Research Article

"There Are Challenging Cases for Us": A Qualitative Study of Cypriot Midwives' Experiences Investigating Incidents of Intimate Partner Violence During Pregnancy

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Background: There are many clinical guidelines worldwide for investigating intimate partner violence (IPV) during pregnancy. However, in Cyprus, these guidelines are not implemented in clinical practice. The midwives themselves choose how to manage the incidents involving pregnant women. This study aims to gain insight into the lived experiences of midwives who investigate incidents of intimate partner violence (IPV) during pregnancy.

Method: The study is qualitative. Data were collected through semi-structured interviews with 15 midwives who work in public and private hospitals, and the community in Cyprus. An inductive thematic analysis was employed for the analysis of data.

Results: The categories that emerged from the analysis of the interviews were: a) challenging cases, b) ambiguous procedures for management, c) barriers in management, d) midwives' needs. The midwives described their various experiences regarding the management of pregnant women who are victims of intimate partner violence, highlighting the emotions and concerns they face. They referred to the different procedures they follow for the care of victims, emphasizing the lack of a unified policy or protocol for handling such cases in Cypriot maternity hospitals. During the investigation, obstacles related to the administrative situation of the maternity hospitals emerged. They mentioned specific ways that would better support them in identifying and caring for victims.

Conclusions: The study highlights the great need for midwives to have continuous and frequent education and training in the recognition and management of victims of violence, as well as the integration of a common tool/guideline for identifying and recording victims in all hospital units in

Cyprus. This tool will contribute to the connection and cooperation with other services involved in supporting victims.

1. Background

The rates of intimate partner violence (IPV) during pregnancy are significant, with a meta-analysis showing that 12.8% of women globally experienced some form of IPV during pregnancy [1]. The risk of violence is significantly higher during pregnancy or shortly after childbirth, with incidents of violence either starting or intensifying during this period.[2] Several clinical guidelines[3][4][5] globally, advise healthcare providers in antenatal care to openly and privately inquire about any experience of violence in a woman's relationship, at least during the first visit of the pregnancy. Reporting IPV during the initial antenatal appointment is linked to increased reporting of all psychosocial risks and higher rates of antenatal admissions [6].Various healthcare professionals have identified obstacles and complexities in screening for and detecting domestic and IPV within clinical settings, including women's reluctance to report, concerns about child custody, fear of retaliation, time constraints, and staff shortages[7].

Antenatal Care in Cyprus and IPV screening

The General Health System (GESY) in Cyprus provides every pregnant woman with free access to 15 visits to a gynecologist/obstetrician and 6 visits to a community midwife. However, it is not commonly practiced to inquire about violence during these visits because many professionals involved in maternity care believe it is not something they should ask about. There are no protocols or clinical guidelines specifying the questions that should be asked of pregnant women or referring the pregnant woman to other social services. The official documents of public hospitals for the initial prenatal examination do not include a question related to the issue. As a result, each obstetrician or midwife decides individually whether to inquire about or investigate issues related to intimate violence. For this reason, there are no statistical data on the cases of pregnant women seeking support or assistance in maternity hospitals. The only available statistical data in Cyprus come from the Non-Governmental Organization, Association for the Prevention and Handling of Violence in the Family (SPAVO)[8], showing that 2% of the 5446 calls in 2020, they received to the hotline that helps and advises abused women who were pregnant. This fact was also documented in the UN Women's report on the "shadow

pandemic," as it was termed, with over half of the world's population under lockdown and reports of domestic violence surging during the initial weeks of the outbreak, including a 30 percent increase in calls to helplines in Cyprus[9]. Also, the Cyprus police record incidents of violence but do not report on pregnant women. They report only victims based on their gender.

Research focusing on the experiences of midwives in managing victims of violence is limited due to the nature of the subject. Despite this, studies have shown the need to make the issue of violence against women more visible in the mandatory education of midwives and to include their active participation to reduce violence against women, so they can understand its significance and impact on pregnancy, access to services, childbirth, and postpartum care[10]. Due to the inadequacy in recognizing and guiding victims, it is recommended to establish not only education but also a monitoring system that includes primary healthcare services[11].

This study will contribute to the body of knowledge regarding the management of intimate partner violence in Cypriot maternity hospitals. It will investigate the existence of clinical practices or hospital policies and the midwifery procedures for evaluating incidents followed in the department, as well as the barriers that affect the assessment of intimate partner violence cases in the clinical setting.

2. Methods

Recruitment and sample

We contacted the Midwives Committee within the Cyprus Association of Nurses and Midwives via letter, requesting their assistance in coordinating with hospital administrations and recruiting participants for the research, which resulted in a purposeful sample of participants being recruited. In the letter, the principal investigator explained the purpose of her research and informed the midwives that it was part of her doctoral thesis. The hospital administrations then referred individuals who expressed interest in participating in the study. For the initial focus group, we had ten attendees (n= 10) from five public hospitals (Nicosia, Limassol, Larnaca, Ammochostos, and Paphos), as well as two private hospitals (Nicosia and Larnaca), who also met the participation criteria. For the second interview, we invited all midwives by invitation letter who worked in the biggest public maternity hospital with a separate antenatal care department and some who worked as GESY Community midwives. Four midwives responded from the antenatal services, and one community midwife - GESY provider, making a total of five (n= 5) midwives. The eligibility criteria were (a) registered midwives of

the Cyprus Midwives' Registry who work in public or private hospitals or are providers within the General Health System in Cyprus, (b) have a good understanding of the Greek language, and (c) had participated in the educational program - STOPIPV on intimate partner violence during pregnancy organized by the research team of the Cyprus University of Technology in 2021.

The initial desired number of participants was based on similar studies conducted in other countries [12][13]. However, the number of participants arose from data saturation, as there was no new information and repeated information appeared during the analysis. A qualitative approach was chosen with semi-structured interviews to give the interviewees the chance to convey the actual situation prevailing in the clinical setting.

The interview questions (Table 1) were developed by the authors (EM, CK, EC, MK, NM) based on the results of the pre-post study conducted to investigate the effectiveness of the educational program - STOP IPV and other similar qualitative studies.

Experiences (focus on inicent managment)	1. How do you feel about assessing security and risk issues concerning pregnant women? Could you provide us with some examples of such cases?
Evaluation of current practices	2. How do you evaluate and manage incidents of intimate partner violence in the workplace? 1. Is there a protocol/policy for domestic violence incidents in your workplace? Please explain the process (recording, referral) 2. If there is no protocol, describe the procedure you follow when assessing domestic violence incidents.
Challengies & Barriers	3. What are the difficulties in investigating cases of domestic violence in your workplace? Can you explain them in more detail?
Multidisciplinary team	4. How would you describe your collaboration with other midwives, supervisors, doctors, and other healthcare professionals in investigating cases of domestic violence in your workplace?
Clinicians needs	5. What do you believe would help you deal with cases of IPV in your workplace?
Educational Intervention	6. Could you tell us what you found useful in the STOPIPV training program you attended and what could be improved?
Closing	7. Is there anything else you would like to mention, even if you consider it not directly related to what we're discussing?

Table 1. Interview Guide

Data Collection

Two focus groups were conducted, the first group with midwives (n=10) working in public and private maternity wards in the 5 districts of Cyprus, and the second group with midwives (n=5) working in antenatal clinics and the community as providers within the General Health System. The interview of

the first focus group took place in a lecture hall of the university, and the second in one tertiary hospital. The two focus groups were conducted with the primary researcher (EM) and under supervision by a member of the research team (EC) who has experience in conducting research and capturing non-verbal responses. Data collection occurred from March to April 2024. Interviews were scheduled at convenient times and followed a semi-structured interview guide. Conducted in Greek, the interviews lasted 60 – 90 min.

Analysis

The data analysis involved all four researchers: a) the principal investigator (PhD student), who was guided through all stages of the research by the others, who were highly experienced in qualitative research; b) an assistant professor of Midwifery with expertise in midwifery and qualitative research; c) an associate professor of Mental Health with experience in qualitative research; d) an associate professor specializing in research methods. All authors (EM, EC, MK, NM) were involved in all stages of the analysis. The consolidated criteria for reporting qualitative research (COREQ) was utilized [14] (Supplementary file 1). Data material was analyzed using inductive content analysis. According to Braun and Clark[15], inductive research involves researchers making observations that lead to the development of theories. This process builds overarching themes based on the views provided by participants.

All interviews were meticulously transcribed word for word, with careful listening to the recordings multiple times to ensure no important points were overlooked. The data were analyzed collaboratively by two researchers (E.M, E.H.), who continuously discussed their findings. All data underwent open coding for analysis and organization, with emerging themes identified and categorized into main theme titles and sub-themes (E.M., E.H.). To validate the data, two additional researchers (M.K., N.M.) independently repeated the analysis process.

Demographics

Two of the fifteen midwives work in private maternity clinics, while the other fourteen work in the public sector, with just one working as a community midwife for GESY. The participants' ages range from 30 to 35. The majority of midwives (n=11) hold master's degrees, while only two have postgraduate diplomas in midwifery. Their years of experience range from 6 to 26, with an average of 15.53 years. (Table 2).

Participant number	Age	Sex	Years' experience	Educational Level	Workplace	Department
1	55	Female	24	Master ‘s degree	Public sector	Maternity Unit
2	50	Female	18	Master’s degree	Public sector	Maternity Unit
3	30	Female	6	Master’s degree	Private Sector	Maternity Unit
4	41	Female	12	Degree	Public sector	Maternity Unit
5	38	Female	17	Master’s degree	Public sector	Maternity Unit
6	39	Female	17	Master’s degree	Public sector	Maternity Unit
7	49	Female	19	Postgraduate Diploma	Public sector	Maternity Unit
8	33	Male	8	Master’s degree	Private sector	Maternity Unit
9	50	Female	18	Master’s degree	Public sector	Maternity Unit
10	42	Female	4	Master’s degree	Public sector	Maternity Unit
11	32	Female	10	Degree	Public sector	Antenatal Unit
12	50	Female	20	Diploma	Public sector	Antenatal Unit
13	55	Female	25	Master’s degree	Public sector	Antenatal Unit
14	55	Female	26	Master’s degree	Public sector	Antenatal Unit
15	34	Female	9	Master’s degree	GESY Provider	Community

Table 2. Socio-demographic characteristics of the participants

Ethics approval

The study protocol was duly approved by the Cyprus National Bioethics Committee (ΕΕΒΚ/ΕΠ/ 2020.01.137) and the Cyprus University of Technology. This study was conducted following the principles outlined in the Declaration of Helsinki, and all methods adhered to the applicable guidelines and regulations. Written consent was obtained from all participants. Before the start of the interviews, all participants were informed orally and in writing about the purpose of the research, the assurance of confidentiality, and their right to withdraw from the research without any consequences. All participants gave written consent for the audio recording, transcription, and thematic analysis of the

discussions. Participants were also requested to provide sociodemographic details to define the sample. This information was documented using an anonymous data collection form. Each participant received a unique code, and all transcriptions omitted personal names. Additionally, the names of maternity services and professionals were anonymized.

3. Results

The experiences of the participants included various cases and incidents of intimate partner violence during pregnancy, ranging from psychological and emotional abuse to physical assault. The reported effects impacted not only the physical condition of the pregnant women and their psychology, but also the fetus and the children in the family.

Four themes emerged from the qualitative analysis of the interviews, and 14 subthemes (Table 3) were identified.

Themes	Subthemes
Challenging Cases	• Fear of victimization/disclosure • Denial of complaint/examination • Safety of midwives
Ambiguous procedures for management	• Team of police and forensic officer • Midwifery management/admission to the antenatal clinic • Referral to hospital social workers and psychologists • Referral to SPAVO``
Barriers in management	• Bad cooperation with Social workers and Psychologists • Presence of partner • Lack of private spaces in hospitals • Language barriers
Midwive's needs	• Management protocol/clinical guidelines • Development of midwifery education

Table 3. Main themes and subthemes

3.1. Challenging Cases

The first issue that emerged was the challenging cases, as the midwives strongly expressed how difficult and complex these cases are. They often feel anxious about how to handle them or even feel saddened when the victim states that they do not want to report it. The theme is supported by three subthemes: a) Fear of disclosure, b) Denial of complaint/examination, c) Safety of midwives.

Most midwives reported that they perceive the victims through their behavior and often through non-verbal communication methods, but they did not hide their fear of disclosure and how they should act.

Fear of disclosure

> ***"When you are in the antenatal clinic and systematically monitor them, you can understand from their behavior when they have experienced violence, but there is fear in us when we disclose this violence, how we will manage it; whether they will accept our help." (M3)***

Seven of the midwives reported this fear, stating that they do not have clear avenues to refer or adequately support the victims. Therefore, they typically mentioned managing the case with the individual in a manner they deem appropriate for the specific incident and its potential needs at that particular moment. Sometimes, they also recognize that the help they offer might not be sufficient or safe for the victim.

Denial of complaint/examination

An intense memory for most midwives regarding the management of pregnant victims of partner violence was the victims' reluctance to report or even examine potential injuries. They understood most of the time the reasons that led them to refuse the exams, and they tried to reassure and calm them down.

> **"I encountered a woman who didn't want to be examined. As soon as the doctor approached her with the speculum, she started crying. She was distressed. Therefore, there was no reason to subject her to further violence." (M8)**
>
> **"Usually, we face this problem where, in the end, the girls do not want to reveal why they are afraid of what will happen next at home." (M6)**

The denial of the victims often caused the midwives to remember the situation and frequently led to frustration, self-criticism regarding their handling of the situation, and doubts about their professional skills.

> **"When she told me she didn't want to report it, I felt a bit upset and disappointed. I suspected maybe she didn't want to." (M5)**

Safety of midwives

Opinions were even expressed that often the perpetrators accompanying victims to maternity wards exhibited aggressive behavior towards midwives, believing they were assisting the victims and exposing episodes of violence.

> **"The perpetrator's behavior towards us was aggressive because he thought we wanted to keep his partner inside and pressure her to disclose the episode of violence." (M10)**

3.2. Ambiguous procedures for management

Most respondents provided detailed and extensive information on the management of pregnant victims in Cypriot maternity wards. Various approaches were noted, as each maternity ward followed its own method. Remarkably, even individuals working in the same space reported different procedures.

Team of police and forensic officer

There were reports of cases of violence against pregnant women, who first go to the police to file a complaint, and then the police transfer them to a maternity hospital or prenatal clinic, usually at a public hospital, for examination.

> ***"If the report of violence is made at a police station, the woman comes to the prenatal services accompanied by police, a forensic doctor, a photographer, or translators."(M9)***

The midwives described this practice as unpleasant and disapproved of it, believing it re-traumatizes victims and exposes them to others in the hospital at that time. Typically, it lacks discretion and confidentiality towards the victim who has decided to report it.

> ***"An officer who picks them up and draws attention, ... people don't know what's going on, but you don't know how she experiences it because she comes with an escort."(M2)***

It was not clarified by any midwife whether women are informed about this process when they report intimate partner violence to the police. It is important for the victim to know the procedure that will follow and the purpose of these examinations.

Midwifery management/admission to the antenatal clinic

Much attention has been given to the victims who confide about the violence they have suffered from their partners during antenatal clinic appointments or to their personal gynecologist or midwife. Often, both in public and private maternity hospitals, the victim is given the opportunity to stay in the maternity hospital as an emergency solution to be immediately protected if she or her fetus is in danger.

> ***"The pregnant women, frightened, came alone to the doctor's appointment, and for this reason, the doctor and we (midwives) admitted her, primarily for her protection so that nothing would happen to her."(M13)***

The midwives reported that there were victims who were hospitalized more than once for intimate partner violence in the maternity wards. There were times when they had injuries and other times when they were there simply for protection from the perpetrator. It was a way for them to somehow escape the violence happening in their homes.

Referral to hospital social workers and psychologists

In Cypriot public hospitals, there is the option, as we were informed, to refer a pregnant victim to a social worker and a psychologist when no further midwifery care is required but psychological support and guidance on community resources and services are needed.

> ***"We had cases that were already being monitored by a social worker. The individuals themselves did not mention it, but when we provided the details to the social worker, she told us, "I am aware of this family, we are monitoring them. "(M1)***

This report was made only by the midwives working in the antenatal clinic. The midwives from the private clinics did not mention the existence of a social worker or psychologist.

> ***"In the private sector, except for a few midwives who are more involved, most are not aware of the services available for women facing this issue. In the public sector, there is an awareness of services, including those provided by the police, psychologists and SPAVO. However, in the private sector, this awareness is lacking." (M15)***

Referral to SPAVO

This specific NGO in Cyprus is the most active in managing victims of violence and offers shelters for female victims in all districts. It is well-known due to its effective communication campaign, with midwives often reporting that they took the initiative to contact the SPAVO helplines themselves or to provide information about the organization to victims in need of immediate shelter or other types of support.

> ***"She is afraid of her partner, so the only thing we could do was offer some counseling. If she needed anything, we gave her the SPAVO phone number. But we couldn't do anything else" (M4)***

Informing victims about the NGO is important, but it also appeared from the midwives' statements that they might believe their role is limited to just providing information to the victims without needing to take further action.

3.3. Barriers in management

A large part of the discussion focused on the barriers midwives face in investigating and managing cases of violence against pregnant women.

Bad cooperation with social workers and psychologists

> **"They don't respond quickly now that they are out of the hospital. We call them, we send faxes, and they respond after 7 days." (M7)**

Although these professionals are present in public hospitals, they are not in areas with direct access for the midwives. Additionally, there are issues with locating them, communicating with them, and the referral process by the midwives. Previously, older midwives reported that the referral process was more organized, but later it was moved to an external building of the hospital, causing communication problems. There was also a form that midwives had to fill out for referrals, but some were unaware of its existence during the discussion.

Presence of partner

All midwives, wherever they worked—whether in antenatal clinics, maternity wards, or in the community—faced the same issue with the presence of the partner, especially in cases where the

pregnant woman sensed that she wanted to mention something important. There is no cultural aspect in Cypriot health services or even a policy that mentions the right of the pregnant woman to have at least one appointment or opportunity to speak with a healthcare professional alone.

> ***"It's like through the way he moved and spoke, the gestures he made seemed like he wanted to tell me something. It was as if he wanted to make me understand that he didn't want her partner to be present in the antenatal clinic. "(M15)***

Lack of private spaces in hospitals

Several structural problems were mentioned, with one major issue being the lack of dedicated spaces for meetings between midwifery staff and pregnant women. Most public hospitals are quite old and have not provided private examination rooms. As for private maternity hospitals, midwives are not even given the opportunity for antenatal meetings and IPV screenings.

> ***"We see the women two at a time during appointments, especially during the first pregnancy visit."(M12)***

Language barriers

Due to Cyprus's geopolitical position and the war-torn situation prevailing in the Mediterranean Sea, the waves of migration are large. Cyprus receives many refugees, asylum seekers, and migrants. Public hospitals are mostly called upon to provide care to this population, with the language barrier between healthcare service users and healthcare professionals being significant. Most of the time, hospitals cannot provide a translator, so the woman's partner takes on the role of translator, and the woman is unable to report issues of violence herself.

> ***"Her sister said she is always missing and is an alcoholic and beats her. However, she herself did not say anything. We brought in a translator. We separated them, told him to go outside until we figured out what to do. The woman did not change her mind and kept saying, 'I can't do anything, I do what my husband wants.'" (M5)***

3.4. Midwife's needs

Management protocol/clinical guidelines

At the end of both focus groups, the midwives mentioned several suggestions for improving the way they investigate incidents of violence in maternity departments. The most common suggestion was the need for a common management protocol in all maternity departments, whether public, private, or within the community.

> ***"Skills and specific questions are needed, as well as a tool that outlines the steps we need to follow and is in written form." (M1)***

Hearing each other and discussing the different ways each one handled these incidents, the need for a common approach and procedure became evident. Everyone involved in this process should adhere to a unified protocol, taking on their professional roles without deviating from their duties.

Development of midwifery education

The two midwives with the most experience emphasized more strongly the need for further ongoing education of midwives on issues of violence, both in terms of recognizing victims and managing situations. One of them highlighted that colleagues who had the opportunity to participate in both continuous education programs and new university midwifery programs felt more empowered

> ***"Perhaps experiential workshops and training on this topic should be increased. I felt that my colleague who attended felt empowered by them." (M8)***

4. Discussion

The present study reports data on midwives' experiences in managing pregnant victims of intimate partner violence. The complexity of these cases and the absence of a unified management approach underscore the lack of a victim management policy and reveal deficiencies in Cyprus's healthcare system. Overall, participants described these cases as "difficult" and expressed fear when these issues were disclosed, concerning both how to handle them and whether the victims would accept or reject their assistance.

Even in systems where the investigation of intimate partner violence has been integrated into midwifery clinical practice for many years, midwives often do not feel adequately prepared or

empowered to conduct such investigations[16]. In Cyprus, this challenge is exacerbated because it is not a standard practice, and those midwives who do engage in investigations do so based on their own sensitivity, without extensive training or a supportive environment. However, women who disclose violence expect healthcare professionals to do more than just talk; they expect them to be knowledgeable about referral methods and the services available in the country for victims, so they can act with support[17].

In a quantitative study[18] aimed at investigating the current practices of healthcare professionals regarding intimate partner violence during pregnancy and postpartum periods, the lack of communication skills was mentioned. However, in our own study, it was not mentioned at all by the participants. Perhaps they considered it unnecessary to discuss or focus on this issue, as they already deemed the way it was being handled to be sufficient.

The complexity of how cases of violence arrive at maternity services in Cyprus and are referred does not appear to have been documented in other studies, as care here varies between public and private maternity hospitals, as well as supportive structures within each maternity department. However, obstacles such as language barriers, the presence of partners, and lack of guidelines are common among professionals [2][19], and lack of a social worker available to assist antenatal patients, with referrals only being made to the hospital service if the woman is admitted as an inpatient[20].

The suggestion that was not proposed to us but was mentioned in other studies was the provision of informational materials, such as brochures and informational leaflets, in antenatal clinics [21].The universal need emphasized in studies over the years is the investigation of midwives' education and training on the violence issue[22][23][24]. Education on violence should include understanding the various types of violence and recognizing the signs and symptoms of violence in victims. It should provide adequate communication skills, such as active listening and empathy, with techniques for safe and supportive conversations with victims of violence. Healthcare professionals should be informed about risk management for themselves and other team members, as well as strategies to avoid secondary victimization. The training should incorporate cultural and social diversity with respect for the cultural particularities of the victims. Additionally, techniques for self-care and psychological support for healthcare professionals should be integrated.

There is a need for expanded research on midwives' needs to investigate incidents of intimate partner violence against pregnant women and ways to improve screening methods.

5. Limitations

The small number of participants definitely affects the results of the research. The sole midwife who reported on what is happening in the community may not reflect the situation accurately. Further research should focus on screening for intimate partner violence by community midwives in Cyprus, as the community midwifery service is a very recent addition to the health system. Additionally, one focus group was conducted in a hospital, resulting in participants being influenced by their work environment in their responses. The strength of the research was that there were midwives from all parts of Cyprus and from both the private and public sectors. Nonetheless, the in-depth experiences and needs of the participants can serve as a starting point for the creation of clinical guidelines in collaboration with all involved stakeholders and enrich educational interventions.

6. Conclusion

Different referral methods of cases from other services to maternity hospitals, or vice versa, have been recorded. Management is usually based on how the victim reports the incident of violence and the support needs they require. This includes whether they wish to report the incident, seek temporary or permanent shelter, if there are others, such as children, who need protection, or if urgent midwifery care is needed.

The findings of this study can inform the health authorities of Cyprus about significant changes needed in administrative areas, such as improving professional relationships and collaboration between midwives and other professionals like social workers and psychologists. It highlights the necessity for upgrading antenatal clinic appointment areas to provide comfort, safety, and privacy for women who wish to report violence, as well as ensuring the presence of translators for non-native speakers.

The needs of midwives highlighted the necessity for a common management protocol for incidents involving all state services, which should be standardized across public and private maternity hospitals as well as within the community. As for education, it should begin in university midwifery programs and continue for clinical professionals to recognize signs of violence, develop communication skills to facilitate sensitive questions about violence, adopt a supportive response to the victims' wishes, and provide all the information a victim needs.

Statements and Declarations

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Ethics approval statement

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