Appendix C: Guideline and Systematic Review Search Results

	Year	*Title*	*Summary*
AHRQ: Research Findings and Reports	2019	Can Physical Activity Improve the Health of Wheelchair Users? A Systematic Review	In-progress
	2018	Achieving Health Equity in Preventive Services: Systematic Evidence Review	In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2012	Closing the Quality Gap Series: Quality Improvement Interventions To Address Health Disparities	The literature on QI interventions generally and their ability to improve health and health care is large. Whether those interventions are effective at reducing disparities remains unclear. This report should not be construed to assess the general effectiveness of QI in the health care setting; rather, QI has not been shown specifically to reduce known disparities in health care or health outcomes. In a few instances, some increased effect is seen in disadvantaged populations; these studies should be replicated and the interventions studied further as having potential to address disparities.
Cochrane Collection Reviews	2015	Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse	Intensive advocacy may improve everyday life for women in domestic violence shelters/refuges in the short term and reduce physical abuse one to two years after the intervention. There is no clear evidence that intensive advocacy reduces sexual, emotional, or overall abuse, or that it benefits women's mental health. It is unclear whether brief advocacy (mostly given in healthcare settings) is effective, although it may provide short-term mental health benefits and reduce abuse, particularly in pregnant women and those suffering less severe abuse. We considered the results of several studies to be potentially biased because of weak study designs. There was little consistency between studies, with variations in the amount of advocacy given, the type of benefits measured, and the lengths of follow-up periods. As a result, it was hard to combine their results, and we cannot be certain of how much advocacy interventions benefit women or the impact of the type of advocacy, the place it was given, or the severity of the abuse experienced by the women receiving the intervention.

	2015	Screening women for intimate partner violence in healthcare settings	The evidence shows that screening increases the identification of women experiencing IPV in healthcare settings. Overall, however, rates were low relative to best estimates of prevalence of IPV in women seeking healthcare. Pregnant women in antenatal settings may be more likely to disclose IPV when screened, however, rigorous research is needed to confirm this. There was no evidence of an effect for other outcomes (referral, re-exposure to violence, health measures, harm arising from screening). Thus, while screening increases identification, there is insufficient evidence to justify screening in healthcare settings. Furthermore, there remains a need for studies comparing universal screening to case-finding (with or without advocacy or therapeutic interventions) for women's long-term wellbeing in order to inform IPV identification policies in healthcare settings.
	2014	Interventions for preventing or reducing domestic violence against pregnant women	There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy outcomes. There is a need for high-quality, RCTs with adequate statistical power to determine whether intervention programs prevent or reduce domestic violence episodes during pregnancy, or have any effect on maternal and neonatal mortality and morbidity outcomes.
Health Technology Assessment Program	None		
Centers for Disease Control and Prevention		https://www.cdc.gov/sexualhealth/	
Institute for Clinical and Economic Review	None		

Veterans Administration Evidence-based Synthesis Program	2013	Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches	We also identified six SRs that evaluated interventions aimed at decreasing exposure to IPV. None of these SRs assessed primary IPV prevention strategies; all summarized literature on secondary prevention strategies such as screening for IPV. Overall, screening in health care settings increases identification of IPV victimization and appears to be feasible and acceptable. Screening alone, however, does not decrease rates of IPV victimization. Other secondary prevention strategies (behavioral interventions, advocacy interventions) provide insufficient evidence to demonstrate significant changes in IPV or IPV-related mental or physical harms.
The American College of Obstetricians and Gynecologists	2015	Racial and Ethnic Disparities in Obstetrics and Gynecology	Reducing racial and ethnic disparities in health and health care should be a priority for all obstetrician–gynecologists and other women's health care providers. Obstetrician–gynecologists can help to meet this objective by • raising awareness among colleagues, residents, staff, and hospital administrators about the prevalence of racial and ethnic disparities and the effect on health outcomes • understanding the role that practitioner bias can play in health outcomes and health care • strongly encouraging the adoption of federal standards for collection of race and ethnicity information in clinical and administrative data to better identify disparities • promoting research that not only identifies structural and cultural barriers to care but also tests the effectiveness of interventions to address such barriers • educating patients in a culturally sensitive manner about steps they can take to prevent disease conditions that are prevalent in their racial and ethnic groups • supporting and assisting in the recruitment of obstetrician–gynecologists and other health care providers from racial and ethnic minorities into academic and community health care fields

2012 (reaffirmed 2019)	Intimate Partner Violence	Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women's health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women's preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.
2017	Domestic Violence	FAQs
2014	Interactive site for clinicians serving women with disabilities	• Part 1 includes an overview of the program,The Scope of Disability in Women, and Psychosocial Issues. • Part 2 includes The GYN Examination, GYN Health Screening, Sexually Transmitted Disease and Skin Examination • Part 3 encompases Medical and Reproductive Considerations. Modules indlude: Contraception; Menses and Abnormal Uterine Bleeding; Pregnancy and Parenting; Urinary and Bowel Considerations; Diet, Physical Activity and Weight; Adolescent Health; and Aging and Osteoporosis. • Part 4 encompases Reproductive Health Specific to Disability. Modules include: Spinal Cord Injury, Spina Bifida, Multiple Sclerosis, Cerebral Palsy, Intellectual and Developmental Disabilities, and Sensory Disabilities. • Part 5 encompases Access to Health Care. Modules include: ADA Requirements and Incentives, Disability Culture, and Universal Design/Office Practice Solutions • Part 6 is the Resources Section with links to resources for providers, patients and those who care for them.
2001	Abuse Assessment Screen	Many women with disabilities are at risk for abuse, however standard screening tools may not unveil abuse common to women with disabilities such as with holding assistance or treatment. McFarlane, J, et al. Abuse Assessment Screen-Disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. J of Women's Health and Gender-Based Medicine 2001;10(9):861-866.

2015	Health Care for Unauthorized Immigrants	Unauthorized (undocumented) immigrants are less likely than other residents of the United States to have health insurance. The American College of Obstetricians and Gynecologists has long supported a basic health care package for all women living within the United States without regard to their country of origin or documentation. Providing access to quality health care for unauthorized immigrants and their children, who often were born in the United States and have U.S. citizenship, is essential to improving the nation's public health.
2018	Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care	The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician–gynecologists and other health care providers to improve patient-centered care and decrease inequities in reproductive health care: • Inquire about and document social and structural determinants of health that may influence a patient's health and use of health care such as access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions. • Maximize referrals to social services to help improve patients' abilities to fulfill these needs. • Provide access to interpreter services for all patient interactions when patient language is not the clinician's language. • Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health. • Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors. • Advocate for policy changes that promote safe and healthy living environments.