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Men's Violence against Women – a Challenge in Antenatal Care

BY

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Abstract

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Men's violence against women is a universal issue affecting health, human rights and gender-equality. In pregnancy, violence is a risk for both the mother and her unborn child.

The overall aims were: to determine the prevalence of such violence in a Swedish pregnant population, to investigate pregnant women's attitudes to questioning about exposure to violence, and to evaluate experience gained by antenatal care midwives having routinely questioned pregnant women regarding violence.

All women registered for antenatal care in Uppsala, Sweden, during 6 months were assessed regarding acts of violence. The Abuse Assessment Screen (AAS) was used twice during pregnancy and again after delivery when the women were asked an open-ended written question regarding attitudes to questioning about violence. Midwives' experiences regarding routine assessment were evaluated in focus group discussions.

The AAS questions were answered by 93% (1,038) of those eligible. Physical abuse by a partner or relative during or shortly after pregnancy was reported by 1.3%, and by 2.8% when the year preceding pregnancy was included. Lifetime sexual abuse was reported by 8.1%. Repeated questioning increased the abuse detection rate. Abused women reported more previous ill-health, and women physically abused during pregnancy more pregnancy terminations than did non-abused women. Abuse assessment was found entirely acceptable by 80%, both acceptable and unacceptable/disagreeable by 5% and solely unacceptable/disagreeable by 3%, while 12% were neutral. Abused and non-abused women did not differ regarding disinclination to answer the abuse questions. According to the midwives the delicacy of the subject and the male partners' presence were the most prominent remaining obstacles to routine determination of violence.

Routines are required to make questioning about violence an integral part of antenatal care. This would necessitate a private appointment for the woman, knowledge among care providers about the nature of men's violence, and awareness of referral options.

Keywords: physical abuse, sexual abuse, prevalence, assessment, pregnancy, antenatal care, attitudes, nurse- midwife, public health practice, induced abortion, nurse-patient relation

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List of Papers

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals.

- I. Stenson, K., Heimer, G., Lundh, C., Nordström, M-L., Saarinen, H., Wenker, A. (2001) The prevalence of violence investigated in a pregnant population in Sweden. *J Psychosom Obstet Gynecol*, 22: 189-97
- II. Stenson, K., Heimer, G., Lundh, C., Nordström, M-L., Saarinen, H., Wenker, A. (2003) Lifetime prevalence of sexual abuse in a Swedish pregnant population. *Acta Obstet Gynecol Scand*, 82: 529-536
- III. Stenson, K., Saarinen, H., Heimer, G., Sidenvall, B. (2001) Women's attitudes to being asked about exposure to violence.. *Midwifery*, 17: 2-10
- IV. Stenson, K., Sidenvall, B., Heimer, G. Routine antenatal questioning regarding men's violence against women. Midwives' experiences and practice. (submitted)

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Abbreviations

AAS	Abuse Assessment Screen
CI	Confidence interval
CSA	Child Sexual Abuse
CTS	Conflict Tactic Scale
DAS	Danger Assessment Screen
ISA	Index of Spouse Abuse
LBW	Low Birth Weight
LSA	Lifetime Sexual Abuse
SA	Sexual Abuse
SVAW	Severity of Violence Against Women Scale

Introduction

Men's violence against women and girls, in its various forms, is endemic in communities and countries around the world, cutting across class, race, age, and religious and national boundaries¹. Such violence has become increasingly recognized as a global health and human rights issue and as a serious obstacle to the achievement of gender equality². In 1993, the United Nations General Assembly defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life"³. Men's violence against women could be summarized as *sexualized violence*, a comprehensive term for physical and emotional abuse of women, sexual abuse of both adults and children, violent pornography, and prostitution⁴. Such violence implies and sustains a disparity in power between perpetrator and victim, being perpetrated mostly by a current or former male partner, a relative, or an acquaintance. These gender aspects are not explicit in frequently used concepts such as 'intimate partner violence', 'spouse abuse', and 'domestic violence'.

The boundaries between actions such as threats and emotional, physical, and sexual abuse are fluid and the actions merge into one another⁵. A particular assault could include various forms of violence; e.g. a sexual assault might involve physical violence and threats. The common denominator is that the abuse is committed by men on women and that women are negatively affected. Hence, sexualized violence can be described as a continuum. The idea of violence as a continuum means that all manifestations of violence against women are interlinked and are to be understood as serious⁵. In this thesis, mainly prevalence of physical violence by a partner, a former partner or a relative and sexual violence by any perpetrator were studied. Nevertheless, it is important to keep in mind the understanding that different manifestations of violence are interrelated.

General introduction

Men's violence against women within intimate relationships

Violence by a male partner occurs mostly in a context of male power and control. The gaining of control on the man's part is a process whereby the woman is gradually isolated and forced into a submissive situation⁶. This process is described as the *normalization of violence*⁷. The violence is particularly serious, as it tends to be recurrent and to become more gross with time. It is usually perpetrated within the privacy of the home with no witnesses except possibly for children. The violence has prompted comparisons to torture as the assaults are often unpredictable for the victim, bearing little relation to the woman's own behaviour. The man who hurts the woman, threatens and humiliates her, may nevertheless be the one who dresses her wounds, comforts her and is compassionate. Even so he will probably not admit responsibility for the violence, but blame the woman. These shifts between violence and warmth are confusing to the woman and cause emotional ties to the perpetrator^{2,7,8}.

Many abused women leave their abusers but there are many barriers for women to leaving. Reasons for staying could be shame and self-blaming, denial, feelings of being under an obligation to keep the family together, concern for children, fear of reprisals, emotional, practical and pecuniary dependence, lack of support from family or society, and hope that the man will change for the better. To leave an abusive relationship is a process rather than an isolated incident^{9,10}. Ending the relationship does not necessarily end the violence, as some partners become even more violent when the woman attempts to leave¹¹.

From the private to the public domain

In privacy, violence against women has a long history. The growing public awareness of the problem is largely a result of the women's rights movement since the 1970s, one concrete result of which was the founding of 'women's shelters' to offer physical and moral support to abused women. In Sweden, violence against women is now regarded as a public concern and as a problem in which State organs should intervene. This can be seen in legislation and other political decisions¹².

Some milestones in Sweden ^{12,13,14}

- 1864 The husband's right to use corporal punishment against his wife, rescinded.
- 1937 Criminal responsibility for the *victim* of incest, rescinded.
- 1965 Rape in marriage, proscribed.
- 1982 The rules concerning prosecution for battery and rape amended so that prosecution is no longer dependent on an accusation being made by the plaintiff. Anyone with knowledge of such an offence can report it to the police, signifying that such offences are not a private matter between the parties involved.
- 1988 Law regarding Restraining Orders inserted into the Penal Code. Injured Party's Counsel Act, introduced. The victim is entitled to free legal counsel during police investigation and trial.
- 1993 The Government appointed an official commission with the mandate to investigate circumstances of sexual violence from a female point of view, to suggest interventions to prevent violence and to alleviate the consequences of the violence.
- 1994 A National Center for Raped and Battered Women, instituted.
- 1998 The Government's Bill for Action Against Violence Against Women, presented. A new offence 'Gross violation of a woman's integrity' introduced into the Penal Code.
- 2003 Law regarding Restraining Orders made more rigorous to include the home in cases when the parties are cohabitant.

One important step to increase the competence in health care regarding violence against women was the setting up in 1994 of The National Center for Raped and Battered Women, in Uppsala. The main tasks in the Government's instructions to the Center were:

- ◆ to undertake medical examinations and to provide treatment and support on a round-the-clock basis to women victims of violence. This includes devising practical ways and means by which the National Health Services receive women victims of violence and serves as a national resource in these matters
- ◆ to provide information and education to the medical services and general public
- ◆ to initiate research within the medical services and on an interdisciplinary basis

Another important step was the insertion into the Penal Code of the offence 'Gross violation of a woman's integrity' dealing with repeated, punishable acts directed by a man against a woman having a close relationship with the perpetrator. In short, gross violation of a woman's integrity means the following: If a man repeatedly commits certain criminal acts (assault, unlawful threat or coercion, sexual or other molestation, sexual exploitation, etc) against a woman with whom he is or has been married to or with whom he is or has been cohabiting, he shall be prosecuted for gross violation of the woman's integrity, instead of for the crime that each of the acts constitutes.

Amending the law or introducing new ones is not enough, however. The legislation has to be implemented. For this purpose, the Government's Bill for Action Against Violence Against Women was presented in 1998. The National Police Board, the National Courts Administration, the Prosecutor-General, the National Board of Health and Welfare, and other state bodies were instructed to institute appropriate measures on issues concerning violence against women. They were instructed to increase their efforts to prevent violence against women. The need for co-operation between public authorities and voluntary organizations was emphasized. Education to enhance competence in the area of gender equality and violence against women was looked upon as essential. Hence, additions were made to the examination regulations governing university and college education for health care staff, lawyers, social workers, teachers, and other professionals.

To improve competence and mode of action in social care, social welfare legislation was complemented by a new regulation. Social services should offer women who are, or have been subjected to violence or other abuse in the home, help and support in order to improve their situation.

Research into violence against women

Research is another expression of the growing public awareness of violence against women. In the last decade, lifetime experiences of physical violence by a partner or former partner have been investigated in prevalence studies

on national samples from various countries all over the world. Prevalence rates ranging between 10 and 34% of women were reported¹⁵. In a national representative sample of women 18–64 years of age in Sweden, 16% of the women who were or had been married or cohabitant reported physical violence by a partner or former partner at any time during the relationship[#]. Furthermore, 46% of the women admitted physical violence, sexual violence, or threats of violence by a man since they were 15 years old¹⁶. The corresponding proportion in a similar Finnish study was 40%¹⁷. Violence against women is a widespread problem and even pregnant women are subjected to violence or suffer from the consequences of abuse in the past.

Physical violence and pregnancy

Consequences of physical violence – two parties at risk

When a pregnant woman is assaulted, two individuals are endangered: the woman herself and her unborn child. Besides injuries caused by the violence, the woman who lives in a relationship with an abusive man or who is abused by a former partner is subjected to severe stress. The stress can contribute to or aggravate various psychological and somatic health problems.

Miscarriages, premature labour and pregnancy losses due to abuse have been reported by affected women¹⁸⁻²¹. Injuries to the unborn child such as subdural haematomas and other serious trauma following violence, have also been described^{22,23}. Of women physically abused by their male partners approximately one-third to one-half have been raped or coerced into sexual activities by their partners^{15,24,25}. Coerced sex can cause genital infection, which increases the risk of preterm rupture of membranes and preterm labour and delivery²⁶. The fetus is also at risk of becoming affected by exacerbation of chronic maternal illnesses such as diabetes, hypertension or asthma, due to violence²⁷.

Pregnancy outcome

The pregnancy outcome most studied is birth weight, one of the most important risk indicators of infant ill-health and mortality during the first year of life^{20,28-38}. Possible indirect pathways for maternal stress affecting birth weight are smoking, alcohol consumption, drugs, decreased utilization of antenatal care, and inadequate nutrition. Direct effects of stress have been

[#] Unpublished data from the prevalence study ‘Captured Queen. Men’s violence against women in “equal” Sweden – a prevalence study’¹⁶

hypothesized to involve the release of catecholamines resulting in for instance placental hypoperfusion²⁷. No pregnancy outcome has been found to be consistently associated with violence during pregnancy, although an association between abuse and low birth weight (LBW) was indicated in a meta-analysis^{35,37}. Difficulties in demonstrating associations might be due to the multi-etiological nature of LBW and other measures of pregnancy outcome, over-representation of risk factors among abused women, and small samples investigated.

Mother – child relation

Another serious consequence of violence during pregnancy is that an abused mother will probably expend much of her energy on coping with the abuse³⁹. This energy she could have spent preparing for her baby emotionally and practically. After delivery this situation could be even more serious, maybe due to the increased stress of the postpartum period or to the man's jealousy of the infant⁴⁰⁻⁴².

Depression has been shown to be more common among abused women^{40,43}. Research has demonstrated associations between postnatal depression and disturbances in mother–infant interactions. These disturbances seem to be able to influence the emotional and cognitive development of the child^{44,45}.

Prevalence

Prevalence figures for physical abuse during pregnancy reported in the literature from Australia, Canada, England, Norway, South Africa, Sweden, Switzerland, and the USA range between 0.9% and 20.1% (Appendix)^{18,19,28-33,41,43,46-66}. Direct comparisons of studies are difficult because of differences in definitions of violence and because of different methods, and samples used. In most studies, separate clinic-based homogeneous samples have been studied. In order to allow generalization to the general population representative samples with initially unknown abuse status should be investigated. When population-based samples were studied, prevalence rates were mostly in the lower part of the interval. It has been demonstrated that disclosure of experiences of violence is more likely with the use of structured in-person interviews than with self-administered questionnaires or unstructured interviews^{62,67}. Repeated questioning throughout the pregnancy or questions in late pregnancy are likely to elicit higher prevalence rates^{68,69}. Also, the choice of the wording of the questions is important. Specific questions applying words to the specific acts will help women to recognize and acknowledge the abuse^{68,70}.

Changes in violence during pregnancy

Many of the women abused during pregnancy had been abused prior to pregnancy as well ^{30,50,56,58,66}. This makes previous abuse a significant risk factor for abuse during pregnancy. For some of those assaulted in the year before pregnancy, the violence ceased during pregnancy. Nevertheless they risked further abuse after the baby was born ^{42,56}. For others the violence continued as usual, while for some it became more serious and frequent during pregnancy ^{59,66}. McFarlane et al. reported that abuse during pregnancy was associated with increased risk for homicide ⁵⁹.

Circumstances correlated with abuse during pregnancy

Social conditions and health problems

Several studies have shown that abuse during pregnancy is correlated with young age, low standard of education, low income, being single or separated and having housing problems, although the findings were sometimes contradictory ^{20,28,29,31,41,43,48-51,54,56,61,63-66,71}. Furthermore, abused women are more likely to have weak social support, to have experienced more stress and distressing life events, and to have an unplanned or unwanted pregnancy, than non-abused women ^{28,31,41,43,48,49,61,62,65}. Unhealthy habits such as smoking and use of alcohol and/or prescribed or illicit drugs were also reportedly correlated with violence during pregnancy although the findings were rather ambiguous ^{20,28,29,31,43,48,55,61,62,65,71}. Abused women are more likely to have a partner using illicit drugs, alcohol or tobacco ^{28,41,61,71}. In addition, when compared with non-victims, women abused during pregnancy were more likely to report poor obstetric history, and physical and emotional health problems prior to pregnancy ^{20,28,65}.

The meaning of correlation

It should be noted that, because correlations between phenomena are found, this does not mean that we know what is cause and what is effect or if there are underlying factors responsible for the correlation. Although many studies have shown that physical abuse during pregnancy is associated with poor social conditions and health problems, abused women can be found in all strata of society and among those 'at risk' many are living in non-violent relationships.

Sexual abuse

The concept lifetime sexual abuse (LSA) includes child sexual abuse (CSA) and rape and molestation during adolescence and adulthood. Such abuse may be an isolated event committed by a stranger, or be inflicted repeatedly by a relative, male partner, or an acquaintance. The concept LSA is used, as there is no distinct boundary between CSA and sexual abuse (SA) of adolescents or adult women. CSA by a family member or an acquaintance of the family can start at any age and continue as the girl grows up. Likewise molestation or rape by a relative, an acquaintance or a stranger can occur at any age. SA is defined in various ways by different investigators. For example some definitions distinguish between tactile and non-tactile sexual abuse and whether or not coercion or force was used. Regarding CSA, they can distinguish between intrafamilial and extrafamilial abuse. Others have taken age differences between the victim and the perpetrator into account.

Pregnancy and childbirth

Even in the best of circumstances pregnancy can be a stressful event for a woman. New demands require role adjustments. Deleterious life experiences, including sexual abuse, may be associated with increased stress during pregnancy and may exacerbate pre-existing maternal symptomatology. Current knowledge regarding the influence of earlier sexual abuse on pregnancy and childbirth originates mainly from case reports and qualitative research. Pregnancy and childbirth are occasions which can awake memories of sexual assaults⁷²⁻⁷⁵. During pregnancy the woman prepares herself mentally for becoming a parent. For this process she needs good role models. If she herself has not been protected from sexual abuse, she may doubt her own ability to be a good mother and to protect her child from abuse^{73,76}. The woman's emotional resources may be employed in coping with the abuse experience rather than devoting sufficient resources for 'binding' to the anticipated child or later to meet the demands of the new baby⁷³. A sexually abused woman may lack a sound perception of her own body and thus doubt its reproductive capacity⁷³. Labour, pain, touch, expulsion, and vaginal examinations may reawaken memories of abuse^{74,75}. For survivors of sexual abuse, privacy, integrity, and control are important aspects of care, as they have learnt that loss of control can be dangerous^{72,74,75}. Furthermore, attitudes to and experiences of breastfeeding can be affected by the experiences of abuse⁷⁷.

Pregnancy may even result from rape or enforced sex⁷⁸. This could be the case within and outside relationships and in war when sexual violence might be employed systematically⁷⁹.

Prevalence

Prevalence rates of reported sexual abuse vary considerably, depending among other things on the population studied, the investigative methods used, response rate achieved, and how the concept of sexual abuse was operationalized⁸⁰⁻⁸³. In a general population survey conducted in Los Angeles, 16.7% of adult women acknowledged LSA and in a nationally representative sample, from the US, 22.9% of the women had at least once in their lives been a victim of sexual violence^{81,84}. When an extensive questionnaire regarding men's violence against women was mailed to 10,000 randomly selected 18–64 year-old women in Sweden, the response rate was 70.1%. Of the responders, 24% reported that a man had at some time forced them to or tried to force them into some form of sexual activity[#]. In a random sample of 16–65 year-old women in a primary care district in the north of Sweden, approximately 14% reported LSA⁴. The same rate was reported in a community sample from District West, a sector of the city of Gothenburg⁸⁵. At the university clinic in Linköping all gynecology patients were assessed about three types of abuse. LSA was reported by 16.6%⁸⁶. In clinical samples from U.S.A., 5% of indigent puerperal women and 9% of pregnant middle-class women disclosed LSA^{87,88}. When reviewing the literature, no investigation of LSA regarding a general population of pregnant women was found.

CSA figures reported for general populations have ranged from 7% up to 36%⁸⁹⁻⁹². The upper age limit for CSA varies from 12–18 years when defined. In a representative Swedish sample of 17-year-old females, 7.1% acknowledged sexual abuse more severe than exposure⁹³.

Associated conditions

CSA is associated with, but not restricted to, children growing up in unstable families, general child neglect and poor parenting^{89,93,94}. One possible explanation for this association is that neglected children may seek affection and caring outside the family. Consequently, they may be more likely to be chosen as targets by molesters. In a dysfunctional or neglectful family the abuse is less likely to be disclosed, and if disclosed, the family might not respond adequately to the disclosure or might be unable to give the child necessary support^{89,94}. Regarding social conditions, no consistent differences have been shown between sexually abused and non-abused adult women, except for their conjugal situation. Sexually abused women are more often single or separated/divorced^{80,87,88,92,95,96 97}.

[#] Unpublished data from the prevalence study 'Captured Queen. Men's violence against women in "equal" Sweden – a prevalence study'¹⁶.

Violence and ill-health

Physical violence

Physical violence can cause injuries, ranging from cuts and bruises to permanent disability and even death. However, injuries are not the most common physical outcome of male intimate partner violence¹⁵. Numerous cross-sectional investigations elucidated a close positive relationship between men's violence against women and physical and psychological health problems^{15,16,24,97-102}. 'Functional disorders', depression and anxiety are frequently reported. Furthermore, there are studies indicating a dose-response relation between the severity of violence and the degree of physical and psychological distress^{103,104}. In one longitudinal study, Sutherland and colleagues showed that women with higher rates of abuse reported higher levels of injuries, physical symptoms, anxiety and depression than women with lower abuse rates. The effects of abuse on physical health and psychological well-being were stable both within and across time periods of measurements in that study. The authors concluded that this strengthens the causal inferences that can be drawn about the effects of abuse on health. They also showed that the alleviation of physical and psychological symptoms following cessation of abuse was slow rather than immediate i.e. the detrimental effect of the abuse persists over time¹⁰³. Women themselves attribute health problems to the abuse^{16,105,106}.

Sexual violence

Furthermore, a positive relationship between sexual abuse and physical and psychological problems has been demonstrated in retrospective studies^{16,84,85,90,97,99,107,108}. Some findings indicate a causal relationship. There are studies showing a 'dose-response' association between LSA and premenstrual syndrome and between a history of sexual abuse or physical violence and various health problems^{109,110}. Weiss et al. pointed to a possible neurobiological link between CSA and mental health problems among adult women by giving evidence from both animal and human studies that early stressors produce long-term dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis similar to that seen in depressed patients and that such dysregulation results in a differential response to stressors in adulthood¹¹¹. Also in adults, chronic or traumatic stress may promote an alteration of the HPA axis, a change associated with a variety of health problems^{112,113}.

Physical and sexual violence

Women both physically and sexually abused were subjected to more frequent and severe violence, were more seriously injured, had higher scores on the Danger Assessment Screen (measuring risk for homicide), and were more likely to be abused during pregnancy^{25,64,88,114}.

Women who experienced sexual violence with or without physical abuse from a partner were more likely to report gynecological health problems (e.g. sexually transmitted diseases, urinary tract infections, pelvic pain, and dyspareunia) than women who experienced physical abuse only, or those never abused. This might be due to abusive sex practices, sexual 'affairs' and refusal to use 'safe sex' on the part of the male partner^{24,115}. Individuals subjected to both physical abuse by a partner and sexual abuse as a child and/or as an adult, showed more physical symptoms and psychological distress than women abused only as a child or only as an adult. This indicates a cumulative impact of violence experiences^{116,117}.

A challenge in health care

Men's violence against women is prevalent and associated with many physical and psychological health problems. Women subjected to violence are above the norm regarding use of the public health services^{96,118}. Consequently, the issue should be a major concern in health care.

Barriers to disclosure and recognition

Abused women are often reluctant to raise the issue of violence^{96,119-121}. Many feel ashamed and blame themselves for the violence they suffer. Others deny that they are abused¹⁰⁵. Fear of escalating violence, dependence upon the abuser and lack of trust in health care staff are other possible barriers to disclosure¹²². Many prevalence studies (Appendix) have concluded that all pregnant women should be questioned regarding abuse. Furthermore, routine questioning, not least in antenatal care, has been officially recommended by many professional organizations¹²³⁻¹²⁵. Despite these recommendations, most women are never asked^{106,121,123,125-128}.

In the literature, several barriers are described among health care staff regarding recognition of women exposed to sexualized violence. Such barriers are lack of education, time constraints, lack of effective intervention, the stereotype of a 'typical battered woman', too empathic identification with the woman/abuser, fear of offending the patient, and feelings of hopelessness and non-responsibility^{6,129}. Identification with the woman or man might trigger feelings about one's own experiences of abuse and violence among

both male and female staff, as abusers or victims⁶. Sugg and Inui investigated factors preventing physicians from intervening in cases of domestic violence. Risk of offending the woman was one of the strongest fears expressed by physicians that prevented them from inquiring about violence¹³⁰. It is therefore essential to understand what women favour and accept. Routine questioning regarding violence and intervention programs are only effective if women are willing to participate.

Women's attitudes to routine questioning regarding violence

In recent years, investigations conducted in antenatal care have shown that almost all women regarded routine enquiry about violence as acceptable^{120,131}. The way the questions are posed and the way the woman is treated are important for her perception. Women wish to be asked in safe and confidential surroundings by an experienced health professional who is empathic and non-judgmental¹²⁰. Abused women expect staff to consider the woman's safety, to inform, and to refer. Nevertheless, they want to maintain control over decisions about their living arrangements and relationships¹²⁰⁻¹²².

Routine questioning regarding men's violence against women

Screening

In the literature the word 'screening' is frequently used for the routine of questioning all women regarding exposure to men's violence. Screening in public health implies the ability to identify a condition with good sensitivity and specificity and to provide an effective response. None of these conditions is met satisfactorily in the case of screening for men's violence against women¹³². Rather, the questions should be regarded as a part of the anamnesis.

Experiences of routine questioning in health care

Several attempts to implement routine questioning regarding violence have been described and evaluated in the literature. Tactics facilitating routine questioning include regular education, an official policy for identifying and assisting women exposed to violence, printed material displayed in waiting rooms, specific questions put to all women, easy access to appropriate referral, and time for staff to reflect upon their experiences^{129,133-135}. Multiple assessments are known to increase the reporting of abuse during pregnancy^{60,69,120}.

During nine months in 2001, The National Board of Health and Welfare, in Sweden carried out a project intended to develop methods for routine 'screening' regarding violence against women. Midwives at about 50 antena-

tal or youth clinics in three counties participated. Uncertainty and lack of time were reported to be hindrances, while knowledge and time for reflection were helpful. Many of the participating midwives asked for counselling to increase their competence and as an emotional outlet for their feelings ¹³⁶.

Antenatal care in Sweden

All pregnant women are guaranteed equal access to antenatal care within the Swedish public health services and virtually every pregnant woman visits her clinic regularly, usually from early pregnancy onward ¹³⁷. The National Basic Program for Obstetric Care comprises 8–10 visits to a nurse-midwife. An obstetrician or primary care physician is involved if needed. Anamnesis for psycho-social and physical risk factors is standardized and designed for early detection. Swedish antenatal care therefore facilitates the study of all pregnant women within a specific district.

Furthermore, considerable effort has been made in antenatal care to involve the partner in his spouse's pregnancy and childbirth and subsequently in childcare and parenthood. He has been encouraged to accompany his spouse to the visits at the antenatal clinics and he is invited to antenatal classes. In recent years it has been increasingly common for the male partner to be present at antenatal appointments.

Outline of the thesis

This thesis is based on the perspective of sexualized violence as a female health and human rights issue that should be recognized in health care. The initial study estimated prevalence rates of physical violence the year before pregnancy and during pregnancy and LSA among pregnant women in Uppsala, Sweden. The study also investigated the pregnant women's attitudes to being questioned about being subjected to violence. As a result of that study, the managers of the antenatal care service introduced questions about emotional, physical and sexual abuse as part of the regular psycho-social assessment in antenatal care in the county. Consequently, we wanted to investigate antenatal midwives' experiences, having routinely questioned pregnant women regarding men's violence.

Aims of the thesis

The overall aims of this research are to determine the prevalence of men's violence against women in a Swedish pregnant population, to investigate pregnant women's attitudes to being asked about exposure to such incidents, and to evaluate the experience gained by antenatal care midwives having routinely questioned pregnant women regarding such violence.

Specific aims are

to determine the prevalence of current and previous violent acts against pregnant women, with the emphasis on physical violence by a current or former male partner or relative. Current violence was defined as occurring during pregnancy or within 20 weeks after delivery (Paper I)

to investigate the prevalence of women reporting LSA when asked a single screening question on the subject (Paper II)

to establish the age at which the sexual abuse had occurred and who the perpetrator was (Paper II)

to establish if repeated questioning during and shortly after pregnancy increases the detection of abused women (Paper I)

to investigate differences between abused and non-abused women regarding socio-economic characteristics, reproductive and general health problems, pregnancy complications, and pregnancy outcome, by using data from the standardized antenatal records (Papers I, II)

to examine women's attitudes to being questioned, during and after pregnancy, by their midwife about exposure to violence (Paper III)

to describe antenatal care midwives' thoughts and feelings regarding routine questioning about violence, persisting obstacles, and possible solutions and aid (Paper IV).

Methods

Design

Papers I and II included all pregnant women who registered for antenatal care in Uppsala, Sweden, during a 6-months' period. Participants were interviewed repeatedly regarding past and current exposure to violence. Characteristics of abused and non-abused women were compared. Paper III was an explorative investigation using content analysis of one open-ended question regarding women's attitude to being questioned about violence. The sample studied was the same as in Paper I. Paper IV used focus group discussions to obtain data on midwives' perceptions and experiences regarding routine determination of violence (Table 1).

Table 1 *Design, data sources, and participants*

Paper	Design	Data sources	Study group
I	Explorative	AAS [‡] on three occasions, antenatal records	1,038 women registered for antenatal care in Uppsala, 1997/98
II	Explorative	AAS [‡] on three occasions, antenatal records	1,038 women registered for antenatal care in Uppsala, 1997/98
III	Explorative	Open-ended question	879 women registered for antenatal care in Uppsala, 1997/98 and who answered an open-ended question after delivery
IV	Explorative	Focus group discussions	21 midwives in antenatal care in Uppsala, 2003

[‡] AAS The original version was developed by the Nursing Research Consortium on Violence and Abuse¹³⁸.

Papers I–III

Sample

All women registered between September 1997 and February 1998 at any antenatal clinic in Uppsala, a university town with 187,000 inhabitants, were consecutively recruited for participation in the study. After excluding those who did not give birth at Uppsala University Hospital (UUH), 1,120 women remained. Those who did not give birth at UUH had moved elsewhere during pregnancy, or had a miscarriage or an elective abortion. A sufficient number of women to participate in the investigation was calculated (1,000 women), assuming a 5% prevalence of physical violence during pregnancy⁶⁸. The assumption would result in a 95% confidence interval (95% CI) of 3.65–6.35%.

Procedures and data collection

Preparations and support to the midwives

The intention was that the regular midwives should interview all participants regarding acts of violence on three occasions. Prior to the study all midwives at the ten antenatal clinics in the municipality attended a one-day information meeting about the nature of emotional, sexual and physical abuse. Several meetings were held at the antenatal clinics before the study. The midwives were instructed how and when to ask and where to refer abused women. Practical matters regarding the study were discussed with the midwives and arranged to fit in with ordinary visits. Many men accompanied their spouses to the antenatal visits. As no questions about violence could be asked in presence of the partner or other relatives, the midwives found different ways of enabling them to talk with the woman in private. They could take the woman to a separate room for an examination, to the laboratory for some test, or make an appointment when the partner was otherwise engaged. In order to interview all women regardless of ethnical background or language spoken, the research instrument used was translated into the six most common foreign languages in Uppsala at the time. The translations were performed to ensure that all women were asked the questions in an identical manner. The female interpreters employed by the municipality were informed about the study and a list of these interpreters was distributed to the antenatal clinics. The midwives were instructed to use interpreters liberally. During the study the clinics were visited regularly by the researchers to ensure that all midwives performed the interviews in the same way and at

stipulated times in pregnancy. The midwives were offered coaching and opportunities to discuss problems.

Information and confidentiality

Verbal and written information was given to all women invited to participate. They were informed that participation meant that they would be asked five questions concerning violence on three occasions during their antenatal care. Those who disclosed violence would be offered support. Before enrolment, verbal consent was obtained for participation and for the use of data extracted from antenatal records. Confidentiality was guaranteed. No information about the woman's situation was passed on without her consent. The woman's answers were noted on specially designed data collection forms that were kept at the antenatal clinic until after the last visit.

Support to abused women

The midwives informed all women about the National Center for Battered and Raped Women and those who reported abuse were offered help. At the National Center, care and consultation are provided by specially trained doctors, social workers and midwives. Other possible referral options were psychologists or special consultations for women afraid of giving birth. Contacts for professional help were arranged by the midwives or by the abused women themselves. It was emphasized to the midwives that it was not their responsibility to act as therapists for abused women.

Data collection

The women were interviewed as early in pregnancy as possible (before 32 weeks), again late in pregnancy, and 4-20 weeks postpartum. At the postnatal visit, before the woman left the antenatal clinic, she was asked to answer an open-ended question worded "Please describe how you felt about being questioned by your midwife at the antenatal clinic concerning violence". If the woman did not make a postnatal visit or if her male partner was present, the midwife conducted the interview by telephone. In these cases the midwife noted down the woman's answer, and checked with the woman that her opinion had been correctly understood.

Instrument

The instrument used was the Abuse Assessment Screen (AAS, Table 2) developed by the Nursing Research Consortium on Violence and Abuse¹³⁸. The instrument consists of five structured and specific questions regarding remote and recent history of violence. Content validity has been established for the five-question AAS with a panel of 12 nurse researchers working in the field of abused women¹³⁹. The researchers were of white, Afro-American,

Table 2. *Questions included in Abuse Assessment Screen*[‡]

1.	Have you ever been emotionally or physically abused by your partner or someone important to you?	Yes	No
2.	During the year before this pregnancy, have you been hit, kicked or shoved or otherwise physically hurt by someone?	Yes	No
	If yes, by whom? Husband Ex-husband Boyfriend		
	Ex-boyfriend Stranger Other		
	Number of times.....		
3.	Since you have been pregnant, have you been hit, kicked or shoved or otherwise physically hurt by someone?	Yes	No
	If yes, by whom? Husband Ex-husband Boyfriend		
	Ex-boyfriend Stranger Other		
	Number of times.....		
4.	Have you ever been forced to participate in or subjected to sexual activity against your will?	Yes	No
	If yes, at what age? 0–12 13–19 20–		
	If yes, by whom? Husband Ex-husband Boyfriend		
	Ex-boyfriend Acquaintance Stranger		
5.	Are you afraid of your partner or anyone you have mentioned here?	Yes	No

[‡] The original version was developed by the Nursing Research Consortium on Violence and Abuse¹³⁸.

and Hispanic extraction. Significant ($p < 0.001$) criterion validity has been established when responses to the two questions concerning recent physical abuse and one question concerning sexual abuse in the last year were compared with the carefully validated research instruments Conflict Tactic Scale (CTS) and Index of Spouse Abuse (ISA)^{57,59,139-141}. When AAS was tested with a test-retest approach it was found almost 100% reliable¹³⁹.

In the present study, AAS was translated into Swedish and modified. In the original version women are asked about physical violence ‘within the last year’. In order to compare the answers from women in different stages of pregnancy, this was altered to ‘the year preceding this pregnancy’¹⁴². The same change was made by the originator of the instrument in a later version¹⁴³. Concerning sexual abuse, each woman was asked ‘Have you ever been forced to participate in or subjected to sexual activities against your will?’ instead of ‘Within the last year, has anyone forced you to have sex?’ Furthermore, she was asked at what age the sexual abuse had occurred (age 0–12, 13–19 or ≥ 20) and who the perpetrator was.

Other data sources

Information regarding age, occupational status, smoking habits, conjugal situation, domestic situation, reproductive and general health history, weight gain, pregnancy complications and pregnancy outcome, was collected from the standardized antenatal records. The information was extracted postpartum. Pregnancy complications were noted only when diagnosed by a doctor. Only those previous illnesses and pregnancy complications reported by at least 2% of the women are reported separately. Pregnancy outcomes extracted were: the baby's sex, Apgar score at 1 and 5 minutes, weeks of gestation at birth, and birth weight and regarding LSA method of delivery (vaginal unassisted, assisted, or cesarean section).

Data analysis

Paper I

Women currently maltreated by a current or former partner or relative were compared with those who denied ever being abused. To avoid misclassification, women who were prepared to disclose previous but not current abuse were excluded from the comparison. Non-parametric statistics were used because of skewed distributions and the small number of abused women. Only univariate analyses were undertaken. The Mann-Whitney U-test was used to compare medians and Fisher's exact test to compare proportions. Missing values were few (0.2–3.3%) and therefore excluded from the analyses. Values of $p < 0.05$ were considered significant. As no corrections for mass significance have been made, the data should be interpreted with caution. The Statistical Package for the Social Sciences was used for the analysis (SPSS 9.0).

Paper II

Women who reported LSA were compared with those who did not report sexual abuse. Prevalence rates were calculated with 95% confidence interval (95% CI). Student's t -test was used to determine whether statistically significant differences existed between continuous variables. For skewed distributions, the Mann-Whitney U-test was used. Categorical variables were compared using chi-square test (χ^2) or Fisher's exact test. Missing values and p -values were treated as in Paper I. The Statistical Package for the Social Sciences was used for the analysis (SPSS 9.0).

Paper III

Content analysis was used to scrutinize the answers to the open-ended questions. The researchers followed the explicitly formulated rules below, which

served as guidelines for the categorizing in order to enable the two investigators (KS and HS) who analyzed the material to obtain the same results¹⁴⁴. Inter-rater reliability was calculated using the following equation: Number of agreements/ (Number of agreements + disagreements)¹⁴⁴.

Data analysis was undertaken in three stages.

1. All answers were assigned to one of the following four categories:

Acceptable: a clearly expressed positive attitude to being questioned about violence. There was no sign that the woman had been offended or that the woman–midwife relationship had been disturbed by the questions (e.g. OK, positive, interesting).

Neither acceptable nor unacceptable/disagreeable: no sign that the woman had been offended by the questions, nor any overtly positive expression. Uncertain or mildly acceptable attitudes were assigned to this category (e.g. not strange, did not bother me at all).

Both acceptable and unacceptable/disagreeable: acceptable attitudes as described above, but also expressions indicating that the questions were felt to be unacceptable/disagreeable (e.g. trying, but good).

Unacceptable/disagreeable: the opinion that the questions about exposure to violence made the woman feel uncomfortable, upset or offended or had disturbed the woman–midwife relationship (e.g. wrong time to ask about upsetting things. It did not bother me very much).

2. The women who answered "no" to all the questions in the AAS every time they were asked were compared with those who answered "yes" at least once to any of the questions. Confidence intervals (CI) for differences between proportions were used to calculate if there were significant differences between women who reported abuse and those who did not ($p < 0.05$).
3. All answers were read carefully by KS and HS, and all the statements were noted that explained why the women felt the questioning acceptable, neither acceptable nor unacceptable /disagreeable, both acceptable and unacceptable/disagreeable or solely unacceptable/disagreeable. Those statements not observed as relevant by both the reviewers were discussed until agreement was reached. KS developed a written category system with 16 categories based on the statements identified. Finally KS and HS categorized the statements independently.

Paper IV

Background

In January 2001 the managers of the antenatal care service in the county of Uppsala introduced questions about emotional, physical and sexual abuse as part of the regular psychosocial assessment performed by midwives. This was a consequence of the study presented in papers I-III. Standardized questions derived from the AAS were used. Official policies and instructions were established regarding questioning, documentation, and referral. Printed laminated cards displaying the questions and important telephone numbers for referral were distributed to all midwives. According to the instructions the questioning was to be carried out twice during pregnancy and again after delivery. The clinics were supplied with information about the assessment intended for display in waiting rooms. They were also supplied with wallet-sized cards with information about resources for abused women. It was intended that a resource card should be given to each registered woman and also be placed in women's toilets.

At the initiation of the new program a midwife with special knowledge of the subject provided training, including ways of questioning and how to intervene when a woman revealed abuse and requested help. To reinforce compliance and to allow for staff turnover, refresher courses, seminars, case discussions and coaching have been arranged at the antenatal clinics and the clinics have been supplied with literature on the subject. A care provider with knowledge of antenatal care and men's violence against women has always been available on the telephone to coach the midwives.

Sample

All midwives ($n=28$) at the seven antenatal clinics in Uppsala were invited to participate in focus group discussions. Three midwives declined participation, 2 others were ill at the time of the interview and 2 did not join because of scheduling conflicts. Thus 21 midwives took part in one of five focus group discussions (2–6 participants in each). The participants were 42–62 years old (median 54), had been midwives for 8–39 years (median 26) and had been working at antenatal clinics in the county for 0.5–26 years (median 12).

Procedures and data collection

Focus group methodology

A focus group is a carefully planned discussion designed to identify perceptions in a defined area of interest in a permissive non-threatening environment¹⁴⁵. The method is a qualitative research technique that collects data through group interaction on a topic determined by the researcher^{146,147}. Focus groups have been shown to be particularly useful when exploring people's behaviours, attitudes, and experiences and what people think or feel about an issue or a problem. The method can be used to examine not only what people think but how they think and why they think that way. Group interaction is used as part of the method. Instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view¹⁴⁸. Thus, ideas and questions that the researchers have not thought about may be discussed. The group usually consists of 4–12 participants¹⁴⁵. Most researchers recommend seeking homogeneity within each group in order to make group members more confident and more likely to voice their views¹⁴⁸. The discussions are led by a Moderator following a question guide. The Moderator is usually assisted by an Observer taking field notes during the discussion.¹⁴⁹

Procedures

Focus group discussions were conducted in February and March 2003. One of the researchers visited all the antenatal clinics to invite the midwives to participate. They were informed orally and in writing about the purpose of the study, the procedures, how confidentiality would be maintained, and that all participants would have opportunity to comment on the results. Voluntariness was stressed. Groups of midwives were drawn together from different clinics in order to elicit a greater range of opinions in the discussions. Nevertheless, the groups were homogeneous since the participants were all female middle-aged midwives with experience of routine questioning regarding violence. Initially four groups with 5–6 participants were planned. Although much time was spent scheduling the groups, a few midwives could not attend their group due to illness or some personal reason. Therefore a fifth meeting was planned for four participants, but only two took part.

The sessions were held by the same Moderator (KS) and Observer (ML), both midwives with knowledge of the subject and more or less known to the participants. The participants knew about the Moderator's previous research into men's violence against women. All interviews followed a similar format and lasted approximately 70–90 minutes. The Moderator explained the purpose of the discussion and the roles of the group before each focus group

meeting. The participants were informed that discussions would be audiotaped but that names would be masked at transcription. The conversation was supposed to take place mainly among the participants. Furthermore, they were reminded that group confidentiality must be maintained, that there were no right or wrong answers, that all comments and opinions were welcome, and that one could change one's opinion. At the end of the session the Moderator summarized the discussion and encouraged the participants to add important views. After each discussion the Moderator and the Observer held a short debriefing regarding the climate in the group, important topics, unexpected views and questions that had arisen, and topics important to check with subsequent groups. Discussions were transcribed verbatim by KS. To facilitate transcription, the Observer made brief notes during the meetings about what was said and by whom.

Question guide

A semistructured guide was designed, comprising open-ended questions concerning modi operandi of abuse assessment, obstacles and difficulties regarding routine questioning and possible solutions, the influence of personal experience of violence on questioning, and advice to colleagues about how to implement routine assessment. The guide was discussed with colleagues experienced in focus group technique and piloted at an antenatal clinic in another town in the region where routine determination of violence was practised. Due to concurrent analysis during data collection, minor revisions of the guide were made in order to confront information obtained in previous groups.

Data analysis

Data analysis was inductive, which means that patterns and themes came from the data rather than being imposed on them prior to analysis¹⁵⁰. The transcripts were read carefully and a summary of each interview was written. The first author (KS) coded the participants' statements in relation to the aims of the study. In the coding process the content of each statement was summarized. Subsequently, preliminary themes were elaborated. The first author (KS) and a senior researcher (BS) critically tested the coherence of each theme several times as well as its separateness from other themes. If the content of a theme was not coherent, the analysis was restarted until the final themes were identified¹⁵¹. To ensure that important ideas had not been overlooked, debriefing protocols and interview summaries were checked. Finally, the Observer, who had been present at all the discussions, and the participants were invited to read and make comments on the preliminary report.

Ethical aspects

The World Health Organization (WHO) has published guidelines for addressing ethical and safety issues in conducting research into men's violence against women ¹. The recommendations urge researchers to undertake such studies only if they are able to maintain minimal safety standards, such as guaranteeing complete privacy during the interview, providing information and referrals to respondents, and providing special training and support for interviewers. Other ethical recommendations are that studies should be based on current research experience, how to minimize underreporting of abuse, and that results should be used to advance policy and intervention development ¹. These recommendations were not available when this research started but the intentions have nevertheless guided the work.

The studies were approved by the Ethics Committee of the Medical Faculty of Uppsala University (registration number 97-199 and 02-369).

Results

Paper I

Of the 1,120 eligible subjects, 1,038 (93%) participated in the study. Twenty-six women declined to participate and 41 women could not be asked as they had a spouse or a relative present at each visit. For five a suitable interpreter could not be arranged, and ten were not asked for a variety of practical reasons. Socio-demographic characteristics of the women eligible for the study are shown in Table 3. Women in our study were less likely to smoke and more likely to have their first child than pregnant women in Sweden at the time.

Table 3. *Socio-demographic characteristics of women eligible for the study (n=1,120) and all women who gave birth in Sweden in 1998[#] (percentage values)*

	Subjects eligible for participation (n=1,120)	Women who gave birth in Sweden in 1998 [#]
Age		
≤19	1.5	1.8
20-24	13.9	15.0
≥25	84.6	83.2
Primipara	44.2	40.9
Married/cohabiting with child's father	94.8	95.2
Smoker	7.4	11.7

[#]Data from Medical Birth Registry in 1998 including ≥88% of all births in Sweden ¹⁵²

Twenty-seven women (2.6%; 95% CI=1.6–3.6%) reported physical abuse by a current or former partner or relative during the year preceding the pregnancy, while 14 (1.3%; 95% CI=0.6–2.0%) reported abuse during or shortly after pregnancy (Table 4). Of those abused during pregnancy, 12 had been abused during the year preceding pregnancy as well. Altogether 29 women (2.8%) admitted abuse by a partner or relative during the year preceding pregnancy, during pregnancy or within 20 weeks after delivery. Emotional or physical abuse at some time in life was reported by 15.4% (95% CI=13.2–17.6%). Fear of her partner or some other person was expressed by

3.3% (95% CI=2.2–4.4%), all of whom reported some act of violence. Repeated questioning increased the detection rate of abuse (Table 4).

Table 4. *Prevalence of violence among 1,038 women attending antenatal clinics and cases revealed at repeated interviews*

Parameter	Revealed at repeated interviews	Total no.	%
Emotional or physical abuse at some time in life	24	160	15.4
Physical abuse the year preceding pregnancy	5	27 [‡]	2.6
Physical abuse during pregnancy or before latest visit to the antenatal clinic	8	14 [§]	1.3
Sexual abuse at some time in life	10	84	8.1
Fear of partner or other perpetrator	9	34	3.3
Emotional, physical, or sexual abuse at some time in life		201 [#]	19.4

[‡] Further 9 had been subjected to violence at their workplace

[§] Further 8 had been subjected to violence at their workplace

[#]Included are 11 women subjected to violence at their workplace the year before and/or during pregnancy.

When comparing women abused during or within 20 weeks after pregnancy with non-victims, the former were more likely not to be cohabiting (Fisher's exact test; $p<0.01$). Women abused during pregnancy reported more preceding ill-health (Fisher's exact test; $p<0.05$) and more elective abortions ($p<0.000$) than non-abused women.

Paper II

Sample characteristics were the same as in Paper I (Table 3). Of the 1,038 who answered the AAS questions at least once, 84 women (8.1%; 95% CI=6.4–9.8%) reported that at some time in life they had been forced to participate in or been subjected to sexual acts against their will. Thirteen women reported sexual abuse solely in the age range 0–12 years, 27 solely in the age range 13–19 and 27 only when they were at least 20 years old. Furthermore, 10 women disclosed sexual abuse during two of the periods and one during three. Altogether 21 (2%; 95% CI=1.1–2.9%) of the women reported sexual abuse in childhood, 36 (3.5%; 95% CI=2.4–4.6%) in teenage and 33 (3.2%; 95% CI=2.1–4.3%) in adulthood (Figure 1).

Regarding those assaulted as children (0–12 years) the perpetrator in most cases was known by the woman (20 of 22 perpetrators). Eight girls were abused by father or stepfather. Of the women sexually abused as teenagers

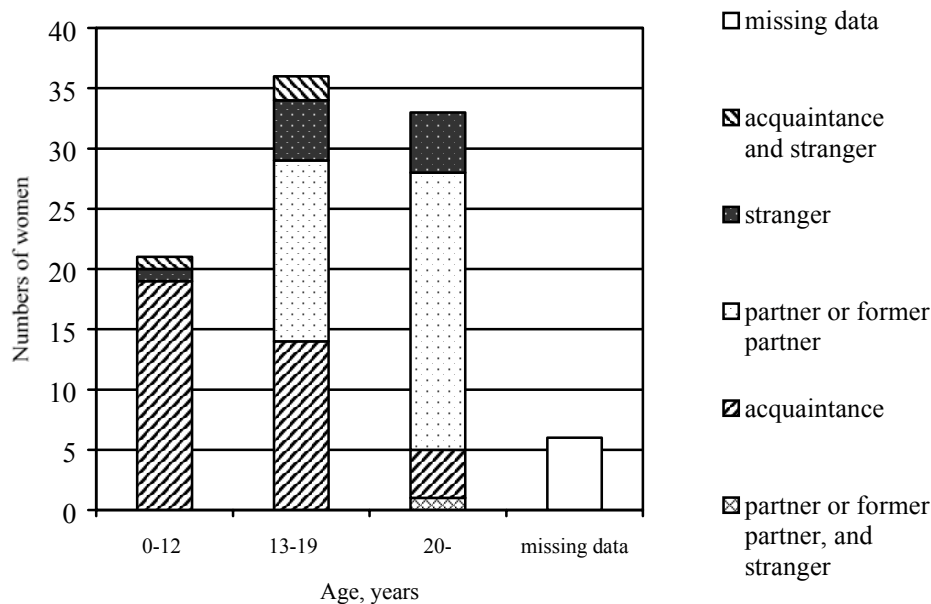


Figure 1. Numbers of women subjected to sexual abuse as children (<13 years old), as teenagers, and as adults (≥ 20 years old) and the perpetrators, as reported by the women (10 women reported more than one period)

($n=36$) 15 reported that the perpetrator was a 'partner or former partner', 17 an acquaintance, and 7 an unknown person. When the abuse occurred in adulthood (≥ 20 years) a 'partner or former partner' was most often the perpetrator (24 out of 34) followed by 'unknown' and 'acquaintance' (Fig. 1). Sixty-nine women reported one perpetrator, 10 two and one three. Of altogether 92 reported perpetrators, 15 (16%) were strangers; the others were equally distributed amongst 'former or present partner' and 'acquaintance' (Fig. 2). Acquaintance was specified by the women as father, stepfather, 'day-care father', acquaintance of the mother, close relative, cousin, brother, 'date', friend, or employer. Concerning 6 women, information was missing regarding age at which the abuse occurred and regarding 4 women, information about the perpetrator was missing.

When compared with non-victims, those sexually abused were found less likely to have a home of their own (Fisher's exact test; $p < 0.000$), but there were no statistically significant differences regarding age, conjugal situation, or smoking habits. Furthermore, those sexually abused reported more general health problems ($\chi^2 = 26.901$; $df=1$; $p < 0.001$), e.g. they were more likely to report some of the most common conditions: gynecological disease and surgery

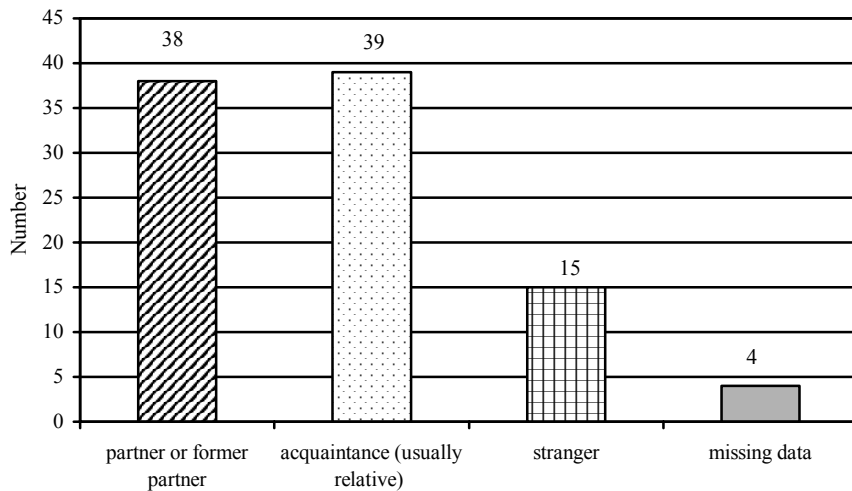


Figure 2. Perpetrators of sexual abuse (10 women reported more than one perpetrator)

($\chi^2 = 9.837$; $df = 1$; $p < 0.01$), pulmonary disease/asthma ($\chi^2 = 9.655$; $df = 1$; $p < 0.01$), and psychiatric care (Fisher's exact test; $p < 0.01$). There were no differences found regarding reproductive history, pregnancy complications or pregnancy outcome except that more of the abused women had experienced pre-term contractions (Fisher's exact test; $p < 0.05$).

Paper III

A total of 879 women answered the open-ended study question. Reasons for not answering are shown in Table 5. About 10% of the women were asked by telephone.

Women's attitudes to being asked about exposure to violence

Of those who responded to the open-ended question, 80% clearly expressed a positive opinion about being asked by their midwife about violence. Twelve percent said they found the questioning neither acceptable nor unacceptable/disagreeable, 5% found it both acceptable and unacceptable/disagreeable and 3% solely unacceptable/disagreeable. Inter-rater reliability for the categorizing was 0.96. When abused women were compared with non-abused women they were more likely to express both acceptable and unacceptable feelings about being asked and less likely to express entirely acceptable opinions, but did not differ significantly regarding unacceptable opinions

Table 5. *Reasons for attrition*

Reasons why women did not answer the open-ended question	Number	Percent of included
Declined to participate when first asked, or left off later	32	3
Participated but did not want to answer in writing	12	1
Practical reasons why the women were lost to follow-up	125	12
Midwife said she preferred not to question the woman by telephone	26	2
Total	195	18

(Table 6). Among those abused during pregnancy, 13 out of 14 answered the open-ended question. Of these, two found the questioning both acceptable and unacceptable/disagreeable and the others found it entirely acceptable.

Reasons underlying such attitudes

The women's explanations as to why they were favourably disposed towards the questions can be summarized thus: It is good that violence is acknowledged and studied and that women are offered help. Such questions can help disclosure, are perceived as a gesture of caring and can make women aware of the problem and inform about available resources. Explanations as to why women were averse to being questioned could be summarized thus: The subject is sensitive and private and can arouse disagreeable thoughts and feelings. Pregnant women want to devote their time to being pregnant.

Paper IV

Conversation in the focus group meetings was animated and permissive. Diverging viewpoints could co-exist. Problems, situations and practical advice were exchanged, ideas generated and discussed, and insights gained. All the participants took part in the discussion although not to the same extent. In the last two groups few new comments emerged. In the analyses, three themes

Table 6. *Attitudes to being questioned about violence*

	No exposure to violence disclosed		Exposure to violence disclosed		Total		95% confidence interval for differences between proportions	Significance
	Number	%	Number	%	Number	%		
Acceptable	585	82.0	119	71.7	704	80.1	1.6% – 19.0%	p< 0.020
Neither acceptable nor unacceptable / disagreeable	90	12.6	16	9.6	106	12.1	-2.1% – 8.1%	p<0.250
Both acceptable and unacceptable / disagreeable	19	2.7	23	13.9	42	4.8	5.8% – 16.6%	p<0.000
Unacceptable / disagreeable	19	2.7	8	4.8	27	3.0	-1.4% – 5.6%	p< 0.234
Total	713	100.0	166	100.0	879	100.0		

with sub-themes stood out regarding the midwives' thoughts and feelings about routine antenatal determination of violence.

Endeavours and obstacles and their influence on procedure

Endeavours and feelings of failure and frustration

The importance of routine questioning about violence was emphasized in all groups but not all midwives accorded the task the same priority as more established tasks in antenatal care. The midwives' estimates of how many of the pregnant women they questioned ranged from 25% up to 90%. Two-thirds said they asked half of their clients or more at least once. Most respondents were satisfied if they managed to ask once. Feelings of failure and frustration were expressed over the fact that not all women were assessed.

Obstacles and difficulties

Many of the midwives said that the questioning per se was not a problem though they reported different situations when they found the assessment questions to be inappropriate. The need to establish a good relationship with the woman before determining the occurrence of violence and the fear that otherwise the questioning might offend her, was commonly expressed. It was felt more sensitive to question women whom the midwife knew. As they knew each other, there ought to be no secrets to be disclosed. Furthermore, it was felt more sensitive to assess pregnant than non-pregnant women. One explanation suggested was that violence during pregnancy is taboo as pregnancy is supposed to be a hopeful time in a woman's life.

Besides the delicacy of the subject and the presence of men and children, the most serious difficulties regarding routine assessment identified by the midwives were lack of time, oversight, many competing duties, language difficulties and a preconceived notion regarding who might or might not be victims.

Current procedures and thoughts about improvements

To overcome sensitivities, the midwives presented men's violence against women as an everyday problem, a public health issue and a women's issue. General information on the extent of the problem and available aids was given before personal questions were asked. Questions about abuse in the past were asked before questions concerning current violence.

The need for routines allowing the questioning of all clients was expressed in all groups. Many midwives wanted to link the abuse assessment with other health issues, which would prompt them to put the questions. The proportion of those questioned was reported to increase when the subject had

been broached in discussions or in training. When women were asked, they mostly responded favourably. Their responses allowed the midwives to gain confidence and thus be more ready to ask.

Presence of the partner and influence on practice

The presence of the partner

At the woman's first telephone contact for booking at the antenatal clinic, her male partner was invited to attend all appointments. According to the midwives, few men insisted on being present. Often the pregnant woman was the one who tried to persuade her man to participate.

Ambivalence to men's presence

Conflicting feelings towards the presence of the male partner were expressed by the midwives. Some emphasized the importance of men's participation. Others were more keen to meet the woman alone sometimes, so as to get to know her better, to allow her to air her private concerns and to satisfy her need for integrity. As a consequence of the man's regular attendance at the antenatal clinic the midwife got to know him and did not think of him as a possibly violent man. To ask about violence when he was not present could then be felt as disloyalty. Consequently, some women were never questioned. In all groups, the problem of the man's exercising control over the woman was raised (e.g. men who dominate the conversation, answer for the woman, make her decisions, insist on acting as interpreter, etc.) while at the same time the feeling was expressed that perhaps such suspicions were unfair.

Ways to facilitate assessment

In order to provide an opportunity to question all women, a separate visit was discussed. One suggestion was to divide the first one-hour registration visit into two shorter visits, one of which should be reserved for the woman and treat issues of special concern for her. Others did not agree with that idea. They preferred to go on asking when the woman was unaccompanied.

Midwives' perceptions of their role and women's responses

To inform, create opportunity to talk and mediate help

By raising the subject, midwives wanted to increase the awareness of violence against women and to inform about available support. Further aims were to send the message to women that abuse is not shameful, that they are

not alone, that midwives care about abused women, and to give women an opportunity to talk and to get help.

The midwives described that their role in caring for abused women was to listen to their stories, to give emotional support, to inform about resources or arrange contacts for additional help, and to observe subsequent developments. The midwives did not find it distressing to share the women's stories and confidences; rather, the task was looked upon as stimulating and instructive.

Experiences and thoughts about women's responses

According to the midwives most of the women reacted positively to the abuse questions and understood their relevance, were grateful that someone cared, and supported the practice. There were few negative reactions. The midwives recognized pregnant women's difficulties in disclosing an ongoing abusive situation, although some women did so when asked directly.

Discussion

Methodological considerations, papers I–III

When planning our study we took advantage of knowledge gained in previous research regarding prevalence of violent acts committed during pregnancy. Studies have shown that the experience of violence is more frequently disclosed in in-person interviews than in self-administered questionnaires^{67,68}. Repeated questioning during the pregnancy or asking the woman late in pregnancy is likely to elicit higher prevalence estimates. The explanation may be the woman's increasing confidence in the interviewer as they meet several times and the questions become familiar, or that incidents of abuse may occur later than the first interview^{18,59,66,69}. Furthermore, questions verbalizing specific acts promote disclosure⁶⁸.

Sample

All pregnant women who registered for antenatal care in Uppsala and who subsequently gave birth at the regional hospital were eligible for the study. The sample included women from both urban and rural areas, women born in Sweden and immigrant women. They had a variety of social and educational backgrounds. Violence against women is a world-wide issue not restricted to certain ethnic or social groups. To be able to interview all women regardless of ethnic background or language, the AAS was translated into the six most common foreign languages encountered in Uppsala. Often in research (not only concerning violence), immigrant women are excluded because of language difficulties. Hence, information about approximately 10–20% of the population is lost. In 1998, 17% of 16–49-year-old women in Uppsala were born abroad¹⁵³.

The women in our sample were similar to pregnant women in general in Sweden regarding age and conjugal status but were less likely to smoke during pregnancy and somewhat more likely to be expecting their first baby. Hence, the women in the study group might have been socially rather more fortunate than the average pregnant woman in Sweden at the time. To allow

generalization to pregnant women in Sweden in general, ideally a national representative sample should have been studied. However, as pregnant women are not included in any national register until after delivery, a representative sample must be selected in antenatal care. In a recent study, all Swedish-speaking women, who booked at almost all antenatal clinics during 3 weeks evenly spread over one year, were invited to participate in a national survey regarding experiences of pregnancy and childbirth¹⁵⁴. About 67% of the eligible women completed the survey. Compared with our participation rate, 93%, this was a low figure. Thus, a national sample would probably not have made our results more valid.

Procedures

In this study we chose to let the regular midwives carry out the interviews primarily because confidence and continuity are important aspects of care for abused women. Abuse is a crime that undermines the woman's confidence in others. Many women exposed to violence by their partner feel ashamed of the abuse. A midwife and a pregnant woman meet several times and a confident relationship can arise. The disclosure rate of abuse increased when the questioning was repeated later in pregnancy, possibly as a result of increased confidence. Another important reason for integrating the questioning in regular care was to enhance awareness of the subject among care providers.

To optimize the study procedures and compliance with them, the 30 midwives who carried out the interviews were involved in the detailed planning and procedures were adapted to current ways of working at the clinics. During the data collection period those responsible for the study visited the clinics regularly to assist the midwives and to emphasize the importance of questioning all women on three occasions. The women's willingness to disclose abusive experiences probably depended on the emotional atmosphere created in the meeting with the midwife. The predominantly acceptable attitude toward questioning, among the women in the study, suggests that in most cases a friendly and supportive atmosphere was created.

Data sources

The AAS

The well-known research instrument AAS has been used in many previous studies (Appendix). The reliability and validity of the instrument has been established¹³⁹. The questions were translated into Swedish. Researchers and

professionals working in the field of physical and sexual violence were called on to analyze the items regarding content validity of the translated questions.

In the original instrument, women were asked about sexual abuse 'within the last year'. Sexual abuse at any time in life can influence attitudes to and experience of pregnancy, labour and parenting. Therefore, in our study the question was altered to cover lifetime sexual abuse. Several descriptive questions about specific acts and perpetrators and a variety of contexts in which abuse could have occurred ascertained higher prevalence rates of sexual abuse than would a single general subjective screening question^{83,90}. As the questions were to be asked during regular antenatal care visits a comprehensive research instrument could not be used. Our question contains the elements 'forced' and 'subjected to sexual activities against your will' and was probably perceived as rather restricted. Consequently, the reported incidents were probably more serious than non-tactile experiences. CSA may be underreported due to the expression 'against your will' as consent is not appropriate regarding children.

According to previous research, about half of women subjected to physical violence by an intimate partner are sexually abused as well^{24,25,114}. The combination of physical and sexual abuse indicates more severe abuse and greater risk of homicide¹¹⁴. In our study of pregnancy complications and pregnancy outcome it would have been interesting to learn if women exposed to both physical and sexual abuse by the same perpetrator were at greater risk. Even if we had retained the original question regarding sexual abuse within last year, the power to detect such risks would have been low.

Antenatal records

The midwives interviewed the women at their first antenatal visit in order to obtain data on socio-economic circumstances and both reproductive and general health history. Data were collected on standard antenatal record forms. There were few missing values. Besides the risk of recall bias there is a general risk of underreporting due to some women's unwillingness to disclose sensitive information such as pregnancy terminations, earlier genital infections, psychological problems or inappropriate behaviour. Of the women eligible for participation in our study, 7.4% reported smoking at some time during pregnancy. Data from Medical Birth Registry showed that in 1998, 11.7% of the women who gave birth in Sweden were smokers (Table III)¹⁵². There seems to be no particular reason why smoking should have been especially underreported in our study.

During pregnancy only those who met a doctor at the antenatal clinic or regional hospital for problems such as bleedings, pre-term contractions, or back pain, or those who told the midwife that they had seen another doctor,

could have a diagnosis inserted in their antenatal record. Thus, pregnancy complications might be underreported.

Open-ended question

As the research area was new we used an open-ended question to elicit information as to how women explained their attitudes. To enhance reliability, two people independently undertook the categorizing. Inter-rater reliability was high both when identifying the statements to be categorized and when actually categorizing, which supports the findings. In order not to overestimate the women's opinions in a positive direction, even a vague expression of opinion that the questioning might have been distressing, was categorized as unacceptable/disagreeable. Thus, we categorized as negative those women who *probably* found it unacceptable/disagreeable, and those who found it uncomfortable to contemplate the fact that violence to women is a reality, as well as those who stated openly that they found the questioning distressing or sensitive. The midwives who had questioned the women about violence also collected the women's written statements of opinion about being asked, which might have caused a 'social desirability' bias.

Attrition

Participation was high in the prevalence study. Only 26 women declined to participate. The written information given to the women invited to participate informed them about the purpose of the study — to enhance knowledge about violence against pregnant women. Consequently, women might have refrained from participating because they did not want to admit abuse, or simply because they were not abused and therefore believed the study did not apply to them. Forty-one women had not been invited to participate because they had their partner or a close relative present at every visit. This group consisted of about equal proportions of native Swedish couples and of immigrants where the spouse acted as interpreter. Non-participants could not be compared with participants regarding background data as we had omitted to apply for permission from the Ethics Committee to use such information from the medical records regarding non-participants.

Eighteen percent of the eligible women were not presented with or did not answer the open-ended question. Practical considerations caused most drop-outs in the follow-up (12%). It is unlikely that these women differed systematically regarding attitudes to the questioning from those who answered all questions. Among those who declined participation (3%), those who did not wish to answer the open-ended question in writing (1%), or those whom the midwives did not want to phone (2%), there might be an overrepresentation

of women with a less favourable attitude to being questioned about violence. However, as these subgroups were relatively small, this might have affected the findings only to a limited degree.

Statistical considerations

Our primary purpose was to estimate the prevalence of physical abuse during pregnancy. Therefore, the sample size was calculated assuming a 5% prevalence of such violence, but the assumption was not confirmed. A power analysis for the comparisons between abused and non-abused women was not performed, as this was not the main purpose of this study. To reveal statistical differences for multi-etiological conditions, multivariate statistics are needed, which would require a larger sample. Values of $p < 0.05$ were considered significant and no corrections for mass significance were made; this increases the risk of type I errors. Awareness of this risk occasioned us to interpret the findings with caution. On the other hand, using a smaller p -value would have increased the risk of type II errors, implying a greater risk of overlooking existing differences. The risk of type II errors is appreciable even with a p -value of < 0.05 .

Ethical considerations

Ethical guidelines concerning research on violence, published by the World Health Organization, recommend that studies should be founded on current research knowledge of how to minimize underreporting of abuse, as underreporting could be used to question the importance of violence as a legitimate area of concern¹. In our study on the prevalence of physical abuse during pregnancy, we applied what was known in the field at the time. Our prevalence rates are not likely to be the result of substandard methods. Regarding sexual abuse, our method of questioning might conceivably have caused underreporting. Nevertheless, our results do highlight sexual abuse as an important issue in antenatal care.

WHO also urges researchers to undertake studies only if they are able to ensure the respondents' safety and provide assistance. Training and support must also be arranged for the interviewers. These recommendations were met in our study. For instance, midwives were informed about the nature of emotional, physical and sexual abuse, and referral options. This knowledge was intended to boost their confidence when questioning women. Disclosure of abuse could arouse different kinds of feelings in the midwives. They might have felt vulnerable if women they could easily identify with, admitted to have been assaulted or they might have felt helpless and frustrated when a woman did not accept the help offered. Other midwives might feel

they had failed in their previous work if a woman they had seen during earlier pregnancies disclosed abuse when asked in this study. To counteract that these kind of feelings might discourage them from asking, debriefing and opportunities to discuss problems were arranged.

Methodological considerations, paper IV

Focus groups were chosen because the research method has been shown to be particularly useful for exploring people's behaviours, attitudes, and experiences and what people think or feel about a particular issue or problem¹⁴⁸. The method uses explicitly group interaction because personal opinions derive rather from communication with others than from internal processes¹⁵⁵. The method has high face validity by virtue of the credibility of the comments from the group members.

Participants

All antenatal care midwives in the area were invited. Seven of the 28 midwives did not participate. There is no reason to believe that those who were ill or who did not participate due to scheduling conflicts differed systematically from those interviewed. The 3 midwives who actually declined to participate might have been less inclined toward routine determination of violence.

Procedures and data collection

Relatively small groups were chosen so as to generate a high level of participant involvement. Moreover, small groups are more appropriate to emotionally charged topics¹⁴⁶. The fifth group had only 2 participants, which undermines the group dynamic inherent to the method. Irrespective of size, all groups echoed the same themes and from the fourth group there were few new comments, and so the fifth group was included in the analysis. The difficulties encountered in scheduling the interviews demonstrate one drawback of the method.

The possibility of response bias cannot be excluded. In group discussions there is a risk that participants censor themselves or say what they think is appropriate if they are not comfortable with other group members or with the Moderator or Observer. However, the range of opinions and the enthusiasm displayed in the discussion make such bias seem unlikely. Different viewpoints could interact and the participants argued for their opinions. The main themes were discussed in all groups.

Data analysis

Data analysis started during the discussions. Towards the end of each meeting the Moderator summed up the content of the discussion and participants were encouraged to comment on the summary and to add further viewpoints. Immediately after the meeting the Moderator and the Observer discussed important topics, unexpected views and questions that had arisen in the group. The person who had moderated all the groups and transcribed the discussions carried out the data analysis. To enhance credibility a senior researcher unfamiliar with the subject and who had not participated in the data collection took part in elaborating and testing of the themes. Finally, the Observer and the participants were invited to read and comment on the preliminary findings. The Observer made a few minor comments, which were considered. None of the participants commented on the content. Checking of the results by members is a problem as participants can only know what was said in their own group. Contents, which they do not recognize, could originate from another group. In this study, participants were promised to read the results, mainly to enable them to be sure they could not be identified.

Transferability

In qualitative research, generalization is not appropriate. Instead it is left to those who apply the results to decide if the findings can be transferred to another situation. To make that decision possible the researcher must thoroughly describe participants, procedures and context ¹⁴⁴.

Ethical considerations

In a focus group discussion, everyone participates on equal terms and has a fair degree of control over the interaction. Nevertheless, focus groups involve the sharing of information with several persons. Hence, confidentiality is a central ethical concern ¹⁴⁷. At the beginning of each meeting the Moderator emphasized the importance of not spreading what was discussed within the group. Furthermore, participants were assured that no individual respondent could possibly be identified in the final report.

General considerations

Prevalence of physical abuse

In this study, for the first time the entire obstetric pregnant population within a specific district was assessed regarding exposure to men's violence against women. Physical violence by a current or former male partner or relative during the year preceding pregnancy, during pregnancy, or within 20 weeks of delivery was reported by 2.8% of the participants and physical violence during pregnancy or within 20 weeks of delivery by 1.3%. Of the latter all but two had been abused during the year preceding pregnancy as well. This is consistent with previous studies showing that a history of abuse is a strong predictor of abuse in pregnancy^{30,50,56,58,65}. Physical abuse is comparable in frequency to obstetric complications such as gestational diabetes and pre-eclampsia (1.6% and 3.6% respectively in this material). Prevalence rates of physical abuse during pregnancy reported in previous studies ranged between 0.9% and 20.1%⁶⁸. Reports from population-based studies and from representative samples are to be found in the lower part of this range, whereas reports based on clinical samples of women living under social deprivation are found in the upper part (Appendix). Social conditions appear to explain some of the differences in reported prevalence of abuse between different samples^{49,65}.

Social conditions

Most women in our study were gainfully employed or studying and most were cohabiting with the father of the child. Studies mainly from USA have demonstrated that higher socio-economic and well-educated groups have a lower reported prevalence of intimate partner violence during pregnancy than women who are socially less advantaged^{49,63,64}. It has also been shown that women who had intended to become pregnant were less likely to report abuse in pregnancy than women with unplanned or unintended pregnancies^{49,65}. In Sweden, contraceptives are easily available, women have a legal right to abortion and attitudes toward legal pregnancy termination are tolerant. Therefore, most pregnancies are probably intended – or at least accepted. These circumstances might have contributed to a lower reported rate of physical abuse in our sample than in studies of less socially advantaged women.

Nevertheless, many women with higher socio-economic status have been found to have a history of abuse^{16,63,64} (Appendix). Pecuniary and educational resources do not necessarily protect women from abuse, but make it easier for them to leave their partner, thus rendering them less likely to be

currently abused⁹⁸. Correspondingly, whereas social problems may not precipitate the violence, lack of social support, unemployment, low income, housing shortage, and drug problems make it far more difficult for such women to leave an abusive partner^{43,156}. The social welfare system can to some extent compensate for a lack of resources among women with social and pecuniary problems, thus making them less dependent on the abuser.

Underreporting

There are several general reasons for underreporting of violence in intimate relationships. Many abused women feel ashamed and blame themselves for their predicament. Fear of reprisals from the abuser, a perception of the experience of violence as being normal, or distressing encounters with health care professionals may discourage women from disclosing their situation⁶. Specific to our study were the circumstances that, despite our efforts to question all the women, 41 could not be assessed because they were accompanied by their partner or a close relative at every visit. As many abusive men try to exercise control over their partner, it is likely that in this category, abused women were overrepresented¹⁶. Furthermore, the public norm of gender equality is strong in Sweden and so is the expectation of pregnancy as a hopeful time. It is therefore difficult for a woman to disclose that she has chosen to have a child with an abusive man. Social expectations might act as a barrier to disclosure, especially for well-educated women and/or those with a good economy.

Prevalence of sexual abuse

When assessed with a single screening question regarding sexual abuse, 8.1% of the participating women reported that at some time in life they had been forced to participate in or subjected to sexual acts against their will. This highlights sexual abuse as a serious concern in antenatal and intrapartum care. The prevalence of LSA in our study is similar to rates based on obstetric clinical samples but lower than reports of LSA in population-based studies^{4,16,81,84,85,87,88}. No reports of LSA based on general populations of pregnant women were found for comparison.

Differences regarding populations studied, methods used, response rate achieved, and definition of sexual abuse make comparison between studies difficult^{80,82,83}. A strength of our study was that the response rate was so high (93%) as is compliance with the obstetric care program in Sweden¹³⁷. The prevalence rate of sexual abuse has been reported to be inversely associated with the response rate⁸². Nevertheless, there are several reasons for underreporting. The delicacy of the subject makes abused women disinclined to disclose abuse. Furthermore, memories that are too disturbing to recall can

be repressed, preventing the woman from recalling them, or making her lessen the gravity of what occurred^{5,157}. Williams reported that, of 129 women with previously documented histories of sexual victimization in childhood, 38% did not recall the abuse when asked detailed questions 17 years later¹⁵⁷.

Health problems and pregnancy outcome

The women in our study who reported physical abuse during pregnancy and/or LSA were more likely than non-abused women to report health problems preceding pregnancy. This is consistent with the results from numerous cross-sectional investigations demonstrating a close positive relationship between men's violence against women and health problems^{15,16,24,40,84,99,101,110}. Although a causal relationship could not be demonstrated in our study, there are studies indicating the existence of such a relationship^{103,109,111}.

A history of elective abortions was more common among women physically abused during pregnancy than among those not reporting abuse. As previously described, women with an unwanted or mistimed pregnancy are more likely to be abused than women with an intended pregnancy⁴⁹. We do not know why, nor do we know all about reasons for unwanted or unintended pregnancies. However, abuse is a matter of power and control. Coerced sex and male control of contraception could explain a proportion of unintended pregnancies¹¹⁵.

Women subjected to physical abuse during pregnancy did not differ from non-abused women regarding serious pregnancy complications and pregnancy outcome, except that abused women were somewhat more likely to give birth after a shorter pregnancy. Neither reproductive history, serious pregnancy complications, nor pregnancy outcome distinguished between sexually abused and non-abused women. Nor was adverse birth outcome a conspicuous finding in previous studies of women who had experienced LSA, or among CSA survivors^{87,95,158}. Multivariate analyses were not performed to take other risk factors into account, which is why the results should be interpreted with caution.

Pregnant women's attitudes to questions about abuse

Most women in our study found the questioning about experiences of violence acceptable and only 3% found it unacceptable or disagreeable. Some women said they perceived the questions as a gesture of caring. Others thought that the midwives' questions helped them to talk about the violence. Non-exposed women readily agreed to be asked about violence if this could help other women. This is a sign of solidarity. Another point of view was that, by tak-

ing up the subject of violence, women would be better prepared if something happened. Many women mentioned that the antenatal clinic is the right place and pregnancy the appropriate time to ask these questions, as the women and the midwife meet several times and have time to build up confidence. More recent studies from antenatal care confirm our results ^{120,131}. Bacchus et al. reported that almost all pregnant women found routine enquiry regarding violence acceptable, on condition that the questions were asked in an empathic non-judgmental way ¹²⁰.

In our study a substantially larger proportion of those who reported a history of abuse compared with the women who denied ever having been assaulted, found it both acceptable and unacceptable/disagreeable to be asked about exposure to violence. Even when the questions aroused unpleasant thoughts and memories, these women were pleased that they had been asked. Some of them welcomed an opportunity to talk about their own situation. The questioning might be the beginning of help and treatment of the consequences of abuse. Similar findings were published in a study by Webster et al. In their study, 98% of 1,263 responding women thought it was a good idea to ask women about domestic violence. Of the 4% who said they felt uncomfortable being questioned, 3 out of 4 still thought it was a good idea to ask ¹³¹.

There was no significant difference in our study regarding a solely critical attitude to being asked about exposure to violence, between those who disclosed abuse and those who did not. Both groups had one wish in common – not to be reminded of what had happened or what might happen. Regarding the abused women who found the questioning unacceptable or disagreeable, the abuse had happened long ago. Of course, the midwife has to be sensitive, respect a woman's unwillingness to talk about the subject, but let her know that she cares and that there are resources available.

Routine assessment regarding violence makes a difference

The effects of assessment regarding violence could be studied from different perspectives. In a telephone survey of a nationally representative sample of women in USA it was found that abused women reported more difficulty in communicating with physicians than did other women. They were four times more likely to say that the physician did not listen attentively and three times more likely not to discuss a medical problem with their physician because they or the physician were uncomfortable or embarrassed ¹¹⁹. Giving abused women opportunities to talk about their concerns and maybe the cause of their health problem would probably help to establish a better communication and make patients more satisfied with care ¹³⁵.

Routine enquiry in antenatal care increased the identification rate of women experiencing domestic violence^{62,69,133}. However, identification is not enough; women who disclose abuse must be offered appropriate help and support. Effectiveness of interventions to reduce abuse is difficult to demonstrate, as the effect is mostly not immediate but an ongoing process. Nevertheless, there are several circumstances indicating that routine questioning does make a difference. To ideally evaluate the effectiveness of interventions, women with a known abuse status should be randomized to intervention or control. However, to withhold support and information from women identified as abused would be unethical. In a study by Parker et al., a resource card with information about community resources was considered to be a minimal-level intervention, from the ethical aspect¹⁴³. In their study, they found that pregnant women who took part in an empowerment intervention reported less abuse than women in a comparison group with no intervention during pregnancy. The comparison group was recruited before the study group, a few weeks post delivery, and questioned retrospectively regarding abuse during pregnancy. This was done to avoid the potential effect of the abuse assessment including the resource card. McFarlane et al. compared three levels of intervention regarding their effectiveness in reducing partner violence to pregnant women¹⁵⁹. The levels were i) a card with information about community resources and written information on safety planning, ii) unrestricted access to counselling services, iii) unrestricted access to counselling services plus the service of a 'mentor mother'. At long-term follow-up (6, 12 and 18 months), the severity and frequency of abuse had decreased in all groups but there were no significant differences between the groups and the authors concluded that abuse screening itself may be an effective intervention to prevent abuse.

Sexual abuse can influence the experience of pregnancy, labour and parenting. In antenatal care the woman can be encouraged to express her wishes and concerns regarding examinations, delivery and breast-feeding and be encouraged towards a more positive belief in her own abilities. Childbirth is a potentially positive experience that can and should offer an opportunity for every pregnant woman to maintain or regain control over her body. Midwives working with women who fear labour should be aware of sexual abuse as a possible cause for such fear. Therefore, by raising the subject of sexualized violence it is possible for midwives in antenatal care to make an appreciable difference for abused women.

A challenge in antenatal care

Important objectives in antenatal care are to identify physical and psychosocial risks to the health and wellbeing of the mother and her unborn child and as far as possible to prevent these risks from having a deleterious effect on mother and child. Another objective is to prepare expectant parents for parenthood¹⁶⁰. Poor psychosocial conditions and lifestyle issues are nowadays the most serious threat to the health and wellbeing of the mother and her unborn child. Men's violence against women constitutes one such risk to both^{27,37}. Routine questioning regarding violence is consistent with the objectives of antenatal care and should be an integral part of obstetrical care. Furthermore, ethical guidelines from the WHO require that results from research regarding violence should be used to promote the development of policy and intervention¹.

Antenatal care and contraceptive counselling may be the only reasons why healthy women contact health care providers. This is where midwives can play an important role in preventing and detecting violence against women. By asking all women about exposure to violence, they can draw attention to the harmful nature of abuse. When medical staff identify abuse as a public health concern that can affect any woman, they are in the position to provide education and anticipatory guidance before the cycle of violence begins. Primary prevention also includes the promotion of gender equality. Secondary intervention occurs after the violence has begun. In these cases the task of the midwife is to inform about available resources and to offer assistance.

To overcome obstacles

The importance of routine determination of violence was emphasized by the midwives in the focus group discussions. Nevertheless, several obstacles were mentioned, the most prominent being the sensitivity of the subject. The perceived sensitivity of the questioning highlighted the need for a natural framing for such questions. Violence was often presented to women as a health problem. The midwives wanted to connect the abuse questions with other questions about health risks routinely determined in early pregnancy. As the male partner had been invited to every visit it was not practicable to establish a procedure where the assessment was connected to related issues and carried out at a particular visit. Instead, the midwives were reduced to seeking suitable opportunities to raise the questions. In cases where the partner was present at all visits, they had to let him know that he should not come on one particular occasion even though invited. The midwives could then feel frustrated.

The purpose of inviting the male partner is commendable, in order to make him feel more involved in his wife's pregnancy and in parenthood

generally, thus promoting gender equality. In one British study, most pregnant women not experiencing violence were happy for their partner to be involved in all aspects of their maternity care¹²⁰. Probably, this involvement would not be wasted even if one appointment were reserved for the woman alone. Should a conflict of interests arise in antenatal care, the interests of the woman (and the child) must take precedence.

To improve the feasibility of questioning all pregnant women and to give them an opportunity to disclose any ongoing abuse, at least one private appointment should be arranged^{120,125}. To women not fluent in Swedish, an interpreter must be provided. When a private visit takes place early in pregnancy there is more time to intervene if the woman reveals abuse and the midwife has not yet formed any preconceived notions about the man which might make her feel disloyal when asking. Furthermore, with early assessment it is possible to repeat the questioning later in pregnancy, which will probably increase the number of women who disclose abuse^{69,120}.

Other obstacles to routine determination of violence identified by the midwives in our study were lack of time, a mere oversight, preconceived notions regarding who might and who might not be a victim, and language difficulties. Some of these obstacles are the same as those found in other studies^{6,129}. According to the midwives, most could be overcome. One obstacle not mentioned by the midwives in the focus group discussions, but tackled on the initiative of the Moderator, was the possibility of abuse experienced by the midwives themselves. Why this factor was not mentioned spontaneously might have been because the midwives did not regard themselves as possible victims of abuse, or because the subject was perceived as too sensitive. Medical staff are not unlike the population as a whole regarding a personal history of violence^{130,161}. Personal experience of violence that has not been faced up to and dealt with might preclude caregivers from raising the subject so as to suppress their own feelings of vulnerability¹³⁰. For others, a history of abuse for which they have received counselling can prompt them to take action against violence. Midwives must have access to personal counselling in order to be able to examine their own experiences and feelings.

Facilitating factors

According to the midwives in our study, a basis for abuse assessment is education concerning the nature of men's violence against women and also a knowledge of referral options. To confront preconceived notions ongoing training is important. However, Waalen et al. concluded in a review that education alone did not significantly promote assessment¹²⁹. Interventions utilizing other strategies in addition to education appeared to be more effective. The midwives in our study emphasized the importance of easy accessi-

bility to organizations providing support for abused women, as midwives have neither time for nor knowledge of counselling. These contacts should be consolidated before routine abuse assessment is introduced. Other basic conditions were assessment protocols, enabling midwives to ask all women the same questions in the same way, and opportunities for coaching of midwives. Well-established routines will facilitate the questioning, save time and avoid strain; whereas contradictory demands arouse feelings of frustration and failure (Figure 3).

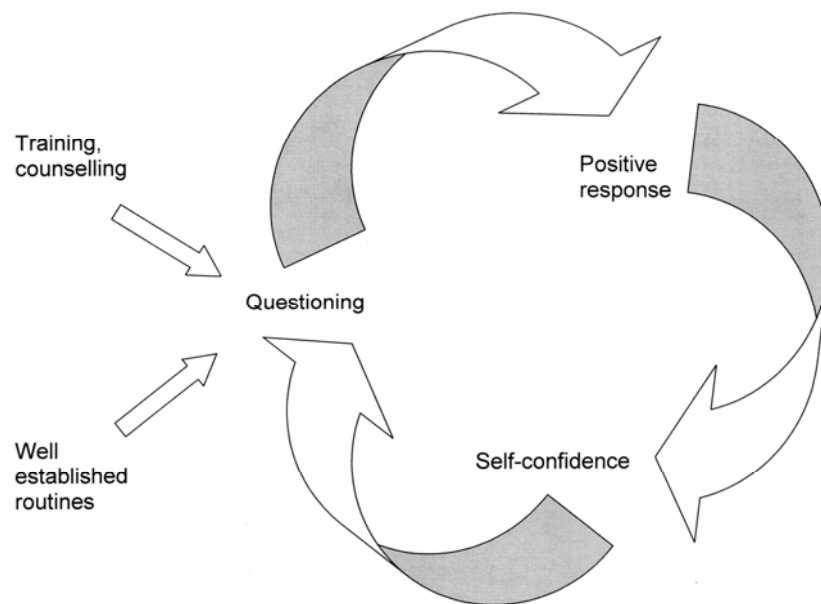


Figure 3. Factors facilitating routine assessment of violence

Favourable responses from pregnant women made the midwives in our study more confident and hence more likely to ask (Figure 3). Thus, emotional resistance by the midwives regarding abuse determination will probably abate as they gain experience. Coelings & Harman described six stages that nurses at an antenatal clinic went through when learning to ask about violence¹⁶². At first they often forgot to ask. Then they did remember, but found excuses not to ask. In the third stage they asked, but explained to the clients that they had been ordered to. When they had begun to ask they also began experimenting to find ways to put the questions in their own words. In the fifth stage, the questions were like any questions and the nurses felt com-

fortable when asking. Finally they accepted full personal responsibility for the enquiry ¹⁶².

It lies within the responsibility of the local health care management to provide training and to establish official policies and instructions regarding questioning, and referral. To implement routine questioning about violence is not a one-off event. The management must provide unflagging support, e.g. by establishing and monitoring routines, and by providing training, coaching and feedback. And one must also bear in mind staff recruitment. Most staff receive no education on this subject during their vocational training.

Antenatal determination of violence should not depend solely on local initiatives. Prevention of men's violence against women should be a concern in antenatal care nation-wide. Therefore routine assessment should be included in the National Guidelines for antenatal care. Some of the midwives in our study asked for a 'check box' in antenatal records to emphasize the importance of the issue and to make it easier to remember the questioning.

The role of the midwives

The midwives in our study perceived their role in abuse determination as: to broach the subject to increase public awareness of the problem, to send the message to all women that being abused is not shameful, to give affected women an opportunity to talk about their situation, and to mediate help. This is a reasonable mandate for antenatal care. Several domestic violence guidelines from American professional organizations require health care workers to help in identifying, intervening in and following up cases of partner abuse ¹⁶³. These duties might be felt overwhelming along with ever-increasing demands and time constraints. In line with what was expressed by the midwives in our study, Gerbert et al. suggested that the role of care-givers should be focused on asking, validating (acknowledging that abuse is reprehensible and confirming their clients' intrinsic worth), documenting and referring to specialist care ¹⁶³. The midwives were aware of pregnant women's reluctance to disclose an ongoing abusive situation. Routine questioning will identify some victims, but many battered women will not directly disclose their situation. However, confirmation does not depend on direct disclosure. Successful questioning about violence should be defined so that the act of compassionate asking itself, rather than the outcome of eliciting direct disclosure, is what characterizes success. Realistic goals will probably reduce the risk of 'burnout' among staff resulting from a perceived lack of success in achieving disclosures.

A growing awareness in Swedish antenatal care

The results of the prevalence study, published in papers I–III of this thesis, were presented at a national symposium in Stockholm on International Women's Day in 2001. The symposium was a collaborative event arranged by

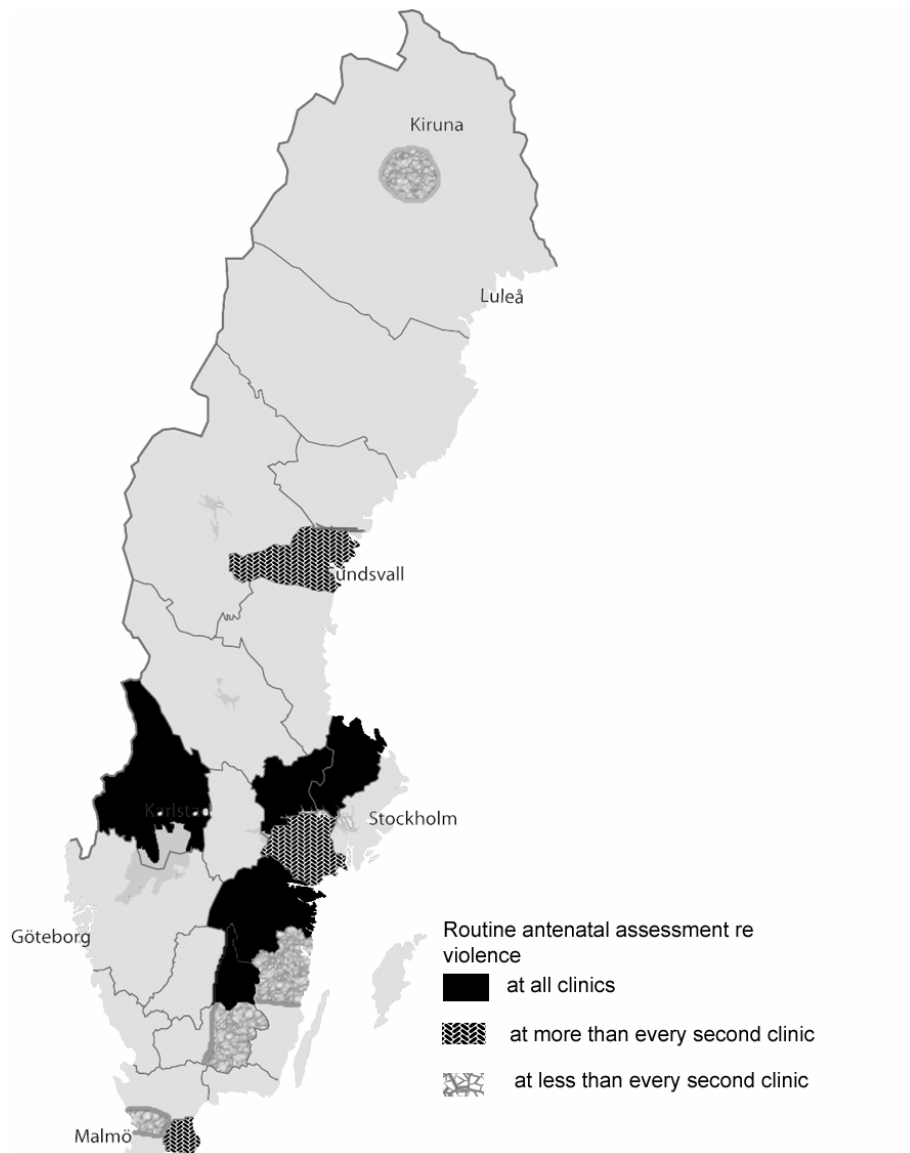


Figure 4. Routine antenatal assessment regarding abuse is practised in the regions marked¹⁶⁴

the National Center for Raped and Battered Women and the Swedish Association of Midwives. Target groups were midwives, obstetricians, psychologists, and social workers in antenatal care. The results aroused great interest and a huge demand for information regarding the subject in antenatal care throughout the country. Another result of the study was that, in 2001, routine assessment regarding violence was established in antenatal care in the county of Uppsala. Furthermore, during nine months, in 2001, the National Board of Health and Welfare carried out a project, intended to develop methods for routine 'screening' for violence against women. Midwives at about 50 antenatal and youth clinics in three counties participated¹³⁶.

In October 2003, the National Center for Raped and Battered Women made a national survey in Swedish antenatal care regarding routine questioning about violence¹⁶⁴. One purpose was to ascertain if midwives working in antenatal care had received training regarding men's violence against women. Another purpose was to survey practice regarding routine abuse assessment. There are 50 co-ordinating midwives in antenatal care in Sweden; all were approached in a telephone survey. Response rate was 96%. The co-ordinators reported that more than 2/3 (1,016/1,475) of the midwives in antenatal care had received some training regarding men's violence against women. Routine assessment about violence has been established in several counties or parts of counties (Figure 4)¹⁶⁴. Several other districts are planning such routines.

The future

Men's violence against women occurs mainly in a context of male power and control. In the long term, promotion of gender equality will be the most appropriate way to put an end to such violence. Parallel with striving for an egalitarian society, the effects of the violence must be identified and treated. Here, health care – and especially midwives in antenatal care – can contribute by introducing and developing the practice of routine questioning regarding violence. To make progress in these efforts, an overall discussion regarding content and priorities in antenatal care must take place. Those who need extra support must be distinguished from those who, for the time being, can manage with basic antenatal care. Therefore, a thorough anamnesis regarding needs and risks to the mother and the unborn child is essential in early pregnancy. This assessment of need could be carried out at two separate visits, one of which should be reserved for the woman alone and the other for the woman and her partner. In this way the woman will get an opportunity to discuss (a) her relationship with the child's father, (b) partner support,

(c) abuse experiences, and other personal matters that she might feel unable to discuss in the presence of her partner.

In the Government's Bill for Action Against Violence Against Women a number of authorities are instructed to take action to counteract and if possible, prevent such violence. The National Board of Health and Welfare is ultimately responsible for formulating guidelines and recommendations for antenatal care. Together with the Swedish Association of Midwives, the Swedish Society of Obstetrics and Gynecology and the National Center for Raped and Battered Women, the National Board should develop new guidelines for antenatal care, taking recent research into account.

Further research

Men's violence against women is a serious female health issue. One consequence of routine assessment for violence will be that, regarding some women with physical, psychological and psychosocial problems, the problems can be attributed to abuse experiences. To understand and to satisfy the needs of these women, our knowledge must be expanded. Important areas for future research are:

- ◆ the development and evaluation of appropriate treatment for women suffering from the consequences of abuse
- ◆ abused women's preferences and needs regarding antenatal care, intrapartum and maternity care
- ◆ the influences of abuse on unintended or unwanted pregnancies and pregnancy termination.

Summary and conclusions

Almost all pregnant women in a Swedish municipality were questioned regarding abuse experiences. Of these, 2.6% reported physical abuse by a partner, a former partner or a relative, during the year preceding the pregnancy, while 1.3% reported abuse during pregnancy or shortly afterwards. Thus, physical abuse is a risk factor comparable in frequency to obstetric complications such as gestational diabetes and pre-eclampsia.

Sexual abuse at some time in life was reported by 8.1% of the women. The assaults had occurred during childhood, adolescence and/or adulthood. In most cases the perpetrator was someone the woman knew. To midwives and obstetricians who work closely both physically and emotionally with women, an awareness of the extent of sexual abuse and of possible sequelae is essential.

More women disclosed abuse experiences when the questioning was repeated late in pregnancy or after delivery.

When comparing women physically abused during pregnancy with non-victims, the former were more likely i) to be single, ii) to report more preceding ill-health, and iii) to have had more elective abortions. Although abuse might be more prevalent among women with certain characteristics, it occurs in every stratum of society.

Sexually abused women reported more general health problems such as gynecological disease and surgery, pulmonary disease/asthma, and psychiatric conditions, compared with those who did not disclose sexual abuse. No differences were found regarding reproductive history, pregnancy complications or pregnancy outcome, except that more of the sexually abused women had experienced pre-term contractions.

Most pregnant women found the midwives' questions about abuse experiences acceptable. Only 3% considered the questions unacceptable/ disagreeable. Abused and non-abused women did not differ regarding disinclination to answer the abuse questions.

Antenatal care midwives having routinely questioned pregnant women regarding men's violence against women emphasized the importance of the assessment, but experienced several obstacles. The most prominent obstacle was the sensitivity of the subject, which highlights the need for a natural framing for the questions. This obstacle was reinforced by the presence of the male partner. As the partner was invited to all antenatal visits it was not possible to establish a routine whereby the assessment was connected to related issues and carried out at a particular visit. Well-established routines were required. A private appointment for all women would enable routine assessment for abuse of all pregnant women.

According to the midwives a precondition for abuse assessment is education concerning the nature of men's violence against women. Other essential requirements are official policies and instructions, opportunities for coaching, and knowledge of referral options. Well-established contacts with organizations providing support are necessary.

Midwives can play an important role in preventing and detecting violence against women. Asking direct questions in pregnancy regarding abuse experiences demonstrates concern for the woman and her unborn child. By asking all women, abused women get opportunities to disclose the abuse and obtain help. By acknowledging that battering is reprehensible and confirming the woman's intrinsic worth, midwives can allay the shame of being abused. Even abused women who do not disclose their situation will have their worth confirmed and a process towards an improved situation can start. For non-abused women the questioning can serve as public health primary preventive measure. Successful questioning regarding violence should be defined so that the act of compassionate asking itself, rather than eliciting direct disclosure, constitutes success.

Summary in Swedish/Svensk sammanfattning

Mäns våld mot kvinnor – en utmaning inom mödrahälsovården

En kvinnohälsofråga

Mäns våld mot kvinnor har internationellt alltmer uppmärksammats som en kvinnohälsofråga och som ett hinder för jämställdhet. Våldet kan vara fysiskt, psykiskt, sexuellt och ekonomiskt i olika kombinationer. Det utövas oftast av närstående män såsom pojkvänner, makar, fäder eller bröder. Våldet bidrar till att vidmakthålla, kvinnans underordnade ställning och kan ses som ett uttryck för att vi inte lyckats skapa ett samhälle med ömsesidig respekt och jämlikhet mellan könen. Enligt en sammanställning som gjorts av WHO, av studier av representativa nationella urval från hela världen, uppger mellan 10 och 34% av de kvinnor som lever eller har levt med en man att de någon gång utsatts för fysiskt våld i en relation. Motsvarande andel i en stor svensk omfångsundersökning från 2001 är 16%[#]. I samma undersökning uppger 24% att de någon gång i livet utsatts för sexuellt tvång eller försök till sexuellt tvång. Den rapporterade förekomsten av fysiskt våld under aktuell graviditet varierar internationellt i olika studier mellan 1 och 20%. Många gravida kvinnor lever dessutom med mer eller mindre obearbetade upplevelser av tidigare övergrepp. Våldet utgör ett hot mot kvinnan och hennes barn både fysiskt och känslomässigt.

Avhandlingen syften

Det övergripande syftet med denna avhandling är att undersöka hur vanligt förekommande det är att gravida kvinnor i Sverige har erfarenhet av våld

[#] Tidigare opublicerade data från omfångsundersökningen Slagen Dam. Mäns våld mot kvinnor i jämställda Sverige – en omfångsundersökning¹⁶.

och hur gravida kvinnor uppfattar att ställas inför frågor om sådana erfarenheter. Syftet är också att tillvarata de erfarenheter som mödravårdsbarnmorskor uppnått i arbetet med att som rutin ställa frågor om våld till gravida kvinnor.

Gravida kvinnors erfarenhet av våld

Den första studien omfattade alla kvinnor, som skrevs in på någon av Uppsalas mödravårdscentraler (MVC) under ett halvår (sept 1997 – febr 1998). Kvinnorna ombads besvara fem frågor om våld (Tabell 7) vid tre tillfällen; tidigt i graviditeten, sent i graviditeten och vid återbesöket efter förlossningen. Mödravårdsbarnmorskorna ställde frågorna. Barnmorskorna hade fått utbildning om mäns våld mot kvinnor och hade under studiens gång kontinuerlig tillgång till stöd. Alla kvinnor i studien informerades om Rikskvinnocentrum och de som berättade om våld erbjöds hjälp.

Table 7 Frågor i den svenska versionen "Abuse Assessment Screen"†

1. Har du någon gång utsatts för psykisk eller fysisk misshandel av din partner eller av någon annan för dig betydelsefull person? Ja Nej
2. Har du under året före den här graviditeten blivit slagen, sparkad eller knuffad eller på annat sätt fysiskt skadad av någon? Ja Nej
Om ja – av vem? Make Fd make Pojkvän Fd pojkvän
Okänd Annan Antal gånger
3. Har du sedan du blev gravid (alt. sedan du senast tillfrågades) blivit slagen, sparkad eller knuffad eller på annat sätt fysiskt skadad av någon? Ja Nej
Om ja – av vem? Make Fd make Pojkvän Fd pojkvän
Okänd Annan Antal gånger
4. Har du någon gång tvingats till eller utsatts för sexuella handlingar mot din vilja? Ja Nej
Om ja – vid vilken ålder? 0–12 13–19 20–
Om ja – av vem? Make Fd make Pojkvän Fd pojkvän
Annan bekant Okänd
5. Är du rädd för din partner eller någon annan du nämnt här? Ja Nej

† Originalinstrumentet har utvecklats av "the Nursing Research Consortium on Violence and Abuse".¹³⁸

I studien deltog 1038 kvinnor (93% av 1120 möjliga). Tjugosex avböjde när de tillfrågades om att delta och 41 kunde inte frågas för att mannen var med vid varje besök. Av de kvinnor som besvarade frågorna om våld uppgav 2,8% att de utsatts för fysiskt våld från en närstående året före eller under graviditeten och 1,3% uppgav fysiskt våld under graviditeten och fram till efterkontrollen. Av dem som misshandlats under graviditeten hade alla utom två utsatts för våld även året före. Det gör våld året före graviditeten till en betydande riskfaktor för våld under graviditeten. Andra studier visar att för dem där våldet upphör under graviditeten finns dessutom risken att det återupptas efter förlossningen. Över tre procent uppgav att de var rädda för förövaren vilket visar på att våldet inte var utagerat från kvinnans synpunkt. De våldsutsatta kvinnorna rapporterade fler hälsoproblem före graviditeten och hade genomgått fler aborter än icke våldsutsatta kvinnor.

Vi frågade om sexuellt våld någon gång i livet därför att det är något som kan påverka kvinnans upplevelse av graviditet, förlossning och föräldraskap. Drygt 8% rapporterade att de någon gång i livet tvingats till eller utsatts för sexuella handlingar mot sin vilja. Förövaren var i flertalet fall någon kvinnan kände. Det var vanligare att de kvinnor som berättade om sexuellt våld rapporterade hälsoproblem, framförallt gynekologiska problem, lungsjukdom/astma och psykiska problem jämfört med de kvinnor som uppgav att de inte utsatts för sexuellt våld. Grupperna skilde sig inte när det gäller graviditetsutfall.

Att frågorna om våld ställdes vid flera tillfällen gjorde att fler berättade om erfarenheter av våld. Trots det är våldet troligtvis underrapporterat. Våld är ett tillitsbrott. Våldsutsatta kvinnor har ofta svårt att lita på andra. Skäl att inte berätta kan vara att kvinnan skäms och lägger skulden på sig själv. Hon kan vara rädd att hon inte ska bli trodd eller rädd för mannens hot. En stark jämställdhetsnorm och egna och andras förväntningar på graviditeten som en lycklig tid bidrar troligen också till att det är svårt för kvinnor att berätta att de utsatts för våld. Ytterligare en anledning till underrapportering kan vara att alla kvinnorna inte kunde tillfrågas. En grupp hade mannen med vid varje besök. Kontrollerande beteende och våld har nära samband.

Kvinnornas uppfattningar om att tillfrågas om våld

Vid sista frågetillfället ombads kvinnorna skriva ner hur de tyckte det varit att få den här typen av frågor av sin barnmorska. Frågan besvarades av 879 kvinnor. Av dessa ansåg 80% att det var enbart positivt att frågorna ställdes, 12% var neutrala, 5% ansåg att det var både positivt och negativt/obehagligt och 3% uppfattade det negativt/obehagligt i varierande grad. När de kvinnor som svarat ja på någon av frågorna om våld jämfördes med dem som svarat nej på alla frågorna visade det sig att färre av de våldsutsatta fann det enbart

positivt att bli tillfrågade medan fler fann det både positivt och negativt/obehagligt. Grupperna skilde sig inte när det gällde att uppfatta frågandet som negativt/obehagligt. De flesta våldsutsatta kvinnor ansåg alltså att det var positivt att frågorna togs upp även om de ibland väckte obehagliga tankar och minnen.

Mödravårdsbarnmorskornas erfarenheter av att ställa frågor om våld

Som en följd av ovannämnda studie infördes år 2001 frågor om våld som en del av anamnesen för gravida kvinnor inom mödrahälsovården i Uppsala län. Fokusgruppsdiskussioner angående erfarenheter av detta arbete genomfördes med mödravårdsbarnmorskor i Uppsala under våren 2003. Tjugoen barnmorskor deltog i någon av fem gruppdiskussioner.

Barnmorskorna ansåg att uppgiften att fråga om våld var viktig, men de berättade också om olika svårigheter som påverkade hur och om de frågade. Ett viktigt hinder var ämnets känsliga natur. Då ämnet av många av barnmorskorna uppfattades som känsligt ville de få in frågorna i ett sammanhang, t ex i samband med att man ställde frågor om hälsorisker och livsstil. Eftersom mannen inbjöds till alla besök var det inte möjligt att skapa en rutin där frågorna knöts till närliggande ämnen och därmed ett visst besök. Barnmorskan fick i stället passa på att fråga om mannen uteblev. Många tyckte det var svårt att få in frågorna på ett naturligt sätt vid senare besök. Barnmorskan hade då dessutom lärt känna mannen och hade svårt att tro att han kunde vara våldsam. Den rådande situationen skapade frustration och fungerande rutiner efterlystes.

Andra hinder var tidsbrist, glömska, motstridiga krav, språksvårigheter, och förutfattade meningar om vem som kan vara utsatt. När det gäller att fråga om våld såg barnmorskorna det som sin roll att öka medvetenheten om problemet, att minska skammen genom att våga tala om våldet, att kunna informera och förmedla hjälp och att ge stöd.

Frågor om våld som en del av anamnesen för varje gravid kvinna

Våld mot kvinnor är vanligt förekommande och många gravida kvinnor har erfarenheter av våld i pågående relation eller sedan tidigare. Det finns många skäl att anta att våld i samband med graviditet är underrapporterat. Dessutom utgör våldet ett hot mot mor och barn. Mödrahälsovårdens mål är att tidigt identifiera medicinska och psykosociala risker mot barnets och moderns hälsa och så långt som möjligt hindra att dessa riskfaktorer påverkar mor och barn negativt. Målet är även att förbereda föräldraskapet. Att identifiera och motarbeta våld mot kvinnor och barn är alltså helt i linje med verksamhetens mål. I princip alla gravida kvinnor i Sverige besöker en barnmorskemot-

tagning och som vår och andras forskning visat är flertalet kvinnor positiva till att frågor om våld ställs av barnmorskan.

Det är därför viktigt att arbeta vidare med att få in frågor om våld som en naturlig del av anamnesen på MVC för varje gravid kvinna. Detta kräver ett fungerande samarbete med andra myndigheter och organisationer som kan hjälpa våldsutsatta kvinnor. När kvinnor berättar om våld ska barnmorskan kunna hänvisa dem vidare för hjälp och stöd. Ett viktigt led i att undanröja de hinder som återstår när det gäller att fråga är att man organiserar vården så att varje kvinna får ett enskilt besök hos barnmorskan helst i tidig graviditet. Att frågor om våld är en naturlig del av anamnesen bör också tydliggöras genom att frågorna får en egen del i den landsomfattande standardiserade mödravårdsjournalen. Ansvariga för mödrahälsovården ska se till att det finns skriftliga riktlinjer för arbetet. Att införa frågor om våld är inte en engångshändelse. Uppdragsgivaren måste även ansvara för att barnmorskorna får utbildning, handledning och fortbildning. Få har fått kunskap om mäns våld mot kvinnor i sin yrkesutbildning. Ny personal måste därför utbildas och introduceras.

Sist men inte minst är det viktigt att lyfta fram att barnmorskans roll främst är att arbeta förebyggande och upplysande. Att frågorna ställs ökar medvetenheten om våld mot kvinnor och kunskapen om var hjälp finns. Den som är utsatt men inte berättar nås ändå av budskapet att barnmorskan vågar tala om våldet, att ingen förtjänar att bli slagen och att det finns hjälp att få. Resultaten av mödrahälsovårdens arbete kan inte främst mätas i hur många kvinnor som berättar om våld utan hur många som får chansen att samtala om sin situation och som får upplysning om möjlig hjälp.

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Appendix

Studies regarding prevalence of physical violence in pregnancy

First Author/ Year/Nation	Sample/ partici- pation rate/ Status	Setting	Method/Timing/Period of observation
Amaro 1990 USA ²⁸	1,243/64% Poor	Public clinic, Boston, Mass	Interview/ First antenatal visit & postpartum/ Entire pregnancy
Berenson 1991 USA ⁴⁶	501/94% Low-risk	Public clinic Galveston, Texas	Interview/ Second antenatal visit/ Up to second visit
Berenson 1992 USA ⁴⁷	342/95% Indigent Teenagers	Pregnancy clinic, Texas	Interview/ First antenatal visit/ Up to first visit
Berenson 1994 USA ²⁹	512/95% Indigent	Public clinic Galveston, Texas	Interview/ First antenatal visit/ Up to first visit
Campbell 1992 USA ⁴³	488/60% Medicaid	Public and private clinics Midwest	Interview/2-5 days postpartum/ Entire pregnancy
Cokkinides 1998 USA ⁴⁸	6,718/ 70% Representative	New mothers South Carolina	Mailed questionnaire or tel. interview/ Postpartum/ Year before delivery
Curry 1998, 1998 USA ³⁰	1,897 Low income	Prenatal clinic Portland, Oregon	Interview/ During pregnancy/ Up to interview
Dye 1995 USA ³¹	357/98% Low income	From Medicaid risk registry, West Virginia	2 different interviews/ During pregnancy/ Up to interview
Gazmararian 1995 USA ⁴⁹	1,2512/71-84% Representative	New mothers 4 US states	Mailed questionnaire or tel. interview/ Postpartum/ Year before delivery
Gielen 1994 USA ⁴¹	275 /48% Low income	Prenatal clinic	Interview/Third trimester/Up to interview
Hedin 2000 Sweden ⁵⁰	207/>99% Swedish born with Swedish man	3 prenatal clinics Göteborg	Interview/ During pregnancy/ Up to interview
Helton 1987 USA ⁵¹	290/99% 22% employed	6 public, 2 private Large metropol. area	Interview/ During pregnancy/ Up to interview
Hillard 1985 USA ¹⁸	742/ 81% Poor	Public clinic, small city, Virginia	Interview/ During pregnancy/ Up to interview
Irion 2000 Switzerland ⁵²	204/84%	University hospital, Geneva	Self-report questionnaire/postpartum/ Pregnancy
Janssen 2003 Canada ⁵³	4,750/48.5% gen population	Available hospitals Vancouver	Interview/Admission to hospital/Pregnancy

Type of violence/ Violence measure	Perpetrator/ specified	Abuse in preg- nancy	Year before delivery	History of abuse
Physical or sexual/ abused involved in fights or beatings	Anyone/ 94% known	7%	10% [#]	
Physical/ Hit, slapped, kicked or otherwise physically hurt	Anyone/ Partner and/or relative (all but 1)	5.6%		19.6%
Physical/ Hit, slapped, kicked or otherwise physically hurt	Anyone/ mate or relative	6.7%		17%
Physical/ Hit, slapped, kicked or otherwise physically hurt	Anyone/-	7.2%		20%
Physical/ Hit, slapped, kicked or otherwise physically hurt	The man you are with or anyone else	7% [§] 8.2% [§]		11.2% [§] 14.4% [§]
Physical abuse/ Physically hurt	Partner		5.1%	
Physical or sexual/ questions)	AAS ^b (3 Someone/-	10.2 [#]		27% ^a
Physically hurt, involved in physical fight.	Someone/-	15.9		
Physical abuse/ hurt	Physically Husband or part- ner		3.8- 6.9%	
Moderate and severe physical violence/CTS ^c	Someone close to you	19%		
Physical abuse minor vio- lence/SVAW ^d	Current or ex- partner	11%		28% 25% [‡]
Physical/ Hit, slapped, kicked (physically hurt)	Male partner	8,3%		23%
Physical/ Hit or tried to hit	Anyone at home	3.9%		10.9
Physical/AAS ^b	Someone/-	3%		11%
Physical/AAS ^b question 3 and 5	Intimate partner	1.2%		

To be continued

(continued)

First Author/ Year/Nation	Sample/ participation rate/ Status	Setting	Method/Timing/ Period of observation
Jewkes 2001 South Africa ¹⁹	1,306/90.3% Random sample	3 provinces women 18-49	Interview/any time / Any pregnancy
Johnson 2003 England ⁵⁴	475/95%	Antenatal clinic North England	Questionnaire/First visit/ Up to first visit
Martin 1996 USA ⁵⁵	2,092/62% Medicaid	Prenatal clinic North Carolina	Interview/ During preg- nancy/ Up to interview
Martin 2001 USA ⁵⁶	2,648/75% Representative	New mothers North Carolina	Mailed questionnaire or telephone interview/ Postpartum/Pregnancy
McFarlane 1992, 1993 USA ^{57,58}	691 Poor	Public clinics Houston, Tex Baltimore, Md	Interview/Each trimes- ter/Pregnancy
McFarlane 1995, 1996, Parker 1994, USA ^{32,59,60}	1,203/>99% Poor	Public clinics Houston, Tex Baltimore, Md	Interview/Each trimes- ter/Pregnancy
Muhajarine 1999 Canada ⁶¹	543/74%	Public clinic Saskatoon	Interview/Third tri- mester/Up to interview
Norton 1995 USA ⁶²	143 />95% Poor, low-risk	Prenatal clinic Providence, RI	Interview/First visit/Up to first visit
O'Campo 1994 USA ³³	358/60% Low income	Public clinic, Baltimore, Md	Interview/Third tri- mester/Last 6 months
Sampsel 1992 USA ⁶³	934/99% Affluent	Private clinic Michigan	Self-report question- naire/ First visit/Up to first visit
Smikle 1996 USA ⁶⁴	563/68%/Stable economically	Private Texas	Self-report question- naire/During pregnancy/ Up to investigation
Stewart 1993 Canada ⁶⁵	548/98%	Private and public, Ontario	Self-report question- naire/20 weeks or more/ Up to survey
Webster 1994 Australia ⁶⁶	1,014/90%	Public clinic Brisbane	Interview/During preg- nancy/ Up to investigation

Type of violence/ Violence measure	Perpetrator	Abuse in pregnancy	Year before delivery	History of abuse
Physical/	Current or ex- partner	4.7-9.1%		19.1- 28.4%
Physical/AAS ^b	Partner or someone close	3.4%		14.7%
Physical/AAS ^b	Someone/	3% [#]		26%
Physical/pushed, hit, slapped or kicked or physically hurt	Someone/ mostly partner ex-partner	6.1%	6.9%	
Physical/AAS ^b (3 questions) Verified with CTS ^c and ISA ^c	Someone/ 92% partner or family	17%	26%	Last year
Physical/AAS ^b verified by self- report on CTS ^c and ISA ^c	Someone/ 77% partner or ex-partner [#]	16%	24.3% [#]	Last year
Physical/AAS ^b	Someone/ 63% husband	5.7%	8.5%	6.2%* Last year
Physical/AAS ^b	Someone/-	10%	15%	Last year
Moderate or severe physical/ CTS ^c	Someone close/ partner, relative other	20.1% [#]		
Physical, sexual and emotional/ Currently abused or mistreated	Someone/-	0.9%		9.7%
Physical/Hit, kicked, slapped or beaten	Someone/ known	1.2%		12%
Physical/Hit, choked, slapped, punched, kicked, injured with a weapon or other object....	Someone/ 97% partner or ex-partner [#]	6.6%		10.9%
Emotional, sexual, psycholo- gical, social and physical	Family member or close friend	5.8%		29.7%
		8.9%**		

[#] Estimates of prevalence calculated from the published data but not reported as such in the original article

[§] The man you are with

^s The man you are with or anyone else

^b AAS = Abuse Assessment Screen, see Table II ¹³⁸

^a Sexual abuse included

^c CTS = Conflict Tactic Scale ¹⁴⁰

^d SVAW Severity of Violence Against Women Scale ¹⁶⁵

[‡] Threats and physical violence the year before pregnancy

^c ISA = Index of Spouse Abuse ¹⁴¹

* Population estimates

** Those asked late in pregnancy (at 36 weeks and more)

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