



Did You Know Your Relationship Affects Your Health?

A Train the Trainers Curriculum on
Addressing Intimate Partner Violence,
Reproductive and Sexual Coercion



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ABOUT THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through ground breaking model professional, education and response programs, cutting-edge advocacy and sophisticated technical assistance. The Center offers a wealth of free culturally competent materials that are appropriate for a variety of public and private health professions, settings and departments.



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INTRODUCTION

Futures Without Violence (Futures), a leading advocate for addressing intimate partner violence (IPV) in the health care setting, has produced numerous data-informed publications, programs, and resources to promote routine assessment and effective responses by health care providers. Our goal is to reframe the way in which health care systems respond to IPV, reproductive and sexual coercion such that the health care provider is the hub of a wheel in a trauma-informed, coordinated health care response that includes universal education and prevention.

Over the past two decades, a growing body of research has recognized the connection between relationship violence and poor reproductive health care outcomes for women. More hidden and often undetected forms of victimization involving coercive behaviors that interfere with reproductive health have emerged from this research.

Health care visits provide a window of opportunity to address both IPV and coercive behaviors related to a patient's reproductive health. However, when it comes to promoting health and safety outcomes for women impacted by IPV, there is a methodology to effective assessment, primary prevention, and anticipatory guidance messaging during health care visits. What a provider says and how a provider says it—whether through universal education or by direct assessment—matters and can make a difference for women experiencing relationship abuse.

Did You Know Your Relationship Affects Your Health?: A Train the Trainers Curriculum on Addressing Intimate Partner Violence, Reproductive and Sexual Coercion, a companion to our *Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings*, focuses on the crucial role of the health care provider in identifying and addressing IPV, reproductive coercion (RC), and sexual coercion (SC). The curriculum provides training, tools, and resources to help health care providers address these complex and sometimes uncomfortable issues. It highlights research that demonstrates how a brief intervention using a safety card to educate female patients about RC and SC during primary care and reproductive health visits can improve reproductive health outcomes and promote safe and healthy relationships. Safety cards and other resources for integrating and sustaining a trauma-informed, coordinated response to IPV, RC, and SC are included in this curriculum. These tools have been designed to facilitate education, safety assessment and supported referrals to domestic and sexual violence (DSV) programs.

Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women (Project Connect), is a national public health initiative funded by the U.S. Department of Health and Human Services' Office on Women's Health to prevent domestic and sexual violence in reproductive, perinatal/MCH, and adolescent health settings. As part of the initiative, state level partners and tribal clinics across the country are creating comprehensive models of public health prevention and intervention that can lead to improved health and safety for their patients. *Project Connect* grantees are working within their states and/or tribes to develop policy and public health responses to DSV with family planning, adolescent health, or other maternal child health and perinatal programs. They are training their health care providers on how to respond to IPV, RC, and SC using the **Did You Know Your Relationship Affects Your Health?** curriculum as well as providing basic health and reproductive health services in DSV programs.

Futures is committed to further developing policy and public health responses to IPV, RC, and SC. System wide changes in practices will only be implemented and sustained when there are tangible changes in policies and the infrastructure to support these changes. Futures developed a quality assessment/quality improvement (QA/QI) tool for family planning clinics, which may be adapted for physicians in private practice. This tool is included to guide managers and policymakers in implementing and evaluating a trauma-informed, coordinated response to IPV, RC, and SC in the reproductive health care setting. The QA/QI tool, which uses a checklist format, can help clinics and reproductive health programs to identify their goals and monitor their progress.

Our hope is that every reproductive health provider will integrate these approaches into their routine care for women and this curriculum into their core training and programming to support safe and healthy relationships, and create futures without violence.

BACKGROUND

In July of 2011, the Institute on Medicine (IOM) released its report, *Clinical Preventive Services for Women: Closing the Gaps*, at the U.S. Department of Health and Human Services request to identify critical gaps in preventive services for women that will be included in basic insurance packages under the federal Patient Protection and Affordable Care Act. In an historic move, the IOM committee recommended that all women and adolescent girls be screened and counseled for interpersonal and domestic violence in a culturally sensitive and supportive manner. The screening will address current and lifetime exposure to violence and abuse. The IOM Committee found that rates of violence are significant, and the data they reviewed supports that women can be helped by screening and counseling.

On August 1, 2011, less than two weeks after the release of *Clinical Preventive Services for Women: Closing the Gaps*, the U.S. Department of Health and Human Services Secretary Sebelius adopted the IOM's recommendations outlining which services for women should be included. Now, a full range of preventive services for women, including: annual well-woman visits; screening for gestational diabetes; breastfeeding support; HPV testing; STI counseling and HIV screening; contraception methods and counseling; and screening and counseling for interpersonal and domestic violence will be covered by new health plans without additional co-payments or deductibles. New health plans and plans that make changes to coverage will be required to comply with these guidelines for policies with plan years beginning on or after August 1, 2012. Through this coverage and training and education of health care providers, this is an historic opportunity to reach thousands more women and children experiencing domestic violence who are not being currently being helped.

Additionally, the federal Patient Protection and Affordable Care Act of 2010 included provisions to support America's Healthy Futures Act, a \$1.5 billion dollar 5-year national initiative to support maternal infant and early childhood home visitation programs. In addition to providing funds to support these services, the legislation also included new benchmark measures including requiring home visitation programs to measure a reduction in "crime or domestic violence."

Further support for screening for intimate partner violence comes from the U.S. Preventative Services Task Force (USPSTF), an independent panel of non-Federal experts in prevention and evidence-based medicine that conducts scientific evidence reviews of a broad range of clinical

preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health care providers. The USPSTF found sufficient evidence for the value of routine screening and follow up for intimate partner violence to issue a Grade B¹ recommendation: “The USPSTF recommends the use of a validated tool to screen women of childbearing age for IPV and follow up with any woman with a positive screen.”²

Specific recommendations that address screening in reproductive health care were provided by the American College of Obstetricians and Gynecologists (ACOG). ACOG’s February 2013 Committee Opinion on Reproductive and Sexual Coercion recommends that OB/GYNs routinely screen women and adolescent girls for reproductive and sexual coercion.³

To meet these governmental and professional guidelines and requirements, health care providers need to understand how to routinely assess for and respond to victims of violence. A trauma-informed, comprehensive approach to relationship violence that includes coercive behaviors that interfere with patients’ reproductive health can improve the quality of care and reproductive health outcomes for patients including higher contraceptive compliance, fewer unintended pregnancies, preventing coerced and repeat abortions, and reducing sexually transmitted infections (STIs)/Human Immunodeficiency Virus (HIV) and associated risk behaviors.

1 *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.”*

2 USPSTF Clinical Guidelines, Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2013;158:478-486.

3 Reproductive and Sexual Coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013; 121(2 Pt 1):411-415.

HOW TO USE THIS TRAINERS CURRICULUM

This curriculum has been designed for reproductive health programs and is focused on developing staff skills and broadening their thinking through interactive exercises and activities. Each module in this curriculum covers a separate topic so that you can include all of the content or delete some modules based on the training needs of your audience and the time available for the training.

There are several factors that will influence the length of your training when you use these slides. Factors include:

- Whether you include all of the modules
- If you adjust the time allowed for interactive activities
- How much time you allow for questions and answers
- The amount of local/regional data and information that you add to your presentation

THE CURRICULUM INCLUDES:

- Overview of how to use the PowerPoint slides, instructions for training, exercises, and directions for small group activities
- A Companion DVD, which includes participant handouts, assessment tools, and video vignettes
- Samples of the *Did You Know Your Relationship Affects Your Health?* materials

Intended audience:

This curriculum was designed for health care providers working in reproductive health settings and programs. It can be adapted for mental health providers, social service workers and educators. *It is important to note, however, that the video vignettes all model health care provider/patient interactions, and when utilizing this training with non-health care provider participants, adaptations to the approach modeled in the vignettes should be discussed.*

Participant familiarity with reproductive and sexual coercion:

Participants receiving this training should have a basic understanding of domestic violence. However, there is considerable variability among reproductive health programs in terms of how much training providers and staff have received. Domestic and sexual violence advocates at local shelters and advocacy programs are an excellent resource to contact for domestic violence training and information.

If your audience has not had domestic violence training or would benefit from a basic overview, partner with your local advocacy organization or state domestic violence coalition for training materials to provide an overview of domestic violence, including definitions and dynamics.

Special notes about PowerPoint:

For those who have not used PowerPoint previously, as you look at the modules in the curriculum, each page shows both the PowerPoint slide view (top half of the page) and the Notes Page view (bottom half of the page). Speakers' notes for slides are provided in the Notes Page view of PowerPoint. Information provided in the Notes Page view includes: sources of data cited and a synopsis of research findings, and recommendations on how to: facilitate discussion of the data/information reviewed in the slide; incorporate the exercises to support participant learning; and use the tools and handouts during the training.

If you have not used the Notes Page view in PowerPoint before, it can be accessed by either selecting the tab called "View" or the tab called "Slideshow" across the top of your computer screen and then selecting the "Presenter View" option. This means that you can access the speakers' notes during your presentation or while you are preparing for a presentation by changing the view on your screen in PowerPoint.

Time needed for training modules:

- If all of the training modules are used, this is an all-day training.
- We strongly suggest working with another trainer as a team. Ideally this team would include a domestic violence advocate and a reproductive health provider.
- The curriculum is designed to be flexible. Each module can be used separately so it is possible to do a series of trainings.
- Each module has its own learning objectives. The modules vary in length depending on the topic.
- Modules include discussion questions and/or activities, which will influence the length of the training depending on how much time is allowed for these interactive components. While estimated times are provided for discussions and activities, these times could be extended so that the training event is more than one day in length.

Trainer's Tip: There are many variables that influence the length of the training including the familiarity of the trainer with the material, the size of the audience, and the time allowed for discussion and activities. Consider doing practice trainings with co-workers to become familiar with the content and activities in this curriculum. We strongly recommend that you keep the interactive activities in place for optimal adult learning.

Materials needed to conduct training:

(Many of these resources may be downloaded at www.FuturesWithoutViolence.org or ordered from our online catalog for a small shipping and handling fee.)

- Trainer the Trainer's Curriculum and PowerPoint slides
 - DVD: Addressing Domestic Violence in Reproductive Health Programs: A Video Training Series
- Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings

- *Did You Know Your Relationship Affects Your Health?* Safety Cards
- PowerPoint set-up: laptop with DVD player or laptop and external DVD player, LCD projector and screen, power cords, and extension cords if needed
- External speakers for playing DVDs (this is very important to have so that your audience can hear the content of the video clips and DVDs)
- Flip-chart with stand and markers
- Masking tape to tape completed flip-chart sheets around the room
- Copies of handouts including the Pre- and Post-training surveys
- All participants should have a pen or pencil and a few sheets of note paper

Technical skills for trainers:

If trainers are not already comfortable using PowerPoint, trainers will need to become familiar and comfortable with this in order to provide training. A copy of the PowerPoint presentation can be downloaded at www.FuturesWithoutViolence.org. It is always important to be prepared for possible equipment issues such as getting your computer to sync with a LCD projector, so test the equipment ahead of time. Also, consider having a back-up projector and/or an extra bulb for the projector available during the training.

Trainer's Tip: Review the notes before the training and add tabs or markers for information in the notes that you want to highlight during the training.



How this trainer's curriculum is organized:

Each training module comprises a separate section in this guide, which includes:

- Estimated time
- Learning objectives
- Instructions for exercises and activities
- Trainer's Notes with additional supporting information or points to emphasize
- References for studies (in alphabetical order by author's last name by module)
- Resources

Important notes for trainers:

- Due to the high prevalence of intimate partner violence, reproductive and sexual coercion among women in the general population, many participants may have had direct or indirect experiences with abuse.
- This type of training can trigger painful memories and feelings for participants. Talking about intimate partner violence, reproductive and sexual coercion, and their effects on women are sensitive topics that can be emotional regardless of whether a person has had any direct experiences with abuse.

- Invite domestic and sexual violence advocates from your local/regional domestic violence program/shelter to participate in the training. They can provide the latest information on resources, contact information, and invaluable insights into the topics being discussed. Including domestic and sexual violence (DSV) advocates in your training can help to build partnerships between health care providers and local domestic and sexual violence service providers.
- It is also advisable, whenever possible, to have a domestic and sexual violence advocate available during this type of training to talk to any participants who need additional support. If this is not possible, have the number of a local/regional DSV program available during the training.
- Remember to be watchful of participants' reactions to the content of this training. Check-in during breaks with any participant that you think may be having difficulties during the training. Give extra breaks as needed, consider turning the lights down if someone is struggling with emotions, give participants an opportunity to debrief, and incorporate breathing and stretching exercises to reduce stress.

Training site:

- If possible, visit the location for the training ahead of time to determine equipment needs and considerations such as where the projector and laptop will be located, tables/carts for the projector and laptop, if extension cords are needed and what type, where the screen will go, etc.
- Whenever possible, round-tables or other flexible seating arrangements are recommended versus traditional classroom seating to facilitate group work and discussion.
- Assess parking options, location of restrooms, places to eat if lunch is not provided, and any information that you need to share with participants prior to the training.
- Provide refreshments if possible.

Trainer's Tip: To learn more information about a study that has been referenced in a slide, paste the citation into your search bar (to be automatically redirected to the article in "PubMed"), go to www.ncbi.nlm.nih.gov/pubmed/, or use a search engine for the term "pub med." Once you are in Pub Med, you can enter the author's name and a word or two from the title of the publication to obtain a listing of publications for that author. When you have identified the publication you are looking for, you can click on that title to access and print an abstract for that article at no cost. Many, but not all, full-text articles are available for free. If you want to purchase the article, that information is often provided. Journal publications can also be accessed and copied at medical and university libraries.



SAMPLE FULL DAY AGENDA

9:00 - 9:15 am	Introduction, Pre-Training Survey, Workshop Guidelines
9:15 - 9:55 am	Module 1: Intimate Partner Violence is a Reproductive Health Issue
9:55 - 10:35 am	Module 2: Making the Connection in Family Planning Settings: The Impact of Reproductive and Sexual Coercion on Women's Health
10:35 - 10:50 am	BREAK
10:50 - 12:35 pm	Module 3: Integrated Assessment for Reproductive and Sexual Coercion in Family Planning Settings: "Is this happening in your relationship?"
12:35 - 1:35 pm	LUNCH
1:35 - 2:15 pm	Module 4: Intimate Partner Violence, Sexually Transmitted Infections, and Safer Partner Notification
2:15 - 2:30 pm	Module 5: Building Bridges Between Reproductive Health and Domestic and Sexual Violence Advocacy
2:30 - 3:00 pm	Module 6: Trauma-informed Mandatory Reporting
3:00 - 3:15 pm	BREAK
3:15 - 3:30 pm	Module 7: Preparing Your Program: Supporting Staff Exposed to Violence and Trauma
3:30 - 3:45 pm	Closing, Resources and Evaluation

SAMPLE HALF DAY AGENDA

See sample slide set on trainer's CD: "Half Day Training"

This session is intended for health settings unable to accommodate a full day of training. We recommend follow-up trainings to cover additional content.

- 8:00 - 8:15 am** Introduction, Pre-Training Survey, Workshop Guidelines
- 8:15 - 8:25 am** Module 1: Intimate Partner Violence is a Reproductive Health Issue
- 8:25 - 9:00 am** Module 2: Making the Connection in Family Planning Settings: The Impact of Reproductive and Sexual Coercion on Women's Health
- 9:00 - 10:45 am** Module 3: Integrated Assessment for Reproductive and Sexual Coercion in Family Planning Setting: "Is this happening in your relationship?"
- 10:45 - 11:00 am** BREAK
- 11:00 - 11:15 am** Module 5: Building Bridges Between Reproductive Health and Domestic and Sexual Violence Advocacy
- 11:15 - 11:45 pm** Module 6: Trauma-informed Mandatory Reporting
- 11:45 - 12:00 pm** Module 7: Preparing Your Program: Supporting Staff Exposed to Violence and Trauma
- 12:00 - 12:15 pm** Closing, Resources and Evaluation

SAMPLE ONE HOUR AGENDA

See sample slide set on trainer's CD: "Introductory Session"

This session is intended to introduce participants to the intervention. We recommend additional training and/or technical assistance before implementing the intervention.

NOTE: You will be covering the "Did You Know Your Relationship Affects Your Health?" card only

- 9:00 – 9:05 am** Welcome and Introduction
- 9:05 - 9:15 am** Intimate Partner Violence is a Reproductive Health Issue
- 9:15 - 9:25 am** Making the Connection in Family Planning Settings: The Impact of Reproductive and Sexual Coercion on Women's Health
- 9:25 - 9:55 am** Integrated Assessment for Reproductive and Sexual Coercion in Family Planning Settings: "Is this happening in your relationship?"
- 9:55 - 10:00 am** Resources and Next Steps

Module 1: Intimate Partner Violence is a Reproductive Health Issue



Did You Know Your Relationship Affects Your Health?

A Train the Trainers Curriculum on Addressing Intimate Partner Violence, Reproductive and Sexual Coercion

Estimated Total Training Time: 5 hours and 30 minutes

(Depending on the amount of discussion time and selected interactive activities)

Notes to Trainer: The goal of today's training is to provide providers with the tools and resources that they need to be comfortable talking to all their patients about intimate partner violence and reproductive and sexual coercion. There are many variables that influence the length of this training including the familiarity of the trainer with the material, the size of the audience, and the time allowed for discussion and activities. It is important to include elements of interactivity (e.g. group discussion, video vignettes, role plays, etc.) for optimal adult learning and to avoid overloading the participants with didactic material. We suggest that you schedule AT LEAST 1 break during the training, with an opportunity to stretch, eat, and socialize. Remember that this is difficult content and participants will need a "breather."



Please complete the Pre-Training Survey



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Estimated Activity Time: 5 minutes

Notes to Trainer: Hand-out the pre-training survey for participants to complete and advise them that they will be asked to do a post-training survey at the end of the training. Allow approximately five minutes for participants to complete the survey. Advise participants that they do not need to put their names on the surveys and that their responses are confidential.



Workshop Guidelines

- Because domestic and sexual violence (DSV) are so prevalent, assume that there are survivors among us.
- Be aware of your reactions and take care of yourself first.
- Respect confidentiality.
- Please turn off your phones, laptops, tablets, etc.



Notes to Trainer: It is very helpful to have a domestic and/or sexual violence advocate present or on call when you are doing a training on domestic and sexual violence (DSV). This type of training can trigger painful memories while also creating the opportunity for survivors to process their feelings and experiences.

Discuss confidentiality, specifically state “what we say here, stays here.” Information that participants may choose to disclose in the workshop should NOT be shared outside of the room.

Encourage participants to do what they need to feel safe and comfortable throughout the training such as leaving the room and taking unscheduled breaks. They may also approach one of the trainers at breaks or lunch to talk about issues. As a trainer, you should anticipate that survivors will come forward and want to talk to you or an advocate for support.

Remain aware of anyone who may be reacting to or be affected by the content of the training. Consider giving extra breaks after particularly sensitive material, or when you observe that someone is having a difficult time. Connect with that person during the break to check-in and ask if he or she would like to talk with someone and determine how follow-up can occur.



Intimate Partner Violence is a Reproductive Health Issue

Estimated Module Time: 40 minutes

Training Outline

- Magnitude of problem
- Importance of addressing intimate partner violence, reproductive coercion, and sexual coercion in health care settings

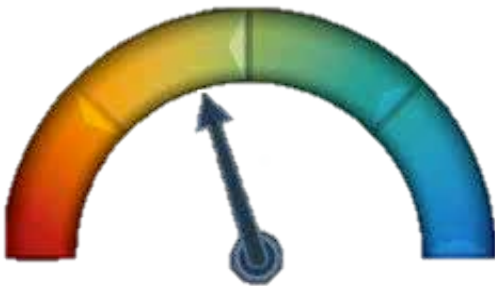
Overview

The purpose of this module is to help the learner understand how screening for intimate partner violence (IPV), reproductive coercion (RC), and sexual coercion (SC) can make a difference in the lives of women and children. The module makes the case for family planning providers – showing how IPV is connected to many family planning outcome goals, and, most importantly, demonstrating how talking with health care providers makes women safer and more likely to seek domestic and sexual violence advocacy services.



“Where Am I?”

- Draw a “comfort meter”
- On the left end of the meter is “not at all comfortable”
- On the right end of the meter is “very comfortable”



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Estimated Activity Time: 2-3 minutes

Notes to Trainer: Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

1. Take out a sheet of paper and draw a line with the words “not at all comfortable” on the far left side of their line and the words “very comfortable” on the far right side of their line.
2. Ask participants to take a minute to think about their current comfort level with talking to patients about IPV—and if he or she feels comfortable asking questions and getting a “yes” as the answer.
3. Discuss how the goal at the end of today’s session is that each person has personally moved that needle toward the ‘very comfortable’ end of the scale.
4. Advise participants that this exercise will be repeated at the end of today’s session and that you will ask them to consider whether the needle moved as a result of the training, where it moved, and their thinking about this in the context of what they have learned.

The “Where Am I?” exercise is followed by small group discussion (see next slide) to help participants identify and share why it is important for providers to know about domestic and sexual violence.

Why is it important for reproductive health providers to know about intimate partner violence?



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Estimated Activity Time: 10 minutes

Notes to Trainer:

1. Ask participants to discuss this question for five minutes, breaking up into small groups of 2 or 3, if feasible. Instruct each group to prepare a two-sentence answer.
2. Ask each group to share their answers (or just 1-2 groups if there is a large number of participants)
3. Go to the next slide, which describes how IPV is connected to the goals of many programs that provide reproductive health services.

IPV negatively impacts meeting family planning program outcomes such as:

- Maternal Health
- Reducing risks for unplanned pregnancies
- Preventing sexually transmitted infections
- Pregnancy outcomes
- Promoting health and safety



These are common goals among many family planning programs. There is an extensive body of research that has shown IPV is connected to each of these outcomes. These connections will be described in this training.

1 in 4 U.S. women
and
1 in 5 U.S. teen girls
report having
experienced physical
and/or sexual partner
violence.



(Black et al, 2011; Silverman et al, 2001)

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Notes to Trainer: Many of the participants have likely seen these statistics. With data slides such as this one, try to make the connection to the participant's practice. For example, "this means that if you see 20 women a day, it is likely that at least 5 of them have experienced physical violence in their relationship...and this doesn't even begin to reflect those who experience verbal, psychological or emotional abuse or sexual coercion..."

You can also ask participants to look at these numbers in relationship to other chronic conditions or illnesses. One in three women is obese, one in five is a smoker, and one in four women will experience intimate partner violence in her lifetime.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association*, 286(5)572-579.



1 in 5 women in the U.S. has been raped at some time in their lives and **HALF** of them reported being raped by an intimate partner.

(Black et al, 2011)



All experiences of sexual violence, including rape, impact sexual and reproductive health. While many providers likely have some knowledge that intimate partner sexual violence happens, some may not realize the extent to which it does. It's important that providers, who may just focus on physical and emotional abuse, expand their assessment to include intimate partner sexual violence as well.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Stop and
Consider...

Can you think of a time when
a patient's presenting health
symptoms made you suspect
there was a problem at home
but neither you nor your
patient said anything?



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Notes to Trainer: Give participants time to reflect on this question. Share that most providers can think of a time where they suspected a patient was experiencing domestic and/or sexual violence but were unsure of how to address it. If you have your own experience, you can share it here.

Module 1

Barriers to Identifying and Addressing IPV

- Providers identified the following barriers:
 - Comfort levels with initiating conversations with patients about domestic and sexual violence (DSV)
 - Feelings of frustration with patients when they do not follow a plan of care
 - Not knowing what to do about positive disclosures of abuse
 - Worry about mandatory reporting
 - Lack of time



Estimated Activity Time: 5 minutes

Notes to Trainer: This Train the Trainer toolkit is designed to address the barriers identified by health care providers in the field.

Optional large group discussion:

What might get in your way when addressing intimate partner violence?

- Ask participants to identify their **personal barriers** in addressing intimate partner violence.
- Ask participants to think about **structural or process barriers** that may exist in their service sites.

Addressing the Barriers

- Simplifying the process of direct assessment and universal education about IPV for providers
 - Connect DSV and health risks to visit type
 - Safety card intervention
 - Harm reduction
 - Referral & support



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Notes to Trainer: The safety-card based assessment that will be presented today is a unique new approach to addressing IPV, reproductive and sexual coercion in reproductive health settings. Health care providers are in the unique position to help their patients make the connection between experiencing violence and health risks, offer harm reduction strategies if they disclose reproductive coercion and/or IPV, and make warm referrals to local DSV programs and/or the National Domestic Violence Hotline.

Women who talked to their health care provider about abuse were:

4 times more likely to use an intervention

2.6 times more likely to exit the abusive relationship

(McCloskey et al, 2006)



Just having the opportunity to talk to a health care provider about domestic violence can increase access to domestic violence and sexual assault services.

In this study by McCloskey et al. (2006), 132 women outpatients who disclosed domestic violence in the preceding year were recruited from multiple hospital departments and community agencies. Abused women who talked with their health care providers about the abuse were more likely to use an intervention and exit the abusive relationship. Women who were no longer with their abuser reported better physical health than women who stayed.

McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. (2006). Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. *Public Health Reporter*, 121(4):435-444.

By conducting an assessment and a brief intervention, health care providers can dramatically decrease risk for violence AND unplanned pregnancy.

(Miller et al, 2011)



14

Health care providers play an essential role in prevention of DSV and reproductive and sexual coercion by discussing healthy, consensual, and safe relationships with all patients.

Health care providers can:

- offer confidential, safe spaces in which to discuss behaviors that may be abusive and that may be affecting a patient's health,
- discuss, in the clinical context, how abusive behaviors are linked to health risks, helping to facilitate the patient's recognition of reproductive and sexual coercion,
- introduce harm reduction behaviors to increase safety and protect patient's health, and
- connect patient to resources to help them stay safe

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*, 83 (3):274-80.

Receiving medical care decreased women's risk of further sexual assault by 32%.



(McFarlane et al, 2005)



Module 1

In a 2005 study of 148 African-American, Hispanic, and white English- and Spanish-speaking abused women, McFarlane J, Malecha A, Watson K, Gist J, Batten E, Hall I, and Smith S. found the following results:

- Sixty-eight percent of the physically abused women reported sexual assault.
- Fifteen percent of the women attributed 1 or more sexually-transmitted diseases to sexual assault, and
- 20% of the women experienced a rape-related pregnancy.
- Sexually assaulted women reported significantly ($P = .02$) more PTSD symptoms compared with non-sexually assaulted women.
- Receiving medical care decreased the woman's risk of further sexual assault by 32%.

CONCLUSION: Sexual assault is experienced by most physically abused women and associated with significantly higher levels of PTSD compared with women who are physically abused only. The risk of re-assault is decreased if contact is made with health or justice agencies.

The USPSTF recommends screening women of childbearing age for IPV and conducting a follow up with any woman with a positive screen.

Strength of Recommendation - “B”



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The U.S. Preventative Services Task Force, an independent panel of non-Federal experts in prevention and evidence-based medicine that conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems, found sufficient evidence for the value of routine screening and follow up for intimate partner violence to issue a Grade B recommendation: “The USPSTF recommends that clinicians provide [this service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*”

USPSTF Clinical Guidelines, Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement. *Annals Internal Medicine*. 2013; 158:478-486.

Your Role is Important - DOABLE

- Providers do not have to be DSV experts to recognize and help patients experiencing domestic and/or sexual violence
- You have a unique opportunity for education, early identification, and intervention
- And to partner with DSV agencies to support your work



Notes to Trainer: It is important to stress that providers have an important and unique role in helping to reduce DSV. Because DSV can have significant, long-term health effects, it is important to address it in the clinical setting. Today's training will offer guidance to providers on how to manage conversations about DSV with patients, as well as how to build relationships with local DSV organizations to support their work.

**Module 2: Making the
Connection in
Family Planning
Settings:
The Impact of
Reproductive and
Sexual Coercion
on Women's
Health**



Making The Connection In Family Planning Settings: The Impact of Reproductive and Sexual Coercion on Women's Health

Estimated Module Time: 40 minutes

(Depending on the amount of discussion time and selected interactive activities)

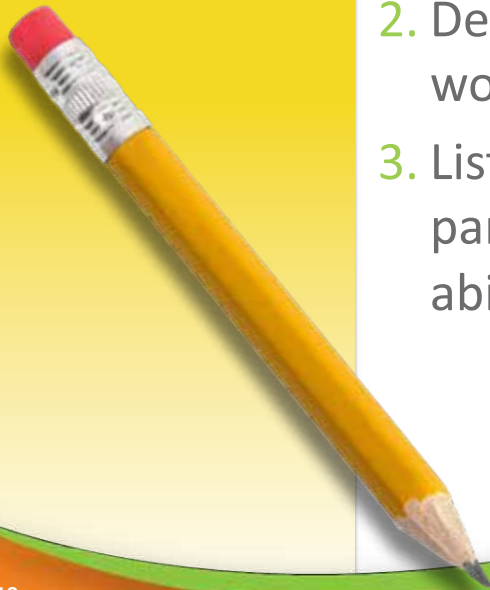
Training Outline

- Learning objectives
- Definitions, statistics and examples of reproductive and sexual coercion
- Relationship between IPV and women's reproductive health
- Group discussion: birth control sabotage and pregnancy pressure
- Considerations for males and same-sex couples

Overview

As we have learned more about different forms of abusive and controlling behaviors that are used by partners to maintain power and control in a relationship, patterns of behaviors that affect women's reproductive health have been identified. These behaviors, which are referred to as reproductive and sexual coercion, include forced sex, birth control sabotage, pregnancy pressure, and condom manipulation. This module defines reproductive and sexual coercion and focuses on the data linking both to poor reproductive health outcomes for adolescent and adult women.

Learning Objectives



As a result of this activity, learners will be better able to:

1. Define reproductive coercion (RC) and sexual coercion (SC).
2. Describe the impact of RC and SC on women's reproductive health.
3. List two examples of how an intimate partner can interfere with a woman's ability to use contraceptives successfully.



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Notes to Trainer: Read the learning objectives aloud. Remind the participants that this section will give a context for today's training – establishing common definitions and building the case for why it is important to address reproductive and sexual coercion in health settings. The rest of the day will focus on specific clinical interventions for family planning providers.

How does intimate partner violence impact reproductive health?



Estimated Activity Time: 10 minutes

Notes to Trainer:

1. Ask participants to discuss this question for five minutes, breaking up into small groups, if feasible. Instruct groups to prepare a two-sentence answer.
2. Ask each group to share their answers.



Domestic violence increases women's risk for **Unintended Pregnancies**

(Miller, 2010; Sarkar, 2008, Goodwin et al, 2000; Hathaway, 2000)



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Sarkar conducted a literature review of publications from 2002 through 2008 on the impact of domestic violence on women's reproductive health and pregnancy outcomes.

In a study by Goodwin et al (2000), women who had unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended.

Hathaway et al. (2000) analyzed data from a population-based survey (Behavioral Risk Factor Surveillance System) in Massachusetts to examine the association between IPV and unintended pregnancy. Among women experiencing IPV who had been pregnant in the past 5 years, approximately 40% reported that the pregnancy was unwanted, as compared to 8% of other women.

Miller E, Levenson R, Jordan B, Silverman JG. (2010). Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. *Contraception*, 81(6):457-9.

Sarkar NN. (2008). The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology*, 28(3):266-271.

Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal*, 4(2):85-92.

Hathaway J, Mucci L, Silverman J, Brooks D, Matthews R, and Pavlos C. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventive Medicine*, 19:302-307.



Adolescent girls in physically abusive relationships were **3.5 times more likely** to become pregnant than non-abused girls

(Roberts et al, 2005)



Notes to Trainer: Pose this question to the audience: *Is this something the average American thinks about when they think about teen pregnancy?*

A large body of research points to the connection between abuse and teen pregnancy. However, few teen pregnancy programs address the connection between abuse and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other. It may be interesting for the participants to consider what we associate with teen pregnancy from the media.

This study by Roberts and colleagues (2005) analyzed data from the National Longitudinal Study of Adolescent Health. The analyses adjusted for sociodemographic factors, the number of intimate partners, and a history of forced sexual intercourse. A past history or current involvement in a physically abusive relationship was associated with a history of being pregnant among sexually active adolescent girls. Physical abuse was defined as “push you,” “shove you,” or “throw something at you.”

In a study by Silverman et al. (2001), adolescent girls who experienced physical or sexual dating violence were 6 times more likely to become pregnant than their peers.

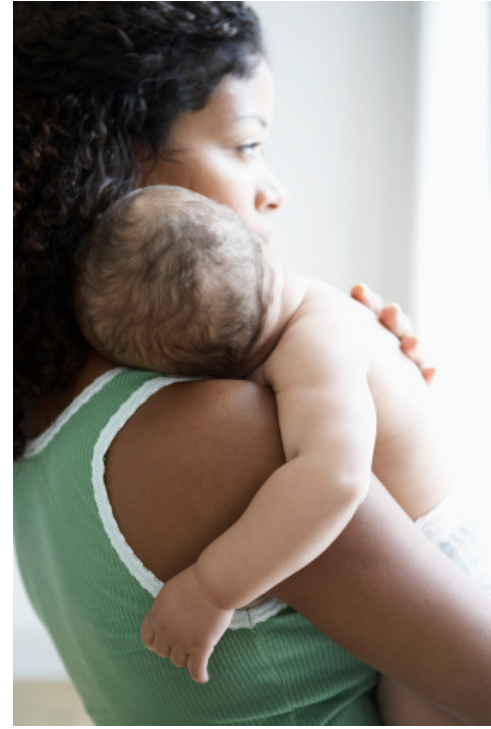
Roberts TA, Auinger MS, Klein JD. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health*, 36:380-385.

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association*, 286(5): 572-579.

Rapid Repeat Pregnancy

Adolescent mothers who experience physical abuse within three months after delivery were **nearly twice** as likely to have a repeat pregnancy with 24 months.

(Raneri & Wiemann, 2007)



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In this study of teenage mothers (age 12-18) who were recruited from a labor and delivery unit at a university hospital, physical abuse by an intimate partner was defined as being hit, slapped, kicked, or physically hurt enough to cause bleeding, or having been hit during an argument or while her partner was drunk or high.

The odds of repeat pregnancy was 1.9 times higher among teen mothers who were physically abused by their partner within three months of delivery compared to non-abused teen mothers.

In an earlier study by Jacoby et al. (1999), low income adolescents who experienced physical or sexual abuse were over 3 times (OR= 3.46) more likely to have a rapid repeat pregnancy within 12 months and over 4 times (OR=4.29) more likely to have a rapid repeat pregnancy within 18 months.

Raneri LG, Wiemann CM. (2007). Social Ecological Predictors of Repeat Adolescent Pregnancy. *Perspectives on Sexual and Reproductive Health*, 39(1):39-47.

Jacoby M, Gorenflo D, Black E, Wunderlich C, Eyler AE. (1999). Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventive Medicine*, 16(4):318-321.





Women and girls who are victims of intimate partner violence are **4X more likely to be infected with HIV.**

(Decker et al, 2007)



Decker MR, Silverman JG, Raj A. (2007). Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis among Adolescent Females. *Pediatrics*, 116(2): e272-276.

What are some ways a partner can interfere with a young woman's reproductive health?



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Estimated Activity Time: 2-3 minutes

Notes to Trainer: Ask participants to give some examples they have seen in their practice. Responses may include examples of birth control sabotage, condom refusal, intentional exposure to STIs, pregnancy pressure, forced sex, etc.

Making the Connection



The following animated video clip introduces viewers to the definition and prevalence of reproductive coercion, as well as the role that health care providers can have in identification and response.



Estimated Activity Time: 3 minutes to watch video

This video gives participants a brief overview of reproductive coercion, and the health care provider's role in its prevention and intervention. If time allows, after the video, ask if participants have any questions or have general reactions/feedback to the video.

What Is Sexual Coercion ?

Creating a feeling, situation or atmosphere where emotional and physical control lead to sexual abuse or rape, or a victim feeling that he or she has no choice but to submit to sexual activity with the perpetrator.



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Notes to Trainer: Read the definition of Sexual Coercion aloud. Ask the group “How many of you think your patients have a clear understanding of sexual coercion?”

Acknowledge that this can be a complex issue to address, and it is important to identify both adult and youth-friendly resources for sexual violence.

This definition expands our understanding beyond traditional definitions of sexual assault and rape. It includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force such as:

- Repeatedly pressuring a partner to have sex when he or she does not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Threatening retaliation if notified of a positive STI result

“ I'm not gonna say he raped me... he didn't use force, but I would be like, "No," and then, next thing, he pushes me to the bedroom, and I'm like, "I don't want to do anything," and then, we ended up doin' it, and I was cryin' like a baby, and he still did it. And then, after that... he got up, took his shower, and I just stayed there, like, shocked)... ”



Notes to Trainer: Review this quote with the audience. Ask, *do you think this woman was raped?* (Nearly 100 percent of your audience will say yes). Then say, let's look at the very first thing she said here— *"I'm not going to say he raped me..."* This kind of response is really common among women in relationships who sometimes have consensual sex with partners and at other times experience sex like what is described here. This is an important detail as you consider the continuum of control from the last slide. In her mind, she may well put this event at a different place on the continuum than rape. So the language we use in clinical encounters should reflect this and is included on the safety card.

Miller E., Personal communication, from "Family Planning Clinic-based Partner Violence Intervention to Reduce Unintended Pregnancy" (NIH Grant #R01HD064407)

Reproductive Coercion involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.



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Notes to Trainer: Read the definition of Reproductive Coercion aloud including the information below and ask the group: *“How many of you have heard the term reproductive coercion before today?”*

Reproductive coercion is related to behaviors that interfere with contraception use and/or pregnancy. This includes:

- Explicit attempts to impregnate a partner against her wishes
- Controlling outcomes of a pregnancy
- Coercing a partner to have unprotected sex
- Interfering with birth control methods

Two types of reproductive coercion, birth control sabotage and pregnancy pressure and coercion, will be described in the following slides. Ask the group: *“How many of you have talked to patients who have experienced this?”*

Tactics Include:

- Destroying or disposing contraceptives
- Impeding condom use (e.g., threatening to leave her, poking holes in condoms)
- Not allowing her to obtain or preventing her from using birth control
- Threatening physical harm if she uses contraceptives



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Birth Control sabotage is active interference with a partner's contraceptive methods. Qualitative and quantitative research have shown an association between birth control sabotage and domestic violence.

Fanslow et al. (2008) conducted interviews with a random sample of 2,790 women who have had sexual intercourse. Women who had experienced domestic violence were more likely to have had partners who refused to use condoms or prevented women from using contraception compared to women who had not experienced domestic violence (5.4% vs. 1.3%).

Miller et al (2007) conducted interviews with 53 sexually active adolescent females. One-quarter (26%) of participants reported that their abusive male partners were actively trying to get them pregnant. Common tactics used by abusive male partners included:

- Manipulating condom use
- Sabotaging birth control use
- Making explicit statements about wanting her to become pregnant

Fanslow J, Whitehead A, Silva M, Robinson E. (2008). Contraceptive Use and Associations with Intimate Partner Among a Population-based Sample of New Zealand Women. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, 48(1):83-89.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

Lang DL, Salazar LF, Wingood GM, DiClemente RJ, Mikhail I. (2007). Associations Between Recent Gender-based Violence and Pregnancy, Sexually Transmitted Infections, Condom Use Practices, and Negotiation of Sexual Practices Among HIV-Positive Women. *Journal of Acquired Immune Deficiency Syndromes*, 46(2):216-221.

“Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.”

(Miller et al, 2007)



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This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. The teen girl was parenting a baby from a different relationship and the abusive relationship started shortly after she broke up with her son's father. She went to a teen clinic and started Depo-Provera injections without her new partner's knowledge.

Question: Do you think the condom was breaking accidentally every time?

Why not? We do know that youth may need more condom education but there is also a red flag: her partner expressing his desire to get her pregnant once she goes on hormonal birth control.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

Women, including teens, experiencing physical and emotional abuse are more likely to report **not using their preferred method of contraception** in the past 12 months (OR=1.9).

(Williams et al, 2008)



Williams and colleagues conducted a case control study with 225 women to examine whether IPV was associated with women's risk for problems in contraception use. This statistic reminds us that many patients are not able to negotiate contraceptive methods with their partners.

Williams CM, Larsen U, McCloskey L. (2008). Intimate Partner Violence and Women's Contraceptive Use. *Violence Against Women*, 14(12) 1382-1396.

Tactics Include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that may cause a miscarriage

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Pregnancy pressure involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to be pregnant. Pregnancy coercion involves coercive behaviors such as threats or acts of violence if a partner does not comply with the male partner's wishes regarding the decision of whether to terminate or continue a pregnancy.

Threats to Promote a Birth

“ He really wanted the baby—he wouldn’t let me have—he always said, “If I find out you have an abortion,” you know what I mean, “I’m gonna kill you,” and so I really was forced into having my son. I didn’t want to; I was 18. [...] I was real scared; I didn’t wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn’t want to have a baby but I was really scared. I was scared of him. ”

(Moore et al, 2010)



This respondent described how her partner threatened her into carrying an unwanted pregnancy to term. Other respondents described abusive partners making them feel bad about their desire to abort a pregnancy; begging, badgering and making promises to support the baby to pressure them into giving birth. Some respondents described giving in to this pressure, and some did not. One woman’s partner kept on making her eat which prevented her from going in for her second trimester abortion for which she needed to be sedated since one of the rules was that she could not eat anything the day of her abortion. Respondents also described more invasive tactics used by partners to keep them from obtaining abortions such as refusing to pay or help pay for an abortion.

Moore AM, Frohwirth L, Miller E. (2010). Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States. *Social Science and Medicine*, 70(11):1737-1744.

One-quarter (26.4%) of adolescent females reported that their abusive male partners were:



TRYING TO GET THEM PREGNANT

(Miller et al, 2007)



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In this qualitative study by Miller and colleagues (2007), 53 teen girls between the ages of 15 and 20 years (21% African American, 38% Latina) with known history of IPV were recruited from adolescent clinics, domestic violence agencies, schools, youth programs for pregnant/parenting teens, and homeless and at-risk youth. Approximately one-third of the participants were recruited from pregnant and parenting teen programs to ensure sufficient representation of teens experiencing both IPV and pregnancy. Older male partners were typical with the median age difference between the female and the male partner being 4 years. Pregnancy-promoting behaviors by their abusive male partners included:

- Poking holes in condoms
- Explicit statements (e.g. "I want a baby")
- Getting angry if she asked him to use a condom
- Removing the condom during intercourse

Several girls reported hiding contraceptive use from their abusive male partner.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females. *Ambulatory Pediatrics*, 7(5):360-366.

The odds of experiencing interference with attempts to avoid pregnancy was **2.4 times higher** among women disclosing a history of physical violence by their husbands compared to non-abused women.



(Clark et al, 2008)



It is important that providers screen *all* women who come to their practice, including those who are married and may have already had a child or children with their husband.

Clark CJ, Silverman J, Khalaf IA, Ra'ad BA, Sha'ar SA, Abu Al Ata A, Batieha A. (2008). Intimate partner violence and interference with women's efforts to avoid pregnancy in Jordan. *Studies in Family Planning*, 39(2):123-132.

Women tell us that controlling reproductive health is used as a tool for abuse

“He [used condoms] when we first started, and then he would fight with me over it, and he would just stop [using condoms] completely, and didn't care. He got me pregnant on purpose, and then he wanted me to get an abortion.”

(Miller et al, 2007)



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This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. A 16-year-old female with a physically and verbally abusive partner who was 6 years older; she left the relationship and continued the pregnancy.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

The risk of being a victim of IPV in
the past year was nearly

3X HIGHER

for women seeking an abortion
compared to women who were
continuing their pregnancies.

(Bourassa & Berube, 2007)



Bourassa and Berube (2007) conducted interviews with 350 adult and teen females who elected to have abortions at a family planning clinic and 653 pregnant women at a perinatal clinic. The probability of being a victim of physical, sexual, and/or psychological IPV was almost three times higher for women electing to have an abortion compared to women who were continuing their pregnancies (25.7% vs. 9.3%, $p < 0.0001$).

Bourassa D, Berube J. (2007). The Prevalence of Intimate Partner Violence Among Women and Teenagers Seeking Abortion Compared with those Continuing Pregnancy. *Journal of Obstetrics & Gynaecology Canada*, 29(5):415-423.

Provider's Quote

“I was surprised how many people actually said that their boyfriend, you know, wanted them to be pregnant or didn’t want them on birth control. I was surprised at how many people that was an issue for. It was more prevalent than I was thinking is, I guess, the best way to word that.”



Miller E., Personal communication, from “Family Planning Clinic-based Partner Violence Intervention to Reduce Unintended Pregnancy” (NIH Grant #R01HD064407)

Can Men Experience Reproductive Coercion?

Yes, and there are gendered differences about the impact of this on men's and women's lives.

- A female partner could lie about contraceptive use and he could become a father as a result.

Question to consider: **Were there threats or harm?**

- To date there have been no studies indicating men have become fathers when they didn't want to be because she threatened to kill him if he didn't get her pregnant.



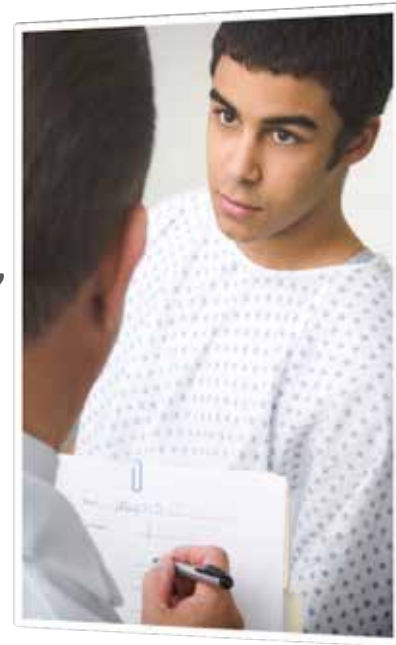
Adolescent and adult males may also experience reproductive and sexual coercion. A recent national survey on intimate partner and sexual violence in the United States provided the first population based data on males' experiences with reproductive and sexual coercion.

- Approximately 10.4% (or an estimated 11.7 million) of men in the United States reported ever having an intimate partner who tried to get pregnant when they did not want them to or tried to stop them from using birth control, with 8.7% having had an intimate partner who tried to get pregnant when they did not want them to or tried to stop them from using birth control and 3.8% having had an intimate partner who refused to wear a condom.
- 6% of men have experienced sexual coercion in their lifetime (i.e., unwanted sexual penetration after being pressured in a nonphysical way)

Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

What are the messages for adult and adolescent men?

- Male patients need to hear the same messages about the importance of healthy relationships, consensual sex, and consensual contraception to prevent unwanted pregnancies.
- Strategies for assessment, harm reduction, and intervention can be adapted for male patients.



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Most forms of behaviors used to maintain power and control in a relationship impacting reproductive health disproportionately affect females. There are, however, some forms of sexual coercion that males experience. As research evidence is being accumulated, clinical experience will help to inform best practices for male patients.

- Approximately 1 in 21 men (4.8%) reported that they were made to penetrate someone else during their lifetime; most men who were made to penetrate someone else reported that the perpetrator was either an intimate partner (44.8%) or an acquaintance (44.7%).
- 11.7% of men have experienced unwanted sexual contact
- 8.0% of men have experienced sexual violence other than rape by an intimate partner at some point in their lifetime
- Male rape victims and male victims of non-contact unwanted sexual experiences reported predominantly male perpetrators.

Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

What about same-sex relationships?

- Sexual coercion or rape may occur in heterosexual or same sex couples.
- Recent research provides some insight into gay and bisexual males' experiences with sexual coercion. In a survey with gay and bisexual men, 18.5% reported unwanted sexual activity.

(Braun et al, 2009; Houston and McKirnan, 2007; Tjaden & Thoennes, 2000)



Qualitative data from interviews with gay and bisexual men suggest many of the factors underlying sexual coercion are related more to masculine sexuality versus gay sexuality and that society's response to same sex relationships leads to circumstances such as marginalization that increases vulnerability to sexual violence.

According to data from the National Violence Against Women Survey approximately 11% of women who lived with a woman as part of a couple reported being raped, physically assaulted, and/or stalked by a female cohabitant compared to 30.4% of the women who had married or lived with a man as part of a couple. Approximately 15% percent of men who lived with a man as a couple reported being raped, physically assaulted, and/or stalked by a male cohabitant compared to 7.7% of men who had married or lived with a woman as a couple. Men and women who had lived with a same-sex partner as part of a couple disclosed significantly higher levels of IPV than opposite-sex cohabitants.

However, comparisons of these rates by the gender of the couple and gender of the perpetrator indicate that same-sex cohabiting women were three times more likely to report being victimized by a former male partner than by a female partner in their lifetime and same-sex cohabiting men were more likely to report being victimized by a male partner than a female partner in their lifetime. These findings suggest that IPV is perpetrated primarily by men, whether against male or female partners.

Braun V, Schmidt J, Gavey N, Fenaughty J. (2009). Sexual Coercion Among Gay and Bisexual Men in Aotearoa/ New Zealand. *Journal of Homosexuality*, 56:336-360.

Houston E, McKirnan DJ. (2007). Intimate Partner Abuse Among Gay and Bisexual Men: Risk Correlates and Health Outcomes. *Journal of Urban Health, Bulletin of the New York Academy of Medicine.*, 84(5):681-690.

Tjaden P and Thoennes N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: finding from the national violence against women survey. U.S. Department of Justice, National Institute of Justice, and U.S. Department of Health and Human Services, Centers for Disease Control. NCJ 183781.

Section Recap



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- Intimate partner violence has a significant impact on reproductive health.
- Intimate partner violence can interfere with a woman's ability to use contraceptives successfully.
- Reproductive and sexual coercion are important issues for family planning providers to address.

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Notes to Trainer: Read the "Section Recap" aloud to close each section.

Module 3: Integrated Assessment for Reproductive and Sexual Coercion in Family Planning Settings



Integrated Assessment for Reproductive and Sexual Coercion in Family Planning Settings

“Is this happening in your relationship?”

Estimated Module Time: 1 hour 45 minutes

(Depending on the amount of discussion time and activities)

Training Outline

- Learning Objectives
- Using the *Did You Know Your Relationship Affects Your Health* Safety Card
- Assessment for reproductive coercion and responding to disclosure
- Video case studies and role plays

Overview

Using a skills-based approach, this module includes assessment questions and responses as well as information about birth control options that may be less visible and more effective for patients whose partners are interfering with their birth control.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Demonstrate how to discuss limits of confidentiality prior to screening patients for IPV.
2. Describe how to use the **Did You Know Your Relationship Affects Your Health?** safety card to assess for reproductive coercion as part of routine care.
3. Offer validation, harm reduction strategies, and support for patients disclosing reproductive coercion.

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Notes to Trainer: Read the learning objectives aloud.

Study Findings

Among a random sample of 1,278 women, ages 16-29, seen at five family planning clinics:

53% experienced domestic/sexual partner violence

This data mirrors other findings from reproductive health clinics nationwide. Family planning patients experience high rates of violence.



(Miller et al, 2011; Miller and Silverman, 2010; Miller et al, 2010; Miller et al 2007; Raiford et al, 2009; Ashley & Foshee, 2005; Keeling & Birch, 2004)



Notes to Trainer: Futures Without Violence, in collaboration with researchers, advocates and community partners shown here had the extraordinary opportunity to work on a community-based NIH funded study—and develop the safety card intervention that we will be describing in this training.

This pilot study conducted in Northern California involved randomization of four family planning clinics, 2 to intervention, and 2 to comparison (control). The women completed baseline (just before their clinic visit) and 4 month follow up surveys on laptops with headphones.

Emphasize the high prevalence of women exposed to abuse who are seeking care in family planning programs – *demonstrating that family planning settings are a critical place to identify and assist women, particularly young women.*

76% of the women in the sample were < 24 years old and 43% were 16-20 years old, so these findings are applicable to both youth and adult populations. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20227548>

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2010). Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy. *Contraception*, 81(4):316-22.

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*, 83:274-80.

Miller E and Silverman JG. (2010). Reproductive Coercion and Partner Violence: Implications for Clinical Assessment of Unintended Pregnancy. *Expert Review in Obstetrics and Gynecology*, 5(5): 511-15.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females. *Ambulatory Pediatrics*, 7(5):360-366.

Raiford JL, DiClemente RJ, Wingood GM. (2009). Effects of fear of abuse and possible STI acquisition on the sexual behavior of Young African American women. *American Journal of Public Health*, 99(6):1067-1071.

Ashley OS, Foshee VA. (2005). Adolescent help-seeking for dating violence: prevalence, sociodemographic correlates, and sources of help. *Journal of Adolescent Health*, 36(1):25-31

Keeling J, Birch L. (2004). The prevalence rates of domestic abuse in women attending a family planning clinic. *Journal of Family Planning and Reproductive Health Care*, 30(2):113-114.

Among women who received the intervention and experienced recent partner violence:

- **71% reduction** in the odds of pregnancy pressure and coercion compared to control group
- **60% more likely** to end a relationship because it felt unsafe or unhealthy



(Miller et al, 2011)



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Notes to Trainer: This study examined the efficacy of a family-planning-clinic-based intervention to address intimate partner violence (IPV) and reproductive coercion. Four free-standing urban family planning clinics in Northern California were randomized to intervention (trained family planning counselors) or standard of care. English-speaking and Spanish-speaking females ages 16-29 years (N = 906) completed audio computer-assisted surveys prior to a clinic visit and 12-24 weeks later (75% retention rate). Analyses included assessment of: intervention effects on recent IPV victims, awareness of IPV services, and reproductive coercion.

RESULTS: Among women reporting past-3-months IPV at baseline, there was a 71% reduction in the odds of pregnancy coercion among participants in intervention clinics compared to participants in the control clinics that provided the standard of care. Women in the intervention arm were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of IPV status (adjusted odds ratio = 1.63; 95% confidence interval=1.01-2.63).

CONCLUSIONS: Results of this pilot study suggest that this intervention may reduce the risk for reproductive coercion from abusive male partners among family planning clients and support such women to leave unsafe relationships. This contributes to the evidence base for using a safety card-based intervention.

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*, 83: 274-80.

How does an intervention for reproductive coercion differ from an intervention for IPV?



Notes to Trainer: Give participants time to reflect on this question.

Answer

When it comes to reproductive coercion, the **health care provider** is now key to intervention.



- This is done through offering harm reduction strategies for reproductive and sexual coercion and providing discreet methods of contraception.



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For IPV, generally, the provider offers validation and strategies to manage health conditions in a trauma-informed manner. Then the provider refers their patient to the DSV advocate for in-depth harm reduction and safety planning.

For reproductive coercion, there is a clinical intervention. The provider offers alternate birth control (less detectable, female controlled) and protective strategies that can lead to improved reproductive health outcomes and enhanced quality of care.

ACOG's February 2013 Committee Opinion No. 554 on Reproductive and Sexual Coercion recommends that OB/GYNs routinely screen women and adolescent girls for reproductive and sexual coercion



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS



The American College Obstetricians and Gynecologists (ACOG), the professional organization of physicians specializing in the reproductive health care of women, issued a recommendation for routine screening of women and adolescent girls for RC and sexual coercion based on the research evidence of the efficacy of screening and intervention. Addressing reproductive and sexual coercion is now becoming a standard of care.

Reproductive and Sexual Coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. *Obstetrics & Gynecology*, 2013;121: 411-5. Available at:
<http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co554.pdf?dmc=1&ts=20130206T0531420146>

4 Cs

1. **Confidentiality** – always review the limits of confidentiality with patients *prior* to doing any assessment
2. **Conversation** – Normalize the activity
3. **Card** – provide, open and review card with all patients
4. **Connect** – make a warm referral to existing support services for DSV in the community



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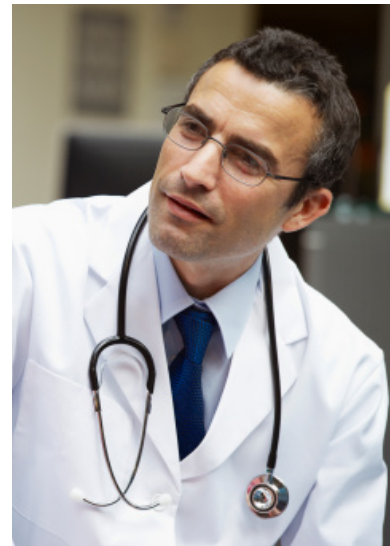
Notes to Trainer: Review the steps of the safety card intervention.

Intervention Elements:

1. Review the limits of confidentiality.
2. Normalize the activity “Because experiencing violence in a relationship is so common, I talk to all of my patients about this” or “I’ve started giving this card to all my patients”
3. Using the safety card as a guide, provide universal education on healthy relationships, followed by an assessment for IPV, RC, and SC.
4. If abused is disclosed, offer support, validation, and harm reduction strategies. Make a warm referral to DSV advocacy services and/or hotline.

Safety, Confidentiality, & Mandatory Reporting

- **Always review the limits of confidentiality** even if you are not asking **DIRECT** questions about abuse in case there is disclosure and you need to report
 - Forms should indicate that there are patient conditions that may have to be reported to health or law enforcement authorities
 - Consent forms should indicate the limits of confidentiality
- **Learn your county's and state's IPV reporting laws**



Notes to Trainer: In preparation for the training, learn about the reporting requirements for your county and state and talk to your state coalition about how implementation varies.

Laws vary widely from state to state when it comes to sexual or physical abuse by a partner. Therefore, as a provider, it is critical to understand your state's minor consent and confidentiality laws as well as physical and sexual abuse laws, and that you are able to clearly articulate them to your patients.

Because providing universal education may trigger a positive disclosure of abuse or other situation that requires a report to law enforcement or child welfare, it is essential that the limits of confidentiality and mandatory reporting requirements are reviewed with all patients prior to *any* anticipatory guidance about healthy relationships or direct assessment for reproductive and sexual coercion.

The following slides address confidentiality and mandated reporting from a general perspective, and have NO state law specific information.

“Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone or planning to hurt yourself”

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Notes to Trainer: Any time a sample script is provided, remind participants that the intention is to give them an idea of how to address the issue, not for them to memorize a script to repeat word-for-word.

Reviewing the Limits of Confidentiality



The following video clip demonstrates common pitfalls providers encounter when addressing confidentiality and mandatory reporting requirements



Estimated Activity Time: 2 minutes to watch video and 5 minutes for discussion

Notes to Trainer: Remind participants to focus on the issues of confidentiality and child abuse reporting, not aspects of the clinical care delivered (for example, don't focus on medication instructions).

See next slide for discussion questions.

- What worked well?
- What would you change?
- What additional safeguards can your setting put into place to ensure that patients understand the limits of confidentiality?

Notes to Trainer: Discuss video clip. Assure participants that there will be time later in the training to discuss mandatory reporting-- this section is intended to remind clinicians about the importance of reviewing the limits of confidentiality.

What worked well:

- It appears the provider had rapport with the patient, since she was willing to open up so quickly.

What would you change:

- Make sure to address the patient's presenting health concerns (take care of medical issues and provide referrals) **BEFORE** discussing the need to report.
- Remind participants that "Report immediately" does not prevent you from providing care.
- Remain calm. If the provider seems flustered or surprised, the patient may assume they have done something "bad"/wrong.

What additional safeguards can you put into place:

- It is important to have MULTIPLE opportunities for patients to hear and see information about confidentiality
- Information sheet at check in
- Posters in waiting rooms and exam rooms
- Providers should discuss confidentiality with patients and check for comprehension

DO NO HARM

- Always screen patients alone and not within earshot of a partner or family member
- Never use a family member or friend as an interpreter, use medically trained interpreters only
- Reports required by law are allowed under HIPAA disclosure
- You violate HIPAA reporting laws if you report something not mandated by law



Notes to Trainer: Remind participants that providers should only assess for IPV, reproductive and sexual coercion when the patient is alone without parents, partners, friends, or children present. If this cannot be done, postpone assessment for a follow-up visit.

Jocelyn: We Always See Patient Alone First



The following video clip demonstrates how to separate accompanying persons from patient prior to assessing for reproductive and sexual coercion.

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**Estimated Activity Time: 2 minutes to watch video and
5 minutes for discussion**

- What worked well?
- What would you change?
- Are there considerations or questions specific to your setting that might make this safety card more useful?



Notes to Trainer: Discuss video clip.

1. What do you think worked well?
2. What did not work well? (When participants identify a problem—ask them: what would work better in their clinic?)

How to Introduce the Card:



- "We've started giving this card to all our patients so they know how to get help for themselves or so they can help others."
- (Unfold card and show it) "See, it's kind of like a magazine or online quiz."

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Notes to Trainer: Before clinicians introduce the safety card with patients, it is important to normalize the activity. This sample script gives guidance on how to begin the conversation. Emphasize that the card should be opened up and introduced to the patient. In this way, the most appropriate panel can be utilized to focus the intervention. It is important to open the card and review it with patients, not simply hand the card to them.

Resource for Targeted Assessment and Response: Reproductive Health Safety Card



Notes to Trainer: Make sure all participants have the “*Did You Know Your Relationship Affects Your Health*” safety card available. Ask participants to take the card out, open it up, follow along as you review the content on the next few slides.

This card focuses on an intervention for reproductive coercion with sexually active women. These are the goals of the safety card intervention.

- Educate patients about IPV, reproductive and sexual coercion.
- Help victims of IPV and RC learn about safety planning, harm reduction strategies and support services.
- Plant seeds for those who are experiencing abuse but not yet ready to disclose.
- Provide primary prevention for patients who have not been in this kind of relationship—so they can identify signs of an unhealthy relationship and ideally avoid them.
- Educate patients about what they can do if they have a friend or family member who may be struggling with abuse.

Emphasize that the goal is NOT disclosure or the patient leaving the relationship, but rather enhancing women’s understanding about healthy relationships and increasing their safety in their relationships.

The safety card-based intervention has been identified as one of five effective in reducing IPV by the US Preventive Services Task Force. For more information, visit the USPSTF website: <http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>

You might be the first person who told her what she deserves in a relationship.



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Notes to Trainer: Ask participants to open the safety card and find the appropriate panel. Read the “Sample Script” aloud, noting that it is a suggested approach, and that each participant should be familiar with the card content and adapt what they say to their own personal style as well as the specific patient and situation.

Part of patient education is talking about healthy, safe, and consensual relationships. Health care providers can also play a role in preventing abuse by offering education and anticipatory guidance about what a healthy relationship looks like, particularly for adolescent girls – but this is true for adult women too.

The following script provides more messaging about healthy, safe, and consensual relationships that can be shared with every patient.

“We have started talking to all of our patients about how you deserve to be treated by the people you go out with and giving them this card—it’s kind of like a magazine quiz. Are you in a HEALTHY relationship?”

What we have learned about our intervention:

- Always give two cards
- Using a framework about helping others helps normalize the situation and allows patients to learn about risk and support without disclosure
- Patients do use cards to help their friends and family
- Having the information on the card is empowering for them – and for the women they connect with



"We have started giving this out to all our patients in case they need this information for themselves or to help a friend. It talks about safe and healthy relationships..."

Practical Application

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer.
- Practice introducing the **Did You Know Your Relationship Affects Your Health?** card. Your goal is to review the *Healthy Relationships* Panel.
- Discuss as a group – what worked, what would you change?

63



Estimated Activity Time: 10 minutes

Notes to Trainer: Having time to practice using the card is CRITICAL. Make sure you build enough time into ANY presentation over an hour to have participants practice AT LEAST ONCE.

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY - in a real clinical interaction there will have been more time for rapport building - assume that has already happened and you are ready to discuss the safety card. There does not need to be a crisis or complicated back story for the patient -- the goal is to introduce the card, NOT do a direct assessment for reproductive coercion.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently introduce a conversation about healthy relationships with all of their patients?



Integrated Assessment: Contraceptive Counseling Visit



Notes to Trainer: Explain to participants that every panel of the card was developed with a specific visit in mind. You do not need to review every panel – or even every question/statement on a panel – with all patients. In this next section, we will highlight how different panels and different questions can be used based on the reason for the visit. As you become more familiar with the card, you will be able to easily identify which panels to use.

Provider Tip:
Use this panel
with
contraceptive
counseling
visits

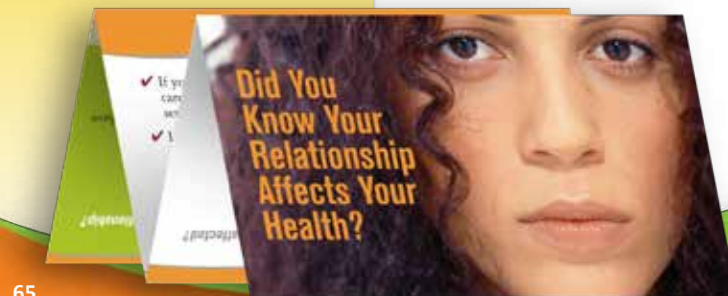


Are you in an **UNHEALTHY** relationship?

Ask yourself:

- ✓ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✓ Does my partner refuse to use condoms when I ask?
- ✓ Does my partner make me have sex when I don't want to?
- ✓ Does my partner tell me who I can talk to or where I can go?

If you answered **YES** to any of these questions, your health and safety may be in danger.



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Before spending valuable time counseling a patient about various contraceptive methods, assess if she is at risk for reproductive coercion. It is important to establish whether or not contraceptive methods are being tampered with, so you can counsel on appropriate method. For example, it does not make sense to spend time talking about condoms if the patient discloses that her partner refuses to use condoms, or to suggest oral contraceptives if her partner has a history of throwing them away.

“Before I review all of your birth control options, I want to understand if your partner is supportive of your using birth control. Has your partner ever messed or tampered with your birth control or tried to get you pregnant when you didn’t want to be?”

Girls who experienced physical dating violence were **2.8 times** more likely to fear the perceived consequences of negotiating condom use than non-abused girls.

(Wingood et al, 2001)



Notes to Trainer: Ask the audience how many of them do condom education with patients. And then ask, how many in the audience routinely ask female patients if they are afraid to ask their partner to use a condom. These data demonstrate how important it is to ask patients about whether it is safe to talk to their partner about using condoms and birth control.

In this study by Wingood et al., black females, 14 to 18 years old, were recruited from several different sites (i.e. health departments, adolescent medicine clinics, and school health classes) to participate in a HIV/STD prevention study (n=522). Girls with a history of dating violence were significantly less likely to use condoms consistently compared to nonabused girls.

In another study by Roberts et al. (2005), girls in verbally abusive relationships were less likely to use a condom during their most recent sexual intercourse. Reduced likelihood of using condoms has also been shown with adult women experiencing IPV.

Wingood and DiClemente (1997) conducted interviews with 165 sexually active African-American women, ages 18 through 29. Women in abusive relationships were less likely than nonabused women to use condoms and were more likely to experience verbal/emotional abuse or threats of physical violence when they discussed condoms. -They were more fearful of asking their partners to use condoms, worried more about acquiring HIV, and felt more isolated than women who were not in abusive relationships.

Wingood GM, DiClemente RJ, McCree DH, Harrington K, Davies SL. (2001). Dating Violence and the Sexual Health of Black Adolescent Females. *Pediatrics*, 107(5):1-14.

What if you redefined the first step of condom education as IPV assessment?

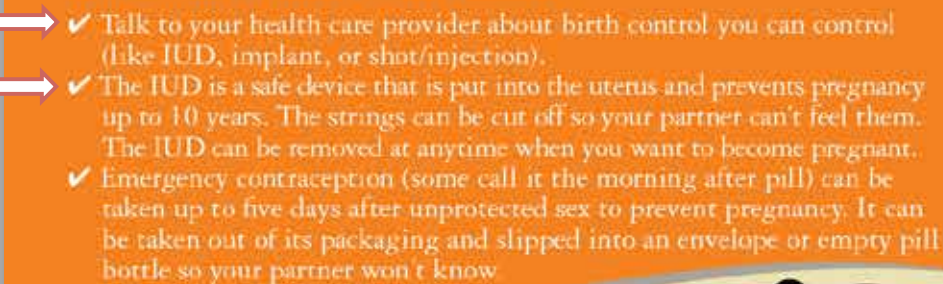


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Screening for IPV and reproductive coercion can save time. There are so many things that providers are responsible for covering in less and less time with every clinical encounter. What if we redefine screening for intimate partner violence as the first step in condom education? If your patients are too afraid to ask their partners to use a condom or asking puts your patients at risk, are we spending that time with our patient in the best way by focusing on condom education? Don't we first want to ask: *"Do you feel comfortable asking your partner to use a condom? Does he/she ever get angry when you ask him/her to use a condom?"*

IUD : Reproductive Coercion Intervention

- 
- Taking Control:**
- Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.*
- If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:**
- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
 - ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
 - ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.

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In addition to assessment and support, offering HARM REDUCTION STRATEGIES is a key component of this intervention. Anytime we talk with women about contraceptive options we highlight this section of the card—to make this connection between partner control and pregnancy risk—we want you to know what your options are in case this is ever a problem for you or a friend or family member.

This panel gives information on the unique and important role that health care providers play in creating safety for young women experiencing reproductive coercion. As a family planning provider, you have the skills, tools, and training to offer her forms of contraception that are less detectable and less able to be tampered with.

These methods are less vulnerable to tampering by a sexual partner—but are detectable due to loss of period/irregular bleeding.

Intrauterine Device



Injection



Implant



69

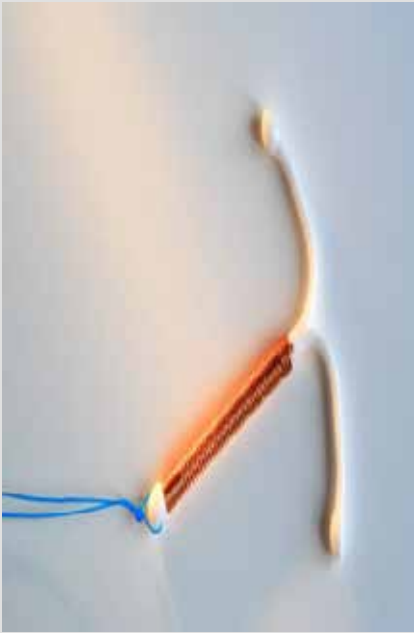
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Notes to Trainer: Safety First! Asking if her partner monitors menstrual cycles/bleeding patterns is essential to enhancing patients' safety. It helps when making a decision about contraception they can control with the least risk of retaliation.

When training participants that are both DV/SA advocates and reproductive health providers, a contraceptive methods handout may be useful to make sure all participants understand in detail the ways various forms of contraception work, and safety considerations to take into account when providing patient education about which method may help keep her safer.

1. Ask participants to review the birth control information sheet
2. Any if there are any questions about these methods and how a partner might interfere with them

Key Consideration



- If her partner monitors her menstrual cycles, an IUD may be the safest method to offer her.
- Especially if we cut the strings in the cervical canal so they can't be pulled out or felt by a partner.
- The inconvenience of IUD removal with ultrasound may well be worth avoiding an unwanted pregnancy by an abusive partner.



If a patient's partner monitors her menstrual cycles, a Copper T IUD may be the safest method to offer her. The FDA says that the Copper T/IUD are good for 10 years. A woman's period or bleeding pattern isn't altered as it may be with other methods mentioned previously. It's important that this information be included in our patient education.

It is possible to cut the strings in the cervical canal so they can't be pulled out or felt by a partner (stories from the field). The inconvenience of IUD removal with ultrasound may well be worth avoiding an unwanted pregnancy by an abusive partner.

American College of Obstetricians and Gynecologists. Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists Committee Opinion Bulletin: Clinical Guidelines for Obstetrician-Gynecologists, Number 539, October 2012. Available at:
<http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Adolescent%20Health%20Care/co539.pdf?dmc=1&ts=20130913T1650450598>. Accessed 13 September 2013.

Practice Bulletin No. 121

- It is important to note that some providers and health care systems have older protocols on IUDs and patient eligibility.
- In fact, ACOG states that LARC methods have few contraindications, and almost all women, including teens, are eligible for implants and IUDs.



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Notes to Trainer: It is important to note that some providers and health care systems have older protocols on IUDs and patient eligibility.

The American College of Obstetricians and Gynecologists states that long acting reversible contraceptive (LARC) methods have few contraindications, and almost all women, including teens, are eligible for implants and IUDs. LARCs are more effective than pills or condoms.

American College of Obstetricians and Gynecologists. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists Practice Bulletin: Clinical Guidelines for Obstetrician-Gynecologists, Number 121, July 2011. Available at <http://www.acog.org/~media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb121.pdf?dmc=1&ts=20130913T1703054905>. Accessed 13 September 2013.

Specific to sexual and reproductive health:

- Birth control that your partner doesn't have to know about (e.g. IUD, Implant)
- Emergency contraception
- Regular STI testing
- STI partner notification in clinic vs. at home



Remember that the goal is to enhance the patient's SAFETY, and she may not want to (or it may not be safe for her to) leave her relationship. These are approaches to reduce the risk of harm (unintended pregnancy or an untreated STI), and while they are not a solution to her abusive relationship, they *are* approaches that reduce her risk.



The following video clip demonstrates how to assess for reproductive coercion when a patient comes in for an oral contraceptive visit.

73



**Estimated Activity Time: 6 minutes to watch video and
5 minutes for discussion.**

- What worked well?
- What would you change?
- What additional safeguards can your setting put into place to ensure that patients are seen alone when assessing IPV, RC, and SC?



Notes to Trainer: Discuss video clip.

1. What do you think worked well?
2. What kinds of examples did you see to help “normalize” the conversation?
3. What did not work well? (When participants identify a problem—ask them: what would work better in their clinic?)
4. Were there some other questions that should have been asked?
5. How could this approach to integrated assessment be adapted for family planning settings?

A frequently asked question is whether it is possible to have someone open up with such a brief assessment. The answer is yes, some women do open up the first time they are asked in a compassionate non-judgmental way; others will take more time. We have learned from providers that once they begin screening using this approach they get many more disclosures than before.

Practical Application

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- **Scenario:** Your patient is coming in for contraceptive counseling. Her main method of contraception is condoms.
- Assess for reproductive coercion, using the **Are you in an UNHEALTHY relationship?** and **Taking Control** panels of the safety card as your guide.
- Discuss as a group – what worked, what would you change?

75



Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY - in a real clinical interaction there will have been more time for rapport building - assume that has already happened and you are ready to discuss the safety card. There does not need to be a crisis or complicated back story for the patient – the goal is to introduce the card and use the appropriate panel to assess for reproductive coercion.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently use the card in all of their reproductive health visits with female patients?

Steps for Responding to Disclosures

1. Validate patient's experience.
2. Offer a safety card for patient to review and keep if it is safe to do so.
3. Discuss where patient can go to learn more about and obtain birth control options.
4. Ask patient if she has immediate safety concerns and discuss options.
5. Refer to a DSV advocate for safety planning and additional support.
6. Follow up at next visit.



Notes to Trainer: Let participants know responding to disclosures will be covered at length later in the training—including a video vignette and practical application.

When a patient discloses reproductive coercion:

Offer support, validation and harm reduction strategies

"I'm really glad you told me about what is going on—it happens to a lot of women and it is so stressful to worry about getting pregnant when you don't want to be. I want to talk with you about some methods of birth control that your partner doesn't have to know about like Implanon or the IUD—so you don't have to worry about unplanned pregnancy."



“What you’ve told me also makes me worried about your health and safety in other ways. Sometimes when a partner is trying to get you pregnant when you don’t want to be, they might also try and control or hurt you in other ways.”



“Is anything like this happening in your relationship?”



Women who experience reproductive coercion are also at risk for other forms of abuse. After addressing reproductive and sexual coercion, providers can make the bridge to asking direct questions about other abusive and controlling behaviors, using a script similar to the one on the slide.

What Should You Do When You Get a Positive Disclosure of IPV?



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Validate:

- Thank patient for sharing
- Convey empathy for the patient who has experienced fear, anxiety, and shame. *“No one deserves this...”*
- Validate that IPV is a health issue that you can help with
- And let her know you will support her unconditionally without judgment

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Notes to Trainer: Ask participants, can talking about abuse make a difference?

Even if a patient is not ready to leave a relationship, your recognition and validation of her situation is important. You can help reduce her sense of isolation and shame as well as encourage her to believe a better future is possible.

Validating Statements:

- *“I’m so sorry this is happening, you don’t deserve this”*
- *“It’s not your fault”*
- *“You’re not alone”*
- *“I’m worried about your safety”*
- *“Help is available”*

Providing a “Warm” Referral

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Formerly Family Violence Prevention Fund
FuturesWithoutViolence.org

 The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org



Notes to Trainer: If there are not any local resources or you do not have information about local referrals, the National Domestic Violence Hotline can help. The National Domestic Violence Hotline staff have been trained on both sexual and reproductive coercion so the staff are very familiar with these issues. They would be an excellent referral for survivors.

If she is not ready for help:

“You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble you can come here for help. I am also going to give you this card with a hotline number on it. You can call the number any time. The hotline staff really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. They have contact with lots of women who have experienced this or know about it in a personal way.”



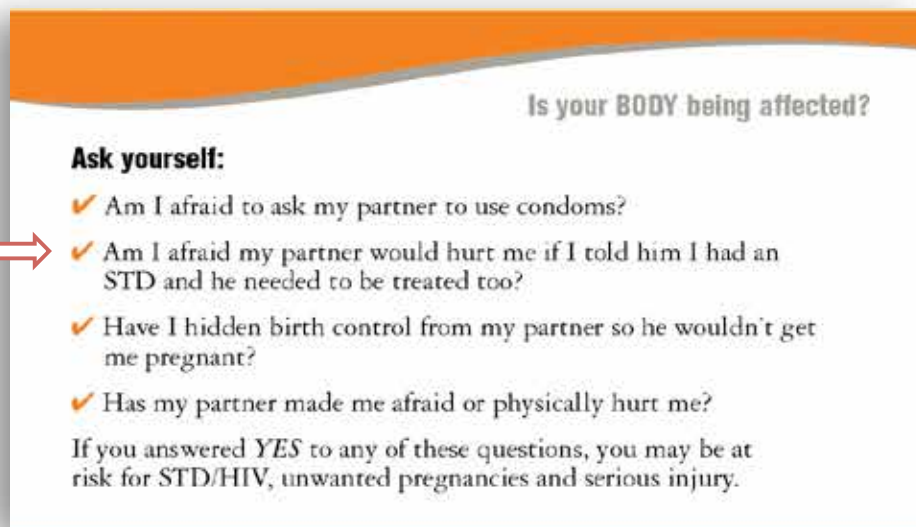
Integrated Assessment: Emergency Contraception Visit

FUTURES
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Whenever someone comes in for Emergency Contraception (EC), often described as the morning after pill, there are key questions to ask and patient education to provide to help determine whether sex was consensual or if any contraceptive tampering may be occurring.



Provider Tip: Use this panel with emergency contraceptive visits



FUTURES
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Notes to Trainer: Review the bullets on the card. The sample script provided is useful when talking to young women whose primary contraceptive method is condoms or if they come in regularly for EC. Point out that the second bullet *“Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated, too?”* is a prompt to discuss safer partner notification which will be discussed later in the training.

For EC visits, also ask *“Does your partner know you are here for EC?”* to start a conversation about her ability to negotiate contraception. Is the patient using EC because she can not talk to her partner about using condoms? Is he sabotaging her other birth control methods?



Abused women are more likely to have not used birth control due to affordability and are more likely to have used emergency contraception when compared to non-abused women.

(Gee et al, 2009)

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Patients requesting emergency contraceptives should also be asked about coercive sex. An example of a screening question for IPV at emergency contraceptive visits is: *“Was this sex consensual?”*

Emergency contraception is often seen as a ‘quick fix visit’ by clinics and providers. If you meet the criteria, this is a quick fix to reduce the likelihood that you’ll become pregnant. But don’t we want to know what happened? Or what is happening? It’s essential that we take that opportunity to ask if the sex she had was consensual and if anything was happening with a partner trying to get her pregnant when she didn’t want to be.

Gee RE, Mitra N, Wan F, Chavkin DE, Long JA. (2009). Power over parity: intimate partner violence and issues of fertility control. *American Journal of Obstetrics & Gynecology*, 201:148.e1-7.

Levonorgestrel (common trade name Plan B) may not be as effective among overweight women.

The **Copper IUD** and **ulipristal acetate (UPA)** (common trade name Ella) are effective alternatives for women desiring emergency contraception.

(Glasier et al, 2011; Glasier et al, 2010)



Women who have intercourse around ovulation should ideally be offered a copper intrauterine device. Women with body mass index $>25 \text{ kg/m}^2$ should be offered an intrauterine device or UPA. All women should be advised to start effective contraception immediately after EC.

Glasier AF, Cameron ST, Blithe D, Scherrer B, Mathe H, Levy D, Gainer E, Ulmann A. (2011). Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception*, 84(4):363-7.



Glasier AF, Cameron ST, Fine PM, Logan SJ, Casale W, Van Horn J, Sogor L, Blithe DL, Scherrer B, Mathe H, Jaspart A, Ulmann A, Gainer E. (2010). Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet*, 375(9714):555-62.

EC Pills: Reproductive Coercion Intervention



Taking Control:
Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.
If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.



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Notes to Trainer: Inform the participants that the cards can be used for either direct assessment or for universal education. For example, to make the information more universal, they can offer the card to the patient or their friend.

“Just in case this is ever an issue for you or a friend...take a look at this last bullet point—we focus on this panel of the card with all our EC visits.”

Emphasize that the sample scripts are offered as an example of how to approach integrating the safety card into their routine work, and that each provider will need to find their own approach to feeling comfortable using the safety cards. We do not expect the participants to memorize the scripts for future use, but provide them to emphasize the key points to cover in the targeted assessment.

“Was the sex you had consensual, something you wanted to do?”

“Are you at all concerned that your partner may be trying to get you pregnant when you don't want to be?”

“Sometimes women have to worry about someone else finding your EC and throwing it away. If that is an issue for you, it may be useful for you to try out some of the strategies listed on the card.”



The following video clip demonstrates how to screen for reproductive coercion and provide harm reduction strategy using a safety card.



Estimated Activity Time: 5 minutes to watch video and 5 minutes for discussion.

Video Debrief

- What worked well?
- What would you change?
- Are there considerations or questions specific to your setting that might make this safety card more useful?

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Notes to Trainer: Discuss video clip.

1. What do you think worked well?
2. What kinds of examples did you see to help “normalize” the conversation?
3. What did not work well? (When participants identify a problem—ask them what would work better in their clinic?)
4. Were there some other questions that should have been asked?
5. How could this approach to integrated assessment be adapted for family planning settings?
6. What kinds of examples did you see to help “normalize” the conversation?

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- **Scenario:** Your patient is coming in for emergency contraception. Her main method of contraception is condoms.
- Assess for reproductive coercion, using the **Is Your Body Being Affected?** and **Taking Control** panels of the safety card as your guide.
- Discuss as a group – what worked, what would you change?



Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real clinical interaction there will have been more time for rapport building- assume that has already happened and you are ready to discuss the safety card. The goal is to introduce the card and use the appropriate panel to assess for reproductive coercion.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently use the card in all of their reproductive health visits with female patients?



Integrated Assessment: Pregnancy Test Visit



Whenever someone comes in for a pregnancy test, pregnancy options counseling that includes assessment questions should occur for all patients with positive and negative pregnancy test results.



Provider Tip: Use This Panel With Pregnancy Test Visits

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered **YES** to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.



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Notes to Trainer: Review the bullets on the card, as well as the sample script. The panel, “Who Controls Pregnancy Decisions?” of the safety card should be reviewed with patients for all positive or negative pregnancy test results.

“Because this happens to so many women, we ask all of our patients who come in for a pregnancy test if they are able to make decisions about pregnancy and birth control without any threats or fear from a partner. Who makes these decisions in your relationship?”

Olivia: Pregnancy Test



The following video clip demonstrates an approach to integrated reproductive coercion during a pregnancy test visit.

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**Estimated Activity Time: 5 minutes to watch video and
5 minutes for discussion.**

- What worked well?
- What would you change?
- Were there some other questions that should have been asked?



Notes to Trainer: Discuss video clip. Universal education and focusing on friends opens the door for direct assessment. *“So Olivia is anything like this happening to you?”*

What did the provider do effectively with Olivia?

- Normalized the prevalence of relationship abuse among her clinic population.
- Talked with Olivia about healthy and safe relationships.
- Talked with her about information she could share with a friend.

Tactics Include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that may cause a miscarriage

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Pregnancy pressure involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to be pregnant. Pregnancy coercion involved coercive behaviors such as threats or acts of violence if a partner does not comply with the male partner's wishes regarding the decision of whether to terminate or continue a pregnancy.

Threats to Promote a Birth

“ He really wanted the baby—he wouldn’t let me have—he always said, “If I find out you have an abortion,” you know what I mean, “I’m gonna kill you,” and so I really was forced into having my son. I didn’t want to; I was 18. [...] I was real scared; I didn’t wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn’t want to have a baby but I was really scared. I was scared of him. ”

(Moore et al, 2010)



This respondent described how her partner threatened her into carrying an unwanted pregnancy to term. Other respondents described abusive partners making them feel bad about their desire to abort a pregnancy; begging, badgering and making promises to support the baby to pressure them into giving birth. Some respondents described giving in to this pressure, and some did not. One woman’s partner kept on making her eat which prevented her from going in for her second trimester abortion for which she needed to be sedated since one of the rules was that she could not eat anything the day of her abortion. Respondents also described other tactics used by partners to keep them from obtaining abortions such as refusing to pay or help pay for an abortion.

Moore AM, Frohworth L, Miller E. (2010). Male Reproductive Control of Women Who Have Experienced Intimate Partner Violence in the United States. *Social Science and Medicine*, 70(11):1737-1744.



The following case study demonstrates how to screen for Pregnancy Coercion with a positive pregnancy test result.

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**Estimated Activity Time: 5 minutes to watch video and
5 minutes for discussion**

- What worked well?
- What would you change?
- Are there considerations or questions specific to your setting that might make this safety card more useful?



Notes to Trainer: Discuss video clip.

1. What do you think worked well?
2. What kinds of examples did you see to help “normalize” the conversation?
3. What did not work well? (When participants identify a problem—ask them what would work better in their clinic?)
4. Were there some other questions that should have been asked?
5. How could this approach to integrated assessment be adapted for family planning settings?

Practical Application

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- **Scenario:** Your patient is coming in for a pregnancy test. She is dreading the result – which she assumes is positive (missed period) – and you confirm.
- Assess for pregnancy coercion, using the **Who Controls Pregnancy Decision?** panel of the safety card as your guide.
- Discuss as a group – what worked, what would you change.

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Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real clinical interaction there will have been more time for rapport building- assume that has already happened and you are ready to discuss the safety card. The goal is to introduce the card and use the appropriate panel to assess for reproductive coercion.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently use the card in all of their reproductive health visits with female patients?

Section Recap

- Use the **Did You Know Your Relationship Affects Your Health?** safety card to assess for reproductive coercion as part of routine care.
- Simple harm reduction strategies can prevent a woman from being a victim of a forced, unwanted pregnancy.
- Health care providers are key to intervention for reproductive coercion by providing harm reduction and discreet methods of contraception.
- Follow-up to disclosures and warm referral



Notes to Trainer: Read the “Section Recap” out loud to close each section.

Module 4: Intimate Partner Violence, Sexually Transmitted Infections, and Safer Partner Notification



Intimate Partner Violence, Sexually Transmitted Infections, and Safer Partner Notification

Module 4

Estimated Module Time: 40 minutes

Training Outline

- Learning objectives
- Association between IPV, RC, SC and STIs
- Safety assessment for STI partner notification
- Approaches to safer partner notification

Overview

This module is focused on a targeted assessment strategy for female patients. It provides guidance for providers to help them include IPV in their differential diagnosis when it comes to Sexually Transmitted Infections and HIV.

As we have learned more about different forms of abusive and controlling behaviors that are used by partners to maintain power and control in a relationship, patterns of behaviors that affect women's reproductive health specific to STIs and HIV have been identified. These behaviors include risk for forced non condom use, increased risk for STI/HIV, and risk for harm associated with partner notification of STI/HIV.

Learning Objectives

As a result of this activity, learners will be able to:

1. Give one example of a clinic policy that should be in place to ensure the safety of all patients presenting for diagnosis and treatment of an STI.
2. Describe how to assess for patient safety prior to any partner STI notification recommendations.
3. List two harm reduction strategies for partner STI notification when you know or suspect that the patient is in an abusive and/or controlling relationship.

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Notes to Trainer: Read the learning objectives aloud.

- Women who experienced past or current IPV are more likely to:
- Have multiple sexual partners
- Have a past or current sexually transmitted infection
- Report inconsistent use or nonuse of condoms
- Have a partner with known HIV risk factors

(Wu et al, 2003)



This study by Wu and colleagues (2003) was part of a larger, randomized clinical trial that recruited urban, minority women (n=1590) from out-patient clinics at a large hospital in New York City. The mean age of participants was 35.4 years with the majority of women identifying as African American or Latina. Sexual risk behaviors were measured with the Sexual Risk Behavior Questionnaire (SRBQ).

- Approximately 1 in 5 women reported experiencing current physical and/or sexual IPV in their primary heterosexual relationship.
- Compared to women who reported never experiencing IPV, women who reported experiencing current or past IPV were:
 - 2.9 times as likely to have multiple sexual partners in the past year
 - 2.5 times more likely to report having a past or current STI
 - 2.1 times more likely to never use condoms
 - 3.6 times more likely to use condoms fewer than half of the instances of sex with their primary partners versus using condoms 100% of the time
 - 3.0 times more likely to report having a partner with a known HIV risk factor

Wu E, El-Bassel N, Witte S, Gilbert L, Chang M. (2003). Intimate Partner Violence and HIV Risk Among Urban Minority Women in Primary Health Care Settings. *AIDS and Behavior*, 7(3):291-301.

Victims of IPV are More Likely to be Infected



- Teen girls who are abused by male partners are **3x** as likely to become infected with an STI/HIV
- Women and girls who are victims of IPV are **4x** as likely to be infected with HIV
- Men and boys who are abusive to female partners are **3x** as likely to have an STI

(Decker et al, 2009; Decker et al, 2005)

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Decker MR, Seage GR, Hemenway D, Gupta J, Raj A, Silverman JG. (2009). Intimate partner violence perpetration, standard and gendered STI/HIV risk behavior, and STI/HIV diagnosis among a clinic-based sample of men. *Sexually Transmitted Infections*, 85:555-60.

Decker MR, Silverman JG, Raj A. (2005). Dating violence and sexually transmitted disease/HIV testing and diagnosis among adolescent females. *Pediatrics*, 116(2):e272-276.



Women with high STI knowledge who were fearful of abuse were **less likely to consistently use condoms** than nonfearful women with low STI knowledge.

(Raiford et al, 2009)



Note to Trainer: Remind participants that this statistic demonstrates that we should not assume a knowledge deficit or automatically give a bag of condoms to prevent disease. First we have to know if she is afraid to ask her partner to use a condom.

In this study by Raiford et al. (2009), women were asked about the degree to which they were worried that if they talked about using condoms with their sexual partner that he would respond in negative ways including threatening to hit, push or kick them; leave them, swear at them; or call them names.

Almost half (47.6%) of the young (18-21 years) African American women (n=715) reported having experienced relationship abuse in their lifetime; 15% reported abuse by a main sexual partner in the past 60 days. Under high levels of fear for abuse, 76% of women with high STI knowledge were more likely to exhibit inconsistent condom use during their last sexual intercourse with a man compared to 60% of women with low levels of knowledge. One of the explanations for this counterintuitive finding that the authors offer is that women with more knowledge about STI transmission may balance the risk of abuse with the risk of acquiring an STI, particularly if they know or suspect that their partner is at low risk for STIs. Overall these findings emphasize the importance of integrating dating violence assessment and prevention into STI and HIV prevention programs.

Raiford JL, DiClemente RJ, Wingood GM. (2009). Effects of fear of abuse and possible STI acquisition on the sexual behavior of young African American women. *American Journal of Public Health*, 99(6): 1067-1071.

Women disclosing
physical abuse

were

3 TIMES

more likely to
experience an STI.

Women disclosing
psychological abuse

were

2 TIMES

more likely to
experience an STI.

(Coker et al, 2000)



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Notes to Trainer: This research highlights the importance of considering a spectrum of control when it comes to risks for STIs and HIV. There are some relationships where we only see verbal abuse. And we want providers to be aware of this and consider screening not only for physical and sexual abuse but also psychological abuse. Examples of this kind of assessment includes things like, does he regularly call you names, shame you, put you down, or make you feel afraid or scared?

- For additional information on the health effects of forced sex, refer to the section on women's health
- In the Coker et al. (2000) study, the relative risk (RR) of physically abused women experiencing a STI was 3.13 compared to non-abused women. The relative risk of psychologically abused women experiencing a STI was 1.82.
- RR is the abbreviation for relative risk. Relative risk is defined as the incidence rate for persons exposed to a factor compared to the incidence rate for persons not exposed to that factor. In this study, the factor or exposure is domestic violence and the incidence rate of sexually transmitted diseases is compared among women who have disclosed domestic violence compared to women who did not disclose a history of domestic violence. (Mausner & Kramer, 1985)

Coker AL, Smith PH, Bethea L, King MR, McKeown RE. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine*, 9:451-457.



More than one-third (38.8%) of adolescent girls tested for STIs/HIV have experienced dating violence.

(Decker et al, 2005)



Notes to Trainer: Remind participants that given this statistic, every patient coming in for testing or treatment of STIs should be considered at risk for domestic violence and coercion—which makes seeking testing for STI a clinical indicator to screen for domestic violence.

In a review study of U.S. and international research on the intersection between IPV and HIV/AIDS, the increased risk of HIV/AIDS related to IPV among women and adolescents was related to several mechanisms, including compromised negotiation of safer sex practices, forced sex with an infected partner, and increased sexual risk-taking behaviors.

- Violence is both a significant cause and a significant consequence of HIV infection in women.
- More than one-half (51.6%) of adolescent girls diagnosed with an STI/HIV experience dating violence
- Qualitative research with adolescent girls who were diagnosed with STIs and disclosed a history of abuse suggests that the powerlessness they feel leads to a sense of acceptance that victimization, STIs, and the negative stigma attached to STIs are all inevitable parts of their lives.

Decker MR, Silverman JG, Raj A. (2005). Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. *Pediatrics*, 116(2):3272-276.

Based on a study of 310 HIV-positive women:

- 68% experienced physical abuse as adults
- 32% experienced sexual abuse as adults
- 45% experienced abuse after being diagnosed with HIV

(Gielen et al, 2000)



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Notes to Trainer: IPV can be a consequence of HIV. In this study by Gielen and colleagues (2000), 4% of women reported that they experienced physical abuse as a direct consequence of disclosing their HIV status. In another study by Koenig et al. (2002), 10% of HIV-positive women reported negative reactions to disclosing their HIV status.

While providers who specialize in HIV treatment may be experts in incorporating the violence factor into their treatment plans, many folks in the medical field doing HIV testing may not realize the extent of the overlap.

Gielen AC, McDonnell KA, Burke JG, O'Campo P. (2000). Women's lives after an HIV-positive diagnosis: Disclosure and violence. *Maternal and Child Health Journal*, 4(2):111-120.

"I told him to put a condom on, he didn't...I went to a clinic, and they were like, "Oh, he gave you Chlamydia." [H]e said it was me messin' around with some other guy, and that's not true, 'cause I was like, "You were the only guy I was with." And he's like, "Oh, that's you, you're messin' around," he's like, "fuck you, I thought you loved me."

(Miller, 2007)



Notes to Trainer: This quote was collected in a qualitative study about young women's experiences with reproductive coercion. In this case, the abusive male partner refused to use condoms and had multiple partners while she remained monogamous. When the young woman tested positive for Chlamydia, he blamed her.

Miller E., Personal Communication, March 2, 2007.

A woman comes to your setting asking for STI/HIV testing



“Anytime someone comes in for STI testing, I always ask if they feel safe asking their partner to use a condom. Or if he ever gets mad at them for asking him to use one? Or if there is ever a situation where they are made to have sex when they don’t want to.”

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Notes to Trainer: Here’s a good way to start a conversation when a woman comes into your setting asking for STI or HIV testing.

Expedited Partner Treatment

The Centers for Disease Control and Prevention (CDC) define Expedited Partner Therapy as:

“...the clinical practice of treating the sex partners of patients diagnosed with Chlamydia or Gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.”

In many states the patient with the infection can bring the medication or the script for medication to their partner and the partner can be treated without ever seeing a health care provider.



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Notes to Trainer: Although Expedited Partner Treatment (EPT) is recommended by the CDC and ACOG as an approach that facilitates partner treatment and disease control, it may present unforeseen risks to a patient in an abusive relationship (e.g. partner retaliation).

In a study with a culturally diverse sample of women seeking care at family planning clinics, female patients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating. Some of the women reported threats of harm or actual harm in response to notifying their partner of an STI.

Always assess for safety before recommending a treatment approach. If EPT is part of your clinic protocol, modify the protocol to include a safety assessment prior to prescribing EPT.

For more information, go to: <http://www.cdc.gov/std/ept/default.htm>

McFarlane J, Parker B, Soeken K, Silva C, Reel S. (1998). Safety Behaviors of Abused Women Following an Intervention Program Offered During Pregnancy. *Journal of Obstetrical, Gynecological and Neonatal Nursing*, 27 (1):64-9.

Committee Opinion No. 506

ACOG recommends EPT for cases of Gonorrhea and Chlamydia when partner is unlikely or unable to otherwise receive in-person evaluation and appropriate treatment.



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While we recognize that EPT can help reduce the spread of STIs, it can also have the unforeseen consequence of putting women at risk of partner retaliation.

American College of Obstetricians and Gynecologists. (2011). Expedited Partner Therapy in the Management of Gonorrhea and Chlamydia by Obstetrician-Gynecologists. Committee Opinion No. 506. *Obstetrics & Gynecology*. 118:761-6. Available at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Adolescent_Health_Care/Expedited_Partner_Therapy_in_the_Management_of_Gonorrhea_and_Chlamydia_by_Obstetrician-Gynecologists. Accessed 13 September 2013.



Implications for STIs/HIV Programs

- Expedited Partner Therapy (EPT) and Partner Notification may be dangerous for patients experiencing abuse.
- Patients may not be able to negotiate safe sex with an abusive and/or controlling partner
- IPV may be a more immediate threat to a patient than a sexually transmitted infection or exposure to HIV.



Notes to Trainer: One strategy to consider with your audience is a recent example of harm reduction being utilized in Virginia.

County STI programs have developed a system to help keep women safer by having health departments from other area codes call to do the partner notification. Calling from a different area code than the one the victim resides in can help reduce the likelihood that he will know it is his current partner who was just diagnosed with the STI. This kind of strategy can help keep a woman safer, reducing the likelihood that he would know to blame her for the infection.

State Specific Considerations Regarding Partner Treatment and Notification

Know your STI/HIV State reporting requirements

- In some states, the Department of Public Health always notifies a partner if they've been exposed to an STI/HIV.
- In other states, the provider notifies the state as to whether their patient has notified their partner of the infection or virus. Based on this report the Department of Public Health would only follow up if the known partner had not been contacted by the patient.



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Notes to Trainer: Harm reduction strategies may look different based on states' and counties' reporting requirements. Thus, it is important that health departments that do positive STI partner treatment notification are educated about ways in which to improve safety and reduce harm for survivors of intimate partner violence.

Harm Reduction: Partner Notification

- **Offer to educate partner about STIs (especially if she is afraid he will blame it on her)**
- **Offer to let her contact the local DV program**
 - “If you would like, I can put you on the phone right now with [name of local advocate] and we can create a plan for you to protect your safety.”
- **If the partner is in clinic with her today—assess for her safety and staff safety.**
 - “Are you worried about what will happen if you tell him about the STI or if we tell him about the STI?”



Notes to Trainer: Encourage providers to offer different strategies to promote safety when they have to notify a partner about an STI. Remind that the risk of STI re-infection may be a more acceptable risk than the risk of abuse by the partner if notified of the need for treatment.

Acknowledge that this is not a perfect solution but that it is better than not addressing safety at all.

Remind participants that they can also play an important role in promoting safety by offering to call the DV program right there in clinic.

Provider Tip:
Use this
panel with
all STI/HIV
related visits

Is your BODY being affected?

Ask yourself:

- ✓ Am I afraid to ask my partner to use condoms?
- ✓ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✓ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✓ Has my partner made me afraid or physically hurt me?

If you answered **YES** to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.



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Notes to Trainer: Remind participants that all patients coming in for an STI test or for treatment of STI should have the following panel of the card reviewed with them. Both questions highlighted by arrows in this panel are essential to ask.

Advise participants that they can introduce the card as we have demonstrated in the video case study.

“Are you worried he will hurt you if you tell him you have Chlamydia or PID?”

Use this panel with all STI/HIV partner notifications



Getting Help

- ✓ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✓ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✓ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.



Notes to Trainer: Harm Reduction is Empowerment: Making the call for her can help keep her safer. Any health care provider can let the partner know that he was exposed to a specific STI by a partner within the last 2 years and needs to be treated—and you cannot divulge the name.

Promising Practice: Some of the staff who work with STIs at the Virginia Department of Health ask their colleagues in another county with a different area code to make the call to notify an abusive partner about exposure to an STI.



The following case study reviews sexual coercion and the risks associated with notifying a partner about an STI.

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**Estimated Activity Time: 5 minutes to watch video and
5 minutes for discussion**



- What worked well?
- What would you change?
- Can you think of a missed opportunity with a patient seeking STI care where a discussion regarding safety and partner violence might have been helpful?



Notes to Trainer: Discuss video clip.

1. What worked well?
2. Were there any questions or things the provider said that especially resonated with you?
3. What questions did you think the provider asked that were helpful?
4. What would you change?
5. What additional safeguards can you put into place?
6. Any final thoughts about what you saw? Concerns?

Practical Application

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- **Scenario:** Your patient has Chlamydia and gonorrhea, and is coming back for a PID follow up appointment.
- Using the **Getting Help** panel of the safety card as your guide, talk with her about her partner, if she is afraid of what he will do if he finds out she has an STD, and harm reduction ideas.
- Discuss as a group – what worked, what would you change.

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Exercise Activity Time: 10 minutes

Notes to Trainer: Divide participants into groups of three. Advise participants that one person will role play the clinician one is the patient, and the third person is the observer.

- Allow 3-5 minutes for the role play.
- Ask the observers to think about the kinds of things that the clinician said that worked well such as how did she/he introduce the card? Did she/he make the discussion comfortable? What would they have liked to see more of?
- Ask the participants who role played the client how the assessment made them feel.
- Ask participants who role played clinician what they thought about using the card for safer partner notification and its implications for expedited partner treatment



Section Recap

- Addressing IPV is a key component of STI and HIV prevention
- It's important to consider a spectrum of control when assessing risks for STIs/HIV
- Assess for a patient's safety prior to any partner treatment notification recommendations
- Clinics should adopt policies to ensure the safety of all patients presenting for diagnosis and treatment of an STI
- Consider harm reduction strategies when using clinic staff and health departments to do anonymous partner treatment notification when needed
- Use the **Getting Help** panel of the safety card to talk to patients about safer partner notification strategies



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Notes to Trainer: Read the "Section Recap" out loud to close each section.

Module 5: Building Bridges Between Reproductive Health and Domestic and Sexual Violence Advocacy

A photograph of the Golden Gate Bridge in San Francisco, viewed from a low angle looking across the water towards the bridge's towers. The sky is blue with some light clouds, and the water is a deep blue. The bridge's orange-red structure is prominent.

Building Bridges Between Reproductive Health and Domestic and Sexual Violence Advocacy

Estimated Module Time: 15 minutes

Training Outline

- Learning objectives
- Partnering with local domestic and sexual violence advocacy groups

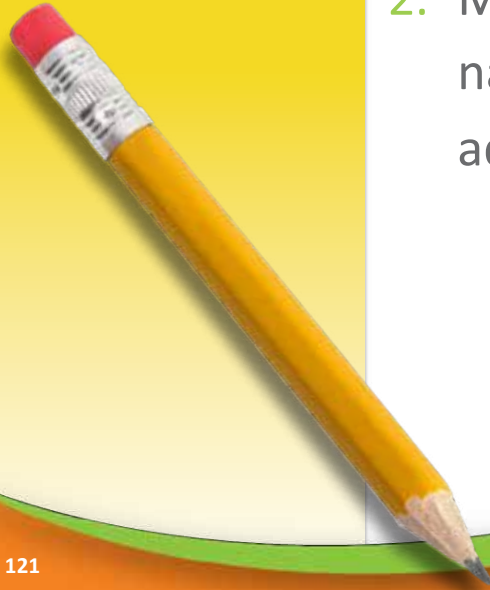
Overview

Prior to assessment for abuse and violence, practitioners should ensure protocols are in place for a safe and effective response. This means having specified roles and responsibilities within the clinic setting, knowledge of existing violence prevention and intervention resources within the local community and an established system for activating these resources depending on the situation. Providers should not feel that they must have “all the answers.” In these moments, having a team in place to call upon is necessary so the provider is not left carrying the weight of the situation alone. It is ideal to have an in-person introduction to an advocate or social worker to connect the person with ongoing support.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Describe the role of domestic and sexual violence advocates.
2. Make a supported “warm” referral to national and local domestic violence advocacy services and resources.



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Notes to Trainer: Read the learning objectives aloud.



- Educate patients that the clinic is safe place for them to connect to such resources
- Providers should know names of DSV services staff, languages spoken, how to get there, etc.
- Annotated referral list for violence related community resources
- Normalize use of referral resources

Outcome: Increased awareness and utilization of IPV/SA victimization services



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Notes to Trainer: Stress here that this is different than just handing out a phone number – that the key here is knowing the services involved, discussing the people who are there “I know a woman Clara – she really understands this – and she could be really helpful to talk to.”

Supported referral is the final element of the intervention. By offering support to facilitate the referral process, providers can increase the likelihood that a patient follows through with a referral. Two key strategies for supported referral are acknowledging a patient’s safety concerns and offering options. Additionally, offering a patient use of a phone at the clinic to call a domestic violence hotline or an advocate can be a safe strategy to increase access to services.

Role of the Domestic Violence Advocate



- Domestic violence advocates provide safety planning and support
- Get to know local programs that SERVE youth
- Advocates can work with youth on safety planning and additional services like:
 - Housing
 - Legal advocacy
 - Support groups
 - One-on-one counseling
 - Referrals to other programs for health, mental health, etc.

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Contact the nearest domestic violence shelter or the domestic and/or sexual violence coalition in your state to talk with domestic and sexual violence advocates and learn more about services they provide, languages spoken, safety planning, training, and resources for patients who have experienced IPV.

When you can connect to a local program it makes all the difference

“If you are comfortable with this idea, I would like to call my colleague at the local program (fill in person's name), she is really an expert in what to do next and she can talk with you about a plan to be safer. ”



A key step in developing a supported referral is to connect with existing support services for IPV in the community. Getting to know your local DSV program staff will help ensure that each referral feels genuine and supportive to your patients. Making this connection can be mutually beneficial. Team-training with domestic and sexual violence advocates from local programs acknowledges their expertise and provides an opportunity to build working partnerships.

- DSV advocates are an excellent resource for training and advocacy
- DSV advocates will become more aware of what reproductive health services are available for women experiencing IPV.

In the clinics that have close partnerships with local advocacy programs:

- Advocates did safety planning on site or by phone
- Advocates escorted woman to safety out the backdoor of clinic



This did not happen in the sites without strong partnerships.



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Notes to Trainer: In work with our *Project Connect* sites, we have seen that strong partnerships with local advocacy programs are key to providing compassionate and effective services.

Strategies for building the partnership included:

- Having an MOU (Memorandum of Understanding) in place, outlining each program's roles and responsibilities
- Cross-training for clinic and DSV program staff. Offering "Reproductive Health 101" to advocates and "Reproductive and Sexual Coercion 101 and Health" to clinic staff helps create the context for the partnership
- Meetings to discuss policies and protocols related to addressing reproductive and sexual coercion, as well as supporting staff affected by relationship violence in the clinic setting
- Case reviews/regular check-ins
- Having a direct number to reach program staff (not having to go through the front desk/voice prompt system)

Hotline Referral

Offer patients the use of your office phone to make the call

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 A5FWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).



Formerly Family Violence Prevention Fund
FuturesWithoutViolence.org



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org



If there are not any local resources or you do not have information about local referrals, the National Domestic Violence Hotline can help. The National Domestic Violence Hotline staff have been trained on both sexual and reproductive coercion so the staff are very familiar with these issues. They would be an excellent referral for survivors.

Offering your patient the use of a phone at the clinic to call a domestic violence hotline or an advocate can be a safe strategy that increases access to services. Remind participants that youth may prefer to use internet, chat or text options instead of a call in hotline.

"There are national confidential hotline numbers, and the people who work there really care and have helped thousands of women. They are there 24/7 and can help you find local referrals, too—and often can connect you by phone..."

Section Recap

- Health care providers play an important role in connecting victims to advocacy services
- Become familiar with the resources on the safety card, including making a call to the National Domestic Violence Hotline
- Create partnerships with your local domestic violence program, so that you can make warm referrals

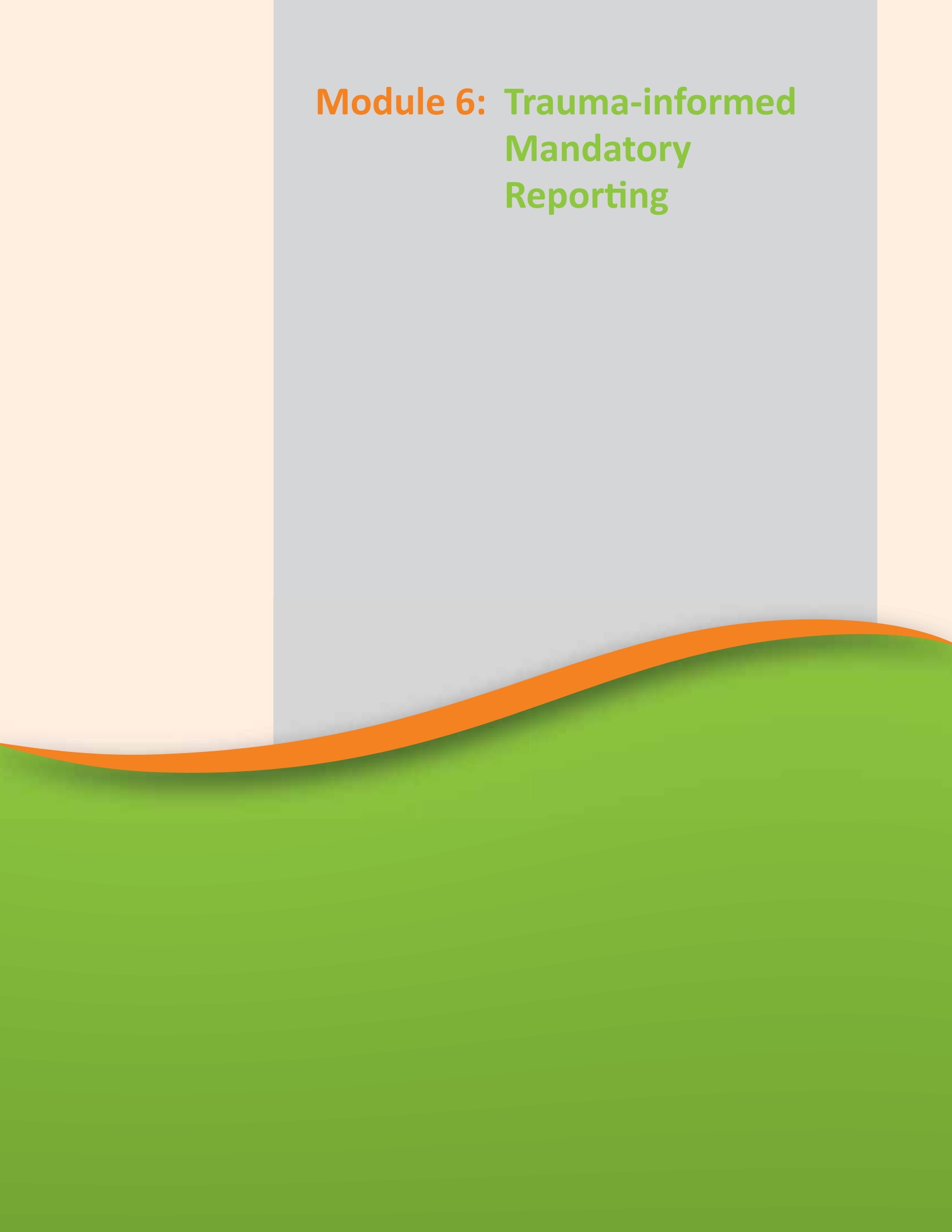


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Notes to Trainer: Read the “Section Recap” aloud to close each section.

Module 6: Trauma-informed Mandatory Reporting





Trauma-informed Mandatory Reporting

Estimated Module Time: 30 minutes

Training Outline

- Learning objectives
- Principles of patient-centered mandatory reporting
- Key considerations
- Supporting patients
- Resource

Overview

This module offers a brief introduction to a complex topic. Many states have mandated reporting laws, requirements and procedures which vary considerably by county and state. It is important for trainers to be aware of local response practices. Trainers should consult with their local domestic and/or sexual violence agency before doing any training to learn the basics and have referral information for further training and consultation available.

If time allows, this module provides an excellent opportunity for a guest speaker to talk about mandated reporting for intimate partner violence in your jurisdiction. For more information on state laws and regulations go to: www.FuturesWithoutViolence.org to see a compendium of state statutes and policies on DV and health care.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Identify two strategies to support and involve patients when making a mandated report.
2. Explain the importance of working with DSV advocacy to learn more about reporting procedures and practices in your community.
3. Describe three best practices for documentation.

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Notes to Trainer: Read learning objectives aloud.

State Laws on Reporting Adult IPV

- Laws vary from state to state
- Implementation varies from county to county
- Contact your state coalition on domestic and/or sexual violence for information about your laws and how they are implemented



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Notes to Trainer: There is a lot of variation between states and implementation of these laws vary from county to county. Thus it is critical for providers to reach out to their state's domestic violence coalition to understand their state's reporting requirements and to find out what happens when a report is made in their county.

Remember

- Many types of IPV are not reportable (e.g. reproductive coercion).
- Providers in most settings are less likely to treat a patient suffering from acute injury or wounds caused by weapons than those working in urgent care.
- Understand what is reportable and which health care providers are required to report in your county/state.



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Notes to Trainer: As you prepare for your training, it is critical that you find out as much as possible about the applicable laws, as well as identify local experts in confidentiality and reporting. Information that you will need to know includes:

- Who is required to report?
- What must be reported?
- To whom is the report made?
- What are the likely outcomes of calling the police or child protective services?
- What are the safety considerations you can address with your patient?
- Are there provisions for confidentiality of reports?

Participants may be concerned about what to do when a report for abuse is mandated. The following three slides cover the basic principles of patient-centered mandatory reporting. They do NOT include specific laws or local referrals.

When You Need to Make a Report



AFTER addressing the reason the patient was seeking care, remind her of the limits of confidentiality discussed at the start of the visit, then inform her of the requirement to report.



Trauma-informed reporting begins with recognizing that a report made against a patient's wishes may lead to feelings of helplessness. Providers should inform patients about the process of reporting, help them to understand what to expect, and involve them in making the report. These actions minimize untoward effects of reporting and give a patient more of a sense of control through the process.

"I really hear that you don't want me to do the report, and I am sorry but I am required by law to do so..."

“Remember at the start of this visit when we talked about situations where if your safety were at risk then we would have to get others involved? This is one of those times. I know it took a great deal of courage to share this with me, and we need to make sure that you are safe. I will need to report what happened to you and I really would like your help making sure that I understand all of the things you need to make this as safe and supportive as possible for you”

Ways to involve the patient in the process include asking if she would like to be present when you make the report if that is safe to do and keeping her informed about the process.

Supporting a patient when you need to make a report

- Assess for immediate danger
- Explain what is likely to happen when the report is made
- Maximize the role of the patient in the reporting process
- Ask your patient if she is willing to call or meet with an advocate to develop a safety plan in case of retaliation
- Offer the patient use of your office phone to make a call to a DSV agency or support services, or use of your office computer to chat with advocates online



It's important to involve the patient in the process. Ways to involve the patient include asking if she would like to be present when you make the report, if that is safe to do, and keeping her informed about the process.

Encourage participants to contact a hotline, local domestic violence program/shelter and/or domestic violence coalitions in their state to learn about additional training, consultation on particular cases, and resources for their patients.

Remind participants that making a report can never substitute for the important care they provide.

Potential Negative Consequences of Reports



- Increased risk for retaliation by partner
- Break down sense of trust with the provider
- Decrease health care utilization by patient
- Providers' fear may prevent them from screening and providing care and referral

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It is important to keep in mind fears about immigration status and child welfare workers. This study overview may be interesting to read aloud to participants:

In a study by Renker & Tonkin (2006), 97% of women stated that they were not embarrassed, angry, or offended by their health care provider asking about domestic violence during prenatal care visits.

Renker P and Tonkin P. (2006). Women's views of confidentiality issues related to and acceptability of prenatal violence screening. *Obstetrics and Gynecology*, 107(2): 348-354

Olivia: Forced Sex



The following video clips demonstrates disclosing limits of confidentiality and trauma-informed reporting



Estimated Activity Time: 5 minutes to watch video and 10 minutes for discussion.

Notes to Trainer: Remind participants to focus on the issues of confidentiality and trauma-informed child abuse reporting, not aspects of the clinical care delivered.

See next slide for discussion questions.

Video Debrief

- What worked well?
- What would you change?
- What are some key approaches to trauma-informed reporting that you can integrate into your practice?

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Notes to Trainer: Discuss video clip.

What did the provider do well?

- Addressed the patient's medical concerns first before discussing the need to report
- Built good patient rapport
- Offered patient a way to feel more in control once it became clear the report had to be made

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- **Scenario:** Your patient discloses abuse: “Yes, sometimes I am afraid.”
- Use the **Six Steps for Responding to Disclosures** and the safety card as your guide to respond
- Discuss as a group – what worked, what would you change?



Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real clinical interaction there will have been more time for rapport building- assume that has already happened and the patient has already disclosed abuse.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently respond to disclosures?

The following information should be documented:

- Was the patient screened for IPV or the reason the screening did not occur
- Patient's response to screening
- Health impact if any abuse disclosed
- Resources provided and discussed such as safety cards
- Referrals offered



Notes to Trainer: The following information should be routinely documented in patients' charts:

- Confirmation that the patient was assessed for IPV and reproductive and sexual coercion or the reason why assessment was not done and any plans for follow-up actions to ensure that the patient will be screened
- Patient response to screening
- Documentation of resources provided such as Safety Cards
- Any referrals provided

In addition to offering appropriate referrals and assistance when a patient discloses victimization, ask the patients if a follow-up appointment can be scheduled at this time. It is also helpful to ask the patient for contact information, such as a phone number at which it is safe to contact her or him, so that any future contact will be done in a way that minimizes risk to the patient.

Documentation

- Good documentation potentially allows a provider to avoid needing to give testimony if subpoenaed
- Write legibly (if not using electronic health records)
- Use documentation forms to help guide you
- Photograph all injuries



Notes to Trainer: Good documentation really matters in cases when charges are pressed against the abuser or if a patient is pursuing a criminal or civil protective order. For example, if at trial the medical record and the abuser's testimony are in conflict, the record is often considered more credible. Old records may also be helpful in uncovering and documenting a pattern of past abuse. So, write legibly so that you're less likely to be called into court to interpret your records.

For more information about documentation: <http://www.healthcaresaboutipv.org/tools/documentation/toolkit> will take you through the best practices for photo documentation and/or how to hand draw a body map if the injuries don't show up well in a photograph. It will also help you consider other diagnostics tools including x-rays and cat scans and other imaging that can provide additional evidence of abuse related to trauma.

- Formalize relationships with local advocacy programs (MOU/MOA)
- Develop a written protocol for identifying and responding to DSV and reproductive coercion
- Utilize a quality assessment/quality improvement tool to identify goals and monitor progress

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Notes to Trainer: System-wide changes regarding practices will only be implemented and sustained when there are tangible changes in policies and there is infrastructure to support these changes. Strong partnerships with local advocates and a formalized protocol are essential steps to institutionalizing a trauma-informed, coordinated response that addresses IPV and reproductive and sexual coercion.

Clinics should consider including the following elements when developing their protocols:

1. Training requirements for staff, including content of training and staff proficiencies for knowledge and skills
2. Confidentiality procedures and mandated reporting requirements
3. Assessment strategies including setting, frequency, and cultural and language considerations
4. Harm reduction counseling for patients disclosing IPV and/or reproductive and sexual coercion
5. Follow-up and supported referral strategies
6. Documentation

Protocols need to be reviewed, updated, practiced, and supported by top-level management. As described in the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*, 70% of providers complied with an IPV protocol when there was strong administrative support and monitoring after a protocol was adopted; however, provider compliance was only 30% when there was minimal administrative support and monitoring during the first year of implementing the protocol.

Institutionalizing changes in practices and policies requires a systemic approach where screening and responding to IPV and reproductive and sexual coercion are integrated into routine practice and health program design, implementation, and evaluation. The QA/QI tool can help programs identify goals and monitor progress.

How Do I Code for the Service Provided?

Although there is no specific CPT code for IPV screening, others can be used:

- Code V82.89 (Special screening for other conditions)
- Preventive Medicine Service codes 99381-99397 include age appropriate counseling/anticipatory guidance/risk factor reduction interventions. These codes could be used to record assessment and counseling for IPV.



Notes to Trainer: Some providers may ask how to code for screening and brief counseling for IPV. It is important to note that there is currently no procedural code (CPT) for IPV. However, these general preventive services codes could be used.

Diagnostic (or ICD9) codes

The following diagnostic codes could also be used:

- 995.81 - Adult physical abuse
- 995.82 - Adult emotional/psychological abuse
- 995.83 - Adult sexual abuse



Notes to Trainer: In addition, the ICD9 codes above can be used as diagnostic codes.


Section Recap

- Know your county and state laws for Intimate Partner Violence
- Address the patient's medical concerns first before discussing the need to report
- Involve the patient when a report needs to be made
- There are tools available that support the best practices for reporting and documentation



Notes to Trainer: Read the “Section Recap” out loud to close each section.

Module 7: Preparing Your Program: Supporting Staff Exposed to Violence and Trauma



Preparing Your Program: Supporting Staff Exposed to Violence and Trauma



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Module 7

Estimated Module Time: 15 minutes

Training Outline

- Learning objectives
- Secondary traumatic stress
- Handout on common reactions to working with trauma
- Strategies for program managers
- Organizational self-assessment tool

Overview

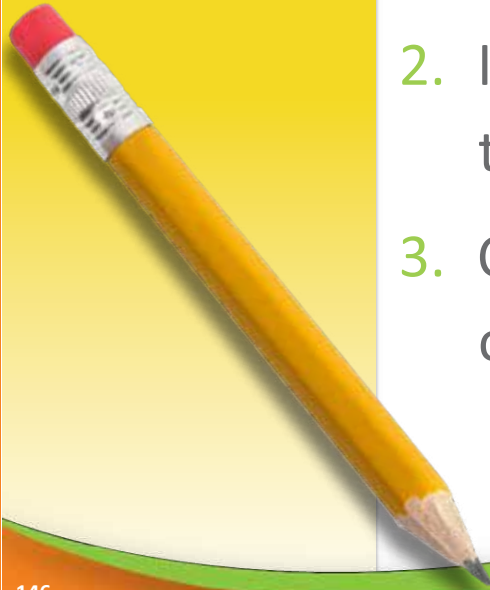
Working with patients who experience trauma can affect the health care provider, creating secondary traumatic stress. This module reviews personal safety and self-care strategies for service providers and policies that managers can implement to support their staff.

Review the explanation of secondary traumatic stress and acknowledge that personal experiences with violence can impact how health care providers respond to patients experiencing violence and vulnerability to secondary traumatic stress. Then provide the handout on common reactions to caring for survivors of trauma and give participants a few minutes to review the handout.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Describe three signs of secondary trauma.
2. Identify three strategies to prevent traumatic stress.
3. Complete a trauma-informed organizational self-assessment.



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Notes to Trainer: Read the learning objectives aloud.

- Ongoing training for public health professionals
- Implement policies to improve the safety of victims and employees in the workplace
- Ensure that employee assistance programs have protocols



Among health care providers and public health professionals, there are IPV victims and perpetrators as well as survivors who may never have had the opportunity to talk about the violence in their lives, so training on IPV can be traumatic for some staff.

Therefore, it is important that trainings include a segment on self-care which emphasizes that participants need to take care of themselves first. This may mean taking a break when needed or deciding that they are not ready to participate in a training. Domestic violence advocacy services should also be available at training events to help participants who need help or counseling to deal with their own circumstances

It is essential that workplaces have policies to educate personnel on safety strategies to protect IPV victims and other workers from perpetrators who become violent or threaten violence at the victim's place of work. Employee assistance programs should also have training and protocols to assist employees with IPV issues.

Secondary Traumatic Stress

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on service providers.

Handout: Secondary Trauma

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Notes to Trainer: Pass out handout “Secondary Trauma”

Have participants review the handout. Can they identify any of the symptoms of vicarious trauma in themselves or their colleagues? Are there other reactions they would add to the list?

Exposure to Violence and Secondary Traumatic Stress

- Lifetime exposure to violence is common
- Working with patients who are experiencing intimate partner violence can trigger painful memories and trauma for staff
- A personal history of exposure to violence increases the risk of experiencing secondary traumatic stress



Notes to Trainer: Revisit the concept that individuals doing this work may have their own personal history with abusive relationships, domestic violence and/or child abuse. These experiences and memories may be triggered by working with patients in similar situations. Self awareness, time for reflection, and organizational support are essential in creating an environment that promotes the health of both patients and providers.

Personal Strategies to Prevent Traumatic Stress

- Identify resources available through employee assistance/human resource programs
- Implement debriefing sessions and periodic case reviews
- Develop plans for how to respond to different situations that are stressful for staff
- Offer stress management training to staff
- Implement policies to maintain a secure and violence-free work environment



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Notes to Trainer: Ask participants what strategies are in place at their workplace. Encourage participants to talk with their supervisors to assure that their safety and well-being is supported by the agency or clinic where they work.

Workplaces Respond to Domestic and Sexual Violence: A National Resource Center, makes it easier than ever for employers to adopt vitally important policies to protect employees from domestic and sexual violence. The new Center was formed by a partnership of seven national organizations led by Futures Without Violence, and funded by the Justice Department's Office on Violence Against Women (OVW). For more information, visit: www.workplacesrespond.org.

Encourage program managers to implement strength-based practices so that only staff who have had training on domestic violence, who are comfortable with doing screening, and who are prepared to respond appropriately to disclosures are assessing patients.

Resource: Trauma-Informed Organizational Self-Assessment

- Instrument designed to help agencies create trauma-informed, supportive work environments
- Self-assessment handout for employees
- Checklist format for organizations to evaluate:



- Training and education
- Support and supervision
- Communication
- Employee control and input
- Work environment



Trauma-informed Organizational Self Assessment. The National Center on Family Homelessness. Download at www.familyhomelessness.org.

Section Recap



- Working with patients who experience violence can affect the service provider, creating secondary traumatic stress.
- A key component to institutionalizing a trauma-informed, coordinated response to IPV and reproductive and sexual coercion is creating a safer and more supportive working environment.

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Notes to Trainer: Read the “Section Recap” out loud to close each section.



- For free technical assistance and tools including:
 - Safety cards
 - Training curricula
 - Clinical guidelines
 - State reporting law information
 - Documentation tools
 - Pregnancy wheels
 - Posters



Notes to Trainer: For more information and program support, contact the National Health Resource Center on Domestic Violence, a project of Futures Without Violence (Futures). Safety cards, posters, clinical guidelines and pregnancy wheels are available from the Futures' website for free with a nominal shipping charge. Patient materials are available in English and Spanish. Safety cards have also been developed for special populations (e.g. Native American women, Perinatal Health, Campus Safety, Behavioral Health, etc). Visit the website to preview and order materials. <http://www.futureswithoutviolence.org/content/features/detail/790/>.

REVISIT: Where Am I?

- Draw a “comfort meter”
- On the left end of the meter is “not at all comfortable”
- On the right end of the meter is “very comfortable”



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Estimated Activity Time: 2-3 minutes

Notes to Trainer: Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

1. Tell participants to take out the sheet of paper they used for their “Comfort Meter” at the beginning of the session.
2. Ask participants to take a minute to think about their comfort level now with talking to patients about reproductive and sexual coercion now that they have completed the training—and if he or she feels comfortable asking questions and getting a “yes” as the answer.
3. Ask them to consider whether the needle moved as a result of the training, where it moved, and their thinking about this in the context of what they have learned.

- ✓ Safe environment for disclosure
- ✓ Educate about the health effects of IPV
- ✓ Supportive messages
- ✓ Offer strategies to promote safety
- ✓ Inform about community resources
- ✓ Create a system-wide response



There are many simple strategies to create a safer environment for education, assessment, and intervention for IPV. These strategies include:

- Displaying posters, pamphlets, and information on services for victims and perpetrators
- Having information on IPV in waiting rooms, other public areas, and in private areas including exam rooms and bathrooms
- Having a private, sound-proof area where your conversation with your patient can not be overheard, or creating as much distance as possible when screening a patient who is accompanied by a partner or another person.
- Using the safety cards with information about safety planning and local advocacy services that can be hidden by a victim
- Educating patients about how abuse can affect their reproductive health
- If staff are not available to help, having phone numbers for local resources available to offer to patients
- Ensuring that response to IPV is system-wide, sustainable, monitored, and not dependent on one individual who is championing the cause

“Success is measured by our efforts to reduce isolation and to improve options for safety.”

Futures Without Violence



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Notes to Trainer: Providers do not need to be experts in domestic violence to help women in your health setting. Our job is not to “fix” domestic violence or to tell victims what to do. We can help victims by understanding their situation and recognizing how abuse can impact health, risk behaviors and parenting. Qualitative research like the insightful work by Dr. Barbara Gerbert and associates (1999) describes the positive impact we can have by acknowledging abuse and confirming a patient’s self-worth. Just providing our patients with support and information can make a difference in their lives.

Gerbert B, Caspers N, Bronstone A, Moe J, Abercrombie P. (1999). A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine*, 131(8):578-84.

Please
complete the
Post-Training
Survey

Thank You!



Notes to Trainer: Hand-out the post-training survey for participants to complete and provide your contact information for any questions and follow-ups. Remind participants that their responses are confidential.

Share your closing thoughts and thank participants for their time, expertise, and dedication to making a difference for the families and communities they work with.

Appendices



PRE-TRAINING SURVEY FOR PROVIDERS

Thank you very much for joining this training!

As you know, lifetime exposure to violence is associated with multiple poor health outcomes, and is likely to impact the lives of many of the clients you work with and counsel. We are developing strategies for incorporating questions about domestic and sexual violence (DSV), and reproductive and sexual coercion (RSC) into current protocols.

We would like to ask you a few questions about your experiences as a health care provider in a reproductive health setting talking to your clients about exposure to DSV and RSC, and in what areas you would like to have additional training and support.

Please take a few moments to answer the following questions. Your responses will be kept confidential. You may skip any questions that you do not want to answer, and can stop taking the survey at any time.

We would also like to contact you in a few months to find out how useful this training was to you in practice, whether you were able to use any of the components presented, and to have you reflect on additional training, resources, and supports you want to see.

We greatly appreciate your taking the time to answer these questions for us as we aim to improve the violence prevention and intervention trainings for health care providers in reproductive health settings.

Date: _____

State: _____



Pre-Training Survey For Providers

1. Have you ever attended any professional development sessions specific to domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) in reproductive health settings?
 - A) Yes
 - B) No

If You Are A Practice Manager/Administrator

(meaning you work in a reproductive health setting but are not directly interacting with clients)

please skip to page 4, question #12

2. How often do you talk to your patients about domestic and sexual violence (DSV)?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
3. How often do you talk to your patients about reproductive and sexual coercion (RSC)?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
4. How often do you review the limits of confidentiality with your clients before asking about DSV or RSC?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable



Pre-Training Survey For Providers

5. How often are you giving your clients a *Did You Know Your Relationship Affects Your Health?* safety card about healthy relationships, DSV and RSC?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
6. When seeing a client for birth control options counseling, how often do you assess for DSV and RSC?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
7. When seeing a client for a pregnancy test, how often do you assess for DSV and RSC?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
8. When seeing a client for an STI test, how often do you assess for DSV and RSC?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable

Pre-Training Survey For Providers

- 9. When seeing a client for emergency contraception, how often do you assess for DSV and RSC?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
- 10. How often do you assess clients' safety and discuss ways to stay safe in an unhealthy or abusive relationship?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
- 11. What are the reasons that you may not address domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) during a clinic visit? (mark all that apply)**
- A) Not enough time
 - B) The partner is present for the visit
 - C) Worried about upsetting the client
 - D) Not sure what to say if they disclose an abusive/violent relationship
 - E) Not sure how to ask questions without seeming too intrusive
 - F) Not knowing where to refer them
 - G) Worried about mandated reporting
 - H) Have already screened them at past visit
 - I) Does not apply to my patient population
 - J) Other (please be as specific as you can)
-
- 12. Does your clinic/practice currently have a relationship with a local domestic violence/sexual assault agency?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know

Pre-Training Survey For Providers

- 13. How would you characterize the relationship you have with the local domestic violence/sexual assault agency? (mark all that apply)**
- A) I know their hotline number
 - B) I know the name and direct number of an advocate at the agency
 - C) I know the types of services the agency provides (e.g. I know they provide shelter, legal aid, counseling, job training, etc.)
 - D) We have a formal Memorandum of Understanding (MOU) with the agency
 - E) We have cross-training sessions with agency staff
 - F) We serve together on a committee or give community education talks together
 - G) An advocate from the agency regularly comes to our clinic/practice (e.g. for patient follow-up, to distribute materials, etc.)
 - H) Not applicable; we do not have a relationship with a local agency
 - I) Other (please be as specific as you can)
-
- 14. In your clinic/practice, are there specific protocols about what to do when a client discloses domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC)?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 15. In your clinic/practice are there any instructions or protocols on when reports on sexual assault or domestic violence need to be filed?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 16. In your clinic/practice are there sample scripts or written instructions on how provide validation and supported referrals to advocacy service with clients who disclose DSV and RSC?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know

Pre-Training Survey For Providers

- 17. In your clinic/practice do you have local and/or regional information about DSV and RSC resources that staff and providers can access easily?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 18. In your clinic/practice are there policies or practices in place to support staff and providers who may experience vicarious (or secondary) trauma?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 19. Does your clinic/practice have (mark all that apply):**
- A) Brochures, cards or information about DSV and RSC
 - B) Posters about DV/SV/RC displayed
 - C) *Did You Know Your Relationship Affects Your Health?* safety cards that clients can take
 - D) A list of violence-related resources and who to call with questions
 - E) Prompts inserted into charts to remind providers to assess for DSV and RSC
 - F) In-service trainings for all clinic staff on DSV and RSC
 - G) Other (please be as specific as you can)
-
- 20. Are educational materials available on domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) in the languages most commonly spoken in your setting?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 21. Are the available materials on DSV and sexual coercion inclusive of diverse relationships, including LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) clients?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know



Pre-Training Survey For Providers

22. What ongoing support do you need to confidently incorporate discussion of DSV and RSC into all of your clinical encounters? (mark all that apply)

- A) Workshops and training sessions
- B) Protocols that include specific questions to ask
- C) List of violence-related resources and who to call with questions
- D) Case consultation
- E) Online training
- F) Other (please be as specific as you can)

23. To what level are you able to affect change in your clinic/practice?

- A) Very able to affect change
- B) Somewhat able to affect change
- C) Uncertain
- D) Somewhat unable to affect change
- E) Very unable to affect change

Additional Comments:

Optional: Please tell us a little about yourself. This information will help us better understand who we are reaching with these trainings. Please remember this information is anonymous and confidential, no names attached.

24. In what kinds of settings do you provide reproductive health care? (mark all that apply)

- A) Free-standing clinic
- B) Community health center
- C) Hospital-based clinic
- D) Reproductive Health/Family Planning clinic
- E) School-based health center
- F) School nurses' office
- G) Other (please specify) _____



Pre-Training Survey For Providers

25. What is your training background? (mark all that apply)

- A) Reproductive health specialist/family planning counselor
- B) Promotora or community health worker
- C) Nurse practitioner (specify specialty area _____)
- D) Physician assistant (specify specialty area _____)
- E) Nurse (specify specialty area _____)
- F) Physician (specify specialty area _____)
- G) Clinic administrator/Practice manager
- H) Other _____

26. How many years have you been providing reproductive health care?

- A) Fewer than 5 years
- B) 5-10 years
- C) More than 10 years

27. How do you describe your gender?

- A) Female
- B) Male
- C) Transgender
- D) Other

28. How do you describe your ethnic background? (mark all that apply)

- A) Caucasian/White
- B) African American/Black
- C) Native American/Native Hawaiian
- D) Asian American
- E) Pacific Islander American
- F) Hispanic/Latino(a)
- G) Multi-racial
- H) Other (please specify) _____

29. What is your age?

- A) 20 years or younger
- B) 20-39 years
- C) 40-59 years
- D) 60 years or older

Thank you for your time!





EXAMPLES OF THE REPRODUCTIVE HEALTH SAFETY CARD

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.futureswithoutviolence.org/onlinestore.

¿Quién controla las decisiones de EMBARAZO?

Pregúntese. Mi pareja:

- ✓ ¿Ha intentado presionarme o forzarme para que me embarace?
- ✓ ¿Me ha lastimado amenazado porque no estoy de acuerdo en embarazarme?

Si alguna vez he estado embarazada:

- ✓ ¿Mi pareja me ha dicho que me lastimaría si no hacía lo que él quería con el embarazo (en cualquier dirección, continuar con el embarazo o aborto)?

Si respondió *SÍ* a cualquiera de estas preguntas, no esta sola y merece tomar sus propias decisiones sin tener miedo.

FOLD >

Obteniendo Ayuda

- ✓ Si su pareja revisa su teléfono celular o textos, hable con su proveedor de atención médica acerca de cómo usar su teléfono para llamar a los servicios de violencia doméstica, para que su pareja no pueda verlo en su registro de llamadas.
- ✓ Si tienen una enfermedad de transmisión sexual (ETS) y teme que su pareja la lastime si le dice, hable con su proveedor de atención médica acerca de cómo estar más segura y como ellos le pueden decir a su pareja de la infección sin usar su nombre.
- ✓ Estudios muestran que educar a sus amigos y familiares sobre el abuso puede ayudarles a tomar pasos para estar más seguros—dándoles esta tarjeta puede hacer una diferencia en sus vidas.

FOLD >

Fundado en parte por el Departamento de Salud y Servicios Humanos de EE. UU. para la Oficina de la Salud de la Mujer (Subsidio #1 ASTWH110023-01-00) y la Administración de Niños, Jóvenes y Familias (Subsidio #90EV0414).

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Todas estas líneas nacionales pueden conectarla a recursos locales y brindarle apoyo. Para obtener ayuda 24 horas al día, llame al:

Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Línea Nacional de Maltrato entre Novios Jóvenes
1-866-331-9474
www.loveisrespect.org

Línea de Crisis Nacional de Abuso Sexual
1-800-656-4673
www.rainn.org

FOLD >

¿Sabía Que Su Relación Afecta Su Salud?

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered *YES* to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✓ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✓ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✓ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

Did You Know Your Relationship Affects Your Health?



pill bottle so your partner won't know.
be taken out of its packaging and slipped into an envelope or empty
Emergency contraception (some call it the morning after pill) can be
The IUD can be removed at anytime when you want to become pregnant.
up to 10 years. The strings can be cut off so your partner can't feel them.
(like IUD, implant, or shot/injection).
Talk to your health care provider about birth control you can control

Birth control or refuses to use condoms:

If your partner makes you have sex, messes or tampers with your
Your partner may see pregnancy as a way to keep you in his life and stay
connected to you through a child—even if that isn't what you want.

Taking Control:

If you answered YES to any of these questions, you may be at
risk for STD/HIV, unwanted pregnancies and serious injury.

- ✓ Has my partner made me afraid or physically hurt me?
- ✓ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✓ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✓ Am I afraid to ask my partner to use condoms?

Ask yourself:

Is your BODY being affected?

- ✓ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✓ Does my partner refuse to use condoms when I ask?
- ✓ Does my partner make me have sex when I don't want to?
- ✓ Does my partner tell me who I can talk to or where I can go?
- ✓ If you answered YES to any of these questions, your health and safety may be in danger.

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✓ Is my partner kind to me and respectful of my choices?
- ✓ Does my partner support my using birth control?
- ✓ Does my partner support my decisions about if or when I want to have more children?
- ✓ If you answered YES to these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and helps your children.

Are you in a HEALTHY relationship?

Ask yourself:



vacía para que su pareja no sepa.
paquete y ponerlos en un sobre o botella de píldoras
sexuales sin protección para evitar un embarazo. Se pueden sacar de su
Anticonceptivos de emergencia (unos le llaman la píldora de la mañana siguiente) se puede tomar hasta cinco días después de tener relaciones
su pareja no los sienta.
un embarazo hasta por 10 años. Los hilos se pueden cortar para que
El DIU es un dispositivo de seguro que se pone en el útero y evita
implante anticonceptivo o inyección anticonceptiva).
que usted pueda controlar (como el dispositivo intrauterino (DIU),
Hable con su proveedor de atención médica sobre anticonceptivos

Anticonceptivo, o se niega a usar condones: Si su pareja le hace tener sexo, se entremete o altera su

Su pareja puede ver el embarazo como una forma de mantenerse en su vida y
mantenirse conectado a través de un niño, aun cuando eso no es lo que usted desea.

Tomando Control:

Si respondió SI a cualquiera de estas preguntas, puede estar en riesgo
de ITS/VIH, embarazos no deseados, y lesiones graves.

- ✓ ¿Mi pareja me ha lastimado físicamente o le he tenido miedo?
- ✓ ¿He escondido los anticonceptivos de mi pareja para que no me embarace?
- ✓ ¿Tengo miedo que mi pareja me lastime si le digo que tengo una infección de transmisión sexual (ITS) y él necesita tratamiento?
- ✓ ¿Tengo miedo pedirle a mi pareja que use condones?

Pregúntese:

¿Está siendo afectado la su CUERPO?

- ✓ ¿Mi pareja se entremete con mi anticonceptivo o trata de que quede embarazada cuando no yo quiero estar?
- ✓ ¿Mi pareja se niega a usar condones cuando se lo pido?
- ✓ ¿Mi pareja me hace tener relaciones sexuales cuando no quiero?
- ✓ ¿Mi pareja me dice con quién puedo hablar o dónde puedo ir?
- ✓ Si respondió SI a cualquiera de estas preguntas, su salud y seguridad puede estar en peligro.

Pregúntese:

¿Está en una relación ENFERMIZA?

- ✓ ¿Es mi pareja bueno conmigo y respetuoso de mis preferencias?
- ✓ ¿Apoya mi pareja mi uso de anticonceptivos?
- ✓ ¿Apoya mi pareja mis decisiones sobre si quiero y cuando quiero tener más hijos?
- ✓ Si respondió SI a estas preguntas, es probable que está en una relación sana. Estudios muestran que este tipo de relación conduce a una mejor salud, una vida más larga, y ayuda a sus hijos.

¿Está en una relación SANA?

Pregúntese:

BIRTH CONTROL EDUCATION

Methods that clients can use without their partners' knowledge

With the exception of Emergency Contraception (EC), all of these methods must be prescribed by a doctor or nurse practitioner. Clients can call 1-800-230-PLAN to find a health care provider near them who can prescribe birth control. If making appointments for birth control may put your client at risk with a partner, talk to them about safety planning around doctor's office reminder calls and scheduling visits. In the U.S., progestin-only EC is available on the shelf without age restrictions to women and men. Look for *Plan B One-Step*, *Take Action*, *Next Choice One-Dose*, *My Way* or other generics in the family planning aisle. *ella* is sold by prescription only, regardless of age.

WHAT IS IT?	HOW DOES IT WORK?	HOW LONG IS IT EFFECTIVE?	HELPFUL HINTS	RISKS OF DETECTION
Emergency Contraception (EC) This is also known as the "Morning After Pill, Plan B, and Next Choice"	A single dose of hormones given by one or two pills within 120* hours of unprotected sex to prevent pregnancy.	Single dose—must be taken after every instance of unprotected sex.	Clients can get emergency contraception to keep on hand before unprotected sex occurs. EC is NOT abortion—just like "regular" birth control pills, it prevents ovulation. Levonorgestrel (common trade name Plan B) may not be as effective among overweight women. The Copper IUD and ulipristal acetate (UPA) (common trade name Ella) are effective alternatives for women desiring EC.	Clients can remove the pills from the packaging so that partners will not know what they are.
Implant Nexplanon	A matchstick-sized tube of hormones (the same ones that are in birth control pills) is inserted into your inner arm that prevents ovulation.	3 years	Unlike previous implantable methods (Norplant), it is generally invisible to the naked eye and scarring is rare.	The implant might be detected if touched. Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles. Many women bruise around the insertion site, which goes away, but may be noticeable for several days after insertion.
Injection Depo-Provera ("the birth control shot")	Depo-Provera is a shot of hormones—the same ones that are in birth control pills.	3 months	Once administered, there is no way to stop the effects of the shot.	Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.
Intrauterine Device (IUD) - ParaGard (non-hormonal)	A small T-shaped device is inserted into the uterus and prevents pregnancy by changing the lining of the uterus so an egg cannot implant.	ParaGard: 12 years	This IUD contains copper. Periods may get slightly heavier. Period cramping may increase. ParaGard can be used for emergency contraception if inserted up to 7 days after unprotected sex.	The IUD has a string that hangs out the cervical opening. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out.
IUD – Mirena and Skyla (hormonal)	A small T-shaped device is inserted into the uterus and prevents pregnancy by: <ul style="list-style-type: none">Thickening cervical mucus to prevent sperm from entering the uterusInhibiting sperm from reaching or fertilizing an eggMaking the lining of the uterus thin so an egg cannot implant	Mirena: 5 years Skyla: 3 years	Hormonal IUDs (Mirena & Skyla) have a small amount of hormone that is released, which can lessen cramping around the time of a period and make the bleeding less heavy. Some women may stop bleeding altogether. All IUDs can be used by women regardless of their pregnancy history; however Skyla was FDA-approved specifically for women who have never been pregnant and younger women.	The IUD has a string that hangs out of the cervical opening, which can be felt when fingers or a penis are in the vagina. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out. Periods may change or stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.



SIX STEPS FOR RESPONDING TO DISCLOSURES

You do not have to be an expert in domestic and sexual violence, or adolescent relationship abuse to help your patient. There are simple strategies and supportive messages you can utilize when a patient discloses that they are experiencing violence in their relationship.

1. Validate patient's experience.
2. Offer a safety card for patient to review and keep if it is safe to do so.
3. Discuss where patient can go to learn more about and obtain birth control options.
4. Ask patient if she has immediate safety concerns and discuss options.
5. Refer to a domestic violence advocate for safety planning and additional support.
6. Follow up at next visit.

Supportive messages

- ✓ "I'm glad you talked to me about this today."
- ✓ "I'm so sorry this is happening in your life, you don't deserve this."
- ✓ "It's not your fault."
- ✓ "I'm worried about the safety of you and your children."
- ✓ "You deserve to be treated with respect."

REMEMBER: Disclosure is not the goal of the safety card intervention. By providing universal education about healthy and safe relationships, helping patients make the connection between experiencing violence and their health, and letting them know about violence-related resources for themselves and loved ones, you are helping to create a health care system that compassionately and effectively addresses violence against women.



CREATING A DOMESTIC VIOLENCE AND SEXUAL ASSAULT RESOURCE SHEET

Call your local programs to find out what services are offered:

- Crisis hotline
- Individual counseling
- Case management
- Support groups
- Emergency shelter (are children allowed? What ages? Boys and girls?)
- Transitional housing
- Housing advocacy
- Transportation vouchers
- Legal advocacy- police & court accompaniment, restraining order assistance, law clinics
- Hospital accompaniment (for sexual assault exams)
- Court-mandated counseling programs (parenting, batterer's intervention)
- Counseling for child witnesses to violence
- Services for adolescents
- Services for LGBT community
- On-site health services
- Community education/outreach
- Children's programming offered?
- Other:

What languages are spoken?

Do they have any other culturally specific programs?

Are they near public transit or do they offer transportation services?

Is there any cost for services?

Are there evening hours?

Are there any restrictions for receiving services (sobriety, active restraining order, etc.)?

Do they currently or would they be willing to provide training to community members?

Ask if there is anything else you should know about their services and explain why you are calling

Identify a key contact for your program

Identify a staff person to update/confirm this information at least once a year



SECONDARY TRAUMA

Common Reactions to Caring for Survivors of Trauma

Helplessness

- Depressive symptoms
- Feeling ineffective with patients [clients]
- Reacting negatively to patients [clients]
- Thinking of quitting clinical [contact with clients] work

Fear

- Recurrent thoughts of threatening situations
- Chronic suspicion of others
- Sleep disruptions
- Physical symptoms
- Inability to relax or enjoy pleasurable activities

Anger

- Reacting angrily to patients [clients] /staff, colleagues
- Feelings of guilt
- Decreased self-esteem

Detachment

- Avoiding patients
- Avoiding emotional topics during patient encounters
- Ignoring clues from patients [clients] about trauma
- Failing to fulfill social or professional roles
- Chronic lateness

Boundary Violation and Transference

- Taking excessive responsibility for the patient [client]
- Seeing patient [client] after hours
- Doing something out of usual practice patterns
- Sharing own problems with patient [client]
- Patient [client] trying to care for service provider

Use of Alcohol and Drugs

- Increased use of alcohol
- Initiation or use of drugs
- Misuse of prescription medication

Source: *Intimate Partner Violence*, 2009 edited by Connie Mitchell and Deidre Anglin, Oxford Press

ORGANIZATIONAL SELF-CARE ASSESSMENT

Using the scale below (1=never, 5=always), identify how frequently your organization engages in the listed activities that support organizational self-care.

5 = Always 4 = Often 3 = Sometimes 2 = Rarely 1 = Never

TRAINING AND EDUCATION

- ☐ The organization provides education to all employees about stress and its impact on health and well-being.
- ☐ The organization provides all employees with education on the signs of burnout, compassion fatigue and/or vicarious traumatization.
- ☐ The organization provides all employees with stress management trainings.
- ☐ The organization provides all employees with training related to their job tasks.
- ☐ Staff are given opportunities to attend refresher trainings and trainings on new topics related to their role.
- ☐ Staff coverage is in place to support training.
- ☐ The organization provides education on the steps necessary to advance in whatever role you are in.
- ☐ Other: _____

SUPPORT AND SUPERVISION

- ☐ The organization offers an employee assistance program (EAP).
- ☐ Employee job descriptions and responsibilities are clearly defined.
- ☐ All staff members have regular supervision.
- ☐ Part of supervision is used to address job stress and self-care strategies.
- ☐ Part of supervision is used for on-going assessment of workload and time needed to complete tasks.
- ☐ Staff members are encouraged to understand their own stress reactions and take appropriate steps to develop their own self-care plans.
- ☐ Staff members are welcome to discuss concerns about the organization or their job with administrators without negative consequences (e.g., being treated differently, feeling like their job is in jeopardy or having it impact their role on the team).
- ☐ Staff members are encouraged to take breaks, including lunch and vacation time.
- ☐ The organization supports peer-to-peer activities such as support groups and mentoring.
- ☐ Other: _____



EMPLOYEE CONTROL AND INPUT

- ☐ The organization provides opportunities for staff to provide input into practices and policies.
- ☐ The organization reviews its policies on a regular basis to identify whether they are helpful or harmful to the health and wellbeing of its employees.
- ☐ The organization provides opportunities for staff members to identify their professional goals.
- ☐ Staff members have formal channels for addressing problems/grievances.
- ☐ Other: _____

COMMUNICATION

- ☐ Staff members have regularly scheduled team meetings.
- ☐ Topics related to self-care and stress management are addressed in team meetings.
- ☐ Regular discussions of how people and departments are communicating and relaying information are addressed in team meetings.
- ☐ The organization provides opportunities for staff in different roles to share what one another's days are like.
- ☐ The organization has a way of evaluating staff satisfaction on a regular basis.
- ☐ Other: _____

WORK ENVIRONMENT

- ☐ The work environment is well-lit.
- ☐ The work environment is physically wellmaintained (e.g., clean, secure, etc.).
- ☐ Information about self-care is posted in places that are visible.
- ☐ Employee rights are posted in places that are visible.
- ☐ The organization provides opportunities for community building among employees.
- ☐ The organization has a no-tolerance policy concerning sexual harassment.
- ☐ The organization has a no-tolerance policy concerning bullying.
- ☐ Workplace issues, including grievance issues and interpersonal difficulties, are managed by those in the appropriate role and remain confidential.
- ☐ Other: _____

Reflection Questions

1. What was this process of filling out the checklist like for you?
2. Were you surprised by any of your responses? If so, which ones?
3. What ideas did you find on the checklist that you liked/did not like?
4. What are the things that you found realistic/not realistic to implement?
5. What are some of the barriers or challenges to implementing these practices?

PERSONAL SELF-CARE ASSESSMENT TOOL

How often do you do the following? (Rate, using the scale below):

5 = Frequently 4 = Sometimes 3 = Rarely 2 = Never 1 = It never even occurred to me

Physical Self Care

- | | |
|--|--|
| <input type="checkbox"/> Eat regularly (e.g. breakfast & lunch) | <input type="checkbox"/> Do physical activity that is fun for you |
| <input type="checkbox"/> Eat healthily | <input type="checkbox"/> Take time to be sexual |
| <input type="checkbox"/> Exercise, or go to the gym | <input type="checkbox"/> Get enough sleep |
| <input type="checkbox"/> Lift weights | <input type="checkbox"/> Wear clothes you like |
| <input type="checkbox"/> Practice martial arts | <input type="checkbox"/> Take vacations |
| <input type="checkbox"/> Get regular medical care for prevention | <input type="checkbox"/> Take day trips or mini-vacations |
| <input type="checkbox"/> Get medical care when needed | <input type="checkbox"/> Get away from stressful technology, such as pagers, faxes, telephones, and e-mail |
| <input type="checkbox"/> Take time off when you're sick | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Get massages or other body work | |

Psychological Self Care

- | | |
|--|--|
| <input type="checkbox"/> Make time for self-reflection | <input type="checkbox"/> Let others know different aspects of you |
| <input type="checkbox"/> Go to see a psychotherapist or counselor for yourself | <input type="checkbox"/> Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event |
| <input type="checkbox"/> Write in a journal | <input type="checkbox"/> Practice receiving from others |
| <input type="checkbox"/> Read literature unrelated to work | <input type="checkbox"/> Be curious |
| <input type="checkbox"/> Do something at which you are a beginner | <input type="checkbox"/> Say no to extra responsibilities sometimes |
| <input type="checkbox"/> Take a step to decrease stress in your life | <input type="checkbox"/> Spend time outdoors |
| <input type="checkbox"/> Notice your inner experience - your dreams, thoughts, imagery, feelings | <input type="checkbox"/> Other: _____ |



Emotional Self Care

- | | |
|---|--|
| <input type="checkbox"/> Spend time with others whose company you enjoy | <input type="checkbox"/> Identify and seek out comforting activities, objects, people, relationships, places |
| <input type="checkbox"/> Stay in contact with important people in your life | <input type="checkbox"/> Allow yourself to cry |
| <input type="checkbox"/> Treat yourself kindly (supportive inner dialogue or self-talk) | <input type="checkbox"/> Find things that make you laugh |
| <input type="checkbox"/> Feel proud of yourself | <input type="checkbox"/> Express your outrage in a constructive way |
| <input type="checkbox"/> Reread favorite books, rewatch favorite movies | <input type="checkbox"/> Play with children |
| | <input type="checkbox"/> Other: _____ |

Spiritual Self Care

- | | |
|---|---|
| <input type="checkbox"/> Make time for prayer, meditation, reflection | <input type="checkbox"/> Express gratitude |
| <input type="checkbox"/> Spend time in nature | <input type="checkbox"/> Celebrate milestones with rituals that are meaningful to you |
| <input type="checkbox"/> Participate in a spiritual gathering, community or group | <input type="checkbox"/> Remember and memorialize loved ones who have died |
| <input type="checkbox"/> Be open to inspiration | <input type="checkbox"/> Nurture others |
| <input type="checkbox"/> Cherish your optimism and hope | <input type="checkbox"/> Have awe-full experiences |
| <input type="checkbox"/> Be aware of intangible (nonmaterial) aspects of life | <input type="checkbox"/> Contribute to or participate in causes you believe in |
| <input type="checkbox"/> Be open to mystery, to not knowing | <input type="checkbox"/> Read inspirational literature |
| <input type="checkbox"/> Identify what is meaningful to you and notice its place in your life | <input type="checkbox"/> Listen to inspiring music |
| <input type="checkbox"/> Sing | <input type="checkbox"/> Other: _____ |

Workplace/Professional Self Care

- | | |
|--|---|
| <input type="checkbox"/> Take time to eat lunch | <input type="checkbox"/> Arrange your workspace so it is comfortable and comforting |
| <input type="checkbox"/> Take time to chat with co-workers | <input type="checkbox"/> Get regular supervision or consultation |
| <input type="checkbox"/> Make time to complete tasks | <input type="checkbox"/> Negotiate for your needs |
| <input type="checkbox"/> Identify projects or tasks that are exciting, growth-promoting, and rewarding for you | <input type="checkbox"/> Have a peer support group |
| <input type="checkbox"/> Set limits with clients and colleagues | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Balance your caseload so no one day is "too much!" | |

SAMPLE MEMORANDUM OF AGREEMENT

This document constitutes an agreement between _____ (reproductive health program) and _____ (domestic/sexual violence program).

The purpose of this agreement is to outline the relationship between the _____ (reproductive health program) and the _____ (domestic/sexual violence program). _____ (domestic/sexual violence program) will identify women exposed to intimate partner violence, reproductive and sexual coercion and inform access to appropriate health care for women through the helpline, shelter intake, outreach, and the dissemination of safety cards as well as other educational information by _____ (domestic/sexual violence program). The _____ (reproductive health program) will provide universal education on healthy relationships, and through clinical assessment, make referrals to the _____ (domestic/sexual violence program).

The parties listed above and whose designated agents have signed this document agree that:

- 1) _____ (reproductive health program) and _____ (domestic/sexual violence program) will meet with each other twice a year to understand the services currently provided by their respective programs, review referral policies between agencies and complete self-assessment of their partnership.
- 2) _____ (reproductive health program) agrees to provide ongoing technical assistance and resources to _____ (domestic/sexual violence program) on reproductive health services, reproductive and sexual coercion, contraception, and emergency contraception.
- 3) _____ (domestic/sexual violence program) agrees to provide every client seeking services with safety planning and information on how to meet their basic human needs (i.e. food, housing, and clothing), including offering to connect them to _____ (reproductive health program) as part of a supportive case management plan.
- 4) _____ (domestic/sexual violence program) will attend training on reproductive health services, contraception and emergency contraception.
- 5) _____ (reproductive program) will attend training on intimate partner violence.
- 6) When reproductive and sexual coercion is identified by providers, _____ (reproductive health program) will review advocacy services available and provide referral to _____ (domestic/sexual violence program).
- 7) _____ (reproductive health program) and _____ (domestic/sexual violence program) agree to work to the amount feasible to ensure that each patient has a consistent staff member assigned to assist them and to minimize the transfer of cases involving intimate partner violence.
- 8) _____ (reproductive health program) agrees to provide same day appointments for clinical services and onsite clinical services if appropriate for sheltered victims of abuse.

We, the undersigned, approve and agree to the terms and conditions as outlined in this Memorandum of Understanding.

Signature: _____ Date: _____
Executive Director
(domestic/sexual violence program)

Signature: _____ Date: _____
President and CEO
(reproductive health program)



RESPONDING TO INTIMATE PARTNER VIOLENCE, ADOLESCENT RELATIONSHIP ABUSE, AND REPRODUCTIVE AND SEXUAL COERCION IN THE CLINICAL SETTING

Quality Assessment/Quality Improvement Tool

Name/Title:

Practice/Program Name:

Date:

Protocols				
Does your clinic have a written protocol for assessing and responding to patients for:				
	Yes (if so, please attach)	No	N/A	Don't Know
Intimate Partner Violence (IPV)				
Adolescent Relationship Abuse				
Sexual Coercion				
Reproductive Coercion (birth control sabotage, pregnancy pressure and coercion, STI/HIV risk, and partner notification risk)				
IUD eligibility following ACOG's guidelines?				
Emergency contraception needs, including a protocol to provide free EC to patient if not stocked on site				
Ensuring that assessment is conducted separately from family friends and partners				
Assessment and Education				
How are patients assessed for IPV and reproductive and sexual coercion?				
	Yes (if so, please attach)	No	N/A	Don't Know
Assessment occurs in a private place				
Staff use safety cards to assess and educate				
Patients answer questions on a medical/health history form or EHR				
Staff review the medical/ health history form and ask additional/follow-up questions				
Which staff members are primarily responsible for assessing patients for IPV and reproductive and sexual coercion? (please pick one) <input type="checkbox"/> Counselor <input type="checkbox"/> Medical Assistant <input type="checkbox"/> NP/RN <input type="checkbox"/> MD <input type="checkbox"/> Other				

How often are patients asked about IPV and/or Reproductive and Sexual Coercion:

- ☐ At least annually
☐ During any reproductive health visit including: **(check all that apply)**
☐ Initial Visit
☐ Birth control counseling visit
☐ EC visit
☐ STD visit
☐ HIV C&T visit
☐ Pregnancy Test visit
☐ Other visit (e.g. Depo revisit)

Are there tools (e.g. cards, scripts, and/or prompts) to help your staff:

	Yes (if so, please attach)	No	N/A	Don't Know
Explain to patients why they are being screened for IPV and reproductive and sexual coercion				
Inform patients about confidentiality and any mandated reporting requirements				
Ask patients about IPV and reproductive and sexual coercion (with sample questions)				
Educate patients about the impact of IPV and reproductive and sexual coercion on reproductive health				

Documentation of Assessment and Response**On the medical/health history/assessment form(s) are following steps documented:**

	Form/Visit Type	Yes	No	Don't Know
Safety card was offered and discussed				
Harm reduction strategies were shared				
Referral to DV/SA program provided				

Intervention Strategies**Do the staff:**

	Yes	No	N/A	Don't Know
Have instructions on how to file a mandated report when needed				
Have an on-call advocate or counselor who can provide follow-up with a patient who discloses IPV/SA or reproductive & sexual coercion				
Have a safe place at your clinic/program where the patient can use a phone to talk to a violence advocate/shelter/support services				
Know to highlight the national hotlines on the safety card with a patient who discloses abuse				



Do your staff have resource lists that:

	Yes	No	N/A	Don't Know
Identify referrals & resources such as shelters, legal, advocacy, for patients who disclose IPV or reproductive/sexual coercion				
Identify referrals and resources for patients who disclose sexual assault				
Identify referrals & resources for perpetrators of IPV or reproductive & sexual coercion				
Include a contact person for each referral agency				
Include referrals to agencies that have adolescent specific services?				
Include referrals to agencies that provide culturally or linguistically specific services?				

Is there a staff person responsible for updating these lists? If so, who?**Are these lists updated at least once a year?****Network and Training**

Within the last year has your staff had contact with representatives from any of the following agencies (contact means: called to refer a patient, called for assistance with a patient, called for information about a program):

	Yes	No	N/A	Don't Know
Domestic violence advocates or shelter staff				
Rape crisis center staff				
Child protective services				
Legal advocacy/legal services				
Law enforcement				

Are there any staff who are especially skilled/comfortable dealing with IPV and reproductive and sexual coercion issues that other staff can turn to for help? (please include staff title/position)

☐ Yes ☐ No If Yes, please include staff title/position: _____

Does any of your staff participate in a local domestic violence task force or related subcommittee? If yes, please describe (and include staff title/position)

☐ Yes ☐ No If Yes, please include staff title/position: _____

Is there a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence with a patient? If yes, please describe.

☐ Yes ☐ No If yes, please describe:

Within the last 2 years have representatives from any of the following agencies either been contacted to schedule a training or come to your practice/program and conducted a training for your staff:

	Yes	No	N/A	Don't Know
Domestic violence advocates or shelter staff				
Rape crisis center staff				
Child protective services				
Legal advocacy/legal services				
Law enforcement (e.g. DV unit)				

What type of training(s) do new staff receive on IPV and reproductive and sexual coercion?

Self Care and Support

Does your practice/program:

	Yes	No	N/A	Don't Know
Have a protocol for what to do if a staff person is experiencing IPV or reproductive and sexual coercion				
Have a protocol for what to do if a perpetrator is on-site & displaying threatening behaviors or trying to get information				
Provide individual clinical supervision for staff where they can discuss any concerns/ discomfort relating to screening IPV and reproductive and sexual coercion cases				
Provide other types (e.g. group supervision, case presentation) of opportunities for staff to discuss any concerns/issues, etc. relating to IPV and reproductive & sexual coercion cases				
Have an employee assistance program (EAP) that staff can access for help with current or past victimization				



Do your protocols advise staff on what to do if they do not feel comfortable or adequately skilled to help a patient when IPV or reproductive and sexual coercion is disclosed? (e.g. Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)

☐ Yes ☐ No If yes, please describe:

Environment and Resources

Does your practice/program have displayed:

	Yes	No	N/A	Don't Know
Posters about IPV and reproductive and sexual coercion				
Information specific to LGBTQ relationship violence				
Brochures/cards/posters placed in an easily visible location				

Has your program adapted any materials to make them more culturally relevant for your patient population?

☐ Yes ☐ No If yes, please describe:

Who is responsible for stocking and ordering materials including reproductive and adolescent health cards, pregnancy wheels and posters?



PROTOCOL FOR INTIMATE PARTNER VIOLENCE, REPRODUCTIVE AND SEXUAL COERCION ASSESSMENT AND INTERVENTION

THIS IS A SAMPLE PROTOCOL INTENDED TO BE ADAPTED FOR USE IN CLINICAL SETTINGS. THE PROTOCOL SHOULD BE REVIEWED BY CLINIC ADMINISTRATION AND LOCAL DOMESTIC VIOLENCE/SEXUAL ASSAULT (DV/SA) EXPERTS FOR CONTENT ACCURACY, RELEVANCE TO LOCAL JURISDICTIONS, AND INSERTION OF LOCAL RESOURCES.

SECTION I: INTRODUCTION

Health care visits provide a window of opportunity to address intimate partner violence (IPV) and coercive behaviors related to patients' reproductive health. There is a substantial body of research describing the dynamics and effects of IPV, reproductive coercion (RC), and sexual coercion (SC) on women's health. Abusive and controlling behaviors range from sexual assault and forced sex, to more hidden forms of victimization that interfere with a partner's choices about sexual activities, safer sex practices, and pregnancy. In a systemic review of the impact of IPV on sexual health, IPV was consistently associated with unplanned pregnancies, induced abortions, sexually transmitted infections (STIs/HIV) and sexual dysfunction. The _____ health center is committed to assessing patients for relationship abuse and intervening if abuse is identified using a safe, supportive, patient-centered approach.

The purpose of this protocol is to encourage assessment for IPV, reproductive and sexual coercion with sexually active female patients. With some studies showing nearly half (45.9%) of women experiencing physical abuse in a relationship also disclosing forced sex by their intimate partner¹, it is necessary that we expand the scope of routine screening for IPV, to include assessment for reproductive and sexual coercion. A trauma-informed, comprehensive approach to relationship violence that includes behaviors that interfere with patients' reproductive health can improve the quality of care and reproductive health outcomes including higher contraceptive compliance, fewer unintended pregnancies, preventing coerced and repeat abortions, and reducing STIs/HIV and associated risk behaviors. As such, we have a unique responsibility and opportunity to intervene.

DEFINITIONS

Intimate Partner Violence is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.

1 Campbell JC, Soeken KL. (1999). Forced sex and intimate partner violence: effects on women's risk and women's health. *Violence Against Women*. 5(9):1017-1035.



Reproductive Coercion (RC) involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Reproductive coercion includes birth control sabotage, pregnancy pressure, and pregnancy coercion.

Birth Control Sabotage is active interference with a partner's contraceptive methods. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure and Coercion involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to become pregnant. Pregnancy coercion involves coercive behaviors such as threats or acts of violence if she does not comply with her partner's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy pressure and coercion include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that she may have a miscarriage

Sexual Coercion (SC) includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force. Examples of sexual coercion include:

- Repeatedly pressuring a partner to have sex when s/he does not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Threatening retaliation if notified of a positive STI result

GUIDING PRINCIPLES

1. Regard the safety of victims as PRIORITY.
2. Treat patients with dignity, respect, and compassion including sensitivity to age, culture, ethnicity and sexual orientation.
3. Honor victims' right to self-determination by recognizing that the process of leaving an abusive relationship can be complex, long, and gradual. It might not occur at all.
4. Adapt a collaborative care model by partnering with local domestic and sexual violence (DSV) advocacy to best support patients and attempting to engage patients in long-term continuity of care within the health care system.

TRAINING REQUIREMENTS

- All health center staff that have contact with patients will undergo mandatory training regarding:
- Dynamics of intimate partner violence, reproductive and sexual coercion
- Effects of violence on women's health
- Assessment and intervention skills
- Collaborate with community-based domestic and sexual violence advocacy programs
- Updates about available resources, both onsite and in the community

Staff members are required to attend at least one training a year on intimate partner violence, reproductive and sexual coercion related issues. Each new staff member will receive comprehensive training as part of their new employee orientation, and numerous opportunities for short booster trainings will be provided, both in-person and online.

CONFIDENTIALITY

Our policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of intimate partner violence, reproductive and sexual coercion respects patient autonomy and confidentiality; serving to improve the safety and health of victims. The Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) apply.

Patient's confidentiality is paramount and must be taken seriously. Therefore, everything discussed with the patient is confidential. Patients should be told that all information is kept private and confidential, unless the patient tells the health care provider they are being hurt by someone, planning on hurting them self (suicidal), and/or planning on hurting someone else.² It is essential to inform patients about mandated reporting requirements prior to assessment.

PRIVACY OF MEDICAL RECORDS:

In cases of IPV, confidentiality of medical records is not only a privacy matter but also a crucial safety consideration. If a patient's partner discovers that she has disclosed abuse this may put her at serious risk for retaliation. Providers and administrators should work together to ensure that any patient summaries or explanation of benefits do not include sensitive information, and should consult with patient about what is safe to document.

Clinicians and administrators must create an environment that prioritizes the safety of victims including respecting the confidentiality, integrity and authority of each victim over their own life choices. Below are guiding principles that should be applied by policy makers, clinicians, nurses, and administrators (or when designing, building or regulating health information systems that will hold or exchange sensitive health information).

² Please note that this section will vary state by state, and should be reviewed by a DSV advocate familiar with all the mandated reporting laws relevant to exposure to relationship abuse and sexual assault.



SECTION II: DIRECT ASSESSMENT FOR INTIMATE PARTNER VIOLENCE, REPRODUCTIVE AND SEXUAL COERCION

Key components of addressing IPV and reproductive and sexual coercion in the health care setting include:

- Promoting healthy, safe, and consensual relationships
- Strengthening harm reduction behaviors
- Providing services that are the safest, most effective options given the patients' personal circumstances
- Offering patients information and resources that will empower them to have more reproductive control and be safer.

WHO SHALL CONDUCT ASSESSMENT:

Assessments will be conducted by a health care professional who has been:

- Educated about the dynamics of IPV, RC and SC, the safety and autonomy of abused patients, and culturally-responsive care;
- Trained on how to ask about and intervene with identified victims of abuse; and
- Authorized to record in the patient's medical record.

HOW TO ASSESS:

- When assessing for IPV, RC, and SC utilize a private, safe environment. Separate any accompanying persons from the patient. If this cannot be done, postpone assessment for a follow-up visit.
- Explain the limits of confidentiality prior to assessment. Patients should be informed of any reporting requirements or other limits to provider/patient confidentiality.
- When unable to converse fluently in the patient's primary language, use a professional interpreter or another health care provider fluent in the patient's language. The patient's family, friends or children should not be used as interpreters when asking about intimate partner violence, reproductive and sexual coercion.
- Introduce the assessment using your own words in a non-threatening, non-judgmental way. *"I talk to all my patients about how they deserve to be treated in a relationship, especially when it comes to decisions about sex. The stress of being in an unsafe relationship can really affect your health, so we want to make sure we are addressing it."*
- **Use the *Did You Know Your Relationship Affects Your Health?* safety card to promote prevention, assessment, and intervention for IPV, RC, and SC.** It includes self-administered questions for IPV, RC and SC, harm reduction and safety planning strategies, and information about how to get help and resources. Select relevant panels of the card based on the type of visit for assessment and offer visit-specific harm reduction strategies when problems are identified. The messaging about healthy, safe, and consensual relationship can be shared with every patient.
 - Contraception/birth control options counseling visit: Use "Are you in an UNHEALTHY relationship?" panel.
 - Emergency contraception visit: Use "Taking control" panel
 - Pregnancy testing visit: Use "Who controls PREGNANCY decisions?" panel

- STI testing visit: Use “Is your BODY being affected?” panel
- Always follow up disclosures of reproductive and sexual coercion with additional questions about intimate partner violence. Please see Section IV: Response, Documentation of Assessment and Follow Up for information on steps to take if a patient discloses IPV.

SAFETY TIPS:

HOW OFTEN SHOULD YOU ASK?

At least annually and with every new relationship.

WHEN SHOULD YOU ASK?

During any reproductive health appointment -- (i.e. Pregnancy tests, STI/HIV tests, initial and annual visits, abortions, and birth control options counseling).

WHERE SHOULD YOU ASK?

In a private setting such as the exam room and only when the patients is by herself without parents, partners, or friends present.

SECTION III: DOCUMENTATION - ASSESSMENT, RESPONSE, AND FOLLOW-UP

For every assessment, the following should be documented in the patient’s chart:

- Confirmation that the assessment occurred, or the reason why it did not, and what follow-up actions were taken to ensure that assessment will occur at a future visit
- The patient’s response to assessment
- Documentation of resources provided, such as safety cards and other health materials
- Referrals provided

This data will be checked quarterly for compliance by our Management Information Systems professional.

POSITIVE ASSESSMENT

- Be supportive of the patient with statements such as:
 - *No one deserves to be treated this way.*
 - *You are not alone; there are people you can talk to for support.*
 - *Is there anything else I can do to help?*
- Let the patient know that you will help regardless of whether s/he decides to remain in or leave the abusive relationship.

- Use the back of the safety card to discuss safety planning and resources that are available for patients who are experiencing IPV and/or reproductive and sexual coercion.
 - Refer the patient to the local DSV advocate _____ (add local number).
 - You can offer the patient use of a phone at a clinic to call the DSV advocate or hotline. By offering support to facilitate the referral process, providers can increase the likelihood that a patient follows through with a referral.
 - Refer the patient to our clinic's social worker/counselor (if available).
 - If the social worker/counselor is in, call directly to _____ (add local number).
 - If the social worker/counselor is out of the office, fill out a referral form. Follow up with the social worker/counselor to ensure that the patient has been contacted.
 - If the patient does not wish to speak with an advocate/social worker/counselor
 - Tell the patient that s/he can always call or make a return visit for support or information.
 - Review safety planning information with patient.
 - Provide patient with a safety card with relevant phone numbers and hotline numbers. Ask patient if it is safe to take safety card with her.
- Safety planning
 - Ask: "Do you feel you are in immediate danger?" If s/he answers yes, find out if the person they fear is present at the clinic. If the person is at the clinic:
 - The goal is to keep everyone safe and not alarm anyone in the waiting room.
 - Call security at _____ (add local number). Explain the situation, inform them you are at the clinic and ask them to enter the back door.
 - Our code for employees that security has been called is "Dr. Jones is needed in room X."
 - Call the domestic and sexual violence advocate at _____ (add local number) for further danger assessment and to discuss next steps.
- Offer to call the police, if s/he would like to press charges.
- Explain to the patient that documentation of past and future incidents with a medical facility may be beneficial to her/him in the event s/he takes legal action in the future.
- In addition to offering appropriate referrals and assistance when a patient discloses abuse, **ask the patient if a follow-up appointment can be scheduled** at this time. It is also helpful to **ask the patient for contact information**, such as a phone number where it is safe to contact her, so that any future contact will be done in a way that minimizes risk to the patient.

Please note: If written information is given to the patient, it should be able to fit in his/her pocket and done so only if the patient feels safe accepting it.

SUSPECTED BUT UNCONFIRMED INTIMATE PARTNER VIOLENCE

There may be situations in which you suspect IPV is occurring, but the patient does not disclose.

Remember: Disclosure is NOT the goal; increasing safety and decreasing isolation IS. Simply having conversations about IPV, RC, and SC lets patients know that this clinic/health care facility is a safe place to talk about any abuse they are facing, if they choose to. Research tells us that many patients do not disclose to health care providers and rely on their family and peers for information and support. Therefore, it is critical that we offer safety cards to EVERY patient.

PATIENT-CENTERED MANDATORY REPORTING

It is critical that staff understand our <State and/or Tribal laws> related to confidentiality and minor consent, physical and sexual abuse, and child abuse. Please refer to our clinic's confidentiality policy and child abuse reporting policy; the same conditions apply. Remember: Always disclose the limits of confidentiality prior to any assessment for IPV, RC, or SC.

Please note: Many forms of intimate partner violence, reproductive and sexual coercion do not meet the legal requirements for mandatory reporting to child protective services and/or law enforcement.

While the language in some mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the patient first. **After** the reason the patient was seeking care has been addressed (such as treatment for a possible STI), the provider should remind the patient of the limits of confidentiality discussed at the start of the visit, and then inform the patient of the requirement to report.

Patient-centered reporting begins with recognizing that a report made against a patient's wishes may lead to feelings of helplessness. Providers should inform patients about the process of reporting, help them to understand what to expect, and involve them in making the report. These actions can minimize untoward effects of reporting and give a patient more of a sense of control through the process. You may say, *"I do have to make the report, but you are welcome to listen as I call in the report so you know what is being said and there are no surprises. I can also put in the report any concerns you have about what will happen when your parents are told about what happened or the best ways to inform them (place, time, one parent over the other etc)."*

LAW ENFORCEMENT INTERVENTION

Inform the patient that in the event s/he elects to take legal action in the future, a law enforcement report on record may help their case. If the patient wishes to make a report to the law enforcement, and is not in immediate danger:

- Assist her/him in contacting the Police Department Domestic Violence Unit at _____ (add local number).
- For support during the police interview, offer to stay in the room with the patient until the DV/SA advocate has arrived.
- Medical reports may be given to the officer only with the written consent from the patient.
- Document that a police report was made and obtain the officer's name and badge number.



TRAINING SATISFACTION SURVEY

Please tell us which type of organization you represent:

- ☐ Family planning clinic (you may mark N/A for Questions 10 and 16)
- ☐ Domestic violence/sexual assault agency (you may mark N/A for Questions 7 and 8)

The training today increased my understanding of:

1. the impact of domestic and sexual violence (DSV) and reproductive and sexual coercion (RSC) on health.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
2. how to discuss the limits of confidentiality with my clients.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
3. how to assess for domestic and sexual violence (DSV).
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
4. how to assess for reproductive and sexual coercion (RSC).
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
5. how to use longer acting contraceptives as a harm reduction strategy for clients experiencing DSV or RSC.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
6. how to use emergency contraceptives as a harm reduction strategy for clients experiencing DSV or RSC.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
7. how to provide safer partner notification as a harm reduction strategy for clients experiencing DSV or RSC.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
8. how to provide supported referrals to local and national resources to assist clients experiencing DSV and RSC.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
9. how to provide patient-centered mandated reporting.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A
10. how to partner with a local family planning service to facilitate client access to emergency contraception.
☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

Following the training today, I am more likely to:

11. offer all clients a *Did You Know Your Relationship Affects Your Health?* safety card about healthy relationships, DSV and RSC.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

12. assess clients' safety and discuss ways to stay safe in an unhealthy relationship.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

13. discuss the limits of confidentiality with my clients before asking about coercion or violence.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

14. assess for domestic and sexual violence (DSV) with any client.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

15. assess for reproductive and sexual coercion (RSC) with any client.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

16. refer clients to local family planning services.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

17. Please mark at least one action that you intend to do or do differently following today's training:

- ☐ Put up posters about DSV and RSC
☐ Make *Did You Know Your Relationship Affects Your Health?* safety cards available to all clients
☐ Insert prompts into medical records to remind providers to assess for DSV and RSC
☐ Offer an in-service training for all of my staff on DSV and RSC
☐ Set up a protocol for assessing for DSV and RSC
☐ Set up new partnerships with local DV/SA organizations
☐ Set up new partnerships with local family planning providers
☐ Other (please be as specific as you can)

18. What ongoing support do you need to confidently incorporate discussion of DSV and RSC in all your encounters with clients?

Additional Comments:

Thank you for your time!



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