REPRODUCTIVE HEALTH matters

FEATURE

Should violence* services be integrated within abortion care? A UK situation analysis

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Abstract: *The prevalence of violence against women worldwide raises the question of the desirability and feasibility of integrating interpersonal violence (IPV) services within abortion care. By examining present services and context in an Inner London borough in the UK, this situation analysis explored the hypothesis that an established, integrated, health-based service (comprising raised awareness, staff training in routine IPV enquiry and referral to a community-based in-reach IPV service) would be transferable into abortion services. Four sources of qualitative data investigated views on integrating services: key stakeholder in-depth interviews including with providers of abortion and IPV services and commissioners and IPV survivors with past abortion service use (3 user, 15 provider); qualitative analysis of the open-ended part of a survey of current abortion service users with and without experience of IPV; feedback from an interactive workshop and data from field observations. While there was consensus among all informants that women experiencing IPV and seeking abortion have unidentified, unaddressed needs, how any intervention might be organised to address these needs was contested; thus questions remain about whether, when and how to raise the topic of IPV and what to offer. Two major anxieties surfaced: a practical concern in terms of interrupting a streamlined abortion service that suits the majority of staff and patients, and a conceptual concern about risk of stigmatising abortion seekers as 'victims in crisis'. Thus, our findings indicate: when integrating IPV interventions into abortion services, local context, the integrity of separate pathways, and women's safety and agency must be considered, especially when abortion rights are under attack. Novel approaches are required and should be researched.*

Keywords: violence against women, interpersonal violence, domestic violence, sexual violence, abortion providers and services, survey, interview study, situation analysis, United Kingdom

Introduction

Violence and abuse against women and girls is prevalent worldwide with health, criminal justice and financial implications.[1,2,3,4] Interpersonal violence (IPV) is increasingly recognised as an important cause of avoidable mortality and morbidity.[5,6,7,8] In international debates, some authorities recommend screening all women of childbearing age for detecting IPV, as reproductive and sexual health services provide an opportune setting for multi-agency interventions.[9,10,11] Others do not, due to lack of evidence of improved outcomes for women,[2,12,13] though they recommend training health professionals to be alert to the signs,[2] provision of safe environments for disclosure, and the commissioning of pathways across health and social care.[12] Thus,

*Over the lifetime of this project, language and terminology have been changing at local, national and international levels. As abortion only affects women and girls, the terms VAWG (violence against women and girls), and GBV (gender based violence) have been eschewed, and the more generic term 'interpersonal violence (IPV)' used in preference, to include both domestic and sexual violence, and which would cover other forms that might intersect with abortion (such as human trafficking or 'honour'-based violence). Other terms are used if described by the specific services, policies or papers.

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health-sector based IPV interventions remain in their infancy.[14,15]

A recent systematic review identified high prevalence of IPV in women seeking abortion and an association with multiple abortions.[16] Meta-analysis showed worldwide rates of IPV in the preceding year in women undergoing abortion ranging from 2.5% to 30%. Lifetime IPV prevalence was shown to be 24.9% (95% CI, 19.9%-30.6%).[16] There is also a high rate of abortion following rape.[17] Despite an early recognition that a commonly cited reason for seeking abortion is 'relationship problems',[18] there are very few studies about the links between abortion and IPV. There are no published articles on integrated IPV interventions within abortion services. Although context-specific and not generalisable, individual studies about IPV disclosure or intervention in relation to abortion services described in detail in the above mentioned systematic review indicate that: IPV questionnaires may be acceptable in abortion facilities;[19] non-responding women may differ from responders in that they have undergone more abortions;[20] only half the women during a period of universal screening were asked about IPV;[21] some women report IPV-defining events although not identifying themselves as experiencing IPV;[22] many women wish to talk about IPV with regard to further management or intervention,[23] with some citing their doctor as the main source of information;[24] and women in violent relationships appear as likely to attend for follow-up[23] and more likely to know about community resources.[24] Previous situation analyses of abortion generally relate to the provision of safe abortion and quality of care rather than the intersection with IPV.[25,26,27]

Thus, it remains moot whether IPV is accepted as rightful business for the abortion sector, and what training and support healthcare professionals need. In particular, in the UK, there is no policy for screening for IPV. Though health services, social care and the organisations they work with should respond effectively, there is no agreed evidence of benefit of screening.[12]

The aim of this study was to explore the desirability and feasibility of offering IPV services within abortion care in a local setting (two boroughs) in London. A nearby, established, maternity-based service had an integrated IPV service comprising raised awareness, staff training in routine IPV enquiry and referral to a community-based in-reach IPV service. There are posters and leaflets displayed around the service. There is mandatory confidential time with pregnant women at the first visit and a routine question can be asked verbally and 'ticked' as having been asked in a coded way in the hand-held notes. Opportunistic case-based questioning also occurs and generates about half the disclosures. Referral is then made to an onsite IPV service. The IPV service has been evaluated[14] and regularly audited. The hypothesis for this study was that the model of an integrated maternity-based IPV service would be transferable to an abortion setting.

Study setting

The study was conducted in 2012 in a deprived, multi-ethnic, inner city area in London, UK where there is a National Health Service (NHS) funded by taxpayers. Abortion has been legal in England, Wales and Scotland since the 1967 Abortion Act, amended by the Human Fertilisation and Embryology Act 1990. The Act requires that two doctors sign in good faith that one of five legalised provisions is fulfilled and ensure that abortion takes place in a licensed premise, unless there is an emergency. Nationally, abortion is provided free of charge if women are resident in the UK and entitled to NHS care. Different NHS trust contractors agree to different add-on services alongside the abortion itself (e.g., pre-abortion counselling or post-abortion contraception).

In the two study boroughs, the NHS subcontracts all but medically complicated abortions (e.g., maternal cardiac disease/ late diagnosis of foetal abnormality) to two non-governmental, non-profit providers (i.e., three abortion services in total). Both of the providers are contracted by the NHS for provision of abortion and contraception services and receive women from all over the UK and Ireland.

IPV services in the UK consist of policy, criminal justice, non-governmental and local government initiatives. There is no formal screening for IPV in the health service as there is no evidence of benefit, though it has been recognised that a health service response is required.[12] There is limited training of healthcare providers in addressing IPV, and no specialist IPV services were provided in any abortion clinic. There is high-level commitment to talking about violence against women and girls at