A DEADLY GAP: THE NEED FOR LEGAL INFRASTRUCTURE TO REDUCE THE INTERSECTION BETWEEN MATERNAL AND FETAL MORTALITY AND INTIMATE PARTNER VIOLENCE

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Homicide is a leading cause of death among pregnant people and those who have recently given birth in the United States. These murders are often linked to intimate partner violence ("IPV"). Despite existing legal, medical, and social interventions, current efforts fail to adequately prevent these deaths, leaving pregnant survivors of IPV at risk of death or serious injury. This is an urgent issue as the United States' maternal mortality rate ranks last among developed countries. While academic research examines the intersectionality of IPV, maternal and fetal mortality, and other negative outcomes, there is little discussion on how to implement preventative safety measures for pregnant people or a push for legal reform to reduce such mortality. This Article argues for an integrated approach that includes expanding legal protections for survivors of IPV through state legislation and regulations, as well as through existing medical and social systems. Part I of the Article provides background on maternal and fetal mortality, its prevalence, and its intersection with IPV and provides a comprehensive research and data overview recognizing IPV as the leading cause of death amongst pregnant people. Part II analyzes some of the legal protections that should be implemented by states to combat the devastating consequences that

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pregnant survivors face. Some of the areas that are identified as in need of legal reform in Part II include targeting the abusive partners with mandatory firearm relinquishment in protective orders and including pregnancy as an aggravating circumstance; combatting reproductive coercion by incorporating reproductive coercion into state protective order statutes and providing abortion access; supporting survivors by incorporating doula-led care in state Medicaid statutes; providing employment protections for pregnant and postpartum survivors; having mandatory IPV screenings during prenatal medical visits; and ensuring the scope of birthright citizenship is not narrowly tailored. Part III conducts a comparative analysis of international strategies to address IPV in pregnant populations, offering insights for more effective death prevention efforts. It concludes by highlighting the urgency in bringing law, medicine, and social services into alignment to prevent maternal and fetal mortality and the death sentence that may await survivors if there is no implementation of the protections this Article advances.

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Introduction

Despite the clear connection between Intimate Partner Violence ("IPV") and maternal health outcomes, few jurisdictions explicitly address pregnancy as a unique vulnerability within their domestic violence frameworks. IPV research infrastructure has been largely developed and understood through the experiences of heterosexual cisgender women, historically excluding transgender people and nonbinary identifying individuals from its body of knowledge, despite the prevalence of IPV among those populations.[1] Thus, despite a research study conducted by the American Journal of Public Health indicating that transgender participants were 1.66 times more likely than cisgender participants to experience any type of IPV, the body of scholarship investigating how this higher rate of IPV correlates with the high mortality rates of transgender and nonbinary pregnant people is nonexistent.[2] I highlight this disparity at the start of this Article to provide a disclaimer that, while this Article strives to be inclusive, the lack of research on birthing parent mortality and non-cisgender female pregnancy links with IPV will be evident through precise usage of gendered and non-gendered verbiage.

This Article examines how states can reform their laws and enact policies to help reduce maternal and fetal mortality and other complications that arise from IPV. It provides a comparative analysis of the regimes that exist in various states, as well as internationally, to identify existing gaps in the law and to highlight different legal reforms to combat IPV-related death suffered by pregnant people. These proposals include mandatory firearm relinquishment when someone is subject to a protective order, aligning with the precedent set forth in *United States v. Rahimi*.[3] They also include recognizing reproductive coercion as a form of domestic violence in protective order statutes, allowing pregnant survivors to obtain protective orders on that basis.[4]

1. Sarah M. Peitzmeier et al., *Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-Analysis of Prevalence and Correlates*, 110 Am. J. Pub. Health e1, e9 (2020).

2. *Id.* at e3.

3. United States v. Rahimi, 602 U.S. 680 (2024).

4. Cal. Fam. Code § 6320(b) (West 2022); 720 Ill. Comp. Stat. 5/12-39 (2025); Mass. Gen. Laws ch. 209A, § 1 (2024); N.Y. Penal Law § 135.60(10) (McKinney 2020); R.I. Gen. Laws §§ 15-15-1(4)(iii), 15-15-3(a) (2025); Wash. Rev. Code § 7.105.010(4)(a)(H) (2022).

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Another proposal seeks to maintain access to abortion care, which is often connected to reproductive coercion. Further, for pregnant people seeking protective orders, the proposals would either automatically grant the maximum duration of protection or require courts to consider pregnancy as an aggravating factor when determining the order's length.[5] An often overlooked proposal that would provide support for survivors is incorporating doula-led care into state Medicaid statutes. This would ensure survivors have support throughout pregnancy and childbirth, helping to reduce the risk of complications or death. Additionally, employers should be required to provide paid prenatal leave. This would allow pregnant people to attend medical appointments without losing income or facing workplace repercussions for missed work.[6] An additional healthcare-related reform would be mandating comprehensive IPV prenatal screenings for survivors at each appointment with medical providers, coupled with training medical professionals on domestic violence and the risks faced by pregnant survivors.[7] Finally, given the heightened risk that birthright citizenship rights may be stripped away, this Article recommends adopting state-level preventative measures to protect pregnant non-citizens from being entrapped into an abusive relationship to ensure they can seek medical care without fear of being apprehended by immigration authorities.[8]

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5. Fla. Stat. § 784.045(2) (West 2021); 720 Ill. Comp. Stat. 5/12-3.05(d)(2) (2022); Mass. Gen. Laws ch. 265, § 13A(b) (2024); Or. Rev. Stat. § 163.160(3)(d) (2023) (elevating Fourth Degree Assault to Class C felony); Del. Code Ann. tit. 11, § 606 (2024).

6. N.Y. Lab. Law § 593(b)(i) (McKinney 2024); N.Y. Exec. Law § 296(1)(a), (c)–(d) (McKinney 2024); *see also Fair Treatment in the Workplace: Know Your Rights as a Victim of Domestic Violence*, Off. of the N.Y. Att'y Gen. (June 3, 2025), https://ag.ny.gov/publications/victims-domestic-violence [https://perma.cc/F8RM-CT53].

7. Jeanne L. Alhusen et al., *Intimate Partner Violence During Pregnancy: Maternal and Neonatal Outcomes*, 24 J. Women's Health 100, 102–03 (2015); *see also* U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults*, 320 J. Am. Med. Ass'n 329, 329 (2018) [hereinafter U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*]; Janet Yuen-Ha Wong et al., *Intimate Partner Violence During Pregnancy: To Screen or Not to Screen?*, Best Prac. & Rsch. Clinical Obstet. & Gynecol., Sep. 2, 2024, at 1.

8. This Article was written before the Supreme Court's ruling that the Fourteenth Amendment's Citizenship Clause guarantees birthright citizenship to children born in the United States regardless of their parents' immigration status, thereby foreclosing the heightened risk mentioned here and throughout the relevant Section. *See Trump v. Barbara*, 609 U.S. ___ (2026). The concerns identified here and throughout Section II.C.4. remain instructive and important to protecting pregnant people whose lives are at risk due to their immigration status. The analysis continues to illustrate how efforts to restrict a child's citizenship can uniquely exacerbate the vulnerability of pregnant survivors of IPV by increasing their dependence on abusive partners. Moreover, these considerations remain relevant to state policymakers evaluating legislation that affects the rights, legal status, or access to services of immigrant families and survivors of IPV.

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The existing legal literature on maternal and fetal mortality and intimate partner violence has largely focused on postnatal abuse and its implications for custody and protective orders. This sole focus could leave judges minimizing, or even overlooking, abuse that occurs during pregnancy, especially if there is an absence of physical injury to the child or immediate postnatal danger.[9] Legal academia has increasingly discussed the intersection of domestic violence and maternal health, particularly highlighting the need for legal frameworks that recognize and address the full spectrum of reproductive coercion and its impact on pregnant individuals and their children, beyond physical injury.[10] This inconsistency has prompted some scholars and advocates to call for a more explicit legal recognition of the harms that are caused by domestic violence during pregnancy—that is, not only to the pregnant parent, but to the child's long-term well-being as well.[11] Fewer scholars have examined how laws can be reformed to combat maternal and fetal mortality that results from intimate partner violence.

This Article argues for statutory reforms, policy changes, and training and education to better protect pregnant survivors. Part I provides a comprehensive overview of the research and data that identifies and supports the conclusion that IPV is the leading cause of death amongst pregnant people. Part II examines existing laws aimed at addressing IPV during pregnancy and focuses on a range of proposed legal reforms. Finally, Part III compares international strategies addressing intimate partner violence in pregnant populations to more effectively prevent maternal and fetal mortality and other complications.

I. Intimate Partner Violence Is the Leading Cause of Mortality Among Pregnant People

In the United States, Intimate Partner Violence ("IPV") is a leading cause of maternal and fetal mortality.[12] Homicide is the most significant risk factor for death during pregnancy and the postpartum period in the United

9. *See* Tosta v. Bullis, 943 A.2d 824, 829 (N.H. 2008).

10. Hillary Sotomayor, *Reproductive Coercion: A Systematic Review*, 16 Aisthesis 8, 8 (2025).

11. Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 Ind. L.J. 667, 700 (2006).

12. Rebecca B. Lawn & Karestan C. Koenen, *Homicide Is a Leading Cause of Death for Pregnant Women in US*, BMJ, Oct. 19, 2022, at 1; Jacqueline Campbell et al., *Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence*, 30 J. Women's Health 236, 236 (2020) (maternal mortality defined as "death that is attributable to a condition that is unaffected by the pregnancy and occurs within 1 year of the pregnancy").

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States, with strong correlations to IPV.[13] The Division of Reproductive Health at the Centers for Disease Control and Prevention ("CDC") reports that women in the United States are more likely to be murdered during pregnancy or soon after childbirth than to die from the three leading obstetric causes of maternal mortality (hypertensive disorders, hemorrhage, or sepsis).[14] Empirical research has shown that IPV impacts up to 34% of pregnant women.[15] Trauma during pregnancy, including abuse, is associated with fetal morbidity and adverse birth outcomes.[16]

IPV during pregnancy can lead to pregnancy complications for both the birthing person and the fetus.[17] Adverse outcomes include preterm birth, miscarriage, fetal growth restriction, and placental abruption.[18] A child born to a person who suffered from IPV while pregnant can have neurological or physical developmental issues after birth or, worse, neonatal death.[19] Infants born to parents experiencing intimate partner violence have higher rates of compromised immune function, which can result in long-term health issues.[20] More studies indicate that stress from intimate partner violence leads to suboptimal fetal brain development, contributing to cognitive and behavioral difficulties later in life.[21] Infants

13. Maeve E. Wallace et al., *Homicide During Pregnancy and the Postpartum Period in the United States, 2018–2019*, 138 Obstet. & Gynecol. 762, 762–66 (2021) [hereinafter Wallace et al., *Homicide During Pregnancy*].

14. Andrea Creanga et al., *Maternal Mortality and Morbidity in the United States: Where Are We Now?*, 23 J. Women's Health 3, 5 (2014).

15. Jiandi Ma & Shuai Zhang, *Prevalence and Risk Factors of Intimate Partner Violence Among Pregnant Women: A Systematic Review and Meta-Analysis*, 25 BMC Pregnancy & Childbirth 1, 7 (2025); Albany Law School, *Maternal Fetal Complications and IPV* (YouTube, Apr. 7, 2023), https://www.youtube.com/watch?v=kDaNWweFS7Q.

16. Michelle B. Mulder et al., *The Unborn Fetus: The Unrecognized Victim of Trauma During Pregnancy*, 55 J. Pediatric Surgery 938, 938 (2020).

17. Jocelyn T. Greely et al., *Violence Against Pregnant Women and Adverse Maternal/Fetal Outcomes in the United States: Racial/Ethnic Disparities*, 62 Women & Health 513, 513 (2022); *Violence and Pregnancy*, Ctrs. for Disease Control & Prevention (Dec. 5, 2024), https://www.cdc.gov/intimate-partner-violence/about/violence-and-pregnancy.html [https://perma.cc/LP78-4Y9P] [hereinafter *Violence and Pregnancy*].

18. Greely et al., *supra* note 17, at 514.

19. Lucy V. Hiscox et al., *Antenatal Maternal Intimate Partner Violence Exposure Is Associated with Sex-Specific Alterations in Brain Structure Among Young Infants*, 60 Developmental Cognitive Neuroscience, Feb. 2023, at 1; Vijyeta R. Jagtap & Padmaja Y. Samant, *Association of Adverse Pregnancy Outcomes and Domestic/Intimate Partner Violence*, 6 Int'l J. Reprod., Contraception, Obstet. & Gynecol. 2527, 2528 (2017).

20. Bethany Kotlar et al., *The Impact of the COVID-19 Pandemic on Maternal and Perinatal Health: A Scoping Review*, Reprod. Health, Jan. 18, 2021, at 35–36.

21. Alhusen et al., *supra* note 7, at 102; *see also* B.M. Donovan et al., *Intimate Partner Violence During Pregnancy and the Risk for Adverse Infant Outcomes: A Systematic Review and Meta-Analysis*, 123 British J. Obstet. & Gynecol. 1289, 1296 (2016).

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exposed to IPV in utero may develop signs of trauma, which can make them less resilient in stressful situations, more susceptible to increased stress levels, and have reduced attention capacity.[22]

IPV during pregnancy not only poses immediate physical risks, but also contributes to long-term health disparities and structural harms.[23] Pregnant people who experience IPV are more likely to delay prenatal care or receive inadequate care, suffer from maternal depression,[24] and be more susceptible to substance abuse.[25] Because of vulnerabilities like these, a pregnant person experiencing IPV is three times as likely to die while pregnant or postpartum as those who do not.[26]

These outcomes contribute to the United States' already high maternal mortality rate, which is the highest among developed and high-income countries.[27] According to a study tracking this crisis, there were approximately 22 deaths for every 100,000 live births in 2022.[28] That is more than double, and sometimes even triple, the rate in other high-income and comparable countries.[29] This reality disproportionately affects Black women, as they are three times more likely to die from pregnancy-related causes than their white counterparts.[30] According to a staggering statistic recorded by the CDC, in 2021, just one year

22. Isabelle Mueller & Ed Tronick, *Early Life Exposure to Violence: Developmental Consequences on Brain and Behavior*, FRONTIERS BEHAV. NEUROSCIENCE, July 2019, at 1.

23. *Violence and Pregnancy*, *supra* note 17.

24. *Intimate Partner Violence and Pregnancy and Infant Health Outcomes — Pregnancy Risk Assessment Monitoring System, Nine U.S. Jurisdictions*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 5, 2024), https://www.cdc.gov/mmwr/volumes/73/wr/mm7348a1.htm [https://perma.cc/VUQ5-NV3S]; Sristy Agarwal et al., *A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health*, CUREUS, May 20, 2023, at 1; Alexander Testa et al., *Intimate Partner Violence and Barriers to Prenatal Care*, SOC. SCI. & MED., Mar. 2023, at 1.

25. Brittany Jamieson, *Exposure to Interpersonal Violence During Pregnancy and Its Association with Women's Prenatal Care Utilization: A Meta-Analytic Review*, 21 TRAUMA, VIOLENCE & ABUSE 904, 907–14 (2020); Donovan et al., *supra* note 21, at 1296.

26. Guadalupe Pastor-Moreno et al., *Intimate Partner Violence During Pregnancy and Risk of Fetal and Neonatal Death: A Meta-Analysis with Socioeconomic Context Indicators*, 222 AM. J. OBSTET. & GYNECOL. 123, 123–31 (2019); Jamieson, *supra* note 25, at 905; Murina Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, COMMONWEALTH FUND (June 4, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison [https://perma.cc/8WRZ-EGT7].

27. Gunja et al., *supra* note 26.

28. *Id.*

29. *Id.*

30. *Maternal Mortality in the U.S. Declined, Though Disparities in the Black Population Persist*, POL'Y CTR. FOR MATERNAL MENTAL HEALTH (Feb. 7, 2025), https://policycentermmh.org/maternal-mortality-in-the-u-s-a-declining-trend-with-persistent-racial-disparities-in-the-black-population/ [https://perma.cc/XH5F-CZTS].

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before the previously mentioned statistic, the maternal mortality rate for Black women was 69.9 deaths for every 100,000 live births.[31] Black, Indigenous, and people of color experience higher rates of maternal mortality due to the intersectional systems of racial, economic, and gender-based oppression.[32] This vulnerability often makes pregnancy a high-risk time for the onset or escalation of IPV, as abusers may leverage the pregnancy to exert greater control, solidify dependence, or interfere with reproductive autonomy.[33]

Multiple research studies have confirmed that IPV is a significant contributor to maternal and fetal mortality in the United States.[34] One study published by the American College of Obstetricians and Gynecologists ("ACOG") analyzed data from female victims aged 15–44 years old identified in the CDC's National Violent Death Reporting System from 2008 to 2019.[35]

The National Violent Death Reporting System collects information about violent deaths from death certificates, coroner/medical examiner reports, and law enforcement reports.[36] Researchers identified pregnancy-associated deaths, defined as those that occurred during or within one year of pregnancy.[37] The study found that, of the 38,417 female victims identified, 10,411 had known pregnancy status.[38] Of those with known pregnancy status, 3,203 died by homicide and 7,208 died by

31. Donna L. Hoyert, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stat., Maternal Mortality Rates in the United States, 2021 (2023).

32. Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, Kaiser Fam. Found. (Dec. 3, 2025), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/ [https://perma.cc/4STG-4PFU]; *see also* Greely et al., *supra* note 17, at 513.

33. Denise Monroe, *Empowering Survivors: Why Abortion Access Is Crucial for Victims of Reproductive Coercion*, Provide (Oct. 8, 2024), https://providecare.org/blog/empowering-survivors-why-abortion-access-is-crucial-for-victims-of-reproductive-coercion/ [https://perma.cc/E5KB-G8DA].

34. Christie Lancaster Palladino et al., *Homicide & Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System*, 118 Obstet. & Gynecol. 1056, 1056 (2011); *see* Grace Keegan et al., *State-Level Analysis of Intimate Partner Violence, Abortion Access, and Peripartum Homicide: Call for Screening and Violence Interventions for Pregnant Patients*, 238 J. Am. Coll. Surgeons 880, 880–83 (2024); Alhusen et al., *supra* note 7, at 102.

35. Anna M. Modest, Laura C. Prater & Naima T. Joseph, *Pregnancy-Associated Homicide and Suicide: An Analysis of the National Violent Death Reporting System, 2008–2019*, 140 Obstet. & Gynecol. 565, 565 (2022).

36. *National Violence Death Reporting System (NVDRS)*, Ctrs. for Disease Control & Prevention (Aug. 25, 2025), https://www.cdc.gov/nvdrs/about/index.html [https://perma.cc/RWS8-4S5T].

37. Modest et al., *supra* note 35, at 566.

38. *Id.* at 568.

suicide.[39] In other words, of those 10,411 with pregnancy status, 3,203 died by homicide, concluding that nearly one-third (30.8%) of those recorded with pregnancy status who died were killed.[40] This ultimately led researchers to conclude that mental health problems, substance use disorders, and IPV are preceding circumstances to pregnancy-associated suicide and homicide. Firearms were involved in 68.3% of pregnancy-associated homicide deaths.[41] Individuals who died by pregnancy-associated homicide were predominantly Black or African American, single or never married, and had less than a high school diploma.[42] Most chilling of all, pregnancy-associated homicide deaths amounted to 20% of all homicide deaths.[43]

Data collected and assessed by the Centers for Disease Control and Prevention over the past thirty-five years show how intimate partner violence during pregnancy can contribute to maternal mortality.[44] One national study reviewed the prevalence, demographic characteristics, and possible factors leading to each cause of death and found that pregnancy-associated homicides made up 8.4% of reported maternal mortality deaths between 1991 and 1999.[45] Additionally, a more recent study (2005–2020) analyzed homicide rates among pregnant or postpartum women from death certificates in thirty-seven states with enhanced pregnancy mortality surveillance and estimated that the pregnancy-associated homicide rate was 2.2 to 6.2 per 100,000 live births.[46] The CDC also created a Pregnancy Risk Assessment Monitoring System which looked at data from 2016 to 2022 across nine U.S. jurisdictions.[47] It revealed that, during that period, 40% of homicides among persons known to be pregnant or within a year of pregnancy were related to IPV.[48] Further, of the participants surveyed, 5.4% self-reported to have experienced any type of IPV during pregnancy.[49]

The National Domestic Violence Hotline is the only national organization that provides direct, free, and confidential services to

39. *Id*.
40. *Id.*
41. *Id.* at 569.
42. *Id.* at 568.
43. *Id.* at 569.
44. Campbell et al., *supra* note 12, at 236–37.
45. *Id.* at 237.
46. *Id.*
47. Megan Steele-Baser et al., *Intimate Partner Violence and Pregnancy and Infant Health Outcomes—Pregnancy Risk Assessment Monitoring System, Nine U.S. Jurisdictions, 2016–2022*, 73 Morbidity & Mortality Wkly. Rep. 1093, 1093 (2024).
48. *Id.*
49. *Id.*

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anyone affected by domestic violence.[50] Established in 1996 following the passage of the Violence Against Women Act ("VAWA"), the organization is in a unique position to collect information and gain insight on the intersections of domestic violence and primary healthcare.[51] Thus, they administered a voluntary, post-interaction, anonymous survey, which found that 53% of participants reported that their abusive partners controlled or restricted their access to healthcare.[52] These barriers exacerbate health risks for both the parent and the child, contributing to higher rates of perinatal death and negative maternal health.[53]

Reproductive coercion, a form of intimate partner violence, has been linked to poor maternal and fetal health outcomes.[54] A study conducted by doctors and published in the American Journal of Obstetrics & Gynecology found that, among the 641 surveyed women seeking obstetric and gynecological care, 16% reported experiencing reproductive coercion.[55] The study was completed by women aged 18–44 years as a self-administered, anonymous survey.[56] Among the women who experienced reproductive coercion, 32% reported that they were also facing IPV within the same relationship.[57] The researchers ultimately concluded that, because of the prevalent relationship between the two existing experiences, doctors should routinely screen for and assess reproductive-age women in order to properly treat them and make recommendations where necessary.[58]

As defined by the CDC, a pregnancy-related death is a death from a pregnancy complication during pregnancy or within one year of the end of pregnancy.[59] The CDC estimates that more than 80% of pregnancy-related deaths in the United States are preventable.[60] Among the contributing factors are missed opportunities for screening, insufficient patient follow-up, and lack of culturally competent or trauma-informed

50. Nat'l Domestic Violence Hotline, Intersections of Domestic Violence and Primary Healthcare Focus Survey (2021).

51. *Id.*

52. *Id.*

53. Alhusen et al., *supra* note 7, at 102.

54. *Id.*

55. Lindsay E. Clark et al., *Reproductive Coercion and Co-Occurring Intimate Partner Violence in Obstetrics and Gynecology Patients*, 210 Am. J. Obstet. & Gynecol. 42.e1, 42.e1 (2014).

56. *Id.*

57. *Id.*

58. *Id.*

59. *Preventing Pregnancy-Related Deaths*, Ctrs. for Disease Control & Prevention (Sep. 25, 2024), https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html [https://perma.cc/6LQ6-PUKZ] [hereinafter *Preventing Pregnancy-Related Deaths*].

60. *Id.*

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care. Critically, all of these conditions can be, and often are, intensified in the context of intimate partner violence.[61] Pregnant survivors have reported feeling unsafe disclosing abuse to healthcare providers or may be unable to access services due to their partner's control over transportation, finances, or medical decision-making.[62] The National Domestic Violence Hotline study found that 53% of respondents reported that a partner who chooses to abuse has also controlled and/or restricted health care access.[63] Thus, a correlation can be drawn between the accessibility issues created by IPV and the contributing factors to the high percentage rate of preventable pregnancy-related death.

The intergenerational effects of domestic violence begin in the womb.[64] Studies have found that maternal stress caused by intimate partner violence correlates with altered fetal neurodevelopment and long-term consequences for the child's emotional regulation, cognitive functioning, and physical health.[65] These early adverse experiences have been linked to increased risks of chronic disease, poor school performance, and future exposure to violence.[66]

Historical and structural inequalities further compound these harms. Communities of color, low-income families, immigrant populations, and people living in rural areas face additional barriers to care and protection, including language access issues, fear of legal retaliation (such as child protective services or immigration consequences), and lack of access to trained advocates or legal remedies.[67] In some regions, mandatory reporting requirements may deter survivors from seeking care, especially when providers are not trained in safe disclosure practices.[68]

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61. *See Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in* 36 *U.S. States, 2017–2019*, Ctrs. for Disease Control & Prevention (May 28, 2024), https://www.cdc.gov/maternal-mortality/php/data-research/mmria-methods/index.html [https://perma.cc/KGL5-VDE9]; *Domestic Abuse*, Maternal Mental Health All., https://maternalmentalhealthalliance.org/campaign/inequalities/domestic-abuse/ [https://perma.cc/X929-KY8Z]; Nicole Amodio, Marie Thoma & Eugene Declercq, *How the U.S. Can Better Understand — and Prevent — Maternal Deaths Related to Substance Use*, Commonwealth Fund (June 3, 2025), https://www.commonwealthfund.org/blog/2025/how-us-can-better-understand-and-prevent-maternal-deaths-related-substance-use [https://perma.cc/38BV-REHT].

62. Nat'l Domestic Violence Hotline, *supra* note 50.

63. *Id.*

64. Huyen Phuc Do et al., *Intergenerational Effects of Violence on Women's Perinatal Wellbeing and Infant Health Outcomes: Evidence from a Birth Cohort Study in Central Vietnam*, BMC Pregnancy & Childbirth, Sep. 2021, at 2.

65. Alhusen et al., *supra* note 7, at 102; *see also* Donovan et al., *supra* note 21, at 1296.

66. Megan R. Holmes & June-Yung Kim, *Prenatal Exposure to Domestic Violence*, Case Western Rsrv. Univ. Ctr. on Trauma & Adversity, Apr. 2019, at 2.

67. *See* Greely et al., *supra* note 17.

68. Tamana Barakati et al., *Barriers to Domestic Violence Disclosure in Healthcare Settings: A Scoping Review of Victim and Provider Perspectives*, 26 BMC Health Servs. Rsch. 162, 163, 168–69 (2026).

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Some states fail to include emotional abuse or reproductive coercion in their definitions of domestic violence, and few provide special protections or enhancements for survivors who are pregnant.[69] Without targeted legal and policy interventions, pregnant survivors of IPV remain invisible when looking at both public health and judicial responses. This systemic invisibility allows lethal patterns of abuse to persist, perpetuating the crisis this country faces with maternal mortality. Without proper legal safeguards, this preventable cycle will continue to harm or, worse, kill pregnant persons.

II. Legal Protections to Combat Maternal and Fetal Mortality Associated with Domestic Violence

The intersection of domestic violence and maternal mortality necessitates legal and policy reforms to protect birthing individuals and their children. Strengthening enforcement of IPV-related legal protections, enhancing medical system interventions, and addressing gaps in child custody and firearm relinquishment laws can contribute to improved maternal and fetal health outcomes.

This Article provides both research and policy-based suggestions on how to combat IPV-related deaths amongst pregnant people. In doing so, it conducts a comprehensive comparative analysis to assess what has and has not been effective. The following analysis highlights state and federal legal frameworks that have been able to protect pregnant survivors and those that have negatively impacted them. Some states are not mentioned because they do not have any of the legal infrastructure discussed throughout this section. To keep this analysis succinct, each recommendation only highlights policies that have either been proven to positively or negatively impact the research and policy-based suggestions.

A. Targeting Abusive Partners

The 1994 Violence Against Women Act ("VAWA") became the first comprehensive federal law to address domestic violence.[70] Although VAWA created a federal framework for addressing domestic violence and required states to honor protection orders across state lines, it did not override state laws as they relate to domestic violence.[71] Each state

69. Teresa Manring, *Minding the Gap in Domestic Violence Legislation: Should States Adopt Course of Conduct Laws?*, 111 J. Crim. L. & Criminology 773, 780, 784 (2021).

70. 34 U.S.C. §§ 12291–12514.

71. 34 U.S.C. § 12491(c)(8) (2022) (providing that nothing in the Reauthorization Act shall be construed to supersede any provision of Federal, State, or local law that provides greater protection); *see also* 18 U.S.C. § 2265 (2018) (requiring states to give

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retains the authority to define domestic violence, determine which acts are criminalized, and set policies for enforcement, prosecution, and victim services.[72] Consequently, the legal definition, available protections, and civil and criminal consequences of domestic violence can vary significantly depending on the jurisdiction.[73]

Protective orders are a tool of legal intervention intended to reduce the risk of future harm that a person perceived as a threat could inflict upon a specific person or persons.[74] Protection order legislation first started infiltrating the legal system in the 1970s, and by 1989, just five years before VAWA, all fifty states had their own version with different requirements and mandates.[75] They can be issued by criminal, civil, and family courts, all on different grounds but with the similar motive of acting as a "stay-away" order.[76] Consequences for violations of protection orders range anywhere from civil contempt penalties and fines to a felony conviction.[77] On their face, these orders are of great value to survivors, but it is their implementation and enforcement on the state level that really measures their value.[78]

1. Mandatory Firearm Relinquishment

Looking globally at women killed by firearms, 91.6% were from the United States, dramatically outpacing the outcomes in other high-income countries.[79] Research shows that women in abusive relationships are five times more likely to be killed if their abuser has access to a firearm.[80] Relinquishment laws require abusers to turn over firearms to law enforcement or a licensed dealer and impose penalties for

full faith and credit to valid protection orders); Nat'l Council of Juv. & Fam. Ct. Judges, A Guide for Effective Issuance & Enforcement of Protection Orders 3–9 (2012) (declaring that barriers in both services and enforcement create real dangers for people obtaining protective orders, that the inconsistencies make this portion of the Act unreliable, and that standardized enforcement is imperative if protective orders are going to be taken seriously).

72. *Id.* at 2; *see also* Manring, *supra* note 69, at 780 (depicting how states have defined domestic violence and how it has evolved over time).

73. Manring, *supra* note 69, at 784.

74. Christopher T. Benitez, Dale E. McNiel & Renée L. Binder, *Do Protection Orders Protect?*, 38 J. Am. Acad. Psychiatry & L. 376, 376 (2010).

75. *Id.*

76. *Id.*

77. *Id.* at 377.

78. *Id.* at 384.

79. Erin Grinshteyn & David Hemenway, *Violent Death Rates in the US Compared to Those of the Other High-Income Countries, 2015*, 123 Preventive Med. 20, 20–26 (2019).

80. Wallace et al., *Homicide During Pregnancy*, *supra* note 13.

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non-compliance.[81] States with comprehensive relinquishment laws see lower rates of intimate partner homicide.[82]

Pregnant and postpartum individuals are at an even heightened risk of intimate partner homicide, with firearms frequently used as the method of killing.[83] One of the leading causes of death for pregnant people is the use of a firearm.[84] Firearms impact pregnant and postpartum people tremendously, as 70% of homicides amongst that population involve a firearm.[85] Post-Traumatic Stress Disorder ("PTSD") is highly prevalent among women who experience IPV with a mean prevalence of more than twelve times the national average.[86] Firearms significantly elevate the likelihood of PTSD among IPV survivors as the weapon may be used to threaten, coerce, and intimidate the survivors.[87] Firearm threat and fear of firearm violence have been proven to be significant and unique predictors of PTSD symptoms.[88]

Although the presence of guns in domestic violence impacts all people in abusive partnerships, women of color are at an even higher risk of death.[89] Indigenous women and Black women are killed in firearm intimate partner homicides at two and three times the rate of white women, respectively.[90] While these data are accurate as related to gendered violence, it is important to point out that these data often exclude transgender and nonbinary populations that also experience gun-related IPV in high numbers.[91] This gap causes inherent limitations

81. Maeve E. Wallace et al., *Firearm Relinquishment Laws Associated with Substantial Reduction in Homicide of Pregnant and Postpartum Women*, 40 Health Affs. 1654, 1654 (2021) [hereinafter Wallace et al., *Firearm Relinquishment Laws*].

82. Wallace et al., *Firearm Relinquishment Laws*, *supra* note 81, at 1660 (finding that state laws with specific relinquishment procedures are associated with reductions in intimate partner homicide).

83. Wallace et al., *Homicide During Pregnancy*, *supra* note 13.

84. *See* S.R. Kegler et al., *Vital Signs: Changes in Firearm Homicide and Suicide Rates — United States, 2019–2020*, 71 Morbidity & Mortality Wkly. Rep. 656, 658–59 (2022); Elizabeth Tobin-Tyler, *Intimate Partner Violence, Firearm Injuries and Homicides: A Health Justice Approach to Two Intersecting Public Health Crises*, 51 J.L., Med. & Ethics 64, 66 (2023); Linda E. Saltzman et al., *Weapon Involvement and Injury Outcomes in Family and Intimate Assaults*, 267 J. Am. Med. Ass'n 3043, 3045 (1992).

85. Modest, Prater & Joseph, *supra* note 35, at 569.

86. Tami P. Sullivan & Nicole H. Weiss, *Is Firearm Threat in Intimate Relationships Associated with Posttraumatic Stress Disorder Symptoms Among Women?*, 4 Violence & Gender 31, 31 (2017).

87. *Id.* at 32.

88. *Id.* at 34.

89. *Guns and Violence Against Women: America's Uniquely Lethal Intimate Partner Violence Problem*, Everytown for Gun Safety Support Fund (Oct. 17, 2019), https://everytownresearch.org/report/guns-and-violence-against-women/ [https://perma.cc/27ZB-AQW9].

90. *Id.*

91. Peitzmeier et al., *supra* note 1.

within scholarship that is the result of a lack of disaggregated information in studies, the lack of trauma-informed interview training for researchers conducting studies that include transgender and nonbinary people, and the overall systemic exclusion of these communities from population-based surveillance.[92]

States should enact mandatory firearm relinquishment laws for respondents/defendants to protective orders in cases involving pregnant survivors of IPV. Federal law, under 18 U.S.C. §§ 922(g)(8) and 922(g)(9), prohibits individuals subject to qualifying domestic violence protective orders or convicted of misdemeanor crimes of domestic violence from possessing firearms.[93] Federal law also prohibits people whose protective orders were issued after notice and hearing and whose order protects an "intimate partner" or a child of the respondent subject to the court order from possessing firearms and ammunition.[94] Problematically, this law lacks a clear enforcement mechanism to ensure the actual relinquishment of those firearms. In response to this gap, thirty-two states and the District of Columbia have enacted laws prohibiting domestic abusers from possessing firearms upon the issuance of a restraining order.[95] Studies show that the states that restrict access

92. *Id.* at e10.

93. 18 U.S.C. § 922(g)(8)–(9) (2018).

94. *Id.*; *see* United States v. Rahimi, 602 U.S. 680, 692 (2024) (upholding the federal statute prohibiting individuals subject to domestic violence protective orders from possessing firearms).

95. ALA. CODE § 13A-11-72(a), (h) (2024); CAL. PENAL CODE § 29825(a) (2025); CAL. FAM. CODE §§ 6210, 6211(c) (2025); COLO. REV. STAT. §§ 13-14-105.5(a), 18-6-800.3 (2024); CONN. GEN. STAT. §§ 53a-217(a)(4), 53a-217c(5), 46b-15(a), 46b-38a(2)(F) (2024); DEL. CODE ANN. tit. 10, § 1041(2) (2025); DEL. CODE ANN. tit. 11, § 1448(a)(6) (2025); FLA. STAT. §§ 790.233, 741.31(4)(b)(1) (2025); HAW. REV. STAT. §§ 134-7(f), 586-3(b)(1), 586-1 (2024); 430 ILL. COMP. STAT. 65/8.2 (2025); 750 ILL. COMP. STAT. 60/214(b)(14.5), 60/201(a)(i), 60/103(6) (2025); IOWA CODE § 724.26(2)(a) (2026); KAN. STAT. ANN. § 21-6301(a)(17) (2022); LA. STAT. ANN. §§ 46:2136.3(A), 46:2151; ME. STAT. tit. 15, § 393(1)(D) (2025); MD. CODE ANN., FAM. LAW § 4-506 (2024); MD. CODE ANN., PUB. SAFETY §§ 5-133(b)(14), 5-205(b)(12); MASS. GEN. LAWS ch. 140, §§ 121F(j)(i), 129B(1)(i), 131(d)(i) (2024); MASS. GEN. LAWS ch. 269, § 10 (2024); MINN. STAT. § 518B.01(6)(g) (2025); NEV. REV. STAT. § 202.360(1) (2024); N.H. REV. STAT. ANN. §§ 173-B:5(II), 173-B:1(I), (XV) (2025); N.J. REV. STAT. §§ 2C:39-7(b)(3), 2C:25-29(b), 2C:25-19(d) (2024); N.M. STAT. ANN. §§ 30-7-16(A)(2), 40-13-5, 40-13A-5, 40-13-2(A), (D), (F) (2024); N.Y. CODE CRIM. PROC. §§ 530.12(a), 530.14(1)(a), (2) (2024); N.Y. FAM. CT. ACT §§ 842(a), 812(1)(e) (2024); N.C. GEN. STAT. §§ 14-269.8, 50B-3.1, 50B-1(a), (b)(6) (2023); OR. REV. STAT. §§ 166.255(1)(a), 135.230(4) (2023); 18 PA. CONS. STAT. § 6105(a), (a.1)(2), (c)(6) (2024); 23 PA. CONS. STAT. §§ 6102(a), 6108(a)(7), (a.1) (2024); 8 R.I. GEN. LAWS § 8-8.1-1(5) (2025); 11 R.I. GEN. LAWS § 11-47-5(b) (2025); 15 R.I. GEN. LAWS § 15-15-1(4) (2024); TENN. CODE ANN. § 39-17-1307(f)(1)(B) (2024); TEX. FAM. CODE §§ 82.002, 71.004, 71.0021 (2024); TEX. PENAL CODE ANN. § 46.04(c) (2024); UTAH CODE ANN. § 76-10-503(1)(b)(x) (West 2024); VA. CODE ANN. §§ 18.2-308.09(5), 18.2-308.1:4 (2025); VT. STAT. ANN. tit. 13, § 4017a(a)(2) (2024); VT. STAT. ANN. tit. 15, §§ 1103(a), 1101(2) (West 2024);

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to firearms by people subject to active domestic violence restraining orders have seen a 13% reduction in intimate partner homicides involving firearms. Under Texas Penal Code § 46.04(c), for example, it is unlawful for any person (other than a peace officer actively engaged in employment as a sworn, full-time paid employee of a state agency or political subdivision) who is subject to a protective order issued under Title 4 of the Texas Family Code (after notice and hearing) to possess a firearm after receiving notice of the order and before its expiration.[96] However, the strength and scope of these laws differ from state to state.

The effectiveness of firearm relinquishment hinges upon the procedures and penalties for non-compliance.[97] In California, state law prohibits people from acquiring or possessing firearms for ten years after they have been convicted of a violent misdemeanor.[98] When a California court issues a domestic violence restraining order, for example, it explicitly orders the abuser to relinquish any firearms they own or possess, typically within twenty-four hours of being served with the order or immediately if they are present in court when the order is made.[99] Additionally, the abuser is required to file a receipt with the court proving the sale or transfer of their firearms to a licensed dealer or their surrender to law enforcement.[100] Court and law enforcement oversight ensures accountability and facilitates the effective removal of firearms from individuals deemed a threat in intimate partner violence cases, thereby enhancing survivor safety. Data from the California Department of Justice show that the California police department saw a 63% reduction in per capita rates of domestic violence-related calls involving firearms and a 61% reduction in domestic violence-related gun homicides from 1993 to 2019.[101]

Colorado provides a similarly robust legal framework for firearm relinquishment aimed at protecting survivors of intimate partner violence. Under Colorado law, individuals convicted of a misdemeanor crime of intimate partner violence are required to

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Wash. Rev. Code Ann. §§ 9.41.040(2)(a)(i), 7.105.100(1)(a), 7.105.010(21); Wis. Stat. § 813.12(4m), (1)(am), (ag) (2026); Wis. Stat. § 941.29(1m)(f) (2026); W. Va. Code §§ 48-27-202, -204, -502; W. Va. Code § 61-7-7(a)(7).

96. Tex. Penal Code Ann. § 46.04(c) (West 2021).

97. Wallace et al., *Firearm Relinquishment Laws*, *supra* note 81, at 1659.

98. Cal. Penal Code § 29805 (West 2026).

99. Cal. Fam. Code § 6389(b)–(c) (West 2026).

100. Cal. Fam. Code § 6389(c)(2) (West 2026).

101. Cal. Dep't of Just., Off. of Gun Violence Prevention, Data Report: Domestic Violence Involving Firearms in California 11 (2023).

surrender any firearms in their possession.[102] This mandate reflects the state's recognition of the correlation between firearm access and the heightened risk of lethal outcomes in abusive relationships.[103] Colorado extends this requirement beyond criminal convictions and mandates firearm relinquishment when a domestic violence protection order—either temporary or permanent—is issued against an abuser.[104] Civil protective orders trigger mandatory firearm surrender provisions that are designed to offer immediate, preventative relief to survivors at a moment of heightened vulnerability and fear.[105] In implementing these laws, Colorado allows for the transfer of firearms to third parties such as federally licensed firearms dealers, law enforcement, or individuals who meet statutory requirements and are not otherwise prohibited from possessing firearms.[106] This approach allows for flexibility in the enforcement mechanism, and it requires documentation and verification procedures intended to ensure compliance and minimize the risk of continued access by the respondent.[107] Through this multi-pronged approach, Colorado's laws aim to proactively disarm individuals deemed dangerous, thereby reducing the likelihood of escalation and protecting survivors from potential harm. The state's efforts reflect a growing recognition of firearm relinquishment as a critical component of comprehensive domestic violence prevention policy.

Wisconsin has also enacted relatively strong provisions for firearm relinquishment in domestic violence cases, particularly in connection with civil protective orders. When a court issues a final domestic abuse injunction, the judge is required to order the respondent to surrender any firearms in their possession within fourty-eight hours and to refrain from acquiring new firearms for the duration of the injunction.[108] The law further requires the court to hold a hearing to verify compliance

102. Colo. Rev. Stat. § 18-6-801(8)(a)(I) (2024) (requiring firearm relinquishment following a misdemeanor domestic violence conviction).

103. April M. Zeoli, Rebecca Malinski & Brandon Turchan, *Risks and Targeted Interventions: Firearms in Intimate Partner Violence*, 38 Epidemiologic Rev. 125 (2016).

104. Colo. Rev. Stat. § 13-14-105.5(1)(a) (2024) (requiring firearm surrender upon issuance of a domestic violence protection order).

105. *Id.*

106. *Id.* § 13-14-105.5(2)(c) (2024) (permitting transfer to licensed dealers, law enforcement, or qualified third parties).

107. *Id.* § 13-14-105.5(5) (2024) (requiring filing of affidavits and compliance hearings).

108. Wis. Stat. § 813.1285(1g)(a)–(c) (2024) (mandating firearm surrender within 48 hours of issuance of a domestic abuse injunction); Wis. Stat. § 813.12(4m)(a) (2024) (prohibiting firearm acquisition during the injunction).

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with the surrender order.[109] Wisconsin law outlines clear procedures for how firearms must be surrendered—either to a county sheriff or to a third party approved by the court—and requires respondents to file a statement or affidavit indicating that they have complied.[110] The statute establishes criminal penalties for individuals who fail to comply with firearm surrender orders or who are found in possession of a firearm while subject to a domestic abuse injunction.[111] Through this legal framework, Wisconsin seeks to reduce the risk of future harm by ensuring that individuals subject to protective orders are disarmed in a timely and verifiable manner. These three states' comprehensive frameworks, marked by mandatory surrender timelines, court oversight, and enforcement tools, stand in stark contrast to the more reactive approaches found in other jurisdictions, where enforcement often relies on the survivor to report violations. California's, Colorado's, and Wisconsin's models shift the burden away from the survivor and onto the system, where it belongs.

Conversely, some states lack clear relinquishment procedures or rely on the abuser's attestation of non-possession, creating significant loopholes. For example, Texas possesses weaker firearm relinquishment laws in cases of intimate partner violence, particularly when compared to models like California.[112] While 18 U.S.C. § 922(g)(8) prohibits individuals subject to qualifying final domestic violence protective orders from possessing firearms, its effectiveness is significantly undermined in states that lack robust state-level mechanisms for enforcement and relinquishment.[113] However, Texas primarily relies on this federal prohibition without a comprehensive, state-mandated process to ensure the actual surrender of firearms.[114] Texas law does not explicitly outline a mandatory, court-supervised process for the surrender of firearms upon the issuance of a protective order.[115] Consequently, the burden often falls on the survivor or law enforcement to discover continued possession, rather than on the system proactively

109. Wis. Stat. § 813.1285(1g)(f), (4)(b) (2026) (requiring courts to hold a firearm surrender hearing and authorizing arrest warrants for failure to appear).
110. Wis. Stat. § 813.1285(3)(a), (5)(a)–(b) (2024) (detailing transfer options and mandatory firearm possession form).
111. *Id.*
112. *Compare* Tex. Fam. Code Ann. § 85.022(b)(6) (West 2023) (indicating that the court *may* prohibit the possession of a firearm but does not require it), *with* Cal. Fam. Code § 6389(a)–(f) (West 2026) (mandating firearm relinquishment for anyone subject to a protective order).
113. 18 U.S.C. § 922(g)(8).
114. Tex. Fam. Code Ann. § 85.022(b)(6) (West 2024).
115. *Id.*

ensuring disarmament.[116] This reactive approach is less thorough and places survivors at continued risk.

Similarly, Virginia's framework exhibits notable gaps. While Virginia law prohibits individuals subject to final domestic violence protective orders from possessing firearms, it does not mandate the surrender of firearms upon issuance of such orders.[117] Courts may order firearm surrender but are not required to do so, and no standard procedural safeguards are outlined in the statute.[118] As in Texas, enforcement depends heavily on survivor reporting or discretionary law enforcement action, leaving a significant gap between the legal prohibition and actual firearm removal.[119] This gap is particularly dangerous for pregnant individuals, who face elevated risks of intimate partner homicide, often by firearm.[120] Virginia's framework exemplifies how reliance on federal prohibitions without meaningful state-level infrastructure can result in hollow protections that fail to proactively disarm abusers.

Alabama's legal framework reflects similar structural deficiencies. Although Alabama law prohibits firearm possession by individuals convicted of misdemeanor domestic violence or subject to a valid protection order, it does not mandate the surrender of firearms or provide a clear, court-supervised mechanism to ensure disarmament.[121] Judges may order firearm surrender but are not required to do so, and no statutory provisions compel verification of firearm relinquishment or transfer to law enforcement or neutral third parties.[122] The absence of these mechanisms leaves a dangerous gap between the law's intent and

116. *Ensuring Effective Implementation of Laws that Disarm Domestic Abusers*, Everytown for Gun Safety (June 27, 2024), https://everytownresearch.org/report/laws-that-disarm-domestic-abusers/ [https://perma.cc/D9EN-8LQA] [hereinafter Everytown, *Ensuring Effective Implementation*] (explaining that, in practice, the enforcement gaps often leave survivors or law enforcement responsible for discovering continued firearm possession).

117. Va. Code Ann. § 18.2-308.1:4 (2026) (prohibiting firearm possession by individuals subject to domestic violence protective orders).

118. *See* Va. Code Ann. § 18.2-308.2(C); *see also Gun Laws in Virginia*, Everytown for Gun Safety (Jan. 14, 2026), https://everytownresearch.org/rankings/state/virginia/ [https://perma.cc/29H5-P8FB].

119. Everytown, *Ensuring Effective Implementation*, *supra* note 116.

120. Tobin-Tyler, *supra* note 84, at 64, 66.

121. Ala. Code § 13A-11-72(a) (2024); Ala. Code § 30-5-7(c) (2024) (prohibiting firearm possession for convicted domestic violence misdemeanants and those subject to domestic violence protection orders).

122. *See* Ala. Code § 30-5-7(c) (2024); *see also Gun Laws in Alabama*, Everytown for Gun Safety (Jan. 14, 2026), https://everytownresearch.org/rankings/state/alabama/ [https://perma.cc/5R56-X6QG].

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its enforcement, which is particularly threatening for pregnant survivors at high risk of firearm-related intimate partner homicide.[123]

The main legal loophole revealed by the preceding comparative analysis lies between the legal prohibition on firearm possession and the actual, confirmed removal of the weapon.[124] When abusers are directed by the courts not to possess firearms but are not required to prove they have surrendered their firearms to a neutral party, the life of the survivor remains in grave danger by allowing the abuser to keep their firearms (unless they are arrested for a separate crime).[125] Consequently, the burden often falls on the survivor or law enforcement to discover continued possession, rather than on the system proactively ensuring firearm removal. This reactive approach places survivors at continued risk.

Louisiana's firearm relinquishment laws demonstrate that while relinquishment mandates are necessary, inconsistent compliance on the ground fueled by political backlash can undercut effectiveness.[126] Similar to the hollow nature of laws in Virginia, Louisiana has implemented relinquishment laws, but the state's strong conservative culture surrounding gun restrictions has resulted in laws that are not sufficiently applied by the necessary agencies on the ground.[127] The state has implemented mandatory firearm relinquishment for domestic violence protective orders.[128] Under Louisiana law, courts are required to order individuals subject to firearm-prohibiting protective orders and certain domestic violence convictions to surrender all firearms to local law enforcement within 48 hours, including filing proof of transfer with the court, as well as to suspend any concealed carry permits held by the

123. *See* Tobin-Tyler, *supra* note 84, at 64, 66.

124. *Id.* at 67.

125. *See* Michelle Pitcher, *Domestic Abusers Under Protective Orders Often Get to Keep Their Guns*, Tex. Observer (Nov. 6, 2023), https://www.texasobserver.org/protective-orders-domestic-abusers-guns/ [https://perma.cc/4KM4-TKEF] (noting that fewer than 10 of Texas' 254 counties have standard protocols for firearm relinquishment and that neither state nor federal law provides clear mechanisms to enforce disarmament); William Melhado, *Texas Struggles to Get Guns Away from Domestic Violence Suspects, Leaving Victims in Danger*, Tex. Trib. (Oct. 20, 2022), https://www.texastribune.org/2022/10/20/texas-domestic-violence-firearm-surrender-programs/ [https://perma.cc/76Q5-FQ6P] (reporting that few Texas jurisdictions have surrender programs in place, leaving survivors at elevated risk of gun violence).

126. Alma Beauvais, *In a Deep-Red State, This Lieutenant's Blueprint for Removing Guns from Abusers Is Spreading*, Trace (Nov. 26, 2024), https://www.thetrace.org/2024/11/protective-order-gun-laws-police-la-tn [https://perma.cc/UJ7P-GDFU].

127. *Id.*; *see also* Court Watch NOLA, All Eyes on Justice: 2020 Annual Report (2021).

128. La. Stat. Ann. § 46:2136.3 (2018).

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individual subject to the order.[129] While these relinquishment laws are good on their face, not all Louisiana sheriffs' offices have developed formal procedures or policies for firearm relinquishment. Reliable enforcement across jurisdictions is critical to effective protection, highlighting the problematic nature of a broader federal framework with little controlling power, leading to diminished protective value.[130]

Pregnant survivors should not have to worry about being murdered by a firearm after they have taken action to protect themselves by obtaining a civil protective order. Mandating and enforcing firearm relinquishment should be a standard protective measure for all survivors of intimate partner violence across all jurisdictions. This protective measure could save the life of a pregnant person and should be urgently applied by all states.

2. Pregnancy as an Aggravating Factor in Domestic Violence Statutes

The significant health risks and negative outcomes linked to domestic violence during pregnancy highlight the urgent need for strong legal protections. One protective safeguard pregnant survivors can utilize is seeking civil protective orders.[131] Civil protective orders are documents issued by courts to prevent further abusive behavior.[132] Such orders can require that the abusive individual stay away from the pregnant person and their home, school, or workplace; refrain from communicating with them (including through a third party); and refrain from committing acts of domestic violence.[133] Each state has domestic violence statutes that provide the legal parameters around obtaining a civil protective order, including the duration of such orders.[134] Not all states' statutes provide aggravating circumstances as a pathway to obtaining the maximum duration of a protective order. States that do recognize aggravating circumstances should amend their domestic violence statutes to explicitly recognize that the commission of domestic violence against a pregnant individual constitutes an aggravating circumstance and shall provide good cause to grant the survivor the maximum protective order duration that the statute provides.[135] This

129. La. Code Crim. Proc. Ann. art. 1002 (2025); *Firearm Relinquishment in Louisiana*, Giffords L. Ctr. (Dec. 31, 2025), https://giffords.org/lawcenter/state-laws/firearm-relinquishment-in-louisiana [https://perma.cc/92B9-D9LV].

130. Nat'l Council of Juv. & Fam. Court Judges, *supra* note 71, at 9.

131. Rachel J. Wechsler, *Intimate Partner Violence: Access to Protection Beyond the Pandemic*, 65 B.C. L. Rev. 2267, 2269, 2276 (2024).

132. *Id.*

133. *Id.*

134. Nat'l Council of Juv. & Fam. Court Judges, *supra* note 71.

135. *See, e.g.*, Fla. Stat. § 784.045(1)(b) (2021).

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recognition should serve as a standalone basis for issuing civil protective orders of maximum duration if this is the remedy the survivor seeks.

An aggravating circumstance is a factor that justifies stronger legal protections in response to acts of domestic violence.[136] They act to increase the degree of the harm inflicted beyond its basic elements to justify why some circumstances can warrant an increase in protective measures by our courts.[137] Such additional factors inherently enhance the consequences an abusive individual will face in civil protective order proceedings.[138] Therefore, if a statute recognizes pregnancy as an aggravating circumstance, the type of protective order issued against the abuser will be reflective of this conduct to deter this type of behavior and protect a vulnerable population. Domestic violence, when committed against someone the abuser knows or should know is pregnant, should be treated as such a factor because pregnancy increases physical vulnerability, puts fetal health at risk, and often marks a time when abuse worsens.[139] Given these heightened risks, the law should respond with longer-lasting protective orders, should the survivors be seeking such a remedy. Survivors should not have to endanger themselves while pregnant to fight to extend the duration of their protective orders.

Some states consider pregnancy as an aggravating circumstance that provides a survivor-centric legal approach for pregnant survivors seeking the court's intervention. New York and Delaware are the only two states that utilize the term aggravating circumstance to warrant the granting of the maximum statutory length of civil protective orders. Delaware allows survivors to obtain a permanent civil protective order once there has been a finding of aggravating circumstances.[140] Aggravating circumstances include physical injury, the use of a weapon or dangerous instrument, history of violations of previous protective orders, exposure of injury to members of the survivor's family, or any other acts which a court determines pose an immediate and ongoing

136. *See Aggravating Circumstance*, Black's Law Dictionary (11th ed. 2019) (defining aggravating circumstance as a fact or situation that increases the degree of liability or culpability for a criminal act); *Aggravating Circumstances*, Legal Info. Inst., https://www.law.cornell.edu/wex/aggravating_circumstances [https://perma.cc/TS37-2B8P] [hereinafter Legal Info. Inst.] (defining aggravating circumstance as factors increasing the severity or culpability of conduct and justifying enhanced penalties or protections).

137. Legal Info. Inst., *supra* note 136; *see generally* U.S. Sent'g Comm'n, Aggravating and Mitigating Role Adjustments (2024).

138. *Id.*; *see also Domestic Violence Restraining Orders and Gun Violence Restraining Order*, Cal. Dep't of Just., https://oag.ca.gov/ogvp/gvro-dvro [https://perma.cc/57JY-8FKZ].

139. Agarwal et al., *supra* note 24, at 7.

140. Del. Code Ann. tit. 10, § 1045(f) (2025).

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danger.[141] None of these aggravating circumstances explicitly include pregnancy, but pregnant survivors might be able to meet some of these aggravating circumstance factors, such as physical injury or immediate and ongoing danger, given the established research that demonstrates maternal and fetal health is at risk if the pregnant person suffers from domestic violence.[142]

New York's statute is similar to Delaware's and includes a finding of aggravating circumstances as a reason for a court to issue a protective order with the maximum duration (i.e., five years).[143] Pregnant survivors in New York should be able to obtain the maximum duration, as domestic violence during pregnancy constitutes an "aggravating circumstance" because it reflects an immediate and ongoing danger to the petitioner and the fetus.[144] The protective order can be extended beyond five years, but this requires a survivor to re-enter the courtroom and further endanger themselves, so New York's law is not as comprehensive and protective for pregnant survivors as that of Delaware.[145]

Other states have used various terms, as opposed to that of aggravating circumstances, to grant permanent civil protective orders. Colorado courts can issue permanent civil protection orders under circumstances including finding that the abuser is likely to continue such acts unless restrained.[146] In cases involving sexual violence, Colorado courts can even issue permanent protection orders upon a finding that a "risk or threat of physical harm or the threat of psychological harm or emotional harm exists to the petitioner."[147] Given the dangers and risks that domestic violence poses to pregnant people and the likelihood of death increasing when a pregnant person experiences domestic violence, pregnant survivors can certainly clear this burden, entitling them to permanent orders of protection.

Oregon similarly allows circuit courts to grant permanent restraining orders to survivors of sexual violence if certain conditions are met.[148] The factors the court must consider in determining the length of the protective order include a history of sexual abuse or domestic violence, familial relationships, and the petitioner's vulnerability.[149] As evinced through this analysis and through our understanding as a society,

141. *Id.*
142. *See* Agarwal et al., *supra* note 139.
143. N.Y. Fam. Ct. Act § 842 (McKinney 2025).
144. *Id.*
145. *Id.*
146. Colo. Rev. Stat. Ann. § 13-14-106 (West 2025).
147. *Id.*
148. Or. Rev. Stat. Ann. § 163.765 (West 2021).
149. *Id.*

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pregnant individuals are considered to have heightened vulnerability. Thus, because the legislature has used the vague phrase "petitioner's vulnerability" as a circumstance for the court to consider when making a ruling about the duration of a protective order, they should specifically classify pregnancy. A pregnant survivor who has experienced sexual violence is extremely vulnerable and should be granted a permanent restraining order on that basis in Oregon.[150]

Another approach to heightened protective order scrutiny is that of Montana. Its legislature allows courts to issue permanent orders of protection based on the history of violence of the abuser, the severity of the offense, and evidence provided during a hearing.[151] Again, the law is silent on pregnancy specifically. While this statute is impactful for survivors of IPV, it ignores the very scary reality that many of them are pregnant with their abuser's unborn child. Pregnant survivors in Montana should be able to obtain a permanent order due to the associated lethality risks when they experience domestic violence while pregnant.

Lastly, New Jersey law also allows for survivors of domestic violence to obtain lifetime restraining orders.[152] Survivors in New Jersey can obtain a permanent restraining order based on circumstances such as existence of immediate danger, financial circumstances, previous history of domestic violence, etc.[153] Pregnant survivors in New Jersey can meet the factors listed given the burden of immediate danger by the nature of being pregnant, but they remain invisible and unnamed in the statute.[154]

Some jurisdictions, like Indiana, Kansas, Maryland, Tennessee, Utah, Virginia, and Wisconsin, permit judges to grant permanent protective orders if there exists a criminal matter involving both parties that resulted in a conviction of certain offenses such as assault or other related offenses like stalking or harassment.[155] However, a carceral approach is not always what would help survivors feel safe. These states exclude protections for survivors that do not cooperate with the district

150. *See* Agarwal et al., *supra* note 139.

151. Mont. Code Ann. § 40-15-204 (West 2025).

152. N.J. Rev. Stat. § 2C:25-29(d) (2024) (asserting that the only way a final restraining order can be dissolved or modified is with a showing of good cause to the same judge who issued the order or to a judge who has access to the complete record of the hearings).

153. *Id.*

154. *Id.*

155. Ind. Code Ann. § 34-26-5-9(g) (West 2024); Kan. Stat. Ann. § 60-3107(e)(2) (2024); Kan. Stat. Ann. § 60-31a06(d) (2024); Md. Code Ann., Fam. Law § 4-506 (West 2025); Tenn. Code Ann. § 36-3-627 (2024); Utah Code Ann. § 78B-7-804 (West 2024); Va. Code Ann. § 19.2-152.10 (2025); Wis. Stat. §§ 813.12, .123, .125 (2025).

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attorney in prosecuting their abuser for whatever their reasoning might be. As compared to other statutes examined that analyze risk factors as aggravating circumstances to heighten the degree of protection taken, the criminal prerequisite to obtain a civil protective order places the burden entirely on the survivors. These statutes place an unreasonable threshold for pregnant survivors to meet should they seek a permanent civil protective order that is needed for their safety.[156]

To effectively address the heightened dangers of domestic violence during pregnancy, states must explicitly amend their statutes to recognize pregnancy as an aggravating factor when considering whether and for how long to grant restraining orders. This reform will enable courts to grant extended or permanent protective orders reflecting the ongoing risk faced by pregnant survivors. Strengthening these legal protections will provide a more robust safeguard for both maternal and fetal health, helping to reduce preventable morbidity and mortality linked to intimate partner violence during pregnancy.

B. Reproductive Coercion

1. Incorporating Reproductive Coercion into State Protective Order Statutes

States should allow reproductive coercion to serve as a standalone basis for obtaining protective orders, whether or not such coercion results in a pregnancy. According to ACOG, reproductive coercion is a distinct and harmful subset of IPV that poses serious health and safety risks, especially during pregnancy.[157] Reproductive coercion is a form of IPV that involves controlling a partner's reproductive autonomy and decision-making abilities.[158] Examples of reproductive coercion include sabotaging contraception methods and pregnancy coercion, including pressure to become pregnant.[159] Pregnancy coercion is defined as "coercive behavior such as threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision to terminate or continue a pregnancy."[160]

156. Katharine R. Skolnick, *A Second Look at Second Look: Promoting Epistemic Justice in Resentencing*, 100 N.Y.U. L. Rev. 1, 29 (2025).

157. Comm. on Health Care for Underserved Women, Am. Coll. of Obstetricians & Gynecologists, Committee Opinion No. 554: Reproductive and Sexual Coercion 1–2 (2013).

158. Morgan E. PettyJohn et al., *Reproductive Coercion, Intimate Partner Violence, and Pregnancy Risk Among Adolescent Women with a History of Foster Care Involvement*, Children & Youth Servs. Rev., Nov. 19, 2020, at 1.

159. Comm. on Health Care for Underserved Women, *supra* note 157.

160. *Id.*

Reproductive coercion is a pervasive and damaging form of abuse with severe implications for maternal and fetal health.[161] It undermines an individual's fundamental right to make decisions about their own body and reproductive life.[162] Research has shown that unintended pregnancies resulting from reproductive coercion are associated with delayed prenatal care, increased risk of preterm birth, low birth weight, and negative maternal health outcomes.[163] These outcomes not only jeopardize the immediate well-being of the parent and child, but can also have long-term implications for the child's development.[164] Given the serious medical and legal consequences of reproductive coercion, it is essential for states' protective order frameworks to explicitly recognize and address this form of abuse to provide adequate protection and resources for pregnant individuals.

Several states have recently taken critical steps towards recognizing coercive control as a legally actionable form of intimate partner violence, such as by including the term in their protective order statutes to warrant the issuance of a protective order on the basis of coercion alone.[165] New York's Family Court Act, Article 8, recognizes coercion as a family offense eligible for protective orders, allowing survivors to seek relief for non-physical forms of abuse.[166] Specifically, the New York Family Court Act section 812 incorporates Penal Law section 135.60, which defines coercion to include threats or pressure used to control another's actions—language broad enough to encompass reproductive coercion, such as interference with contraception or forced pregnancy decisions.[167] This flexible statutory framework positions New York as a state capable of addressing complex power dynamics in abusive relationships, particularly those involving threats to reproductive autonomy.

Notably, in 2022, Washington state made significant advancements with its comprehensive overhaul of civil protection order laws because

161. *Id.*

162. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) ("These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.").

163. Heidi D. Nelson et al., *Associations of Unintended Pregnancy with Maternal and Infant Health Outcomes: A Systematic Review and Meta-Analysis*, 328 J. Am. Med. Ass'n 1714, 1715 (2022).

164. *Id.*

165. *See* Mass. Gen. Laws ch. 209A, § 1 (2025); N.Y. Fam. Ct. Act § 812(1) (McKinney 2024); Wash. Rev. Code § 7.105.010(4)(a) (2025).

166. N.Y. Fam. Ct. Act § 812(1) (McKinney 2024) (establishing coercion as a form of non-physical abuse that survivors can seek protection from).

167. N.Y. Penal Law § 135.60 (McKinney 2024).

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the previous policies were fragmented in such a way that they did not provide procedural or substantive protections to survivors who had not experienced physical harm in the pattern of IPV they suffered. Under RCW 7.105.010(4)(a), Washington now defines coercive control as "a pattern of behavior that is used to cause another to suffer physical, emotional, or psychological harm, and in purpose or effect unreasonably interferes with a person's free will and personal liberty."[168] The statute goes further than most jurisdictions by specifying that "sexual or reproductive coercion" qualifies as coercive control.[169] By directly naming reproductive coercion, Washington removes any ambiguity as to whether reproductive coercion falls within the scope of a civil protection order and gives survivors a clear and direct path to legal relief. The clarity found in Washington's statute directly supports the autonomy and safety of survivors.

Fairly recently, in 2024, as legislatures are starting to realize the complex ways in which abusers obtain and hold power, Massachusetts enacted significant amendments to its domestic abuse statute. Massachusetts General Laws chapter 209A expressly incorporates coercive control within its definition of abuse.[170] While the statute does not explicitly include *reproductive* coercion in its definition of coercive control, Massachusetts now provides survivors with legal grounds to seek protective orders when subjected to behaviors aimed at undermining their bodily autonomy and decision-making capacity, especially regarding reproductive health.[171]

Other states have also recently begun to expand protections beyond physical violence to encompass patterns of psychological and reproductive control.[172] In Connecticut, the passage of Jennifer's Law in 2021 redefined domestic violence to include coercive control, which encapsulated actions such as isolation, surveillance, and deprivation of basic needs.[173] This expansive definition offers clear legal recourse for survivors of non-physical abuse by including tactics of psychological abuse, including reproductive coercion. Similarly, New Jersey amended

168. Wash. Rev. Code § 7.105.010(4)(a) (2025).
169. *Id.*
170. Mass. Gen. Laws ch. 209A, § 1 (2025) (as amended to include coercive control, including conduct that interferes with personal liberty, autonomy, and reproductive decision-making).
171. *Id.*
172. *See* Conn. Gen. Stat. Ann. § 46b-15 (West 2021); Cal. Fam. Code § 6320(b) (2025); Colo. Rev. Stat. § 18-6-800.3 (2021); Haw. Rev. Stat. § 709-906 (2025); N.J. Stat. Ann. § 2C:25-19 (West 2024); Wash. Rev. Code § 10.99.020 (2025).
173. 2021 Conn. Acts No. 21-78 (Reg. Sess.); Michelle Kirby, Conn. Gen. Assemb. Off. of Legis. Rsch., 2023-R-0107, Jennifer's Law (Connecticut) (2023).

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its Prevention of Domestic Violence Act in 2024 to explicitly include coercive control, identifying behaviors such as economic abuse, emotional degradation, and threats to housing, employment, or immigration status.[174] Again, by defining actions that are not physical in nature, the legislature is validating the power of psychological abuse and coercion on victims. While Colorado has not yet codified coercive control in its statutory definitions, it does include "coercion" as a basis for protection orders and has passed legislation (HB24-1350) that formally incorporates coercive control into family law, including custody and parenting time determinations.[175] These statutory shifts reflect a growing consensus that coercive control—especially in the form of reproductive coercion—must be treated as a serious and independent ground for legal intervention, particularly given the heightened risk of intimate partner homicide during pregnancy.[176]

In contrast to the states that have taken steps to highlight the importance of reproductive coercion, whether it be through protective order classifications or domestic violence definitions, other jurisdictions maintain domestic violence statutes with narrow definitions of abuse. Contrary to the states just discussed, this narrow definition of domestic violence, which does not include coercion of any kind, limits survivors of that kind of abuse in their ability to obtain protective orders against their abusers and promotes an antiquated understanding of what counts as domestic violence. For example, Texas, Alabama, and Florida primarily characterize domestic violence in terms of either physical harm, specific threats of physical harm, or certain enumerated crimes like assault, sexual assault, harassment, stalking, etc.[177] Reproductive coercion is frequently part of a broader pattern of coercive control designed to undermine a partner's autonomy.[178] However, statutes focused on discrete incidents of physical violence or specific criminal acts may not capture the gravity of reproductive coercion.[179] In Florida, for example, for reproductive coercion to have occurred, the perpetrator must have committed acts that align with the criminal definitions

174. N.J. Rev. Stat. § 2C:25-29(a) (2024) (as amended).

175. Colo. Rev. Stat. § 13-14-101(2) (2023); H.B. 24-1350, 74th Gen. Assemb., 2d Reg. Sess. (Colo. 2024).

176. Comm. on Health Care for Underserved Women, *supra* note 157 (recognizing reproductive coercion as a distinct and pertinent form of intimate partner violence).

177. *See* Tex. Fam. Code Ann. §§ 71.0021(a)(2), .004(1) (West 2025); Ala. Code § 30-5-2; Ala. Code § 13A-6-22(a) (2023); Fla. Stat. § 741.28(2).

178. PettyJohn et al., *supra* note 158, at 2.

179. Laura Tarzia & Mandy McKenzie, *Reproductive Coercion and Abuse in Intimate Relationships: Women's Perceptions of Perpetrator Motivations*, PLOS One, Apr. 16, 2025, at 6, 9–11.

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of "assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death."[180] Even when states create lists like this that include "sexual assault" or some forms of reproductive-related sexual coercion, such as taking off a condom during sex without the consent or knowledge of the other party (i.e., "stealthing"), they may not always be recognized or easily proven under existing criminal definitions within the context of a civil protective order.[181] Without explicitly naming reproductive coercion within protective order statutes, there is too much room for interpretation and deference to definitions that would require too many logical jumps to be considered expansive enough to include it. Consequently, survivors whose primary experience of abuse is reproductive coercion may be unable to obtain protective orders in these states until the abuse escalates to include explicit physical violence or threats that meet the higher statutory criteria. It is not uncommon for jurisdictions to defer to legislatures, and without clear naming in statutes, these survivors will go unheard.

States must explicitly include reproductive coercion in their protective order frameworks to ensure meaningful protection for pregnant individuals. Recognizing reproductive coercion as domestic violence minimizes ambiguity and affirms that violating reproductive autonomy is a serious offense, on par with the other types of IPV that are explicitly listed in states' protective order statutes. Making it a standalone basis for a protective order will ensure that survivors are not forced to endure ongoing control and protect pregnant people who have experienced reproductive coercion.

2. Abortion Access

Legal access to abortion must be protected to mitigate reproductive coercion and its consequences on maternal mortality.

Restrictions on abortion exacerbate reproductive coercion by removing survivors' ability to make autonomous reproductive choices.[182] Reproductive coercion often shows up as an abuser deliberately causing

180. Fla. Stat. § 741.28(2).

181. *See* Mikaela Shapiro, *Yes, "Stealthing" Is Sexual Assault… And We Need to Address It*, 37 Touro L. Rev. 1643, 1652–53 (2021) (discussing the legal limitations in categorizing stealthing as sexual assault and the challenges this presents in both criminal and civil proceedings).

182. Grace Keegan et al., *Trauma of Abortion Restrictions and Forced Pregnancy: Urgent Implications for Acute Care Surgeons*, Trauma Surgery & Acute Care Open, Jan. 4, 2023, at 1–6.

or maintaining a pregnancy against their partner's will.[183] In these cases, abortion access can be one of the few ways that a survivor can regain control of their body.[184] A forced pregnancy emboldens an abuser to continue to exert power and control over a survivor even beyond the pregnancy.[185] It can entrap a survivor into the abusive relationship when the alternative is the looming threat of child custody litigation and disputes that force continued contact with their abuser.[186]

After *Dobbs v. Jackson Women's Health Organization* overturned *Roe v. Wade*, this path to safety narrowed significantly.[187] Since *Dobbs*, domestic violence service providers have reported increased demand for assistance as well as new forms of reproductive coercion arising that are connected to abortion bans.[188] One study found that roughly 64,000 pregnancies resulted from rapes in states with total abortion bans within 18 months from the *Dobbs* decision, underscoring the real-world consequences.[189] Implementing reproductive coercion as a standalone and distinct form of IPV will further clarify and emphasize the importance of bodily autonomy, tantamount to that of providing safe and accessible pathways to abortion.

In states with abortion bans or severe restrictions, an abuser's power to force a pregnancy is amplified. By criminalizing or eliminating abortion access, states remove an essential survival tool for survivors to

183. *See generally* Karen T. Grace & Jocelyn C. Anderson, *Reproductive Coercion: A Systematic Review*, 19 Trauma, Violence, & Abuse 371 (2016) (providing a comprehensive overview of reproductive coercion).

184. *See* Dhaval M. Dave et al., *Abortion Restrictions and Intimate Partner Violence in the* Dobbs *Era*, J. Health Econ., Dec. 2025, at 1–2; Tanya Albert Henry, *Access to Abortion and Women's Health: What the Research Shows*, AMA (July 5, 2022), https://www.ama-assn.org/public-health/population-health/access-abortion-and-women-s-health-what-research-shows [https://perma.cc/8TQJ-RYZX].

185. Alana Semuels, *Abortion Bans Worsen Violence in Relationships, Study Finds*, TIME (June 17, 2025, 14:53 ET), https://time.com/7295172/abortion-bans-relationship-violence/ [https://perma.cc/VY7U-YR5Y].

186. *Continuing Abuse Tactics – Post-Separation Legal Abuse & Parental Alienation*, Domestic Violence Servs. Network (Aug. 20, 2024), https://www.dvsn.org/august-2024-continuing-abuse-tactics-post-separation-legal-abuse-parental-alienation/ [https://perma.cc/DZ3W-AQJF].

187. Becca Damante & Kierra B. Jones, *A Year After the Supreme Court Overturned* Roe v. Wade*, Trends in State Abortion Laws Have Emerged*, Ctr. for Am. Progress (June 15, 2023), https://www.americanprogress.org/article/a-year-after-the-supreme-court-overturned-roe-v-wade-trends-in-state-abortion-laws-have-emerged/ [https://perma.cc/3GLW-BF38].

188. Julianne McShane, *"What Can I Even Say Without Having to Go to Jail?"*, Ctr. for Health Journalism (Feb. 22, 2024), https://centerforhealthjournalism.org/our-work/reporting/what-can-i-even-say-without-having-go-jail [https://perma.cc/MZ64-QEFY].

189. Samuel L. Dickman et al., *Rape-Related Pregnancies in the 14 US States with Total Abortion Bans*, 184 J. Am. Med. Ass'n Internal Med. 330, 331 (2024).

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resist reproductive control.[190] This does not just undermine autonomy—it can trap survivors in abusive situations for longer periods, putting them at higher risk of continued violence during a particularly vulnerable time.[191] These outcomes are especially alarming given that homicide is one of the leading causes of death for pregnant and postpartum women in the United States, with pregnancy-related homicides rising significantly in recent years.[192]

When a pregnant survivor has no access to abortion, survivors are stripped of a crucial means of protecting themselves.[193] Forced parenthood with an abusive partner can deepen the cycle of violence and control and runs directly counter to public health goals aimed at reducing maternal mortality.[194]

Reproductive coercion can also look like pressuring or forcing someone to terminate a wanted pregnancy.[195] While this discussion focuses on access to abortion as a tool for survivors trying to escape forced pregnancy, true reproductive freedom means having the ability to make *any* pregnancy-related decision without fear or coercion. But when abortion access is stripped from survivors, it forces them to carry pregnancies that increase their likelihood of future harm or, worse, death.[196]

Efforts to combat reproductive coercion are fundamentally weakened in states that restrict or ban abortions.[197] When a survivor is denied the ability to terminate a coerced pregnancy, they lose one of the few tools available to reclaim bodily autonomy and safely separate

190. *Human Rights Crisis: Abortion in the United States After* Dobbs, Hum. Rts. Watch (Apr. 18, 2023), https://www.hrw.org/news/2023/04/18/human-rights-crisis-abortion-united-states-after-dobbs [https://perma.cc/SUD3-NKJF] [hereinafter Hum. Rts. Watch].

191. *Understanding Domestic Violence and Abortion Access*, Connections for Abused Women & Their Child. (July 7, 2023), https://www.cawc.org/news/understanding-domestic-violence-and-abortion-access/ [https://perma.cc/7QBK-F79N].

192. Wallace et al., *Homicide During Pregnancy*, *supra* note 13.

193. *See* Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Closer Look at Rape and Incest Exceptions in States with Abortion Bans and Early Gestational Restrictions*, Kaiser Fam. Found. (Aug. 7, 2024), https://www.kff.org/policy-watch/rape-incest-exceptions-abortion-bans-restrictions/ [https://perma.cc/QR9N-EUL6]; *see also* Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, Kaiser Fam. Found. (June 6, 2024), https://www.kff.org/womens-health-policy/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/ [https://perma.cc/FE9F-LQU6].

194. Steele-Baser et al., *supra* note 47.

195. Grace & Anderson, *supra* note 183, at 371.

196. Dan Fost, *UCSF Turnaway Study Shows Impact of Abortion Access on Well-Being*, UCSF News (June 30, 2022), https://www.ucsf.edu/news/2022/06/423161/ucsf-turnaway-study-shows-impact-abortion-access [https://perma.cc/BHS6-R445].

197. Hum. Rts. Watch, *supra* note 190.

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from their abuser.[198] This creates a legal and ethical contradiction: A state may purport to protect survivors through statutes recognizing reproductive coercion yet deny the very tool that allows them to reverse the consequence of said coercion. For example, Tennessee includes non-physical coercive conduct within its domestic violence statute but has an abortion ban starting at fertilization.[199] In doing so, the state becomes an unwitting enabler of the abuser's control, prolonging the survivor's entanglement in the abuse and increasing their exposure to harm.

Forced continuation of pregnancy amplifies maternal stress, increases the risk of further violence, and worsens health outcomes, including the risk of maternal mortality.[200] While protective orders and other legal remedies are essential, they are incomplete if survivors remain legally barred from making critical decisions about their own reproductive futures. The ability to access abortion is not a separate or secondary issue—it is central to any meaningful legal response to reproductive coercion. States addressing reproductive coercion must simultaneously protect and ensure meaningful abortion access to guarantee full reproductive autonomy and effectively mitigate the severe health risks, including maternal mortality, associated with coerced pregnancies.

C. Supporting Survivors

1. Incorporating Doula-led Care into State Medicaid Statutes

States should amend their Medicaid statutes and State Plans to provide comprehensive reimbursement for doula services, explicitly recognizing their role as a preventive strategy to reduce IPV-related maternal morbidity and mortality. Doulas provide continuous emotional, physical, and informational support to pregnant people, which is associated with improved birth outcomes such as lower cesarean rates and more positive birth experiences.[201] Research highlights the crucial role community-based doulas can play in supporting pregnant individuals experiencing domestic violence and other traumas.[202] Doulas

198. Monroe, *supra* note 33.
199. Tenn. Code Ann. § 36-3-601 (2024); Tenn. Code Ann. § 39-15-213 (2024).
200. Fost, *supra* note 196.
201. Medicaid & CHIP Payment & Access Comm'n (MACPAC), Doulas in Medicaid: Case Study Findings 2 (2023) [hereinafter MACPAC]; *see also* Am. Coll. of Obstetricians & Gynecologists, Committee Opinion No. 766: Approaches to Limit Intervention During Labor and Birth e166–67 (2019) (discussing continuous labor support, including by doulas).
202. Stephanie Arteaga et al., *"They're Gonna Be There to Advocate for Me So I'm Not by Myself": A Qualitative Analysis of Black Women's Motivations for Seeking and Experiences with Community Doula Care*, Women Birth, May 2023, at 2.

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provide continuity of care throughout the prenatal period—a critical benefit when pregnant people often see different clinicians at each visit and may never meet the nurses attending their birth.[203] This continuity enables doulas to build trusting relationships with clients over time.

A key role of doulas is advocacy within healthcare settings. Community members have emphasized that doulas can address healthcare system gaps by advocating for clients when their symptoms or concerns are minimized by clinicians—a particularly important function for those experiencing domestic violence who may face additional barriers to care.[204] As trusted, non-clinical support providers who are often culturally concordant with their clients, doulas can connect people to broader community services and resources, including domestic violence support services.[205] This support system is invaluable for mitigating the isolation and danger faced by IPV survivors during the vulnerable perinatal period. Expanding access to doulas via Medicaid can also address significant health disparities, as women of color and low-income individuals, who are disproportionately enrolled in Medicaid, face higher rates of both IPV and maternal mortality.[206]

States have the legal authority to cover doula services through their Medicaid programs.[207] This is typically accomplished by submitting a State Plan Amendment ("SPA") that designates doulas as preventive care providers.[208] Fifteen states and the District of Columbia have successfully implemented such amendments, demonstrating that this approach is both practicable and approved by federal authorities.[209] For instance, Massachusetts' Medicaid program, MassHealth, provides

203. Laura B. Attanasio et al., *Community Perspectives on the Creation of a Hospital-Based Doula Program*, 5 HEALTH EQUITY 545, 549–50 (2021).

204. ASTEIR BEY ET AL., ADVANCING BIRTH JUSTICE: COMMUNITY-BASED DOULA MODELS AS A STANDARD OF CARE FOR ENDING RACIAL DISPARITIES 15–16 (2019).

205. Attanasio et al., *supra* note 203; BEY ET AL., *supra* note 204; Elizabeth A. Mosley & Rhonda K. Lanning, *Evidence and Guidelines for Trauma-Informed Doula Care*, MIDWIFERY, Apr. 2020, at 1.

206. Greely et al., *supra* note 17, at 515; *see also* MACPAC, *supra* note 201, at 1 (noting doula care is linked to improved outcomes, especially for Black individuals, and discussing how states view doula coverage as a strategy to address health disparities).

207. *See, e.g.*, Social Security Act, Pub. L. No. 74-271, § 1905(a) (1935) (defining "medical assistance"); Anoosha Hasan, *State Medicaid Approaches to Doula Service Benefits*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Apr. 16, 2022), https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/ [https://perma.cc/LS23-DPW3] (detailing state use of SPAs and classification of doula services as preventive); *see also* MACPAC, *supra* note 201, at 16 (discussing SPAs as a common pathway).

208. Hasan, *supra* note 207.

209. *Id.* (showing the number of states with active coverage and those implementing it); *see also* MACPAC, *supra* note 201 (reflecting a narrower count of identifiable, fully implemented statewide programs, differing from that of the preceding study which included states that had adopted or were in the process of implementing Medicaid doula benefits).

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coverage for doula services for pregnant people.[210] This framework provides a clear and effective model for other states seeking to expand access to doula care for Medicaid-enrolled pregnant individuals, a population often at elevated risk for adverse maternal health outcomes.

Moreover, doula integration is cost-effective. Upfront reimbursement is offset by fewer cesarean deliveries, shorter hospital stays, and reduced emergency interventions.[211] Existing State Plan Amendment processes already allow states to add doulas as preventive providers; models like MassHealth show that credentialing, billing, and quality oversight can be implemented efficiently.[212] In sum, Medicaid coverage of doula services strengthens preventive care, enhances IPV intervention, promotes equity, and aligns with public health goals to reduce maternal morbidity and mortality.

IPV imposes a substantial economic burden, with related healthcare costs exceeding $5.8 billion annually.[213] Amending Medicaid statutes to reimburse doula services offers a proven, cost-effective approach to improve maternal health and address IPV. By formalizing doula care as a preventive benefit—modeled by MassHealth—states can enhance abuse detection, connect survivors to resources, and reduce expensive interventions. This policy advances health equity and aligns with fiscal priorities, ultimately reducing IPV-related maternal morbidity and mortality.

2. Employment Protections for Pregnant and Postnatal Survivors

States should enact or strengthen paid leave and job protection laws to meet the real needs of pregnant and postnatal survivors of IPV. Without clear, accessible protections—including paid time off and guaranteed job security—too many survivors are forced to choose between their health and safety and their ability to provide for themselves and their children. The already existing, albeit scarce, protections were not made

210. 130 Mass. Code Regs. §§ 463.401–.407.

211. Karen S. Greiner et al., *Cost-Effectiveness of Doula Support for Vulnerable Pregnant Women: A Modelling Study Applied to the Netherlands*, 64 J. Midwifery & Women's Health 410, 410, 419 (2019) (demonstrating potential cost savings from doula support through reduced medical interventions).

212. 130 Mass. Code Regs. §§ 463.401–.407; *see also MassHealth Doula Services Program Information for MassHealth Members*, MassHealth, https://www.mass.gov/info-details/masshealth-doula-services-program-information-for-masshealth-members [https://perma.cc/6HKJ-3SKF]; *MassHealth Doula Services Program Information for Doulas*, MassHealth, https://www.mass.gov/info-details/masshealth-doula-services-program-information-for-doulas [https://perma.cc/N6NY-3F2L].

213. Greely et al., *supra* note 17, at 514.

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with survivors of IPV in mind, inherently placing an unmanageable economic burden on them.

Pregnant and postpartum survivors of IPV face significant employment challenges that can directly impact their health and safety. They often need time off work for prenatal medical appointments, mental health care, legal proceedings, or to secure safe housing and care for their newborns. Without access to paid leave or job protection, many pregnant individuals are forced to choose between their safety and financial stability—a choice that can have devastating effects on both maternal and fetal health. Research consistently shows that IPV during pregnancy is associated with adverse maternal and neonatal outcomes, all of which are exacerbated by economic insecurity.[214] Economic abuse frequently escalates during pregnancy, with over one-third of such cases reportedly beginning or worsening at this vulnerable time.[215] Data indicate that abusive partners disrupt a survivor's ability to work in over 80% of cases, leading to job loss, missed work, and inability to pursue education or training.[216] In states lacking paid leave and strong employment protections, pregnant survivors may be more likely to forego essential health care due to fear of losing income or employment, which unfortunately renders their pregnancy at greater risk. Policies like paid family and medical leave and "safe leave" (specifically for domestic violence needs) are crucial, as they can provide job-protected time off for survivors to address their safety, health, and legal needs without jeopardizing their economic independence.[217] Academic analyses further highlight how providing job-protected and paid leave minimizes the significant economic costs associated with IPV, benefiting both survivors and employers.[218] This dynamic highlights the urgent need for comprehensive paid leave

214. Alhusen et al., *supra* note 7, at 100.

215. *Economic Wellbeing and Maternity – A Guide for Employers*, Surviving Econ. Abuse, https://survivingeconomicabuse.org/im-supporting-someone/resources-for-professionals/economic-wellbeing-and-maternity-employer-guide/ [https://perma.cc/7YH4-AER6]; Adrienne E. Adams et al., *Impact of Intimate Partner Violence on Low-Income Women's Economic Well-Being: The Mediating Role of Job Stability*, 18 Violence Against Women 1345, 1354–59 (2013).

216. Cynthia Hess & Alona Del Rosario, Inst. for Women's Pol'y Rsch., Dreams Deferred: A Survey on the Impact of Intimate Partner Violence on Survivors' Education, Careers, and Economic Security 23 (2018).

217. Nat'l P'ship for Women & Fams., Americans Need Access to Paid Safe Leave 2 (2023) [hereinafter Americans Need Access to Paid Safe Leave].

218. All. for Safety & Just., Lost Work, Pay, and Safety: Victims of Violence Urgently Need Safe Leave 2 (2024) (noting that intimate partner violence causes billions in lost work, pay, and productivity annually; over half of survivors report job loss due to victimization; lifetime costs exceed $100,000 per woman impacted; and protected leave policies improve employee retention and the national economy).

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policies and workplace protections that support pregnant IPV survivors and reduce barriers to their health and safety.

Federal law, primarily the Family and Medical Leave Act ("FMLA"), provides a baseline of unpaid job-protected leave for eligible employees for reasons including pregnancy and postpartum leave or to care for a newborn.[219] But the FMLA does not cover all needs related to intimate partner violence. To address the specific needs of survivors of domestic violence, some states have gone further by mandating paid family and medical leave, paid "safe leave" specifically for domestic violence-related needs, and prenatal leave.[220] These laws are most effective when the statutory language includes job protection, anti-retaliation provisions, and eligibility standards that do not exclude vulnerable workers.[221]

In New York, for example, survivors of domestic violence are protected under employment laws that recognize the unique challenges they face—particularly during pregnancy and the postpartum period. New York offers employment protections that can be especially impactful for pregnant and postnatal survivors of IPV. In 2025, New York implemented paid prenatal leave for private sector employees, which provides eligible employees with twenty hours of job-protected, paid leave each year specifically for prenatal medical appointments and procedures.[222] This protection is separate from existing paid leave programs[223] and ensures that pregnant individuals, including intimate partner violence survivors, can attend critical prenatal care without risking their income or job security. Additionally, under the New York State Human Rights Law, it is unlawful for employers to discriminate against someone because they are a survivor of domestic violence.[224]

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219. *Family and Medical Leave Act*, U.S. Dep't of Labor, https://www.dol.gov/agencies/whd/fmla [https://perma.cc/4MFS-QM3A] (providing an overview of FMLA provisions and eligibility).

220. Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601–54 (2023); *State Paid Family and Medical Leave Insurance Laws*, Nat'l P'ship for Women & Fams., https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/state-paid-family-leave-laws.pdf [https://perma.cc/4P7N-BFXY]; *Our Issues: Paid Sick Time*, A Better Balance, https://www.abetterbalance.org/resources/paid-sick-time-legislative-successes/ [https://perma.cc/G37C-46VZ].

221. Georgetown Ctr. on Poverty & Ineq., The Paid Family and Medical Leave Opportunity: What Research Tells Us About Designing a Paid Leave Program that Works for All 28–29 (2019).

222. N.Y. Lab. Law § 196-b(4-a) (McKinney 2025).

223. N.Y. Workers' Comp. Law § 204(1) (McKinney 2025); 29 U.S.C. § 2612(a)(1)(A)–(D).

224. N.Y. Exec. Law § 296(1)(a), (c), (d); *see also Victims of Domestic Violence: Know Your Rights*, Off. of N.Y. State Att'y Gen. (June 3, 2025), https://ag.ny.gov/publications/victims-domestic-violence [https://perma.cc/53XQ-KC4D].

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This includes discrimination in hiring, firing, terms and conditions of employment, promotion, and retaliation for seeking accommodations or reporting abuse. New York also may grant unemployment insurance benefits to survivors who are forced to leave their jobs for safety reasons, if they can provide documentation of the abuse and demonstrate a reasonable belief that continued employment would jeopardize their safety.[225] This provides a critical financial safety net for survivors navigating sudden separation or relocation due to violence.

While New York has enacted comprehensive laws aimed at protecting pregnant and postnatal survivors of IPV, other states fail to protect pregnant survivors of domestic violence in the workplace. In Texas, statewide employment protections for domestic violence survivors are notably absent, creating significant vulnerabilities.[226] While some employers may offer general sick leave, it is often unpaid, limited in scope, and not explicitly job-protected for reasons related to domestic violence, forcing survivors to deplete leave balances or risk their employment to address critical safety concerns.[227] The absence of robust non-discrimination laws for domestic violence survivors and specific unemployment eligibility for those forced to quit due to violence further exacerbates their precarious financial situation. Similarly, in Georgia, there is no statewide law requiring private employers to provide paid or unpaid leave specifically for domestic violence or sexual assault beyond the federal FMLA, which

225. N.Y. Lab. Law § 593(b)(i).

226. Legal Momentum, Texas: Domestic Violence, Sexual Assault & Stalking Victims' Employment Rights (2022) (noting that Texas law does not require employers to provide paid or unpaid sick leave, or leave to address domestic violence, sexual assault, or stalking); *Texas Paid Sick Leave Laws*, WorkforceHub, https://www.workforcehub.com/hr-laws-and-regulations/texas/texas-paid-sick-leave-laws/ [https://perma.cc/STY4-ZQ2H] (confirming no state law mandates paid or unpaid sick leave for private employers).

227. *See, e.g.*, Molly Weston Williamson, *The State of Paid Sick Time in the U.S.*, Ctr. for Am. Progress (Jan. 15, 2025), https://www.americanprogress.org/article/the-state-of-paid-sick-time-in-the-u-s-in-2025/ [https://perma.cc/JA7X-3J98] (detailing the widespread lack of access to paid sick leave, particularly among low-wage and part-time workers); Lisa Guerin, *Domestic Violence Leave: Taking Time Off Work*, NOLO, https://www.nolo.com/legal-encyclopedia/domestic-violence-leave-taking-time-30129.html [https://perma.cc/UP4D-TWY7] (explaining that general sick leave policies rarely meet the specific and ongoing needs of domestic violence survivors); Americans Need Access to Paid Safe Leave, *supra* note 217, at 3 (arguing that a lack of paid safe leave forces survivors to choose between safety and a paycheck); All. for Safety & Just., *supra* note 218 (describing how violence-related work interruptions lead to economic hardship and increased risk of job loss); Hess & Del Rosario, *supra* note 216, at 11 (finding that over half of IPV survivors lost a job due to abuse and 83% reported reduced productivity or missed work).

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has strict eligibility requirements and is unpaid.[228] While Georgia law does prohibit employers from discharging or discriminating against an employee who is a "crime victim" for taking time off to attend court proceedings, this limited protection does not cover other essential needs like counseling, medical appointments, or safety planning related to abuse.[229] North Carolina also offers minimal explicit protections. While it allows for "reasonable time off" for survivors of domestic violence to obtain protective orders, this leave is typically unpaid and does not encompass the broader range of needs faced by survivors, nor does the state mandate employers to provide paid sick days that could be used for such purposes.[230] While survivors are not prohibited from using their sick days for purposes relating to their abuse, they should not have to, and they will not get compensated for those days, placing yet another economic burden on them. The lack of a comprehensive statutory framework leaves pregnant and postnatal survivors with few formal workplace safeguards, amplifying the cruel choice between their physical safety and the economic stability essential for themselves and their newborns. This gap exemplifies the urgent need for comprehensive legislative action across the nation.

States must strengthen paid leave and employment protections tailored to pregnant and postnatal IPV survivors. Without clear job security and paid time off, survivors face untenable choices between safety and financial stability, risking their health and that of their unborn children. Comprehensive, survivor-focused policies that include prenatal and IPV-related leave, along with robust anti-discrimination safeguards, are essential to reduce barriers to care and promote the well-being of survivors. States lacking such protections leave pregnant survivors vulnerable to increasing abuse, unmet health needs, and economic insecurity.

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228. Legal Momentum, State Guide on Employment Rights for Survivors of Domestic Violence, Sexual Assault, and Stalking 27–28 (2024) (noting that Georgia does not require private employers to provide leave specifically for domestic violence survivors).

229. *What Should I Know About Losing a Job?*, Ga. Legal Aid, https://www.georgialegalaid.org/resource/what-should-i-know-about-losing-a-job [https://perma.cc/TL5X-G4VK] (stating that employers cannot fire or punish crime victims for taking time off to attend court proceedings).

230. *North Carolina Workplace Protections*, WomensLaw, https://www.womenslaw.org/laws/nc/workplace-protections [https://perma.cc/K4H9-M8VY] (stating that employers cannot take adverse action against employees solely for taking "reasonable time off" to obtain a domestic violence protective order, but such leave is generally unpaid); Legal Momentum, Survivor State Employment Guide: North Carolina (2022) (providing an overview of North Carolina's limited employment protections for victims, including lack of mandated paid leave).

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3. Mandatory IPV Screening During Prenatal Visits

Leading medical bodies also provide guidance on how to address IPV amongst pregnant persons when they seek medical care. The U.S. Preventive Services Task Force ("USPSTF") recommends that clinicians screen all women of reproductive age for IPV and provide or refer those who screen positive to ongoing support services.[231] ACOG similarly advocates for regular IPV screening during pregnancy and postpartum care.[232] Medical bodies have developed several screening instruments to accurately detect IPV among adult women.[233] The screening tools typically assess factors such as emotional and physical IPV, frequency of IPV, and frequency of sexual assault related to IPV through a series of questions and items.[234] State and local reporting requirements that mandate service providers inform local law enforcement vary jurisdictionally. While some only mandate reporting when there is an injury obtained from a weapon, others require reporting of abuse.[235] Criminal intervention is not what all survivors want or need to keep themselves safe, so it is not going to be further discussed as a gap for pregnant persons when they seek medical care and whether the providers are subject to mandatory reporting laws. Instead, this Article's emphasis is on requiring mandatory medical provider screenings for pregnant people to provide additional safety nets if they experience IPV.[236] Despite existing recommendations and available tools, current screening practices remain inconsistent and ineffective.[237] State law should mandate routine, trauma-informed IPV screening at every prenatal appointment. Mandating such screening at every prenatal visit would standardize care, activate critical support systems, and ensure timely intervention.[238] By aligning state-level policy with established public health frameworks and survivor-centered principles, this mandate offers a practical, evidence-based approach to protecting some of the most vulnerable patients in the healthcare system.[239]

231. U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7.
232. Wong et al., *supra* note 7, at 5.
233. U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7, at 331–33.
234. *Id.*
235. *Id.*
236. *Id.*
237. Sarah Halpern-Meekin et al., *Intimate Partner Violence Screening in the Prenatal Period: Variation by State, Insurance, and Patient Characteristics*, 23 Maternal & Child Health J. 756, 758 (2019).
238. Debra Houry et al., *Violence-Inflicted Injuries: Reporting Laws in the Fifty States*, 39 Annals Emergency Med. 56, 58–59 (2002).
239. *Id.*

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Federal law emphasizes the importance of addressing intimate partner violence and supporting survivors by providing a foundation for state-level mandates for intimate partner violence and domestic violence screening in prenatal care.[240] VAWA supports pregnant survivors by funding healthcare services, counseling, and protective programs that address their unique needs and reduce health risks to both mother and unborn child.[241] These initiatives include training medical professionals to provide trauma-informed care and ensuring access to critical prenatal and mental health services.[242] The Family Violence Prevention and Services Act ("FVPSA") provides a full range of trauma-informed support for survivors to help communities thrive.[243] In 2023, FVPSA-funded programs served over 1.3 million survivors and their children and responded to 2.7 million crisis calls.[244] The FVPSA funds over 1,500 shelters and 1,300 nonresidential sites; a national domestic violence hotline; a national Indigenous domestic violence hotline; 35 culturally specific domestic violence and sexual assault programs; 55 specialized services for abused parents and their children; and 26 national, special issue, and culturally specific resource shelters.[245] Despite this, data from the Pregnancy Risk Assessment Monitoring System ("PRAMS") show that 65.7% of female respondents to the survey were not screened for IPV before pregnancy, 29.7% were not screened during pregnancy, and 48.0% were not screened postpartum.[246] This exemplifies the major gap between the federal frameworks and state-level implementation.

Despite federal mandates, state-level implementation of IPV screening and reporting is insufficient. While the states discussed below offer robust and comprehensive screening requirements, in practice, implementation can be minimal. For example, even though California

240. *See Women's Preventive Services Guidelines*, Health Res. & Servs. Admin. (Dec. 2025), https://www.hrsa.gov/womens-guidelines [https://perma.cc/M76C-QCEV]; Nat'l Acads. of Scis., Eng'g, & Med., Essential Health Care Services Addressing Intimate Partner Violence 169 (Susan J. Curry & Crystal J. Bell eds., 2024).

241. *Violence Against Women Act (VAWA) 30th Anniversary, September 2024*, Nat'l Ctr. on Domestic & Sexual Violence, https://www.acf.hhs.gov/ofvps/news/ofvps/fvpsa-40th-anniversary [https://perma.cc/LXE2-TWJX]; U.S. Dep't of Just., Off. on Violence Against Women, VAWA Funding Supports Evidence-Based Practices 21–23 (2024) [hereinafter VAWA Funding Supports Evidence-Based Practices].

242. *See supra* note 241 and accompanying sources.

243. *See, e.g.*, Esta Soler, *40th Anniversary of FVPSA a Time to Boost Our Investments in Violence Prevention, Health*, Futures Without Violence (Oct. 9, 2024), https://futureswithoutviolence.org/news/fvpsa-40th-anniversa/ [https://perma.cc/3JFC-PHJY].

244. *Id.*

245. *Id.*

246. Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 240, at 44.

law technically mandates hospitals to establish policies for routine spousal or partner abuse screening, it lacks enforcement mechanisms.[247] As a result, only 14% of providers report "always" screening patients for intimate partner violence.[248] Iowa law similarly requires hospitals to create and implement protocols for patients who are survivors of IPV, including private interviews, confidentiality provisions, providing IPV hotlines and community resources, and education of emergency department staff.[249] However, like California, the statute lacks specific enforcement mechanisms or penalties for non-compliance.[250] New York also requires hospitals to develop, maintain, and disseminate written policies and procedures for the identification and treatment of confirmed or suspected cases of domestic violence.[251] New York's Department of Health specifically requires domestic violence screenings when a patient is admitted to the emergency department, during pre-established intervals in ambulatory and specialty services, and at primary care practices for new patients and at annual visits.[252] While comprehensive, enforcement is based mainly on hospital accreditation standards rather than statutory penalties.[253]

Simply put, states with laws requiring screening with clear tools for enforcement and penalties for non-compliance will have higher screening numbers. One national study found that only 49.2% of women reported being screened for IPV during prenatal care, with state-level variation ranging from 29.9% in Utah to 62.9% in New Mexico.[254] Utah has no statutory requirement for hospitals to establish domestic violence screening protocols or provide training,[255] while New Mexico requires medical personnel to document IPV. The study further estimated that

247. Cal. Health & Safety Code § 1259.5 (West 2025); Summer Sherburne Hawkins, *Screening for Intimate Partner Violence*, 53 J. Obstet. Gynecol. Neonatal Nurs. 106, 110 (2024).
248. Hawkins, *supra* note 247, at 110–11.
249. Iowa Admin. Code r. 481-51.7 (2024).
250. *Id.*
251. N.Y. State Dep't of Health, Informational Letter No. 21-07 on Hospital Domestic Violence Policies and Procedures (Aug. 11, 2021); N.Y. Pub. Health Law § 2805-z (McKinney 2020).
252. N.Y. State Dep't of Health, Informational Letter No. 21-07, *supra* note 251, at 2.
253. N.Y. Pub. Health Law § 2805-z.
254. Halpern-Meekin et al., *supra* note 237, at 756 (study includes the states of Alaska, Arkansas, Colorado, Georgia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington, and Wisconsin, as well as New York City).
255. Utah Code Ann. § 26B-8-232 (West 2023).

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48% of pregnant IPV survivors—approximately 142,000 individuals annually—went unscreened.[256]

The discrepancy in pregnancy screenings is unacceptable when there are several validated screening tools available to providers, each with varying levels of sensitivity and specificity.[257] Mandating routine, trauma-informed screening for IPV at every prenatal appointment is a necessary intervention to address systemic gaps in the identification and protection of pregnant survivors.[258] This policy would operationalize best practices, align with federal public health priorities, and improve maternal and fetal outcomes.[259]

A proper policy for IPV screening involves both a comprehensive mandate and an enforcement mechanism. First, a statewide mandate would standardize screening protocols and eliminate current inconsistencies. Presently, IPV screening during pregnancy is inconsistently implemented, leaving a significant number of survivors unidentified.[260] Universal screening at every visit would increase detection rates and facilitate earlier interventions.[261]

Second, mandatory screening strengthens the effectiveness of existing federal frameworks, such as VAWA and the FVPSA.[262] These programs fund essential survivor services, but their impact is limited unless survivors are first identified. Routine screening serves as a critical gateway to these resources.[263]

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256. Halpern-Meekin et al., *supra* note 237, at 764.

257. U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7, at 331–33; *see* Halpern-Meekin et al., *supra* note 237, at 756–67.

258. *See* Halpern-Meekin et al., *supra* note 237, at 756–67; U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7; Hawkins, *supra* note 247, at 108, 109, 118; Katy B. Kozhimannil et al., *Screening for and Experiences of Intimate Partner Violence in the United States Before, During, and After Pregnancy*, 113 Am. J. Pub. Health 297, 303 (2022); Jay G. Silverman, *Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health*, 195 Am. J. Obstet. & Gynecol. 140, 145, 146 (2006); Am. Coll. of Obstetricians & Gynecologists, Committee Opinion No. 518: Intimate Partner Violence 1017–26 (2012) [hereinafter Committee Opinion No. 518].

259. U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7, at 329, 334–35.

260. Kozhimannil et al., *supra* note 258, at 299.

261. *See* Committee Opinion No. 518, *supra* note 258; U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7, at 331, 334–35.

262. *See* Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 240, at 146–67, 169; Soler, *supra* note 243; *see also* U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7, at 336 (concluding there is adequate evidence that available screening instruments can identify IPV in women, specifically empirically demonstrating the benefit of ongoing support services for pregnant or postpartum women).

263. U.S. Preventive Servs. Task Force, *Screening for Intimate Partner Violence*, *supra* note 7.

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Third, the mandate must require trauma-informed practices.[264] Research on IPV disclosure in healthcare settings found that survivors were more likely to disclose abuse when clinicians demonstrated empathy, careful listening, and the ability to take ample time to address patient needs, sensitivity, privacy, and clear communication.[265] Training providers to use nonjudgmental language creates an environment that fosters trust and patient safety and increases patient disclosure rates.[266] Survivors identified open communication, shared decision-making, and provider concern as key factors facilitating disclosure.[267] This approach aligns with survivor-centered and trauma-informed care models endorsed by national healthcare organizations, which emphasize privacy, patient autonomy, supportive communication, and trust-building during IPV screening and intervention.[268]

Fourth, positive screenings should trigger structured risk assessments and safety planning.[269] Studies of IPV screening protocols in healthcare settings describe the use of standardized follow-up assessments, safety planning, and referrals to social workers or protective services after disclosure of violence.[270] Providers are trained to assess immediate danger, document abuse, conduct risk assessments, and connect patients with community resources and protective support services.[271]

Finally, the mandate must include enforceable provisions.[272] Without oversight, screening policies risk becoming symbolic rather than functional.[273] Clear protocols, provider training, and accountability mechanisms are essential to ensure meaningful implementation.[274]

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264. *Domestic Violence*, U.S. Dep't of Just., Off. on Violence Against Women, https://www.justice.gov/ovw/domestic-violence [https://perma.cc/9EVH-3B67]; VAWA Funding Supports Evidence-Based Practices, *supra* note 241.

265. Jane Liebschutz et al., *Disclosing Intimate Partner Violence to Health Care Clinicians – What a Difference the Setting Makes: A Qualitative Study,* 8 BMC Pub. Health 229 (2008).

266. *Id.*

267. *Id.*

268. *See generally* Elizabeth Miller et al., *Integrating Intimate Partner Violence Assessment and Intervention into Healthcare in the United States: A Systems Approach*, 24 J. Women's Health 92 (2015).

269. Lisa Colarossi et al., *Barriers to Screening for Intimate Partner Violence: A Mixed-Methods Study of Providers in Family Planning Clinics*, 42 Persps. on Sexual & Reprod. Health 236 (2010).

270. *Id.*

271. *Id.*

272. *See* Kozhimannil et al., *supra* note 258, at 299 (suggesting IPV screening could be required as a condition of payment to improve compliance).

273. *See* Hawkins, *supra* note 247, at 111, 114.

274. Halpern-Meekin et al., *supra* note 237, at 766.

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Given the severe health consequences of IPV during pregnancy and the availability of validated screening tools, mandatory trauma-informed screening is a critical public health and legal measure that supports early intervention, enhances survivor access to care, and promotes equitable maternal health outcomes.[275] Mandatory screening with proper enforcement mechanisms that hold providers accountable for lack of proper implementation will bring survivors out of the shadows and allow for the systems built for them to actually work.

4. ICE Enforcement & Birthright Citizenship

The threats of policies that seek to curtail birthright citizenship, combined with documented reports of Immigration and Customs Enforcement ("ICE") presence near or within medical facilities, create a profound "chilling effect" on healthcare access.[276] President Trump's mission to restrict birthright citizenship, amplified deportation efforts, and ongoing litigation over immigration enforcement signals to immigrant communities that seeking medical care could carry immigration consequences.[277] As a result, many face an impossible choice between safeguarding their health and protecting their family's safety.[278] This decision can lead to delayed or forgone medical attention during critical stages of pregnancy.[279]

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275. Steele-Baser et al., *supra* note 47.

276. Maria-Elena De Trinidad Young et al., *Beyond "Chilling Effects": Latinx and Asian Immigrants' Experiences with Enforcement and Barriers to Health Care*, 61 Med. Care 306, 307 (2023); *see* Sara Moniuszko, *Doctors Fear ICE Agents in Health Facilities Are Deterring People from Seeking Care*, CBS News (July 9, 2025, 15:50 ET), https://www.cbsnews.com/news/doctors-fear-ice-agents-health-care-facilities-deterring-people/ [https://perma.cc/WH46-EG5X]; *see also* Mary Anne Pazanowski, *Hospitals Brace for ICE Raids as Safe Space Shield Falls Away*, Bloomberg L. (Aug. 14, 2025, 05:00 ET), https://news.bloomberglaw.com/health-law-and-business/hospitals-brace-for-ice-raids-as-safe-space-shield-falls-away [https://perma.cc/7A4X-44YV]; Romina Tome et al., *Heightened Immigration Enforcement Impacts US Citizens' Birth Outcomes: Evidence from Early ICE Interventions in North Carolina*, PLOS One, Feb. 3, 2021, at 2 (finding that immigration enforcement impacts birth outcomes).

277. Lucía Félix Beltrán et al., UCLA Latino Pol'y & Pol. Inst., Born into Uncertainty: The Health and Social Costs of Ending Birthright Citizenship 5 (2025).

278. *See* Karen Hacker et al., *The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA*, 73 Soc. Sci. & Med. 586, 588–89 (2011) (discussing how immigration enforcement discourages immigrants from accessing health services).

279. Beltrán et al., *supra* note 277 (a key finding of the report shows that restricting birthright citizenship will worsen barriers to prenatal care, driving up costs and harming infant health).

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i. Consequences of ICE Enforcement

Heightened immigration enforcement and anti-immigration policies negatively impact health outcomes, especially for pregnant individuals in marginalized communities. Pregnant people—particularly those who are undocumented—may avoid necessary medical care, including routine prenatal checkups, vital screenings, and even emergency delivery services, out of fear of being identified, detained, or deported.[280] For example, a study conducted in South Texas found that the regular, highly visible presence of Border Patrol agents in hospitals contributes to the hesitation of undocumented individuals to seek care.[281]

Fear of detention, deportation, or other legal consequences discourages many from seeking routine prenatal care. This avoidance increases the risk of pregnancy-related complications and maternal and fetal mortality.[282] ICE presence in maternity wards and postnatal units further intensifies the danger pregnant survivors face by deterring them from delivering in hospitals, increasing the likelihood of unattended or births in a non-medical setting and depriving both parent and child of immediate postnatal care.[283] The effects are disproportionately felt by communities already facing systemic barriers to healthcare, compounding health disparities and producing preventable deaths and long-term complications.[284]

A study in North Carolina provides empirical evidence of these dynamics. When localities implemented Section 287(g) programs—a federal program empowering local law enforcement to act as ICE agents—birth outcomes and prenatal care utilization worsened

280. Victoria F. Keeton et al., *Latina Women's Perinatal Experiences and Perspectives Around Discrimination, Anti-Immigrant Policies, and Community Violence*, 53 J. Obstet. Gynecol. Neonatal Nurs. 635, 636 (2024); *see also* Shannon Schumacher et al., *KFF Survey of Immigrants: Views and Experiences in the Early Days of President Trump's Second Term*, Kaiser Fam. Found. (May 8, 2025), https://www.kff.org/racial-equity-and-health-policy/kff-survey-of-immigrants-views-and-experiences-in-the-early-days-of-president-trumps-second-term/ [https://perma.cc/J8UD-NEJA].

281. Christine Crudo Blackburn et al., *Examining the Presence of Border Patrol Agents in Hospitals in South Texas*, 27 J. Immigr. & Minority Health 424, 428 (2025).

282. *Preventing Pregnancy-Related Deaths*, *supra* note 59 (describing prenatal care throughout pregnancy as a critical preventative factor in reducing maternal and infant mortality).

283. *See* Am. Coll. of Obstetricians & Gynecologists, Committee Statement: Health Care for Immigrants 429–30 (2023) (explaining that policies that infringe on the health and rights of immigrants have detrimental effects on health and limit access to care).

284. Valerie Lacarte, *The Health Costs to Children of Stepped-Up U.S. Immigration Enforcement*, Immigr. Pol'y Inst. (June 18, 2025), https://www.migrationpolicy.org/news/health-costs-immigration-enforcement [https://perma.cc/7F89-5SAE].

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significantly.[285] The study observed a reduction in average birth weight by approximately 58.5 grams, an increase in small-for-gestational-age births by about 2.3 percentage points, and a nearly 9-point rise in inadequate prenatal care among less-educated, foreign-born parents after the program's enactment.[286] Additional research analyzing birth certificate data to further understand the ripple effect of immigration enforcement confirms that structural and social stressors, including immigration enforcement and policy uncertainty, directly increase risks of adverse maternal and fetal outcomes. This highlights the compounding effects of legal insecurity on pregnancy and birth.[287]

Although no state has codified protections from ICE enforcement activities at healthcare facilities, states such as California and Washington have pursued litigation to block the sharing of Medicaid data with federal immigration authorities by framing their arguments in terms of patient privacy and public health.[288] By legislating safe-access zones, states could directly address the chilling effect of immigration enforcement on healthcare utilization by pregnant survivors of intimate partner violence.[289]

ii. SCOTUS Contracting Birthright Citizenship[290]

The threats of policies that seek to curtail birthright citizenship also contribute to the profound "chilling effect" on healthcare access discussed above.[291] President Trump's mission to restrict birthright citizenship, amplified deportation efforts, and ongoing litigation over immigration enforcement signals to immigrant communities that seeking

285. *See* Tome et al., *supra* note 276, at 1–2, 10, 12 (finding that immigration enforcement impacts birth outcomes).

286. *Id.* at 9.

287. Hoa Vu, *I Wish I Were Born in Another Time: Unintended Consequences of Immigration Enforcement on Birth Outcomes*, 33 HEALTH ECON. 345, 357 (2024).

288. Press Release, Cal. Dep't of Just., Attorney General Bonta Secures Preliminary Relief Blocking Federal Use of Medicaid Data for Immigration Enforcement (Aug. 12, 2025), https://oag.ca.gov/news/press-releases/attorney-general-bonta-secures-preliminary-relief-blocking-california%E2%80%99s-medicaid [https://perma.cc/CJQ8-GZ2K]; Press Release, Wash. State Att'y Gen., Judge Blocks Sharing of WA Medicaid Data for Immigration Enforcement (Aug. 13, 2025), https://www.atg.wa.gov/news/news-releases/judge-blocks-sharing-wa-medicaid-data-immigration-enforcement [https://perma.cc/NY2N-QN7V].

289. *See* Christine Show, *Abortion Is a Migrant Women's Issue*, WOMEN'S REFUGEE COMM'N (Nov. 4, 2024), https://www.womensrefugeecommission.org/blog/abortion-is-a-migrant-womens-issue [https://perma.cc/P2B7-2E8P].

290. *See supra* note 8 (explaining that the Supreme Court's decision in *Trump v. Barbara* forecloses constitutional challenges to birthright citizenship).

291. Young et al., *supra* note 276, at 307; *see* Moniuszko, *supra* note 276; Pazanowski, *supra* note 276; Tome et al., *supra* note 276, at 2.

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medical care could carry immigration consequences.[292] As a result, many face an impossible choice between safeguarding their health and protecting their family's safety.[293] This decision can lead to delayed or forgone medical attention during critical stages of pregnancy.[294]

The political rhetoric surrounding birthright citizenship and the fear it instilled in those it may affect have exacerbated this public health crisis. The Citizenship Clause of the Fourteenth Amendment provides: "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside."[295] In *United States v. Wong Kim Ark*, the Supreme Court held that the Citizenship Clause applies to children born in the United States to non-citizen parents.[296] Despite this precedent, recent legal litigation and political rhetoric have sought to narrow the scope of birthright citizenship, claiming that children of undocumented immigrants are not "subject to the jurisdiction" of the United States.[297]

Should the Supreme Court narrow the scope of the Citizenship Clause, states could respond by enacting statutory "safe-access" zones that bar immigration enforcement from reproductive and perinatal health facilities, strengthen medical-privacy protections to limit disclosure of immigration status, and invoke state constitutional guarantees of equal protection, due process, and public health to challenge federal overreach.[298] Such measures would revive, at the state level, protections

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292. BELTRÁN ET AL., *supra* note 277, at 5.

293. *See* Hacker et al., *supra* note 278, at 588–89 (discussing how immigration enforcement discourages immigrants from accessing health services).

294. BELTRÁN ET AL., *supra* note 277 (a key finding of the report shows that restricting birthright citizenship will worsen barriers to prenatal care, driving up costs and harming infant health).

295. U.S. CONST. amend. XIV, § 1 ("All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside."); PHYSICIANS FOR HUM. RTS., CONSEQUENCES OF FEAR: HOW THE TRUMP ADMINISTRATION'S IMMIGRATION POLICIES AND RHETORIC BLOCK ACCESS TO HEALTH CARE 7–10 (2025).

296. 169 U.S. 649, 693 (1898).

297. *See* Trump v. CASA, Inc., 606 U.S. 831, 831 (2025) (declining to reach the question of whether the Fourteenth Amendment guarantees birthright citizenship to children of undocumented immigrants); *see also* Barbara v. Trump, 790 F. Supp. 3d 80, 86–87 (D.N.H. 2025) (preliminarily enjoining enforcement of the executive order narrowing birthright citizenship); *see generally* Exec. Order No. 14,160, 90 Fed. Reg. 8449, 8449 (Jan. 29, 2025) (directing federal agencies to implement restrictions on birthright citizenship).

298. *See Factsheet: Trump's Rescission of Protected Areas Policies Undermines Safety for All*, NAT'L IMMIGR. L. CTR. (Feb. 26, 2025), https://www.nilc.org/resources/factsheet-trumps-rescission-of-protected-areas-policies-undermines-safety-for-all/ [https://perma.cc/HE9M-6W6L] (describing the Department of Homeland Security's "protected areas" policy and its role in safeguarding hospitals and clinics from immigration enforcement); *see also* PHYSICIANS FOR HUM. RTS. & NAT'L IMMIGR. L.

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once embedded in the Department of Homeland Security's "sensitive locations" policy, which for nearly a decade restricted immigration enforcement in hospitals, clinics, and other healthcare facilities to avoid deterring patients from seeking care.[299]

For survivors of IPV, the potential harms are compounded. If birthright citizenship is limited to children with at least one U.S. citizen parent, survivors whose abusive partner is the only U.S. citizen parent will be forced to maintain contact or cooperate with that partner to prove their child's citizenship status, placing them at a heightened risk of continued abuse and undermining safety planning.[300]

III. Comparative Law Analysis: International Strategies to Combat Maternal and Fetal Mortality Associated with Domestic Violence

While VAWA established a foundational domestic legal framework, the United States' engagement with international human rights instruments remains limited. Globally, various treaties and conventions protect fundamental rights, many of which encompass protections against gender-based violence. The International Covenant on Civil and Political Rights ("ICCPR"), ratified by the United States in 1992, safeguards the right to life (Article 6) and freedom from torture and cruel, inhuman, or degrading treatment (Article 7) and expressly prohibits the death penalty for pregnant women.[301] However, the United States ratified the ICCPR with extensive reservations, understandings, and declarations ("RUDs"), which render many

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Ctr., Health Care and U.S. Immigration Enforcement: What Providers Need to Know (2025) (outlining healthcare institutions' responsibilities to maintain patient confidentiality and reduce enforcement-related deterrents to care); *see generally* Susan Fluerant & Marisa London, *What States Can Do to Fill the Gap in Health Care Access for Immigrant Communities*, Network for Pub. Health L. (Apr. 11, 2025), https://www.networkforphl.org/news-insights/what-states-can-do-to-fill-the-gap-in-health-care-access-for-immigrant-communities/ [https://perma.cc/K6R7-UU7F] (recommending state-level measures, including safe-access approaches, to preserve healthcare access amid immigration enforcement).

299. Memorandum from John Morton, Director of U.S. Immigration and Customs Enforcement on Sensitive Locations and Courthouse Arrests (Oct. 24, 2011), https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf [https://perma.cc/RC9E-SZMQ].

300. *See* Elizabeth Aranda et al., *Hesitation to Seek Healthcare Among Immigrants in a Restrictive State Context*, 14 Soc. Sci. 433, 433 (2025) (noting that anti-immigrant rhetoric and restrictive policies lead to immigrants' fear of deportation, which is a major contributor to health inequities).

301. International Covenant on Civil and Political Rights arts. 6(1), 6(5), 7, Dec. 16, 1966, 999 U.N.T.S. 171.

provisions non-self-executing and significantly constrain the treaty's domestic legal effect.[302]

Similarly, the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), adopted in 1979 and widely recognized as an international bill of rights for women, defines violence against women as a form of discrimination and obligates states to address it through legislative and policy measures.[303] CEDAW also uniquely affirms women's reproductive rights.[304] Despite its near-universal ratification by 189 countries, the United States has signed but not ratified the treaty, thereby avoiding binding legal obligations under its provisions and inviting continued criticism regarding the country's commitment to international standards on gender equality.[305]

While the United States continues to struggle with high rates of maternal and fetal mortality, which are exacerbated by IPV, other nations have implemented more robust, integrated approaches to preventing violence during pregnancy.[306] A comparative analysis of international legal frameworks, healthcare protocols, and employment protections reveals critical insights for improving United States policy.[307] This section examines legislative strategies from other high-income and developed countries including the European Union and Scandinavia,

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302. *See Status of Ratification: Interactive Dashboard*, Off. of the U.N. High Comm'r for Hum. Rts., https://indicators.ohchr.org [https://perma.cc/TS4F-WB9L] (select "ICCPR" and "United States"); Kristina Ash, *U.S. Reservations to the International Covenant on Civil and Political Rights: Credibility Maximization and Global Influence*, 3 Nw. J. Int'l Hum. Rts. 1, 4 (2005).

303. Convention on the Elimination of All Forms of Discrimination Against Women arts. 1–2, Dec. 18, 1979, 1249 U.N.T.S. 13; Convention on the Elimination of All Forms of Discrimination Against Women, General Recommendation No. 35: Updating General Recommendation No. 19, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017).

304. Convention on the Elimination of All Forms of Discrimination Against Women art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13; *see also* Pooja Khanna, Zachary Kimmel & Ravi Karkara, U.N. Women, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) for Youth 10 (2016).

305. *See* Luisa Blanchfield, Cong. Rsch. Serv., R40750, The U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW): Issues in the U.S. Ratification Debate (2011).

306. World Health Org., *Violence Against Women* (Mar. 25, 2024), https://www.who.int/news-room/fact-sheets/detail/violence-against-women [https://perma.cc/CB43-UN4G] (noting that intimate partner violence exacerbates the risk of miscarriage).

307. *Id.* (describing the World Health Organization's global plan of action, which includes strengthening health systems to respond to IPV, collaborating with international agencies to collect data on IPV, and determining political strategy); *see also* Org. for Econ. Co-operation & Dev., PF2.1 Parental Leave Systems 2 (available at OECD Fam. Database 2026, https://www.oecd.org/en/data/datasets/oecd-family-database.html [https://perma.cc/DLW8-JNUW]) (providing an overview of parental leave policies across OECD countries and finding that the United States is the only OECD country that does not offer statutory paid leave on a national basis).

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Australia, New Zealand, and Japan, highlighting best practices for legal reform in the United States. These regimes are utilized as part of the comparative analysis due to the breadth of their legal infrastructure as it relates to IPV and its intersectionality with pregnant people. Similarly, they provide a proper framework for comparison as these regimes have similar governmental and legal systems to that of the United States. Their frameworks are supported by both data and societal desire to address these issues. While not every regime utilizes as comprehensive a reform as this Article calls for in the United States, they do lay the groundwork for every proposal outlined in the previous Part. Comparative lessons from the European Union and Scandinavia, Australia, and New Zealand show that integrated legal, medical, and social strategies save lives. By contrast, Japan's reliance on voluntary disclosure highlights the limits of a piecemeal approach.

A. European Union and Scandinavia

In 2024, the European Union adopted Directive (EU) 2024/1385 on *Combating Violence Against Women and Domestic Violence*, a landmark measure establishing binding minimum legal standards across member states. By June 14, 2027, member states must enact national legislation that criminalizes psychological violence and coercive control, sets minimum sentencing requirements, expands access to protective orders and other legal remedies, and ensures the availability of survivor support services, including specialized assistance for pregnant women.[308] This Directive plays a critical role in combating violence against women and domestic violence and represents a landmark instrument mandating minimum legal standards across member states.[309]

308. Directive 2024/1385, of the European Parliament and of the Council of 14 May 2024 on Combating Violence Against Women and Domestic Violence, 2024 O.J. (L 1385) art. 2(b) (defining domestic violence to include psychological violence), art. 5 (requiring criminalization of non-consensual sharing of intimate material), art. 14(2) (guaranteeing access to legal aid for victims of domestic violence), art. 18 (providing for referral of victims to support services), art. 19 (mandating protective orders), arts. 25–31 (establishing specialist support services for victims); *see also id.* pmbl. ¶ 11 (recognizing coercive control as a common feature of domestic violence), pmbl. ¶ 39 (acknowledging that pregnant victims may require special attention).

309. *Id.* arts. 3–9 (criminalizing female genital mutilation, non-consensual sharing of intimate or manipulated material, cyber stalking, cyber harassment, cyber incitement to violence or hatred, and inciting, aiding and abetting and attempt of any of the prior mentioned criminal offenses), arts. 14–24 (requiring member states to ensure that "victims can report acts of violence against women" to competent authorities, that authorities investigate and prosecute violence against women, that victims are given individual assessments to determine their protection and support needs, that victims are referred to support services, that victims' private lives are protected, that law enforcement follows investigatory guidelines, that national bodies report recommendations relating

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Scandinavian countries, particularly Sweden, further extend protections through strong labor frameworks. Under Swedish law, employers must assess risks to pregnant workers and make necessary adjustments to ensure their safety.[310] These laws, while not explicitly framed around IPV, provide either a nuanced legal framework for employers to ensure a safe working environment for pregnant employees or the necessary social benefits to provide compensation for pregnancy-related work restrictions and leave.[311] The Swedish Gender Equality Agency advocated for this legislation, and their community outreach evinced a strong desire in both the private and public sector for appropriate discussions of domestic violence and how to properly address survivors' needs in the workplace.[312]

When it comes to legal recourse through a protective order, Sweden is silent on coercive control or reproductive coercion, as protections are provided by general criminal statutes.[313] But those legal frameworks have broad language that pregnant survivors can utilize to demonstrate that what they suffered should be covered by the statute, including reproductive coercion.[314] Interestingly, Sweden's case law does reference aggravating circumstances as it relates to acts of domestic violence and the severity of punishment that may be warranted.[315]

In the European Union, Ireland has taken significant steps to support domestic violence survivors, including the implementation of employer paid time off due to domestic violence. Under the Work Life Balance and Miscellaneous Provisions Act 2023, survivors are entitled to up to five paid days off annually to access safety, medical,

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to violence against women, that non-consensual online material is removed, and that victims receive fair compensation).

310. *Pregnancy and Breastfeeding*, Swedish Work Env't Auth. (Feb. 11, 2026), https://www.av.se/en/health-and-safety/pregnancy-and-breastfeeding/ [https://perma.cc/3NWW-V2BH].

311. *Id.*

312. *More Workplaces Are Including Domestic Violence in Their Occupational Health and Safety Efforts*, Swed. Gender Equal. Agency (Mar. 23, 2025), https://swedishgenderequalityagency.se/news/more-workplaces-are-including-domestic-violence-in-their-occupational-health-and-safety-efforts/ [https://perma.cc/Q7RJ-CHX9].

313. Lag om kontaktförbud [Restraining Order Act] (Svensk författningssamling [SFS] 1988:688) (Swed.).

314. *Id.* (including access to a contact ban to protect survivors against "influence" from an abuser with the intent to prevent the victim from providing information to a court or a law enforcement authority regarding the abuse and with consideration for victims who are being "persecuted, improperly monitored, or otherwise seriously harassed").

315. Baker McKenzie, Fighting Domestic Violence: Europe 1–2 (2021) (analyzing Swedish Penal Code (Brottsbalken, SFS 1962:700)).

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or legal resources.[316] Furthermore, Ireland's Domestic Violence Act 2018 significantly strengthened protections for survivors, notably by criminalizing coercive control and expanding eligibility for various protective orders.[317]

B. Australia

In 2016, the Victorian Royal Commission into Family Violence recommended and supported routine screening for family violence and advocated that it be introduced in prenatal settings.[318] This signaled to the legislature that inquiring into proactive IPV mandates was of the utmost importance. Following that, the 2021 National Community Attitudes Towards Violence Against Women Survey ("NCAS"), conducted by the Australian National Research Organisation for Women's Safety ("ANROWS"), showed that there is evidence of a strong societal understanding within Australia that domestic violence is a serious issue within the country.[319] This survey was conducted on 19,000 Australians and will be used as a tool of advocacy to inform policy and legislation.[320]

In response to this societal push, Australia has developed one of the most comprehensive models for addressing IPV during pregnancy by embedding a five-step domestic violence screening directly into maternal healthcare.[321] The New South Wales Health Policy Directive outlines a structured five-phase process: "(1) delivering the domestic violence routine screening preamble; (2) asking the screening questions; (3) taking appropriate actions in response to the person's answer; (4) explaining and offering the domestic violence Z-card [(information card)]; and (5) documenting screening and outcomes in clinical records."[322] Queensland Health's guidelines mandate routine screening, thorough documentation, the use of detailed risk assessment tools, and individualized safety planning, with particular

316. Arthur Cox, Domestic Violence Leave to Be Effective from 27 November, at 1 (2023).

317. Domestic Violence Act 2018 (Act No. 6/2018) (Ir.) ¶ 10 (protection orders), ¶ 39 (offense of coercive control), https://www.irishstatutebook.ie/eli/2018/act/6/enacted/en/html.

318. Strengthening Hosp. Responses to Fam. Violence Leadership Team & Ctr. for Prevention of Fam. Violence, Antenatal Screening for Family Violence: Evidence Brief 3 (The Royal Women's Hospital & Univ. of Melb. eds., 2024).

319. Christine Coumarelos et al., Attitudes Matter: The 2021 National Community Attitudes Towards Violence Against Women Survey (NCAS), Findings for Australia 22–23 (2023).

320. *Id.*

321. *See, e.g.*, N.S.W. Health, Domestic Violence Routine Screening 4 (2023).

322. *Id.*

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emphasis on supporting Aboriginal and Torres Strait Islander communities.[323]

These practices are complemented by nationwide employment protections. In 2023, the Fair Work Act of 2009 was amended to entitle all employees in Australia to ten days of paid family and domestic violence leave annually.[324] This leave enables pregnant IPV survivors to relocate, attend appointments, seek legal protection, or access shelter without risking job loss or lost income.

Additionally, Victoria's Family Violence Protection Act of 2008, along with legislation in other states, recognizes coercion, and specifically sexually coercive behavior, as part of the legal framework for family violence.[325] In Queensland and New South Wales, Acts were passed to criminalize coercive control in the IPV context.[326] While some scholars continue to call for reproductive coercion to be incorporated into the statutes, arguments can be made for survivors under the coercive control additions to the laws which went into effect in recent years.[327]

C. New Zealand

New Zealand's Family Violence Act ("FVA") of 2018 provides one of the most expansive statutory definitions of family violence, including physical, psychological, sexual, and economic abuse and coercive control.[328] The FVA provides various types of protective orders for survivors to seek safety including "the police safety orders," which are temporary 10-day orders requiring perpetrators to leave the joint residence and stay away from survivors.[329] There are also court-ordered protection orders that prohibit violence, contact, and weapon possession, as well as property orders granting survivors the right to occupy and use the premises of their home, with the furniture included.[330] The Act directs courts and agencies to consider the safety of children, recognizing their vulnerability and the risk of lasting harm to them from domestic violence.[331] The FVA also promotes interagency

323. Queensland Health, Antenatal Screening for Domestic and Family Violence Guideline 14 (2018).
324. *Fair Work Act 2009* (Cth) s 106B (Austl.).
325. *See, e.g.*, *Family Violence Protection Act 2008* (Vic) s 5 (Austl.).
326. *Domestic and Personal Violence Act 2007 No 80* (NSW) ss 5, 6A (Austl.).
327. Stephanie Komazec & Clare Farmer, *Reproductive Coercion and Abuse: The Potential Protective Scope of Existing Family Violence Legislation in Australia*, 11 Violence & Gender 14, 16 (2024).
328. Family Violence Act 2018, s 9 (N.Z.) [hereinafter N.Z. Family Violence Act].
329. *Id.* s 26.
330. *Id.* ss 90, 98–102, 114.
331. *See* N.Z. Family Violence Act, *supra* note 328, at ss 4(d)–(e), 11(2)–(3), 59(d)–(f), 62, 79, 83, 86, 105 (defining family violence to include psychological abuse

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collaboration by removing legal barriers to information sharing across agencies and allowing the ten designated agencies to share information easily and accessibly, which is a critical framework for IPV response.[332] This coordinated model allows healthcare workers, law enforcement, and social workers to ensure support for identified pregnant survivors.

In 2024, the Women's Refuge Center provided data surveyed from 2,010 community members evincing the desire for active community support for victims and survivors.[333] The report highlights that this has been a positive shift in societal attitude following the passage of the FVA in 2018.[334] The New Zealand Ministry of Justice found that the programs created by the FVA have reduced reoffending and improved feelings of safety and mental well-being for survivors.[335] Similarly, the Integrated Safety Response pilot shows emerging evidence that collaborative, multi-agency interventions can improve safety planning and response coordination.[336]

These protective and robust statutes, coupled with mandated screening, present a model that proves to be survivor-centered. While universal IPV screening is not required, the Well Child/Tamariki Ora Program provides preventive maternal and child health services that proactively ensure family health and wellbeing and that form the foundation for expanding IPV screening during pregnancy.[337] A 2025 report by Te Tāhū Hauora, New Zealand's Health Quality and Safety Commission, found that 63% of maternal suicides between 2006 and

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that a child sees or hears and directing courts to consider the abuse's effects on children when assessing risk and issuing protection orders).

332. *See A New Family Violence Act*, N.Z. Ministry of Just., https://www.justice.govt.nz/justice-sector-policy/key-initiatives/addressing-family-violence-and-sexual-violence/a-new-family-violence-act/ [https://perma.cc/2DFQ-QMW4].

333. Women's Refuge, 'Safer When, Safer How?' How Communities Feel About Responding to Family Violence 9, 45 (2024).

334. *Id.* at 45.

335. *An Evaluation of Ministry-Funded Domestic Violence Programmes*, N.Z. Ministry of Just. (Mar. 4, 2020), https://www.justice.govt.nz/justice-sector-policy/research-data/evaluation-of-domestic-violence-programmes/ [https://perma.cc/WAA9-AYBW].

336. Elaine Mossman, Judy Paulin & Nan Wehipeihana, Evaluation of the Family Violence Integrated Safety Response Pilot: Final Report 2–5 (2017) (finding that the Integrated Safety Response pilot's multi-agency collaborative method led to the development of safety plans for 10,000 families, more efficient case management, and increased responsiveness to family violence among government agencies).

337. *Well Child Tamariki Ora Visits*, N.Z. Ministry of Health (Aug. 19, 2025), https://www.healthnz.govt.nz/health-topics/pregnancy-maternity/pregnancy-birth-and-children-services/well-child-tamariki-ora/well-child-tamariki-ora-visits [https://perma.cc/95WF-7AS8].

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2023 involved a police-reported family violence history.[338] These findings have sparked the New Zealand College of Midwives to release a "call to action" to implement the report's recommendations.[339] Such recommendations include enhancing midwifery training, supports, and interventions for violence during pregnancy, as midwives are the strongest points of contact during pregnancy as New Zealand's primary care providers for pregnant people.[340]

Similar to Australia, New Zealand's Domestic Violence Victims' Protection Act, enacted in 2018, guarantees ten days of paid leave and provides the right to request short-term flexible work arrangements.[341] This legal protection gives pregnant survivors the time and space to navigate housing, legal, and healthcare needs without risking their livelihoods.

D. Japan

In contrast to the preceding countries, Japan demonstrates the issues faced when a piecemeal approach is taken to address IPV. Comparatively, this analysis operates to evince the importance of societal support and coordinated legislative responses. Japan's system relies largely on voluntary disclosure—a model that often fails to protect pregnant IPV survivors before violence escalates. The legislature addresses IPV primarily through the Act on the Prevention of Spousal Violence and the Protection of Victims, enacted in 2001.[342] The act defines domestic violence to include both physical and psychological abuse and allows survivors to obtain protection orders and emergency shelter.[343] Despite this helpful framework, domestic violence remains widespread; approximately one in seven women experience IPV while pregnant.[344]

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338. Te Tāhū Hauora Health Quality & Safety Comm'n, Femicide: Deaths Resulting from Gender-Based Violence in Aotearoa New Zealand 42 (2025).

339. *Media Release 1 July 2025: Report Reveals Urgent Need to Address Pregnancy-Related Deaths from Gender-Based Violence*, N.Z. Coll. of Midwives (July 1, 2025), https://www.midwife.org.nz/news/12637/ [https://perma.cc/9UGF-7AUK].

340. *Id.*

341. Domestic Violence—Victims' Protection Act 2018, s 72H (N.Z.).

342. Haigūsha kara no bōryoku no bōshi oyobi higaisha no hogo tō ni kansuru hōritsu [Act on the Prevention of Spousal Violence and the Protection of Victims], Law No. 31 of 2001, *translated in* (Japanese Law Translation [JLT DS]), https://www.japaneselawtranslation.go.jp/en/laws/view/4476/en (Japan).

343. *Id.* art. 1, para. 1 (defining spousal violence to include physical and psychological harm), art. 3, para. 3 (emergency shelter), art. 10 (protective orders).

344. Naho Maruyama, Sachiyo Horiuchi & Yaeko Kataoka, *Prevalence and Associated Factors of Intimate Partner Violence Against Pregnant Women in Urban Areas of Japan: A Cross-Sectional Study*, BMC Pub. Health, June 17, 2023, at 8.

The Maternal Protection Act governs sexual and reproductive health in Japan and is highly restrictive and in need of reform.[345] It restricts sterilization, requiring spousal consent, and has very limited contraception options.[346] Abortions are criminalized in Japan, absent specific conditions requiring spousal consent or a partner's consent if the parties are not married, limiting the reproductive autonomy of pregnant people.[347] Abortions are legal if the pregnancy was a result of a violent rape or if continuing the pregnancy would harm the pregnant person's physical health.[348] Language utilized around rape in this statute is extremely troublesome as it places harmful parameters around what counts as consensual sex and whether someone is able to freely make decisions as to their physical autonomy. Legal advocates in Japan are calling for legal reform around this antiquated act to protect the reproductive rights of pregnant people.[349]

Similar gaps are seen within Japan's labor laws, despite the fact they offer parental leave and prohibit the dismissal of pregnant employees.[350] These protections are not integrated with domestic violence response systems, creating a lack of supportive responses that would connect survivors to needed resources. Without mandated cross-agency coordination between law enforcement and employers or IPV screening in prenatal care, Japan's system relies on self-reporting—leaving pregnant survivors vulnerable to escalating harm. Self-reporting can be difficult for survivors as it places a burden on them and fails to consider a holistic and intersectional approach in protecting pregnant people. Consequently, these directives have proven of little value without addressing the full swath of necessities a survivor may have when in crisis.

345. Botai Hogo Hō [Maternal Health Act], Act No. 156 of 1948, *translated in* (Japanese Law Translation [JLT DS]), https://www.japaneselawtranslation.go.jp/en/laws/view/2603/en (Japan).

346. *Id*. art. 3, para. 3 (consent), art. 15, para. 1 (restricting the issuance of practical guidance regarding contraception to doctors and other officials designated by the governor).

347. *Id*. art. 14 (limiting the availability of abortions to cases of emergencies and rape, and requiring consent for abortions in those circumstances); Keihō [Penal Code], Act No. 45 of 1907, arts. 212–16, *translated in* (Japanese Law Translation [JLT DS]), https://www.japaneselawtranslation.go.jp/en/laws/view/3581/en (Japan).

348. *See supra* note 343 and accompanying sources.

349. Kimiko Abe et al., JAWW NGO Report for Beijing +30 (2024).

350. Emp./Equal Opportunity Div. (Off.), Mun. Lab. Bureau, Mistreating Employees Such as Dismissing for Their Pregnancy, Childbirth, or Taking Childcare Leave Is Prohibited by Law (Japan).

Conclusion

The preventable deaths of pregnant and postpartum people at the hands of intimate partners reveal a profound failure in our legal and public health systems.[351] For years, research has indicated there is a clear intersection between IPV and maternal and fetal mortality, yet our responses remain fragmented and reactive.[352] This failure hits hardest in marginalized communities, where Black, Indigenous, and other women of color face the highest risks.[353] Their disproportionate burden reflects the intersection of racial, economic, and gender-based oppression—and it demands urgent, systemic change.

This Article calls for a comprehensive approach that brings law, medicine, and social support into alignment to prevent these deaths. Strengthening legal protections through targeted state legislation, integrating doula-led care into Medicaid, and ensuring paid prenatal and postnatal leave would allow survivors to prioritize safety and health without risking their economic security.

Key reforms also include mandatory firearm relinquishment in domestic violence cases, universal trauma-informed IPV screenings at every prenatal appointment, and specialized training for healthcare providers to recognize and respond to abuse. States must also recognize reproductive coercion in their statutes to address this often invisible, but deeply harmful, form of control that threatens pregnant survivors. The United States must act now to prevent more maternal and fetal deaths from happening. Ultimately, implementing the reforms outlined in this Article is not just a matter of policy—it is a moral obligation. Without them, pregnant survivors will continue to face a preventable death sentence.

351. *See generally* Brooke W. Jones et al., *Perinatal Homicide in the United States: A Systematic Literature Review*, 25 Trauma, Violence, & Abuse 2452 (2024) (documenting deaths of pregnant and postpartum people due to intimate partner violence and gaps in legal protections).

352. Greely et al., *supra* note 17, at 520.

353. Hill et al., *supra* note 32.

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