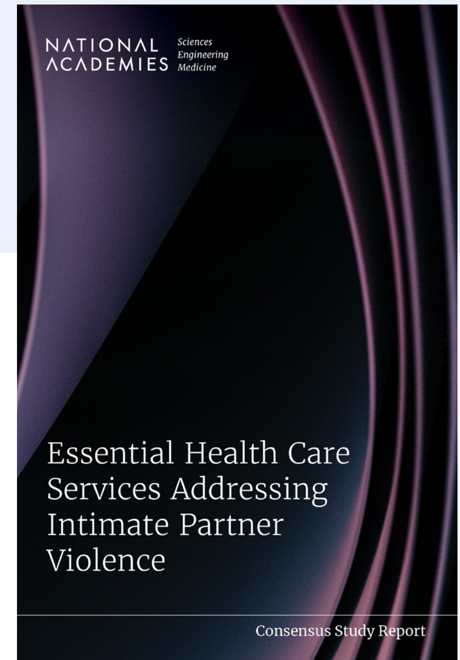
Essential Health Care Services Addressing Intimate Partner Violence



Intimate partner violence (IPV)—abuse or aggression by a current or former intimate partner—affects nearly half of women in the United States at some point during their lifetime. IPV has several adverse effects on women's physical and mental health. In addition to acute physical injuries, conditions associated with experiencing IPV include unintended pregnancy, HIV infection, post-traumatic stress disorder, substance use disorder, and several serious perinatal and obstetric complications up to and including fetal death and intimate partner homicide.

Researchers have found that women's health and well-being are disproportionately adversely affected by public health emergencies (PHEs)—events with health consequences that can overwhelm the routine capabilities of the affected geographic area. Examples include infectious disease outbreaks, hurricanes, earthquakes, wildfires, and oil spills. PHEs are also a time of increased prevalence and severity of IPV. This was widely reported during the COVID-19 pandemic and noted by researchers in the aftermath of Hurricane Katrina.

The Health Resources and Services Administration's (HRSA's) Office of Women's Health asked the National Academies of Sciences, Engineering, and Medicine to convene a multi-disciplinary committee of experts to identify the essential health care services for women related to IPV during steady state conditions, determine any changes to that list during PHEs, and identify strategies to ensure women can access this essential care during PHEs. *Essential Health Care Services Addressing Intimate Partner Violence* reports the findings of the committee's research and deliberations, including recommendations for leaders of health care systems, federal agencies, health care providers, emergency planners, and those involved in IPV research.

DEFINING ESSENTIAL HEALTH CARE SERVICES

The committee defines essential health care services related to IPV as care that is provided in or referred from the health care setting that addresses the most common and serious adverse physical, mental, and behavioral health effects associated with IPV; facilitates disclosure of IPV; and protects the safety of women experiencing IPV (and their children, if needed). This care is delivered in multiple settings within the traditional health care system and in community-based settings. In addition to fear of retaliation, women cite several reasons for hesitating to disclose or seek care for IPV, such as not being aware of available services, concerns that clinicians do not have time or are uninterested in addressing IPV, and concerns about the safety of their children and pets. Clinicians can reduce these barriers by pairing IPV education with IPV screening, ensuring that safety planning is centered on the woman's needs, and providing warm referrals to care and support services (*see Recommendation 2 in the report*).

Recommendation 1: The committee recommends that HRSA and all U.S. health care systems classify the following as essential health care services related to IPV:

- **Universal IPV screening and inquiry**
- **Universal IPV education**
- **Safety planning**
- **Forensic medical examinations**
- **Emergency medical care**
- **Treatment of physical injuries**
- **Reproductive health care, including all forms of Food and Drug Administration (FDA) approved contraception and pregnancy termination**
- **Screening and treatment of sexually transmitted infections and HIV**
- **Treatment for substance use disorders and addiction care**
- **Pharmacy and medication management**
- **Obstetric care, including perinatal home visits**
- **Primary and specialty care**
- **Mental health care**
- **Support services, including shelter, nutritional assistance, and child care**
- **Dental care**

The committee recognized that some essential health care services may currently be unavailable due to state-level restrictions on reproductive health care services and federal restrictions on the use of federal funding for such services. However, substantial scientific evidence of increased risk for negative maternal and fetal health outcomes, including death and elevated risk for increased severity or frequency of IPV and intimate partner homicide in the perinatal period support their inclusion in the list of essential health care services related to IPV.

FACILITATING BETTER RESEARCH

The committee found that most studies and surveys used different terms and definitions for IPV and its various forms (physical violence, sexual violence, stalking, psychological aggression, and reproductive coercion), as well as different approaches for collecting and analyzing demographic data. Without comparable data, it is difficult to compare the outcomes of intervention studies and develop accurate estimates of IPV prevalence, particularly among populations that may be underrepresented in a single study. This has undoubtedly slowed the process of identifying effective, scalable interventions for IPV and led to an incomplete understanding of its prevalence. The Centers for Disease Control and Prevention (CDC) developed its *Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements* to reduce inconsistencies, but it has not yet been widely adopted.

Researchers and health care systems should adopt CDC's IPV-related terminology to improve data collection efforts moving forward (*see Recommendation 10 in the report*).

ADDRESSING PHE-RELATED SERVICE BARRIERS

Health care services are considered essential based on the health needs of an affected population, not the ease of providing that care. Given the serious adverse health effects associated with experiencing IPV, the essential health care services related to IPV during steady state conditions remain essential during PHEs (*see Recommendation 5 in the report*). However, PHEs create substantial obstacles to delivering care. Storms can render roads impassable, or an infectious disease outbreak can cause patient surges that overwhelm a local health care system. The committee developed a phased approach to balance the realities of PHE-related service barriers with the need to provide the essential health care services related to IPV. It is organized by dividing the response phase of emergency management into three subphases (see Figure 1). Essential health care services related to IPV or components of those services that are most integral to protecting life safety are prioritized during the initial phase. As health care staff and supplies become more available in later response phases, the full essential health care service can be delivered more broadly (see Table 1).

TABLE 1 Essential Health Care Services for Intimate Partner Violence During Public Health Emergencies—A Phased Return to Steady State.

	PHASE WHEN SERVICE SHOULD BE RESTORED		
Essential Health Care Service	**Initial**	**Response operations**	**Stabilization**
Universal IPV screening/ inquiry and education			
Safety planning			
Forensic medical exams			
Emergency medical care			
Treatment of physical injury			
Gynecologic and reproductive health care including pregnancy termination	Urgent	Non-urgent	
Obstetric care	Urgent	Non-urgent	
Perinatal home visits			
Contraception and emergency contraception	Contraceptives not requiring procedures or immediate follow-up	All types of contraceptives	
Screening and treatment of sexually transmitted infections, and HIV	Treatment and rapid testing	Treatment and all screening	
Substance abuse treatment	Withdrawal mitigation	All treatment	
Pharmacy/medication management			
Primary and specialty care			
Mental health care	Urgent/Crisis	Non-urgent	
Dental care	Urgent treatment for acute injuries	Urgent treatment for acute injuries	
Support services including shelter, nutritional assistance, child care			

Restore services for all patients
Selectively restore services for acute needs or restore targeted services
Do not restore services during this phase

SUBPHASES OF RESPONSE PHASE

- Initial/Immediate Phase: The situation is unstable and before additional resources can be deployed. Health care delivery efforts are focused on saving and sustaining life using limited available resources.

- Response Operations Phase: Additional supplies and staff have arrived and temporary care sites have been set up. Health care capacity has increased beyond life saving and sustaining activities, but is not adequate to support the full delivery of all essential health care services related to IPV for all individuals.

- Stabilization Phase: Basic services have been provided to PHE survivors, either through rapid restoration or deployment of a contingency solution. All essential health care services related to IPV are available for all individuals.

FIGURE 1 Emergency management phases with divided response phase.

PLANNING AND PREPARING ACCORDINGLY

The essential health care services related to IPV can be delivered during PHEs if considerations for this care are incorporated into planning and preparation. This requires education, training, protocols, and supplies for IPV care during PHEs. The responders providing health care during PHEs are likely to encounter women

experiencing IPV, but their steady state roles may not include the necessary training to recognize IPV and ensure these women receive the care they need. Currently, the limited public facing information among federal disaster response entities and national volunteer organizations about training, protocols, or guidance specific to IPV care during PHEs is scattered and difficult to find. Training and guidance for IPV care protocols needs to be standardized and accessible, without barriers such as paywalls that are common for training modules (*see Recommendations 6 and 7 in the report*). Additionally, while women experiencing IPV during PHEs have similar essential health care needs to those not experiencing IPV, there are some unique care and supply considerations, particularly for IPV-related sexual assault or rape. Protocols are needed to ensure that disaster response medical supply caches include resources to provide all essential health care services related to IPV (*see Recommendation 9 in the report*).

IMPROVING HEALTH EQUITY

Many of the populations that experience health inequities also report higher prevalence of IPV. These include racially and ethnically minoritized populations, people with low incomes, populations residing in under resourced urban and rural areas, and sexual and gender minority populations. Many of these populations are also more likely to be disproportionately adversely affected by PHEs. Women who experience IPV in this context are more vulnerable to serious adverse health outcomes. Women from minoritized populations also encounter language barriers and limited availability of culturally appropriate care when seeking IPV care. Health care systems have a responsibility to ensure their IPV care programs are informed by the needs of the populations that they serve (*see Recommendation 3 in the report*).

LOOKING FORWARD

The recommendations put forth by the committee outline critical measures that, if acted upon, will reduce health inequities related to IPV, increase access to essential health care services related to IPV, and ultimately save lives.

COMMITTEE ON SUSTAINING ESSENTIAL HEALTH CARE SERVICES RELATED TO INTIMATE PARTNER VIOLENCE DURING PUBLIC HEALTH EMERGENCIES **Susan J. Curry** (*Chair*), University of Iowa College of Public Health; **Sue Anne Bell,** University of Michigan School of Nursing; **Jacquelyn Campbell,** Johns Hopkins University School of Nursing; **Regardt "Reggie" Ferreira,** Tulane University School of Social Work; **Francisco Garcia,** Chief Medical Officer for Pima County, Arizona; **Rosa M. Gonzalez-Guarda,** Duke University School of Nursing; **Elizabeth Miller,** University of Pittsburgh School of Medicine; **Mona Mittal,** University of Maryland School of Public Health, College Park; **Heidi D. Nelson,** Kaiser Permanente Bernard J. Tyson School of Medicine; **Usha Ranji,** KFF; **Merritt Schreiber,** Harbor–UCLA Medical Center Lundquist Institute; **Jamila K. Stockman,** University of California, San Diego, School of Medicine; **Mitchell Stripling,** New York City Pandemic Response Institute; **Lindsay F. Wiley,** University of California, Los Angeles School of Law

STUDY STAFF **Crystal Bell,** Study Director; **Karen L. Helsing,** Senior Program Officer; **Taylor King,** Associate Program Officer; **Lyle Carrera,** Research Associate; **Anesia Wilks,** Senior Program Assistant; **Marjani Cephus,** Research Associate (through June 2023); **Scott Wollek,** Senior Program Officer; **Sharyl Nass,** Senior Director, Board on Health Care Services; **Rose Marie Martinez,** Senior Director, Board on Population Health and Public Health Practice

FOR MORE INFORMATION
This Consensus Study Report Highlights was prepared by National Academies' staff based on the Consensus Study Report *Essential Health Care Services Addressing Intimate Partner Violence* (2024).

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Copies of the Consensus Study Report are available from the National Academies Press, (800) 624-6242 or https://nap.nationalacademies.org/catalog/27425.

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