



Council of International Neonatal Nurses (COINN) Position Statement on Routine Screening for Intimate Partner Violence

COINN Position:

Intimate Partner Violence (IPV) is defined as physical, emotional, or sexual abuse by an individual of one gender by an individual of the opposite gender who they are intimate or are involved partners in a relationship i.e. spouse, ex-spouse, or current friend.^{1,2} There are instances where IPV which can be within same sex partnerships.³ IPV is a global problem affecting 25% of women in the United States (U.S.).¹ IPV is most common in women 26 to 30 years of age⁴ with non-fatal is highest among women age 16-24 years. Fatal IPV is highest among women age 35-49 years.

There are nearly 5.3 million female victims of IPV per year in the U.S., resulting in 2 million injuries and 1,300 deaths each year.² Globally the figures reflect a similar problem. In Paraguay and the Philippines 10%; United States 22.1%, Canada 29%, and Egypt 34.4% IPV physical assault rates women annually. Some of these rates especially for non-fatal incidences may be under-reported due to cultural influences.³ Globally (China, Colombia, Egypt, India, Mexico, Philippines, South Africa, and the U.S.) IPV is closely associated with child abuse.³ There are two patterns of violence which have been documented. One is an escalating and repeated form of abuse while the second pattern is a gradual escalation of anger leading ultimately to violence.³ The concept of “just cause” is used more in the developing than developed world where men are often viewed as having rights over women.³ For men, the youth, heavy drinking, victim or witness of abuse, traditional male dominance, low self-esteem, low socioeconomic status, low level of education, stress in family, poverty are all risk factors.³ However IPV crosses socioeconomic and educational levels. Pregnancy may intensify existing IPV or trigger the first occurrence of IPV in a relationship. Femicide (death occurring during or within 1 year of pregnancy) is the leading cause of death among pregnant women who are otherwise healthy. Maternal deaths have been linked to IPV in India, Bangladesh and U.S.³ In the U.S. reported range of IPV occurrence during pregnancy is from 1% to 20% with the most common range reported in research studies being 3.9% to 8.3%.

Long-term health consequences are associated with IPV. These include gynecological problems, fibromyalgia, abdominal/thoracic injuries, disabilities, fractures, gastrointestinal disorders, pregnancy complications, sexually transmitted infection, psychiatric disorders and substance abuse.³ Victims of IPV self medicate (alcohol, illicit drugs, and tobacco) to cope with the increased depression associated with IPV. Some will commit homicide or suicide.

Actions Taken

In 1985 the Surgeon General C. Everett Koop U.S. declared IPV a public health dilemma.⁵ Followed in 1985 by the Institute of Medicine (IOM) publishing a known list of modifiable risk factors to prevent

premature birth, a document still widely cited today.⁶ Then in 1992 the Joint Commission (formerly JCAHO) first mandated initial and annual IPV training regarding routine IPV screening/assessment for health care providers. This mandate was updated in 2002 and most recently in 2004.⁷ The recognition of the global nature of this problem came when the World Health Organization (WHO) declared IPV a world-wide epidemic.³ In that same year the IOM endorsed IPV training and routine IPV screening/assessment.⁶ The support for routine IPV screening/assessment has been support to date.

The problem is that there are multiple IPV screening/assessment tools.^{8,9} There are also multiple IPV training programs.⁶ There is insufficient/inconclusive validity and reliability of existing tools and the training programs. No gold standard has emerged. The Centers for Disease Control & Prevention (CDC) has made no recommendations for:

- For routine screening
- For/against specific IPV training program
- For/against specific IPV screening/assessment tool.¹⁰

The Joint Commission and the Institute of Medicine support use of

- The National Consensus Guidelines on Identifying & Responding to Domestic Violence Victimization available at www.endabuse.org/programs/healthcare/files/Consensus.pdf (Family Violence Prevention Fund, 2004).
- Screening Instruments
 - Abuse Assessment Screen (AAS) available at www.nnvawi.org
 - Danger Assessment (DA) available at www.dangerassessment.org and www.nnvawi.org
- Victim Safety Planning. Sample templates available at: www.abanet.org/tips/dvsafety.html and www.geocities.com/Wellesley/3059/dv.html

The Council of International Neonatal Nurses (COINN) is the international voice of neonatal nurses who provide care during this vulnerable period. In order to address identified gaps in current practice in recognition of this global epidemic, COINN makes the following recommendations:

COINN Recommends

1. The promotion of positive health outcomes for neonates via routine screening for IPV among women of childbearing age to prevent fetal loss, fetal injury, and premature birth associated with IPV in addition to promoting the overall health of the family.
2. The promotion of increased training and awareness campaigns regarding IPV training among community health care workers and health professionals.
3. Support for the IOM's Recommendations for IPV training.
4. The use of the Family Violence Prevention Fund, *National Consensus Guidelines on Identifying & Responding to Domestic Violence Victimization* (2004) that incorporates use of the *Abuse Assessment Screening* (AAS) instrument and the *Danger Assessment* (DA) tool.
5. Support for programs such as the March of Dimes (MOD) Prematurity Awareness Campaign that acknowledges IPV as a link to premature births.

References

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