

# Sex Workers' Experiences of Screening for Intimate Partner Violence

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## ABSTRACT

**Objective:** To examine experiences of intimate partner violence (IPV) screening among women who sell sex.

**Design:** A qualitative descriptive study.

**Setting:** Telephone interviews during the COVID-19 pandemic (June 2020 to October 2020).

**Participants:** Women aged 18 to 49 years who sold or traded sex for food, drugs, money, or shelter at least three times during the past 3 months before recruitment ( $N = 22$ ).

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**Methods:** We used individual, semistructured telephone interviews to collect data about participants' experiences with IPV and IPV screening during health care encounters. We used reflexive thematic analysis to examine these data.

**Results:** We identified two overarching themes related to IPV screening experiences: *Preferences for IPV Screening* and *Barriers to Disclosure of IPV Experiences*. Participants described a preference for IPV screening done face-to-face with providers who show a genuine interest in their responses. Stigma was a barrier of IPV disclosure.

**Conclusion:** Health care providers are a trusted safety net for disclosure of IPV experiences. Providing screening in a trauma-informed, nonstigmatizing manner may facilitate disclosure of IPV by women who sell sex. Future research among marginalized populations is needed to examine ways to address IPV in clinical settings with a harm reduction empowerment lens.

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Intimate partner violence (IPV), defined as physical, sexual, and/or psychological violence by an intimate partner, is a public health issue that affects nearly one third of women in the United States (Smith et al., 2018). Intimate partner violence is associated with significantly worse physical and mental health outcomes for women, including sexually transmitted infections, unintended pregnancy, and posttraumatic stress disorder (Stubbs & Szoek, 2021). Women who experience IPV are seen by health care providers acutely related to a violent episode, chronically for health consequences from violence, or regularly as part of routine care (Stubbs & Szoek, 2021).

## Literature Review

Experiences of IPV are more common among women who sell sex (WSS) than among women in the general U.S. population (Sherman et al., 2019; Zemlak et al., 2021). As many as 50% to 90% of WSS in street-based settings (women who

exchange sex for food, drugs, money, shelter, or goods and meet clients in public settings or on the street) experience IPV (Zemlak et al., 2020) compared with 30% of women in the general U.S. population (Smith et al., 2018). Street-based WSS often experience violence from different types of sexual partner perpetrators within and outside of the occupation (Deering et al., 2014). Intimate sexual partners (partners who do not pay for sex), clients (people who pay for sex), and/or pimps/managers perpetrate this violence (Decker et al., 2020), often through encounters that overlap in time.

The prevalence of violence within and outside of the occupation is associated with worse mental and physical health outcomes for WSS. Experiences of violence threaten their health by limiting their agency to safely engage and advocate for health-promoting practices. Thus, WSS who experience IPV were significantly more likely to engage in sex without a condom, which increases the risk of HIV infection, sexually

## Many women who sell sex experience violence; however, their experiences with intimate partner violence screening are not well-understood.

transmitted infections, and unintended pregnancy (Peitzmeier et al., 2020). Experiencing IPV was also associated with worse symptoms of depression, anxiety, and posttraumatic stress disorder (Kanayama et al., 2022; Park et al., 2019), which exacerbates the downstream mental and physical health consequences for WSS.

The American College of Obstetricians and Gynecologists (2021) and the U.S. Preventive Services Task Force (2018) published practice guidelines for health care providers and recommended screening for IPV as an essential step to link women to support and follow-up care. Screening for IPV, however, remains inconsistent. For example, as few as 27% of women who received care in family planning clinics or primary care clinics reported being screened for IPV by their providers (Ramaswamy et al., 2019). Some health care providers hesitated to screen patients for IPV because of lack of training, time constraints, or lack of available referral networks for patients who disclose IPV (Ibrahim et al., 2021). However, screening for IPV might be an important component to delivering trauma-informed care through recognition of the prevalence and effect of violence and trauma in women's lives (Decker et al., 2017; Roberts et al., 2019).

Screening can offer health care providers an opportunity to provide education about IPV and to link survivors to support services. Most WSS use health care services regularly. In a study among WSS in Baltimore, Maryland ( $N = 218$ ), nearly half of participants (45%) reported having a regular provider (i.e., a primary care provider), 50% had been to the emergency department during the past 3 months, and most (80%) had health insurance (Zemlak et al., 2021). However, reports of experiences of IPV screening among marginalized women such as WSS are largely absent from the published literature despite the high prevalence of violence experienced in this population. Understanding IPV screening experiences among these women may have important implications for improving referrals to IPV support services.

Best practices for implementing screening among women more likely to experience

cumulative traumatic episodes due to extensive experiences of violence by multiple perpetrators remain limited (Zemlak et al., 2021). The current clinical screening paradigm links disclosure to the provision of resources or referrals (Auster et al., 2023). Women who sell sex often experience stigma within the health care system that results in delayed care, unsatisfactory experiences, and diminished capacity to disclose ongoing violence exposures (Rocha-Jiménez et al., 2018). These biases likely diminish the frequency and quality of IPV screening questions in a health care setting (Ma & Loke, 2019; Zemlak et al., 2020). Clearer understanding of experiences of IPV screening among WSS may lead to tailored interventions to improve IPV screening among marginalized populations of women. Therefore, the purpose of our study was to examine experiences of IPV screening among WSS.

## Methods

### Design

For this study, we used a qualitative descriptive design, which is used to elicit straightforward descriptions of experiences and perceptions (Sandelowski, 2010). Researchers focus on discovering the nature of specific events. A qualitative descriptive design is particularly helpful to understand the health experiences of populations who have traditionally been silenced; those whose voices are not often heard or represented in research (Doyle et al., 2020). We aligned this study design with the aim of obtaining a "true understanding" of experiences of IPV screening among WSS. We carefully monitored confidentiality and data security and obtained institutional review board approval from Johns Hopkins Bloomberg School of Public Health. We attended to consolidated criteria for reporting qualitative research (COREQ) guidelines in planning and reporting of this study (Tong et al., 2007). These guidelines include a 32-item checklist for comprehensive reporting of qualitative studies.

### Setting

This qualitative study was nested within a parent study called Enabling Mobilization, Empowerment, Risk Reduction, and Lasting Dignity (EMERALD), a longitudinal cohort study among street-based WSS in Baltimore, Maryland (Sherman et al., 2021). In the EMERALD study, researchers recruited 385 women from September 2017 to January 2019 using a

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targeted sampling frame to identify times and places sex work is likely to occur (Allen et al., 2018).

### Participants

Eligibility criteria for the EMERALD study included age 18 years or older; assigned female sex at birth and identify with female gender; exchanged sex for money, goods, or drugs in Baltimore City at least three times during the past 3 months; willing to undergo testing for HIV, gonorrhea, and chlamydia; and willing to provide locator information (e.g., phone number, e-mail address, Facebook Messenger). Exclusion criteria included inability to provide written consent in English, impaired related to alcohol or drug use, cognitive impairment, and enrolled in the SAP-PHIRE study (a previous cohort study among street-based sex workers in Baltimore City). Participants were eligible to participate in this qualitative study if they were part of the EMERALD study cohort, age 18 to 49 years, and willing to participate in one interview to discuss interpersonal relationships, violence, and sexual relationships.

### Data Collection

During the COVID-19 pandemic (June 2020 to October 2020), we recruited women to participate in the qualitative study through contact via preferred contact methods (e.g., phone numbers, e-mail, Facebook Messenger) provided as part of EMERALD study participation. We read an institutional review board-approved verbal consent form to eligible and interested women, and if they provided verbal consent they were enrolled in the qualitative study. The method of data collection for this study was telephone interviews. One researcher, the first author (J.Z.) conducted the interviews. We encouraged participants to be in safe private places during the interviews because their safety and comfort were priorities. The interviewer used verbal check-ins to assess their comfort and willingness to continue the interview. Throughout the recruitment process, the interviewer kept a reflexive journal to log thoughts and perceptions and to record various topics, including flow of the interview, initial thoughts, and possible data meanings. We developed a trigger protocol with referrals in place for participants who experienced distress or safety concerns. We audio-recorded interviews that lasted 45 to 60 min. We mailed participants a \$50 Visa gift card to compensate them for their time. We sent completed audio recordings for professional

transcription, and then J.Z. checked them for accuracy and completeness.

**Interview guide.** We developed a semi-structured interview guide to facilitate a discussion regarding experiences with IPV screening. After initial questions to build rapport, we asked participants about their experiences of violence and then about their past experiences with IPV screenings. The first author (J.Z.) used a reflexive journal kept during recruitment to guide minor adjustments to the interview guide. Sample questions and prompts from the interview guide included the following: (a) "Describe your experience with health care providers asking you about intimate partner violence"; (b) "How important is it for health care providers to ask you about experiences of violence?"

### Data Analysis

We used the six-step, reflexive thematic analysis method described by Braun and Clarke (2022). Consistent with this reflexive thematic analytic method, in Step 1 the researchers (J.Z. and D.W.) familiarized themselves with the data by listening to audio-recorded interviews, reviewing professionally transcribed transcripts, and rereading the entire data set. After becoming familiar with the data, we began Step 2: generating codes. We considered that certain semantic codes were likely related to how questions were phrased. For example, we used semantic codes that closely communicated the statements of participants (e.g., "health care provider asked about violence"). Throughout the coding process, we also developed latent codes that reflected meanings beyond the surface level (e.g., "resilience"). We kept reflective memos during coding and throughout the analysis process and used them to discuss our experiences of coding, interpretation of the data, and coding decisions. After coding transcripts, we began Step 3: generating themes. During this process, we used memos, used word clouds, and established codes to identify patterns and potential themes to arrive at Step 4: reviewing potential themes. Once initial themes were constructed and defined, we mapped them out in Excel spreadsheets with definitions and exemplar quotes in Step 5: defining and naming themes. We met to discuss, review, and name the themes. When we wrote our report/results, team members again reviewed themes and refined selection of exemplar quotes that highlighted the voice of participants (Step 6: producing the report).

## Health care providers inconsistently use intimate partner violence screening, which limits opportunities for linking survivors to support services.

We carefully considered our own positions and the lenses through which we viewed the data in the analysis process. Our identities, personal experiences, and professional roles were important to consider as we interpreted data. All members of the team identify as cisgender women. The first author (J.Z.) and three other team members are nurses with clinical experience in caring for members of marginalized populations and survivors of IPV. The first author is a nurse practitioner who has cared for WSS in her practice. Her clinical experience of providing violence screening and sexual and reproductive health services to marginalized women within the U.S. health care system shaped the development of the research question. The senior author (S.S.) on our team has more than two decades of experience in conducting research and uses a harm reduction lens when leading projects with and for WSS. Our team members have expertise in public health, violence research, HIV prevention, social determinants of health, and structural drivers of health inequities. These areas of expertise shaped how we considered our final presentation of the results and their interpretation in our discussion.

## Results

### Participant Characteristics

A total of 22 women aged 24 to 45 years (mean = 34.7) participated in a single semi-structured interview. Women who sell sex often have different types of sexual partners. Over their lifetimes, all the participants in our study had client sexual partners and intimate sexual partners. Lifetime experiences of violence by one or both partner types were common, with 18 participants (82%) reporting client-perpetrated violence and 12 (55%) reporting IPV. Most participants ( $n = 20$ , 91%) identified their race as White. More than one third of the participants ( $n = 8$ , 36%) were able to recall being screened for IPV by a health care provider, but 14% ( $n = 4$ ) were unsure if they were screened in the past. Participants described accessing care in varied settings such as the emergency department, primary care, and the offices of obstetricians-gynecologists.

### Themes

We identified two overarching themes in our analysis: *Preferences for IPV Screening* and *Barriers to Disclosure of IPV Experiences*.

**Preferences for IPV Screening.** We identified two subthemes in the first overarching theme, *Preferences for IPV Screening: Consistency* and *"They Should Care Enough to Ask."*

**Consistency.** In response to questions and prompts regarding IPV screening experiences, one participant who survived IPV noted that IPV screening practices were absent: "I've never been asked anything by a doctor like that" (Participant 27). Despite absent or inconsistent screening practices, participants valued dependable and regular screening: "I think it's definitely important [screening for IPV]. I don't see a lot of doctors do that" (Participant 27). Similarly, another participant acknowledged how disclosure seemed more likely with screening: "No, I have not been asked. If you are asked by a doctor, you might open up" (Participant 40).

Among those who recalled being screened for IPV, participants reported that IPV screening had occurred primarily in the offices of obstetricians-gynecologists or with primary care providers with whom they had established trusting relationships. When asked to describe health care encounters that included IPV screening, one participant recalled most often being screened by her primary care provider: "The doctor, she covers a lot. ... She makes it known that if I need her, I can always call her. I don't feel uncomfortable. I know I can call her. It's nice to know" (Participant 436).

Participants noted that screening occurred only after a relationship was formed and their providers knew them well. These screenings occurred more often during visits for injuries or sexually transmitted infections instead of as part of routine care. One participant described disclosing an abusive relationship when she was screened by a primary care provider with whom she had a trusting relationship:

I was in several relationships that were physically violent. I stayed with the same doctor for years. I was going to the doctor for black eyes or hiding bruises on my arms. I was open with them and told them I was in a physically abusive relationship. (Participant 98)



Other participants noted that they were routinely screened during obstetrician-gynecologist visits for prenatal care: "That's the first question they ask: Am I in an abusive relationship, and am I scared to get out of it?" (Participant 40). Another noted, "I know the [obstetrician-gynecologist] doctor does [ask about IPV]. He has experience on people who are abused" (Participant 101). The screenings at obstetricians-gynecologists' visits often felt integrated as a regular routine aspect of care.

**"They Should Care Enough to Ask."** Under the second subtheme, participants described a preference for being asked about IPV consistently with each health care encounter and expressed how this step showed that providers cared about their well-being and understood the potential effect of violence on women's mental and physical well-being. However, one participant acknowledged the challenge associated with self-disclosure:

Because, you know, it [IPV] goes on a lot of the time, you know. It's hard to, um, you know, talk to people about it. But you know, if you're asked about it, you know, by a doctor and you might open up. I think they should at least care enough to ask. (Participant 303)

Participants described feeling cared for when health care providers asked about violence:

I think it's really important for providers to ask because sometimes a patient might not feel comfortable bringing it up. If a provider lets her know "I'm here, you're safe, this is a safe spot, you could talk to me," they might feel more open about talking about it. (Participant 341)

Participants saw health care providers as potential safety nets. One survivor of client-perpetrated violence stated the following:

That's [screening for IPV] super important. There's a lot of women that are not going to answer truthfully. If they're asked the question every time, and there's only one woman that asks for help, and it only saves one person from being hurt, well it would be worth it, right? (Participant 436)

Participants noted that consistent screening with each encounter allowed them to consider

disclosure of IPV at a time that felt best for them: "I think it's important in a way because you never know that the person that you're asking is currently going through a situation like that at that time, and you could save them from that" (Participant 105).

**Barriers for Disclosure of IPV Experiences.** The second overarching theme, *Barriers to Disclosure of IPV Experiences*, included two subthemes: *Stigma* and *Ineffective Screening Methods*.

**Stigma.** Some participants described how they felt judged by health care providers because of the frequency of their visits for reproductive concerns, sex work, and substance use and indicated that these experiences prevented them from disclosing violence. One participant described her low expectations for a health care provider's response to her disclosure: "I want one that didn't judge me or treat me like I was a piece of shit" (Participant 303).

Participants who felt stigmatized during health care encounters described barriers to building trusting relationships with providers. They indicated that they kept experiences of violence private because they feared that divulging violence in addition to substance use or sex work would result in judgment: "... because you don't want to just get instantly judged [by the health care providers]. Even if they didn't say anything about it [sex work], they're going to have their own opinion. Everyone does" (Participant 105).

**Ineffective Screening Methods.** Participants described the varied IPV screening protocols (e.g., face-to-face, before visit survey) used by health care providers. Many advocated for IPV screening, but they felt that implementation was important and could facilitate or hinder disclosure. For example, one participant described how IPV screening practices could feel uncaring: "It was very clinical. I mean, [the family planning clinic] approaches it [asking about IPV] a little bit, but I feel it was in and out and not a very therapeutic way" (Participant 315).

Participants noted that they preferred to be asked about IPV face-to-face by a provider who was genuinely interested in learning about their experiences. Based on participant responses, ineffective screening seemed to correlate with the provider's need to fill out a form rather than actual concern for the patient:

## Providers should use trauma-informed and healing-centered approaches to develop trust with women and facilitate their disclosure of intimate partner violence.

Yeah, I think they should directly ask. ... When you're back in the exam room, 9 times out of 10 you'll be back there—you [the health care provider] can see someone's reaction. You [the health care provider] can judge better by asking someone a question and reading them than you can on some paper. (Participant 318)

Participants reported the ability to sense whether providers asked out of obligation or genuine concern for patients' well-being:

I feel like it's important, but they need to experiment in doing it in different ways. It was like they asked, but it was a quick overpass. I felt like I would bother them if I told them about my situation. It felt like that. (Participant 361)

Participants favorably viewed providers who allowed time and safe space for disclosure by asking about IPV with genuine interest. They preferred when providers initiated screening because they were uncomfortable with starting the conversation. Asking about IPV face-to-face allowed providers to assess comfort levels and nonverbal cues that could be missed using a paper questionnaire.

## Discussion

Our findings provide valuable insights that deepen understanding of preferences for IPV screening and barriers to disclosure among WSS. Participants valued being screened for IPV; however, barriers such as stigma and ineffective screening practices influenced their willingness to disclose. Participants felt there was value in screening for IPV using a nonstigmatizing approach, and the presence of a trusting relationship and use of trauma-informed approaches were critical to increase willingness to disclose IPV. Our results have important implications for IPV screening for WSS and for women from other marginalized populations.

Participants in our study wanted to be screened for IPV; however, they described inconsistent practices similar to women in other studies on IPV screening (Miller et al., 2021; Perone et al., 2022).

Previous researchers described provider barriers to screening for IPV, including personal resistance to a change in practice (Saber et al., 2023), discomfort with the topic, time constraints, absence of safety plans, and lack of support for women who report IPV (Palmieri & Valentine, 2021). In some instances, participants described an absence of screening or a sense that screening was rushed. These instances may be exacerbated among WSS because of stigma about their occupation, high rates of drug use, and other factors and may reflect provider- or health care system-level barriers that impede IPV screening.

Often, the absence of IPV screening in a visit is presented as a provider-level issue (Sharpless et al., 2018). However, this position fails to acknowledge that health care systems are responsible for building infrastructure that adequately supports providers so they can screen. This infrastructure must include adequate time for trust-building visits, appropriate training in trauma-informed care, an interdisciplinary approach to safety planning (Bair-Merritt et al., 2014), and effective referral mechanisms. Infrastructure building should be a priority within health care systems because IPV is not a rare occurrence for women who seek health care and carries significant ramifications for mental and physical health. Thus, providing the necessary systematic support for screening has potential benefits to significant patient populations.

Some participants described how screening felt like a compulsory component of a visit rather than the provider's genuine interest in potential violence. In these experiences, participants felt that providers failed to recognize the effect that trauma can have on all facets of patients' lives. Disclosing trauma, even long after the traumatic event, can be triggering and retraumatizing for many women (Palmieri & Valentine, 2021). Thus, nurses and other care providers who screen for IPV must also be trained in trauma-informed care. Screening for IPV with a trauma-informed approach may promote disclosure in a way that is not retraumatizing. The experiences of participants in our study highlight that screening alone is insufficient and that screening with a trauma-informed approach is warranted (Decker et al., 2017). In fact, current strategies call for development of healing-centered approaches that are not centered on disclosure as the prioritized outcome (Auster et al., 2023).

Healing-centered engagement approaches may be particularly well-suited for use with members of marginalized populations such as WSS because of their focus on partnership and empowerment, which aligns with the screening preferences described by WSS (Auster et al., 2023). Healing-centered approaches are strengths-based approaches that move beyond focusing on harm and injury with a shift in focus from “what happened to you” to “what’s right for you” (Ginwright, 2018). For example, in current IPV screening paradigms with a focus on “what happened to you” (i.e., violence), a response of “no” about abuse might not result in additional discussion of IPV in a clinical setting. The use of motivational interviewing techniques using a healing-centered engagement approach may help care providers to shift from disclosure-driven practice to practice grounded in the autonomy and strengths of patients (Auster et al., 2023). The provision of universal education (e.g., brief education regarding healthy relationships and IPV resources) and harm reduction counseling regarding IPV in each clinical encounter, regardless of IPV disclosure, may result in more meaningful discussions and future downstream benefits (Todahl et al., 2020). This approach was effective among adolescent family planning patients (Miller et al., 2015). In a randomized control trial, participants who received universal education on relationship abuse from their care providers showed improved recognition and knowledge about sexual coercion compared with those who received usual care. Notably, participants who engaged more intensively with the intervention, such as having discussions with a health care provider or receiving an educational brochure, demonstrated increased knowledge of relationship abuse resources and self-efficacy to use harm reduction behaviors (Miller et al., 2015). Research on the implementation of healing-centered approaches, universal education, routine screening, and care planning is ongoing (Miller et al., 2018). These approaches should be examined in primary and acute care settings, and future research on the use of alternatives to IPV screening, such as healing-centered engagement, among WSS is warranted.

Nurses and other health care providers should also receive adequate training on the downstream health effects of violence. Among WSS, IPV was associated with more mental health symptoms (Park et al., 2019), greater risk of HIV infection (Peitzmeier et al., 2020), and unintended pregnancy (Zemlak et al., 2021). If health care

providers are aware of these downstream consequences, they will be more prepared to incorporate IPV disclosure into holistic health care planning inclusive of HIV risk reduction, unintended pregnancy prevention, and mental health management. Care planning in these cases can expand to include discussions about pre-exposure prophylaxis for HIV (Jeffers et al., 2022) and woman-controlled contraceptive methods (Zemlak et al., 2021).

### Implications for Practice

Health care for WSS must be safe, and the provider must recognize consensual sex work as legitimate work (Cimino, 2014). A focus on building trust rather than enforcing strategies for alternative work centers on the needs of WSS rather than minimizing the complexity of their work (Cimino, 2019; Preble et al., 2016). Nurses work in a variety of settings in which WSS seek care; they are trained and well-positioned to meet WSS where they are and to serve as leading health advocates for survivors of IPV. This holistic care approach, grounded in a trusting relationship, might improve health outcomes among women who experience violence.

### Limitations

The findings of our study should be considered in light of some limitations. We conducted the study when COVID-19 stay-at-home policies limited in-person research. We contacted participants by telephone, which may have resulted in a sample of women with more structural stability than women who are street-recruited. Participants’ recent experiences with IPV screening may have been affected by varied access to in-person health care related to the COVID-19 pandemic during the study recruitment period. The participants in our study were part of a larger longitudinal cohort study. The experiences of WSS in our study may be different from those of WSS who chose not to participate. Finally, the data represent the perceptions and recollections of IPV screening of participants; we did not observe the process directly.

### Conclusion

Our findings highlight that the study participants, who were WSS, highly valued screening for IPV, yet they experienced screening for IPV inconsistently. Disclosure of IPV was more likely to occur in settings of trusting care provider relationships with adequate safety planning. Efforts to integrate IPV screening into care setting are needed and should explore use of healing-centered

approaches. Future holistic care initiatives for violence-exposed women must include significant health system support for trauma-informed care, IPV screening, and increased access to care.

### CONFLICT OF INTEREST

The authors report no conflicts of interest or relevant financial relationships.

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### REFERENCES

- Allen, S. T., Footer, K. H. A., Galai, N., Park, J. N., Silberzahn, B., & Sherman, S. G. (2018). Implementing targeted sampling: Lessons learned from recruiting female sex workers in Baltimore, MD. *Journal of Urban Health*, 96(3), 442–451. <https://doi.org/10.1007/s11524-018-0292-0>
- American College of Obstetricians and Gynecologists. (2021). Caring for patients who have experienced trauma: ACOG Committee Opinion. Number 825 *Obstetrics & Gynecology*, 137(4), e94–e99. <https://doi.org/10.1097/aog.0000000000004326>
- Auster, L., Chang, J., & Miller, E. (2023). Healing justice frameworks and motivational interviewing: Supporting survivors of intimate partner violence. In A. Douaihy, T. M. Kelly, & M. A. Gold (Eds.), *Motivational interviewing: A guide for medical trainees* (2nd ed., chap. 12). Oxford University Press.
- Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., ... Cronholm, P. (2014). Primary care-based interventions for intimate partner violence: A systematic review. *American Journal of Preventive Medicine*, 46(2), 188–194. <https://doi.org/10.1016/j.amepre.2013.10.001>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.
- Cimino, A. (2014, January). *Online and street-based sex work exposed: Differences in perceived risk and stigma*. Paper presented at the Society for Social Work and Research 2014 annual conference, San Antonio, TX. [https://www.researchgate.net/publication/268106372\\_Online\\_and\\_Street-Based\\_Sex\\_Work\\_Exposed\\_Differences\\_in\\_Perceived\\_of\\_Risk\\_and\\_Stigma](https://www.researchgate.net/publication/268106372_Online_and_Street-Based_Sex_Work_Exposed_Differences_in_Perceived_of_Risk_and_Stigma)
- Cimino, A. (2019). Uncovering intentions to exit prostitution: Findings from a qualitative study. *Victims & Offenders*, 14(5), 606–624. <https://doi.org/10.1080/15564886.2019.1628144>
- Decker, M. R., Park, J. N., Allen, S. T., Silberzahn, B., Footer, K., Huettner, S., ... Sherman, S. G. (2020). Inconsistent condom use among female sex workers: Partner-specific influences of substance use, violence, and condom coercion. *AIDS and Behavior*, 24(3), 762–774. <https://doi.org/10.1007/s10461-019-02569-7>
- Decker, M. R., Flessa, S. F., Pillai, R. V., Dick, R. N., Quam, J., Cheng, D., ... Miller, E. (2017). Implementing trauma-informed partner violence assessment in family planning clinics. *Journal of Women's Health*, 26(9), 957–965. <https://doi.org/10.1089/jwh.2016.6093>
- Deering, K., Amin, A., Shoveller, J., Nesbitt, N., Garcia-Moreno, C., Duff, P., ... Shannon, K. (2014). A systematic review of the correlates of violence against sex workers. *American Journal of Public Health*, 105(5), e42–e54. <https://doi.org/10.2105/AJPH.2014.301909>
- Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, 25(5), 443–455. <https://doi.org/10.1177/1744987119880234>
- Ginwright, S. (2018). *The future of healing: Shifting from trauma informed care to healing centered engagement*. <https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c>
- Ibrahim, E., Hamed, N., & Ahmed, L. (2021). Views of primary health-care providers of the challenges to screening for intimate partner violence, Egypt. *Eastern Mediterranean Health Journal*, 27(3), 233–241. <https://doi.org/10.26719/emhj.20.125>. PMID: 33788212
- Jeffers, N. K., Zemlak, J. L., Celius, L., Willie, T. C., Kershaw, T., & Alexander, K. A. (2022). "If the partner finds out, then there's trouble": Provider perspectives on safety planning and partner interference when offering HIV pre-exposure prophylaxis (PrEP) to women experiencing intimate partner violence (IPV). *AIDS and Behavior*, 26, 2266–2278. <https://doi.org/10.1007/s10461-021-03565-6>
- Kanayama, Y., Yamada, H., Yoshikawa, K., & Aung, K. W. (2022). Mental status of female sex workers exposed to violence in Yangon, Myanmar. *Asia Pacific Journal of Public Health*, 34(4), 354–361. <https://doi.org/10.1177/10105395221083821>
- Ma, H., & Loke, A. Y. (2019). A qualitative study into female sex workers' experience of stigma in the healthcare setting in Hong Kong. *International Journal for Equity in Health*, 18, Article 175. <https://doi.org/10.1186/s12939-019-1084-1>
- Miller, C. J., Adjognon, O. L., Brady, J. E., Dichter, M. E., & Iverson, K. M. (2021). Screening for intimate partner violence in healthcare settings: An implementation-oriented systematic review. *Implementation Research and Practice*, 2. <https://doi.org/10.1177/26334895211039894>
- Miller, E., Beach, S. R., ... Thurston, R. C. (2018). Addressing intimate partner violence and abuse of older or vulnerable adults in the healthcare setting—Beyond screening. *JAMA Internal Medicine*, 178(12), 1583–1585. <https://doi.org/10.1001/jamainternmed.2018.6523>
- Miller, E., Goldstein, S., McCauley, H. L., Jones, K. A., Dick, R. N., Jetton, J., & Tancredi, D. J. (2015). A school health center intervention for abusive adolescent relationships: A cluster RCT. *Pediatrics*, 135(1), 76–85. <https://doi.org/10.1542/peds.2014-2471>
- Palmieri, J., & Valentine, J. L. (2021). Using trauma-informed care to address sexual assault and intimate partner violence in primary care. *Journal of Nurse Practitioners*, 17(1), 44–48. <https://doi.org/10.1016/j.nurpra.2020.08.028>
- Park, J. N., Decker, M. R., Bass, J. K., Galai, N., Tomko, C., Jain, K. M., ... Sherman, S. G. (2019). Cumulative violence and PTSD symptom severity among urban street-based female sex workers. *Journal of Interpersonal Violence*, 36(21–22), 10383–10404. <https://doi.org/10.1177/0886260519884694>
- Peitzmeier, S. M., Wirtz, A. L., Peryshkina, A., Sherman, S., Colantuoni, E., Beyrer, C., & Decker, M. R. (2020). Associations between violence and HIV risk behaviors differ by perpetrator among Russian sex workers. *AIDS and Behavior*, 24(3), 812–822. <https://doi.org/10.1007/s10461-019-02668-5>



- Perone, H. R., Dietz, N., Belkowitz, J., & Bland, S. (2022). Intimate partner violence: Analysis of current screening practices in the primary care setting. *Family Practice*, 39(1), 6–11. <https://doi.org/10.1093/fampra/cmab069>
- Preble, K., Praetorius, R., & Cimino, A. (2016). Supportive exits: A best practices report for a sex worker intervention. *Journal of Human Behavior in the Social Environment*, 26(2), 162–178. <https://doi.org/10.1080/10911359.2015.1082852>
- Ramaswamy, A., Ranji, U., & Salganicoff, A. (2019, November). Intimate partner violence (IPV) screening and counseling services in clinical settings. Women's Health Policy. Kaiser Family Foundation. <https://files.kff.org/attachment/Issue-Brief-Intimate-Partner-Violence-IPV-Screening-and-Counseling-Services-in-Clinical-Settings>
- Roberts, S. J., Chandler, G. E., & Kalmakis, K. (2019). A model for trauma-informed primary care. *Journal of the American Association of Nurse Practitioners*, 31(2), 139–144. <https://doi.org/10.1097/JXX.000000000000116>
- Rocha-Jiménez, T., Morales-Miranda, S., Fernández-Casanueva, C., Brouwer, K. C., & Goldenberg, S. M. (2018). Stigma and unmet sexual and reproductive health needs among international migrant sex workers at the Mexico–Guatemala border. *International Journal of Gynecology & Obstetrics*, 143(1), 37–43. <https://doi.org/10.1002/ijgo.12441>
- Saberi, E., Hutchinson, M., & Hurley, J. (2023). Implementing intimate partner violence (IPV) screening within emergency departments—Barriers, challenges and enablers experienced by intimate partner violence practice change champions. *International Emergency Nursing*, 69, Article 101311. <https://doi.org/10.1016/j.ienj.2023.101311>
- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health*, 33(1), 77–84. <https://doi.org/10.1002/nur.20362>
- Sharpless, L., Nguyen, C., Singh, B., & Lin, S. (2018). Identifying opportunities to improve intimate partner violence screening in a primary care system. *Family Medicine*, 50(9), 702–705. <https://doi.org/10.22454/FamMed.2018.311843>
- Sherman, S. G., Park, J. N., Galai, N., Allen, S. T., Huettner, S. S., Silberzahn, B. E., ... Footer, K. H. A. (2019). Drivers of HIV infection among cisgender and transgender female sex worker populations in Baltimore City: Results from the SAPHIRE study. *Journal of Acquired Immune Deficiency Syndromes*, 80(5), 513–521. <https://doi.org/10.1097/QAI.0000000000001959>
- Sherman, S. G., Tomko, C., White, R. H., Nestadt, D. F., Silberzahn, B. E., Clouse, E., ... Galai, N. (2021). Structural and environmental influences increase the risk of sexually transmitted infection in a sample of female sex workers. *Sexually Transmitted Diseases*, 48(9), 648–653. <https://doi.org/10.1097/OLQ.0000000000001400>
- Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2018). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data brief—Updated release*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. <https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf>
- Stubbs, A., & Szoek, C. (2021). The effect of intimate partner violence on the physical health and health-related behaviors of women: A systematic review of the literature. *Trauma, Violence, and Abuse*, 23(4), 1157–1172. <https://doi.org/10.1177/1524838020985541>
- Todahl, J., Nekkanti, A., & Schnabler, S. (2020). Universal screening and education: A client-centered protocol for normalizing intimate partner violence conversation in clinical practice. *Journal of Couple & Relationship Therapy*, 19(4), 322–346. <https://doi.org/10.1080/15332691.2020.1835595>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
- U.S. Preventive Services Taskforce. (2018, October 23). Intimate partner violence, elder abuse, and abuse of vulnerable adults: Screening [Final Recommendation Statement]. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening>
- Zemlak, J. L., Bryant, A. P., & Jeffers, N. K. (2020). Systematic review of contraceptive use among sex workers in North America. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 49(6), 537–548. <https://doi.org/10.1016/j.jogn.2020.08.002>
- Zemlak, J. L., White, R. H., Nestadt, D. F., Alexander, K. A., Park, J. N., & Sherman, S. G. (2021). Interpersonal violence and contraceptive method use by women sex workers. *Women's Health Issues*, 31(6), 516–522. <https://doi.org/10.1016/j.whi.2021.08.001>