BMJ Open

Women's experiences and expectations of intimate partner abuse identification in healthcare settings: a qualitative evidence synthesis

Evangelica Korab-Chandler,[1] Minerva Kyei-Onanjiri,[1] Jacqueline Cameron ,[1,2] Kelsey Hegarty,[1,3] Laura Tarzia [1,3]

To cite: Korab-Chandler E, Kyei-Onanjiri M, Cameron J, *et al*. Women's experiences and expectations of intimate partner abuse identification in healthcare settings: a qualitative evidence synthesis. *BMJ Open* 2022;**12**:e058582. doi:10.1136/bmjopen-2021-058582

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2021-058582).

Received 26 October 2021
Accepted 28 June 2022

[1]Department of General Practice, The University of Melbourne, Melbourne, Victoria, Australia
[2]School of Health and Society, University of Wollongong, Wollongong, New South Wales, Australia
[3]Centre for Family Violence Prevention, The Royal Women's Hospital, Parkville, Victoria, Australia

Correspondence to
A/Prof Laura Tarzia;
laura.tarzia@unimelb.edu.au

ABSTRACT

Objectives To explore women's experiences and expectations of intimate partner abuse (IPA) disclosure and identification in healthcare settings, focusing on the process of disclosure/identification rather than the healthcare responses that come afterwards.

Design Systematic review and meta-synthesis of qualitative studies

Data sources Relevant studies were sourced by using keywords to search the databases MEDLINE, EMBASE, CINAHL, PsychINFO, SocINDEX and ASSIA in September 2021.

Eligibility criteria Studies needed to focus on women's views about IPA disclosure and identification in healthcare settings, use qualitative methods and have been published in the last 5 years.

Data extraction and synthesis Relevant data were extracted into a customised template. The Critical Appraisal Skills Programme checklist for qualitative research was used to assess the methodological quality of included studies. A thematic synthesis approach was applied to the data, and confidence in the findings was appraised using The Confidence in the Evidence from Reviews of Qualitative research methods.

Results Thirty-four studies were included from a range of healthcare settings and countries. Three key themes were generated through analysing their data: (1) *Provide universal education,* (2) *Create a safe and supportive environment for disclosure* and (3) *It is about how you ask*. Included papers were rated overall as being of moderate quality, and moderate-high confidence was placed in the review findings.

Conclusions Women in the included studies articulated a desire to routinely receive information about IPA, lending support to a universal education approach that equips all women with an understanding of IPA and options for assistance, regardless of disclosure. Women's suggestions for how to promote an environment conducive to disclosure and how to enquire about IPA have clear implications for clinical practice.

PROSPERO registration number CRD42018091523.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study used an extensive search strategy and well-defined study selection criteria.
⇒ Systematic, transparent methods were used to extract data, appraise the quality of included papers and assess confidence in the findings.
⇒ Multiple reviewers were engaged at each stage in the research process, some highly experienced in conducting systematic reviews.
⇒ A limitation of this study is the lack of data relating to the experiences of women in marginalised groups.
⇒ There are some concerns regarding the utility of quality appraisal techniques for qualitative research.

INTRODUCTION

Intimate partner abuse (IPA)—defined as the behaviour of a current or former intimate partner that causes psychological, physical or sexual harm—is a serious public health and human rights issue.[1] It is estimated to affect almost one-third of women worldwide and is linked to a range of serious short and long-term health consequences.[1 2] These include chronic pain, suicidal ideation, gynaecological issues, depression, addiction and death.[2] While any individual can be the victim of IPA, it is largely a gendered experience, with women being the targets of more severe physical violence, sexual violence and coercive control from their male partners.[1] To prevent IPA and effectively support those experiencing it, action is required at multiple levels alongside an understanding of the social norms and structural inequalities that maintain violence against women.[3–5]

Healthcare practitioners (HCPs) are in a critical position to assist those experiencing IPA.[1] Women exposed to IPA present disproportionately in healthcare settings, particularly in emergency, obstetrics and gynaecology, mental health and addiction services.[6 7] Studies indicate that of all professionals, survivors most trust HCPs to discuss IPA and that they want to be asked about

it.[1 8] For many women, healthcare settings also have the advantage of an established relationship with a HCP and are safe, confidential environments.[6] HCPs can deliver immediate care for the range of health conditions that may be caused or complicated by IPA as well as an empathetic response that can help women understand their experiences.[1 9] In addition, HCPs can provide a first-line response, documentation and referral to specialist support services that may assist women in their long-term safety and well-being.[1 6]

Providing women with support first requires their exposure to IPA to be recognised. Despite the high prevalence of IPA and the dangerous nature of an abusive relationship, many women do not seek help early.[10 11] Women's disclosure of IPA has been described in the literature as a non-linear process that is influenced by anticipated risks and benefits.[4 12 13] Barriers to disclosure for women include fear, isolation, shame, self-blame and the belief that healthcare services are not able to offer help.[4 10 11 14] Many barriers also exist to practitioner-led identification, despite the fact that almost all HCPs will at some point care for patients who have experienced IPA.[15 16] These include a reluctance to interfere in a patient's 'private' issues, frustration and feelings of helplessness when patients do not take their advice, and resistance to taking responsibility for dealing with IPA.[15]

Several clinical guidelines have recently been developed to assist HCPs in responding to IPA. For example, a comprehensive resource of evidence-based guidelines was released by the WHO in 2013.[1] It recommends the provision of women-centred clinical and psychological care, be an integrated part of practitioner training. These guidelines include a discussion around the importance of identifying women experiencing IPA, strongly recommending that HCPs enquire about exposure when assessing health conditions linked to IPA. It also establishes several minimum requirements for asking about IPA, including that HCPs are trained in how to ask and respond, that it is conducted in a private setting, and with referral systems in place.[1] The implementation of best practice guidelines such as these are an important part of safely and effectively identifying those experiencing IPA, yet it is unclear to what extent they have been normalised into practice.

In 2006, a meta-synthesis of qualitative research was published exploring women's experiences and expectations of HCPs in identifying and responding to IPA.[10] This paper found that women wanted HCPs to raise the issue in a sensitive way, without pressuring them to disclose. Women expressed that their preferred form of identification was dependent on their relationship to the HCP, and that both verbal and non-verbal indicators of IPA should be attended to. Even if a woman chose not to disclose, having had the HCP raise the issue in a sensitive way demonstrated trustworthiness and could facilitate disclosure at a later date.[10] In the 15 years, since this meta-synthesis was published, IPA has increasingly received public and academic attention.[1 17 18] We, therefore, sought to undertake an updated systematic review and qualitative evidence synthesis to understand what, if anything, has changed in women's experiences and expectations of disclosure in healthcare settings. We chose to focus on the process of *disclosure/identification* of IPA rather than the healthcare responses that come afterwards, which are explored in a separate paper.[19] Although a recent review by Heron and Eisma[18] also addresses a similar topic, their review focuses primarily on barriers and facilitators to disclosure, whereas we have chosen to highlight the ways that women perceive HCPs and how health settings can more effectively promote disclosure and identification of IPA.

METHODS

Our methodology was based on Cochrane guidelines.[20] The specific research question for this systematic review was: *What are women's experiences and expectations of IPA disclosure and identification in healthcare settings?* Ethics approval was not required for this project; however, any ethical issues within the primary literature were considered during the quality appraisal process. The protocol for this review was registered with PROSPERO.

Search strategy

The key terms 'women', 'qualitative research', 'IPA', and 'healthcare setting' were identified. Synonyms for each of these terms were then combined in a range of online databases. The Boolean operators 'OR' and 'AND' were used to combine all synonyms within a category of key terms and to combine each category. Various commands were employed to enable multiple spellings and positionings of key terms, which were then mapped to relevant subject headings and search fields. See online supplemental file 1 for full search strategy.

In September 2021, this search strategy was used in the bibliographic databases MEDLINE, EMBASE, CINAHL, SocINDEX, PsycINFO and ASSIA. Grey literature was included through a search of GreyLit and OpenGrey databases. A non-systematic search was also conducted through Google Scholar, forward citations, reference checking and expert consultation. These literature sources were selected to allow for the inclusion of multiple perspectives on the issue from a range of healthcare settings.

Inclusion and exclusion criteria

To be included, articles must have been published from 2016 onwards. There was no restriction on geographic location nor language. Studies were excluded if they met one or more of the following conditions: (1) focus was not on women's experiences or expectations of IPA disclosure or identification, (2) participants were not women experiencing IPA or were indistinguishable from other participants in analyses, (3) was not a primary study in a healthcare setting or (4) qualitative methods were not used for both data collection and analysis. Two

independent reviewers used the programme Covidence[21] to first screen titles and abstracts, then full text papers, against these criteria. A third reviewer then resolved any disagreements over study inclusion. These criteria were selected to locate papers closely aligned with the research question, and the engagement of multiple members of the research team promoted accuracy throughout the screening process.

Data extraction

Papers that were included after full-text screening underwent a process of data extraction. Relevant data were copied into a specifically designed form, then checked for accuracy by a second reviewer. The data extraction template included the setting, objectives, sample characteristics, methods of data collection and analysis, qualitative design, supporting quotations and conclusions of reviewed articles. These documents were then imported into the qualitative data analysis programme NVivo V.12,[22] to assist in the organisation and development of themes.

Quality appraisal

The methodological quality of each included article was assessed using a modified version of the Critical Appraisal Skills Program (CASP) checklist for qualitative research.[23] This framework was employed as a transparent method of critical appraisal and included 10 questions regarding the validity and value of results.[23] Scores were used to easily visualise their assessed quality, with two points assigned to a criterion that was completely met, one point awarded when an item was partially fulfilled, and zero given when left unaddressed. For the final CASP criterion, 'How valuable is the research?', a judgement was made based on the originality and significance of the study, with two points given when a paper was appraised to be valuable and one point as somewhat valuable. A total score of 20 was deemed to reflect a high-quality study, 16–19 moderate quality and 15 or below as low quality, a scoring system based on a systematic review by Njau *et al*.[24] One reviewer (EK-C) applied the CASP checklist to each included study, and a second reviewer (MK-O) checked for discrepancies.

Data analysis

Data analysis occurred using the thematic synthesis approach proposed by Thomas and Hardin.[25] This involved immersion in the data and line-by-line coding of both participant quotes and author interpretations. Initial codes with a shared meaning were then grouped together to form descriptive themes. The views captured in these descriptive themes were interpreted and combined to create analytical themes representing women's experiences and expectations of IPA disclosure and identification.[25] Members of the research team met several times throughout this process to discuss and refine the developing themes. A thematic synthesis approach was selected as it functions as an accessible method of analysis that maintains a clear link between the primary studies and any conclusions formed.[25 26] The combined analysis of author interpretations and participant quotes differs from other methods of qualitative meta-synthesis, such as that employed in the original review by Feder *et al*,[10] in which the text was coded for first, second and third-order constructs.

Assessment of confidence in the findings

The Confidence in the Evidence from Reviews of Qualitative research (GRADE-CERQual)[27] framework was used to assess each theme developed from the literature. The CER-Qual framework provides an assessment of how closely the review themes represent the phenomenon of interest. Four key components were involved in this appraisal process: methodological limitations, coherence, adequacy and relevance.[27] After the methodological limitations were assessed using the CASP,[23 28] coherence was evaluated by reviewing the fit between the primary data and the review findings.[29] Adequacy was determined by assessing the depth of data supporting a synthesis theme,[30] and relevance was appraised through a comparison of each finding to the context of the research question.[31]

Review author reflexivity

The authors recognise that their views regarding the context and dynamics of IPA and the role of the healthcare system may have affected their interpretation of the data. The authors are comprised of students and academics working across the areas of social science, healthcare and violence, some with and some without a practitioner background. All authors approached the topic of this review from the standpoint of seeing the healthcare system as a critical piece of the puzzle in identifying and supporting women experiencing IPA.

Patient and public involvement

No patients were involved in this study.

RESULTS

Study selection

We identified 37 papers describing 34 studies conducted in 17 countries. Figure 1 below illustrates the process of study selection.

Sample characteristics

The 34 included studies represented 17 countries: 13 were conducted in the USA,[32–45] 4 in Australia,[46–51] 3 in the UK[5 52 53] and 1 each in Ecuador,[54] India,[55] Israel,[56] Japan,[57] Kyrgyzstan,[58] Mexico,[59] New Zealand,[60] Nigeria,[61] Norway,[62] Palestine,[63] South Africa,[64] Spain,[65] Sweden[66] and Taiwan.[67] The 37 papers resulting from these studies were published in 2016 (n=7), 2017 (n=10), 2018 (n=4), 2019 (n=9), 2020 (n=6) and 2021 (n=1), and included a total of 1016 participants. Participants ranged from 16 to 72 years old, were from diverse ethnic backgrounds and had different family structures. One study, documented in two papers, explored the experiences of Indigenous women in Australia,[46 48] one on the perspectives of

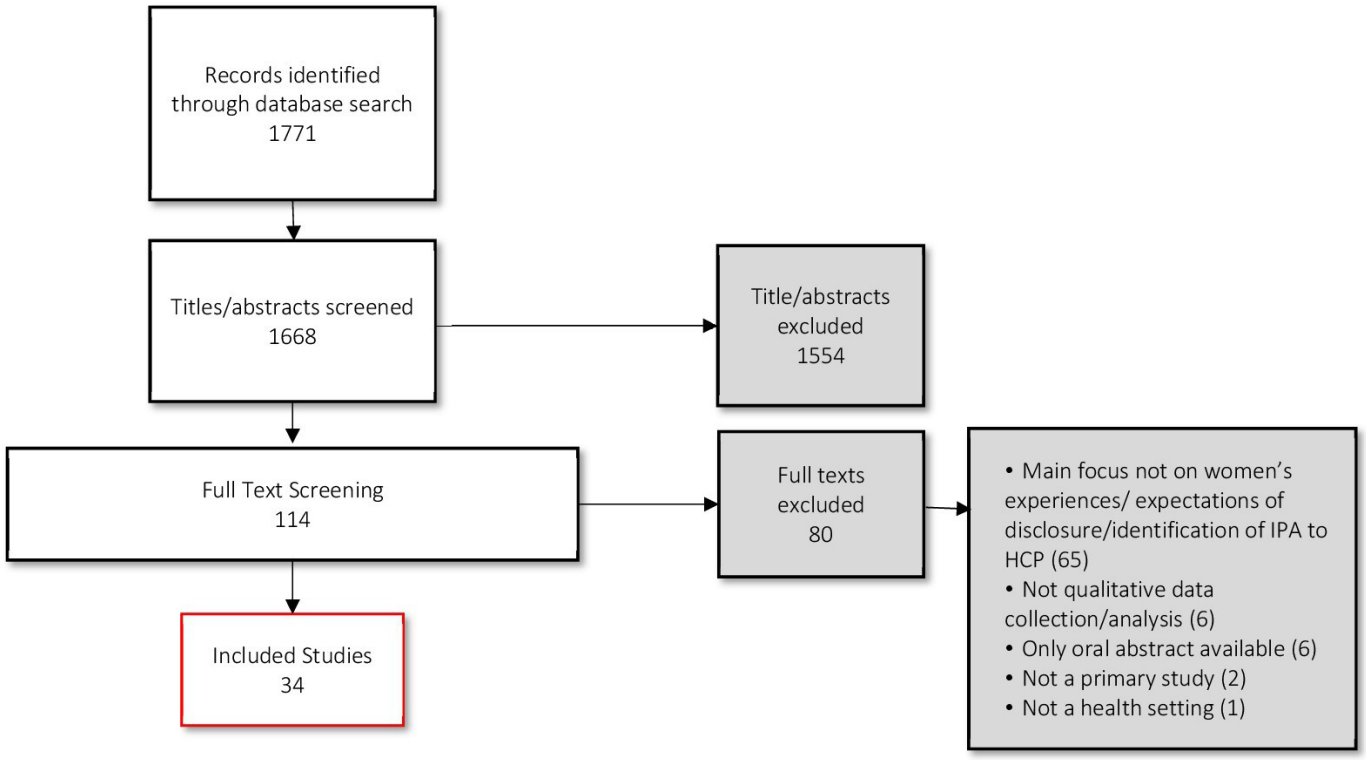

Figure 1 Study selection flow diagram. HCP, healthcare practitioner.

women with disabilities,[65] and no studies included in this review focused on the experiences of women who were not heterosexual. Online supplemental table 1 contains a summary of study characteristics.

Quality of included studies

Most of the included studies were found to be of moderate methodological quality, with six studies appraised as high quality and none as low. Most studies did not consider the relationship between researcher and participants, and several concerns were found relating to data analysis. In contrast, for each study, a qualitative methodology was appropriate, the design and data collection methods addressed the aims of the research, and findings were clearly presented. See table 1 below for the individual criterion and total scores assigned to each study using the CASP checklist for qualitative research.[23]

Key themes

Applying a thematic synthesis approach to the data generated three key themes describing women's experiences and expectations of IPA disclosure and identification in healthcare settings: (1) *Provide universal education,* (2) *Create a safe and supportive environment for disclosure* and (3) *It is about how you ask.* These themes are detailed below, supported by quotations from women in the primary studies.

Provide universal education

The concept of 'universal education'—meaning the routine provision of information to all women entering a health service, irrespective of risk factors or disclosure—was repeatedly mentioned across the included studies. Women had the expectation that HCPs would raise the issue of IPA and provide them with information, a theme supported by 20 of the included studies.[5 32 33 35 37–42 44–46 49 51 57 60–62 65 66] Information could be given independently from or paired with a screening tool and was seen to facilitate both woman-led and practitioner-initiated disclosures. Potential areas of knowledge included understanding the dynamics of a healthy relationship,[39 65] the warning signs of IPA,[5 33 37 41] the relationship between mental and physical health,[33 62] the impact of IPA on children[33 39 62 66] and options for assistance.[32 39 41 42 45 60 62 66] For some women, it was not until the violence had escalated or they had left the abusive relationship that they sought healthcare support to understand their experiences. Informed by this, participants viewed routinely providing information about IPA as a way to protect and empower women in violent relationships. Several participants explained aspects of IPA that they wished HCPs had spoken to them about earlier:

> The constant verbal abuse, you know, people think that "Oh they're just angry" but they don't realize that that's a form of abuse, you know? Red flags like that… Information is power, and this [receiving information early] is really powerful because it took me years after being in treatment to realize the effects that my emotional health had on my physical health[33] (p12).

> If I would have known what could happen to the baby when the mother is stressed and impatient, and that it's not only things you eat that influences the health

Table 1 Critical appraisal of included studies

First author (year of publication)	CASP criteria*										
	1	2	3	4	5	6	7	8	9	10	Total score
Almqvist (2018)[66]	2	2	2	2	2	0	2	1	2	1	16
An (2019)[32]	2	2	2	1	2	0	2	2	2	2	17
Bacchus (2016a; 2016b)[37 41]	2	2	2	2	2	2	2	2	2	2	20
Bradbury-Jones (2016)[53]	2	2	2	2	2	2	2	2	2	2	20
Burry (2020)[60]	2	2	1	2	2	0	2	1	2	2	16
Childress (2017)[58]	2	2	2	2	2	1	2	2	2	2	19
Correa (2020)[42]	2	2	2	2	2	0	1	2	2	2	17
Decker (2017)[38]	2	2	2	2	2	0	1	1	2	2	16
Dichter (2020)[43]	2	2	2	2	2	1	2	2	2	2	19
Fawole (2019)[61]	2	2	2	2	2	1	2	2	2	1	18
Garnweidner-Holme (2017)[62]	2	2	2	2	2	2	2	1	2	2	19
Grillo (2019)[33]	2	2	2	2	2	1	2	2	2	2	19
Hatcher (2016)[64]	2	2	2	2	2	2	2	2	2	2	20
Hester (2017)[52]	2	2	2	2	2	0	2	1	2	1	16
Jack (2017)[39]	2	2	2	2	2	1	2	1	2	2	18
Kataoka (2018)[57]	2	2	2	2	2	0	2	2	2	1	17
Liao (2017)[67]	2	2	2	0	2	0	2	2	2	2	16
Mackenzie (2019)[5]	2	2	2	2	2	2	2	2	2	2	20
Manor-Binyamini (2021)[56]	2	2	2	2	2	0	2	2	2	2	18
Miller (2017)[40]	2	2	2	2	2	0	2	1	2	2	17
O'Doherty (2016)[47]	2	2	2	2	2	1	2	2	2	2	19
Reeves (2017)[34]	2	2	2	2	2	0	2	2	2	2	18
Ruiz-Perez (2017)[65]	2	2	2	2	2	0	2	2	2	2	18
Sabina (2019)[54]	2	2	2	1	2	0	2	2	2	1	16
Shaheen (2020)[63]	2	2	2	2	2	1	2	2	2	2	19
Sorrentino (2020)[44]	2	2	2	2	2	1	2	2	2	2	19
Spangaro (2019; 2016)[46 48]	2	2	2	2	2	2	2	2	2	2	20
Spangaro (2019; 2016)[49 50]	2	2	2	2	2	1	2	2	2	2	19
Srinivasan (2019)[51]	2	2	2	2	2	1	2	2	2	2	19
Vranda (2016)[55]	1	2	2	2	2	0	2	1	2	2	16
Wadsworth (2018)[35]	2	2	2	2	2	0	2	2	2	1	17
Wallin Lundell (2017)[59]	2	2	2	2	2	1	2	2	2	1	18
Williams (2020)[45]	2	2	2	2	2	2	2	2	2	2	20
Zelazny (2019)[36]	2	2	2	2	2	1	2	2	2	2	19

*CASP criteria: 1. Was there a clear statement of the aims of the research? 2. Is a qualitative methodology appropriate? 3. Was the research design appropriate to address the aims of the research? 4. Was the recruitment strategy appropriate to the aims of the research? 5. Was the data collected in a way that addressed the research issue? 6. Has the relationship between researcher and participants been adequately considered? 7. Have ethical issues been taken into consideration? 8. Was the data analysis sufficiently rigorous? 9. Is there a clear statement of findings? 10. How valuable is the research?[23] (2=criterion fully met, 1=partially fulfilled, 0=not addressed, total score of 20=high quality, 16–19=moderate quality, and 0–15=low quality.[24]
CASP, Critical Appraisal Skills Program.

of your child… I think I would have talked about it earlier[62] (p5).

The participants emphasised that information should be given routinely to avoid stigmatising women and to provide all women with an understanding of IPA irrespective of their personal experiences. In addition, If HCPs were going to ask questions about IPA, women wanted to be provided with information first about why the HCP was asking and what assistance was available if they did make a disclosure.[39 42 45 49 62]

I think if they had asked the questions differently or given more information on why they wanted to know and what would be done with the information, people might be more inclined to tell[49] (p346).

Participants articulated a desire for written information, such as posters and pamphlets, to be displayed within the safety of their health clinic, so that they could understand their experiences.[45 62]

> But if you, for example—I go to my son's pediatrician, and I see a booklet in the pediatrician's office which catches my attention, and I can look at it while I'm sitting. There is a nice one here [at the family justice center], which has a circle. And in that circle it identifies what kind of man is an abusive man. When I read that the first day, I said, "I have all of that," and I didn't know I was abused. So if you see in the doctor's office those little things—how many women go to take their children, and could identify, "This happens to me." And they might have some numbers in the back that say, "Don't worry, there are people here who can help you. You will not be deported," there obviously has to be something that links you directly in a doctor's office that can help you[45] (p5564).

In three of the contributing studies, HCPs were trained to provide women with IPA information cards regardless of disclosure, which were perceived as a demonstration of care and empowerment and helped women understand that HCPs are there to help[38 40 49]:

> It was awesome. She would touch on having, no matter what the situation you're in, there's something or someplace that can help you. I don't have to be alone in it. That was really huge for me, because I was alone most of the time for the worst part[40] (p89).

When considering the practice of routine or universal screening, some participants thought that all women should receive questions about IPA and appreciated being asked themselves.[5 37 38 41 46 49 57 61 66]

> Yes, [to universal screening] so that their treatment can be holistic. Women can easily confide in their doctors[61] (p5).
>
> It shows me that I can talk to her about it, if I chose—if I wanted to. If she didn't ask those questions, then I just wouldn't even approach the topic with her[46] (p795).

However, other participants were uncomfortable with this idea due to the private nature of the topic and believed that IPA enquiry should only be initiated with women who showed specific signs of abuse.[5 46 57 61] The conflicting opinions around routine screening perhaps lend support to a universal education approach, as it removes emphasis away from who to ask in giving all women the resources to understand IPA and their options for assistance.

Create a safe and supportive environment for disclosure

Thirty-one of the included studies supported the idea that HCPs need to create a safe and supportive environment to facilitate women's disclosure.[5 32 34–52 54–60 62–67] For many participants, deciding to share their experiences of IPA was a difficult process entangled in a range of fears.[5 34 35 37 39 41–43 45–50 52 54–59 62–64 66 67] These fears encompassed two main dimensions: safety for themselves and their children from the perpetrator and concerns relating to the patient–provider interaction. The most commonly expressed fear was that of perpetrator retaliation,[5 35 39 41–43 45 50 52 55 57 59 62–64] described below by participants from two studies:

> I mean, there has been a lot o' things that I've went in and no' told my GP because I thought 'Somebody's sitting out in the waiting room'[5] (p1167).
>
> I just kept my mouth shut. You know, I was always walking on eggshells like I didn't want to look up at anybody. I didn't want to talk to nobody because if I said something wrong that might piss him off, I was getting beat[42] (p190).

Women were concerned about having their children removed, partners incarcerated and suffering financial consequences as a result of making a disclosure.[5 35 39 42 45 46 48–50 56 62–64]

> I guess a lot of people, they're so scared that their kids are gonna get taken away if they seek out help or they're so scared that their partner's gonna be put in jail, the partner's gonna come after them or they're not gonna have nowhere to live[35] (p756).

Women also felt afraid of being judged negatively by the HCP for not seeking help earlier, that they would be blamed for their abuse, or labelled as a victim.[5 34 37 39 41–43 47 51 55 59 62 63 66 67]

> Sometimes it's hard to talk to somebody, especially when you don't want to be judged… Because that's what I heard when I got raped—"You did something to have this man rape you"[34] (p1177).
>
> I wouldn't say I had a good or a bad relationship with my GP, but it's just that stigma, I think, of reporting and being a victim… Like your card's marked[5] (p1167).

Considering the many fears implicated in women's disclosure of IPA, it was viewed as essential that HCPs demonstrate care in their interactions with patients.[5 32 34 36–51 56 59 60 62–66]

> I definitely trusted her and she's a very caring person. That was really important to me because I hadn't dared tell anybody about this before[47] (p39).
>
> If you are friendly, people are able to be honest and speak to you about their problems. … If a person is warm like the way you talk to me right now, they will find a way to talk about their problems[64] (p1342).

Central to this sense of being cared for was the attitude of the HCP and whether they seemed to be actively listening to what the woman had to say.[5 32 34 36 37 39 41 42 46 47 51 59 64–66]

> I'm not gonna wanna sit here and tell all my personal information to someone who's having like an 'I don't

care' attitude… Someone that's (looking) at me in my eyes and telling me, 'oh I'm here for you, this is what I do, if you need anyone to talk to I'm here.' I would want to tell my story to them more than the other person[36] (p37).

Unfortunately, several women had experiences with HCPs who did not have a caring attitude, and this influenced their decisions not to seek help.[42 43 46–48 50 59 62]

They have even said it straight to my face that they don't have time, as other patients who are sicker than me need their time. Since I'm not dying, I should just hold on for a while. When they treat you like that, you don't feel like telling them when they do have time, even if it is only ten minutes later[59] (p953).

Women in the included studies had several recommendations for how HCPs can promote a sense of safety and support in their interactions with survivors.[5 32 34–37 39 46 48 51 54 57 62 64–66] To create an environment conducive to disclosure, participants suggested that HCPs emphasise confidentiality and conduct consultations in private.[5 32 34 36 37 39 41–43 45 49 54 55 57 60 62 63 66]

It felt really safe talking to [the nurse] about [my abusive experiences]. She let me know everything that I tell her will be confidential. Once I got it out there too it felt good to actually talk about it… She just listened, listened really well[39] (p11).

A participant in a study by Reeves and colleagues highlights how counterproductive, isolating and scary it was to have her abuser present in the healthcare encounter:

Him standing there just made me so nervous… He brought me [there], and [he was] gonna have to take me home. If I [said] the wrong thing, then I'm gonna get [hurt] or it's gonna be worse when I get home[34] (p1174).

The findings from Spangaro *et al*'s study with Aboriginal Australian women highlight the need for culturally safe care, experienced by the participants as feeling understood and comfortable throughout the healthcare interaction.[46 48] When seen in an Aboriginal service, women reported a heightened sense of security that helped them feel safe speaking about their experiences.

Knowing that other Koori girls go there, you know what I mean? If I went to a non-Aboriginal place I would have felt more—I don't know, not as comfortable[46] (p796).

Women in a Spanish study by Ruiz-Perez and colleagues[65] discussed the importance of providing disability sensitive care. When healthcare services were not adapted to their needs, women were unable to disclose IPA and access support.

I couldn't call, I couldn't get access to any services and if I did they would talk to me and I wouldn't understand, I think that it's more difficult for deaf people, because the barrier we face is communication[65] (p1061).

Participants spoke of how taking a woman's disability into account allows for effective and safe provision of care, and the absolute necessity of providing deaf patients with interpreters in all healthcare interactions.[65]

It is about how you ask

This theme included data from 27 studies.[5 32–39 41–51 53 57–64 66] Women in these studies spoke of the importance of the context in which HCPs ask questions about IPA. Participants suggested that HCPs initially focus on building a relationship and fostering a sense of trust.[32 34–39 41 43 45–49 62 64 66]

Don't just straight out jump into it. Just make friends with them or something first. At least get some type of relationship with them, make them comfortable[46] (p799).

Through establishing a relationship, women believed that HCPs would better understand what was happening in their lives, which could inform individually tailored enquiry and help patients open up. Other key considerations were having enough time to talk and impressing the feeling that the women's issues would be heard.[32 38 42 45–47 49 59 63 64 66]

Some doctors just—I guess you need to see a thousand patients in a day so you don't really have time. That's what pretty much held me back because when I go in the doctor's office, it's so rushed and you kinda just feel like he doesn't care. He just wants to get to the next patient. That's kinda what took me so long to open up and talk about it[45] (p5559).

You often feel stressed when talking during a medical appointment because the staff keeps looking at their watches and you know [that] they have many patients waiting. But with her [HCP] I never felt that way… she made me feel [that] I mattered[59] (p953).

In addition to having sufficient time, women suggested that HCPs needed to introduce questions about violence with appropriate timing, such as towards the middle of a healthcare consultation.[36 57 60 62]

People aren't so willing to right away give information up so maybe you might have to ask again in the middle of the…appointment or at the end maybe just drop some hints or something and get them comfortable with you talking to them[36] (p37).

Participants in the included studies had several suggestions for how HCPs should ask women about their exposure to IPA.[33–36 39 44 47 49–51 57 58 61 62 64 66] When considering the wording of a direct IPA enquiry, women suggested that HCPs use straightforward language that was friendly and non-judgmental.[36 46 57 60]

I know (IPA assessment at the clinic) could be hard because you're supposed to be in a professional setting but if you just kind of wipe away the certain

words that you're supposed to use when it comes to a patient, the disconnecting words and be like 'I know it's scary…I do this for everyone but I have to make sure 'cause anyone could be hurting so I…got to talk,' but you have to be the friend. You can't be the doctor (because) I know some many people are afraid of medical professionals[36] (p36).

Women in the included studies articulated a desire to receive questions about non-physical abuse,[42 45 50 51 55 63] believing that this would help them recognise their experiences as abuse and as relevant to the healthcare encounter.

Maybe talk about the question a bit more thorough[ly], like, any arguments, dug in a little. Because you think just the hitting but it's more, it's verbal. It's everything[50] (p51).

Participants wanted HCPs to recognise the influence of IPA on other health issues, such as multiple abortions and anxiety and suggested that they introduce questions within this context.[34 39 45 47 51 53 58 61 63]

It could be sort of an opportunity to grab someone that could be vulnerable to other things. Like, say particularly if you're having like, a second [emergency contraceptive pill] within a couple of weeks, and go "Okay, is there a problem with your contraception, or are you in … a risky situation?"[51] (p496).

In addition, women believed that HCPs should link IPA enquiry with children's development and safety,[33 45 50 62 64 66] as explained by a pregnant woman in a South African study by Hatcher and colleagues:

What I know you must say is: "What's happening to your life is important for your safety and the safety of your child." That's the only thing[64] (p1342).

Some women spoke of the need for HCPs to use both direct and indirect questions and ask multiple times to help the women feel comfortable opening up about their experiences.[35 39 42 44 48–51 60 62–64]

It's just so easy to say yes to "Yeah I'm safe" … I think maybe they should ask more specific questions because it's bound to hit a nerve, and they're going to pick up on that… maybe they should ask you if you're happy [that you're pregnant][35] (p756).

Researcher: in a case where a woman refused to talk about, what should the doctor do? SW03: Ask the first time, and second time, third time[63] (p5).

Although women in the included studies largely wanted to be asked about IPA (and asked more than once), they emphasised that the HCP should not try to force disclosures.[5 35 37 43 44 48 49]

She's a great doctor. …I feel like I'm going in and I'm talking to people who honestly care who have been my friends for a lifetime and I'm able to be open and honest. So I think it's the person, I think it's the way the questions are set up, and I think it's the presentation. Because everybody is in their own bubble and if you make things where people feel like they're more interrogated, then we're less likely to say anything[43] (p2659).

When these expectations were met, participants in the included studies were more likely to form a positive relationship with their HCPs and honestly disclose their exposure to IPA.

Confidence in the findings

By applying GRADE-CERQual methods[27] to these review findings, the theme *'Provide universal education'* was appraised as moderate confidence and the themes *'Create a safe and supportive environment for disclosure'* and *'It is about how you ask'* were appraised as high confidence. The confidence ratings indicate that these themes are likely to be reasonable representation of women's experiences and expectations of IPA disclosure and identification in a healthcare setting. See online supplemental table 2 for a detailed GRADE-CERQual evidence profile explaining individual assessments made.

DISCUSSION

Principal findings

This qualitative evidence synthesis was conducted to answer the question: *What are women's experiences and expectations of IPA disclosure and identification in healthcare settings?* We sought to capture the more recent research on the topic of how IPA can be addressed in health settings. Overall, the 34 studies included in our review were found to have a moderate level of methodological quality, mostly due to a lack of consideration of the researcher–participant relationship.

Three key themes were developed by analysing the data with a thematic synthesis approach: (1) *Provide universal education* (suggesting that information provision to all patients may be more useful than universal screening in healthcare settings in terms of facilitating disclosures), (2) *Create a safe and supportive environment for disclosure* (which emphasised the need for the HCP to demonstrate care and confidentiality in their approach) and (3) *It is about how you ask* (highlighting the importance of fostering trust and rapport when enquiring about IPA). Using the GRADE-CERQual assessment,[27] two themes were graded as high confidence and one as moderate confidence, indicating that they are likely to be reasonable representations of women's views on the topic.

Significance and implications for practice

Consistent with previous existing research,[10 18 19] our review findings highlight the importance of HCP interpersonal skills in facilitating woman-led disclosure. Participants across the included studies articulated that HCPs need to demonstrate a caring, empathetic attitude and skills in active listening to help them feel safe. To further establish a sense of security and support, participants

suggested that HCPs emphasise confidentiality and minimise power differentials through shared decision-making. HCP attitudes and a sense of patient–provider connectedness have been established in the literature as enablers of IPA disclosure,[45 50 68] and important factors in patient satisfaction and health outcomes more generally.[36 69–72] When HCPs failed to meet women's expectation of a safe environment, they experienced a sense of distrust and disengagement from the healthcare system and were unlikely to feel comfortable disclosing IPA. Additionally, although there were few studies focused on the experiences of women from marginalised groups, the findings suggest that HCPs must adopt practices of cultural safety and disability sensitive care to ensure that healthcare settings are safe and supportive environments for all women.[1 46 48 65 73–80]

Women's experiences and expectations documented in this review also demonstrate the value placed on the way that HCPs ask about IPA. Participants expected HCPs to consider the context in which they initiate an enquiry and phrase questions in a way that is sensitive to the difficulties of disclosure. By developing rapport first, having enough time to talk, using straightforward language and asking questions about violence on different occasions, HCPs can establish a setting conducive to disclosure and signal that they are trustworthy. These expectations align with the recommendations from international guidelines that HCPs should ask about IPA in an appropriate way and be prepared to do so more than once.[1] The findings are also congruent with the established importance of good communication skills to patient comfort when discussing IPA.[10 81]

In terms of specific recommendations for practice, the suggestion that HCPs link questions about IPA with women's health and the health of their children offers a clear route to enquiry which may be particularly helpful for practitioners worried about offending their patients. Studies exploring the perceptions of HCPs consistently indicate that this fear is a very real barrier to enquiry and response.[15] Given that a range of clinical conditions may be caused or complicated by IPA, including chronic pain, suicidal ideation, gynaecological issues, depression and addiction, asking about patient exposure is highly relevant to the medical encounter and the provision of appropriate healthcare support.[1 6 10] Children also experience detrimental effects from IPA exposure, and studies indicate that children are a significant factor in women's decisions to seek professional support.[6 45 82–86] The findings from this review show that women want to be asked about IPA in the context of wider health issues and the well-being of their children, and that by doing so, HCPs can demonstrate that they are there to offer help.

A novel finding not described in the previous literature[10 18] is the emphasis placed on women's desire to routinely receive information about IPA. While previous debates have focused on universal *screening* (with limited evidence being found for its effectiveness[87]) a universal *education* approach seeks to equip all women with an understanding of IPA and support options, not only those who disclose their experiences.[88] Research from the USA indicates that both HCPs and those experiencing IPA find this to be a beneficial and empowering approach.[40 88–91] The findings from this review suggest key areas of desired knowledge for women: what constitutes a healthy relationship, warning signs of abuse, the impact of emotional trauma on physical health, how IPA affects children, and options for support. Conversations about IPA were viewed as important to raise in a healthcare setting as they provided a critical opportunity to talk. While the term 'universal education' was not articulated by participants in this review, women had experienced the impact of not receiving information when they needed it and spoke of the necessity of all women having access to IPA knowledge and resources. As explored elsewhere,[1 40] this could be achieved through the utilisation of IPA education cards to discuss and give to patients (if safe to do so), and the placement of informative posters in healthcare clinics. Future opportunities for universal education (for contexts where the internet is available) might involve referral to online resources, which have shown promise in raising awareness,[92] but have yet to be evaluated in healthcare settings. This would have particular relevance for the context of COVID-19, which was not addressed by the studies in this review.

The emphasis placed on universal education by participants in the included studies represents a fundamental shift in women's experiences and expectations since the previous review by Feder and colleagues[10] was conducted. Although Feder's review does report that the use of posters and brochures in the healthcare setting can raise women's awareness about the issue of IPA, subsequent studies in the intervening years have been more specific about the role of universal education. In our review, we found that women wanted more detailed information that could potentially help them identify abuse in their relationships and make decisions about what to do next. Provision of this information was not tied to disclosure or inquiry by the HCP but could act as a facilitator to disclosure in the future. We suggest that the provision of universal education might be more woman-centred than universal screening, since it seeks to empower women through awareness and information. Further, it provides opportunities for HCPs to sensitively inquire by using the education materials as a way to broach the subject of IPA with patients.[37 41]

Strengths and limitations

The use of an extensive search strategy and well-defined study selection criteria act as strengths of this study. Transparency and validity were promoted by using systematic methods to extract data, appraise the quality of included studies and assess confidence in the findings. The engagement of multiple reviewers at each stage in the research process, some highly experienced in conducting systematic reviews, further added to a robust interpretation of the data. An additional key strength of this review is

the use of thematic synthesis as the method of analysis. Thematic synthesis, with its focus on the generation of new themes across the dataset,[25] allowed our findings to move beyond a simple categorisation of barriers and facilitators towards themes that are more meaningful and relevant to improving healthcare responses to IPA.

The findings from this review also contain some limitations. While the included studies were from a diverse range of countries, research from high-income settings such as the USA and Australia was still over-represented. Furthermore, only one included study explored the perspectives of women with disabilities and one of an Indigenous population, despite these populations of women being at high risk of experiencing IPA.[1 46 48 65 77–79] Our study is also limited by methodological concerns regarding the included papers, and the contentious value of relying on quality appraisal checklists in qualitative research.[93] Finally, the minor concerns identified using GRADE-CERQual methods[27] may limit the level of confidence placed in review findings.

Recommendations for future research

There are several gaps in knowledge that should be addressed by emerging research. More research is required to understand how universal education could most effectively be implemented and the acceptability of this approach in different settings. In addition, future studies should investigate the views of women from low-income countries, as these voices were largely absent from this review. With limited data exploring the perspectives of disabled and Indigenous women, and none relating to those who identified as sexual minorities, there is a clear need for future research to explore the experiences and expectations of IPA disclosure in these marginalised groups.

CONCLUSION

This systematic review and qualitative evidence synthesis aimed to understand women's experiences and expectations of IPA disclosure and identification in healthcare settings, focusing on the process of disclosure/identification rather than the healthcare responses that come afterwards. The findings indicate that women want to routinely receive information about IPA, lending support to a universal education approach that equips all women with knowledge and resources. Contemplating disclosure raised significant fears for women, making it essential that HCPs create a safe and supportive environment. Participants also expected HCPs to consider how they ask about IPA and recommended that it be done in a private setting with sufficient time and be linked with the well-being of women and their children. The included studies were from 17 countries spanning six continents, indicating that regardless of geographic boundaries, women want to be informed about IPA and to feel that HCPs consider their safety and comfort. Implementation of the suggestions described in this study may help empower women experiencing IPA to seek healthcare support and improve the confidence of HCPs in their interactions with female patients. Future research should explore the implementation of universal education in different settings and the perspectives of under researched populations.

Twitter Jacqueline Cameron @JacquiCameron18 and Laura Tarzia @DrLauraTarzia

Contributors EK-C led the data collection and data analysis and wrote the first draft of the manuscript. MK-O supervised data collection and analysis and commented on all drafts. JC supervised and contributed to the quality appraisal and CER-Qual process and commented on manuscript drafts. KH led study conception and contributed to study design and analysis and commented on drafts. LT led study design, supervised data collection and analysis, wrote the final draft and commented on all drafts. LT is the guarantor for this study and accepts full responsibility for the work.

Funding This review was supported by the National Health and Medical Research Council (NHMRC) through the Centre for Research Excellence in Safer Families (APP1116690). The funding body played no role in the study design; the collection, analysis, and interpretation of data; writing of the report; or the decision to submit the article for publication

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. This study is a systematic review and meta-analysis of published qualitative studies. Full-text studies are available either open-access or via an institutional or personal subscription to the relevant journal/s. Our analysis of the included studies is available upon reasonable request.

ORCID iDs
Jacqueline Cameron http://orcid.org/0000-0003-1253-1282
Laura Tarzia http://orcid.org/0000-0002-0220-4985

REFERENCES

1 World Health Organization. *Responding to intimate partner violence and sexual violence against women: who clinical and policy guidelines*. World Health Organization, 2013.
2 García-Moreno C, Pallitto C, Devries K. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and Non-Partner sexual violence*. World Health Organization, 2013.
3 Montesanti SR, Thurston WE. Mapping the role of structural and interpersonal violence in the lives of women: implications for public health interventions and policy. *BMC Womens Health* 2015;15:1–13.
4 García-Moreno C, Jansen H, Ellsberg M. WHO Multi-Country Study on Women's Health and Domestic Violence Against Women 2005;204:1–18.

5 Mackenzie M, Gannon M, Stanley N, *et al*. 'You certainly don't go back to the doctor once you've been told, "I'll never understand women like you."' Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. *Sociol Health Illn* 2019;41:1159–74.
6 Miller E, McCaw B. Intimate partner violence. *N Engl J Med* 2019;380:850–7.
7 Plichta S. The effects of woman abuse on health care utilization and health status: a literature review. *Womens Health Issues* 1992;2:154–63.
8 McNutt LA, Carlson BE, Gagen D, *et al*. Reproductive violence screening in primary care: perspectives and experiences of patients and battered women. *J Am Med Womens Assoc* 1999;54:85–90.
9 Reisenhofer S, Seibold C. Emergency healthcare experiences of women living with intimate partner violence. *J Clin Nurs* 2013;22:2253–63.
10 Feder GS, Hutson M, Ramsay J, *et al*. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med* 2006;166:22–37.
11 McCleary-Sills J, Namy S, Nyoni J, *et al*. Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Glob Public Health* 2016;11:224–35.
12 Alaggia R, Regehr C, Jenney A. Risky business: an ecological analysis of intimate partner violence disclosure. *Res Soc Work Pract* 2012;22:301–12.
13 Ansara DL, Hindin MJ, Formal HMJ. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Soc Sci Med* 2010;70:1011–8.
14 Hegarty KL, Taft AJ. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Aust N Z J Public Health* 2001;25:433–7.
15 Tarzia L, Cameron J, Watson J, *et al*. Personal barriers to addressing intimate partner abuse: a qualitative meta-synthesis of healthcare practitioners' experiences. *BMC Health Serv Res* 2021;21:567.
16 Sprague S, Madden K, Simunovic N, *et al*. Barriers to screening for intimate partner violence. *Women Health* 2012;52:587–605.
17 Keynejad R, Baker N, Lindenberg U, *et al*. Identifying and responding to domestic violence and abuse in healthcare settings. *BMJ* 2021;373:n1047.
18 Heron RL, Eisma MC. Barriers and facilitators of disclosing domestic violence to the healthcare service: a systematic review of qualitative research. *Health Soc Care Community* 2021;29:612–30.
19 Tarzia L, Bohren MA, Cameron J, *et al*. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: a qualitative meta-synthesis. *BMJ Open* 2020;10:e041339.
20 Higgins JP, Thomas J, Chandler J. *Cochrane Handbook for systematic reviews of interventions*. John Wiley & Sons, 2019.
21 Cochrane Community. About Covidence [Internet], 2020. Available: https://community.cochrane.org/help/tools-and-software/covidence/about-covidence [Accessed 26 Apr 2020].
22 International QSR. Fueling Academic Research [Internet], 2020. Available: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo/who-its-for/academia [Accessed 01 May 2020].
23 Critical Appraisal Skills Programme. CASP Qualitative Research Checklist [Internet], 2018. Available: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf [Accessed 25 May 2020].
24 Njau B, Covin C, Lisasi E, *et al*. A systematic review of qualitative evidence on factors enabling and deterring uptake of HIV self-testing in Africa. *BMC Public Health* 2019;19:1–16.
25 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol* 2008;8:45.
26 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
27 Lewin S, Booth A, Glenton C, *et al*. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci* 2018;13:1–10.
28 Munthe-Kaas H, Bohren MA, Glenton C, *et al*. Applying GRADE-CERQual to qualitative evidence synthesis findings—paper 3: how to assess methodological limitations. *Implement Sci* 2018;13:25–32.
29 Colvin CJ, Garside R, Wainwright M, *et al*. Applying GRADE-CERQual to qualitative evidence synthesis findings—paper 4: how to assess coherence. *Implement Sci* 2018;13:34–41.
30 Glenton C, Carlsen B, Lewin S, *et al*. Applying GRADE-CERQual to qualitative evidence synthesis findings—paper 5: how to assess adequacy of data. *Implement Sci* 2018;13:43–50.
31 Noyes J, Booth A, Lewin S, *et al*. Applying GRADE-CERQual to qualitative evidence synthesis findings–paper 6: how to assess relevance of the data. *Implement Sci* 2018;13:51–61.
32 An S, Choi G-Y. Is TANF Truly Accessible and Helpful? Victims' Experiences With Domestic Violence Screening Under the Family Violence Option. *Affilia* 2019;34:461–80.
33 Grillo AR, Danitz SB, Dichter ME, *et al*. Strides toward recovery from intimate partner violence: elucidating patient-centered outcomes to optimize a brief counseling intervention for women. *J Interpers Violence* 2021;36:1–23.
34 Reeves EA, Humphreys JC. Describing the healthcare experiences and strategies of women survivors of violence. *J Clin Nurs* 2018;27:1170–82.
35 Wadsworth P, Degesie K, Kothari C, *et al*. Intimate partner violence during the perinatal period. *J Nurse Pract* 2018;14:753–9.
36 Zelazny SM, Chang JC, Burke JG, *et al*. Adolescent and young adult women's recommendations for establishing comfort with family planning providers' communication about and assessment for intimate partner violence. *J Commun Healthc* 2019;12:32–43.
37 Bacchus LJ, Bullock L, Sharps P, *et al*. Infusing technology into perinatal home visitation in the United States for women experiencing intimate partner violence: exploring the interpretive flexibility of an mHealth intervention. *J Med Internet Res* 2016;18:e302.
38 Decker MR, Flessa S, Pillai RV, *et al*. Implementing trauma-informed partner violence assessment in family planning clinics. *J Womens Health* 2017;26:957–65.
39 Jack SM, Ford-Gilboe M, Davidov D, *et al*. Identification and assessment of intimate partner violence in nurse home visitation. *J Clin Nurs* 2017;26:2215–28.
40 Miller E, McCauley HL, Decker MR, *et al*. Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: provider and patient perspectives. *Perspect Sex Reprod Health* 2017;49:85–93.
41 Bacchus LJ, Bullock L, Sharps P, *et al*. 'Opening the door': A qualitative interpretive study of women's experiences of being asked about intimate partner violence and receiving an intervention during perinatal home visits in rural and urban settings in the USA. *J Res Nurs* 2016;21:345–64.
42 Correa NP, Cain CM, Bertenthal M, *et al*. Women's experiences of being screened for intimate partner violence in the health care setting. *Nurs Womens Health* 2020;24:185–96.
43 Dichter ME, Makaroun L, Tuepker A, *et al*. Middle-aged women's experiences of intimate partner violence screening and disclosure: "It's a private matter. It's an embarrassing situation". *J Gen Intern Med* 2020;35:2655–61.
44 Sorrentino AE, Iverson KM, Tuepker A. Mental health care in the context of intimate partner violence: Survivor perspectives. In: *Psychological services*, 2020.
45 Williams JR, Gonzalez-Guarda RM, Halstead V, *et al*. Disclosing gender-based violence during health care visits: a patient-centered approach. *J Interpers Violence* 2020;35:5552–73.
46 Spangaro J, Herring S, Koziol-McLain J, *et al*. 'Yarn about it': Aboriginal Australian women's perceptions of the impact of routine enquiry for intimate partner violence. *Cult Health Sex* 2019;21:789–806.
47 O'Doherty L, Taket A, Valpied J, *et al*. Receiving care for intimate partner violence in primary care: barriers and enablers for women participating in the weave randomised controlled trial. *Soc Sci Med* 2016;160:35–42.
48 Spangaro J, Herring S, Koziol-Mclain J, *et al*. 'They aren't really black fellas but they are easy to talk to': Factors which influence Australian Aboriginal women's decision to disclose intimate partner violence during pregnancy. *Midwifery* 2016;41:79–88.
49 Spangaro J, Koziol-McLain J, Rutherford A, *et al*. "Made Me Feel Connected": A Qualitative Comparative Analysis of Intimate Partner Violence Routine Screening Pathways to Impact. *Violence Against Women* 2020;26:334–58.
50 Spangaro J, Koziol-McLain J, Zwi A, *et al*. Deciding to tell: qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. *Soc Sci Med* 2016;154:45–53.
51 Srinivasan S, Marino J, Hegarty K, *et al*. Women's expectations of healthcare providers in the context of reproductive abuse in Australia. *Cult Health Sex* 2020;22:489–503.
52 Hester M, Lilley S-J. More than support to court: rape victims and specialist sexual violence services. *Int Rev Vict* 2018;24:313–28.
53 Bradbury-Jones C, Clark M, Taylor J. Abused women's experiences of a primary care identification and referral intervention: a case study analysis. *J Adv Nurs* 2017;73:3189–99.

54 Sabina C, Figueroa DP. "Hay que tener suerte": Gender-based Violence Service Provision in Quito, Ecuador. *Health Hum Rights* 2019;21:295–307.
55 Vranda MN, Kumar CN, Muralidhar D, *et al*. Barriers to disclosure of intimate partner violence among female patients availing services at tertiary care psychiatric hospitals: a qualitative study. *J Neurosci Rural Pract* 2018;9:326–30.
56 Manor-Binyamini I, Schreiber-Divon M. Listening to Bedouin women who were affected by intimate partner violence and sought help from a doctor. *J Interpers Violence* 2021;36:NP11155-NP11175.
57 Kataoka Y, Imazeki M. Experiences of being screened for intimate partner violence during pregnancy: a qualitative study of women in Japan. *BMC Womens Health* 2018;18:1–9.
58 Childress S, Hanusa D. “All the System is Simply a Soap Bubble”: Legal Help-Seeking for Domestic Violence Among Women in Kyrgyzstan. *J Fam Violence* 2018;33:147–60.
59 Wallin Lundell I, Eulau L, Bjarneby F, *et al*. Women's experiences with healthcare professionals after suffering from gender-based violence: an interview study. *J Clin Nurs* 2018;27:949–57.
60 Burry K, Thorburn N, Jury A. ‘I had no control over my body’: Women’s experiences of reproductive coercion in Aotearoa New Zealand. *Aotearoa New Zealand Social Work* 2020;32:17–31.
61 Fawole OI, Balogun BO, Adejimi AA, *et al*. Training medical students: victim’s perceptions of selectively screening women for intimate partner violence in health care settings. *BMC Med Educ* 2019;19:1–11.
62 Garnweidner-Holme LM, Lukasse M, Solheim M, *et al*. Talking about intimate partner violence in multi-cultural antenatal care: a qualitative study of pregnant women’s advice for better communication in South-East Norway. *BMC Pregnancy Childbirth* 2017;17:1–10.
63 Shaheen A, Ashkar S, Alkaiyat A, *et al*. Barriers to women’s disclosure of domestic violence in health services in Palestine: qualitative interview-based study. *BMC Public Health* 2020;20:1–10.
64 Hatcher AM, Woollett N, Pallitto CC, *et al*. Willing but not able: patient and provider Receptiveness to addressing intimate partner violence in Johannesburg antenatal clinics. *J Interpers Violence* 2019;34:1331–56.
65 Ruiz-Pérez I, Pastor-Moreno G, Escribà-Agüir V, -Agüir E V, *et al*. Intimate partner violence in women with disabilities: perception of healthcare and attitudes of health professionals. *Disabil Rehabil* 2018;40:1059–65.
66 Almqvist K, Källström Åsa, Appell P, *et al*. Mothers' opinions on being asked about exposure to intimate partner violence in child healthcare centres in Sweden. *J Child Health Care* 2018;22:228–37.
67 Liao M-Y. Integrating body–mind–spirit services used by women experiencing intimate partner violence: a case study in Taiwan. *Int Soc Work* 2019;62:549–66.
68 Robinson L, Spilsbury K. Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health Soc Care Community* 2008;16:16–30.
69 Epstein RM, Street RL, Communication Shared Mind:. Decision making, and autonomy in serious illness. *Ann Fam Med* 2011;9:454–61.
70 Windover AK, Boissy A, Rice TW, *et al*. The REDE model of healthcare communication: optimizing relationship as a therapeutic agent. *J Patient Exp* 2014;1:8–13.
71 Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. *Acad Med* 2001;76:390–3.
72 Beck RS, Daughtridge R, Sloane PD. Physician-Patient communication in the primary care office: a systematic review. *J Am Board Fam Pract* 2002;15:25–38.
73 Laverty M, McDermott DR, Calma T. Embedding cultural safety in Australia's main health care standards. *Med J Aust* 2017;207:15–16.
74 Teal CR, Street RL. Critical elements of culturally competent communication in the medical encounter: a review and model. *Soc Sci Med* 2009;68:533–43.
75 Anderson J, Perry J, Blue C, *et al*. Riting" cultural safety within the postcolonial and postnational feminist project: toward new epistemologies of healing. *ANS Adv Nurs Sci* 2003;26:196–214.
76 Gerlach AJ. A critical reflection on the concept of cultural safety. *Can J Occup Ther* 2012;79:151–8.
77 Iudici A, Antonello A, Turchi G. Intimate partner violence against disabled persons: clinical and health impact, Intersections, issues and intervention strategies. *Sex Cult* 2019;23:684–704.
78 UNICEF. Breaking the silence on violence against Indigenous girls, adolescents and young women, 2013. United nations population fund
79 Breiding MJ, Armour BS. The association between disability and intimate partner violence in the United States. *Ann Epidemiol* 2015;25:455–7.
80 Fiolet R, Tarzia L, Hameed M. Indigenous Peoples’ Help-Seeking Behaviors for Family Violence: A Scoping Review. *Trauma, Violence, & Abuse* 2019:1–14.
81 Tan E, O'Doherty L, Hegarty K. GPs' communication skills - a study into women's comfort to disclose intimate partner violence. *Aust Fam Physician* 2012;41:513.
82 Bair-Merritt M, Zuckerman B, Augustyn M, *et al*. Silent victims--an epidemic of childhood exposure to domestic violence. *N Engl J Med* 2013;369:1673–5.
83 Lapierre S. Striving to be ‘good’ mothers: abused women’s experiences of mothering. *Child Abuse Review* 2010;19:342–57.
84 Kelly UA. "I'm a mother first": The influence of mothering in the decision-making processes of battered immigrant Latino women. *Res Nurs Health* 2009;32:286–97.
85 Petersen R, Moracco KE, Goldstein KM, *et al*. Moving Beyond Disclosure: Women’s Perspectives on Barriers and Motivators to Seeking Assistance for Intimate Partner Violence. *Women Health* 2005;40:63–76.
86 Chang JC, Decker MR, Moracco KE, *et al*. Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Educ Couns* 2005;59:141–7.
87 O'Doherty L, Hegarty K, Ramsay J, *et al*. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev* 2015:CD007007.
88 O’Connor T. *Implementing a universal education approach to intimate partner violence in a patient centered medical home*. Oregon Health & Science University, 2018.
89 Tancredi DJ, Silverman JG, Decker MR, *et al*. Cluster randomized controlled trial protocol: addressing reproductive coercion in health settings (ARCHES). *BMC Womens Health* 2015;15:1–16.
90 Miller E, McCaw B, Humphreys BL, *et al*. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *J Womens Health* 2015;24:92–9.
91 Miller E, Decker MR, McCauley HL, *et al*. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception* 2011;83:274–80.
92 Hegarty K, Tarzia L, Valpied J, *et al*. An online healthy relationship tool and safety decision aid for women experiencing intimate partner violence (I-DECIDE): a randomised controlled trial. *Lancet Public Health* 2019;4:E301–10.
93 Mohammed MA, Moles RJ, Chen TF. Meta-synthesis of qualitative research: the challenges and opportunities. *Int J Clin Pharm* 2016;38:695–704.

Supplementary Table 1: Study Characteristics

Authors	**Year (Country)**	**Aim(s)**	**Qualitative Method (Analysis)**	**HCP Studied**	**Sample (Age)**
Almqvist et al. [66]	2018 (Sweden)	To explore mothers' experiences of and thoughts on being asked about exposure to IPA at a child healthcare centre and to investigate prevalence rates.	Interviews (Thematic analysis)	Nurses	n = 128 (Age not specified)
An et al. [32]	2019 (USA)	To explore the experiences of domestic violence victims with their Temporary Assistance for Needy Families (TANF) applications, focusing on the conditions related to their disclosure of abuse and their post-disclosure experiences.	Interviews (Thematic analysis)	Social workers	n = 5 (Age not specified)
Bacchus et al. [37 41]	2016 (USA)	This study was reported in two papers, one with the aim to explore perinatal home visitors' and women's experiences of screening for IPV and receiving Domestic Violence Enhanced Home Visitation Program (DOVE) in the form of either mHealth technology (ie, a computer tablet) or a home visitor-led method. The second paper aimed to explore (i) women's views and experiences of being screened for IPV during perinatal home visits in rural and urban contexts in the USA and (ii) their perceptions of how the DOVE intervention helped them.	Interviews (Thematic analysis)	Perinatal home visitors	n = 26 (16-35)
Bradbury-Jones et al. [53]	2016 (UK)	To report the findings of a qualitative case study that investigated abused women's experiences of an identification and referral intervention and to discuss the implications for nurses, specifically those working in primary and community care.	Interviews (Thematic analysis)	Nurses	n = 10 (21-72)

Burry et al. [60]	2020 (New Zealand)	To understand the experiences of victims of reproductive coercion in Aotearoa New Zealand.	Survey and interviews (Categorisation)	HCP not specified	n = 111 for the survey and n = 5 for interviews (16+)
Childress et al. [58]	2017 (Kyrgyzstan)	To use women's own experiences to shed light on the barriers to and motivations for seeking help from the criminal justice and public health systems, and to inform possible refinements.	Interviews (Comparative analysis)	HCP not specified	n = 16 (20-49)
Correa et al. [42]	2020 (USA)	To qualitatively describe experiences of survivors of intimate partner violence (IPV) in being screened for IPV and to identify opportunities to improve screening and response by health care providers.	Focus groups (Constant comparative method)	HCP not specified	n = 17 (22-70)
Decker et al. [38]	2017 (USA)	To describe the uptake and impact of a brief, trauma informed, universal IPV/RC assessment and education intervention.	Interviews (Thematic analysis)	Family planning clinics	n = 26 (18-35)
Dichter et al. [43]	2020 (USA)	To examine the perspectives of middle-aged women who had experienced past-year IPV regarding IPV screening and disclosure in the healthcare setting.	Interviews (Thematic analysis)	Veterans' Health Administration service providers	n = 27 (45-64)
Fawole et al. [61]	2019 (Nigeria)	To gather the perceptions of victims of IPA on the relevance of raising the topic at healthcare facilities and to determine specific categories of women to target for screening.	Interviews (Thematic analysis)	Doctors	n = 33 (Mean age of 35.9)
Garnweidner-Holme et al. [62]	2017 (Norway)	To explore how women from different ethnic backgrounds experienced IPV and what their recommendations were about how midwives should communicate about IPV in antenatal care.	Interviews (Thematic analysis)	Midwives	n = 8 (Age not specified)

Grillo et al. [33]	2019 (USA)	To elucidate patient-centred outcomes identified by women veterans' who have experienced IPA.	Focus groups (Content analysis)	HCP not specified	n = 25 (29-70)
Hatcher et al. [64]	2016 (South Africa)	To explore the views of patients, HCPs, and community members around assessing and addressing IPA in urban antenatal care.	Interviews (Thematic analysis)	Antenatal HCPs	n = 5 (Age not specified)
Hester et al. [52]	2017 (UK)	To assess referrals, victim/survivor needs and agency responses.	Interviews (Thematic analysis)	Specialist sexual violence workers	n = 15 (Age not specified)
Jack et al. [39]	2017 (USA)	To develop strategies for the identification and assessment of intimate partner violence in a nurse home visitation programme.	Interviews (Conventional content analysis)	Nurses	n = 26 (Age not specified)
Kataoka et al. [57]	2018 (Japan)	To investigate women's experiences of reading and completing an IPA screening questionnaire during pregnancy.	Descriptive survey and interviews (Content analysis)	HCP not specified	n = 43 (Majority in their 30s)
Liao [67]	2017 (Taiwan)	To investigate the types of help-seeking services sought by abused Taiwanese women and their experiences of using them.	Interviews (Thematic analysis)	HCP not specified	n = 15 (30-59)
Mackenzie et al. [5]	2019 (UK)	To elicit women's stories of disclosing or withholding information about their abuse to general practitioners and of how disclosures, if made, were responded to.	Interviews (Thematic analysis)	General practitioners	n = 20 (20-69)
Manor-Binyamini et al. [56]	2021 (Israel)	To examine how Bedouin women perceived and interpreted seeing a doctor for help in the aftermath of intimate partner violence.	Interview (Thematic analysis)	Doctors	n = 19 (26-55)

Miller et al. [40]	2017 (USA)	To explore how patients and providers perceived the intervention and to elucidate how the intervention [Addressing Reproductive Coercion in Health Settings] was actually delivered, as a step toward refining implementation of such interventions.	Interviews (Consensus coding approach)	Nurse practitioners, medical assistants, and health educators at family planning clinics	n = 49 (18-30)
O'Doherty et al. [47]	2016 (Australia)	To elucidate factors involved in women's uptake of a counselling intervention delivered by family doctors in the weave primary care trial.	Interviews (Theory of planned behaviour)	Family doctors	n = 20 (age not specified)
Reeves et al. [34]	2017 (USA)	To develop knowledge on women survivors' healthcare experiences and strategies.	Interviews (Thematic analysis)	HCP not specified	n = 14 (22-63)
Ruiz-Perez et al. [65]	2017 (Spain)	To understand the experiences of women with disabilities who are or have been abused by their partners and to explore the knowledge, views, and training requirements of primary care professionals.	Interviews (Thematic analysis)	Primary HCPs	n = 14 (34-66)
Sabina et al. [54]	2019 (Ecuador)	To understand the availability, accessibility, adaptability, and appropriateness of IPA services from the perspective of victims.	Focus groups (Thematic analysis)	HCP not specified	n = 21 (Mean age of 38)
Shaheen et al. [63]	2020 (Palestine)	To articulate Palestinian survivors' of DV attitudes towards and experiences of disclosure in a health setting.	Interviews (Thematic analysis)	HCP not specified	n = 20 (20-59)

Sorrentino et al. [44]	2020 (USA)	To explore what constitutes client-centered mental health care in the context of recent/ongoing IPV with women IPV survivors who receive health care through the Veterans Health Administration.	Interviews (Inductive approach)	Veterans' Health Administration service providers	n = 50 (22-64)
Spangaro et al. [46 48]	2019 and 2016 (Australia)	This study was reported in two papers, one with the aim to explore Aboriginal women's perceptions of the impact of IPA enquiry on themselves or their family, and the conditions associated with positive or negative impact. The second paper aimed to test, among Indigenous women, a model for decisions on whether to disclose intimate partner violence in the context of antenatal routine screening.	Interviews (Comparative analysis)	Antenatal HCPs	n = 12 (20-36)
Spangaro et al. [49 50]	2019 and 2016 (Australia)	This study was reported in two papers, one with the aim to understand the pathways leading to perceptions of positive impact of screening and, equally, pathways leading to perceptions of neutral or negative impact. The second paper aimed to test a model for women's decisions to disclose IPV in response to routine inquiry as part of antenatal assessment.	Interviews (Qualitative configurational approach and thematic analysis)	Antenatal service providers	n = 32 (17-41)
Srinivasan et al. [51]	2019 (Australia)	To understand the expectations of women in Australia when encountering healthcare providers in the context of reproductive abuse.	Interviews (Thematic analysis)	HCP not specified	n = 13 (18-44)
Vranda et al. [55]	2018 (India)	To explore barriers in disclosing IPV to mental health professionals (MHPs) of multidisciplinary team (such as psychiatrists, psychiatric social workers, and clinical psychologists) by women with mental illness experiencing IPV at a tertiary care psychiatric hospital.	Interviews (Frequency analysis)	Psychiatric service providers	n = 100 (18-56)

Wadsworth et al. [35]	2018 (USA)	To offer suggestions from women for nurse practitioners and other HCPs on improving care for women experiencing IPA during the perinatal period.	Interviews (Thematic analysis)	Perinatal HCPs	n = 20 (22-37)
Wallin Lundell et al. [59]	2017 (Mexico)	To describe how women in Mexico who have suffered from gender-based violence experience their encounters with HCPs.	Interviews (Content analysis)	HCP not specified	n = 7 (21-49)
Williams et al. [45]	2020 (USA)	To better understand victims' perspectives regarding decisions to disclose gender-based violence, namely, intimate partner violence (IPV) and human trafficking, to health care providers and what outcomes matter to them when discussing these issues with their provider.	Interviews (Qualitative content analysis)	HCP not specified	n = 25 (28-43)
Zelazny et al. [36]	2019 (USA)	To learn more about adolescent and young adult women's preferences in IPA assessment delivery in family planning clinics.	Interviews (Thematic analysis)	Doctors and nurses	n = 44 (18-29)

Supplementary Table 2: GRADE-CERQual Evidence Profile

Review Finding	**Contributing Studies**	**Assessment of Methodological Limitations**	**Assessment of Coherence**	**Assessment of Adequacy**	**Assessment of Relevance**	**Overall Assessment of Confidence in the Evidence**	**Explanation of Overall Assessment**
Provide Universal Education	Twenty studies [5 32 33 35 37-42 44-46 49 51 57 60-62 65 66].	No or very minor concerns about methodological limitations. Four of the included studies were appraised as high quality and sixteen as moderate quality, with some limited considerations of the researcher-participant relationship.	No or very minor concerns about coherence. This finding reflected the data from the primary studies, capturing that women wanted HCPs to raise the issue and provide information. Variation was also explored in the conflicting views around screening.	Minor concerns regarding adequacy. Twenty-one of the thirty-six included studies supported this theme, leading to minor concerns relating to the quantity of data when compared with the other review findings.	Minor concerns about relevance. Two studies included some participants who had not experienced IPA or did not report IPA [37 38 41], one study included some survivors of other types of violence [45], and one study included a small subset of participants who were not women [60]. Care was taken to only include quotations from IPA survivors in this theme.	Moderate confidence.	Minor concerns were found relating to adequacy and relevance. No or very minor concerns were found in relation to methodological limitations, and coherence.

Create a safe and supportive environment for disclosure	Thirty-one studies [5 32 34-52 54-60 62-67]	Minor concerns about methodological limitations. While studies were appraised as moderate-high quality, fifteen studies included in this theme contained no consideration of the researcher-participant relationship which may have influenced findings.	No or very minor concerns about coherence. Fears experienced, the need for a caring environment, and suggestions for safety promotion were described in detail by the primary studies.	No or very minor concerns about adequacy. Fears implicated in making a disclosure were well supported, as was the need to demonstrate care and recommendations for safety.	Minor concerns about relevance. Two studies included some participants who had not experienced IPA or did not report IPA [37 38 41], three papers included some survivors of other types of violence [34 45 52], and two studies included a small subset of participants who were not women [52 60]. These may have informed some of the author's conclusions, and care was taken to only include quotations from IPA survivors in this theme.	High confidence.	Minor concerns were found relating to methodological limitations and relevance. No or very minor concerns were found in relation to coherence and adequacy.

It's about how you ask	Twenty-seven studies [5 32-39 41-51 53 57-64 66].	No or very minor concerns about methodological limitations. Six of the included studies were appraised as high quality and twenty-one as moderate quality, with some limited considerations of the researcher-participant relationship.	No or very minor concerns about coherence. This theme captured women's experiences and recommendations for practitioner-led identification.	No or very minor concerns about adequacy. Suggestions around how to enquire about IPA were supported in depth by included papers.	Minor concerns about relevance. Two studies included some participants who had not experienced IPA or did not report IPA [37 38 41], two studies included some survivors of other types of violence [34 45], and one study included a small subset of participants who were not women [60]. These may have informed some of the author's conclusions, and care was taken to only include quotations from IPA survivors in this theme.	High confidence.	Minor concerns were found relating to relevance. No or very minor concerns were found in relation to methodological limitations, coherence, and adequacy.

#	Ovid (Medline, EMBASE, Cochrane, PsychINFO)	Ebsco (SocIndex & CINAHL)	ProQuest (ASSIA)
1	Battered women/	MH battered women	mainsubject(battered women)
2	Domestic violence/	MH domestic Violence	mainsubject(domestic violence)
3	Spouse Abuse/	MH Intimate Partner Violence	mainsubject(spouse abuse)
4	Marital rape/	"marital rape"	mainsubject(marital rape)
5	(abuse$ adj3 wom#n).tw	abuse* N3 wom?n	abuse* Near/3 wom?n Anywhere except full text
6	(abuse$ adj3 spous$).tw	abuse* N3 spous*	abuse* Near/3 spous* Anywhere except full text
7	(abuse$ adj3 partner$).tw	abuse* N3 partner*	abuse* Near/3 partner* Anywhere except full text
8	(abuse$ adj3 (wife or wives)).tw	abuse* N3 (wife or wives)	abuse* NEAR/3 (wife or wives) Anywhere except full text
9	(batter$ adj3 (wife or wives)).tw	batter* N3 (wife or wives)	batter* Near/3 (wife or wives) Anywhere except full text
10	(batter$ adj3 wom#n).tw	batter* N3 wom?n	batter* Near/3 wom?n Anywhere except full text
11	Domestic violence.tw	"domestic violence"	ti("domestic violence") or ab("domestic violence")
12	Family violence.tw	"family violence"	ti("family violence") or ab("family violence")
13	Dating violence.tw	MH dating violence or "dating violence"	ti("dating violence") or ab("dating violence")
14	(partner$ adj3 violen$).tw	partner* N3 violen*	partner* Near/3 violen* Anywhere except full text
15	(spous$ adj3 violen$).tw	spous* N3 violen*	spous* NEAR/3 violen* Anywhere except full text
16	(gender adj3 violen$).tw	gender N3 violen*	gender* NEAR/3 violen* Anywhere except full text
17	Reproductive coercion.tw	"reproductive coercion"	ti("reproductive coercion") or ab("reproductive coercion")
18	OR/1-17	OR/1-17	OR/1-17
19	(wom#n or femal$).tw	AB wom#n or femal* OR TI wom#n or femal*	Ab("wom?n" or "femal*") or ti("wom?n" or "femal*")
20	exp Qualitative Research/	MH qualitative studies or "qualitative research" or "qualitative studies"	mainsubject(qualitative research) OR ti("qualitative research") or ab("qualitative research")
21	Phenomenology.mp	MH phenomenology or "phenomenolog*"	mainsubject(phenomenology) OR ti(phenomenology*) or ab(phenomenology*)
22	exp Hermeneutics/	hermeneutic*	mainsubject(hermeneutics) OR ti(hermeneutic*) or ab(hermeneutic*)
23	Constructivism.mp	constructivis*	mainsubject(constructivist approach) OR ti(constructivis*) or ab(constructivis*)

24	interview/	MH interviews	ti(interview*) OR ab(interview*)
25	questioning/ or information seeking/ or interviewing/	question* or "information seek*" or interview*	mainsubject(questioning) OR mainsubject(information seeking) OR mainsubject(interviewing)
26	Observation/Mt [Methods]	MH observational methods or "observation method*"	mainsubject(observation)
27	grounded theory/	MH grounded theory or "grounded theory"	mainsubject(grounded theory)
28	program evaluation/	MH program evaluation or "program evaluation*"	ti("program evaluation") or ab("program evaluation")
29	Verbal Communication.mp	"verbal communication*"	ti("verbal communication") or ab("verbal communication")
30	Exp personal narratives/	MH narratives	mainsubject(personal narratives)
31	discourse analysis or content analysis.mp	MH discourse analysis or "discourse analysis" or MH content analysis or "content analysis"	mainsubject(discourse analysis) OR mainsubject(content analysis)
32	(qualitative or ethno$ or emic or etic or phenomenolog$ or hermeneutic$ or heidegger$ or husserl$ or colaizzi$ or giorgi$ or glaseror strauss or van kaam$ or van manen or constant compar$).ti,ab	qualitative or ethno* or emic or etic or phenomenology* or hermeneutic* or Heidegger* or Husserl* or colaizzi* or Giorgi* or glaser or strauss or "van kaam*" or "van manen" or "constant compar*" Limit title & abstract	ti(qualitative OR ethno* OR hemic OR ethic OR phenomenolog* OR hermeneutic OR heidelberg OR cusser OR blaized OR giorgio OR glaser OR strauss OR van ogam OR van maned OR constant compar*) OR ab(qualitative OR ethno* OR hemic OR ethic OR phenomenolog* OR hermeneutic OR heidelberg OR cusser OR blaized OR giorgio OR glaser OR strauss OR van ogam OR van manen OR constant compar*)
33	(focus group$ or grounded theory or narrative analys$ or lived experience$ or life experience$ or theoretical sampl$ or purposive sampl$ or ricoeur or spiegelberg$ or merleau or metasynthes$ or meta-synthes$ or metasummar$ or meta-summar$ or metastud$ or meta-stud$ or maximum variation or snowball).ti,ab	"focus group*" or "grounded theory" or "narrative analys*" or "lived experience*" or "life experience*" or "theoretical sampl*" or "purposive sampl*" or ricoeur or spiegelberg* or merleau or metasynthes* or meta-synthes* or metasummar* or meta-summar* or metastud* or meta-stud* or "maximum variation" or snowball Limit title & abstract	ti(focus group OR grounded theory OR narrative analys* OR lived experience OR life experience OR theoretical sampl* OR purposivesampl* OR tricolour OR spiegel berg OR merles OR metasynthes* OR meta-synthes* OR metasummar* OR meta-summar* OR metastud* OR meta-stud* OR maximum variation OR snowball*) OR ab(focus group OR grounded theory OR narrative analys* OR lived experience OR life experience OR theoretical sampl* OR purposivesampl* OR tricolour OR spiegel berg OR merles OR metasynthes* OR meta-synthes* OR metasummar* OR meta-summar* OR metastud* OR meta-stud* OR maximum

			variation OR snowball*)
34	((thematic adj3 analy$) or (content analy$ or field notes or fieldnotes or field record$ or field stud$) or (participan$ adj3 observ$) or (nonparticipan$ adj3 observ$) or (non-participan$ adj3 observ$)).ti,ab	thematic* N3 analys* or "content analy*" or "field note*" or fieldnote* or "field record*" or "field stud*" or participant* N3 observ* or nonparticipant* N3 observ* or non-participant* N3 observ* Limit title & abstract	thematic* Near/3 analys* or "content analy*" or "field note*" or fieldnote* or "field record*" or "field stud*" or participant* Near/3 observ* or nonparticipant* Near/3 observ* or non-participant* Near/3 observ* Anywhere except full text
35	(semi-structured or semistructured or structured categor$ or unstructured categor$ or action research or (audiorecord$ or taperecord$ or videorecord$ or videotap$) or ((audio or tape or video$) adj5 record$) or interview* or quasi-experiment* or (case adj stud*)).ti,ab	semi-structured or semistructured or "structured category*" or "unstructured category*" or "action research" or audiorecord* or taperecord* or videorecord* or videotap* or (audio or tape or video* N5 record*) or interview* or quasi-experiment* or (case N stud*) Limit title & abstract	semi-structured OR restructured OR "structured category*" OR "unstructured category*" OR "action research" OR audiorecord* OR taperecord* OR videorecord* OR videotap* OR (audio OR tape OR video* NEAR/5 record*) OR interview* OR quasi-experiment* OR (case NEAR/2 stud*) Anywhere except full text
36	OR/20-35	OR/20-35	OR/20-35
37	Health facilities/ or exp health services/ or primary health care/ or health care delivery	Exp health facilities or Exp health maintenance organizations or medical care or primary health care or community health services	MAINSUBJECT("Health visitors") OR MAINSUBJECT.EXACT.EXPLODE("Health care") OR MAINSUBJECT("Health centres") OR MAINSUBJECT.EXACT.EXPLODE("Health services")
38	18 AND 19 AND 36 AND 37	18 AND 19 AND 36 AND 37	18 AND 19 AND 36 AND 37
39	Limit 2016-current	Limit 2016-current	Limit 2016-current