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Prevention in Focus Webinar Series

Welcome!

We will begin shortly.

Prevention in Focus Webinar Series

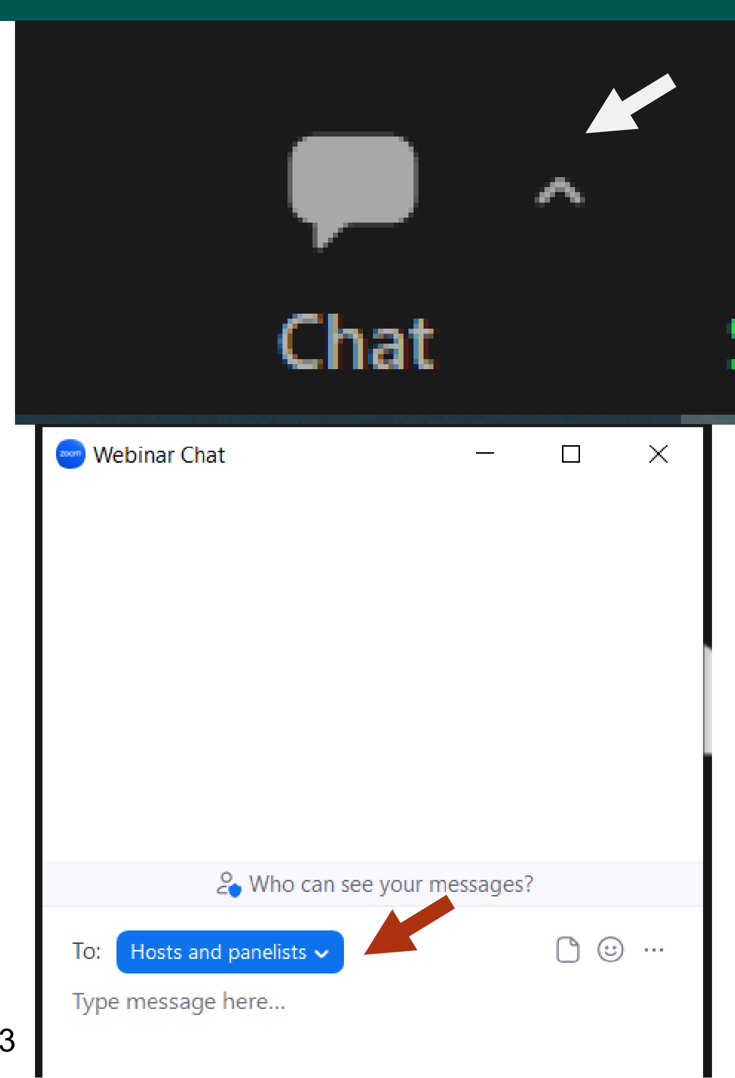
Intimate Partner Violence Among Birthing People: Rural-Urban Differences and Implications for Safety and Equity

Katy Backes Kozhimannil, PhD., M.P.A.
Presenter | University of Minnesota School of Public Health

Janine Austin Clayton, MD
Speaker Introduction | Associate Director, Research on Women's Health
Director, NIH Office of Research on Women's Health (ORWH)

Rosalind (Roz) King, Ph.D.
Q & A Moderator | Chief, Scientific Development and Coordination Section
NIH Office of Behavioral and Social Sciences Research (OBSSR)

Prevention in Focus Webinar Series



Upcoming Q&A Session

Please send us your questions via the Chat pod directed to Hosts and Panelists

Please use the Chat pod to request technical assistance

Janine Austin Clayton, MD
Speaker Introduction | Associate Director, Research on Women's Health

Director, NIH Office of Research on Women's Health (ORWH)

Promoting Healthy Relationships: ORWH's Innovative Approach to IPV

Janine Austin Clayton, M.D., FARVO
NIH Associate Director for Research on Women's Health
Director, Office of Research on Women's Health
National Institutes of Health

June 3, 2024 – Prevention in Focus Webinar Series

https://www.who.int/campaigns/world-health-day

Facebook: /NIHORWH
Twitter: @NIH_ORWH

www.nih.gov/women
#ResearchForWomen

Just Imagine a Day When Every Women has Access to and Receives Comprehensive Evidence-Based Maternity Care

Source: https://www.statnews.com/2022/10/11/maternity-care-deserts-on-the-rise-across-the-u-s-report-finds/

Brief History of Women's Health Research

Office of Research on Women's Health (ORWH) Established (Director Vivian Pinn, M.D. [1991])
1990

2000

***Building** Interdisciplinary **Research Careers** in **Women's Health** (BIRCWH)* Program

***Specialized Centers Of Research** Excellence on Sex Differences (SCORE)* Program
2002

2016

NIH Policy on Sex as a Biological Variable

(21st Century Cures Act)

New NIH-Wide Strategic Plan for Research on the Health of Women
2024

ORWH Mission

Enhance and expand women's health research

Include women and minority groups in clinical research

Promote career advancement for women in biomedical careers

NIH Vision

Sex and gender integrated into biomedical research

Every woman receives evidence-based care

Women in science careers reach their full potential

The White House Initiative on Women’s Health Research

Executive Order 14120

March 18, 2024

Galvanize New Research on Women’s Midlife Health

Assess Unmet Needs to Support Women’s Health Research

The NIH is Addressing Maternal Mortality

Preeclampsia
Placental Function
Birth Rate
Preterm Birth
Human Trophoblast
Drug Development
Endothelial Function
Natural Cycle FET
Safety Profile
Weight
Disorders

Public Health
Cause of Death
Community
Integration
HIV
Black Women
Depression
Health Center
Mixed Methods
DNA
Weight

Perinatal Care
Pregnant Women
Implementation
Mechanisms
Antenatal Care
Safety Profile
Disorders
HIV
Stillbirth
Weight
Function

sub-Saharan Africa
South Africa
Cesarean Sections
HIV
Antenatal Care
Mixed Methods
Longitudinal Data
Mental Disorders

Placentation
Fetal Growth Restriction
Endothelial Function
IFNs
Assays
Mechanistic Insights

Mental Health

Drug

HIV Care

Viral Infections

Cesarean Delivery

Labor

Long Term

Racial/ethnic Disparities

Heart Failure

Caesarean Section

DHS

LMICs

Errors

Low-income Countries

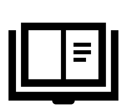
*estimated. https://report.nih.gov/funding/categorical-spending#/

NIH National Institutes of Health
Office of Research on Women's Health

Pathways to Prevention (P2P) Program: *Identifying Risks and Interventions to Optimize Postpartum Health*

Independent Panel Report: Maternal Mortality - A National Institutes of Health Pathways to Prevention Panel Report

Independent Panel Summary



Systematic Evidence Review: Evidence Map for Social and Structural Determinants for Maternal Morbidity and Mortality

Federal Partners Report Released April 2

https://prevention.nih.gov/sites/default/files/2024-04/P2P-PostpartumFPMReport-FINAL.pdf

https://prevention.nih.gov/research-priorities/research-needs-and-gaps/pathways-prevention/identifying-risks-and-interventions-optimize-postpartum-health

https://prevention.nih.gov/sites/default/files/2023-12/P2P-PostpartumHealth-PanelSummary-FINAL-508.pdf

https://journals.lww.com/greenjournal/fulltext/2024/03000/an_evidence_map_for_social_and_structural.10.aspx

https://journals.lww.com/greenjournal/fulltext/2024/03000/maternal_mortality__a_national_institutes_of.25.aspx

SOCIETAL
Lack of Paid Parental Leave
Medicaid Pregnancy Coverage Limits
Medicaid Non-expansion

COMMUNITY
"Maternity Care Deserts"
Care Quality at
Black-serving Hospitals

INTERPERSONAL
Providers' Implicit Bias
Perceived Racial Discrimination
Differential Obstetric Procedures

INDIVIDUAL
Chronic Conditions
Causes and Timing of
Maternal Deaths

Preconception
Pregnancy
Delivery/Birth
Postpartum (pp)
1 to 42 days pp
43 to 365 days pp

Early Childhood
Adolescence
Reproductive Years
Later Adulthood

- Highlights key topics related to morbidity and mortality in women in the US
- The fact sheets outline the state of the science for women's health on

- Autoimmune diseases
- Cancer
- Cardiovascular disease
- Dementia
- HIV
- Maternal morbidity and mortality
- Menopause
- Mental health
- Substance use disorder
- Violence against women

https://www.whitehouse.gov/briefing-room/presidential-actions/2023/11/13/memorandum-on-the-white-house-initiative-on-womens-health-research/

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The Pulse

Monthly Email

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**All Bitly addresses are case-sensitive*

@JanineClaytonMD
@NIH_ORWH
NIHORWH
NIH.gov/women

E-LEARNING

- Bench to Bedside: Integrating Sex & Gender to Improve Human Health
- SABV Primer
- And more!

bit.ly/ORWHeLearning

http://www.nih.gov/women

Intimate Partner Violence Among Birthing People: Rural-Urban Differences and Implications for Safety and Equity

Dr. Katy Backes Kozhimannil
Ph.D., M.P.A.
University of Minnesota
School of Public Health

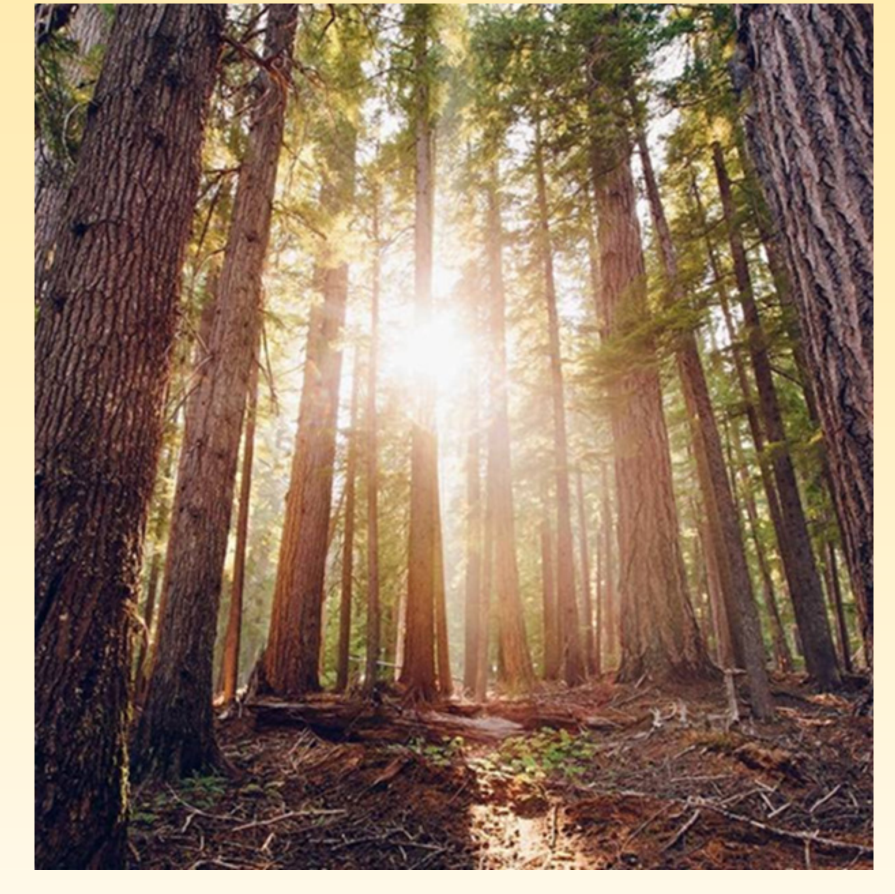
Intimate partner violence among birthing people: rural-urban differences and implications for safety and equity

Katy Backes Kozhimannil, PhD, MPA
University of Minnesota School of Public Health
University of Minnesota Rural Health Research Center
Center for Antiracism Research for Health Equity
Email: kbk@umn.edu

RHRC
Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

Land Acknowledgment

- I gratefully acknowledge this land as the traditional, ancestral Indigenous territories of the Dakota people.
- I recognize the value of Indigenous wisdom about land and childbirth, and encourage everyone to be respectful of the distinctive and permanent relationship that exists between Indigenous people and their traditional knowledge and territories.
- Indigenous women experience high rates of violence (including IPV) and maternal mortality.



Disclosure Statement

- Relevant to the content of this educational information, I do not have any financial conflicts to disclose.

Photo: Kathleen Henning

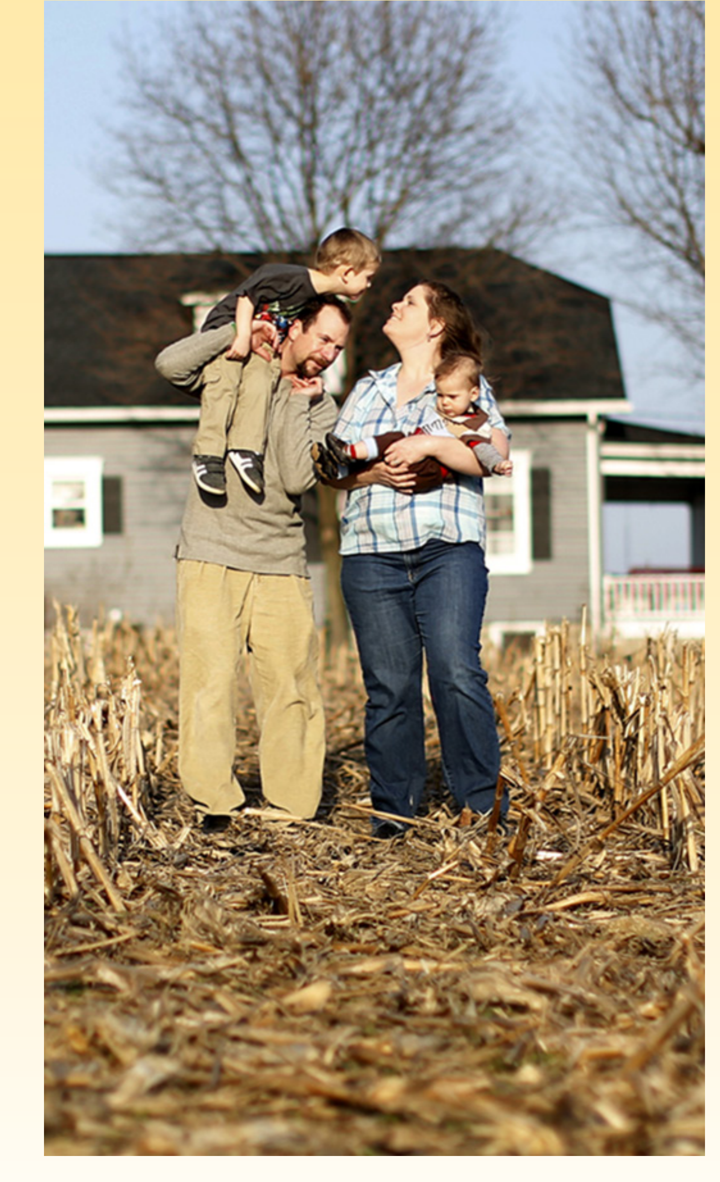
Funding acknowledgement

Research described in this presentation was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under PHS Grant #5U1CRH03717, and by the National Institutes of Health (NIH) under PHS Grant #R01 HD099197.

The information, conclusions and opinions expressed are those of the authors and no endorsement by FORHP, HRSA, HHS, or NIH is intended or should be inferred.

Goals

1. Provide context on rural-urban disparities for birthing people
2. Describe rural-urban differences in reports of perinatal IPV and abuse screening
3. Among rural residents, describe differences by race/ethnicity and health insurance status
4. Discuss policy solutions for increasing safety, hope and healing



The US maternal mortality crisis deeply affects rural residents

Pregnancy-related mortality ratio by urban-rural classifications: 2017-2019

Pregnancy-related deaths*

30
25
20
15
10
5
0

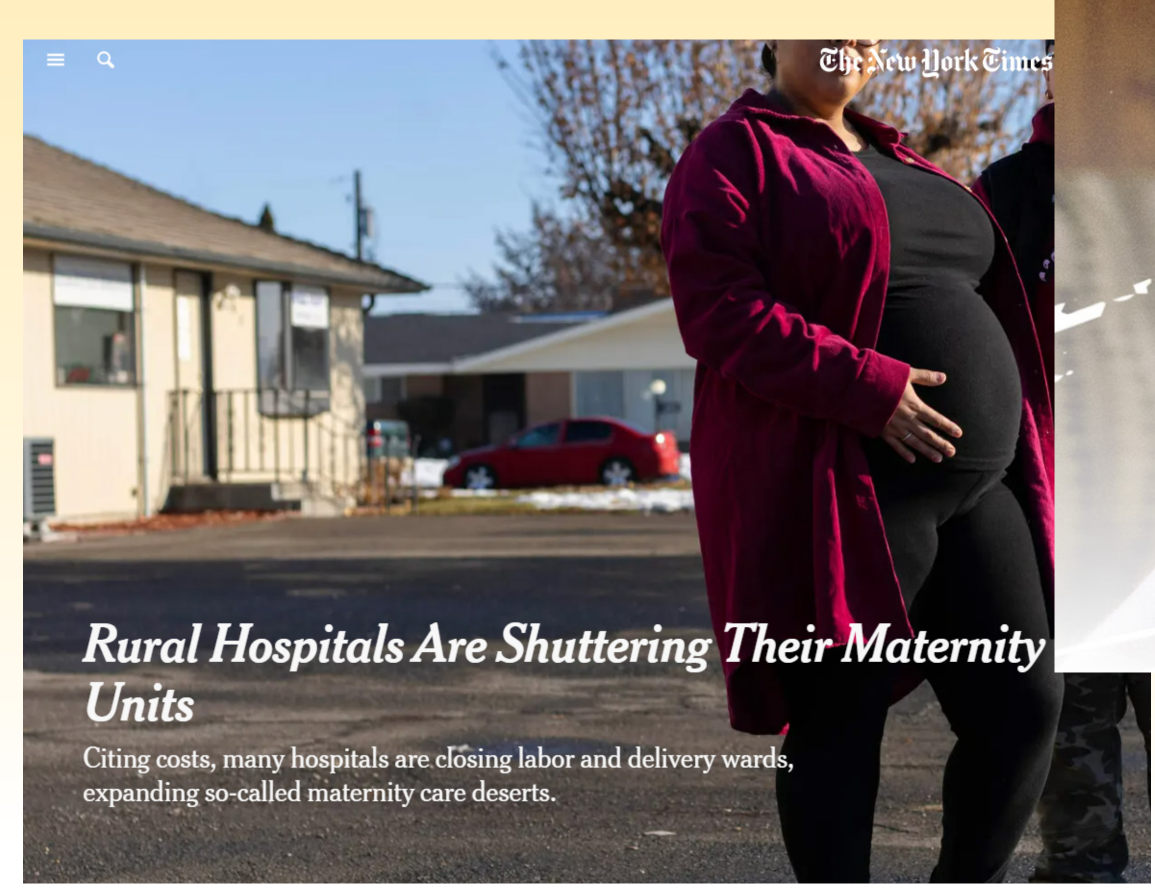
15.9
14
17
18.6
21.8
26.1

Large central metro
Large fringe metro
Medium metro
Small metro
Micropolitan
Noncore

*Per 100,000 live births

Pregnancy-related mortality ratio
Reset

Media coverage and context for pregnancy and childbirth in rural America



PREGNANT BUT UNEQUAL

In rural America, maternal health care is vanishing. These moms are most at risk.

As more rural hospitals and obstetric units close, the federal government is just beginning to define the scope and impact of maternity care 'deserts'

Nada Hassanein USA TODAY

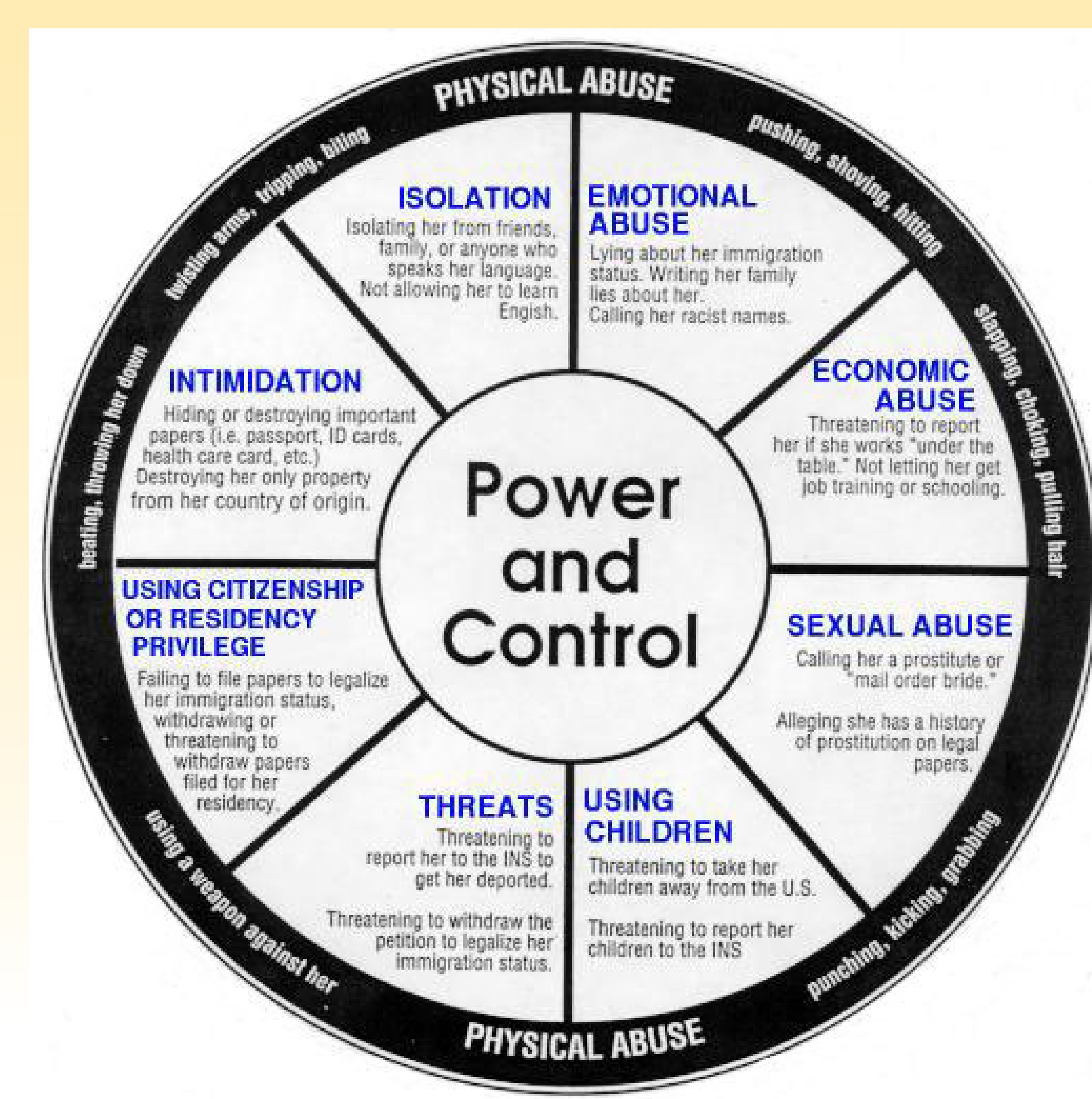
Published 4:30 AM CDT Aug. 11, 2022 | **Updated 10:19 AM CST Dec. 16, 2022**

Language matters

- Communities without access to maternity care are not “deserts”
- Deserts are naturally occurring; medically underserved areas aren’t
- When we focus on “maternity care deserts” as a cause of rural maternal mortality, we miss:
  - Non-clinical risks for mortality
  - Chances for prevention

Intimate Partner Violence is about power and control

- Intimate partner violence (IPV) encompasses physical, emotional, and sexual violence.
- Violence is one of the most common health concerns in pregnancy.
- IPV is the leading non-obstetric cause of maternal mortality.



Violence and safety in rural communities

- Rural areas pose risks for pregnant people
  - More firearms, more injuries
  - Fewer legal resources, health services, shelters, supports
  - Higher risk of maternal morbidity/mortality, losing OB care

Harms of and screening for perinatal IPV

- Maternal IPV is associated with
  - Preterm birth, low birth weight, low breastfeeding rates
  - Death by homicide

60% of homicides that occur around the time of pregnancy are related to IPV.

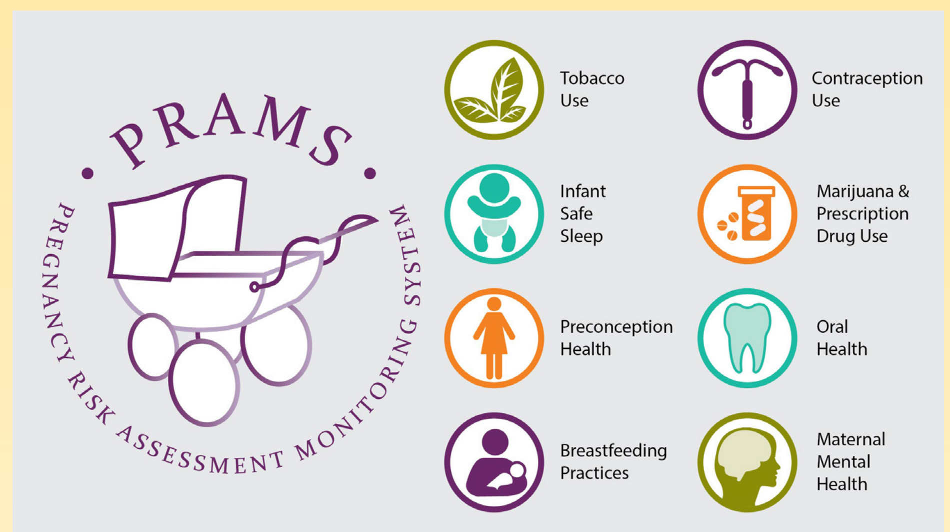
- Universal screening is recommended
  - Since 2012, ACOG has recommended screening during pregnancy and postpartum
  - In 2018, USPSTF upgraded their recommendation to universal screening

Goals of this analysis

- To describe rates of IPV among rural and urban US residents who gave birth 2016-2020
- To describe predictors of non-screening for abuse among rural and urban victims of perinatal IPV

Data and measures

- Data
  - Pregnancy Risk Assessment Monitoring System (PRAMS) from 2016-2020
- Key outcome measures
  - Experienced physical violence by a current/former intimate partner before or during pregnancy
  - Non-screening for abuse at health care visits among those with IPV



29. During *your most recent pregnancy*, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

		No	Yes
a.	My husband or partner	☐	☐
b.	My ex-husband or ex-partner	☐	☐
c.	*State option (Another family member)*	☐	☐
d.	*State option (Someone else)*	☐	☐

14. *During any of your prenatal care visits*, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check **No** if they did not ask you about it or **Yes** if they did.

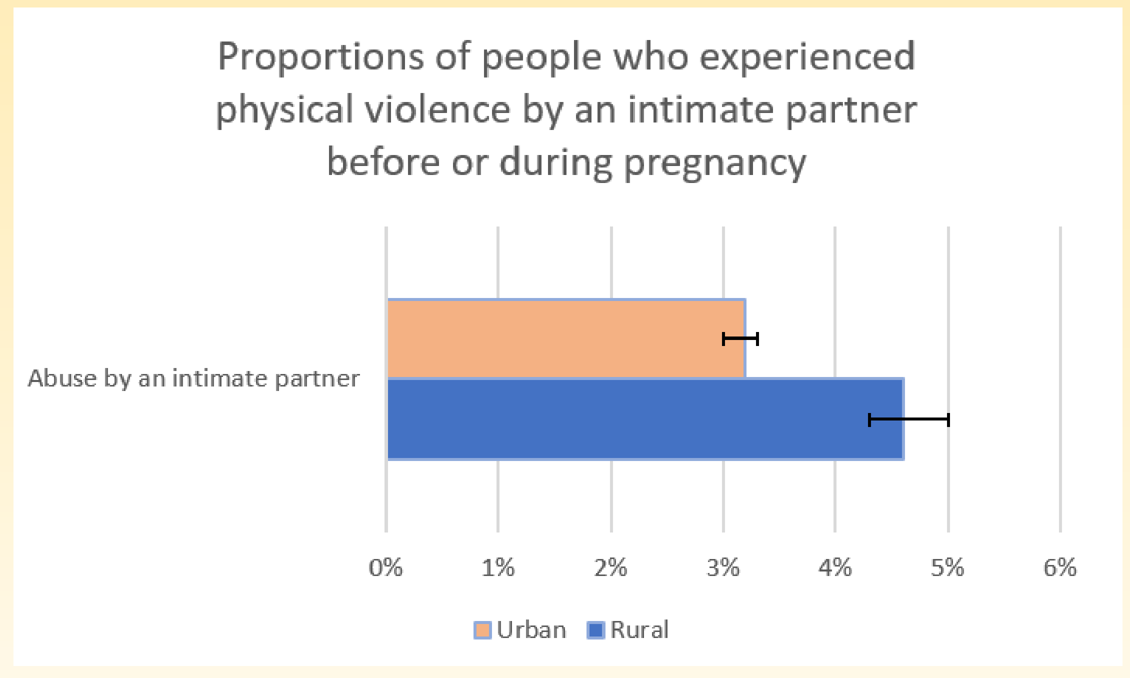
		No	Yes
a.	If I knew how much weight I should gain during pregnancy	☐	☐
b.	If I was taking any prescription medication	☐	☐
c.	If I was smoking cigarettes	☐	☐
d.	If I was drinking alcohol	☐	☐
e.	If someone was hurting me emotionally or physically	☐	☐
f.	If I was feeling down or depressed	☐	☐
g.	If I was using drugs such as marijuana, cocaine, crack, or meth	☐	☐
h.	If I wanted to be tested for HIV (the virus that causes AIDS)	☐	☐
i.	If I planned to breastfeed my new baby	☐	☐
j.	If I planned to use birth control after my baby was born	☐	☐

Methods and study population

- We used logistic regression to compare outcomes for rural vs. urban residents in
  - Predicted probabilities of experiencing physical IPV
  - Among IPV victims
    - Predicted probabilities of not being screened for abuse
    - Proportions of people who attended health care visits and were not screened for abuse
- Study population
  - N=201,413 total, 7,933 IPV victims

More rural residents experienced physical violence by an intimate partner

4.6% of rural residents experienced physical violence by an intimate partner before or during pregnancy, compared to **3.2%** of urban residents.

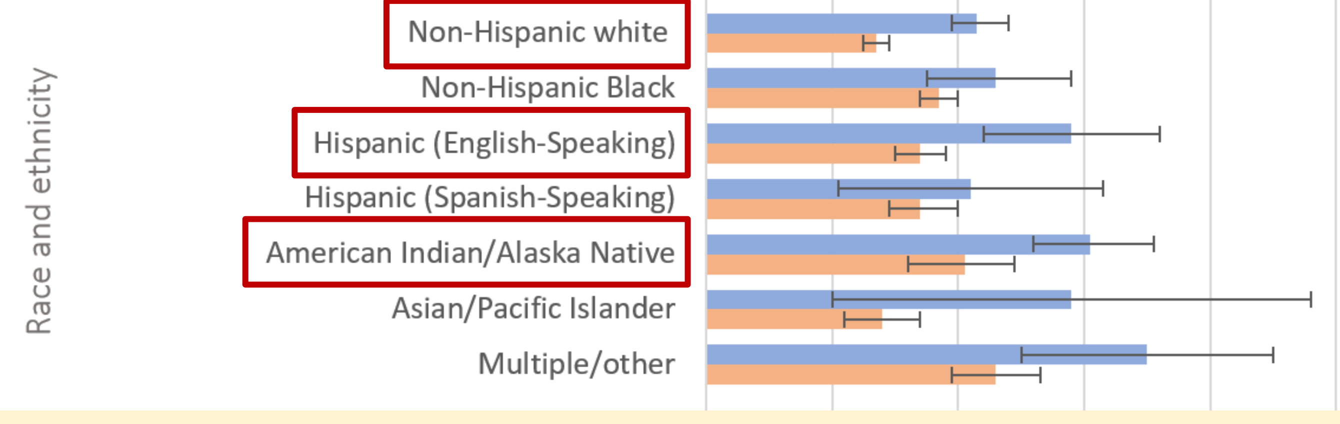


Rural birthing people were more likely to experience IPV

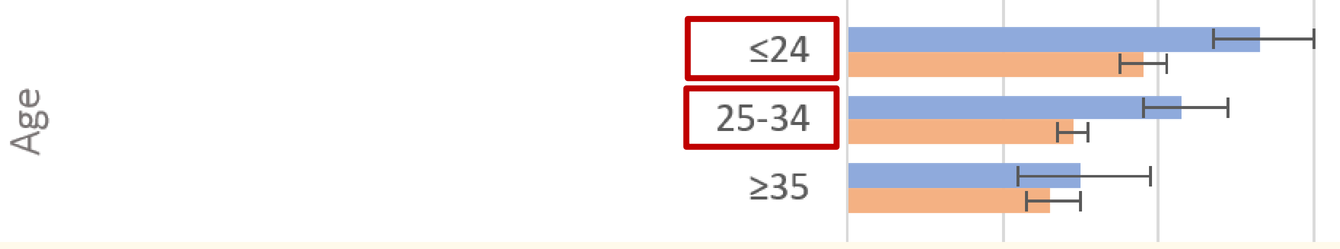
Predicted probabilities of experiencing physical violence by an intimate partner were **higher among rural residents across most measured characteristics,** compared to urban residents.

...and rural-urban differences were more pronounced among certain groups

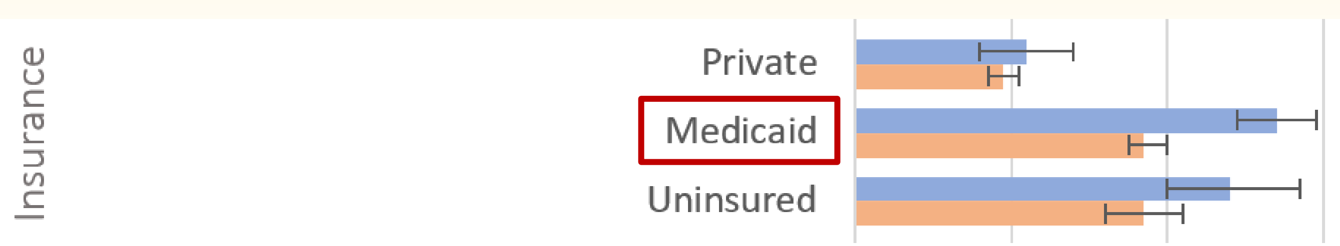
Rural residents who identified as Non-Hispanic white, Hispanic (English-speaking), and American Indian/Alaska Native



Rural residents who were 18-34 years of age

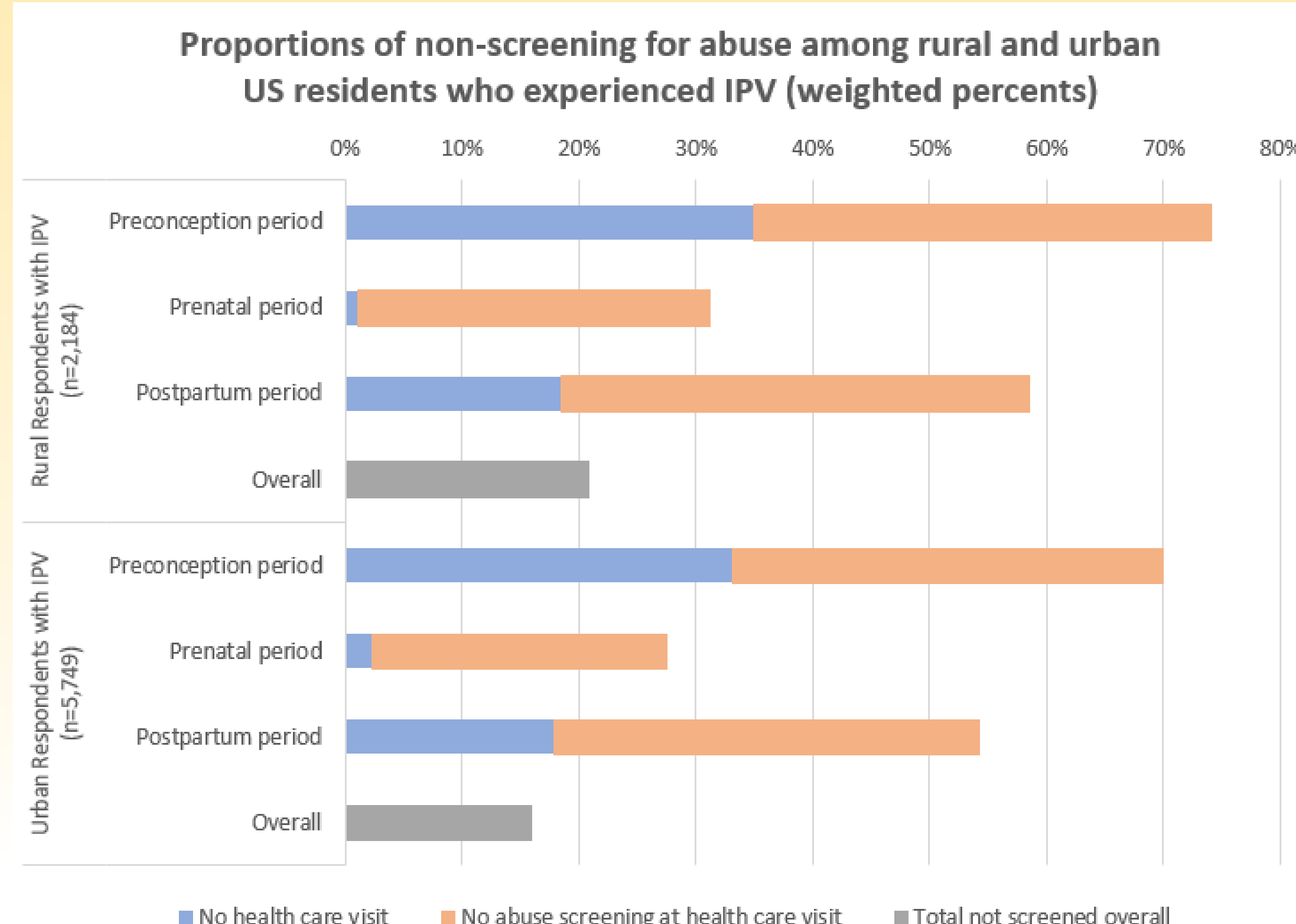


Rural Medicaid beneficiaries



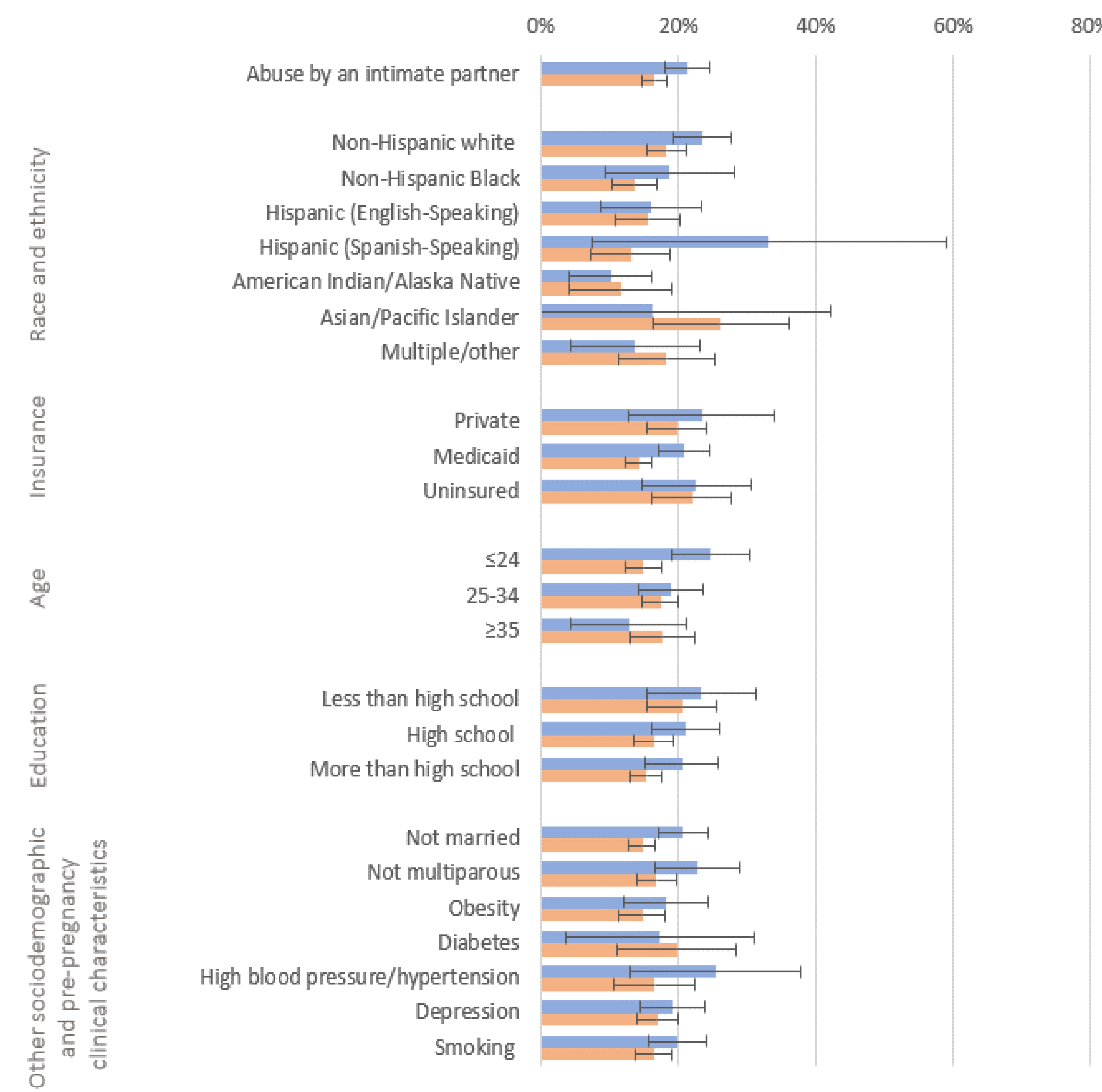
IPV victims are not being screened for abuse

- Rates of non-screening for abuse are too high among rural and urban IPV victims.
- Proportions of non-screening are higher among rural IPV victims than among urban IPV victims.



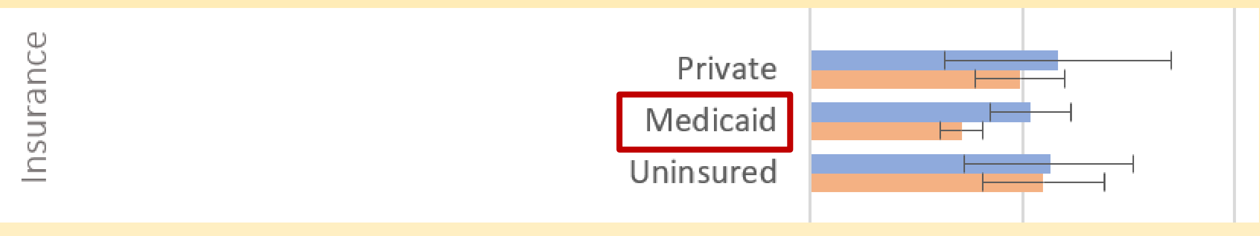
Rural IPV victims are more likely to not be screened for abuse

Predicted probabilities of non-screening for abuse by an intimate partner were **higher among rural IPV victims** across some measured characteristics, compared to urban IPV victims.

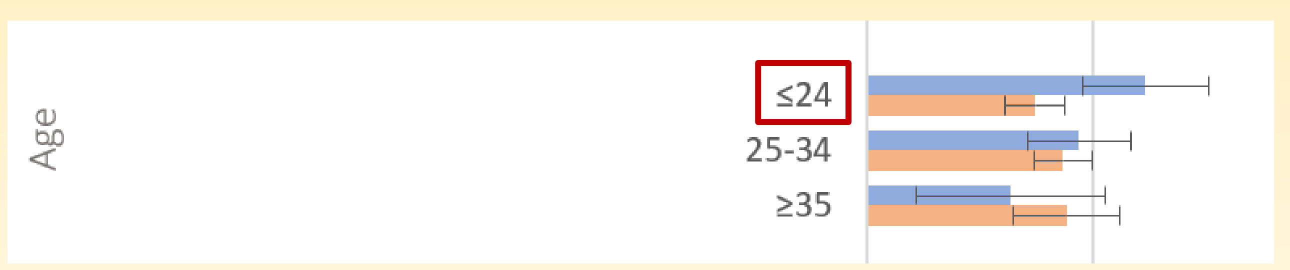


...and rural-urban differences were again more pronounced among certain groups

Rural Medicaid beneficiaries



Rural residents who were 18-24 years of age



Rural residents who were unmarried at the time of birth

Findings summary

- Intimate partner violence before or during pregnancy is more common among rural US residents compared to urban residents.
- Compared to urban IPV victims, a higher proportion of rural IPV victims – more than 1 in 5 – were never screened for abuse before, during, or after pregnancy.

Examining racial inequities in IPV among rural residents who give birth

- Half of pregnancy-associated homicides are IPV
  - Black people have the highest rates of pregnancy-associated homicide
  - Indigenous people have the highest rates of IPV overall (but data reporting practices limit available data)
- Racial inequities in access to care and screening practices among rural people
- Goal: To describe racial/ethnic differences in IPV and postpartum abuse screening among rural US residents.

Elevated rates of perinatal IPV among Indigenous and multiracial rural residents

Figure 1. Reports of physical violence by an intimate partner among rural residents who gave birth 2016-2020, by race/ethnicity

Elevated risk of not being screened among non-Hispanic white rural residents

Figure 2. Proportions of people who were NOT screened for abuse during the postpartum period among all rural US residents who gave birth 2016-2020, by race/ethnicity

Examining differences in perinatal IPV based on insurance coverage and churn

- Rural residents have higher risks of perinatal insurance churn & higher rates of Medicaid coverage, compared with urban people.
- Goal: To describe the relationship between perinatal health insurance, IPV, and postpartum abuse screening among rural US residents.
- Predictors: health insurance at childbirth and postpartum, and insurance transitions.

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Rural residents insured by Medicaid are at elevated risk for IPV

Figure 1. Proportions of rural US residents who experienced physical violence by an intimate partner by insurance status, Pregnancy Risk Assessment Monitoring System, 2016-2020 (N=42,193)

Weighted percent (95% CI)

0% 1% 2% 3% 4% 5% 6% 7% 8% 9% 10%

All rural residents

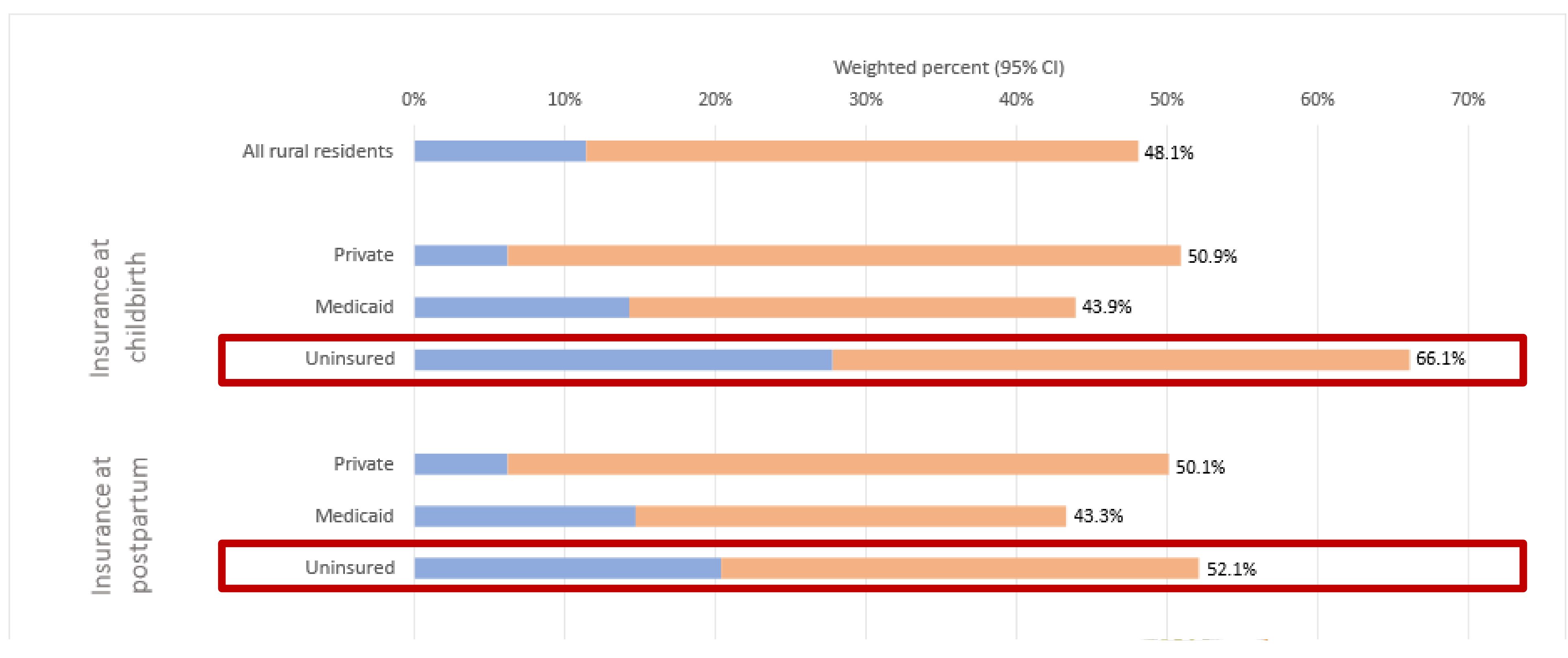
Insurance at childbirth
- Private
- Medicaid
- Uninsured

Insurance at postpartum
- Private
- Medicaid
- Uninsured

Insurance transitions
- Continuous private
- Continuous Medicaid
- Medicaid-private
- Medicaid-uninsured

Rural (n=42,193)

Half of rural residents lack postpartum abuse screening; most common among uninsured at childbirth and postpartum



Perspectives from IPV victim support and advocacy organizations

- 15 key informant interviews (30-60 minutes, via phone/zoom)
  - 5 nationally-serving policy and advocacy service organizations
  - 5 state-based coalitions (Maine, Minnesota, North Carolina, South Dakota, Wisconsin)
  - 5 direct service organizations that serve rural communities in four states (Michigan, Minnesota, Montana, North Carolina)

University of Minnesota Rural Health Research Center

In their words:

- *“I think there's also this reality in our movement, that domestic violence and sexual assault do not exist in a vacuum. And they exist because of the societal structure we've created, which is a patriarchal structure.”*

- *“One of the greatest challenges for clients is being in a rural area…Rent is outrageous compared to wages, so many victims choose to stay with their abuser for the lack of financial resources elsewhere.”*

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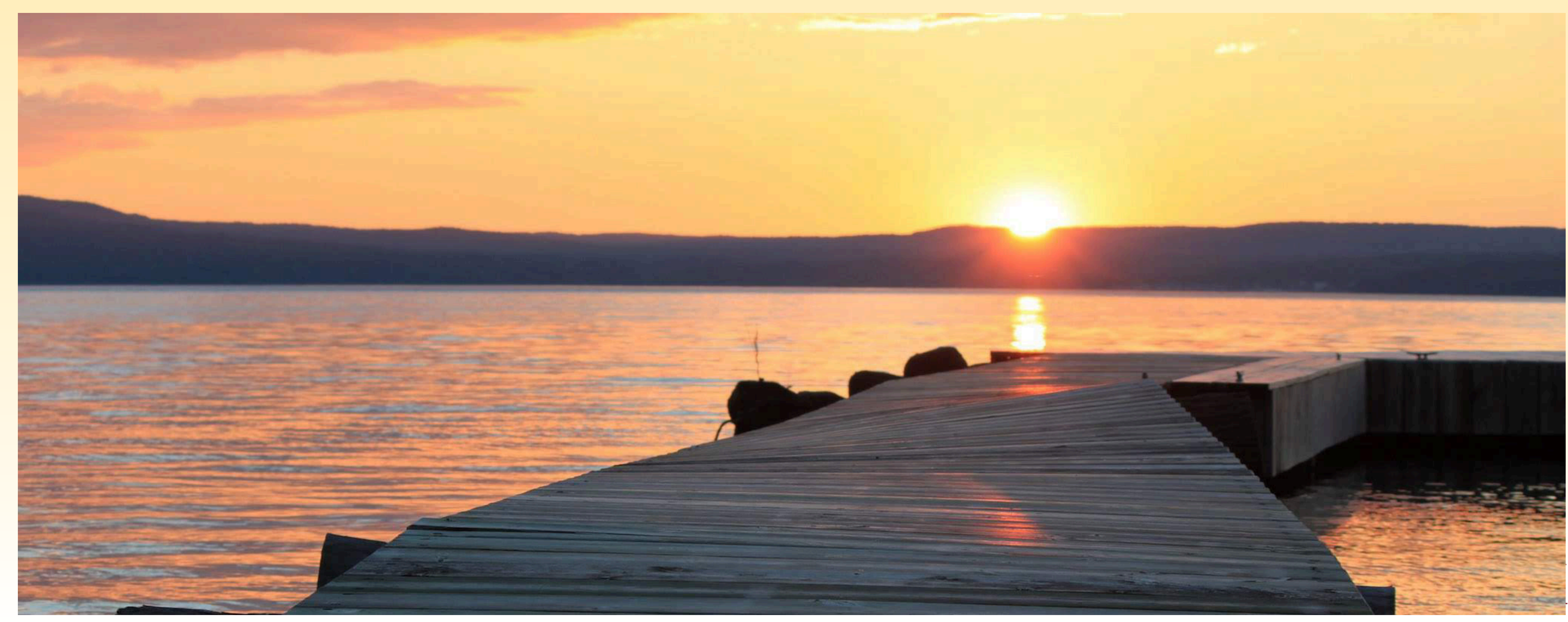
Next steps so that rural residents have safety, hope, and healing



Clinical implications

- Most rural residents are not screened for IPV
- Rural IPV victims at greatest risk of not being screened are unmarried, younger (18-24), and lower income
- Address barriers to universal abuse screening
  - Improve access to care
    - More + more diverse workforce, mobile care, telehealth
  - Screening at visits
    - Clinician training, trauma/violence-informed training
    - Increasing connections to referral resources

In their words:

- *“There's no statewide statute [in our state] for mandatory training for health care professionals on domestic violence or domestic violence screening…. There's still large numbers of professionals in [our] trainings who said that they've never received training on domestic violence. So I think that there's a lot of missed opportunities for screening survivors and responding to domestic violence. I think having that in policy would be really helpful toward [rural victims and pregnant and postpartum victims].”*

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Policy implications

- Access to perinatal care
  - Reduce distance to care, fund innovative models
  - Expand access to continuous health insurance
    - Extend postpartum Medicaid coverage (note high IPV risk)
- Invest in communities
  - Targeted support for people at-risk of IPV in rural communities before, during, and after pregnancy
  - Resources, support services, SDOH

In their words:

- *"Just bolstering the funding and services that are available in rural places [would support the health and safety of rural IPV victims, such as] … access to affordable housing and jobs that provide living wages, access to childcare, access to other things that the federal government can do like tax credits for children or low-income individuals."*

Policy implications for prevention

- Racial inequities
  - Prevention efforts needed in rural Indigenous and tribal communities
- Insurance coverage differences
  - postpartum Medicaid extension to address churning/uninsurance
  - Medicaid-based prevention and support program efforts

Research implications

- Prevention research – how to prevent IPV?
- Policy research - what programs work for harm reduction?
  - Victims' services
  - Batterer intervention programs
  - Health care provider trainings, requirements, support
  - Health insurance benefits/coverage
  - Coordination across sectors (family court, health, law enforcement)

In their words:

- *“There's just nothing, there's nothing like listening to women. Because their lived experience is just so vital and it has to be heard.”*

- *“The foundational layers of structural oppression and structural inequity end up impacting survivors in so many ways that approaching this kind of violence from an individual paradigm really just only leaves people to continue to experience harm… generationally-speaking or at a community level.”*

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Perinatal IPV is too common, especially among rural people, and many victims aren't even being screened.

Every pregnant person who is physically, emotionally, or sexually hurt by an intimate partner deserves – at the very least – to be asked about this during health care visits, and ideally also to be supported and safe outside of the health care setting.

Maternal mortality is a crisis in rural communities, and IPV is a contributor.

Gateway provides easy and timely access to research conducted by the Rural Health Research Centers

ruralhealthresearch.org

This free online resource connects you to:

- Research and Policy Centers
- Products & Journal Publications
- Fact Sheets
- Policy Briefs
- Research Projects
- Email Alerts
- Experts
- Dissemination Toolkit

Connect with us

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- twitter.com/rhrgateway

Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration.

Thank you!

National Domestic Violence Hotline:
https://www.thehotline.org/
National Resource Center on Domestic Violence:
https://www.nrcdv.org/
National Coalition Against Domestic Violence:

https://ncadv.org/

Our RHRC research:

https://rhrc.umn.edu/

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NIH National Institutes of Health
Office of Disease Prevention

Prevention in Focus Webinar Series

SAVE THE DATE!

July 22, 2024
12 pm – 1 pm EST

Webinar Topic: Menthol

Rosalind (Roz) King, Ph.D.
Q & A Moderator | Chief, Scientific Development and Coordination Section

NIH Office of Behavioral and Social Sciences Research (OBSSR)

Upcoming OBSSR Events

June 2024

- Behavioral and Social Science Insights for the Future of Scientific Conferencing – A Workshop (6/6, 6/7, and 6/11)

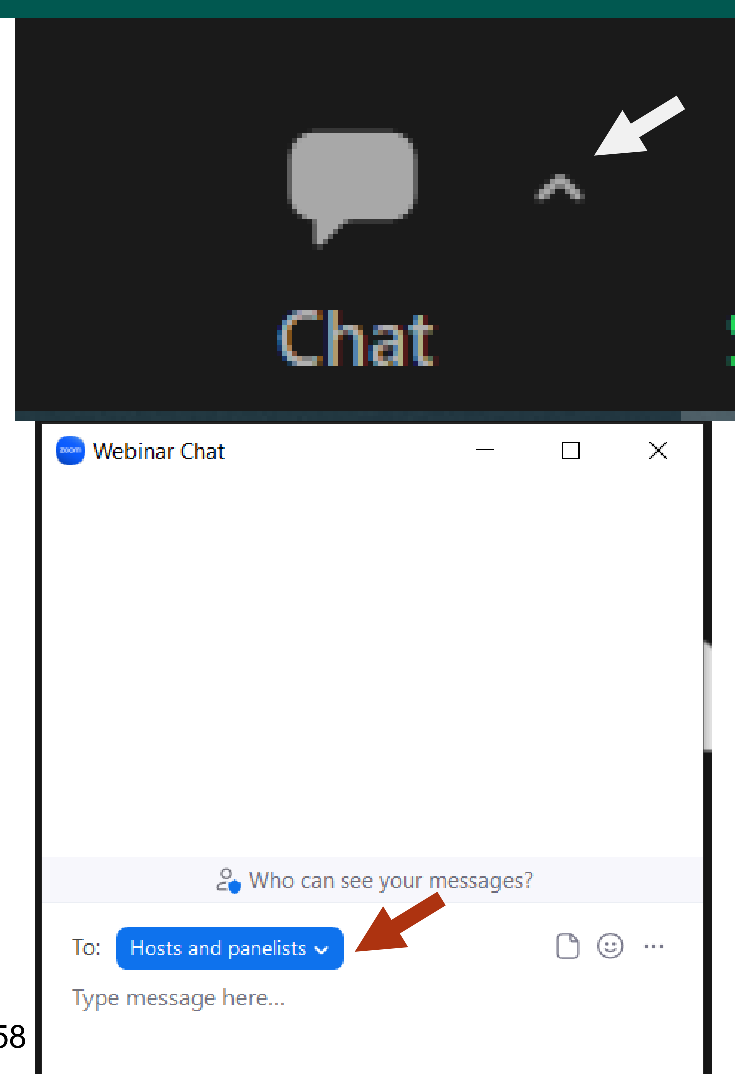
July 2024

- Director's Webinar on the intersection of social science, aging, and health disparities with Dr. Rebeca Wong (**7/23**)

September 2024

- Director's Webinar on justice-involved individuals and access to healthcare with Dr. Emily Wang (**9/17**)

Prevention in Focus Webinar Series



Q&A Session

- **Please send us your questions via the Chat pod directed to Hosts and Panelists**

Thank You!

See you for our next webinar
on July 22, 2024!

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