share information. The challenge of this international workshop consisted of translating the needs of the three partner CSOs with each of them working in different contexts, into one research question. This question needed to be formulated in such a way that it could be used in a comparative study by students to lead to comparative data across three European countries and agenda-setting for further research. We also decided on the research method and the time scheme.

We took advantage of the opportunity to meet at the **consortium meeting in Dublin** (October 2011) and frame the research question. During the following months students were recruited, research designs were discussed and data were gathered, analyzed and reflected on with the collaborating partners. The research design was not specified to enable students to develop their own research design. We decided to encourage students to use a mix of qualitative and quantitative research in all three countries but allowed students to develop a research method appropriate to their national context and the interpretation they made with their supervisor of the overall research question.

In the meantime, during summer 2012, in the frame of WP2, an online debate on domestic violence was held on the Living Knowledge website. CSO partners and related CSOs were invited to start this open online discussion. UCAM and VUB took care of the introduction and the debate moderation. Questions for future research were posed by representatives of CSOs working on domestic violence issues, as well as recommendations on research literature shared by CSOs and researchers.

The next step was a **second transnational workshop** in Stavanger (September 2012), at which data were presented and compared, and experiences exchanged. We made plans to formulate recommendations for local, national and transnational governments and to publicize a study report which we also will make available to governments (local, national and EU). We also discussed dissemination activities we had performed to date, and future dissemination plans via websites, media, related CSOs, networks from partner CSOs and via presentations in Living Knowledge Conferences 5 and 6. We also visited the Norwegian CSO at that point to explore the similarities and differences. As discussed in the ‘Dissemination’ section, during LK5 we presented a paper and led a workshop about this work packages. One student, Nicole Person-Rennell from the University of Cambridge, was able to attend to discuss her research in the context of the work package and to meet other transnational partners, midway through conducting her interviews and data collection.

Subsequently, we also took advantage of the opportunity to meet at the **consortium meeting in Cambridge** (March 2013) to revise a first written version of this report and to plan the evaluation part. We also agreed on the agenda of our upcoming transnational meeting in April.

During the **third transnational workshop** in Cambridge (April 2013), we focused on the evaluation of this pilot, both of the content and the process, and dissemination. CSOs and science shops evaluated and compared the different studies, engagement and involvement of CSOs, the project as a pilot joint initiative and the place of a science shop within this process, based on the criteria developed in WP9. Furthermore, we decided on the dissemination and future plans, which include a presentation at the GUNI conference in May, a work session at the consortium meeting in September and a presentation with the WP6 team at the 6th LK conference in April 2014. As during the previous
transnational workshop, we also visited the Cambridge CSO at that point to explore the similarities and differences.

4. Research question and method

The primary goal of the first transnational workshop in Brussels was the framing of a mutual research question of the comparative study. A secondary focus on immigrant pregnant women was added to the original focus on pregnant women. Throughout the discussion, it became obvious that other key topics needed to be clarified and defined by students as they carry out the research, such as: What is violence? Who are relevant care providers and healthcare providers for women who may be affected by domestic violence? Likewise, the additional focus on immigrant women also caused new questions to arise because each country uses different definitions of migrants, immigrants and foreigners. Who should be included in the population of immigrants? And moreover: do the students need to use the same definitions? It did not make sense to pin down a common definition of immigrants, for example, because each country has different policies for how immigrants can access health care and social services. Addressing these questions within each national context was important for the research design process itself and relevant to how useful CSOs in each national context would ultimately find the research. We agreed on the fact that ‘immigrant’ should be defined separately by every student according to her national context and defined domestic violence as follows: “Behavior within an intimate relation which possibly causes the other partner harm. This might be passive or active behavior and comprises any form of physical, sexual, psychological or economic violence of one of the partners or ex-partners that is aimed at domination and control of the other.” (cfr. World Health Organization or WHO)

Another challenge faced in framing a mutual research question was the variety of health care services and research regulations among the three countries. For example, whereas in the UK and Norway, student researchers can be given ethics committee approval to work directly with victims of domestic violence, in Belgium this poses more ethical issues. In the UK and Norway, it is common that pregnant women visit a midwife for their prenatal care, but in Belgium, women are mostly cared for by gynecologists. By means of sharing experiences and gaps in knowledge, including the most urgent needs, and agreeing upon barriers and definitions, the project team finally managed to formulate a common goal and research question: “To explore how to overcome the barriers that health care providers face in identifying and responding to the needs of pregnant women experiencing domestic violence, with a secondary focus on immigrant women within that group”.

During an additional meeting in Dublin, we discussed the choices of research method and sampling. We decided to encourage students to use a mix of qualitative and quantitative research in all three countries but allowed students to develop a research method appropriate to their subjects and CSO contexts, rather than the project obliging students to use the same method. It was also important from the student perspectives to have some freedom of choice in their Masters studies, regarding developing a research question, deciding on appropriate methods and so forth. It was important since the curriculum states that through the Masters thesis, the student is expected to develop and demonstrate the ability to conduct an independent research project.
II. Studies on domestic violence and pregnancy

In this part, we focus on the studies carried out by students, supervised by academic experts and mediated by local science shops. Because the Brussels student-researcher was not able to complete her empirical study at that time, only the literature review and research design of the VUB study are discussed beneath. In February 2013 the Brussels science shop received the good news that the student has resumed her study and is working on the same research question – with the exception of the migrant aspect, together with a psychology student who already graduated as a midwife. More details about this new study, which is planned to be handed in June 2014, can be found in the last section of this report, beneath ‘impact assessment’.

a. VUB study

Student: Tinneke Cardon  
Masters programme: developmental psychology  
ECTS Masters thesis: 21  
Student status: working student  
Timing: started in November 2011, was supposed to hand in in June or August 2012  
Supervisor: Prof. dr. Caroline Andries (VUB)  
Subject-related expert involved: An-Sofie Van Parys (UGent)  
CSO-partner involved: Koen Dedoncker (Beweging tegen geweld - vzw Zijn)

1. Research questions

Based on the mutual research question, the aim was to explore how to overcome barriers that Flemish gynecologists face while identifying and reacting adequately to the needs of pregnant women that experience domestic violence, with a secondary focus on migrant women in this group. This question is subdivided in the following questions:

1) What experiences do Flemish gynecologists have concerning domestic violence?  
2) What barriers do they face during a routine questioning of the experiences of domestic violence? Do those experiences match the barriers they face with migrant women?  
3) Which barriers do they face while reacting adequately to the needs of pregnant women that experience domestic violence? Are those the same as the ones the barriers encountered when working with migrant women?  
4) What do they need to do to address the problem of domestic violence in their daily practice adequately?

2. Literature

2.5%-47% of the women who participated in different international studies reported the occurrence of partner violence during pregnancy (Bacchus, Mezey, Bewley & Haworth, 2004; Beydoun, Tamim, Lincoln, Dooley & Beydoun, 2011; Campbell, 1995; Charles & Perreira, 2007; Devries et al., 2010; D’Avolio et al., 2001; Ezebialu, Nwora & Eke, 2010; Gartland, Hemphill, Hegarty & Brown, 2011;
Violence occurring during the perinatal period may cause numerous complications with serious consequences for women, fetuses and babies (premature birth, toxemia of pregnancy, miscarriages and infections). Those consequences may be both physical (bruises etc.) (Brownridge et al., 2011; Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999; Green & Ward, 2010; Gremillion & Kanof, 1996; Jaffee et al., 2005; Jasinski, 2004; Jaspaert, Groenen & Vervaeke, 2011; Leone et al., 2010; Moore & Wesa, 1997; Parsons, Zaccaro, Wells, & Stovall, 1995; Stampfel et al., 2010; Sugg, Thompson, Thompson, Maiuro & Rivara, 1999) and psychological (fear, depression, posttraumatic stress disorder etc.) (Mahony C, 1997; Bailey & Daugherty, 2007; Brownridge et al., 2011; Gerbert et al., 1999; Green & Ward, 2010; Gremillion & Kanof, 1996; Jaffee et al., 2005; Jasinski, 2004; Jaspaert et al., 2011; Jeanjot et al., 2008; Karmaliani et al., 2008; Lazenbatt et al., 2005; Leone et al., 2010; Martinez-Torteya, Bogat, von Eye, Levendosky & Davidson II, 2009; McCoy, 1996; Parsons et al., 1995; Shadigian & Bauer, 2004; Slack, 2007; Stampfel et al., 2010; Sugg et al., 1999) and social (social deprivation etc.) (Brownridge et al., 2011; Jaffee et al., 2005; Jeanjot et al., 2008; Lazenbatt et al., 2005; Leone et al., 2010; Offerhaus & Buitendijk, 2003; Protheroe, Green & Spiby, 2004). Therefore, perinatal care often is one of the few opportunities to detect violence and to offer these women the care and help they need. Inquiring about the occurrence of partner violence communicates a willingness of healthcare providers to respond to women's needs.

Women living in a context of violence often are isolated from social support (Chamberlaine & Perham-Herster, 2000; Chescheir, 1996). A pregnancy is for most women the only period in life in which they are exposed to healthcare providers on a regular basis (Bacchus et al., 2004; Chamberlaine & Perham-Herster, 2000; Devries et al., 2010; Edin & Högberg, 2002; Escribà-Agüir, Ruiz-Pérez & Saurel-Cubizolles, 2007; Green & Ward, 2010; Jasinski, 2004; Moraes et al., 2011; Offerhaus & Buitendijk, 2003; Protheroe, Green & Spiby, 2004). Therefore, perinatal care often is one of the few opportunities to detect violence and to offer these women the care and help they need. Inquiring about the occurrence of partner violence communicates a willingness of healthcare providers to respond to women's needs.
providers to talk about it. This in itself may be an important intervention in tackling partner violence (Bailey, 2010; Gerbert et al., 1999; McFarlane et al., 2000). The majority of pregnant women experiencing domestic violence do not talk about the violence unless someone inquires (more than once) after it. (Bacchus et al., 2004; Bailey, 2010; Keeling & Mason, 2010; Lazenbatt et al., 2005; Pieters et al., 2010; Roelens et al., 2008; Stenson, Sidenvall & Heimer, 2005). Knowledge about the occurrence of partner violence not only leads to a higher quality of perinatal caretaking (Gerbert, Caspers, Bronstone, Moe & Abercrombie, 1999; Roelens, Verstraelen & Temmerman, 2011; Tower, 2006), it also may help to prevent future violence and the negative consequences for the health of woman and child (Escribà-Agüir et al., 2007; McFarlane et al., 2000; Spangaro, Zwi, Poulos & Man, 2011; Stenson et al., 2005).

Several national and international professional bodies (American College of Obstetricians and Gynaecologists, American Academy of Paediatrics, American College of Emergency Physicians, American Academy for Family Physicians, Centers for Disease Control, Domus Medica...) make recommendations for **routinely asking pregnant women about their experience of partner violence**. Different authors (Campbell, 1995; Cook & Bewley, 2008; Jeanjot et al., 2008; Richardson et al., 2002; Roelens, Verstraelen, Van Egmond & Temmerman, 2008; Stenson et al., 2005) also found that the majority of women do not take offence at routine inquiries about partner violence during prenatal visits, but instead consider the questions as a chance to obtain information and support (Chang et al., 2005; Natan et al., 2012; Spangaro et al., 2011). Despite all this (Chamberlain & Perham-Hester; 2000; Elliot, Nerney, Jones & Friedmann, 2002; Hindin, 2006, Horan et al., 1998; Lazenbatt et al., 2009; Lazenbatt et al., 2005; Natan, Ari, Bader & Hallak, 2012; Roelens et al., 2006; Sugg et al., 1999), routinely inquiring after partner violence appears to be challenging. Research revealed (Mahony C, 1997; Colarossi, Breitbart & Betancourt, 2010; Chamberlain & Perham-Hester, 2000; D’Avolio, et al., 2001; Edin & Högberg, 2002; Elliot et al., 2002; Escribà-Agüir et al., 2007; Gerbert et al., 1999; Gremillion & Kanof, 1996; Hindin, 2006; Horan et al., 1998; Jaffee et al., 2005; Lazenbatt et al., 2009; Lazenbatt et al., 2005; McCloskey et al., 2005; Natan et al., 2012; Offerhaus & Buitendijk, 2003; Parsons et al., 1995; Richardson et al., 2002; Sugg & Inui, 1992; Sugg et al., 1999; Tower, 2006; Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000) that healthcare providers who meet pregnant women within their practice don’t screen women universally about whether partner violence is experienced or not. Likewise in **Belgium**, only 7%-8.4% of the studied gynecologists screen each patient at least once during pregnancy (Jeanjot et al., 2008; Roelens et al., 2011; Roelens et al., 2006). Instead, patients tend to be asked about domestic violence only if there is a conjecture that the patient is at risk. This conjecture is often based on physical injuries, and only rarely on psychological signs (Jeanjot et al., 2008; Roelens et al., 2011; Roelens et al., 2006). So, selective screening may result in the lack of detection of many women dealing with domestic violence. In this way opportunities are missed to invite these women to reflect about their situation, prevent worse or stop the violence (Gremillion & Kanof, 1996; Tower, 2006).

Health and social care providers (gynecologists, midwives, nurses, doctors, and social workers in public health sector) indicated in different studies (Colarossi, 2010; Jeanjot et al., 2008; Lazenbatt et al., 2009; Roelens et al., 2006; Tower, 2006) that they face many **barriers** concerning routinely inquiring after violence and reacting appropriately to the needs of victims. One of the first studies on those barriers was done by Sugg & Inui (1992). Based on semi-structured interviews, several factors...
related to non-recognition of partner violence and non-intervention were identified. The results of this study were the basis for later qualitative and quantitative research around this topic. Later research on barriers while screening for domestic violence during pregnancy was not restricted to gynecologists and midwives, but also included other nurses and doctors etc. (Tower, 2006) which is why we use the more general term healthcare providers to allude to respondents of the different studies. Gremillion & Kanof (1996) distinguish different types of barriers which doctors can experience in the detection of and dealing with violence:

- **Societal & cultural barriers**: these may include a level of social tolerance of violence, desensitization as a result of exposure to violence, implicit/explicit standards and power inequality within relationships (Gremillion & Kanof, 1996; Tower, 2006). The societal and cultural discourse with regard to domestic violence forms the frame for the meeting between healthcare providers and patients who are possibly experiencing partner violence (Gremillion en Kanof, 1996). If partner violence is tolerated by sections of society because people consider it as a private matter, the subject may be under taboo and people avoid talking about it. Hereby, reporting violence as well as inquiring after it is liable to be pushed aside. Fear of offending the patient and an uncomfortable feeling while inquiring after partner violence may be related to this (Sugg & Inui, 1992; Tower, 2006). However, from those studies, we cannot deduce if the fear and the uncomfortable feeling are related to the societal and cultural frame in which healthcare providers perceive the women. Roelens et al. (2006; 2011) report that Flemish gynecologists do not perceive partner violence as a private matter in which both partners should take their responsibility. Nevertheless, the gynecologists indicated that they are afraid to offend the patient. This may indicate that the fear to offend a patient also has other bases. Sugg, Thompson, Tompson, Maiuro & Rivara (1999) also stated that healthcare providers did not experience inquiring about partner violence as an invasion of patients’ privacy. They also reported that the fear of offending the patient was not a major concern of their respondents. It was found that existing prejudices about the culture of the woman can affect the screening behavior of the healthcare providers. On the other hand, the culture of the woman can cause partner violence to be named or approached differently. Several authors (Sugg & Inui, 1992) found that healthcare providers determine the probability of the occurrence of partner violence with patients based on the social-economic class of the patient at which the violence became less probable when the patient has the same social economic status as the caretaker.

- **Professional barriers**: lack of time, lack of knowledge and education/training, insufficient skills or a feeling of acting non-adequately, maintaining relationship based on mutual trust and the medical model which prescribes the role of objective observer of the doctor (Gremillion & Kanof, 1996; Tower, 2006).

- **Personal barriers**: these could include gender bias, experience of domestic violence the healthcare provider’s own life, an idealized family picture, identification with the woman who faces domestic violence, identity of the doctor as problem solver which could lead to feelings of impotence and loss of control, prejudices and attitudes, worrying about becoming too involved in the patient’s privacy, or fear for one’s own security (Gremillion &
Kanof, 1996; Tower, 2006). Finnbogadóttir & Dykes (2012) state that the person of the healthcare provider can be the biggest obstacle to enter into a dialogue about violence. The healthcare provider’s own development, knowledge, prejudices and attitude form a frame that can either hamper or facilitate the discussion of a charged subject.

- **Institutional or legal barriers.** Fear of being entangled in a legal tangle, having a limited number of institutional support sources, including insufficient/unclear scenarios and limited referring possibilities and the fear that the woman might lose the benefits of health insurance (Gremillion & Kanof, 1996; Tower, 2006).

Tower (2006) found support for this listing and categorization. He studied how barriers affect the screening practice of healthcare providers and how they help the identification of women facing domestic violence. Screening is a necessary but not a sufficient condition: even when a caretaker screens, there are still some barriers remaining that prevent every woman that faces domestic violence from being identified (Tower, 2006).

A lot of the research about the barriers to screening for violence and intervention if partner violence occurs is from British and American sources. In Belgium, barriers were studied in a qualitative way by Jeanjot et al. (2008) and Roelens et al. (2006). In the first study, Belgian healthcare providers mentioned language and cultural barriers as main obstacles to inquiring routinely after partner violence. Other barriers included the presence of a partner during the consultation, feeling uneasy about the topic, feeling unsatisfactorily trained in dealing with partner violence, a lack of knowledge of the possibilities of referral and the denial of the existence of partner violence by patients themselves.

Roelens et al. (2006) started from a knowledge-attitude-practice model, in which they studied to which extent knowledge of partner violence and the attitude about inquiring after partner violence have an influence on the practice of screening. The study revealed that Flemish gynecologists often have insufficient knowledge of partner violence but they are willing to tackle the problem within their practice. The barriers they found included: underestimation of the prevalence of partner violence, feeling insecure about tackling partner violence, time and a perceived impropriety of the inquiry after partner violence.

Next to this, prejudices about the cultural background of the woman can affect the screening behavior of the healthcare providers. The cultural background of the woman may also mean that partner violence has to be approached or named differently. Several authors found that healthcare providers determine the probability of the occurrence of partner violence based on the socio-economic class of the patient, whereby violence thought to be less of a concern if the patient and caretaker have the same socio-economic status.

In literature, a lot of attention has been paid to the discovery of barriers healthcare providers face while inquiring about partner violence and how those barriers can be tackled. Knowledge seems to be a critical barrier which can affect the screening practice directly or indirectly (Elliott et al., 2002; Sugg & Inui, 1992; Tower, 2006). Based upon past studies (Jeanjot et al., 2008; Roelens et al., 2011; Roelens et al., 2006), we suppose that Flemish gynecologists may also experience similar barriers.
...while screening for and the detection of domestic violence. Roelens et al. (2006; 2011) found that greater knowledge had a positive association with a positive attitude towards a universal screening and the screening practice (Roelens et al., 2011; Roelens et al., 2006). Nevertheless, no qualitative research has been carried out regarding identification of the barriers gynecologists experience while routinely inquiring about partner violence. For quantitative research, Belgian researchers (Jeanjot et al., 2008; Roelens et al., 2006; Roelens et al., 2011) used the knowledge that resulted from mainly British and American research. Further exploration and questioning of experiences may in this way reveal new barriers, specific to the Belgian situation. Furthermore, in Belgium, as far as we know, no research was done yet on the barriers gynecologists face once they have detected partner violence in their pregnant patients. As already mentioned, Roelens et al. (2006) studied the influence of knowledge and attitude on the practice of gynecologists concerning the screening for partner violence. Nevertheless, no research has yet been carried out to identify what Flemish gynecologists perceive as necessary to overcome the barriers they face in their daily practice.

Regarding the dimension of the study relating to migrant pregnant women, the definition of migrant to be used in the Belgian case was: ‘someone who leaves his country because of official or unofficial reasons to move to another country, as well as his/her children and grandchildren’ (Centrum voor gelijkheid van kansen en voor racismebestrijding, 2009).

3. Method

Since literature revealed that approximately 99% of the Belgian women consult a gynecologist at least once during pregnancy, the student aimed at interviewing 15-20 gynecologists, working in a hospital context or private practice. All participants would sign an informed agreement and would take part voluntarily. Interviews would be recorded and written notes would be taken. Supported by the academic supervisor, the student-researcher designed an interview structure based on literature and research questions and did test interviews to test the practicability of the instrument. However, these interviews did not take place because the student withdrew from the project.

As a sample frame, the student planned to use a phone book, searching with terms ‘gynecologist’ and ‘vrouwenarts’ (synonym), to address several hospitals in the region. In this sample frame, she would take a random sample based on accidental numbers. The gynecologists would receive a letter in which the study was described with an invitation to participate. After having received the letter, she would contact the gynecologists one more time to ask them to participate. After an affirmative response, further agreements would be made about the timing and location of the interviews, according to the preference of the participants. Just before the interview, the participants would be informed once more about the theme and kind of the study, what was expected of them and the eventual possibilities of referring to another gynecologist if the theme would upset them. To accommodate the busy agendas of the respondents, the interviews would last on average 30 minutes. The confidentiality of the conversations and anonymity of the participants would be strictly respected.
b. UIS study

Student: Oddny Karin Sunde  
Masters programme: social work  
ECTS Masters thesis: 50  
Student status: full time masters student  
Timing: starting in November 2011, approval and oral examination in September 2012  
Title: “Jordmødres opplevelser av barrierer mot å snakke om vold i nære relasjoner med gravide, og spesielt innvandrerkvinner, og tiltak for å overvinne disse” (Midwives’ experiences of barriers towards identification and response to domestic violence affecting pregnant women, and immigrant women in particular, and possible solutions) (Sunde, 2012)  
Supervisor: Ingunn Studsrød  
CSO-partner involved: Monica Monsen (Krisesenter Stavanger)

1. Research questions
   This study aimed to explore how Norwegian midwives in antenatal care identify and respond to domestic violence in pregnant women, with a special focus on immigrant women. The aim was also to explore barriers and to make recommendations to overcome these barriers. This study focuses on all pregnant women, with a secondary focus on immigrant women within that group. The resulting research questions were:
   1. How do midwives identify and respond to domestic violence experienced by their patients?  
   2. What are the organizational, cultural and communication barriers that midwives face in responding to the needs of pregnant (non-immigrant and immigrant) women experiencing domestic violence?  
   3. What solutions may be appropriate to overcome these barriers and to meet the needs of pregnant (non-immigrant and immigrant) women experiencing domestic violence?

2. Literature
   Violence prevention has increasingly become a priority task for Norwegian government and public sector. During the last 30 years, a number of prevention of violence activities and programs emerged, with a wide range of preventive initiatives ran by public authorities and NGOs with governmental support (Saur, Hustad, & Heir, 2011). In general, although crime statistics show an increase in the number of reported crime acts, compared to other countries, Norway has a low rate of violence (Lid and Stene, 2010 reported by Saur et al., 2011). Nevertheless, violence during pregnancy occurs in all social groups and has extensive consequences for women and children. Norwegian research indicates that 2-4% of women are exposed to physical violence by their partner during pregnancy (Scheie 1990, 1992; Haaland, Clausen og Schei, 2005; Hjemdal & Engnes, 2009). Since only physical violence was investigated, the percentage would probably raise significantly if other types of domestic violence, such as psychological violence, was investigated. Domestic violence constitutes an important risk factor for poor health of women and children.

   A main goal of Norwegian antenatal care is to ensure equal health care for all people, regardless of cultural background and religious affiliation (St.meld. nr. 12, 2008-2009). Research indicates that few women with immigrant women attend antenatal courses in Norway (Ibid), which raises concern
since \textbf{women from some countries outside Western Europe have shown a risk profile in pregnancy when} compared with Norwegian women. Reviews of stillbirths indicate that women originating outside Western Europe, North Australia and Australia are at increased risk for stillbirths and loss in antenatal care, as well as facing communication problems. Birth may pose a particular challenge for women with immigrant background, and women may perceive cross-pressures between traditionally expected practice and advices given by health professionals. Hence, antenatal care for women with immigrant backgrounds needs to be strengthened and health personnel in antenatal care needs necessary skills to meet the challenges. Their situation will often require more extensive medical attention.

“The World Health Report 2005 - make every mother and child count” argues that \textbf{antenatal care provides an opportunity for identification of instances of violence during pregnancy}, as a first step towards providing support to the expectant mother and helping her to find solutions. So far the Norwegian health sector has not implemented routine questioning for violence and has been criticized for overlooking violence as cause of illness (NOU, 2003). Although research (Hjemdal and Stefansen, 2003) indicates that health personnel relatively often ask questions about violence if there are \textit{clear indications} of exposure, this probably varies from person to person, and indications of exposure may be difficult to detect.

In 2004 the former social and health ministry raised questions about new policies for routine screening in antenatal care in Norway, and recommended a pilot exercise to try it out. Hence in 2007-2008 the Centre for Violence and Traumatic Stress Studies and Alternative to Violence implemented a pilot project whereby routine questions were asked about violence during maternity check-ups in four municipalities (Hjermdal & Egenes, 2009). The pilot showed that although every pregnant woman was supposed to be asked about exposure to violence, \textbf{midwives only asked 51% of the women}. The reasons why women were not screened were mainly because they came with their partners, they were immigrants and the translation possibilities were not satisfactory, the women came to consultation late in pregnancy, the midwife felt lack of time, the check-up was disrupted by holiday or illness, or that stress and forgetfulness made the midwife neglect the screening. Furthermore, 92% of the pregnant woman and 82% of victims of domestic violence reported that they felt it was acceptable, or very positive to be screened for domestic violence. Even though several midwives at the start of the project expressed scepticism and uncertainty regarding asking about exposure to violence in maternity care, the scepticism decreased rapidly when they became familiar with the screening. In total, 25% of the women reported some sort of physical, sexual or emotional violence and abuse or being afraid or concerned about children’s safety. The conclusion was that there were good reasons to implement routines for asking questions about violence in antenatal care (Hjemdal & Engnes, 2009). Nevertheless, at present, screening for domestic violence is not introduced as a permanent part of Norwegian antenatal care.

\textbf{Antenatal care in Norway} is mainly based on a white paper from 1984 (NOU, 1984), and recommendations from the World Health Organization. It has its own guidelines, stated by the Directorate for Health and Social Affairs in 2005, for midwives, doctors and other health care personnel who are involved with antenatal care (Directorate for Health and Social Affairs, 2005). It is a unique part of the health services, and includes all antenatal check-ups, measures and referrals
that are required during a normal pregnancy. The guidelines are not obligatory, but intended to achieve a safe and good quality prenatal care for all. The purpose of antenatal care is to reduce social inequalities in health, ensure that pregnancy and birth extend in a natural way, and to maximize mother’s physical and mental health, as well as her social wellbeing. The aim is also to support both parents in a way that enables them to take good care of their child. It is also worth noting that antenatal care aims to discover risk factors for poor health in women and children (Sosial- og helsedirektoratet, 2005), such as domestic violence, and extra attention and care for people in high-risk groups are particularly important. Both midwives and doctors are generally providing antenatal care to pregnant women, therefore women can choose between doctor or midwife or a combination of both. Every municipality in Norway is required to have antenatal care available for all pregnant women. Antenatal care can offer women who need it more check-ups than those included in the basic program (8 check-ups during pregnancy, an ultrasound and frequent check-up after 40 weeks of pregnancy). The check-ups consist of physical examination, information and opportunities to discuss problems. Seven out of ten pregnant women go to midwives during pregnancy (St.meld. nr. 12, 2008-2009) (Sosial- og helsedirektoratet, 2005).

Although in the guidelines stated by the ministry no routines have been implemented to ask questions about violence as part of antenatal care, midwives and doctors are expected to be aware of the problem, to give pregnant women an opportunity to disclose such issues and to get help. The guidelines recommend midwives and doctors to signal that violence is unacceptable and that they provide support to the victims of violence. The antenatal care providers are expected to have knowledge of institutions providing aid to the victims of domestic violence, and in addition to help them to contact those institutions (Sosial- og helsedirektoratet, 2005).

Regarding the dimension of the study relating to migrant pregnant women, the definition of immigrant to be used in the Norwegian case was: ‘a person with two foreign-born parents who have immigrated to Norway’ (Dzamarija & Kalve, 2004).

3. Method

In this study a qualitative research design, with semi-structured interviews with five midwives was employed. Midwives were chosen as respondents because they have specialist expertise in antenatal maternity and postnatal care and offer a unique chance for identification of and intervention for domestic violence victims who are pregnant. They also provide the majority of care to pregnant women in Norway. Midwives working in community health were believed to offer unique insight into the topic and were included in this study.

Recruiting was planned through purposeful informant based sampling but proved to be challenging. Therefore, the sampling became a convenience sample. Two midwives were recruited in the community health centre, and three more through snowball sampling. All participants offered insight into the research topic and had 10-30 years of work experience as midwives. All together, the five midwives probably meet 400-600 pregnant women each year and they have consultations with pregnant ethnic majority as well as minority women.

The interviews lasted between 30 minutes to 1,5 hours. One interview was conducted by telephone, the others face-to-face. An interview guide containing questions covering midwives’ experiences in
identifying and responding to domestic violence during pregnancy, as well as barriers and solutions were used during the interview. The study was approved by the Norwegian Social Science Data Services (NSD ref. nr.29094/3/MSI) and informed consent was obtained from all participants. All data have been treated anonymously, and followed ethical procedures in line with standards for research ethics.

4. Results
All midwives reported lack of experience in identification of domestic violence victims. Two of them had a routine asking all pregnant women about exposure to violence by their intimate partner. One reported that all midwives in her health centre ask routinely and give a brochure to everyone at first meeting, for the other it seems more like a personal choice. Some midwives asked women indirectly, e.g. by asking “Are you all right at home?”. Others only asked if they assumed the pregnant woman was suffering from it. The midwives expressed how they looked for different signs of domestic abuse such as bruises. At the same time they said that a sign of abuse may be difficult to detect, especially with women with different language and cultural background. None of them reported that they had identified exposure to violence nevertheless they felt insecure and anxious on how to respond to it.
All midwives reported domestic violence as a difficult topic to identify and respond to due to:

a) Organizational Barriers
All midwives reported lack of time to deal with issues as domestic violence. They felt that in order to bring up the topic, it was necessary that the pregnant woman felt she could trust the midwife, which takes time. Several interviewees felt that antenatal care as a whole was characterized by time pressure. All participants reported time pressure in particular in consultations with immigrants, refugees or other women facing problems with understanding or speaking Norwegian. Hence language and communication were considered to be barriers by all midwives in this study. In consultations with foreigners, midwives reported extra time was needed in order to provide basic information, such as where and how the delivery takes place etc. Therefore there was less time to bring up topics as domestic violence with these women. Several midwives also expressed problems with translation and mistrust of the interpreter. Examples included reporting doubt about the correctness of the translation of the translator, or believing that the interpreter undermined the problem of domestic violence.

Furthermore, the structure of Norwegian antenatal care, with both doctors and midwives involved, leads to blurred allocation of responsibility and uncertainty of roles because of lack of continuity between these health professionals. Midwives reported that it was difficult to decide what to do or where to go if they discovered domestic violence. They felt they lacked knowledge, also on how to help victims even though they were aware of institutions or services they could contact for a consultation or further reference. Although at least two midwives had taken courses learning more about domestic violence, they still felt they lacked knowledge of domestic violence in general and lack of training on how to ask questions in particular. Midwives reported that they, due to lack of knowledge, probably had missed identifying abuse victims. According to the law, midwives are bound to confidentiality. The midwives in this study reported that they felt that this confidentiality was a barrier toward the identification of and responding to domestic violence. They assumed that the victim could prevent them from going further with their knowledge of abuse. Often it was
difficult to bring up the subject on the discussion, also because the father or other family members were present at the scheduled check-up. All midwives expressed the need to be alone with the women when asking about exposure to violence.

b) Cultural and Personal barriers

In order to identify and respond to domestic abuse, the midwives’ perceptions of role expectations and their definition of “what is a part of antenatal care” seem important. Midwives differed to what extent they felt detecting violence and meeting the needs of victims is a part of antenatal care. But all of them felt that they and their colleagues shared a similar pattern of behaviors and approaches towards identifying and responding to domestic violence. They worked in five different organizations with dissimilar expectations on how to approach domestic violence. In three health centres the participants felt a drive for asking routinely questions about domestic violence, whereas this was not the case for the two other ones. Thus some of the barriers probably reflect cultures in workplaces.

Although all informants expressed that pregnant women who are victims of abuse should be given the opportunity to talk about violence at their antenatal check-up, it seemed difficult and a sensitive issue to discuss in practice. These findings may indicate or reflect that domestic violence is a taboo in the Norwegian society and an area of stigmatization. At the same time the findings may also indicate that some barriers are more of a personal character, when it comes to perceptions of domestic violence. One midwife told she was afraid to offend anyone by bringing up the topic of domestic violence. She felt that it was a personal issue and pregnancy is a period where difficult things shouldn't be focused on, she preferred to focus on the positive upcoming happenings.

The midwives felt their definition of domestic violence may differ from an understanding that some immigrant women may have. They believed immigrants more often have a history with violence and therefore have developed a higher tolerance or acceptance for violence. Some also expressed the belief that immigrant women suffer more domestic violence than ethnic Norwegians. Some also mentioned that they believe immigrant men more often want to control their pregnant partners. Some midwives thought immigrant men came to check-ups regularly as a way of controlling and using violence against their partner. This may reflect the stigmatization of immigrants, particularly immigrant men as violent and immigrant women as submissive. On the other hand, it may reflect how midwives try to balance between ethnocentrism vs. cultural relativism and communication problems since they felt that it's often difficult to get an appropriate answer to their questions of violence from immigrant women.

c) Solutions to overcome barriers

- Implementation of screening as a tool to detect domestic violence
- Improvement of guidelines for antenatal care: clarification of the responsibility/roles of midwives and doctors. Facilitation of antenatal care in a way that at least one meeting is with the pregnant women only and more time to follow up multicultural pregnant women.
- More knowledge and training in domestic violence and cultural competence and how to improve working with minority women. Midwives need knowledge about violence and methods to screen and about what to do if anyone confirms that they are victims of violence.
- Development of better formal procedures after discovering domestic violence and on inter-institutional cooperation to identify violence and meet the needs of victims. Midwives also need access to information material on domestic violence, to hand over to pregnant women.

d) Conclusion

All the midwives interviewed reported that they paid attention to signs/symptoms of abuse or violence, but they faced several problems in identifying signs, meeting the needs of women and how to approach the topic. The barriers they face seem to be of a combination of personal, cultural and organizational nature. Although this was not a representative study, those barriers seem to be in accordance with the ones identified in previous research. Hence implementing solutions are important.
C. UCAM study

Student: Nicole Person-Rennell, Masters student Public Health
MA programme: Masters of Philosophy, Public Health
ECTS Masters thesis: UCAM doesn’t use the ECTS system but the thesis and in-course assessment (two 3.000-word essays) accounts for 70% of the assessment for the MPhil
Title: “Midwives’ Identification of and Response to Domestic Violence during Pregnancy: An Analysis of Midwives’ Accounts including Barriers Encountered”
Timing: starting in November, handing in in July
Student status: full time foreign (USA) masters student
Supervisors: Dr Felix Naughton, Institute of Public Health, University of Cambridge and Dr Emily Taylor, Institute of Public Health, University of Cambridge
Subject-related expert involved: Halliki Voolma
CSO-partner involved: Angie Stewart (Cambridge Women’s Aid)

1. Research questions
The research aim of this study is how to overcome barriers Health Care Practitioners (HCPs) face in identification and response to abuse, including an exploration of midwives’ accounts of experiences when encountering domestic violence. The objective is ultimately to understand midwives’ identification of and response to domestic violence in pregnant patients, including barriers and utilised solutions, with formation of recommendations for overcoming current barriers. This study will also comment on midwives’ accounts of experiences working with domestic violence in the context of patients with insecure immigration status (IIS); this will be focused on exploring the challenges of cross cultural communication and barriers and solutions to this interaction. Finally, in the quantitative section, the aim is to utilise an existing data set to frame the quantitative portion of the study, including commenting on differences between pregnant women in treatment for domestic violence, definitions of domestic violence, and utilisation of health services for injuries.

1. How do midwives identify and respond to domestic violence experienced by their patients?
2. How do midwives represent the interaction with pregnant women experiencing domestic violence and what are the implications?
3. What are the barriers that midwives face in responding to the needs of pregnant women experiencing domestic violence and how do they overcome these barriers?
4. How do midwives represent cross-cultural interaction with pregnant women experiencing domestic violence, especially women with potentially insecure immigration status (IIS)?

2. Literature
Domestic violence can start at any time in a relationship, but often begins or intensifies during pregnancy (RCM, 2009; Bohn, 1990). According to a WHO study, 3%- 50% of women in situations of abuse were physically abused for the first time during pregnancy (Garcia-Moreno, Jansen, Ellsberg, Heise, Watts, 2005). Also, 8%-34% of women reporting previous violence indicated that the violence got worse during pregnancy (Garcia-Moreno, Jansen, Ellsberg, Heise, Watts, 2005). In the UK, 30% of abuse originates during pregnancy (Department of Health, 2005). In addition to increased risk for domestic abuse, pregnant women also suffer numerous negative health effects from domestic
abuse, including physical injury, depression, anxiety and post-traumatic stress disorder, increased risk for drug dependence, homelessness, and unemployment (Lazenbatt, Taylor, Cree, 2009). An additional negative effect is seen on fetal health as pregnant women experiencing abuse are at increased risk for miscarriage, premature birth, low birth weight, and other negative birth outcomes (Lazenbatt, Taylor, Cree, 2009; Department of Health, 2005; Bacchus, Mezey, Bewley, 2002). Domestic abuse is therefore a major issue for those who care for pregnant women as well as public health practitioners due to its large, negative impact on the population.

Health service utilization is highest during pregnancy and women’s reproductive years versus any other time (O’Reilly, Beale, Gillies, 2010). Pregnancy is an ideal time for HCPs to identify and work with women experiencing domestic violence because of the combination of increased risk for domestic violence during pregnancy and access to women at risk (O’Reilly, Beale, Gillies, 2010). In the UK, midwives play a key role among the health care providers who provide care to pregnant women within the National Health System (NHS). Other HCPs come in contact with pregnant women experiencing domestic violence, including emergency care providers, general practitioners (GPs), and obstetrician/gynecologists (Hindin, 2006).

As part of a public health approach in a health care setting to improve the outcomes for abused pregnant women, the interaction between midwives and their pregnant patients experiencing abuse must be understood. This interaction includes identifying and responding to domestic abuse and can pose a number of challenges for midwives. The identification of domestic violence presents many challenges, not only from the midwives’ perspective, but also due to women’s hesitancy to disclose. Lazenbatt et al (Lazenbatt, Taylor, Cree, 2009) point out that victims of domestic violence may not disclose abuse due to a number of reasons, including fear of reprisal from their partner, fear of losing children, or embarrassment. However, many women hope that they will be asked about the abuse, which highlights the importance of questioning about domestic violence (Lazenbatt, Taylor, Cree, 2009; Department of Health, 2005; Bacchus, Mezey, Bewley, 2002). In the setting of screening, women find it acceptable to be asked about domestic violence (Stenson, Saarinen, Heimer, Sidenvall, 2001; Bacchus, Mezey, Bewley, 2006) although in a safe, confidential environment by trained practitioners (Bacchus, Mezey, Bewley, 2002). Thus, barriers from the perspective of the patient should not stop the HCPs from respectfully enquiring and providing support.

The Royal College of Midwives (RCM) and, in this study setting, Cambridge University Hospitals NHS Foundation Trust (CUHNHSFT) recommend routine screening to identify domestic violence, along with referral and support. But midwives in both the local and national context face challenges in identification of and response to domestic violence. A national survey associated with the RCM and conducted in 2004 found that more than 1 in 15 pregnant women treated by midwives over five days experienced domestic abuse and that midwives found it difficult to ask women about abuse because of partner presence, lack of time, knowledge, and available help (RCM, 2009). The most recent available CUHNHSFT audit (2010/2011) indicates that screening (or documented means of identification) is not consistent, despite guidelines, training, and pathways put in place to identify and respond to women in need (Goddard, 2012).

Some solutions have been evaluated, e.g. the Identification and Referral to Improve Safety (IRIS) training program in Hackney and Bristol by Feder et al in a Randomized Control Trial (Feder et al.,...
2011). Significant improvement in recorded identification of domestic violence and increased referrals compared to controls was found, suggesting that, with training and routine screening, more women are identified. Because domestic violence is known to be present, the lack of identification in a certain practice implies areas for improvement. More ideas for improving identification of and response to domestic abuse are needed, especially in local contexts.

Definition of immigrant:
- Immigrant: in this study women with insecure immigration status were studied. A person’s immigration status is their legal position defining whether their stay in the UK has restrictions attached to it. Women with insecure immigration status in the UK include women who are migrant workers, have student visas or spousal visas (UK Border Agency http://www.ukba.homeoffice.gov.uk/glossary)

3. Method
A qualitative design was used to conduct 9 interviews and 3 micro-focus groups with 19 midwives. To overcome the challenges of recruiting midwives for interviews, strategies of on-site recruitment, increased scheduling flexibility and peer-to-peer recruitment were employed. Interviews were guided by a predetermined list of key questions and topics for discussion around how interviewees work with pregnant women who may be exposed to violence. Thematic analysis was then utilized.

The project was augmented by framing of the qualitative methodology with quantitative data that describe healthcare provider and patient interaction. Data was analyzed from the most recent Crime Survey for England and Wales (2010-2011), a face-to-face victimization survey regarding experiences and perceptions of crime in the preceding year, and the only national or large scale survey to the author’s knowledge that asks about abused women’s relationship with health care providers. To complete the project within the setting of UCAM and CUHNHSFT, the following were required:

- Approval from Ethical and Research & Development departments
- University sponsorship, insurance and ethical approval from Cambridge Psychology Research Ethics Committee
- Research passport to conduct research in NHS facilities
- Special license access to the Crime Survey for England and Wales for quantitative portion of research

4. Results
a) Qualitative portion

i. How do midwives identify domestic violence in pregnant women?

Midwives mentioned the universality of risk for domestic violence among pregnant women, and how this was behind the need for routine screening. They did talk about the conflict between not relying on value judgments to identify domestic violence, yet because there were barriers to carrying out routine screening, midwives frequently had to rely on judgments or intuition to identify women to ask about domestic violence. Environmental clues, including drug or alcohol abuse or social deprivation, were referred to among other signals stimulating them to ask about domestic violence. Environmental clues, including drug or alcohol abuse or social deprivation, were referred to among other signals stimulating them to ask about domestic violence in the context of obstacles to routine screening. But this was followed in midwives’ accounts by recognition that all women were at risk from domestic violence.
**Barriers to routine screening**

Strikingly, one barrier to routine screening cited by every midwife was the presence of a partner, child or other individual present during the consultation. Calling upon strategies to work around **family member presence** and other barriers to routine screening, midwives reported using situational clues: observations of couple interaction, history of multiple admissions, physical signs of abuse, especially with incongruent explanations, lack of attendance at appointments, and higher rates of certain issues (miscarriage, urinary tract infection or UTI, multiple terminations, premature delivery). Amid barriers to routine questioning, midwives stated using these clues to identify women who needed to be asked about domestic violence. Additionally, midwives frequently cited partner presence at every clinic visit, which midwives linked to concerns about controlling behavior, as a clue.

Many midwives described complex situations requiring **ingenuity and informal strategies** to question women when barriers to routine screening were present. The most dominant strategy was asking the patient for a urine sample, showing her to the toilet and asking at that time. This is consistent with the current domestic violence pathway, which requires midwives to identify domestic violence by routine screening and if not possible, to “engineer [an] opportunity to see [the] woman alone.” (Goddard, 2012) Despite being the dominant strategy, following the patient to the toilet was described as infrequent because of challenges such as women bringing urine samples with them or arousing partner suspicion. Furthermore, this strategy brings up multiple concerns for identification of domestic violence: it was described as only being done if midwife concerns were present, and also the toilet was identified as a challenging environment for disclosure, bringing up questions of patient comfort.

In essence, midwives’ accounts describing identification techniques have illustrated that with the need for intuition and midwife ingenuity, what is designed to be a situation of easy identification through routine guidelines is actually represented as uncertain and challenging in the reality of practice. In different midwife care settings, the **routine screening conflict** is described as being met with potential solutions. In the antenatal clinic, some midwives reported ushering a woman into the consultation first if a partner is present and use that time alone to question the woman about domestic violence. In one of the focus groups, community midwives said that the way in which antenatal midwives sought to collaborate with them and health visitors, calling on them to follow up suspicions of domestic violence, could be perceived sometimes as passing responsibility. But an antenatal midwife in the study explained that if she had suspicions but had not been able to ask the woman privately, she and her colleagues "would highlight it to the community midwife that we have concerns and then she might do the whole visit or see if she can get the lady on her own." This antenatal midwife could be highlighting her personal and perceived role limitations in the context of the interview, applying a solution to collaborate in the setting of her own constraints.

Despite these challenges of different solutions in different settings, ultimately the routine questioning environment, studied here in the setting of the antenatal clinic, was encouraging to midwives. Ultimately, applying midwife perceived positive solutions to different settings could form a method of collaboration and means of **overcoming barriers** to identification.
ii. How do midwives respond to domestic violence in pregnant women?

While having access to and knowledge of a clear referral pathway, midwives experienced a challenge in the application of that pathway because of uncertainty related to the complexity of navigating practice within a policy setting, sometimes requiring effort outside of the stated pathway.

Midwives report responding to domestic violence by **collaborating with others**, including the safeguarding midwife, to establish confidence in their response and overcome uncertainty, including the uncertainty about whether the pathway applies (e.g. during response to concern without patient disclosure). Midwives discussed a challenge of collaborating with supplemental services available outside of the referral pathway. While working with a multi-disciplinary team presented a solution to service provision outside the scope of midwifery (including social workers, police and GPs), it can also present a barrier when it is used as diffusion or shifting of responsibility. These workings and limitations suggest that midwives utilize the multi-disciplinary team to actively establish the boundaries of their role when responding to a case.

Regarding the **principles of confidentiality and autonomy**, midwives represented themselves as having respect for a woman’s complex situation and her autonomous decision making. Some utilized a confidentiality statement in appointments, allowing the woman to choose to disclose domestic violence in the knowledge that a midwife’s response might include other agencies. This respect for autonomy contributes to a positive midwife-patient relationship and diffuses some of the burden of disclosure onto the women. These principles present a challenge, however, when respecting women’s autonomy comes into tension with providing care for both the mother and fetus. In the case of a pregnant woman who remains with a violent partner and thus puts the fetus at risk, midwives reported engaging with the pathway for the fetus’ protection, which overrides any desired action of the pregnant woman. Whereas respect for autonomy characterized midwives’ discussion of identification, at the point of response a woman’s disclosure required midwives to violate confidentiality and autonomy.

Some midwives described **fear** as a motivating force to reinforce their sense of midwives’ duty to respond. In cases of uncertainty regarding whether a disclosure or concern requires action on her part, midwives reflected that uncertainty and challenges in responding to domestic abuse were overcome by action because of fear for the woman reinforcing their duty of action.

iii. What are the barriers that midwives report facing in responding to the needs of pregnant women experiencing domestic violence and how do they overcome these?

Midwives expressed awareness of a range of barriers present in identifying and responding to domestic violence. A common significant barrier was the **presence of a family member** at appointments, as a challenge to routine screening. Because there was no routine arrangement to speak to women alone, midwives relied on the use of ingenuity, intuition and situational clues. However, these tools were described as not being applied routinely, but only when the midwife was concerned about the likelihood of domestic violence. This is related to further challenge of loss of normalisation of domestic violence, which is used for routine enquiry.
Challenges with logistical management were also discussed, including lack of time to spend on documentation or on the telephone and diversity of practice settings, which made identification and response more challenging in certain settings (such as urgent care). Lack of time was presented as an obstacle that was surmountable with extra effort, but that did contribute to the passing of responsibility under logistical pressure. The barriers presented by some practice settings served as an explanation for not identifying domestic violence, sometimes resulting in further passing of responsibility to midwives in practice settings that were viewed as more appropriate (such as clinical or community practice).

Midwives reported the midwife-patient relationship as an important component of identifying and responding to domestic abuse. While the discomfort of discussing domestic violence was represented as a challenge to this relationship, midwives also discussed ideas of duty as useful in overcoming discomfort and sometimes overriding concerns around breakdown in the relationship, including in situations where the relationship was established and also in situations where the midwife had no relationship with the patient. In some cases where no relationship was present, fear of offense due to anticipated negative reactions could form a barrier, but ultimately most midwives described the relationship as a tool used as a solution to overcome barriers. One structural change implied as a challenge to the midwife-patient relationship was the reduction of home visits and elimination of “main” midwives assigned to be a pregnant woman’s primary care giver during pregnancy. This change resulted in the lack of continuity of care and implied poorer midwife-patient relationships as a significant barrier to identifying and responding to domestic abuse.

To negotiate the challenges of discussing domestic violence with patients, midwives reported using the CUHNHSFT guidelines, knowledge about domestic violence and other resources to overcome discomfort and other barriers to questioning. The guidelines were used to normalize questioning of women by midwives’ explaining that their questions were part of required guidelines. Midwives reported using knowledge about the prevalence of domestic violence to contextualize their identification techniques. While accessing resources such as small information cards was cited as having been useful in the past, discussion indicated that resource availability was inconsistent, which could hamper easy response to domestic violence. However, along with the citation of guidelines and use of knowledge to contextualize questioning, additional resources were represented as tools used to maintain normalization of questioning and a positive midwife-patient relationship.

Training was referenced by many midwives as effective in overcoming the lack of knowledge of how to ask about domestic violence as well as knowledge about the potential consequences of domestic violence, which reinforced the sense of duty to identify and respond to domestic violence.

Almost all midwives described challenges with feeling comfortable when first starting to ask regularly about domestic violence. Midwives reported using tools such as having a set way of asking, including written phrases and using knowledge to feel comfortable. One midwife reported working with an experienced midwife who still found asking so challenging after years of practice that her discomfort prevented enquiry. However, midwives also described becoming habituated to asking through routine, suggesting that through familiarity and routine use of questions regarding domestic violence, discomfort can be reduced. Ultimately, routine screening and the resulting frequency of midwife questioning was seen as improving midwife comfort in asking about abuse.
iv. How do midwives represent cross-cultural interaction with pregnant women experiencing domestic violence, especially women with potentially insecure immigration status (IIS)?

The themes that emerged regarding this were communication complexity and “No recourse to public funds,” referring to the lack of access to services for women with IIS.

Cross-cultural interactions between midwives and pregnant women were represented as challenging and sometimes required midwives to depart from the usual pathway. One midwife reported the challenge of a negative cultural response to the stated pathway when working with a woman experiencing abuse in the Traveller community. The midwife reported that she was obligated to refer the woman to social services after learning about the abuse, but that after she made the recommended referral the woman responded negatively, severed her relationship with the midwife and ultimately refused further treatment from any midwife. This negative response was understood to be related to her community’s history with social services. Most midwives indicated that they had or would respond in the same way, referring the patient to social services and acting according to the designated pathway regardless of cultural background. However, one midwife held the opposing perspective that autonomy and the challenge of alternate cultural normative experience should override the pathway obligations for the midwife.

Cultural differences in the identification of domestic violence also presented a challenge, although midwives initially maintained that this did or should not constitute a barrier to identification. Even with the services of an interpreter, complex situations were identified as emerging when cultural understandings of acceptable behavior abuse meant that a patient might not understand what the midwife meant with the usual approach to questions around domestic violence. Midwives reported desiring to use the same techniques regardless of cultural background, but truly communicating about domestic violence and sharing understanding provided significant challenges and required a different approach. Midwives reported dealing with this challenge by asking more specifically and directly about domestic abuse, as well as describing what is meant specifically to the interpreter to ensure effective communication. Some participants also described utilizing their midwife training as education for patients. Ultimately, midwives responded to the barriers of differing definitions of domestic abuse by utilizing training, patient education and resource provision.

Women with IIS, although not frequently encountered, were represented as challenging because of lack of access to services. Most midwives indicated that they would treat IIS women in a routine manner, but that immigration issues were outside of their role. However, some midwives reported encountering significant challenges when trying to help patients with IIS and struggling to negotiate public and community services within her role. This highlights the barrier for midwives responding to domestic violence against women with IIS: referrals to social services are not likely to be successful. While midwives described collaborating to find opportunities for aid, solutions for women with IIS were not easily found.

b) Quantitative portion

872 participants in the most recent Crime Survey for England and Wales (2010-2011) experienced abuse by at least one partner in the previous year, with 59 of those being pregnant during that year. Of these 872 respondents, 346 disclosed to a listed professional organisation, including police,
council departments, government agencies and legal professionals. HCPs were informed second most frequently, with police informed most frequently. Of respondents disclosing to HCPs, 45.7% told HCPs exclusively. In women who were in an abusive relationship in the last 12 months and were pregnant during that year, 22% disclosed to HCPs, and 30% of those women responded to HCPs exclusively. When non-pregnant participants reported to a HCP for injuries due to domestic violence, including psychiatric reporting, the majority were asked about the cause by the HCP (80%), with a similar number of pregnant women asked about the cause of injuries (81%). In response to asking if participants considered the abuse experienced to be domestic violence, a greater portion of pregnant women (63.5%) considered their abuse to be domestic, compared with non-pregnant respondents who had experienced abuse (31.2%). Perceptions of support received from HCPs by survey participants varied, the majority (78%) indicated either “very helpful” or “fairly helpful” with 22% reporting either “slightly helpful” or “not helpful”. Eight different types of support provided by HCPs to those disclosing abuse were identified. Listening to the patient’s problem was the most common type selected (42/64); however, support varied and included “no support provided.”

Implications/recommendations

Many of the barriers in identification and response to domestic abuse highlighted in this analysis are consistent with previously identified midwife barriers. Midwives utilised a variety of strategies to navigate these barriers, but based on the analysis, the following recommendations are made to address some of the barriers and practice challenges in attempting to meet policy objectives.

1) **Formalising the requirement for each midwife consultation to contain designated time where the woman is seen alone as part of a routine visit** would allow for the inclusion of routine screening. This could form a solution to the challenge of partner presence, preventing midwives from having to routinely engineer an opportunity to ask, and allowing midwives to increase comfort with questioning about domestic violence through repetition. This recommendation could be applied in this setting by exploring a policy of always taking the woman back alone for blood pressure and urine sampling, thereby providing a consistent space.

2) A potential barrier to successful identification is lack of continuity of care and thus a poorer midwife-patient relationship. **Revisiting this policy decision and potentially incorporating a “named midwife,”** might address this continuity and relationship concern.

3) **Sharing of solution techniques and best practices** at a training or other session could be helpful to address midwife uncertainty. This includes solutions for the presence of a partner if a routine visit policy is not possible. Additional confidence with this solidarity and informal training could also reduce pressure on the safeguarding midwife.

4) **A summary location in the electronic medical record available to midwives** might facilitate the midwife observing if the woman had been asked three times in compliance with trust guidelines. This has the potential to save time and allow midwives to easily check if the guidance had been met instead of looking through all of the notes specifically for previous questioning regarding abuse.

5) Ensure resources are easily available to all midwives to utilise and provide to their patients. **Resource availability** could help midwives more easily provide education and a referral, thus
reducing some barriers such as time required in response to domestic abuse.

6) **Work towards effective communication in all settings**, including cross-cultural, regarding domestic violence. This would address the expressed complexity in asking about domestic violence and the quantitative data highlighting the potential for misunderstanding with differing definitions of domestic violence. For example, if domestic violence were asked about with a brief statement of what is included as abuse per policy, differing definitions could be reconciled.

7) **Further research is needed to identify and evaluate solutions to barriers faced by midwives** and other HCPs in working with domestic abuse. Multiple training programmes (Price, Barid, Salmon, 2007; Feder, Davies, Baird et al., 2007; Mezey, Bacchus, Haworth, Bewley, 2003) have been evaluated, with results of varying effectiveness, to address barriers such as lack of comfort and knowledge, but these are not the only barriers to providing care and thus research is needed to support new policy and training programme development. Especially in the context of women with IIS, more research is needed to understand the care challenges and solutions, particularly from the perspective of the women.

c) **Conclusion**

Midwives expressed challenges in negotiating the complexities of encounters with women potentially experiencing domestic violence and working within a policy framework. Some of these challenges included the undermining of routine screening, confidence and discomfort challenges, pathway uncertainty, and fear of harm to the midwife-patient relationship. These challenges were described as being met with a variety of solution and additional solutions were recommended.

Reducing domestic violence requires the action of many groups and movements to tackle the root causes of violence (Garcia-Moreno, Jansen, Ellsberg, Heise, Watts, 2005). HCPs cannot pursue this improvement alone, but as part of the public health response to domestic violence, they must fulfill their important role if progress is to be achieved (Garcia-Moreno, Jansen, Ellsberg, Heise, Watts, 2005). CUHNHSFT provides institutional support, particularly in the form of a safeguarding midwife and an action plan for midwives. Progress has been made with the formation of these policies in accordance with the literature (Finnbogadóttir, Dykes, 2012) and recommendations of professional bodies, like the RCM. In addition, as midwives in this study indicated, support for routine screening and the resulting frequency of midwife questioning suggested improved midwife comfort in asking about abuse. However as indicated by the most recent audit and challenges identified in this study, more work is needed in addressing domestic violence and in further development of policy and practice to enable midwives to identify and respond to domestic violence.
III. Transnational comparison and interpretation of studies

a. Research questions based on mutual question

All three students translated the mutual research question we agreed on into several smaller questions. They shared the first research question which asked respondents about their experiences with identifying and responding to domestic violence. Next, both UIS & VUB students discuss the barriers respondents face and potential solutions, while the UCAM student first takes a closer look at how respondents represent the interaction with pregnant women experiencing domestic violence and afterwards discusses the barriers and how to overcome them.

Each student used a different approach to address the focus on migrant women. While the UCAM student dedicates a separate research question to women with insecure immigration status, the VUB and UIS students incorporated the issue in the barrier questions.

National differences, e.g. smaller amount of illegal migrants in Norway, have also influenced these choices. Since each study is conducted in a different country, different definitions of the involved concepts may be used. We agreed on using the definition the World Health Organization proposes when it comes to domestic violence, but ‘Immigrant’ is a vague concept which may contain different people due to different contexts (cfr. IIS in the UK). The UCAM student focuses on women with insecure immigration status (IIS) – including those who are migrant workers, have student visas or spousal visas - while the UIS student defined an immigrant as a person with two foreign-born parents who have immigrated to Norway and the VUB student ‘someone who leaves his country because of official or unofficial reasons to move to another country, as well as his/her children and grandchildren’. Another result of the different countries involved, is the choice of different respondents (midwives in UK and NO, gynecologists in B), which is explained beneath.

b. Method

All three students used a qualitative research design to answer the research question, which the UCAM student complemented with quantitative research and analysis. The UCAM student also organized micro focus groups in addition to the one-to-one interviews. Both UCAM & UIS students interviewed midwives. Midwives were chosen as interview subjects in the Norwegian context because “they have specialist expertise in antenatal maternity and postnatal care”, “offer a unique chance for identification of and intervention for domestic violence victims who are pregnant” and “provide the majority of care to pregnant women in Norway“(UIS). Likewise in the UK “[midwives] play a key role among the HCPs who provide care to pregnant women within the National Health System (NHS)” (UCAM). In Belgium this role is taken up by gynecologists, which is why the VUB student planned to interview 15-20 gynecologists. The UCAM student managed to reach 19 respondents (9 interviews and 3 focus groups) by using on-site and peer-to-peer recruitment. The UIS student had to change from the planned informant based sampling into to snowball sampling due to weak responses and recruited 5 respondents. The VUB student planned to use a phone book
as sample frame, but since she didn’t start her empirical research part, there are no results to report regarding the success of this model. The UIS student also interviewed some respondents by phone instead of face-to-face. In all three studies, the **confidentiality** of the conversations and **anonymity** of the participants was to be strictly respected and **ethical procedures** were to be followed in accordance with standards for research ethics. Moreover, approval was needed and obtained by the Norwegian Social Science Data Services (UIS) and in the UCAM case several documents were required, including approval from Ethical and Research & Development departments and a research passport to conduct research in NHS-facilities. Those approvals considerably slowed down the research process, which is challenging within the limited time span of a Masters degree. As mentioned above, the UCAM project was augmented by framing of the qualitative methodology with **quantitative data** that describe health care providers’ and patients’ interactions. Data was analyzed from the most recent Crime Survey for England and Wales, a face-to-face victimization survey regarding experiences and perceptions of crime in the preceding year, and a national or large scale survey that asks about abused women’s relationship with health care providers.

**c. Results**

*Several similarities emerge when comparing both study results, discussed beneath by theme. In general, the Cambridge study focuses more on solutions to overcome barriers, while the Stavanger study focuses more on the barriers as such, but this may be a result of the difference in respondent numbers.*

1. Health care during pregnancies (& role of routine questions in perinatal care)

Approximately 99% of **Belgian** women consult a gynecologist at least once during pregnancy. But only 7-8.4% of studied gynecologists screen each patient at least once during pregnancy and only if there is a conjecture about domestic violence, are patients then interviewed about it. A pregnancy is for most women the only period in life in which they are exposed to healthcare professionals on a regular basis, so **perinatal care** often is one of the few opportunities to detect the violence and to offer these women (and their children) the care and help they need.

**Antenatal care** in **Norway** has its own guidelines, for health care personnel providing perinatal care. It is a unique part of the health services, including all antenatal check-ups, measures and referrals that are required during a normal pregnancy. The guidelines are not obligatory, but are intended to achieve a safe and good quality prenatal service. The purpose is to reduce social inequalities in health, ensure that pregnancy and birth occur in a natural way and maximize mother’s physical and mental health, as well as her social wellbeing. The aim is to support both parents in a way that enables them to take good care of their child. Moreover, antenatal care aims at revealing risk factors for poor health in women and children and extra attention and care for people in high-risk groups is particularly important. Midwives and doctors generally provide antenatal care, therefore pregnant women can choose between them or combine both care services. The majority of care is provided by midwives, with 70% of pregnant women visiting them during pregnancy. Although every Norwegian municipality is required to have antenatal care available for all pregnant women, it is voluntary for women to choose to go to antenatal care. The recommended basic program consists of eight controls during pregnancy, an ultrasound and frequent check-up appointments after 40 weeks of
pregnancy. Antenatal care has the opportunity to offer women who need it more controls than those included in the basic program. The controls consist of physical examination, information and opportunities to discuss problems. Although in the guidelines stated by the ministry no routines have been implemented to ask questions about violence as part of antenatal care, midwives and doctors are expected to be aware of the problem, giving pregnant women an opportunity to disclose such issues and to get help. The guidelines recommend that health care providers communicate that violence is unacceptable and provide support to victims of violence. The antenatal care provider is expected to have knowledge of and the ability to refer to institutions providing aid to victims of domestic violence, in addition to helping them to contact those institutions.

The UK study mentions that health service utilization is highest during pregnancy and women’s reproductive years versus any other time. Pregnancy is an ideal time for health care workers to identify and work with women experiencing domestic violence because of the combination of increased risk for domestic violence during pregnancy and access to women at risk. In the UK, midwives play a key role among the health care providers who provide care to pregnant women within the National Health System (NHS). A pregnant woman has eight contact times and afterwards, the midwife comes home after they had a baby. Other HCPs come in contact with pregnant women experiencing domestic violence, including emergency care providers, general practitioners (GPs), and obstetrician/gynecologists. The Royal College of Midwives (RCM) and, in this study setting, Cambridge University Hospitals NHS Foundation Trust (CUHNHSFT) recommend routine screening to identify domestic violence, along with referral and support. But midwives in both the local and national context face recognized challenges in identification of and response to domestic violence.

A striking point of similarity is that – despite recommendations for routine questioning – HCPs often only inquire after the occurrence of domestic violence if they are concerned about the likelihood (UCAM) or if they assumed the pregnant woman was suffering from it (UIS).

2. Barriers to identifying & responding to domestic violence during pregnancy

Lack of time to deal with issues such as domestic violence and time pressure in the antenatal care as a whole are perceived as serious barriers. The UCAM study also mentions that the lack of time to spend on documentation or on the telephone is surmountable with extra effort, but that contributes to the passing of responsibility under logistical pressure. In order to bring up the topic, it was necessary that the pregnant woman felt she could trust the midwife, which takes time.

Another mutual barrier is family member presence during consultations, which makes it difficult to bring up the subject of domestic violence on the discussion. Due to the lack of routine arrangements to speak to women alone, midwives relied on the use of ingenuity, intuition and situational clues to identify women who needed to be asked and used informal strategies to question women, e.g. showing them to the toilet and asking at that time. They also linked partner presence at every clinic visit to concerns about controlling behavior. A striking point of similarity with the Norwegian study, where some midwives thought (immigrant) men came to consultancy regularly as a way of controlling and using violence against their partner.

The challenge of respecting the principles of confidentiality was mentioned in both studies. The
Norwegian midwives assumed that victims could prevent them from going further with their knowledge of abuse. Next to confidentiality, the UCAM study mentions patient's autonomy: having respect for a woman's complex situation and her autonomous decision making. Some British midwives use a confidentiality statement in appointments, allowing the woman to choose to disclose domestic violence in the knowledge that a midwife’s response might include other agencies. They state that this respect for autonomy contributes to a positive midwife-patient relationship and diffuses some of the burden of disclosure onto the women. These principles present a challenge, however, when respecting women’s autonomy comes into tension with providing care for mother and fetus. Respect for autonomy characterized midwives’ discussion of identification, while at the point of response a woman’s disclosure required midwives to violate confidentiality and autonomy. The fact the UCAM study dedicated a separated research question to the midwife-patient relationship may confirm that midwives perceive it as an important component of identifying and responding to domestic abuse and as a tool to overcome barriers. Challenges to the relationship were the reduction of home visits and elimination of “main” midwives assigned to be a pregnant woman’s primary care giver during pregnancy. This resulted in the lack of continuity of care and implied poorer midwife-patient relationships as a significant barrier to identifying and responding to domestic abuse.

Another challenge to the midwife-patient relationship is the discomfort of discussing domestic violence. Although both studies state that the universality of risk for domestic violence among pregnant women stimulated midwives to ask about domestic violence, they also reveal a clear taboo on the topic. In Norwegian society it appears to be an area of stigmatization and a sensitive issue to discuss in practice. Midwives are afraid to offend anyone by bringing it up. They perceive it as a personal issue or see pregnancy as a period where difficult things should not be focused on. The British midwives interviewed in Cambridge reported feeling uncomfortable when first starting to ask regularly, and some of them reported using tools such as having a set way of asking, including written phrases and using knowledge, to overcome their discomfort. However, midwives also described becoming habituated to asking through routine, suggesting that through familiarity and routine use of questions regarding domestic violence, discomfort can be reduced. Ultimately, routine screening and the resulting frequency of midwife questioning was seen as improving midwife comfort in asking about abuse.

When it comes to the perception of domestic violence, the Norwegian respondents stated that their definition of domestic violence sometimes differed from the one that immigrant women have (cfr. migrant section beneath). The UCAM study mentions that cultural differences in the identification of domestic violence presented a challenge, although midwives initially maintained that this did not constitute a barrier. Even with the services of an interpreter, complex situations were identified as emerging when cultural understandings of acceptable behavior abuse meant that a patient might not understand what the midwife meant with the usual approach to questions around domestic violence. Midwives reported desiring to use the same techniques regardless of cultural background, but truly communicating about domestic violence and sharing understanding provided significant challenges and required a different approach. They deal with this by asking more specifically and directly about domestic abuse, as well as describing what is meant specifically to the interpreter to ensure effective communication. Ultimately, midwives responded to the barriers of differing definitions of domestic abuse by utilizing training, patient education and resource provision. In this
case perceptions of role expectations and definitions of “what is a part of antenatal care” also are important. Norwegian midwives differed as to what extent they felt detecting violence and meeting the needs of victims of violence is a part of antenatal care. This might be a result in part of differences in ‘workplace cultures’: organizations might have dissimilar expectations on how to approach domestic violence, which has an effect on how midwives are trained or encouraged to perform routine screening.

Lack of knowledge and experience are stated as barriers to identify as well as to respond to domestic violence. Whether they ask questions about it or not, respondents find domestic violence difficult to detect and feel insecure on how to respond. This is related to the lack of routines and appropriate support for further referrals, which makes it difficult to decide what to do or where to go if they discover domestic violence. Since in Norwegian antenatal care both doctors and midwives are involved, the Norwegian midwives reported a blurred allocation of responsibility and uncertainty of roles. They lacked knowledge on how to help victims even though they were aware of institutions or services they could contact for a consultation or further reference. They still felt they lacked knowledge of domestic violence in general and lack of training on how to ask questions in particular. To negotiate these challenges, British midwives reported using CUHNHSFT guidelines, knowledge about domestic violence and other resources. Nevertheless, diversity of practice settings made identification and response more challenging in certain settings and the barriers sometimes resulted in further passing of responsibility to midwives in practice settings that were viewed as more appropriate. While having access to and knowledge of a clear referral pathway, British midwives experienced a challenge in the application of that pathway because of uncertainty related to the complexity of navigating practice within a policy setting, sometimes requiring effort outside of the stated pathway. They collaborated to establish confidence in their response and overcome uncertainty and discussed a challenge of collaborating with supplemental services available outside of the referral pathway. While working with a multi-disciplinary team presented a solution to service provision outside the scope of midwifery, it can also present a barrier when it is used as diffusion or shifting of responsibility. To end with, in cases of uncertainty regarding whether a disclosure or concern requires action on their part, midwives reflected that uncertainty and challenges in responding to domestic abuse were overcome by action because of fear for the woman reinforcing their duty of action.

3. (Im)migrant focus

As mentioned before, the UCAM study dedicates a separate research question to the immigrant focus, while the UIS student refers to it in each part of her results. To begin with, Norwegian midwives reported the organizational barrier of time pressure in particular in consultations with immigrant, refugees or other women facing problems with understanding or speaking Norwegian. In those consultations, extra time was needed in order to provide basic information and therefore there was less time to bring up topics as domestic violence with these women. Several midwives also expressed problems with translation and mistrust with the interpreter.

As a cultural/personal barrier, Norwegian midwives felt their domestic violence definition differed from the one that immigrant women have. They believed immigrants more often have a history with violence and therefore have developed a higher tolerance or acceptance for violence. Some also expressed their belief that immigrant women suffer more domestic violence than ethnic Norwegians.
and mentioned that immigrant men more often want to control their pregnant partner. Some midwives thought immigrant men came to consultancy regularly as a way of controlling and using violence against their partner. The UCAM study also links partner presence with controlling behavior, but without specific investigations of whether partners from immigrant or different ethnic backgrounds demonstrated controlling behaviour. Another theme that emerged regarding immigration and cross-cultural interaction was communication complexity (which partly coincides with the Norwegian barrier above). Cross-cultural interactions between midwives and pregnant women were represented as challenging and sometimes required midwives to depart from the usual pathway. Cultural differences in the identification of domestic violence also presented a challenge, although midwives initially maintained that it did or should not constitute a barrier (opposed to the Norwegian opinions above). Even with the services of an interpreter, complex situations were identified as emerging when cultural understandings of acceptable behavior and abuse meant that a patient might not understand what the midwife meant with the usual approach to questions around domestic violence. Midwives reported desiring to use the same techniques regardless of cultural background, but truly communicating about domestic violence and sharing understanding provided significant challenges and required a different approach.

Women with IIS were also represented as challenging because of lack of access to services (no recourse to public funds), although not frequently encountered. Most British midwives indicated that they would treat IIS women in a routine manner, but that immigration issues were outside of their role. However, some reported encountering significant challenges when trying to help patients with IIS and struggling to negotiate public and community services within her role. This highlights the barrier for midwives responding to domestic violence against women with IIS: referrals to social services are not likely to be successful because many women with IIS will struggle to access publicly-funded services as they officially have ‘no recourse to public funds’. While midwives described collaborating to find opportunities for aid, solutions for women with IIS were not easily found.

4. Policy recommendations

Although the UCAM recommendations are more concrete, some mutual topics can be recognized:

- Both encourage the implementation of screening as a tool to detect domestic violence.
- At least one meeting with the pregnant woman alone as part of antenatal care is suggested as a way to overcome the family presence barrier. In the UCAM study this is slightly different expressed by “Formalizing the requirement for each midwife consultation to contain designated time where the woman is seen alone as part of a routine visit”.
- Both studies suggest more knowledge of domestic violence through sharing of solution techniques and best practices at training events, to address midwife uncertainty. The Norwegian study adds more knowledge on cultural competence and how to improve working with minority women to this. Midwives need knowledge about violence and methods to screen and about how to assist patients who identify themselves as victims of domestic violence.
- In this respect and related to the ‘lack of continuity’, the studies suggest better formalised procedures after discovering domestic violence and on inter-institutional cooperation to identify violence and to meet the needs of victims. The UCAM study suggests incorporating a ‘named midwife’ and using a summary location in the electronic medical record to track how
many times routine screening has occurred.

- When it comes to the **immigrant focus**, the UIS study recommends more time to follow up with pregnant women from other cultural backgrounds, while the UCAM study focuses on working towards effective cross-cultural communication and the need for further research to understand the care challenges and solutions from the perspective of the women.
- To conclude, the results of the studies suggest better **resource availability**, which could help midwives more easily provide education and referrals, thus reducing barriers such as time required in response to domestic abuse. In this case, the Norwegian study mentions clarification of the responsibility /role of midwives versus doctors in antenatal care and the midwives’ access to information material on domestic violence which they can hand over to pregnant women.

Further research is needed to identify and evaluate solutions to barriers faced by health care providers in working with domestic abuse. Multiple training programmes (Price S, Barid K, Salmon D, 2007, 100-6; Feder G, Davies, Baird K et al., 2007, 100-6; Mezey G, Bacchus L, Haworth A, Bewley S, 2003, 744-52) have been evaluated, with results of varying effectiveness, to address barriers such as lack of comfort and knowledge, but these are not the only barriers to providing care and thus research is needed to support new policy and training programme development.
IV. Evaluation of the process

Considering the pilot character of this transnational science shop case, a thorough process evaluation is essential to be able to offer our own science shops and other science shop colleagues recommendations on how a similar project can be dealt with in the future. Supported by the evaluation forms of work package 9, we evaluated the process with all three science shops, supervisors, experts, students and CSOs. While using the evaluation forms of PERARES work package 9 gave a good first guidance, we realized that closed questions and quantitative data needed to be complemented with an extensive qualitative evaluation. Even more so, this qualitative evaluation part was the main theme of the third transnational workshop in Cambridge. The evaluation was classified into the following three subsections: CSOs about their involvement, the project as a pilot joint initiative and the experience of science shops as facilitators.

a. CSOs about their involvement on the information process and research agenda setting

1. Research theme/question
The Brussels science shop – established in 2002 – was part of the very first stage of the PERARES project in 2009. As the work packages were taking shape, the science shop was offered to closely involve one of their close CSOs in the preparations. The choice for Vzw Zijn was quickly made, as the CSO was involved since the creation of the science shop and has been cooperating in around a dozen science shop studies since then. At the time of the PERARES preparations, vzw Zijn was finishing a campaign on domestic violence and pregnancy and was eager to compare knowledge, good practices, and policy regulations with other European countries. Once proposed by the Brussels science shop and vzw Zijn, the topic also met with interest from new science shop-type structures at UCAM and UiS, and their partner CSOs in each case. That is why the topic of domestic violence and pregnancy rose from topic of a local campaign to main theme of a four year European project.

About this first involvement, vzw Zijn is very positive. Thanks to this opportunity they got to more or less ‘choose’ the topic. Since they normally focus on vulnerable groups of people within their campaigns, they proposed the migrant aspect, which made it through the research question. The research topic was defined in the PERARES Description of Work as domestic violence and pregnancy, including the migrant aspect. Afterwards, the other involved CSOs couldn’t influence those three aspects to a great extent.

During the first transnational workshop on the formulation of the research question, vzw Zijn could have their say and propose research questions that would be interesting for them as the only CSO involved in the project which does not provide a refuge for victims of domestic violence.

Stavanger shelter, on the contrary, expressed the feeling of being overlooked during the formulation of this research question. Their main objection was that the research question was too narrow, so that it would be difficult to find it relevant for midwives who participated in the study made by the Norwegian student. To acquire information from the informants, the student decided to have a broader perspective, and then use the agreed research question as a sub question, which choice the CSO supported. The cooperation between all the members during the next workshops was perceived
as good and to mutual benefit for all.

_Cambridge Women’s Aid_ also found it useful to be involved in an academic study around the topic of domestic violence and pregnancy since there were many aspects of it they had questions about. In their opinion, the original focus on pregnant women in general became a bit cluttered afterwards, because additional aspects had to be included including the focus on migrant women. With the subsidiary focus on migrant women, they thought the research question would be better suited for a PhD-research study since it seemed too ambitious for a Masters student.

2. Student interaction

Once a student was recruited and the Brussels study had officially started, the involvement of _vzw Zijn_ decreased. The student didn’t communicate often with them and gradually also their campaign priorities changed. The CSO would have liked more interaction with the student about literature, contacts, research methods and target research outcomes. When the student left the project, _vzw Zijn_ wasn’t informed by her about this. Nevertheless, they still are interested in the study results, in order to try to adapt those to the Flemish situation, and to formulate policy recommendations.

Also in _Stavanger_, there was no student interaction with the CSO during the study. They only met once when the study was finished. The starting science shop acted as the intervening party between both. This may be partly caused by the fact that the student lived in another city - she also only communicated with her supervisor by e-mail. Maybe the student felt that no contact was necessary in the frame of the study, because she needed to get in touch with professionals instead of women in the shelter. However, two previous UIS students (Jensen, 2011; Sunde, 2011) who were studying topics related to domestic violence already had been interacting regularly with the CSO.

The _Cambridge_ shelter met the UCAM student before she started to work, which was useful, and the CSO provided introductions to the specialist midwife for safeguarding at the maternity hospital. But once the student had started, there wasn’t any contact anymore. The CSO reports that it would have been nice to have more contact because there were some things in the study they would suggest amending from their point of view.

To conclude with a recommendation: at the very first beginning of a science shop case, all parties should have to set out expectations of what students, supervisors, science shop staff and CSOs will do for their part of the project. For example, CSOs should emphasize they are willing to help students during the research. In this way, students are encouraged to contact them regularly.

3. Cooperation with the other CSOs

All CSOs state that the PERARES project has been a great opportunity, concerning the results of the studies, but also the cooperation with other CSOs and the forthcoming informal contacts. On the other hand, all three would have liked to spend more time together with the others to exchange information and good practices.

The Stavanger and Cambridge shelters were in contact from the beginning and keep on communicating and exchanging, even beyond the scope of PERARES, e.g. about checklists to use with clients regarding different types of violence, codes of conduct within the shelters. Since the Brussels CSO missed some transnational meetings, they had less contact with the others, which they
regret because it could have been useful. In their opinion new international contacts can be great added benefits from an international project, also to maintain after a project, in case of future collaboration or funding opportunities as well. Related to this, vzw Zijn also appreciates the example of the online debate as a very good new networking place for people working around similar topic, wherever they are in the world.

4. Cooperation with science shops and universities
In spite of their former close connection, vzw Zijn had difficulties with the cooperation with VUB in this transnational case. The first science shop contact person at the university had many tasks next to the PERARES work, which caused a work overload. Therefore, the start of the project was delayed and it was hard to follow it up on a frequent basis. During this delay the priorities of vzw Zijn changed and the focus on domestic violence and pregnancy shifted to a new campaign theme. Towards the end of the project, they report it would have been a better idea to have chosen a topic they weren’t working on yet due to the time the process has taken for students to start producing research results. Because of all this, they had less involvement than the other CSOs.

In the opinion of the Stavanger shelter, UiS included them from the start and has managed to communicate all required information during the project. The shelter being a member of the Stavanger science shop advisory board has proved to be a good experience and has made the contact with the university necessary on a regular basis. Likewise, Cambridge shelter is very positive about the contact with UCAM. Since they already knew the science shop staff and trusted them, they were open to the idea of collaborating in this transnational case. Since the time and resources of a CSO are limited, they express the need to know it is likely to be worthwhile in advance.

All three CSOs consider that a science shop-like collaboration relies on personalities, finding a good fit between people and respect between partners. Despite the successes, they mention that CSOs and universities operate in different worlds, using different languages, which is why it is important to spend time communicating with one another to get on the same track.

5. Results/usefulness
All three CSOs think that this pilot gave them a lot of useful information. They consider it very useful to hear about experiences of the midwives and to get to know which processes are efficient and which are not. E.g. what do questionnaires look like for women who enter the hospital after potentially having experienced domestic violence during pregnancy? How effective are they and what could be changed? CSOs can adapt the results to their local situations and might formulate resulting policy recommendations. Likewise, the online debate on domestic violence offered interesting information, e.g. links, research questions, literature, sources, and completed studies.

The Stavanger shelter has already used the student’s study results to inform other HCPs about domestic violence and pregnancy. The Cambridge shelter on the other hand will place more focus on the topic of barriers and how to remove them since the studies have given them more insight into these barriers. They will also clarify their confidentiality policy with midwives, and what they will do with sensitive information that women give them.

The fact that the studies of Cambridge and Norway are focused on midwives, compared to gynecologists in Flanders, confirmed the already existing belief of vzw Zijn that the role of Belgian
midwives should be extended, so they can be more supportive for women during their pregnancy. Nowadays, a midwife in Belgium has mostly nursing responsibilities, but this role is changing towards a more wide-ranging one. It seems to be the case that if workshops about domestic violence and pregnancy are held, midwives are willing to come, while gynecologists don’t have the time to do so.

In conclusion, the findings from the studies have made the CSOs aware of the fact that they can communicate in different ways with healthcare providers and the process has opened doors regarding working with universities and students. In addition, CSOs have exchanged experiences with each other, both regarding service provision and campaigning.

b. The project as a pilot joint initiative

1. Difficulties and challenges

During the first workshop – which focused on the formulation of a mutual research question – the first challenges of this transnational case became clear. Before that point, local parties (CSO, supervisor and science shop) had been discussing and developing several possible areas of focus for research, research designs etc. At the first meeting, people met and ideas were shared and the process was started to bring together local knowledge, partnerships and capacities. Immediately, a few differences came to the surface, which continued to have an effect during the studies. Many of those were related to contextual differences in the three countries.

2. Contextual differences

a) Different types and sizes of CSOs

All CSOs were attracted because of their interest in the topic of domestic violence and pregnancy, but without taking into account the kind and size of the CSOs. While the Cambridge and Stavanger CSOs are shelters, the goal of the Brussels one is prevention by running awareness campaigns of kinds of violence. Vzw Zijn moved on to new awareness campaigns, after earlier campaigns on domestic violence and pregnancy, already mentioned above. Furthermore, the CSOs differ in size. While in vzw Zijn only two fulltime equivalent (FTE) is working, the shelters are broader staffed: the Stavanger one with seventeen FTE, the Cambridge one with seven and a half FTE. This might have influenced the amount of time and work the CSOs could spend on the case.

b) Differences in Masters programmes structures

Since all students were studying at different institutions following different Masters programmes, their study programmes and the time and attention they could donate to their Masters study differed. To allow the students the independence necessary at Masters level, and to take account of different health care and immigration contexts, a mutual research design was not specified. The process also had to allow for different research time schemes in each context, according to the timelines of each Masters programme and the deadlines they had to meet. Furthermore, for all science shops, recruiting students was relatively challenging.

Even though we hoped the three students would share knowledge, references and experiences with each other, they did not make contact. Nevertheless they did have each other’s contact details and were encouraged to do make contact if they would find it useful. Due to our decision to let them
choose their own research methods, we could have expected they would not need to make contact initially. It was not essential in this case, but it could be necessary for a larger project. Not all students were able to join the group at the transnational meetings, due to personal, family or work situations and due to the timeframes of the Masters theses set by their universities already mentioned above. To conclude, to involve all students and let them meet each other and the other partners might be quite challenging in future similar transnational cases too. If it had been an essential part of this project, the science shop staff would have needed to set up Skype or video-conference sessions to provide the clear opportunity for the students to interact, and could have suggested an agenda for a virtual meeting, possibly one which involved CSOs too. The UCAM student joined the transnational workshop in Norway by Skype which provided an opportunity for her to discuss the findings of her study with researchers and a CSO representative from Stavanger.

c) Differences in antenatal care and studying it

Practices differ when it comes to the service delivered to pregnant women in the three countries. As we have mentioned in the first part, the main antenatal care to pregnant women is offered by gynaecologists and/or midwives, depending on the country.

The differences mentioned above raised questions considering the respondents and the (mutual) research design. For example, the CSOs were interested in the possibility of interviews being carried out with women facing domestic violence during pregnancy but since this is difficult for students at Masters level in the Belgian higher education context, another plan was necessary. Also ethical procedures required for interviewing respondents caused some delays and differences in research approaches. In order to interview HCPs, students also need ethics committee approval. Due to the complexities of carrying out research within the National Health Service in the UK, for the UCAM student there was a lot of time pressure due to the ethical approval procedures of the NHS combined with the research approval processes of the University.

So, many differences had to do with national contextual differences. We concluded during the evaluation meeting that a comparative study would require a Masters or PhD student or researcher/research team based at one university surveying three different national contexts and carrying out research. On the other hand, it was important that each study was relevant in its own national context, to be useful for CSOs and other partners. It was still possible to draw some points of comparison between the findings of the three studies carried out, regarding barriers to identification of domestic violence during pregnancy, and recommendations for how these can be overcome.

3. Benefits

From a number of different points of view and for several reasons, the transnational science shop case provided a great opportunity and achieved several positive outcomes.

CSOs could influence the eventual transnational research question, came in contact with international colleagues, became acquainted with and learned from the good practices in the resulting studies which may help their own work, and were part of the dissemination and in this way are part of a bigger research agenda. In the new science shops of both Stavanger and Cambridge
they also had the opportunity to start up a (possible long term) relationship with the university. The positive interactions between the science shops in Brussels, Cambridge and Stavanger could also form the start of a long-term cooperation between universities and CSOs on this topic, both nationally and internationally.

*Masters students* got the chance to participate in a European project which contributed to their communication and research skills and in that way also their curriculum vitae. They had a chance to reflect on studies being carried out at other universities, and to explore key European research questions regarding domestic violence as well as receiving support from the WP5 group and opportunities to present at international conferences and workshops.

Both new and experienced *science shops* could share good practices and learn from each other. In contrast with traditional local science shop cases, they could share experiences with and ask advice from colleagues, e.g. in recruiting students, handling ethical procedures etc. This case could also lead to a renewed and stronger cooperation with the involved local CSO and/or the involved supervisor and might lead to more promotion of their work. One main condition for all this is that science shops should communicate clearly about their role as a mediator between all parties.

The Cambridge *supervisor* considered supervising the project to be among the best opportunities she had had to be involved in qualitative research in the health service. The project also benefited from the advice of an experienced PhD student, Halliki Voolma, who was studying European policies relating to domestic violence and immigration, building on her previous research with Cambridge Women’s Aid, which came about through the Cambridge Community Knowledge Exchange. Likewise, the Stavanger supervisor took advantage of the pilot to get in touch with national and international CSOs and colleagues, but since she was also a science shop staff member, she could take double advantage of it. As a supervisor and lecturer in social work, she is more closely connected to the topic than the other science shop staff members and the contacts and studies were in this way also useful for her courses.

### c. The experience of the Science Shops as facilitators

During the process science shops were cooperating in two ways: both on a national and an international base. The national cooperation - which is the usual science shop process - occurred between CSO, student and supervisor. The international cooperation – which is the new/pilot aspect - between all partners in the three countries took place in the beginning, while searching for common research needs and the framing of the research question, and at the end, while disseminating the study results and during the preparations for this final report.

This process was led by an experienced science shop (B) and supported by two starting shops (NO & UK). The double goal was to end the process with this project having contributed towards the set-up of three shops established at the three universities, and a maximum application of the recommendations formulated in the study of domestic violence and pregnancy. When it comes to the science shop learning process, this was certainly successful. The three science shops communicated well about their way of work and difficulties they and their students faced during the different stages of the case: finding literature, recruiting students, overcoming ethical procedures,
recruiting respondents etc. Although the Brussels science shop was the only already established science shop, they experienced this communication and cooperation as very helpful. Since the Flemish science shops sometimes have to re-state the case for their support in order to continue operating in Flanders, having colleagues that acted as sounding boards and learning from other science shops dealing with similar difficulties felt very supporting.

At the start of this work package, in May 2010, Stavanger University did not have an existing science shop at all. In fact, parallel with working with the objective of WP5, they have been trying to set up a science shop. Therefore, in this project there has been no support from a science shop, but the member of the PERARES group have altered the roles in order to proceed and succeed with the project. This led to the fact that a science shop staff member also fulfilled the role of supervisor the student, which had the advantage that she could directly be in touch with both student and CSO.

Cambridge had been operating the Cambridge Community Knowledge Exchange since 2008, a science shop-like structure, brokering a few student research projects each year with local CSOs, in consultation with academic supervisors. They consider this project to have been helpful in developing the expertise of science shop mediating staff in framing research questions, maintaining ongoing relationship with CSOs locally and learning from international colleagues.

d. Why some studies did not work out as we hoped they would: Science shop risk assessment

During this cooperation, all science shops faced several risks of student research and specifically science shop research. In order to turn the drop out of the Brussels student and other difficulties into an experience which we can learn from, we evaluated the case thoroughly.

First of all, science shop cases are characterized by modest financing. In all three cases the supervisors knew the science shop way of work and even appreciated the ‘free’ aspect of student research. But since there wasn’t any researcher at the VUB with expertise in the domain of domestic violence and pregnancy, in this specific case a PhD-student doing research on the topic was attracted from another university. Since she was used to getting paid for her input into European projects and had many other tasks, she expected to be paid for supervising the student. So, VUB was the official PERARES partner paid in the project, while another university was supervising, which was a difficult situation. In this specific case the conflict of universities thus was a threshold, also for the student, who had to communicate with several parties. At UCAM, the supervisors were found within the University of Cambridge, and modest funds available through PERARES assisted the student with transcription expenses from interviews, a lunch for midwives, and travel for the student and advisor to international conferences. At UIS, all Masters-supervisors are founded by the university.

Since Masters students are not paid for their dissertation and they don’t sign a contract that obligates them to produce a certain result, a finished result of good quality unfortunately cannot be guaranteed. As a mediating mechanism the science shop tries to support the student as much as possible, but sometimes neither science shop nor supervisor can prevent students leaving their studies. In the Brussels case this was probably caused by the overload of work that goes with being a
working student and perhaps also the pressure to achieve she experienced from being engaged in this transnational study.

Another science shop risk factor is the **search for a suited and motivated student** once a research question is formulated. The *Brussels* science shop finally succeeded in recruiting a Masters student after a large-scale promotion campaign, in which the supervisor strongly was involved. But after a few months, it became clear that the first student found was mainly urgently looking for a topic because she didn’t pass her previous Masters thesis. She lacked motivation, left her studies and the science shop was forced to start a new recruiting mission. The second student already had a Masters’s degree and was working in the domain of violence so seemed to have the right motivation, but also left her studies, see above. Likewise, the *Stavanger* science shop found it time-consuming to recruit students for this project, among other things because Norwegian Masters students often work while being part time students. Masters students reported to be worried that involvement in this project would require extra effort and time, which made them hesitate about participating. In fact, the recruitment of the actual student was done by the science shop internet site. Hence the student that took on the research question was not a part of the project when the pilot was developed, she was included at a later stage. In Cambridge, the process of recruiting a student worked well. The science shop staff appreciated the brainstorming at the second transnational workshop which identified that a Masters student in Public Health might be particularly well suited to the project, (previously there had been more contacts for science shop projects in Sociology, and no previous science shop project with Public Health). The course director for the MPhil in Public Health, Dr Oscar Franco, was receptive to the idea of the research question. He put the science shop co-ordinator in touch with the first supervisor, Dr Felix Naughton, and they found the second supervisor, Dr Emily Taylor. There was discussion between the supervisors and science shop co-ordinator about the comparatively small number of Masters students in Public Health who carry out qualitative research, but a very good student was found, and a supervisor with experience of supervising qualitative research – it was also suggested that the student included a quantitative portion in her research, which she did.

**Staff changes**, another risk of science shop studies, didn’t facilitate this project either. Luckily the three CSO partners didn’t change during the whole project. As a matter of fact, the most prominent staff change occurred in a science shop itself. The Brussels science shop staff member left the VUB and the PERARES project in March 2012. Other VUB PERARES members tried to replace her as well as they could, but since they also had to take over the non-PERARES tasks of their former colleague, this replacement could have been insufficient in the beginning. Both the Cambridge and Stavanger science shops also had to deal with staff changes, but fortunately this occurred in a later phase, when the research process and the reporting were finished.
V. Dissemination and Impact Assessment

Dissemination of the results of WP5 began in May 2011, prior to the completion of the students’ research projects, and these results have continued to be shared through both national and transnational platforms. Because of the close involvement of CSOs and other national partners, and a range of opportunities to discuss research topics throughout the delivery of WP5, there has also been some impact via CSO partners already, in addition to the dissemination of the research that has occurred. The maximal application of recommendations formulated in the studies will take place when further plans for dissemination have been carried out.

a. Dissemination - Transnational

Prior to the completion of WP5, results have been disseminated in the following transnational contexts:


- A summary of the objectives and methods of WP5 is available on the Living Knowledge website (last updated 11/9/12): http://www.livingknowledge.org/livingknowledge/perares/perares-work-packages-at-a-glance

- “Setting shared research agendas by CSO’s and research institutes: a case study on connecting CSO’s and researchers through science shops on the topic of domestic violence and pregnancy.” Nicola Buckley, Halliki Voolma, Nicole Person-Rennell, University of Cambridge, UK; Jozefien De Marrée, University of Brussels, Belgium; Prof. Ingunn Studsrød and Prof. Elisabeth Willumsen, University of Stavanger, Norway. Paper and workshop presented at the 5th international Living Knowledge conference, 11 May 2012, Bonn, Germany.
• “PERARES Transnational Online Debate – Domestic Violence,” July-August 2012. Discussion was moderated by the science shop from University of Cambridge, with a starting text written by Vrije Universiteit Brussel and engaged 17 online participants, including 9 CSO representatives, 3 researchers and 3 unaffiliated members of the public who did not claim an affiliation, in addition to 2 science shop staff who participated. 38 research questions were suggested in the context of this discussion which will be summarised by theme and shared with science shop partners as proposed science shop projects. [http://www.livingknowledge.org/discussion/diskutiere/2012/domestic-violence/](http://www.livingknowledge.org/discussion/diskutiere/2012/domestic-violence/)

• “Setting internationally shared research agendas by CSO’s and research institutes through a science shop case.” Jozefien De Marrée and Audrey Van Scharen, University of Brussels; Halliki Voolma, University of Cambridge; Global University Network for Innovation (GUNI) 6th International Barcelona Conference on Higher Education, 13-15 May 2013, Barcelona, Spain.

**Future plans for dissemination on the transnational level include the following:**

- The European commission has shown interest in the results of this study. By addressing several contacts we hope to provide inspiration for possible future calls in HORIZON 2020 based on the conclusions and the recommendations of this WP, in order to make progress toward the ultimate goal of the PERARES project: influence research agenda’s through community based research.
- At the last transnational meeting, we considered writing an academic journal article on the basis of the research conducted. This discussion will continue over summer 2013. A potential venue for this article may be Journal of Comparative Social Work ([http://jcsw.no/](http://jcsw.no/)), an Open Access journal that publishes peer reviewed scientific articles related to comparative social work.

**b. Dissemination - National**

Plans for dissemination on the national level are as follows and, in the case of Norway and the UK dissemination of results has already begun. In each context, results of both the science shop process and the content of the domestic violence research are being shared. Each national partner takes the responsibility for identifying stakeholders in their own contexts with whom to share the results of the study, both those interested in the science shop process (i.e., the method of working) and those interested in domestic violence and pregnancy (i.e., the topic and its implications for services and policy).

**Belgium**

While the study in Brussels has been postponed, there are plans for this study to be completed in 2014. The former student has restarted and is doing research on the same topic, supervised by the same supervisor, together with another Masters student who has already obtained a midwifery
degree.

The CSO partner vzw Zijn maintains a website dedicated to campaigning for domestic violence and pregnancy (http://www.geweldenzwangerschap.be/) where the results of the VUB research and the WP5 study will be shared, in order to raise awareness of this issue among policymakers and to lobby for expanding the role of midwives in domestic violence interventions.

Norway

In Stavanger a debate over domestic violence was organized in Folken, the town’s main cultural venue for students. Around 90 people filled the floor for the debate. The audience included a wide range of social workers, students, university lecturers and members of the immigrant community.

On stage was psychologist Yalila Castro Guerrero from the NGO Alternative to Violence in Oslo, politician and ex-refugee worker Ali Mubarak, Stavanger Shelter leader (and PERARES member) Monica Monsen and Ingunn Studsrød from UIS. Editor for Culture and Debate at the regional newspaper Stavanger Aftenblad was Masters of ceremonies for the evening. The PERARES group at the University of Stavanger saw this event as yet another way of reaching out to the public with our activities, engaging them and providing meeting places for university staff, students, NGOs and public service workers.

Before the debate, a newspaper/feature article was broadcasted in Stavanger Aftenblad (9.10.2012) entitled: Are minority children in particular exposed to domestic violence? (Er minoritetsbarn særlig utsatt for vold?)

There are also plans to publish an academic publication and chapters in books in Norway, and the results of Oddny Karin Sundes study, as well as the two other Masters thesis studies of domestic violence are shared on the UIS internet (http://www.uis.no/samfunnskontakt/samarbeid/forskningstorget/utfoerte-prosjekter/?s=10366) and all of them is available in the UIS library. In terms of dissemination through CSOs, the staff participant from Stavanger Kommune is in discussion with the CSO partner from Cambridge about writing an article together. Results from the study have also been shared on the Stavanger Kommune Facebook page https://www.facebook.com/krisesenteret.i.stavanger

UK

The results from research carried out in Cambridge is available on the science shop website http://www.cam.ac.uk/public-engagement/voluntary-sector/community-knowledge-exchange and the science shop will continue to work with the student to disseminate her research to contacts in CUHNHSFT as well as to other colleagues in public health and midwifery.

Through the online debates about domestic violence in July-August 2012, a research question was proposed by the Cambridge CSO partner Cambridge Women’s Aid, which was taken up as a science shop project and is now being carried out by a third year undergraduate student who is currently working with CWA to do research for her dissertation.

There are plans to engage with the national Women’s Aid organization to build awareness of the
possibilities for future science shop type projects.

c. Impact - Transnational

The CSO partners in Stavanger (Stavanger Kommune) and Cambridge (Cambridge Women’s Aid), both of which offer a refuge as their main service, also reported that, because of their involvement in WP5, they were able to develop a useful connection and to compare and collaborate on aspects of their work. Cambridge Women’s Aid stated that, in the future, development of their services might imitate aspects of the Stavanger shelter in expanding their services to support women in school and at work.

The social work professor supervising the science shop project in Stavanger reported that there were benefits to her as a teacher in working with the CSO partners and incorporating the resources they shared with project partners.

To maximize transnational impact from the online debate, other questions from the discussion will be summarized and sent to all three partners to propose as science shop projects. Further impacts will be determined following from the dissemination of the research through national and transnational channels (see ‘Dissemination’ section, above).

d. Impact – National

Early impact has been achieved through the sharing of resources (e.g., brochures and other literature) among CSO partners who were brought into dialogue through WP5.

In Brussels, this took the form of dissemination on vzw Zijn’s website dedicated to domestic violence, as detailed above. The fact that the studies of Cambridge and Norway were focused on midwives, compared to gynecologists in Flanders, confirmed the already existing belief of vzw Zijn that the role of Belgian midwives should be extended towards the role they have in countries as the United Kingdom and Norway. Vzw Zijn is thinking about using the study results and the experiences of the other CSOs to formulate policy recommendations on this extension.

In Cambridge, CWA was able to identify areas for improving communications around domestic violence services. They stated that the research was useful for identifying barriers to disclosure of domestic violence, and showing the importance of giving women more opportunities to disclose domestic violence. For example, as a result of the study CWA thought that they could emphasise to midwives that they could say to a women who may have been a victim of domestic violence that they could refer them to CWA without the woman having to disclose domestic violence to the midwife. Although disclosure of domestic violence could make women worry about children being taken into care, CWA have much experience in helping victims of domestic violence when they are ready to talk about the details, and discussing with them what will happen when they disclose information.

Because the student worked with midwives at Cambridge University Hospitals on her public health MPhil project, there was also an opportunity for CWA to build on their contacts with the Named Midwife for Safeguarding at Cambridge University Hospitals NHS Foundation Trust. CWA stated that
the project would give them further material to consider in their own work and more to feed back to CUHNHSFT in the future. The science shop staff plan to continue liaising with the Cambridge student who has now graduated to see if they can offer assistance in writing summaries of research to be shared in the CUHNHSFT maternity magazine.

Through the online debates, a research question was proposed by CWA which was taken up as a science shop project in Cambridge, and is now being carried out by a third year undergraduate student who is currently working with CWA to do research for her dissertation.

At present, the impact at national Norwegian level based on this project is rather unknown. Nevertheless through publicizing the findings, highlighting the issues in teaching, and through debates, and newspapers, as well as in local and national meetings, they hope to attract interest of the findings and motivation to improvements in antenatal care as well as other care services for pregnant women exposed to domestic violence.
VI. Conclusion

In the view of the participating partners PERARES’ work package 5 “Structuring PER in Research on Domestic Violence” achieved the goals set by the Description of Work.

CSOs and research bodies from three different countries were actively engaged, facilitated through and managed by science shops. All partners have taken advantage of these contacts, both in a national and transnational context. Through the work of the researchers, CSOs have gathered information to improve the well-being of pregnant women facing domestic violence, with a special focus on immigrant women within that group. Moreover, public stakeholders and CSOs could (indirectly) influence the research agenda both by the comparative study and the online debate on the topic of domestic violence. The data and recommendations in this and following studies could be useful for policymakers regarding research agendas on a national and European level. On the other hand, science shops were able to evaluate/monitor the process of engagement between CSOs and researchers, to obtain recommendations for good practice for this kind of engagement, and to gain important information on the involvement and influence of CSOs in research (and research agendas). Furthermore they were happy to exchange good practices and other experiences with international science shop colleagues.
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