January 2004

ADDRESSING VIOLENCE AGAINST WOMEN

Results from a National Survey of Title X Family Planning Providers

Each year in the United States, intimate partner violence (IPV) affects approximately 1.5 million women(1). Although women at all stages of life are at risk, current research indicates that the incidence of IPV is highest among women of reproductive age, particularly those in their 20s(2). IPV can affect many aspects of women's reproductive health, including pregnancy, childbearing, contraceptive use, and risk for human immunodeficiency virus (HIV).

Across the nation, approximately 4,500 Title X-supported clinics provide essential reproductive health care services to more than 4 million women each year. Eighty percent of women seeking care at Title X clinics are younger than age 30 years, and 30% are younger than age 20. Increasingly, addressing IPV in primary care settings is recognized as an important component of behavioral risk assessment. Although some data exist on prevalence for IPV screening and barriers to screening in reproductive health care settings, the extent to which family planning clinics and clinicians in the United States incorporate screening for IPV into their practice is relatively unknown.

During 2001–2002, the Centers for Disease Control and Prevention (CDC) coordinated the National Survey of Title X-Supported Family Planning Clinics and Intimate Partner Violence (FPC/IPV Study) to assess current practice related to IPV in these clinics. Funding, design, implementation, and analysis of the survey resulted from the collaborative efforts of CDC's Division of Reproductive Health and Division of Violence Prevention, the Office of Public Health and Science (OPHS), Office of Population Affairs (OPA), and the State Family Planning Administrators (SPFA). The study was conducted by Battelle Centers for Public Health Research and Evaluation.

This publication presents findings from the FPC/IPV Study and provides background information to help clinic staff interpret the data and determine how IPV can be addressed in their setting. Although incorporating IPV screening and intervention into clinical settings can be challenging, these efforts can be critical in improving the lives of women who experience violence. We hope this information will generate discussions regarding the need for an increased focus on IPV, as well as efforts to address it appropriately in clinical settings.

KEY FINDINGS OF THE IPV STUDY

- Clinicians in Title X-supported clinics are aware that IPV is a problem: more than 80% indicated that IPV is a common problem affecting their clinic's client population.
- IPV screening rates are high in Title X-supported clinics: more than 80% of clinicians reported that either verbal or written screening for IPV occurs routinely in their clinic.
- More than 60% of clinicians in Title X-supported clinics report that they have received IPV training within the last 2 years.
- Title X clinicians continue to cite the need for additional training and greater familiarity with community resources for women who have experienced IPV.

See pages 3–9 for more detailed findings.

1. Tjaden P, Thoennes N. Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey. *Research in brief.* Washington, DC, and Atlanta GA: National Institute of Justice, and Centers for Disease Control and Prevention, 1998.

2. Bachman R, Saltzman LE. *Violence against women: Estimates from the redesigned survey.* Bureau of Justice Statistics Special Report. Washington DC: U.S. Department of Justice, 1995.

THE FPC/IPV STUDY: PURPOSE AND DESIGN

PURPOSE

The primary objective of the FPC/IPV Study was to describe current practices used in Title X-supported family planning clinics to identify and refer abused clients. Specifically, the study assessed activities in six general areas:

1) Clinicians' perceptions of the magnitude of the IPV problem in their client population.
2) Existence of clinic policies and protocols.
3) Approaches to screening for IPV.
4) Clinicians' concerns about screening for IPV.
5) Clinician training on IPV and the need for future training and planning.
6) Clinician familiarity with community resources for referral of women needing assistance.

Contributors

Mary Goodwin, Epidemiologist
Stephen Bacak, Fellow

Centers for Disease Control and Prevention
National Center for Chronic Disease
Prevention and Health Promotion
Mail Stop K-20, 4770 Buford Highway, NE
Atlanta, Georgia 30341-3717
Tel: (770) 488-6250
E-mail: ccdinfo@cdc.gov

For information on research related to violence against women and reproductive health, please visit the CDC's Division of Reproductive Health (DRH) Website at www.cdc.gov/reproductivehealth/wh_violence.htm.

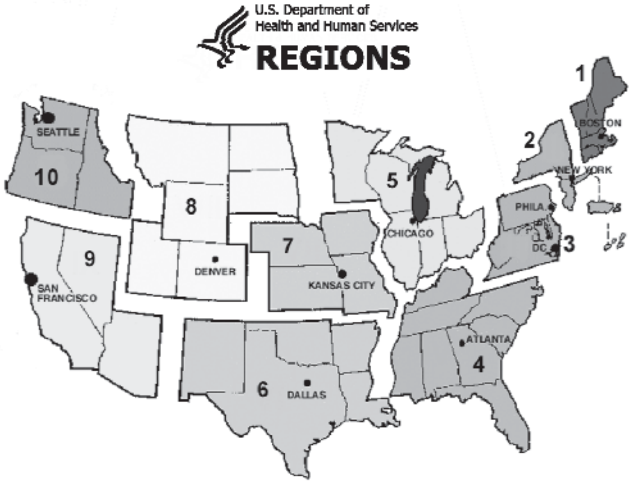
For more information on research and prevention activities on violence against women, visit the Division of Violence Prevention website at www.cdc.gov/ncipc/factsheets/ipvfacts.htm

STUDY DESIGN

The FPC/IPV Study collected information from a nationally representative sample of approximately 4,500 Title X-supported clinics in the continental United States. To obtain information from both the administrative and service delivery perspectives, one clinic director and at least one clinician were contacted in each sampled clinic. The survey used a two-stage sampling design, separately interviewing clinic directors by telephone and subsequently contacting randomly selected clinicians by mail.

The sample was stratified by U.S. Public Health Service (PHS) Region for Regions 1–6 and 9 [Figure 1]. Because of budget limitations, Regions 7, 8, and 10 were combined into a single stratum, thereby allowing a smaller sample size for the overall study. Response rates for the survey were high; on average, 78% of sampled clinicians responded either by mail or telephone (ranging from 69% to 79% by PHS Region).

Figure 1. U.S. Public Health Service Regions



Source: U.S. Department of Health and Human Services, www.hhs.gov/about/regionmap.html.

The study protocol was reviewed and approved by the Institutional Review Boards at CDC and Battelle Centers for Public Health Research and Evaluation and by the Office of Management and Budget (OMB).

Characteristics of Participating Clinicians

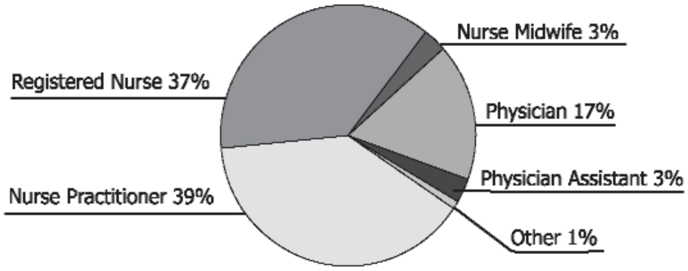
The FPC/IPV Study sample reflected the general characteristics of clinicians employed in Title X clinics, who are predominantly women with nursing backgrounds. On average, participants were in their mid-forties and had worked in the health care field for 17 years. Nearly half of that time had been spent working in the clinic where they were contacted to participate in this study.

Clinicians Characteristics

- **91% were women**
- **Average age: 46 years**
- **Average number of years in health care field: 17**
- **Average years at participating clinic: 8**
- **75% were nurses**

More than three-quarters of the responding clinicians described their position as nurse practitioner, registered nurse, or nurse-midwife [Figure 2]. Seventeen percent of clinicians were physicians, and 3% were physician assistants.

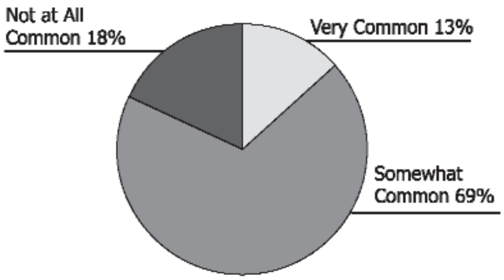
Figure 2. Type of Clinician



Clinicians' Perception of the Magnitude of the IPV Problem

In the FPC/IPV Study, most clinicians considered IPV "somewhat common" in their client population [Figure 3]. Thirteen percent considered IPV "very common," and 18% "not at all common."

Figure 3. Clinicians' Perceptions of the Magnitude of IPV in the Clinic Population



Clinicians' perceptions varied by clinic type and type of provider. Nurse practitioners and clinicians working in Title X-funded Community Health Centers and Hospital-affiliated clinics, were more likely to report that IPV was "very common," compared with other types of clinics and providers.

Terminology and Definitions Used in Questionnaires

Intimate Partner Violence (IPV): (also known as domestic violence) threatened or actual physical force against an intimate partner that either results in or has potential to result in injury, harm, or death. IPV may be physical, sexual, or psychological.

Intimate Partners: current or ex husbands, boyfriends, dates, and same sex partners.

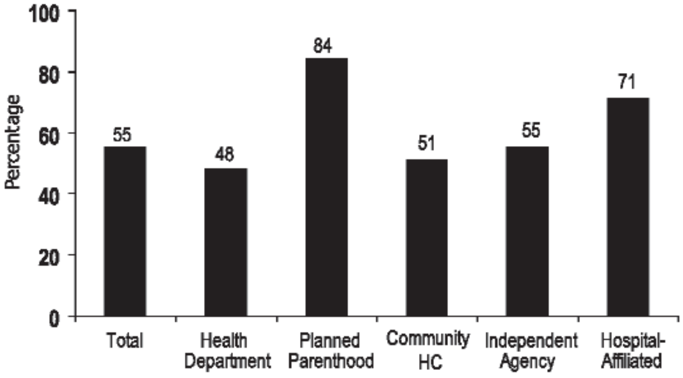
Screening for IPV: Attempts to identify IPV victims using several possible methods for all clients (including asymptomatic) including 1) questions on a self-administered health history form or 2) questions asked directly by clinic staff during a clinic visit.

Protocol: Written document describing clinic procedures and guidelines for identifying, treating, and referring clients affected by IPV.

Clinic Protocols for Addressing IPV

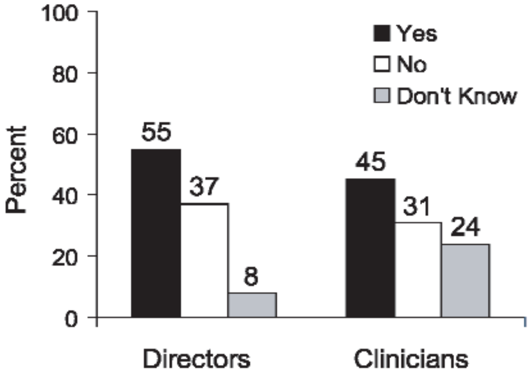
Clinic protocols and policies on IPV are intended to establish the clinic's procedures for handling IPV and to guide staff on the clinic's screening and intervention policies. The FPC/IPV Study asked clinic directors and clinicians whether their clinics had written protocols that established guidelines for addressing IPV. Fifty-five percent of clinic directors reported that their clinic had a protocol [Figure 4]. This proportion varied by clinic type, with Planned Parenthood reporting the largest proportion of clinics with protocols.

Figure 4. Percentage of Clinics with an IPV Protocol, by Clinic Type (N = 665)



A slightly smaller percentage of clinicians reported that their clinic had a protocol for IPV [Figure 5]. Also, a greater proportion reported not knowing whether their clinic had a protocol.

Figure 5. Percentage of Clinic Directors and Clinicians Reporting Their Clinic Has a Written Protocol



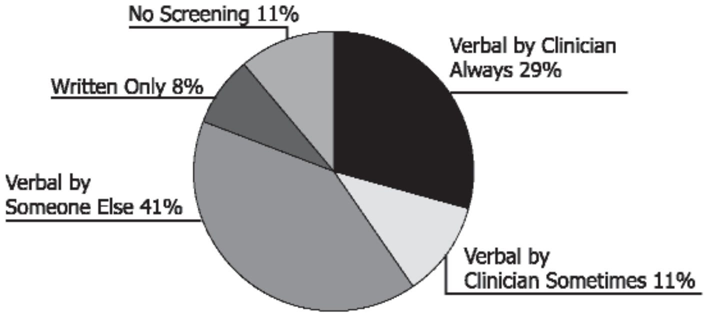
Approaches to Screening for IPV

The FPC/IPV Study estimated the prevalence of IPV screening on the basis of the following questions asked of all clinicians:

- **In general, are clients who come to your clinic screened for IPV?**
- **Is screening usually done verbally or in written form?**
- **If screening is done verbally, who generally asks clients about IPV, you or someone else?**
- **If you do verbal screening routinely, do you screen "always" or sometimes" (at intake and at periodic visits, such as annual exam)?**

Twenty-nine percent of clinicians reported that they "always" screen verbally at an intake visit, and an additional 11% screen verbally "sometimes" [Figure 6]. Forty-one percent reported that "someone else" in the clinic usually screens the clients for IPV. Eight percent of clinicians stated that screening occurs in written form only, and 11% reported that no screening occurs in their clinic.

Figure 6. IPV Screening Approaches* in Clinics at Intake Visits (N = 643)



* Screening may occur in multiple ways in a given clinic. Data shown here reflect the most common method according to the clinician.

Screening approaches varied by PHS Region, clinic type, provider type, and whether the clinician had received training on IPV [Table 1]. In Regions 1, 3, 4, and 7, 8, and 10 (combined), over 40% of clinicians reported that they screen patients verbally. Approximately one-third in Regions 1, 4, and 7, 8, and 10 (combined) reported that they "always" screen. Screening by "someone else" was most prevalent in Regions 2, 6, and 9. The proportion of clinicians reporting "written only" screening was greatest in Regions 1 and 5 (17% and 18%, respectively), and the percentage who reported "no screening" was greatest in Regions 4 and 6 (21% and 14%, respectively). Clinicians in community health centers and hospital-affiliated clinics reported the highest prevalence of verbal screening by the clinician. Those in Planned Parenthood clinics reported the highest prevalence of "written only" screening, and clinicians in health department clinics reported the highest proportion of "no screening." Registered nurses reported more verbal screening "always" compared with other categories of clinicians. Clinicians who had received training within 2 years before the study reported more screening "always," "sometimes" and by "someone else" in the clinic compared with those who had training more than 2 years before the study or who never had IPV training. Among clinicians who reported that "someone else" does verbal screenings, most identified the person as "another nurse." However, in Planned Parenthood and urban clinics, a notable proportion were identified as counselors or social workers.

Table 1. Summary of Approaches at Intake Visits, by Clinician Characteristics (N = 634)

	Verbal by clinician (%)		Verbal by someone else (%)	Written only (%)	No screening (%)
	Always	Sometimes			
Public Health Region					
Region 1	38	8	30	17	8
Region 2	23	12	53	7	5
Region 3	28	17	40	9	6
Region 4	32	10	34	3	21
Region 5	26	10	39	18	7
Region 6	27	7	51	14	14
Region 7, 8, 10	30	13	37	14	5
Region 9	26	3	54	13	4
Clinic Type					
Health Department	29	9	37	7	17
Planned Parenthood	31	7	34	21	5
Community Health Center	20	20	49	5	3
Independent Agency	18	20	45	9	1
Hospital Clinic	43	14	37	4	1
Type of Clinician*					
CNP/CNM	27	12	41	7	13
RN	37	6	35	8	14
MD, PA	20	19	49	9	3
Clinician Training on IPV					
<2 years	31	13	41	7	7
No training within last 2 years	26	7	38	10	18

*Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Registered Nurse (RN), Medical Doctor (MD), Physician Assistant (PA)

CLINICIANS' CONCERNS ABOUT IPV SCREENING

The FPC/IPV Study asked clinicians about a list of potential concerns that have been cited by clinicians in previously published studies. Fourty-two percent agreed that "there is too little time to screen" 42% reported concerns about clients getting the help they need and 27% were concerned that documentation of IPV could jeopardize patient confidentiality [Table 2]. The percentage of clinicians who expressed concern about these topics varied by clinic type, location, and title.

Clinicians working in Planned Parenthood clinics and community health centers reported with greater frequency that there is too little time to screen, whereas clinicians in health department clinics more commonly reported the concern that clients would not get needed help and that documentation could jeopardize client confidentiality.

Clinicians in clinics located in surburban areas reported more commonly that there is too little time to screen, compared with those working in urban and rural clinics. Compared with clinicians in urban and suburban areas, a greater proportion of those in rural areas expressed concern that their clients would not get the help they need and that documentation could jeopardize their client's confidentiality. Nurse practitioners reported more than other provider types that there is too little time to screen. In general, nurses were more concerned about clients getting the help they need compared with medical doctors/physician assistants.

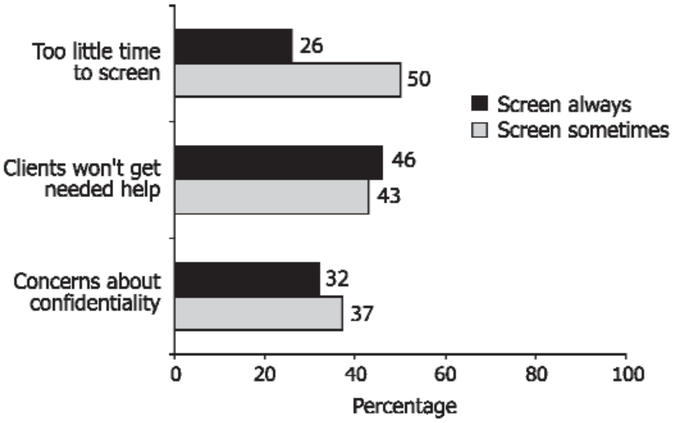
Table 2. Clinicians' Concerns About IPV Screening, by Selected Characteristics (N = 665)

	Too little time to screen clients (%)	Clients will not get the help they need (%)	Documentation could jeopardize client confidentiality (%)
Total	42	42	27
Clinic Type			
Health Department	40	46	32
Planned Parenthood	60	40	21
Community Health Center	58	39	15
Independent Agency	44	35	30
Hospital-Affiliated Clinic	22	32	15
Clinic Location			
Urban	45	36	21
Suburban	50	32	21
Rural	38	50	33
Type of Clinician*			
CNP/CNM	45	45	26
RN	39	45	32
MD/PA	41	34	18

*Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Registered Nurse (RN), Medical Doctor (MD), Physician Assistant (PA)

When clinicians' concerns were analyzed according to reported frequency of screening for IPV, the proportion of clinicians who screen verbally and who reported concerns about having too little time to screen was greater among those who screen "sometimes," compared with those who screen "always" [Figure 7]. In contrast, a greater proportion of clinicians who screen "always" reported concerns that clients will not get needed help compared with those who screen "sometimes." Concerns about confidentiality did not vary by frequency of screening.

Figure 7. Concerns Among Clinicians Who Screen Verbally, by Screening Frequency (N = 254)



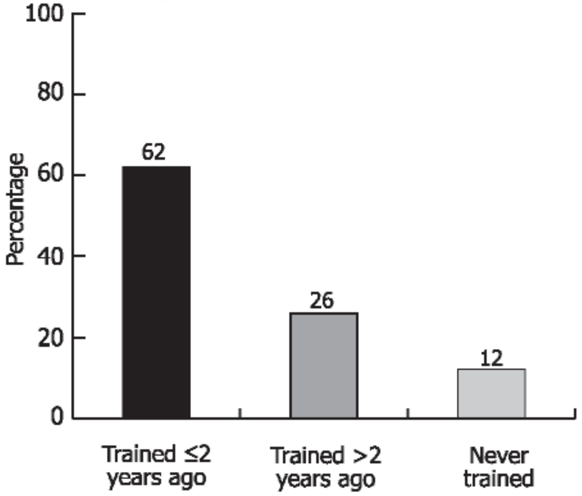
CLINICAN TRAINING ON IPV

Training is an essential component of raising awareness about IPV in clinics and increasing clinicians' confidence to address it appropriately with their clients. The FPC/IPV Study asked clinicians

- How recently they had received IPV training.
- Topics they needed more training on.
- Whether they had plans to attend future IPV training.

More than 60% of clinicians had received training for IPV within 2 years before the survey [Figure 8]. About one-fourth reported that they had received training more than 2 years before the survey, and only about 12% had never received any type of IPV training.

Figure 8. Clinician Training



The proportion of clinicians who reported needing more training on two basic components of IPV varied according to the timing of their most recent IPV training [Table 3]. Not surprisingly, 90% or more of clinicians who had never received IPV training reported needing more training in the two key areas. However, even among those who had received training within 2 years of the study, most reported that they needed additional training.

Table 3. Clinicians Reporting the Need for More Training on Selected Topics (N = 665)

		Clinician Training		
	Total	<2 years ago	2 years ago	Never
How to talk to patients about IPV	72%	67%	73%	94%
What to do when patients disclose IPV	71%	64%	78%	92%

IPV Needs Identified by Clinicians

The FPC/IPV Study asked clinicians what additional resources they need to address IPV in their practice. Listed below are the most commonly reported needs.

Needed Clinic Resources

- Client education materials (brochures, pamphlets, posters)
- Literature in languages other than English.
- On-site counselor/social worker

IPV Needs Identified by Clinicians (cont'd)

Needed Clinician Resources

- Sample protocol/questions.
- More IPV training (seminars, programs).
- IPV training videos.
- List of referral services (religious, legal, cultural).
- More time for patient care.
- Information on how to deal with a perpetrator on-site.
- More local media attention (TV and newspapers).

FAMILIARITY WITH COMMUNITY RESOURCES

Strong referral networks are essential follow-up components of an IPV screening program. To access appropriate resources for clients affected by IPV, clinic staff must have up-to-date referral information readily available and feel comfortable referring clients to community services. In the FPC/IPV Study, 25% of clinicians reported feeling "very familiar" with community resources, 53% reported feeling "somewhat familiar," and 21% said they were "not very familiar" or "not at all familiar" with community resources [Table 4].

When clinic types were compared, clinicians in independent agencies reported with greatest frequency feeling "very familiar" with community resources, although almost a quarter in the same type clinics did not feel familiar with such resources. Planned Parenthood clinics were found to have the lowest proportion of clinicians responding that they were not familiar with community resources, compared with community health centers, where one-third of clinicians did not feel familiar with community resources.

Familiarity did not vary notably by type of provider. However, familiarity with community resources did vary substantially according to the recency of training received by the clinician. Among clinicians who had received training within the last 2 years, 33% felt "very familiar" with community resources, compared with 13% of those who had received training more than 2 years before the study and 14% of those who had never received IPV training. Among the latter group, 42% stated that they were not familiar with community resources.

Table 4. Clinician Familiarity with Community Resources (N = 665)

	Very familiar %	Somewhat familiar %	Not very/ not at all familiar %
Total	25	53	21
Clinic Type			
Health Department	25	52	22
Planned Parenthood	23	65	11
Community Health Center	17	49	33
Independent Agency	39	36	24
Hospital Clinic	27	60	13
Type of Clinician *			
CNP/CNM	26	53	21
RN	22	58	20
MD/PA	27	44	28
Most Recent IPV Training			
Within 2 Years	33	53	14
> 2 years	13	56	31
No Training	14	45	42

*Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Registered Nurse (RN), Medical Doctor (MD), Physician Assistant (PA)

HOW DO FINDINGS OF THE FPC/IPV STUDY COMPARE WITH OTHER STUDIES?

The FPC/IPV Study collected the first national data on IPV screening in family planning clinics. Most other studies in reproductive health care settings have focused on physicians. In a 1998 survey of fellows of the American College of Obstetricians and Gynecologists (ACOG), 39% reported that they regularly screen for IPV although most screened only when they suspected that a patient was abused(1). In a California study, 10% of primary care physicians reported that they screened new patients for IPV, and 9% screened during subsequent clinic visits(2). Among primary care physicians in Alaska, 17% screened at first visit and 5% screened during follow-up visits(3). In comparison, prevalence of screening in the FPC/IPV Study was high, with 30% of clinicians reporting that they "always" conduct verbal screening and 50%–60% reporting that they "sometimes" screen, that someone else screens, or that screening occurs in written form.

Why do screening rates appear to be higher in family planning clinics? Although further research is needed to better understand how IPV is addressed in family planning settings, one study suggests that clinicians working in public settings are more likely to screen compared with clinicians who practice in private institutions(4). Another possible explanation is that because Title X clinicians are more involved in preventive screening and counseling on other health concerns for women, they are more open to additional types of screening.

HOW ROUTINE SHOULD IPV SCREENING BE?

Several professional organizations in the United States recommend that clinicians screen routinely for IPV. Evidence from the FPC/IPV Study suggests that IPV screening has gained acceptance among many clinicians in family planning settings. However, many unanswered questions remain, including:

- Does screening and identifiying IPV victims in clinical settings help decrease their risk for and experience of violence?
- Do women use the referrals they are given, and are these referrals helpful?

In the absence of research findings to establish an evidence base for IPV screening, CDC has suggested a balanced approach(5). Routine screening should continue in institutions where appropriate systems are in place, including standard policies and procedures, adequate provider training, and an established referral network. Institutions and individuals without such systems can choose not to institute routine screening programs until they are better equipped to respond to the almost certain increase in disclosures of IPV.

> *Regardless of whether routine screening is implemented, health care providers and institutions must understand the problem of violence and be prepared to address it.*

Whether IPV is revealed through routine screening, client disclosure, or visible symptoms of abuse, clinicians will encounter it. As researchers continue to evaluate screening and interventions, institutions and health care providers must adopt appropriate response procedures and receive adequate training.

1. Horan D, Chapin J, Klein L, et al. Domestic violence screening practices of obstetricians-gynecologists. *Obstetrics & Gynecology* 1998;92(5):785–9.

2. Rodriguez MA, Bauer HM, McLoughlin E, et al. Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *JAMA* 1999;282:468–474.

3. Chamberlain L, Perham-Hester KA. Physicians' screening practices for female partner abuse during prenatal visits. *MCHJ* 2000;4:141–148.

4. Durant T, Gilbert BC, Saltzman LE, et al. Opportunities for intervention: Discussing physical abuse during prenatal care visits. *Am J Prev Med* 2000;19:238–244.

5. Goodwin MM., Dietz P., Spitz AM., Arias I. Saltzman LE. Screening for domestic violence. Balanced approach is needed. [comment, letter]. *BMJ* 2002;325(7377):1417.

CLINICAL IPV CONCERNS: THE BASICS OF ADDRESSING IPV

How can clinics address IPV when funds to support such activities are scarce? Here are a few ways to get started or to expand measures already in place(6).

CLINICIAN LEVEL

Become Educated About IPV

Violence is a complex issue that can affect many aspects of the lives of women and their families. Clinic staff must be aware of the emotional, economic, and social challenges that women face and understand the potential difficulties in disclosing abuse or ending an abusive relationship.

Respect Patient Confidentiality and Autonomy

Make every effort to see each client in a private and comfortable environment for at least some part of the clinic visit. Women living with violence may have diminished control over their lives and personal decision-making. Clinic staff must help women while also respecting their needs and choices.

Understand and Observe Your Clinic's Policy for Addressing IPV

Clinics differ in the way IPV cases are handled. Become familiar with your clinic's policy for addressing IPV and support fellow staff members in adhering to the policy.

Know How to Manage Emergencies and Facilitate Referrals When Needed

Safety assessment and emergency management skills are crucial for responding to clients who are in crisis situations. In addition, clinic staff must also be familiar with IPV services available in the community and facilitate referrals when appropriate. Clinics can also display information about such resources in the clinic setting.

Understand the Legal and Ethical Implications of IPV Screening

State laws that address violence differ, and clinic staff must be aware of state reporting laws related to disclosures of violence against other family members, including children. The ethical implications of screening for IPV are significant and must be discussed and understood by clinic staff.

Consider Client's IPV History When Providing Family Planning Counseling

An abusive relationship may affect a woman's autonomy in many areas including sexual activity and use of contraceptive methods. Asking a woman about her relationship may help you suggest the most appropriate method for her at the time.

INSTITUTIONAL LEVEL

Have a Written Protocol or Policy About How Clinic Staff Will Address IPV

Clinics must have a site-specific assessment and intervention plan that is documented in a written policy or protocol. Clinic staff should be aware of the clinics policy, including how and when screening is required and how to respond when a client discloses IPV.

Establish Collaborative Relationships with Community Organizations

Because problems posed by IPV often extend beyond what any one facility can offer, clinics should establish partnerships with other local agencies that assist victims of IPV. A current list of such organizations should be readily available to clinic staff who need to refer a client.

Display IPV Resource Materials in the Clinic

Once a clinic identifies what services other local agencies provide to IPV victims, materials about these services should be displayed in the clinic setting. Examples include posters, flyers, or pocket cards. Materials should include specific contact information such as hotline numbers.

Ensure that Clinic Staff Has Periodic Training Opportunities

Staff training is critical to keep staff updated and aware of the problem of IPV and the effective approaches to addressing it, including screening practices and safty assessment. Training should occur periodically so that acquired skills are reinforced and sustained.

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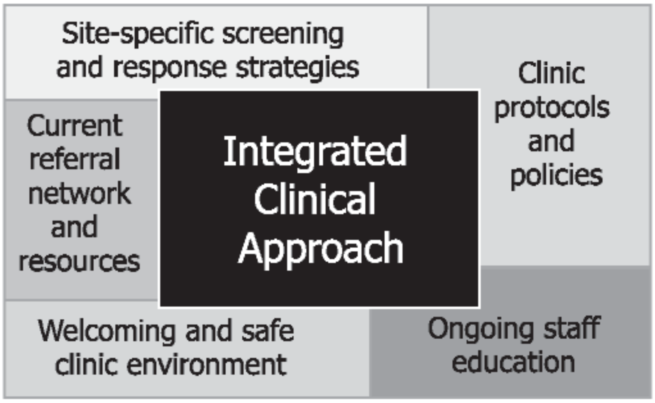
6. Based on recommendations originally published in *International Planned Parenthood Federation Western Hemisphere Region*. Basta: Summer 2000.

Integrated Approach is Needed

The best way to address IPV is through a comprehensive, integrated program that involves a variety of components [Figure 9]. Together these components ensure that health care providers and institutions are adequately prepared to respond appropriately and that follow-up measures are in place to assist women.

Figure 9. Components of a Comprehensive Clinical Approach



Available Resources

Guidelines/Toolkit
Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. The Family Violence Prevention Fund, May 1998.

Family and Intimate Partner Violence: Resources for use in Family Planning Clinics. John Snow Inc. (JSI) Research and Training Institute, forthcoming.

Websites

Federal Organizations

Division of Reproductive Health, CDC
www.cdc.gov/reproductivehealth/index.htm

Division of Violence Prevention, CDC
www.cdc.gov/ncipc/factsheets/ipvfacts.htm

Office on Women's Health, Department of Health and Human Services (HHS)
www.4woman.gov/violence/index.cfm

Office of Population Affairs, HHS
http://opa.osophs.dhhs.gov/titlex/ofp.html

Health Resources and Services Administration
www.hrsa.gov/OMH/violenceprevention.htm

Websites

Nonprofit and Professional Organizations

Physician's for a Violence-Free Society
www.pvs.org

Family Violence Prevention Fund
www.fvpf.org

American Nurses Association
www.nursingworld.org/readroom/position/social/scviol.htm

American College of Obstetricians and Gynecologists
www.acog.org/from_home/departments/dept_web.cfm?recno=17

American College of Nurse Midwives
www.midwife.org/prof/display.cfm?id=112

Follow-Up Activities

In Summer 2002, the Office of Population Affairs (OPA) and CDC convened an advisory panel to discuss potential strategies to follow up the FPC/IPV Study. The panel identified the following activities: 1) compile resource and training information for Title X grantees, delegates, and clinics, emphasizing specific examples from family planning/reproductive health settings; 2) assess model programs of IPV screening, management, and referral currently used in Title X-supported clinics; and 3) maintain dialogue within and among PHS Regions to increase awareness of IPV and improve resources available to Title X clinics and clinicians. All activities are currently underway, and OPA continues its commitment to this issue.

ADDRESSING VIOLENCE AGAINST WOMEN: RESULTS FROM A NATIONAL SURVEY

Across the nation, Title X-supported clinics provide an important point of contact for women seeking reproductive health care services. Intimate partner violence (IPV) may affect many aspects of women's reproductive health, including pregnancy, childbearing, contraceptive use, and risk for human immunodeficiency virus (HIV). Increasingly, addressing IPV in primary care settings is recognized as an important component of behavioral risk assessment.

During 2001–2002, the Centers for Disease Control and Prevention (CDC) coordinated the National Survey of Title X-Supported Family Planning Clinics and Intimate Partner Violence (FPC/IPV Study) to assess current practice related to IPV in these clinics. This publication reports findings from the study, provides a resource list for clinic staff, and updates. Please look inside for useful information about how Title X-supported family planning clinics across the United States have approached the problem of violence against women.

A WORD FROM . . .

Office of Population Affairs (OPA), Department of Health and Human Services (HHS)

Since 1970, Title X has provided essential preventive health services to women. IPV affects the lives of many women served in Title X clinics. OPA is working to raise awareness of this important issue and to improve resources for Title X staff and clients. We thank the clinicians who participated in this study and hope this feedback will help generate discussion and increase awareness.

Centers for Disease Control and Prevention (CDC), HHS

For almost a decade, CDC has explored the potentially key role that reproductive health care services can play in identifying and linking abused women to appropriate intervention services. Assessing activities in family planning clinics was a natural extension of our work on the role of reproductive health care providers in addressing IPV. CDC is pleased to present the results of this study to Title X clinics and clinicians.

Centers for Disease Control and Prevention
Division of Reproductive Health
Mail Stop K-35, Maternal and Infant Health Branch
4770 Bufford Highway, NE
Atlanta, GA 30341–3717

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