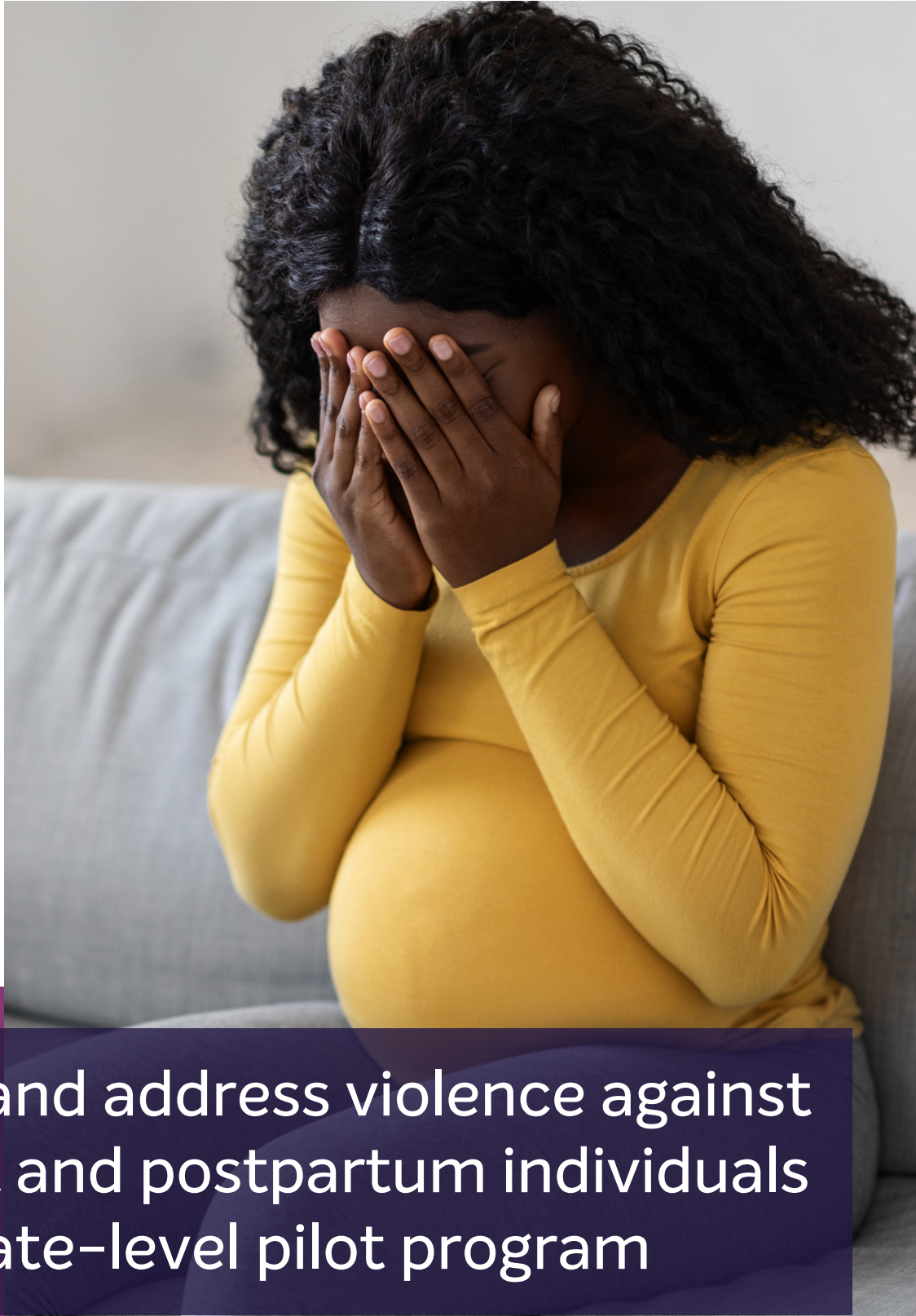


GOALS 5

Action 5.4

WHITE HOUSE
BLUEPRINT
EVIDENCE TO
ACTION BRIEFS



Prevent and address violence against pregnant and postpartum individuals with a state-level pilot program



Maternal Health
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**THE WHITE HOUSE BLUEPRINT
FOR ADDRESSING THE
MATERNAL HEALTH CRISIS**

The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Action 5.4 of the Blueprint, part of the effort to “Strengthen economic and social supports for people before, during, and after pregnancy” (Goal 5 of the Blueprint).

Maternal Health Action 5.4

Prevent and address violence against pregnant and postpartum individuals with a state-level pilot program incentivizing providers to receive training on pregnancy and postpartum intimate partner violence.

Contribution to Quality of Life

The [White House Blueprint](#)¹ is a “whole-of-government approach to combating maternal mortality and morbidity” so that all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe.

Women are uniquely vulnerable to intimate partner violence during pregnancy and the postpartum period; intimate partner violence intersects with the leading causes of pregnancy-associated deaths from homicide, suicide, and drug overdose, making intimate partner violence a critical area in which to target resources.² To mitigate its impacts, it is imperative that the human workforce that supports women and all birthing people during the perinatal period has access to training and resources to better identify and respond to intimate partner violence.

Basic Facts

Research has found that pregnant and postpartum persons are at a greater risk for intimate partner violence, sexual assault, and other forms of gender-based violence during the perinatal period.³ Intimate partner violence is also known as domestic violence, and includes physical violence, sexual violence, threats, and economic, emotional, and psychological abuse.⁴ Gender-based violence generally refers to any “harmful threat or act directed at an individual or group based on actual or perceived sex, gender, gender identity, sex characteristics, or sexual orientation.”⁵

During the perinatal period, high levels of stress—which are linked to intimate partner violence and gender-based violence—have been associated with maternal depression, miscarriage, preterm delivery, low-birth-weight infants, and higher rates of cesarean sections.⁶ Research also has found significant correlation between “neighborhood-level violent crime and maternal mortality.”⁷ Shockingly, pregnant and birthing people in the US are more likely to die from homicide during pregnancy or soon after than to die from the three leading causes of maternal mortality (hypertensive disorders, hemorrhage, and sepsis).³ These pregnancy-associated deaths are preventable.

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services.⁸ This recommendation also applies to women with no signs or symptoms of abuse. From pregnancy and through the postpartum period is generally the interval during which a woman will access a health care provider more frequently, making it an opportune time for providers to screen for intimate partner violence. The American College of Obstetricians and Gynecologists (ACOG), in line with the U.S. Department of Health and



Human Services and the Institute of Medicine, recommends that intimate partner violence screening and counseling be a core part of women’s preventive health visits and take place at periodic intervals, including during the perinatal period (at first prenatal visit, at least once per trimester, and at the postpartum checkup).⁹ It is also recommended that providers offer ongoing support and review available prevention and referral options with their patients.

Various screening tools recommended by the USPSTF (see the Maternal and Child Health Innovations section of this brief) are available and can be self-administered or used in a clinician-interview format. Studies have shown that self-administered or computerized screenings are as effective as clinician interviews in terms of disclosure, comfort, and time spent screening.⁹ The World Health Organization and other research supports intimate partner violence screening only if it is offered alongside appropriate post-screening action, such as referral to sources of support that are accessible to the referred population.¹⁰

One successful evidence-based model is a systems-model approach to improving intimate partner violence identification at Kaiser Permanente Northern California. Since 2000, intimate partner violence identification has increased 18-fold as the model was fully implemented, from 1,022 patients newly diagnosed with intimate partner violence in 2000 to 18,197 in 2015.¹¹ The systems-model approach has five components: a supportive environment, clinician inquiry and referral, on-site intimate partner violence services, linkages to community resources, and leadership and oversight.

There can be limitations when intimate partner violence screening is not accompanied by universal education. It is well documented that intimate partner violence disclosure rates are much lower than intimate partner violence rates revealed through research; among known survivors, only 21.1% of women and 5.6% of men report disclosing intimate partner violence to a health care professional.¹² In a study of instances when universal education models were applied, there was a threefold increase in disclosure among youth who experienced relationship abuse.¹³ In a study that evaluated the Addressing Reproductive Coercion in Health Settings (ARCHES) intervention, which offers universal education and brief counseling about intimate partner violence/reproductive coercion to all women seeking care in family planning clinic settings, results showed: reduced reproductive coercion in women with high baselines of reproductive coercion, increased awareness of partner violence resources, and greater self-efficacy to enact harm reduction. As noted by Miller et al. (2012), “shifting the health sector response from screening and disclosure to universal education and brief counseling about the impact of intimate partner violence on health with all patients may serve as primary prevention (for those never exposed), secondary prevention (for individuals with histories of intimate partner violence), and intervention for those experiencing intimate partner violence (including individuals who do not disclose).”¹⁴

Beyond screening and universal education, holistic interventions with the greatest potential to prevent intimate partner violence include: social-emotional learning programs for youth, improved organizational policies, strengthened household financial security, establishing men

CALL TO ACTION

Every birthing person deserves access to a community of care that is truly equitable, where racial identity holds no influence over health outcomes. Violence against pregnant individuals has a negative impact throughout the entire perinatal period and intersects with the leading causes of pregnancy-associated deaths from homicide, suicide, and drug overdose.² Innovations to combat these preventable deaths should focus on equity, provider training, screening, universal education, and social support. It is critical that the health care teams have access to training and resources needed to identify and refer all people who experience violence before, during, and after pregnancy. By better identifying and subsequently preventing cases of violence during pregnancy, there is the potential to positively impact the rate of severe maternal morbidity and maternal mortality.



and boys as allies in prevention, and survivor-centered services.¹⁵ In addition, evidence from randomized trials supports counseling, home visits, and mentoring support.⁸ At the policy level, stricter gun laws are a strategy that many advocates call for to reduce the risk of intimate partner homicide.¹⁶

To bolster the number of pregnant individuals who are safe and protected before, during, and after pregnancy, the [White House Blueprint](#) commits the federal government to implementing the USPSTF’s evidence-based recommendations. As outlined in the White House Blueprint, the Department of Health and Human Services will develop and implement a state-level program that incentivizes providers to become trained on screening for intimate partner violence and referring for appropriate services before, during, and after pregnancy. The program will increase partnerships with domestic and sexual violence organizations at the local and state levels. The intersection of intimate partner violence and substance use disorders also will be addressed within these pilot programs.

How are we doing?

Below we highlight data related to Action 5.4. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should be focused to improve health outcomes related to the action.

Table 1: Prevalence (%) of Intimate Partner Violence during Pregnancy and 1 Year Postpartum

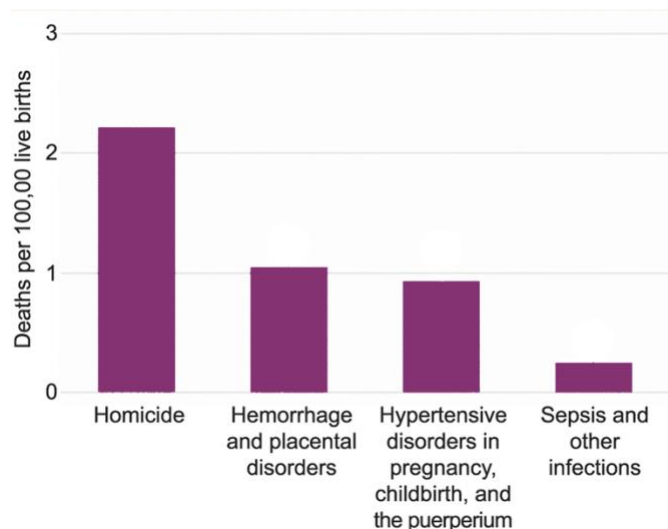
	Physical		Emotional		Coercion/control		Total	
	During	After	During	After	During	After	During	After
Total Sample	9.6	3.1	13.1	27.0	–	41.0	19.8	51.7
Reports								
Partner reports of violence (n = 2,310)	8.2	–	7.0	13.3	–	27.7	13.4	34.1
Mother reports of violence (n = 2,310)	1.7	3.1	7.5	17.3	–	21.4	8.5	30.0
Maternal race-ethnicity								
Black (n = 918)	13.6	4.0	16.7	32.2	–	43.0	11.9	34.1
Hispanic (n = 686)	12.5	3.8	16.3	32.9	–	43.9	11.6	38.2
White (n = 612)	5.1	2.2	8.5	17.8	–	34.0	4.5	21.1
Other (n = 94)	6.2	1.2	10.6	26.9	–	52.9	3.9	24.2
Maternal nativity								
US-born (n = 1,928)	10.2	3.1	12.5	25.5	–	40.1	7.9	27.4
Foreign-born >5 years in USA (n = 262)	7.9	3.0	15.4	32.0	–	44.1	11.7	36.8
Foreign-born ≤5 years in USA (n = 120)	6.4	3.1	15.5	41.0	–	44.6	9.1	44.4

During pregnancy, a striking 20% of all mothers and their partners reported experiencing either physical violence (10%) or emotional abuse (13%).

Source: Charles P, Perreira KM. [Intimate partner violence during pregnancy and 1-year post-partum](#). *J Fam Viol.* 2007(2);609–619.



Figure 1: Cause-specific Mortality Ratios (deaths per 100,000 live births) among US Females during Pregnancy and up to 42 Days from the End of Pregnancy, 2018–2019



Researchers estimated the US national homicide mortality ratio during pregnancy or within 42 days of the end of pregnancy. Homicide exceeded all the leading causes of maternal mortality, including hypertensive disorders, hemorrhage, and infection, by more than twofold. The prevalence of pregnancy-associated homicide was highest among non-Hispanic Black females and females younger than age 25.

Source: National Center for Health Statistics 2018 and 2019 mortality files. Wallace M, et al. [Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019](#). *Obstet Gynecol.* 2021;1(138)5:762-769.

Table 2: Race and Ethnicity of US Female Homicide Victims, by Pregnancy Status, 2018–2019

Characteristic	Pregnant or Within 1 year Postpartum (n=273)	Neither Pregnant Nor Within 1 year Postpartum (n=4,432)
Total homicides	273 (100)	4,432 (100)
Race and ethnicity		
Non-Hispanic White	82 (30.0)	1,621 (36.6)
Non-Hispanic Black	137 (50.2)	1,812 (40.9)
Hispanic	26 (9.5)	441 (10.0)
Other	28 (10.3)	558 (12.6)
Age (y)		
10–19	36 (13.2)	628 (14.2)
20–24	97 (35.5)	803 (18.1)
25–29	57 (20.9)	841 (19.0)
30–34	49 (18.0)	799 (18.0)
35–44	34 (12.5)	1,361 (30.7)
Time of Death		
Pregnant	129 (50.9)	--
Within 42 days from the end of pregnancy	28 (10.3)	
43 days to 1 year from the end of pregnancy	106 (38.8)	--
Firearm Involvement		
No	84 (30.8)	1,481 (33.4)
Yes	189 (69.2)	2,951 (66.6)

Among pregnancy-associated homicide victims between ages 10 and 44, non-Hispanic Black women had the highest rates. Almost half were women younger than age 25 at the time of death. Most of the fatalities involved firearms.

Source: National Center for Health Statistics 2018 and 2019 mortality files. Wallace M, et al. [Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019](#). *Obstet Gynecol.* 2021;1(138)5:762-769.

Story Behind the Data: Factors Affecting Progress

Particular communities that are disproportionately impacted by violence during pregnancy include Black, Indigenous, and other people of color, as well as incarcerated pregnant individuals.⁶ These populations are already at a greater risk of pregnancy complications (before, during, and after birth), which compounds the disparity. For example, research indicates that



Black and Hispanic persons are less likely to seek care for intimate partner violence injuries due to mistrust in the health care system, lack of insurance, and factors that stem from structural and ongoing racism, trauma, and immigration status.¹⁷ These disparities were exacerbated during the COVID-19 pandemic—evidence suggests that intimate partner violence increased and became more severe at that time.¹⁸ (See Table 1 and Figure 1.)

More broadly, intimate partner violence has been shown to have a pervasive impact on a survivor's lifetime wellness, detrimentally affecting factors such as housing stability, employment, educational opportunities, food security, financial stability, and entanglement in civil and criminal legal systems.^{12,19} All of these factors have been shown to have a significant impact on pregnancy outcomes and maternal health. (For more details about how each of these areas impacts pregnancy, see the Goal 5 Evidence to Action Brief.) (See Table 2.)

While intimate partner violence screening is recommended, studies have shown very low screening rates—ranging from 1.5% to 12%—in primary care settings.²⁰ Several factors influence whether a provider inquiry about intimate partner violence during a routine antenatal or postnatal visit. In one study, the main barriers cited by physicians and nurses were lack of time, lack of training, language or cultural practice, and a partner's presence.²¹ The need for additional training was also a concern. The most frequently reported facilitators were training, community resources, and professional tools/protocols/policies.

Other research shows that providers may not recognize that intimate partner violence screening is part of their role; may lack intimate partner violence screening policies and/or reminder systems; and may not be confident in undertaking screening and referral of women when intimate partner violence is detected.¹⁰ Other documented barriers include fear of offending the patient or partner, discomfort with the topic, a misconception regarding the patient population's risk of exposure to intimate partner violence, and perceived lack of power to change the the situation.¹⁵

What can be done to address the issue?

The [White House Blueprint](#) identifies actionable steps to address Action 5.4. In addition, experts from the maternal and child health (MCH) field have identified innovative, evidence-informed strategies from several databases and national repositories.

Maternal and Child Health Innovations

MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub](#) (AMCHP), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what's working” in the MCH field; the [Robert Wood Johnson Foundation's What Works for Health](#) (RWJ) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.

- [AIM Community Care Initiative](#). The Alliance for Innovation on Maternal Health Community Care Initiative (AIM CCI) is developing an intimate partner violence bundle, and national expansion of AIM CCI will reach communities in 25 states by the end of 2023. AIM “maternal safety bundles” are sets of proven practices that improve patient



outcomes and reduce severe illness and death. Research shows that these practices are effective in improving health outcomes.

- [Cross-Disciplinary Training](#). This training is designed to give health care and social service providers the tools to complete consistent domestic violence screening, counseling, and referrals.
- [CUES](#). This evidence-based intervention supports providers to talk with all patients about the elements of healthy and unhealthy relationships and the health effects of violence using these steps: confidentiality, universal education and empowerment, and support.
- [FUTURES](#). Working with reproductive health care providers, FUTURES provides tools to screen for and respond to violence as well as training and education on the links between reproductive health and domestic and sexual violence.
- [Health Care Screening and Follow-up for Intimate Partner Violence](#). The initiative assesses past or present experience of intimate partner violence among female patients in health care settings and provides follow-ups such as counseling or referrals for services. (RWJ)
- [Implementation Framework for HRSA-Supported Settings of Care](#). The [Health Resources & Services Administration](#) (HRSA) and the Office of Women's Health (OWH) have developed an implementation framework to prevent and respond to intimate partner violence. In addition, HRSA and OWH have developed a joint [strategic plan for 2023–2025](#).
- [HITS](#) (Hurt-Insult-Threaten-Scream). This domestic violence screening tool (recommended by the USPSTF) has been [validated for use](#) among women across health care settings and for use in the community by family physicians. (Literature)
- [Intimate Partner Violence Screening](#). USPSTF, ACOG, the Department of Health and Human Services, and the Institute of Medicine provide guidance and recommended validated intimate partner violence screening tools for health care providers to implement in their practices.
- [PREMIS](#) (Physician Readiness to Manage Intimate Partner Violence Survey). A comprehensive screening tool, PREMIS assesses the preparedness of physicians to manage intimate partner violence and evaluates the effectiveness of physician education and training.
- [Preventing Intimate Partner Violence Across the Lifespan](#). The Centers for Disease Control and Prevention developed a technical package of programs, policies, and practices designed to help communities and states implement evidence-based intimate partner violence prevention strategies.
- [RADAR](#) (Routinely screen adults, Ask direct questions, Document your findings, Assess patient's safety, Review options and referrals). A training and screening protocol for health care providers, RADAR focuses on detection, treatment, and referral of victims of domestic violence.
- [Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines](#). These standards for health-care providers give evidence-based guidance on clinical interventions and emotional support for women suffering from intimate partner violence and sexual violence. They seek to improve capacity-building of health care providers and other members of multidisciplinary teams and support the development of training curricula in medicine, nursing, and public health.
- [Systems Model for Intimate Partner Violence Prevention](#). This evidence-based approach to domestic violence screening and intervention from Kaiser Permanente in Northern California focuses on: inquiry and referral, on-site services, community linkages, a supportive environment, and leadership and oversight.



- [Women Abuse Screening Tool \(WAST\)](#). These screening questions are used primarily in doctors' offices to detect verbal, emotional, physical, and sexual abuse. WAST (recommended by the USPSTF) has been shown to be a successful tool in screening for intimate partner violence during pregnancy and antenatal visits.

State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees

The [State Maternal Health Innovations](#) (MHI) initiative, funded by [HRSA's MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations from the MHI cohorts (2019–2024) that address Action 5.4:

- [Maryland](#). The Maryland Department of Health promotes universal screening for mental health challenges, substance use disorder, and intimate partner violence.
- [Massachusetts](#). The Massachusetts Medical Society's "Use your RADAR" approach provides a step-by-step resource for conducting effective conversations with patients about intimate partner violence and developing appropriate referral networks to ensure continuity of care for patients who screen positive.

Evidence-based Strategy Measures from the [MCH Evidence Center](#) Related to Action 5.4

Throughout the country, state-level [Title V MCH](#) agencies develop measures to help track their efforts around improving the health and well-being of women, children, and families. Below are selected measures related to improving equitable maternal and child outcomes that can support Action 5.4.

- Percentage of Medicaid prenatal care providers screening pregnant women for smoking, alcohol and drug use, domestic violence and depression using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool. ([SC](#))
- Number of maternity centers that disseminated the state's injury prevention curriculum. ([VA](#))

Resources from the [MCH Evidence Center's Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, and white papers with seminal and historic resources. The following may support Action 5.4.

- Cantor A, et al. [Effectiveness of Telehealth for Women's Preventive Services](#). Comparative Effectiveness Review. No. 256. U.S. Agency for Healthcare Research and Quality. 2022 June. Accessed September 12, 2023.
- [Futures Without Violence. Health Cares about IPV: Intimate Partner Violence Screening and Counseling Toolkit](#). 2013. Accessed September 12, 2023.
- Lorenzo SB. [Intimate Partner Violence \(IPV\): Professional Resource Guide](#). National Center for Education in Maternal and Child Health. 2013. Accessed September 12, 2023.
- U.S. Health Resources & Services Administration, Office of Women's Health. [The HRSA Strategy to Address Intimate Partner Violence 2017–2020](#). 2017. Accessed September 12, 2023.



Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit maternalhealthlearning.org/Blueprint for more details.



References

1. The White House. [The White House Blueprint for Addressing the Maternal Health Crisis](#). June 2022.
2. Campbell J, et al. [Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence](#). *J Womens Health (Larchmt)*. 2021 Feb;30(2):236-244.
3. Wallace M, et al. [Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019](#). *Obstet Gynecol*. 2021 Nov 1;138(5):762-769.
4. National Coalition Against Domestic Violence. [Domestic violence](#). Factsheet. 2020. Accessed September 12, 2023.
5. The White House. [U.S. National Plan to End Gender-Based Violence: Strategies for Action](#). May 2023. Accessed September 12, 2023.
6. Wang L. [Unsupportive Environments and Limited Policies: Pregnancy, Postpartum, and Birth During Incarceration](#). Prison Policy Initiative. 2021 August. Accessed September 12, 2023.
7. Masi CM, et al. [Neighborhood Economic Disadvantage, Violent Crime, Group Density, and Pregnancy Outcomes in a Diverse, Urban Population](#). *Social Science & Medicine*. 2007;65(12):2440-2457.
8. Moyer VA. [Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement](#). U.S. Preventive Services Task Force. *Ann Intern Med*. 2013;158:478-486.
9. American College of Obstetricians and Gynecologists. [Intimate Partner Violence. Committee Opinion](#). Number 518. February 2012 (Reaffirmed 2022). Accessed September 12, 2023.
10. O'Reilly R, Peters K. [Opportunistic Domestic Violence Screening for Pregnant and Postpartum Women by Community-based Health Care Providers](#). *BMC Women's Health*. 2018;18(128).
11. Young-Wolff KC, et al. [Transforming the Health Care Response to Intimate Partner Violence: Addressing "Wicked Problems"](#). *JAMA*. 2016;315(23):2517-2518.
12. Black MC, et al. [The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report](#). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2011;19:39-40.
13. Miller E, et al. [A School Health Center Intervention for Abusive Adolescent Relationships: A Cluster RCT](#). *Pediatrics*. 2015;135(1):76-85.
14. Miller E, et al. [A Family Planning Clinic-based Intervention to Address Reproductive Coercion: A Cluster Randomized Controlled Trial](#). *Contraception*. 2016 Jul;94(1):58-67.
15. Niolon PH, et al. [Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices](#). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2017. Accessed September 12, 2023.
16. Lawn RB, Koenen KC. [Homicide Is a Leading Cause of Death for Pregnant Women in US](#). *BMJ*. 2022;379.
17. Stockman JK, et al. [Intimate Partner Violence and Its Health Impact on Ethnic Minority Women](#). *Journal of Women's Health*. 2015:62-79.
18. Usher K et al. [Family Violence and COVID-19: Increased Vulnerability and Reduced Options for Support](#). *International Journal of Mental Health Nursing*. 2020;29(4):549-552.
19. Goodman S. [Intimate Partner Violence Endangers Pregnant People and Their Infants](#). Mom and Babies Series. National Partnership for Women & Families. National Birth Equity Collaborative. 2021. Accessed September 12, 2023.
20. Waalen J, et al. [Screening for Intimate Partner Violence by Health Care Providers: Barriers and Interventions](#). *American Journal of Preventive Medicine*. 2000;19(4):230-237.
21. Beynon CE, et al. [Why Physicians and Nurses Ask \(or Don't\) About Partner Violence: A Qualitative Analysis](#). *BMC Public Health*. 2012;12:473-85.





The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit

<https://maternalhealthlearning.org/connect>.

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