Intimate partner violence and women's reproductive health

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Abstract

Intimate partner violence (IPV) is common among women. An estimated 30% of all women globally report having experienced physical or sexual violence by a husband, intimate partner or ex-partner. It is important for those working in reproductive health settings to be aware that sexual assault can occur in the context of relationships. IPV can also include reproductive and sexual coercion. Reproductive coercion includes behaviours that interfere with contraception use and/or pregnancy, while sexual coercion includes behaviours related to pressuring or coercing a person to have sex without using physical force. Past or current IPV in a woman's life can have profound implications for her reproductive and general health, and healthcare providers need to have the skills to identify IPV, and provide appropriate support and referrals as required.

Keywords domestic violence; intimate partner violence; reproductive coercion; reproductive health; sexual assault; sexual coercion; spouse abuse

Background

Intimate partner violence (IPV) is defined as attempted, threatened or actual physical, sexual or mental abuse by a current or former intimate partner. The term "domestic violence" is used in many countries to refer to intimate partner violence but in some settings domestic violence is also used to describe child abuse and neglect, and elder abuse and neglect. Men are the most common perpetrators of IPV against women, although IPV can also occur in same sex relationships, and may be perpetrated by women against men.

Globally, IPV accounts for the largest proportion of the problem of violence against women, with an estimated 30% of women likely to experience physical or sexual IPV in their lifetime. While substantial, it is also likely that these prevalence rates are underestimates, due to the social stigma associated with disclosing victimization. The physical and mental health effects resulting from experience of IPV are also considerable; a consequence of this is that the rates of IPV among women presenting to healthcare services are even greater than IPV rates within the general population. However, IPV is frequently under-recognised by healthcare providers, as many women do not disclose abuse unless they are directly asked about it.

> *"It doesn't matter how rich or poor a person is, what gender or social class, or how much fame or education she possesses. Verbal, mental, and physical abuse can happen to anyone. It doesn't matter what a woman's ethnicity is because the only distinguishing color of abuse is black-and-blue."*
> ***- La Toya Jackson, Starting Over***

One of the reasons that healthcare providers may find identification of IPV a challenge is that it can encompass a broad range of abusive behaviours. The Power and Control Wheel, developed by the Domestic Abuse Intervention Program in consultation with over 200 women who had experienced violence, has been widely used internationally to help people recognize and name the tactics that are used within violent relationships (Figure 1). This model highlights that, through use of these tactics, the abuser can wind up with significant levels of power and control over a woman, in ways that compromise her autonomy. The ability to recognize and help women name these tactics is an important step in helping to identify and counteract the cumulative effects of experiencing abuse. Copies of the Power and Control Wheel are available at: https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf

What are some of the risk factors for intimate partner violence?

Current scholarship seeking to explain the risk factors for being a victim or perpetrator of IPV, emphasize the multifactorial nature of the problem. Influences at the societal, community, relationship and individual levels all play a role. Some of factors that increase a women's vulnerability to IPV and a man's risk of perpetrating IPV across these levels are summarized in Figure 2.

Dynamics of intimate partner violence

A violent episode can be a single act, or a series of violent acts that may persist over a period of minutes, hours, or days. A violent episode may involve single or multiple types violence (e.g. physical violence, sexual violence, psychological/emotional abuse, or all three types together). Violent episodes tend to occur at multiple times throughout an abusive relationship and, without intervention, often increase in frequency and severity over time. The abusive partner can also directly target a woman's reproductive freedom. This can take the form

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Figure 1 Power and control wheel. (Reproduced with kind permission from DOMESTIC ABUSE INTERVENTION PROGRAMS. 202 East Superior Street Duluth, Minnesota 55802. 218-722-2781. www.theduluthmodel.org).

of sexual assault but can also include reproductive coercion and sexual coercion.

Sexual assault

This is an act in which a person intentionally sexually touches another person without their consent, and/or physically forces a person to engage in a sexual act against their will. Sexual assault takes many forms including vaginal or anal penetration or attempted penetration, drug assisted sexual contact, groping, any unwanted oral and/or digital genital contact without that person's consent. Although physical force, which may include strangulation, is commonly utilised by the perpetrator, verbal threats of harm to the victim, her children or family may also be used.

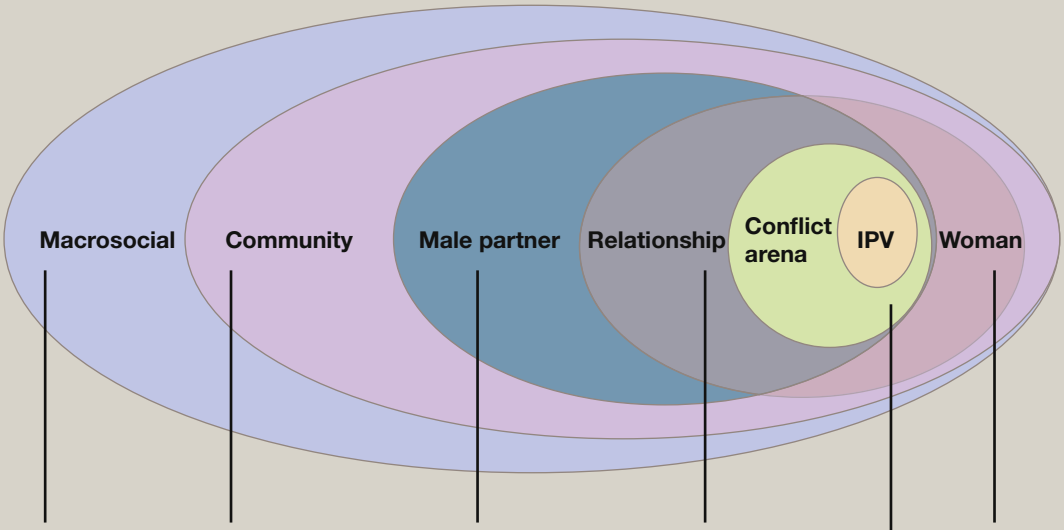
Reproductive coercion: is defined as behaviours that interfere with contraception use and/or pregnancy, such as threatening to end a relationship if the woman does not get pregnant, or if she does not terminate a pregnancy.

Control of contraception (‘birth control sabotage’): internationally, there is evidence that men who use violence against their intimate partners are more likely to interfere with a woman's access to contraception. This can be through controlling her access to healthcare services or family planning care, or through tactics such as hiding or destroying her contraceptive methods (pills, rings, patches), refusing to use a condom, or not withdrawing when that was the agreed upon method of contraception.

Control of pregnancy: women who have experienced IPV are more likely to have an abortion, with one study reporting a 2.5 increased likelihood of abortion. Taken together, these findings, and the findings on pregnancy intendedness also suggest that IPV creates or contributes to a situation in which women are less prepared to have a child, emotionally or financially.

Sexual Coercion: this includes a range of behaviours that a partner may use related to sexual decision-making to pressure or

Revised conceptual framework for partner violence



Gender order

Lack of economic rights & entitlements for women

Discriminatory family law

Ease of divorce for women

Composite measures of gender inequality

Cultural factors

Collectivist versus individual cultural orientation

Emphasis on women's purity & family honour

Economic factors

Level of development

Women's access to formal wage employment

Norms

Acceptance of wife beating

Male right to discipline/ control female behaviour

Tolerance of harsh physical punishment of children

Stigma for divorced or single women

Norms linking male honour to female purity

Family privacy

Lack of sanctions

Lack of legal or moral sanction for violence

Others do not intervene

Neighbourhood

Community violence

High unemployment

Low social capital

Poverty

Violence in childhood

Harsh physical punishment

Witnessing parental violence

Other childhood traumas

Psychological dysfunction

Antisocial behavior

Adult attachment issues

Attitudes

Accepting of violence as a means to resolve conflict

Acceptance of partner violence

Gender hierarchical or transitional attitudes

Alcohol abuse

Gender role conflict

Delinquent peers

Sociodemographic

Young

Low educational level

Interaction

Non-equalitarian decision making

Poor communication

High relationship conflict

Conflict arena

Situational triggers

Sex/infidelity

Money/distribution of family resources

Children or in-laws

Division of labor

Male drinking

Patriarchal triggers

Female challenge to male authority

Failure to meet gender role expectations

Assertions of female autonomy

Childhood violence

Child sexual abuse

Other childhood traumas

Witnessing mother being beaten

Attitudes

Tolerance of wife beating

Socio-demographic

Young age (for current violence)

High educational attainment (protective)

Low social support

Factors that operate differently in different settings:

Women's employment

Participation in credit schemes or other development programs

Asset ownership

Drawn from Heise L. *What works to prevent partner violence? An evidence overview*. London: London School of Hygiene and Tropical Medicine; December 2011.

Figure 2 Revised conceptual framework for partner violence. (From Heise, LL. (2011) What works to prevent partner violence: An evidence overview. London: STRIVE: London School of Hygiene and Tropical Medicine. ISBN: 978 0 902657 85 2. http://strive.lshtm.ac.uk/resources/what-works-prevent-partner-violence-evidence-overview. Reproduced with kind permission.).

coerce a person to have sex without using physical force. Sexual coercion may occur in heterosexual or same sex relationships. Examples include threatening to end a relationship if the person does not have sex; intentionally exposing a partner to a sexually transmitted infection (STI) or HIV; forced non-condom use or not allowing other prophylaxis use; retaliation by a partner if notified of a positive STI result.

Impact of IPV on Women's and Children's health

Given the multiple and recurrent types of IPV that can occur, it is not surprising that there are immediate and long-term physical, mental and reproductive health consequences for women who experience abuse. IPV can also trigger memories of other forms of trauma that the women may have previously experienced such as child sexual abuse and prior sexual assault

Physical injury from IPV can range from minor bruises or cuts to long-term disability or even death. In the United States, homicides accounted for 8.4% of pregnancy-related mortality, the second most common cause of injury-related deaths in pregnancy. In India, up to 16% of deaths during pregnancy were related to domestic violence. Women with violent partners are at increased risk of contracting STIs; violent partners are more likely to have multiple concurrent partners, and forced sex increases the risk of transmission of infection.

IPV can also create a substantial mental health burden for women, with depression, anxiety, phobia, post-traumatic stress disorder (PTSD) and sleep disorders common problems among women who have been abused by their partners. PTSD is characterised by symptoms of intrusive and recurrent recollections, mental or physical distress to trauma-related cues, attempts to avoid trauma-related cues, reliving the trauma through 'flashbacks' and nightmares that persist for longer than one month after the trauma. It is more common after interpersonal trauma such as sexual assault than after non-assault trauma, e.g. car accident. Women who have experienced IPV are also are at heightened risk for suicide and self-harm, alcohol and other substance misuse.

Cumulative mental trauma can alter the structural development of neural networks and the biochemistry of neuroendocrine systems. Long-term health effects which can result from this stress response include accelerating the processes of disease and compromising the immune system. In addition, the body's attempts to mediate trauma-related stress through the production of adrenalin, cortisol and other chemical messengers can become both overloaded and overly reactive, particularly if frequently activated. These biochemical responses may explain some of the observed associations between IPV and chronic pain, symptoms of the central nervous system (headaches, cognitive problems, hearing loss), unexplained chronic genitourinary symptoms (frequent bladder or kidney infections, repeated STI's), gastrointestinal and gynaecological symptoms (pelvic pain, dyspareunia, vaginismus). Exposure to IPV, with attendant effects on maternal stress and depression, have been shown to have epigenetic effects on infants.

Sometimes the way in which a woman presents to access healthcare can indicate that IPV is an underlying issue. For example, women that repeatedly attend for consultations with a wide variety of symptoms with no clear diagnosis, women that repeatedly do not attend appointments or cancel appointments at the last minute, or present with repeated traumatic injuries with vague and/or implausible explanations. In other cases, there are indicators of IPV such as an intrusive partner who will not allow the women to be alone or repeated attendances for pregnancy tests and emergency contraception.

Pregnancy intendedness

Women's experience of violence and sexual and reproductive coercion impacts on pregnancy intendedness (choice to become pregnant). One study reported that 28% of women who had experienced violence during pregnancy "wanted to be pregnant then", compared with 55% of women who had not experienced violence abuse during pregnancy. Women who experienced IPV also reported that their male partners were less likely to want the pregnancy. Intendedness of pregnancy is strongly correlated with parental attachment and bonding to the child, which in turn contributes to later health and social outcomes of the child.

Adverse pregnancy outcomes

Violence during pregnancy has been associated with pregnancy complications including miscarriage, preterm labour, placental abruption, fetal injury, stillbirth and low birth weight. Possible explanations for these associations include:

1. Direct abdominal trauma
2. The abusive partners' controlling behaviours that limit the woman's access to healthcare and other resources to care for themselves during pregnancy
3. The adoption of maternal behaviours that are associated with poor pregnancy outcomes, such as smoking, drug use and poor diet
4. The association between stressful events such as violence, and its impact on the woman's reactive inflammatory response

The USA Centers for Disease Control and Prevention reported that abused women were 1.8 times more likely to have delayed entry into antenatal care, compared to women who had not experienced violence. This late access to antenatal care can be the result of perpetrators of violence not allowing the woman to access care, or because she has to seek care when her partner is not around. The inter-related risks of delay in access to antenatal care, the stress resulting from the experience of IPV, with adoption of high risk behaviours during pregnancy, may all contribute to the increased risk of pregnancy complications.

Violence during pregnancy

There are mixed reports of the degree to which violence within relationships may start, increase or decrease when pregnancy occurs. Various explanations are proposed for IPV starting or increasing during pregnancy. Some authors suggest pregnancy is a time when extra resources and commitment are required in a relationship, which may lead to extra psychological/emotional stress and strain. Other authors report that IPV may result from the male partner's jealousy or resentment of the attention the women is paying the unborn child.

"I remember walking up to her and smacking her full force, I grabbed her by her neck, and I kind of held her against the car. Then, I walked her over to the bushes and threw her in there, and I just started choking her. It was with every bit of rage, every bit of anger I've ever had." ~ Confession of a violent offender

In other cases, pregnancy may act as a protective mechanism when the abusers may make an effort to avoid harming the fetus. This has led some women to become pregnant intentionally to avoid violence. One study reported 53% of women who were in an abusive relationship were not beaten during their pregnancies. In this study, a woman said "I tried to stay pregnant" so that her partner would not abuse her. However, the abuse may restart after the pregnancy ends, with one study reporting that the greatest risk of IPV is immediately after birth when the women is most focused on the care of her baby and less able to perform 'roles and duties' that he sees as necessary. Coerced sex can also be a problem at this stage.

See Table 1 for an additional list of gynaecological and obstetric consequences of exposure to violence and abuse.

Gynaecological and obstetric consequences of lifetime abuse

Gynaecological
Chronic pelvic pain
Dyspareunia
Vulvodynia
Vaginismus
Sexual dysfunction
Premenstrual syndrome/premenstrual dysphoric disorder
Pelvic inflammatory disease
Infertility
Increased STIs, including HIV
Recurrent UTI's
Increased risk of cervical cancer
Obstetric
Teen pregnancies
Unintended pregnancy
Miscarriage
Hyperemesis gravidarum
Preterm labour
Low birth weight
Substance misuse in pregnancy
Trauma/death in pregnancy
Placental abruption
Stillbirth and neonatal death
Post-partum depression

Adapted from Exposure to Violence and Abuse. D. McCollum. See: https://www.avahealth.org/resources/ava_publications/ava_publications_new.html for a more extensive list of health consequences associated with lifetime exposure to violence and abuse.

Table 1

Women's responses to violent relationships: most women in abusive relationships make concerted efforts to maximize their safety and that of their children (i.e. they are not passive victims). However, leaving a violent relationship is difficult if they are subjected to high levels of violent and controlling behavior. Some factors that make it difficult for women to leave violent relationships include:

- Fear of violent retaliation from their partner about attempts to leave
- Lack of alternative means of economic support
- Concern for the loss of a father figure and potential impact on their children
- Lack of support from family and friends or needing to move away from their house and support networks to be safe.
- Fear of losing custody of the children (which is often directly threatened by the perpetrator)
- Love with the hope that the partner will change (i.e. love the person, but want the violent behavior to stop)

The majority of women in abusive situations do eventually leave their abusive partners, sometimes after multiple attempts. Support to do so, accompanied by realistic assessments of the degree to which their partner's violent behaviour is likely to change (or not), an escalation in severity of violence they are experiencing, and desire to protect their children, can all facilitate women's efforts to seek help.

"As painful as it is to admit that we are being abused, it is even more painful to come to the conclusion that the person we love is someone we cannot afford to be around."~ Survivor of domestic violence

What can healthcare providers do about intimate partner violence?

Healthcare providers can do a great deal to help their patients who have or are experiencing IPV. Proactive helping is part of an ethical responsibility on par with contributing to effective provision of sexual and reproductive healthcare. Reproductive healthcare providers, including midwives, nurses, general practitioners and obstetricians, have a unique advantage for assisting with IPV, as they may see the woman multiple times over a relatively short period, and can tap into her desire to ensure optimal health outcomes for herself, her unborn child and/or her children.

However, healthcare providers cannot assist women unless they know that violence is occurring, and unless they take into consideration how violence may be affecting women's ability to access necessary resources and make healthy decisions. Many providers miss opportunities to help by being unaware of the violent situation. Women might choose not to disclose information about the violence because they are afraid that healthcare medical providers may respond in ways that put her at further risk.

In order to support women and their children who are experiencing violence, healthcare providers need to have appropriate systems, support and training to a) identify violence, b) respond

appropriately and assist in appropriate risk assessment, and c) connect women with appropriate local referral systems.

Responding to intimate partner violence

System support

The World Health Organization (WHO) recommends four minimum requirements which need to be in place prior to the implementation of routine inquiry for IPV:

1. A protocol on standard IPV response procedure
2. Staff training on how to ask, and appropriate minimum response guidelines
3. A private setting, and assurance of confidentiality of response
4. A system for referral to appropriate support services

Identification

Healthcare visits provide a window of opportunity to identity IPV. While violence can be identified easily if a patient presents with physical injuries and an implausible explanation, there are a myriad of other clinical presentations that may indicate IPV. Numerous studies have shown that reliance on signs and symptoms alone results in poor identification of women who experience violence. Instead, routine verbal inquiry about the experience of IPV among all patients is recommended.

Routine inquiry during consultations increases identification of IPV, especially when women are screened several times during pregnancy. Women have indicated that, if undertaken with appropriate consideration of privacy and sensitivity, they find routine inquiry is acceptable. Routine inquiry for violence also serves the purpose of increasing knowledge in the general community about the health consequences of violence, removing stigma about experience of violence, and raising awareness among patients that healthcare providers can provide help with this important issue. Most importantly, routine inquiry increases the opportunities to support women who are experiencing IPV to get necessary help and support.

How to ask?

The WHO outlines some guiding principles for healthcare providers asking women about violence in ways that patients find acceptable, with empathy and support (see Appendix 1). Consultations should take place in a private setting when the patient is by herself, without her partner or other family/friends. Introducing the topic and creating a safe environment for assessment and disclosure is also important (Box 1).

It is important to follow up these framing statements with routine enquiries about specific types of abusive behaviours: asking a very general question, such as 'Are you safe at home?' is not effective and is unlikely to result in disclosures of violence.

Direct questions need to be asked about all major types of violence: physical violence, sexual violence, psychological/emotional abuse, and controlling behaviours (Box 2). Asking specifically about each type is necessary to enable you to respond appropriately to, the scope of the violence the person may be experiencing. Questions about feelings of safety are also relevant for identifying situations of stalking, or other experiences that are creating unease.

Examples of Framing Statements

"I don't know if this is a problem for you, but many of the women I see are dealing with situations at home that hurt them or make them scared. Since this can have a big effect on their health, I've started asking about it routinely."

'Because violence affects people's health, I routinely ask all my patients about any violence they may have experienced.'

'We know that family violence is common and affects women's and children's health, so we are asking routinely about violence in the home.'

"When thinking about which method of contraception is best for you, an important factor is whether you can or cannot anticipate when you will have sex. Do you generally feel you can control when you have sex? Has your partner been suggesting any particular form of contraception?

Box 1

Note that while the labels 'physical violence', 'sexual violence' and 'psychological/emotional abuse' are useful as conceptual frames for what might be going on, they are not terms that should be used when first discussing the topic of IPV with an individual patient.

Response and risk assessment after identification of IPV

The Advocacy Empowerment Wheel provides a useful visual reminder of key components of a helpful response to disclosures of IPV (Figure 3). If a woman identifies that she is experiencing violence, it is crucial for the healthcare provider to state that the violence is not her fault and that no one deserves to be abused.

In addition, the healthcare provider can carry out a risk assessment, and make sure women have access to information about safety planning strategies, and information about resources that can provide help [see Appendix 2]. Risk assessment needs to be accompanied by offering appropriate health interventions for the women's reproductive needs, such as:

Examples of routine inquiry questions.

'Within the past year, did anyone scare you or threaten you, or someone you care about? (If so, who did this to you?)'

'Within the past year, did anyone ever try to control you, or make you feel bad about yourself?' (If so, who did this to you?)'

'Within the past year have you been hit, pushed or shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)'

'Within the past year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you? When did this happen (the last time?)'

Note: Consistent with good clinical practice and communication skills, healthcare providers may need to ask these questions in slightly different ways, using different words (the person's words if possible), and verify that they have been understood by the patient. Be prepared to pick up cues from the patient, and seek clarification or expansion as appropriate, e.g., 'What do you mean when you say that your partner is "grumpy"?'

Box 2

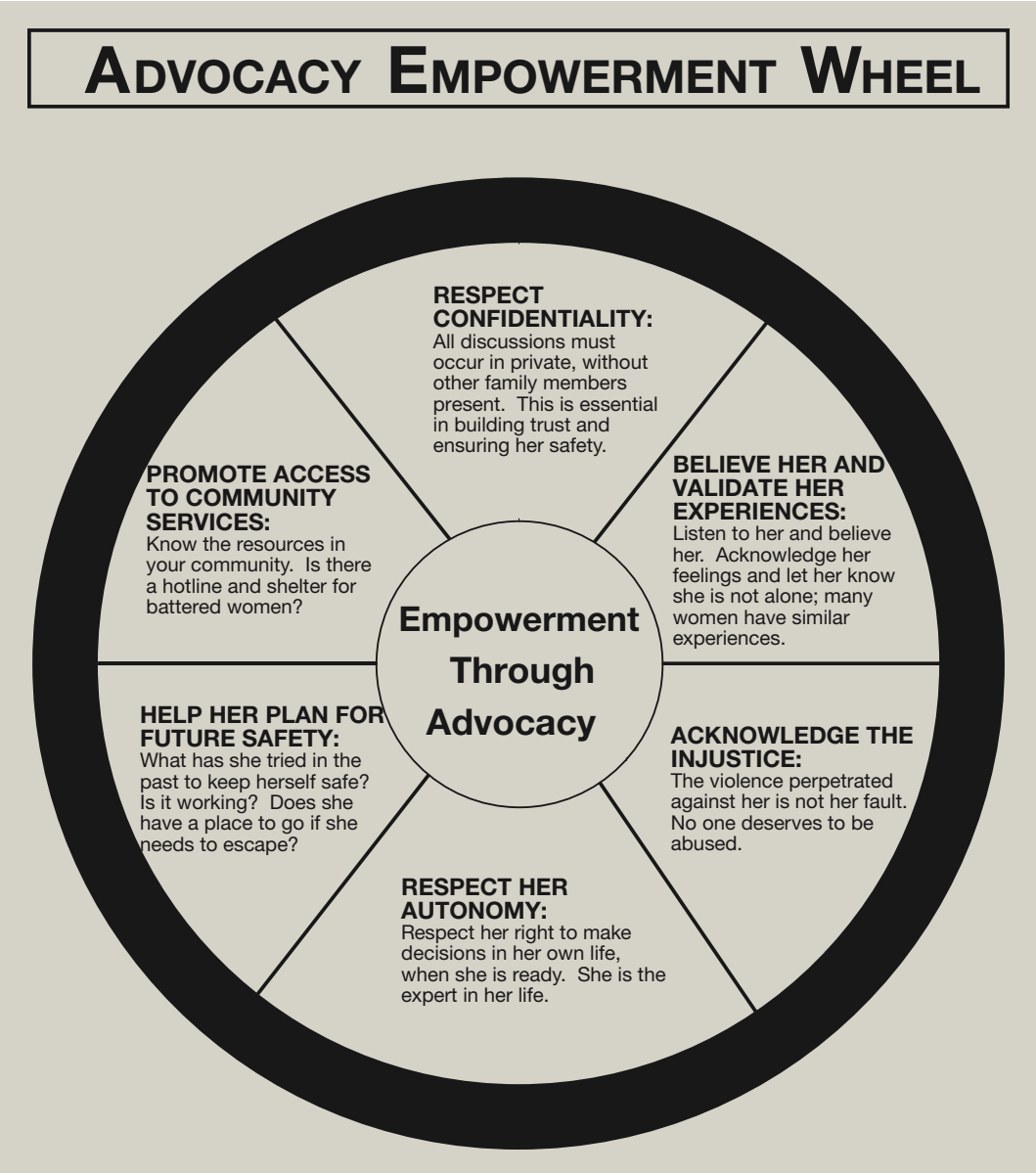


Figure 3 The advocacy empowerment wheel.(Reproduced with kind permission from The National Center on Domestic and Sexual Violence, Austin Texas, USA.).

- Contraceptive counselling (including emergency contraception)
- STI testing
- Pregnancy testing

Developing a safety plan

"Women who received information about safety were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of intimate partner violence" ~ Futures Without Violence

Asking women what strategies they currently use to keep themselves safe if they think that violence or retaliation may occur is a positive way of affirming the woman's power in these situations. These strategies can be built on and supported by assisting women to connect with other services, which may have greater powers to contain, challenge and change the behaviour of the abusive partner.

Appropriate local referral systems

Healthcare providers can also assist women in abusive relationships by referring them to existing support services for IPV, such as women's refuge or the police. As abusive partners may monitor the women's phone, offering patients use of the clinic phone to contact a domestic violence hotline

during the course of the clinical consultation or while she is still within the health service is one strategy to increase access to support services. If women are suffering mental health effects from the trauma of current or past violence, women can also be referred to counseling or psychological therapy, preferably to a service that is equipped to respond to the effects of trauma and abuse.

Healthcare providers can also inform women what legal protections exist for victims, such as protection orders or nonviolence orders. In some cases, if there is a high risk to children, the healthcare provider may need to report this to the child protection service. In such cases, informing the woman about the process of reporting as well as ensuring she gets support for her own safety is imperative.

Documentation and follow-up

Careful documentation of the results of the routine inquiry, the health and safety assessments carried out, the intervention provided, and the referrals made should be undertaken, with due regard to the confidentiality of this information on the patient's medical record (ensuring her abusive partner does not have access to it). This documentation can be of great assistance to the woman when she is trying to access legal protections.

Follow-up should also be scheduled, to ensure that patients' safety and medical needs continue to be appropriately addressed. Careful documentation of contact information for the patient can also be helpful when following up to confirm the patient's safety.

While methodological limitations in studies conducted to date preclude absolute identification of long-term increases in safety, there are promising indications, such as studies which have shown how interventions undertaken by healthcare providers can contribute to significant increases in women's safety behaviours and produce improvement in emotional function. Other studies have shown that supportive advocacy in community settings can reduce the frequency of revictimization relative to non-treatment controls.

Overall, if healthcare providers take an active and knowledgeable role in responding to IPV, they can play a crucial part in supporting the safety of women and their children.

Policy implications and systems response

Internationally, work has shown that change in healthcare provider response to victims of IPV is more likely where there is support for such change from the wider healthcare system. This includes having written guidelines or protocols of care for IPV, but also systemic supports such as leadership support, resources including posters and cue cards, training, and strong links with external support services. Annual audits of IPV screening and intervention practices are also helpful, particularly when coupled with feedback to the providers and management about concrete strategies for improving responses.

True prevention of violence against women will require changing societal and individuals' attitudes towards IPV; cross sectoral efforts involving education, media, justice, and other sectors; and stronger responses to perpetrators. Healthcare providers can be a strong contributor to this effort by actively engaging in the early identification of, and effective response to, IPV. ◆

"Break the silence. When you witness violence against women and girls, do not sit back. Act." ~ Ban Ki Moon, United Nation Secretary-General

Appendix 1. WHO Guiding Principles

Promote women's autonomy and dignity by:

- Being aware of the power dynamics and norms that perpetuate violence against women
- Reinforce her value as a person
- Respect her dignity
- Listening to her story, believing her, and taking what she says seriously
- Not blaming or judging her
- Providing information and counselling that help her to make her own decisions.

LIVES

Listen	Listen to the woman closely, with empathy, and without judging
Inquire about needs and concerns	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g., childcare)
Validate	Show her that you understand and believe her. Assure her that she is not to blame.
Enhance Safety	Discuss a plan to protect herself from further harm if violence occurs again.
Support	Support her by helping her connect to information, services and social support.

Reprinted from: Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. World Health Organization, pages 4-5, and 100 (2013).

Appendix 2. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ogrm.2019.09.003.

FURTHER READING

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Practice Points

- Violence during pregnancy has been associated with pregnancy complications including miscarriage, preterm labour, placental abruption, fetal injury, stillbirth and low birth weight.
- Healthcare systems need to: have policies and procedures in place about response to IPV; provide staff training; and ensure appropriate local referral systems are in place.
- To provide the best care for their patients, healthcare providers should actively engage in routine inquiry (screening) and risk assessment about IPV.
- Healthcare providers can also assist women by making sure they have access to information about safety planning strategies, and information about resources that can provide help, such as women's refuge or police.
- In addition to helping the woman to consider her personal safety strategy, the healthcare provider can also offer appropriate health interventions for the women's reproductive and gynaecology needs.
- Careful documentation of the results of the routine inquiry, the health and safety assessments carried out, the intervention provided, and the referrals made should be undertaken, and appropriate follow-up should be scheduled.