Spotlighting Women's Health in October – Intimate Partner Violence

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The National Perinatal Association (NPA) is an interdisciplinary organization that strives to be a leading voice for perinatal care in the United States. Our diverse membership is comprised of healthcare providers, parents & caregivers, educators, and service providers, all driven by their desire to give voice to and support babies and families at risk across the country.

Members of the NPA write a regular peer-reviewed column in Neonatology Today.

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Each October, women’s health becomes the focus of national awareness campaigns, media advocacy, and all sorts of imagery dedicated to pink - the color of

breast cancer awareness month. Did you know that October is also Domestic Violence Awareness month? Although breast cancer dominates the women’s health spotlight throughout the month of October, domestic violence – also known as intimate partner violence – is a public health problem that deserves equal spotlighting.

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Intimate partner violence (IPV) refers to any abuse directed at one household member from another. IPV can be physical abuse, emotional, psychological, or sexual abuse. For those experiencing pregnancy, the incidence of intimate partner violence is even higher. IPV is the primary cause of injury for women between ages 16-44. (1) In the United States, about 1.5 million women report being victims of some form of IPV every year. Of these reported cases, approximately 325,000 are pregnant during acts of violence. (2) The reason for this spike in IPV during pregnancy is unknown but could be due to the relationship dynamic changes between partners or that the frequency of prenatal visits yields more positive screens simply because patients are being screened more frequently. What is known is that intimate partner violence affects pregnancy more than any other common pregnancy complication like gestational diabetes, hypertension, and pre-eclampsia. Though IPV contributes to several known poor health outcomes, specific risks of IPV in pregnancy include physical injury, chronic pain, gastrointestinal injury, gynecological problems (including sexually transmitted infections), complications during childbirth and pregnancy (such as inadequate weight gain, infec-

tions, and bleeding), and adverse pregnancy outcomes (such as low birth weight, preterm delivery, and neonatal death). (3) Experiencing IPV during pregnancy has been shown to be associated with higher rates of depression, suicide attempts, and behavioral risk factors, including the use of tobacco, alcohol, and drugs. (3)

The perinatal and postpartum periods create unique opportunities for screening for IPV and intervention for prenatal, postpartum, and pediatric providers. Screening for IPV should be completed for each patient and done appropriately and privately. Providers must navigate screening, taking care of their patients, who in many cases may not be the parent, and providing their patients with a safe and comfortable atmosphere. Several studies noted that provider constraints served as a barrier to effective screening for IPV. A meta-analysis of studies that researched barriers to screening identified a provider’s discomfort with discussing IPV, lack of knowledge, and time constraints as the greatest barriers to screening. (4) Clinicians’ lack of confidence in their ability to screen women for IPV or to provide assistance to women experiencing violence were also identified as barriers. (5) Although most physicians feel they should screen patients for IPV, only a small percentage do so, largely because they feel uncomfortable having such conversations. (6)

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The challenge for perinatal care leaders lies in creating a top-down and bottom-up systemwide approach for understanding, identifying, and responding to IPV. Education of all levels of perinatal caregivers, standards of care that support uniform clinical protocols, and effective linkage with community resources contribute to a system that promotes better outcomes for IPV victims and their families. All of us have a role to play in reducing the harm of IPV. Clinical care leaders and staff are key to creating a safe environment for women to answer honestly about their experiences and be connected to supportive services. Health system executives and administrators create and endorse the culture and environment that communicate internally and externally that the institution considers IPV is a serious health risk. Educators can ensure that curriculum content addresses IPV at an appropriate level for their student audience, whether the learners are health professionals, childbearing families or members of the public. Advocacy for public policy supportive of violence prevention is a role for everyone.

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Mindfulness of the opportunities we have to make a difference is a task that we should take seriously.

The National Perinatal Association supports the following initiatives to improve perinatal outcomes related to intimate partner violence:

- All providers of perinatal care should utilize screening tools to identify victims of intimate partner violence.
- All patients should be screened for intimate partner violence at the time of routine gynecologic care.
- All pregnant people should be screened for intimate partner violence at least once per trimester and whenever behavioral indicators or physical complaints suggest.
- All healthcare providers should familiarize themselves with local or regional resources, including crisis shelters, helplines, and safe spaces, and should be prepared to expedite referrals when indicated.

To learn more about the National Perinatal Association's advocacy and education regarding intimate partner violence, please visit www.nationalperinatal.org.

References:

1. Walby S, Allen J. *Domestic violence, sexual assault and stalking: findings from the British Crime Survey*. Home Office, 2004. 144 p.

2. Deshpande, Neha A., and Annie Lewis-O'Connor. (2013). *Screening for Intimate Partner Violence During Pregnancy*. *Reviews in Obstetrics and Gynecology*, 6(3-4), pp. 141-148.
3. Kiely, M., El-Mohandes, AE., and El-Khorazaty, MN. (2010). *An Integrated Intervention to Reduce Intimate Partner Violence in Pregnancy: A Randomized Trial*. *Obstetrics & Gynecology*. 115(2), pp. 273-283.
4. Sprague S, Madden K, Simunovic N, Godin K, Pham NK, Bhandari M, Goslings JC. *Barriers to screening for intimate partner violence*. *Women Health*. 2012;52(6):587-605. doi: 10.1080/03630242.2012.690840. PMID: 22860705.
5. Tavrow P, Bloom BE, Withers MH. *Intimate Partner Violence Screening Practices in California After Passage of the Affordable Care Act*. *Violence Against Women*. 2017;23(7):871-886. doi:10.1177/1077801216652505
6. O'Doherty, Lorna, et al. (2015) *Screening Women for Intimate Partner Violence in Healthcare Settings*. *Cochrane Database Systematic Review*. 22(7).

Disclosure: The National Perinatal Association www.nationalperinatal.org is a 501c3 organization that provides education and advocacy around issues affecting the health of mothers, babies, and families.

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