AMERICAN COLLEGE of NURSE-MIDWIVES

POSITION STATEMENT

Gender-Based Violence

The American College of Nurse-Midwives (ACNM) affirms the following:

- Although all people can experience or be exposed to violence and trauma, cisgender women, transgender women, and gender-nonbinary persons are disproportionately affected. Marginalized and intersectional identities such as those related to race, disability, sexuality, and social class potentiate vulnerability.
- Violence includes verbal, physical, emotional, and/or sexual violence or harassment; sexual or reproductive coercion; psychological aggression; and/or stalking.
- Certified nurse-midwives (CNMs) and certified midwives (CMs) are advocates for and providers of primary health care and have a critical role in mitigating the effects of violence in their clients' lives.
- CNMs and CMs are educated to understand the dynamics of gender-based violence and the effects of violence on the lives of people who experience it.
- Appropriate assessment, intervention, and referral for gender-based violence should be an integral part of all health care services, and techniques for this process should be included in all education programs for health care professionals.
- Development of health care policies that promote universal screening for past or current violence is essential as a first step to address health care risks of gender-based violence.

Background

Gender-based violence is an enormous public health problem that affects more than one-third of cisgender women in the United States[1] and globally[2] and up to 89% of transgender and gender-nonbinary people.[3] Violence may be directed at the individual by an intimate partner or by a nonpartner[2] and may include verbal, physical, emotional, or sexual violence; sexual or reproductive coercion; psychological aggression; and/or stalking.[1-3] Gender-based violence is experienced by people of all ages[4-8] and all racial, ethnic, and socioeconomic groups.[9-10] Between 2003 and 2014, more than half of all adult homicides of people who identified as female were related to intimate partner violence (IPV).[11] In addition, police violence against people of color has been a significant problem historically, and these rates have increased in recent years.[12]

Significant health consequences for individuals exposed to gender-based violence persist even when the violence ends. Individuals with histories of exposure to violence have increased risk for an array of negative health outcomes, including but not limited to chronic pain, gastrointestinal symptoms, respiratory symptoms, fatigue, insomnia, abnormal uterine

bleeding, dyspareunia, high blood pressure, and heart disease.[10] Estimates of IPV in pregnancy vary, with reported rates of as high as 6.5%.[13] For some individuals, violence may begin or worsen during pregnancy, but for others, pregnancy may be a time of reprieve from violence.[14] Violence in the perinatal period is associated with delayed initiation of prenatal care, poor nutrition, and perinatal and postpartum depression for the pregnant person, and with low birth weight, preterm birth, and perinatal death for the newborn.[15]

IPV is associated with concurrent reproductive coercion,[16-22] in which a person coerces their partner to become pregnant, deliberately limits access to contraception, or coerces them to terminate a pregnancy.[23] Reproductive coercion affects adults and adolescents,[8] is linked to unplanned pregnancy,[21,24] and is recognized as a form of violence.[25]

Sexual violence may include forced sex; sexual coercion; or unwanted, noncontact experiences, such as sexual harassment.[1,3] In the 2015 National Intimate Partner and Sexual Violence Survey,[1] it was estimated that 43.6% of people who identified as women, or 52,192,000 people, experienced contact sexual violence victimization during their lifetime. Transgender and gender-nonbinary people are at an even greater risk for physical or sexual IPV.[26,27] The incidence of sexual harassment is likely underestimated because harassment frequently goes unreported.[28] Sexual harassment in the workplace is experienced by an estimated 25% to 85% of people.[29] In 2 studies with adolescents, of those who identified as female, nearly half of middle-school-aged respondents and nearly one-third of high-school-aged respondents reported experiencing sexual harassment, which was linked to declines in school performance and school satisfaction.[30,31] A growing body of research also documents that transgender and gender-nonbinary youth experience pervasive victimization, bias-based harassment, and bullying based on their gender identity.[32] In a national survey of youth, 75% of transgender and gender-nonbinary youth reported feeling unsafe at school because of their gender expression.[33] These findings suggest that sexual harassment begins at a young age and continues into adulthood. Chronic sexual harassment is associated with increased anxiety, depression, and substance use.[34]

ACNM supports a zero-tolerance policy for violence. In recognition that many individuals disclose violence in their lives to their health care providers, health care policies that promote universal screening for past or current violence are essential. In addition, ACNM recognizes gender-based violence as a community-level issue that requires a multidisciplinary, community-based response. As such, ACNM recommends the following:

- CNMs/CMs should screen regularly for current and past experience of violence, including reproductive coercion, using best practices to create an environment in which people feel safe and supported.[35]
- Screening should be conducted using validated instruments.[35]
- CNMs/CMs should be trained to respond to disclosures of violence, including harassment; be prepared to conduct follow-up screening for level of physical danger and mental health sequelae; and be equipped to make appropriate recommendations and referrals.[34]
- CNMs/CMs should partner with community agencies to coordinate support for individuals who experience gender-based violence.

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Note. "Midwifery" as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

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