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Views from midwives and perinatal nurses on barriers and facilitators in responding to perinatal intimate partner violence in Japan: baseline interview before intervention

Naoko Maruyama[1,2*] and Shigeko Horiuchi[2]

Abstract

Background Midwives and perinatal nurses play a crucial role in responding to intimate partner violence (IPV) against pregnant women; however, these roles are often not performed adequately. This study aimed to identify provider-related, healthcare system, and social barriers and facilitators to IPV response from the perspective of midwives and perinatal nurses.

Methods This qualitative descriptive study used semi-structured interviews with five midwives and a nurse from perinatal care facilities in Tokyo, Japan. A framework approach was employed to analyze the interview transcripts.

Results Barriers included inadequate knowledge about IPV and reluctance to provide support by healthcare providers. Barriers in the healthcare system included the absence of structural infrastructure for IPV response. This involved the lack of screening tool adoption, the partner's presence during interviews, and time constraints. Additionally, there was insufficient systematic and collaborative coordination within and outside the team. Another barrier was the lack of in-service training to develop IPV-related knowledge and skills. Finally, there was uncertainty about how the support at healthcare facilities impacts women's lives. Further barriers in the social system included the absence of additional reimbursement for IPV response. There was also a lack of a comprehensive approach to IPV that provides for the rehabilitation of perpetrators and care for the children of victims and a culture that discourages separation from the perpetrator. Conversely, facilitators included healthcare providers recognizing the perinatal period as an opportunity to address IPV. They also acknowledged IPV as a prevalent issue, practiced conscious self-care, and systematically collaborated within the healthcare team.

Conclusion This study emphasized the need for routine IPV screening in perinatal care and the importance of team-based educational interventions for healthcare providers to facilitate implementation.

Keywords Intimate partner violence, Perinatal care, Screening, Healthcare team, Continuing education

*Correspondence:
Naoko Maruyama
naokomr@slcn.ac.jp

[1]National Center for Child Health and Development, 2-10-1 Okura, Setagaya-Ku, Tokyo 157-8535, Japan
[2]St. Luke's International University, 10-1 Akashi-Cho, Chuo-Ku, Tokyo 104-0044, Japan

Background

Intimate partner violence (IPV), which is violence in intimate relationships with spouses and partners, is a global issue that threatens women's health and human rights. Globally, approximately 1 in 3 women aged 15–49 have experienced IPV [1], and approximately 1 in 4 women experience IPV during pregnancy [2].

IPV demonstrates serious health consequences. In addition to suffering various injuries from violence, women who are under the control of perpetrators who use a variety of violence, including psychosexual violence, are at high risk of experiencing psychiatric disorders such as depression, anxiety disorders, posttraumatic stress disorder, sexually transmitted diseases, and unintended pregnancy and abortion [3]. Violence during pregnancy increases the risk of premature birth, low birth weight [4], and maternal–infant maltreatment [5]. Thus, these health consequences have led the victims to have higher rates of long-term healthcare utilization and costs compared with women without a violence history [6]. Furthermore, the perinatal period is characterized by high healthcare costs [7] and a high number of emergency room visits and hospitalizations during pregnancy and postpartum [4, 8].

Previous studies revealed that pregnant women are more likely to disclose IPV when screened [9] and that interventions, such as short-term empowerment counseling and advocacy support for pregnant women, exhibit short-term effects on improving mental health and reducing violence [10]. Ongoing screening and intervention are possible after childbirth through home visits; however, no consistent reports exist on the effectiveness of these interventions in reducing violence [11, 12]. Nevertheless, a meta-synthesis of qualitative studies of victimized women indicates that women consistently seek non-judgmental, non-directive, and individually tailored responses from their healthcare providers [13, 14]. The World Health Organization (WHO) [15] highlights that all healthcare providers have a crucial role in victim identification and support based on the women-centered care principle. Moreover, necessary elements are found at the healthcare provider level, healthcare system, and broader social system to make such a response possible [16].

IPV is a serious and pervasive problem in Japan, with 1 in 4 adult women who experienced spousal violence [17]. Of the women who experienced IPV, 54% had consulted someone, and very few (1.9%) had consulted a healthcare professional [17]. Moreover, approximately 1 in 7 pregnancies experience IPV [18]. IPV's prevalence in the perinatal period is highest during pregnancy and has been reported to continue significantly in the postpartum period [19]. The IPV screening tool developed for Japanese women is reliable and validated in pregnant women [20]. Furthermore, the use of a self-administered questionnaire has demonstrated a higher detection rate than the use of a face-to-face interview [21]. Based on this and other international evidence, guidelines for responding to IPV were primarily developed for midwives and perinatal nurses [22]. Subsequently, the Midwifery Guidelines [23], which was issued by the Japan Midwifery Society, recommended conducting IPV screening for all pregnant women and described the latest international results on screening and responding to women victims. However, a recent survey revealed that only 6.9% of perinatal care facilities nationwide have implemented IPV screening [24].

We developed and evaluated an e-learning program for midwives and perinatal nurses to address IPV to close this evidence-practice gap [25]. According to the results, the intervention significantly improved knowledge and increased preparatory behavior toward support. We conducted a qualitative study with two purposes in developing the e-learning program. First, we aimed to determine differences between perinatal facilities that implemented IPV screening and those that did not by interviewing midwives and nurses who provided specific support to pregnant women suffering from IPV [26]. Subsequently, the results were used in the case development chapters of the e-learning program. Second, we aimed to conduct a baseline interview before the intervention on barriers and facilitators related to responding to IPV. This study aimed to identify provider-related, healthcare system, and social barriers and facilitators to IPV response from the perspective of midwives and perinatal nurses.

Methods

Design

The study design was a qualitative descriptive study [27].

Recruitment of participants

The inclusion criteria for participants were 1) midwives or nurses who provide care to pregnant women in their daily work and 2) those who had asked about IPV or had been disclosed by their patients (pregnant or postpartum women). We conducted selective sampling to contact these participants. Facilities that systematically implement and do not implement IPV screening and should be selected to achieve the first purpose of this qualitative study. Since limited facilities systematically implement IPV screening, we selected facilities that have interacted with researchers who have been addressing IPV for more than 10 years. Meanwhile, facilities that did not systematically implement IPV screening were selected from general hospitals and advanced medical facilities with a high number of deliveries per year (approximately 1,000–1,500). This was because few midwives and nurses at facilities that did not systematically implement IPV screening would have met the inclusion criteria for this

study, even if they had contact with potential victims. All these facilities were located in Tokyo, Japan. Furthermore, we had relationships with the nursing managers at these collaborating facilities, because we had asked these facilities in the past to collaborate on research on IPV and had conducted it. Nursing managers at each facility distributed a detailed description of the study to their staff, and those who met the inclusion criteria voluntarily participated. Participants were clearly informed in the study description that the study would be used to develop educational programs on IPV and that the researchers were not in a position to evaluate or criticize diverse values on IPV. Although how many staff members at each facility's nursing managers distributed the study description to their staff remained unclear, none of the participants who indicated their intention to participate withdrew their consent to participate.

Data collection

Semi-structured face-to-face interviews were conducted using an interview guide developed for this study (Additional file 1), asking participants about their involvement and feelings toward the one case that impressed them most about their experience of asking about or disclosing IPV and what barriers and facilitators were present in responding to IPV. At the time of the interviews, NM, the female researcher who conducted the interviews, was a doctoral student in nursing. Prior to the interviews, NM attended a course on qualitative research and was trained in conducting interviews by a nurse researcher who had experience interviewing midwives and other professionals regarding violence and abuse.

The interviews were conducted either in a room at the participant's facility or in a room at the researcher's university, with only the participant and researcher present. Participants were requested to answer a questionnaire, which gathered basic information about them, before the interview. Subsequently, the interviews were recorded on an audio recorder with the participants' permission. This study was conducted from May to June 2017.

Data analysis

The recordings were transcribed verbatim by NM and analyzed using a framework approach [28]. Statements related to those that inhibit and promote IPV response were extracted, interpreted for meaning, and coded. Subsequently, similarities and differences in the content were organized, and those with the same semantic content were abstracted and categorized. The inductively identified barriers and facilitators were mapped to the individual healthcare provider, healthcare system, and social system levels. These data management was conducted using Microsoft Excel. The results of this preintervention interview were used to inform the design and implementation of an intervention using e-learning programs to promote IPV response in perinatal care facilities. Two Doctor of Philosophy researchers (NM and SH), with expertise in midwifery and IPV issues, discussed the issues for a sufficient time to reach a consensus after independently conducting the analysis. Member checks were obtained from one participant with the most IPV response experience and the most representative narrative to ensure the reliability of the analysis. NM translated the participants quotes from Japanese to English, and then SH and native English speakers from translation service companies checked and corrected the appropriateness of the expressions.

Ethical considerations

Free will to participate in the study, the right to refuse to answer questions for any reason, the right to interrupt the interview and withdraw consent, and the protection of anonymity were explained orally and in writing; thus, written consent was obtained. St. Luke's International University Research Ethics Review Committee approved this study (Approval No. 17-A012).

Results

Participants characteristics

Table 1 presents the details of the participants, comprising three individuals who belonged to facilities with an organized IPV response (OR1, OR2, and OR3), one individual who belonged to a facility that had an organized response in the past but did not currently have one (NOR4), and two individuals who belonged to a facility without an organized response (NOR5 and NOR6). Their mean age was 36 years, the mean number of years of obstetric clinical experience was 11 years, and the number of cases in which they supported maternal victims of IPV ranged from 2 to 30. The average interview time was 69 min.

Overall view of the relevant factors

Figure 1 shows the overall view of the relevant factors. The barriers and facilitators related to IPV response were categorized into healthcare providers, healthcare systems, and social systems.

Barriers

There were some barriers at the healthcare provider level. These included a *lack of knowledge* and *reluctance to provide support*. At the healthcare system level, there was a *lack of structural infrastructure*, *systematic and collaborative coordination within and outside the team*, *in-service training*, and *uncertainty about how support at healthcare facilities contributes to women's lives*. Further, at the social system level, there was *no additional reimbursement for IPV response*, *a lack of a comprehensive*

Table 1 Characteristics of participants

ID[a]	OR1	OR2	OR3	NOR4	NOR5	NOR6
Qualification	**Midwife**	**Midwife**	**Midwife**	**Midwife**	**Midwife**	**Registered Nurse**
IPV efforts at current facility	Yes	Yes	Yes	No (Yes, in the past at the facility to which she belonged)	No	No
Age	36	35	36	44	31	33
Years of obstetric clinical experience	13	13	6	15	9	10
Number of cases of support for maternal victims of IPV	30	10	5	5	2	3
History of learning about IPV[b]	1,2,3,4,9	1,3,4,9	1,3,5	1,2,3,4,9	2,3	5

[a] *OR* Organizational efforts are currently underway at her facility, *NOR* No organizational efforts are currently being made at her facility

[b] 1: Reading procedures at own facility, 2: Viewing of video visual learning materials, 3: Attending lectures and public presentations, 4: Attending skills training and workshops, 5: Classroom teaching at medical/nursing/other schools, 6: Clinical practice at medical/nursing/other schools, 7: Fellowship/other post-graduate education, 8: On-line continuing education programs, and 9: Sexual Assault Nurse Examiner-Japan (SANE-J) Training Courses

IPV Intimate Partner Violence

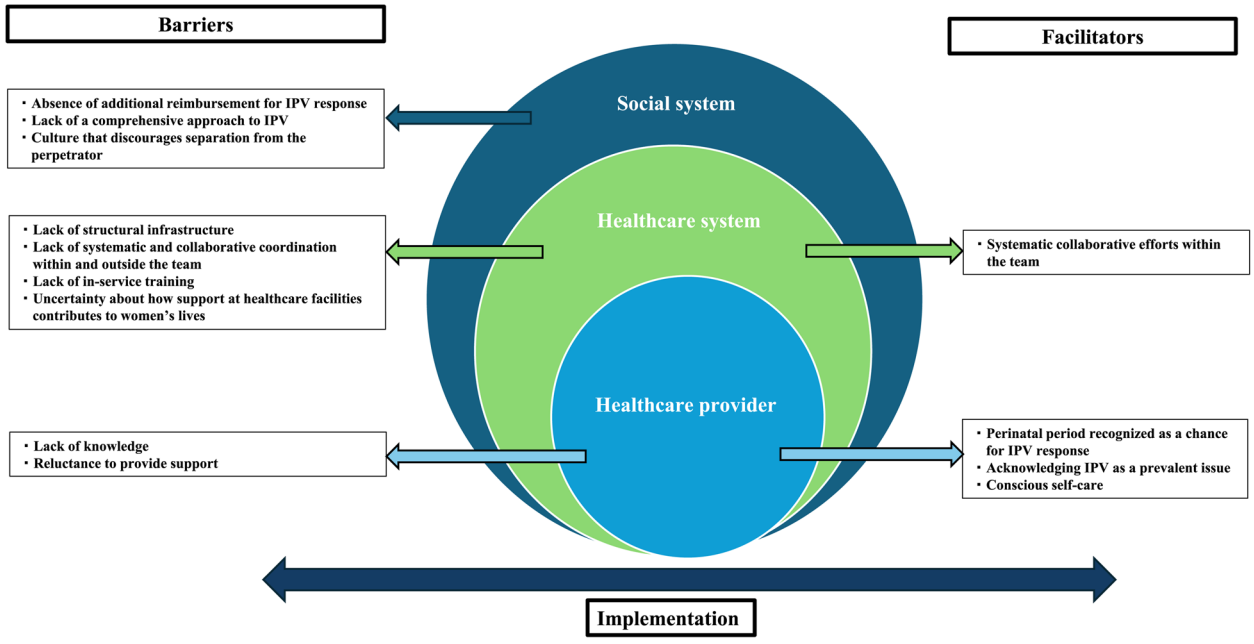

Fig. 1 Barriers and facilitators in IPV response

approach to IPV, and a *culture that discourages separation from the perpetrator*.

Barriers to providers: Lack of knowledge and reluctance to provide support

The lack of knowledge, including those related to the nature of IPV and human rights, the appropriate approach to ask about violence, and the response after IPV was discovered. Participants with more experience in learning about and supporting IPV highlighted the importance of understanding IPV as a human rights issue against women.

> *"Japan is a country that is unaware of women's rights, so I think midwives need to learn more about it. 'What is intimate partner violence?' 'What do you mean by human rights?' or 'What does self-determination mean?' Knowing these things first is necessary." (NOR4)*

Conversely, participants with limited experience in learning about and supporting IPV perceived a lack of knowledge about how to appropriately ask about violence and respond after IPV was discovered, thus resulting in indirect inquiries when they encountered women who are

suspected of being victims or not asking if the woman did not complain.

> *"I would talk to her, not about violence or anything like that, but rather ask, 'How's it going?' or 'How's your baby growing up?' Unless she complained about something or we had something to ask about, we didn't ask that much." (NOR5)*

Reluctance to provide support included the perception that we should not go deeper, a sense of heavy responsibility for encouraging separation from the perpetrator, and a distrust of women. Participants with limited experience in learning about and supporting IPV, who belonged to organizations that did not have a systematic response to IPV, held these perceptions. The distrust of women was described as follows.

> *"We did not know if she suffered from IPV or not, and a borderline personality disorder diagnosis will be made upon a psychosomatic doctor consultation, and we and the obstetricians felt that she was acting out because she had a personality disorder. We felt as if the mother was acting like a strange person." (NOR6)*

Barriers to the healthcare system: Lack of structural infrastructure, lack of systematic and collaborative coordination within and outside the team, lack of in-service training, and uncertainty about how support at healthcare facilities contributes to women's lives

Lack of structural infrastructure included non-adoption of screening tools, interviews with partners present, and lack of time. Regarding "lack of systematic and collaborative coordination within and outside the team," the issues related to coordination within the team included team members with low awareness of IPV and information sharing that was not facilitated. Moreover, the issues related to coordination outside the team included difficulty in the systematic collection and information integration in cooperation with other departments as well as accessing information about local support agencies. The responsibility for collecting and integrating information on IPV was unclear due to these hard and soft problems in the healthcare system. Consequently, the direction of support centered on women, based on a holistic view of women, was unclear.

Participants reported a lack of accessible in-service training to help them acquire basic knowledge regarding violence and human rights. They also noted the need for updated knowledge on social systems for responding to victims, including practical skills development.

> *"I want to attend some training programs to learn more about IPV and improve my care. However, attending such training sessions while raising my child is difficult for me." (OR3)*

> *"First of all, knowledge, IPV, human rights, self-determination, etc. There is no regular license renewal system, but midwives and nurses anywhere in Japan would obtain the latest information every two years or so if there were a license renewal system, although it may be the same information. It would make standardizing the support easier." (NOR4)*

Furthermore, participants with experience in providing continued support to victims highlighted another barrier: few women choose to leave their perpetrators during the perinatal period. Moreover, once a woman's involvement with healthcare facilities ends, it is difficult to observe any long-term changes, leading to uncertainty about how the support at healthcare facilities impacts their life.

> *"I want them to leave as soon as possible for the health of the child and the woman, but they end up having the delivery and the one-month checkup in the same situation as they were, and that is where the follow-up stops, so we do not see the outcome." (OR2)*

Barriers to the social system: Absence of additional reimbursement for IPV response, lack of a comprehensive approach to IPV, and culture that discourages separation from the perpetrator

Participants with experience providing continued support to victims identified the absence of additional reimbursement for IPV response and a lack of a comprehensive approach to IPV as barriers. The absence of additional reimbursement for IPV responses indicates that responses, such as IPV screening and subsequent ongoing interviews, were not covered by reimbursement. Furthermore, the lack of a comprehensive approach to IPV included the inadequacy of addressing the rehabilitation of perpetrators and the insufficiency of mental health care for children in families with IPV. Midwives were aware of these social system barriers through their experience of continued support.

> *"I feel that the problem will never be solved if the victim always runs away... the perpetrator himself will eventually change the target and make another victim. Thus, while mental care for the victims must be provided simultaneously, I have always thought that*

education for the rehabilitation of the perpetrators is also necessary." (OR1)

The culture that prevented separation from the perpetrator included the culture of not asking for help and a stigma that single mothers will have difficulty living. These aspects consciously and unconsciously influenced the perception of reluctance to provide support.

"In Japanese society, students do not have much experience in consulting with others, and consulting with others is not easy even after entering the workforce. Especially regarding IPV, people still do not know where to ask for help, and it is still perceived to be something to be ashamed of, embarrassed about, or conceal. Therefore, I hope that everyone in society, not just healthcare providers, will be aware that it is normal and their right to know where to ask for help, and that it is all right to discuss such matters with others." (OR1)

"I have heard that men who commit violence are not easily cured; thus, part of me wonders if the victim's first choice is to run away. It's as if I'm asking them to break up, and I wonder if I should encourage them to do so. I'm being entrusted with an important life decision, or perhaps I'm afraid that my words will change the direction of their life. Being a single mother and living alone can be extremely difficult, in my opinion." (NOR6)

Facilitators

The facilitators at the healthcare provider level were *the perinatal period recognized as a chance for IPV response*, *acknowledging IPV as a prevalent issue*, and *conscious self-care*. Moreover, at the healthcare system level, it included *systematic collaborative efforts within the team.* No facilitators were found at the social system level.

Facilitator of provider: Perinatal period recognized as a chance for IPV response, acknowledging IPV as a prevalent issue and conscious self-care

Participants with experience learning about and supporting IPV remained committed based on their perception that the perinatal period was a chance for IPV response, acknowledging IPV as a prevalent issue and conscious self-care despite the barriers mentioned above. Perceptions of the perinatal period as an opportunity for IPV responses included the idea that it is a time for all women to respond and that pregnancy and childbirth are opportunities to interact with professionals.

"If a woman experiences she was well-taken care of during her pregnancy and birth, she may think about consulting (perinatal care facility) again if she has such experience (IPV) in the future. A woman stated that remembering that she gave birth at the midwifery center warmed her heart although she went through many hardships. It would be beneficial for women to have a good experience in childbirth for them to remember when they are in trouble. It would be nice to have a place to return to when women are in trouble, other than their parents' home." (NOR4)

Another perception was the positive change in the women we supported. Although women did not leave their perpetrators, they found seeing each step that resulted in support as a positive change to be worthwhile based on the women's responses, such as "*I am glad we talked about it*" and "*I am glad to know there is a way to help.*"

Acknowledging IPV as a prevalent issue included supporting diverse cases, attending continuing education inside and outside the facility, and learning from facility initiatives and role models. Participants realized the importance of support through these various experiences, motivating them to support such women.

"I joined an IPV-related activity group here at the hospital and took a Sexual Assault Nurse Examiner training course, and through my experiences working with various professionals, all of these things became clear to me, so I think that you cannot put them into practice unless you have experiences that become clear to you." (OR1)

Conscious self-care included a balance between work and private life, self-understanding, and learning how to cope with stress. According to the participants, these efforts were important in building equal relationships with the women they supported.

"I balancing work and private life. Therefore, I can put so much energy into my work, and I also have hobbies that I can work hard toward. I am afraid that without that balancing act, support may become an imposition. If I tell a woman, 'I'm doing so much,' it would be the end. Yes, I don't take women's problems as my own. I think we have to draw a line in the sand and not get caught up in their problems." (OR1)

Facilitator of the healthcare system: Systematic collaborative efforts within the team

Systematic collaborative efforts within the team included routine IPV screening for all pregnant women, coordinating time and tasks within the team, assigning roles according to individual abilities, consulting with and empowering colleagues, and conducting team reflections. They allotted time to respond to victims using common screening tools and protocols developed for pregnant women in Japan to identify targets and by gaining cooperation in coordinating their work while increasing the number of staff within the team who understood their efforts. Furthermore, they believed in the importance of respecting the opinions and diversity of the staff, assigning roles, and reflecting as a team to continue collaborative efforts.

> *"I do not think that all midwives should be able to do this because everyone has their strengths and weaknesses. If there is a hierarchy in the team approach, and one of them is good at that area and can control herself well, then you should adapt to that person's level and the level of the patient. It would be better to have a system whereby any staff member can consult with a superior if she feels that she can handle the situation up to this point, but she may not be able to handle the situation any longer if it goes beyond this point. Thus, a system should be established so that midwives do not have to deal with things alone." (NOR4)*

Discussion

From inadequate healthcare system to the establishment of a systematic collaborative healthcare system

This study aimed to identify provider-related, healthcare system, and social barriers and facilitators of IPV response from the perspective of midwives and perinatal nurses. Barriers for providers included a lack of knowledge and reluctance to provide support. Barriers to the healthcare system included lack of structural infrastructure for responding to IPV, lack of systematic and collaborative coordination within and outside the team, lack of in-service training, and uncertainty about how support at healthcare facilities contributes to women's lives. Furthermore, social barriers were the lack of additional reimbursement for IPV response, the lack of a comprehensive approach to IPV, and the culture discouraging separation from the perpetrator. Previous research has consistently identified barriers to this effort that are structural to the healthcare facility and personal to the healthcare provider. Furthermore, the provider barriers of lack of knowledge and reluctance to offer support align with previous studies [29, 30]. Moreover, structural barriers in the healthcare system, including lack of structural infrastructure, lack of systematic and collaborative coordination within and outside the team, and lack of continuing education, were consistent with previous studies [29, 31]. This study revealed that acknowledging IPV as a prevalent issue was a facilitating factor. The participants increased their understanding of IPV as a predominant issue through various experiences, such as supporting diverse cases, attending continuing education inside and outside the facility, and learning from facility initiatives and role models. Specifically, the lack of knowledge of healthcare providers, related to the lack of in-service training, is a barrier to IPV efforts in Japan. Further, offering them educational intervention is crucial for promoting IPV efforts.

The study identified barriers and facilitators as a baseline before implementing the developed e-learning intervention and examining intervention strategies. Participants desired in-service training that was easy to access and would enable them to acquire knowledge and practical skills related to IPV, suggesting that e-learning education meets the needs of midwives. Conversely, our e-learning has not promoted practical behavior effectively [25]. Thus, further interventions are needed to encourage behavioral change in addition to the e-learning program.

The facilitators identified in this study indicated the direction for further intervention. The facilitators were systematic collaborative efforts within the team, including routine IPV screening, assigning roles according to individual abilities, and conducting team reflections. Therefore, to advance the efforts of healthcare providers to address IPV, individual providers should be motivated and know how to approach the issue. Additionally, they have strong organizational support, such as clinical protocols, capacity building, and teamwork [32]. Therefore, we need to target the intervention to the team, support the development and maintenance of protocols to promote systematic efforts, organize and conduct reflection for practical follow-up, and provide step-by-step development of human resources while considering the readiness of the staff within the team in implementing an educational intervention. For such interventions, the cooperation of the team's administrator is essential.

Our results indicated the need to identify outcome measures for the intervention because barriers at the healthcare system level include uncertainty about how support at healthcare facilities impact women's lives. The debate on whether to promote routine IPV screening is inconclusive due to insufficient evidence on the effects of screening on reducing violence and improving women's well-being [9]. Referrals to specialized institutions and the creation of safety plans among victims are recommended as intermediate evaluation indicators in

interventions at healthcare facilities [33]. Some previous studies revealed the effectiveness of IPV screening as an educational intervention targeting healthcare teams [34, 35]. However, no evaluation of these indicators has been conducted in Japan, even in facilities that have pioneered the introduction of IPV screening. Therefore, monitoring these intermediate indicators in interventions targeting healthcare facilities is highly warranted.

The presence of social-level barriers to IPV efforts was similar to that of a previous study [31]. This study identified social barriers as the absence of additional reimbursement for IPV response, lack of a comprehensive approach to IPV, and a culture that discourages separation from the perpetrator as barriers at the social level. This finding indicates the need to accelerate IPV efforts in Japan in terms of policy and the importance of healthcare providers with an active role in promoting IPV efforts. The results of a national survey on violence [17], which was answered by approximately 1,800 women aged > 20 years, indicated that 42% of women who have experienced IPV have not consulted anyone. The most prominent reason for not consulting was "*I didn't think it was worth it*" at 47%, followed by "*I thought it would be useless to consult*" (25%), "*I thought I could get along if I just held off*" (21%), and "*I was too embarrassed to tell anyone*" (13%). These perceptions of reluctance to seek help or receive support exceeded the reason for "*I didn't know where to go for help*" (7.3%). Moreover, Japanese women who experienced IPV and recovered from trauma reported that traditional Japanese norms and gender roles, such as beliefs about the ideal way of life for women and fear of not behaving differently from others, significantly influenced their recovery process [36]. Screening all pregnant women who visit perinatal care for IPV, in addition to those at risk, is important to ensure that women have the right and opportunity to discuss IPV in Japan, where speaking out about IPV is difficult. Furthermore, midwives who had experience in continuing support for IPV victims in this study experienced positive evaluations from women, such as "*I am glad I consulted with you*," indicating that good care may result in consultation and support. An education-based intervention should be targeted to midwife/nurse teams in perinatal care, including administrators, to promote implementation.

Limitations and further research

This study had certain limitations. The participants in this study were limited to advanced medical facilities and general hospitals in Tokyo. Different barriers may exist, especially in rural clinics and midwifery centers, since fertility rates differ between urban and rural areas [37], and clinics and midwifery centers, unlike hospitals, have fewer professions to make up the healthcare team. The participating facility in this study that systematically addressed IPV was a hospital with only obstetrics, gynecology, and pediatrics departments. Therefore, collaboration with other departments was excluded as a facilitating factor at the healthcare system level. A previous study indicated the importance of considering the target population and context in implementing an IPV response [38]. Using the results of this study to implement it requires identifying the challenges of the target organization and the readiness of the team and adjusting strategies.

Conclusions

Barriers and facilitators related to IPV response as viewed by midwives and perinatal nurses included those at the provider, healthcare system, and social system levels. The barriers included lack of knowledge and reluctance to provide support at the provider level, inadequate structural infrastructure, and lack of systematic and collaborative coordination within and outside the team. Further, there was a lack of in-service training and uncertainty about how support at healthcare facilities impacts women's lives at the healthcare system level. Additionally, there was an absence of additional reimbursement for IPV response, a lack of a comprehensive approach to IPV, and a culture that discourages separation from the perpetrator at the social system level. Meanwhile, the facilitators included providers recognizing the perinatal period as an opportunity to address IPV, acknowledging IPV as a prevalent issue, practicing conscious self-care, and engaging in systematic collaborative efforts within the healthcare team. Systematic IPV screening and collaborative team building should focus on continuous educational interventions for healthcare provider teams to promote IPV efforts.

Abbreviations

IPV	Intimate partner violence
WHO	World Health Organization
OR	Organizational effort
NOR	Non-organizational effort

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-024-11737-y.

Additional file 1.

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Authors' contributions

NM designed the study, acquired and analyzed the data, and drafted and edited the draft; SH designed the study, analyzed, and edited the draft. All authors have read and approved the final manuscript.

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Data availability
The datasets used and/or analyzed in the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
St. Luke's International University Research Ethics Review Committee approved this study (Approval No. 17-A012). All study participants were informed orally and in writing, and their written consent was obtained.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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