Reproductive Health and Partner Violence Guidelines:

An Integrated Response to Intimate Partner Violence and Reproductive Coercion

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PART 1: INTRODUCTION

The Family Violence Prevention Fund (FVPF), 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.

This new resource, the *Reproductive Health and Partner Violence Guidelines,* focuses on the transformative role of the reproductive health care provider in identifying and addressing IPV and reproductive coercion.

Background

In October, 2009, the FVPF convened a round table discussion of leading experts in the fields of reproductive health and IPV to discuss the clinical and policy implications of addressing IPV and reproductive coercion within the context of reproductive health visits. The round table discussion and consultations with reproductive health experts highlighted the need for a resource that provides basic guidelines and tools for addressing reproductive coercion in the reproductive health care setting.

In response to the round table discussion and driven by twenty years of data that make the connection between violence and poor reproductive health care outcomes, the FVPF developed these guidelines. **The goal of this resource is to reframe the way in which health care systems respond to IPV and reproductive coercion such that the reproductive health care provider is the hub in a wheel of a trauma-informed, coordinated health care response.**

What is Trauma-Informed Care?

According to Substance Abuse and Mental Health Services Administration (SAMSHA): Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.
(http://www.samhsa.gov/nctic/trauma.asp)

The round table members identified family planning visits as a window of opportunity to reduce and prevent adverse reproductive health outcomes associated with IPV and reproductive coercion. Strategies discussed at the round table included educating clients on the impact of reproductive coercion and IPV on women's reproductive health and choices, counseling clients on harm reduction strategies, preventing unintended pregnancies by offering long-acting methods of birth control that are less detectable to partners, and assessing for safety prior to partner notification for STIs/HIV.

Integrating assessment and intervention for IPV and reproductive coercion into standard reproductive health care practices can enhance the quality of care and improve reproductive health outcomes including higher contraceptive compliance, fewer unintended pregnancies, preventing coerced and repeat abortions, and reducing sexually transmitted infections (STIs)/HIV and associated risk behaviors. The goal of this integrated approach is to promote safe, consensual relationships by strengthening harm reductive behaviors, by providing services that are the safest, most effective options given the client's personal circumstances, and to provide clients with information and resources that will empower them with greater reproductive control and safety.

The Reproductive Health and Partner Violence Guidelines include:

- Definitions of IPV, adolescent relationship abuse, reproductive coercion and related terminology
- A brief overview of the prevalence of IPV among women of reproductive age
- The latest research on the impact of violence and coercion on women's and girls' reproductive health
- Strategies and guidelines for addressing reproductive coercion with clients seeking reproductive health care services and providing clinical interventions
- An overview of preparing your practice or program and keys for success including developing relationships with local domestic violence advocates and community programs
- How to use FVPF tools to assist with assessment and intervention for reproductive coercion
- Policy implications and recommendations

The information provided in this document focuses on the link between reproductive health and violence. The guidelines are designed to augment the core recommendations for assessing and responding to IPV that are described in the FVPF's ***National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings.***[1]

These guidelines are applicable, but not limited to, the following settings:

- Family planning clinics
- OB/GYN and women's health
- Prenatal care and programs
- STI/HIV clinics
- Title X clinics
- HIV prevention programs
- Adolescent health clinics and programs
- Abortion clinics and services
- Any provider or setting that offers reproductive health services

Definitions

One of the challenges in the field of family violence research has been a lack of standardized definitions. A working definition for intimate partner violence (IPV), also known as domestic violence (DV), is provided in the *FVPF National Consensus Guidelines.*[1] The Guidelines, which were developed in collaboration with national experts and approved by the Agency for Health Care Research, are widely accepted in research and practice. Although adolescent relationship abuse (also known as dating violence) is included in the definition of IPV, experts in the field have noted that while many aspects of adolescent relationship abuse are similar to IPV, there are also distinct characteristics relative to the age of the victim and/or perpetrator and different patterns of abusive behaviors. For this reason, a definition for adolescent relationship abuse, also developed by the FVPF, is included below.

Intimate Partner Violence

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.[2]

Adolescent Relationship Abuse

Adolescent relationship abuse refers to a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person whom they are dating or in a relationship with, whether of the same or opposite sex, in which one or both partners is a minor. Similar to adult IPV, the emphasis on the repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (e.g. a single experience of sexual assault occurring at a party where two people did not know each other). Sexual and physical assaults occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors that aim to maintain power and control in a relationship. For adolescents, such behaviors include monitoring cell phone usage, telling a partner what she/he can wear, controlling whether the partner goes to school that day, as well as manipulating contraceptive use.

The intersections between IPV, reproductive coercion, and reproductive health have expanded our understanding of the dynamics and health effects of abusive adult and teen relationships. This has led to new terminology to describe forms of abuse and controlling behaviors related to reproductive health. For the purposes of these guidelines, working definitions for key terms are provided below.

Reproductive Coercion

Reproductive coercion can be present in same sex or heterosexual relationships. **Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health.** Examples of reproductive coercion include:

- Explicit attempts to impregnate a female partner against her will
- Controlling the outcomes of a pregnancy

- Coercing a partner to engage in unwanted sexual acts
- Forced noncondom use
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a STI/HIV

While these forms of coercion are especially common among women experiencing physical or sexual violence by an intimate partner, they may occur independent of physical or sexual violence in a relationship and expand the continuum of power and control that can occur in an unhealthy relationship. The following definitions are examples of reproductive coercion.

Birth Control Sabotage

Birth control sabotage is active interference with contraceptive methods by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking a condom on purpose
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure

Pregnancy pressure involves behaviors that are intended to pressure a partner to become pregnant when she does not wish to be pregnant. These behaviors may be verbal or physical threats or a combination of both. Examples of pregnancy pressure include:

- I'll leave you if you don't get pregnant
- I'll have a baby with someone else if you don't become pregnant
- I'll hurt you if you don't agree to become pregnant

Pregnancy Coercion

Pregnancy coercion involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy coercion include:

- Forcing a woman to carry to term against her wishes through threats or acts of violence
- Forcing a partner to terminate a pregnancy when she does not want to
- Injuring a partner in a way that she may have a miscarriage

Magnitude of the Problem and Focus

IPV and dating violence are pervasive and persistent problems that have major health implications for women and adolescents.

- Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner[3]
- Almost half (45.9%) of women who were physically abused by their intimate partners also disclosed forced sex by their partners[4]
- Each year, 400,000 adolescents experience serious physical and/or sexual dating violence[5]

These estimates do not include other forms of victimization such as psychological abuse, threatening harm, or reproductive coercion. Much higher prevalence rates are reported in clinical settings.

- Among women enrolled in a large health maintenance organization, 44.0% reported having experienced physical, sexual, and/or psychological IPV in their lifetime[6]
- Two in five (40%) of female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization[7]
- Among women seen at family planning clinics, more than one-half (53%) reported physical or sexual IPV[8]

IPV costs the US economy $12.6 billion on an annual basis[9]

While either men or women can be victimized by an intimate partner, women are at significantly higher risk of experiencing IPV, of sustaining serious injuries, and being killed by an intimate partner.[3,10] These guidelines focus on partner violence as a health disparity issue for women and girls with a particular focus on how men interfere with and limit their female partners' ability to make choices about their reproductive health. A growing body of evidence has documented patterns of reproductive coercion that women experience with their male partners which is in contrast to the common perception that women trap their male partners by becoming pregnant.

It is important to acknowledge that men are also victims of IPV and that abuse also occurs in same sex relationships. Most of the research on the impact of relationship violence on reproductive health has focused on the experiences of heterosexual women who have been abused by an intimate partner. It is anticipated that future studies will provide more information on how to better serve other at-risk populations.

There are decades of research that demonstrate the connection between relationship violence and poor pregnancy outcomes. These guidelines focus on recent research that examines the impact of relationship violence on family planning, abortion services, and sexually transmitted infections/HIV.

PART 2: REPRODUCTIVE HEALTH EFFECTS

General Reproductive Health Effects of Abuse

There is a substantial body of research describing the dynamics and effects of IPV on women's and adolescents' 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, contraception, safer sex practices, and pregnancy. **In a systematic review of the impact of IPV on sexual health, IPV was consistently associated with sexual risk taking, inconsistent condom use, partner nonmonogamy, unplanned pregnancies, induced abortions, sexually transmitted infections and sexual dysfunction.**[11]

IPV can be a barrier to women and teens accessing reproductive health care.

> In one study, adolescent girls who experienced IPV were **nearly 2 ½ times more likely to have forgone health care** in the past 12 months compared to nonabused girls.[7]

Sexual victimization increases the likelihood of adolescent risk behaviors and other health concerns.

> Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.[12]

"It got so bad, I tried to kill myself. I tried jumping off the bridge, and stuff like that; 'cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them."[13]

Contraceptive Use and Birth Control Sabotage

Women who have experienced IPV are more likely to report a lack of birth control use because of partner unwillingness to use birth control or wanting to get her pregnant.[14] Abused women are also more likely to have not used birth control because they could not afford it and are more likely to have used emergency contraception compared to nonabused women. Similar to other forms of controlling behavior in abusive relationships, partners interfere with women's birth control use as a means to control them.

Recent research conducted by the Harvard School of Public Health, University of California at Davis School of Medicine, and the FVPF indicates that a significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV and/or reproductive coercion. In family planning clinics, 15% of female clients with a history of physical and/or sexual IPV reported birth control sabotage.[8]

Birth control sabotage has been documented in the following studies:

- Among teen mothers on public assistance who had experienced recent IPV, 66% disclosed birth control sabotage by a dating partner[15]
- **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 nonabused women**[16]
- Among women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use, 21% disclosed physical abuse, and 14% said their partners threatened abandonment[17]

"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."[18]

– 17 year old female who started Depo-Provera without partner's knowledge

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom.[19,20,21,22,23] Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships,[24] while girls **experiencing dating violence are half as likely to use condoms** consistently compared to nonabused girls.[25] The connection between IPV and condom use is not limited to physical violence. In a national study of adolescents, girls' current involvement in a verbally abusive relationship was associated with not using a condom during the most recent sexual intercourse.[26]

Unintended Pregnancies

Due to the high rates of birth control sabotage and pregnancy pressure and coercion in abusive relationships, it is not surprising that IPV is highly correlated with unintended pregnancies. The following studies have documented this connection:

- Among female clients seen at family planning clinics, **1 in 5 women** who disclosed physical or sexual IPV also reported having experienced pregnancy promotion by their abusive partner[8]
- Women with unwanted pregnancies are **4 times** more likely to experience physical violence by a husband or partner compared to women with intended pregnancies[27]
- In a qualitative study of adolescent girls who experienced dating violence, **one-quarter (26.4%)** reported that their partners were trying to get them pregnant[18]
- Adolescent girls who are currently involved in physically abusive relationships are **3.5 times** more likely to become pregnant than nonabused girls[26]
- Adolescent mothers who experienced physical partner abuse within three months after delivery were **nearly twice** as likely to have a repeat pregnancy within 24 months[28]
- A focus survey conducted by the National Hotline on Domestic Violence found that 25% of the more than 3,000 participants said that their partner or ex-partner had tried to force or pressure them to become pregnant[29]

The Role of Pregnancy Coercion in Women Terminating or Continuing Their Pregnancies

The relationship between violence and continuing or terminating a pregnancy is bidirectional. Women who want to continue their pregnancies may not be allowed to and women who want to terminate their pregnancies may be coerced by their partners into carrying their pregnancies to term.

"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 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."[30]

- 26 year old female

"My boyfriend was trying to push me to have an abortion. . . He said, 'you won't keep that thing,' and he threatened to kill me. Then he said he would kill the child. . . Several times I felt like I wanted to kill myself. I felt like if I had an abortion, I would have to kill myself. . . When we first met, he said he wanted a family, wanted to marry me, then he changed his mind after I was pregnant."[31]

A significant proportion of women seeking abortions have a history of lifetime or current IPV. Reproductive coercion behaviors such as forced sex, insisting on unprotected sex, and/or refusing to allow a woman to use birth control may result in several unintended pregnancies that are then followed by multiple coerced abortions.

- Among women seen at abortion clinics, 14% to 25.7% have experienced physical and/or sexual IPV in the past year[32,33,34,35]
- **Women and teens seeking abortions are nearly 3 times more likely to have been victimized by an intimate partner in the past year compared to women who are continuing their pregnancies**[35]
- Women presenting for a third or subsequent abortion were more than 2.5 times as likely as those seeking a first abortion to report a history of physical abuse by a male partner or a history of sexual abuse/violence[36]

Sexually Transmitted Infections (STIs) and HIV

Experiencing IPV and/or childhood sexual abuse dramatically increase the risk of STIs and HIV among women and girls.[37,38,39] **According to the American Foundation for AIDS Research, violence is both a significant cause and a significant consequence of HIV infection in women.**[40] A history of IPV is a common denominator in studies of women who are HIV-positive.[41,42,43] The following studies demonstrate the complex intersection between STIs/HIV and victimization:

- Women experiencing physical abuse by an intimate partner **are 3 times more likely to have a STI** while women disclosing psychological abuse have nearly double the risk for a STI compared to nonabused women[44]
- **More than one-half (51.6%)** of adolescents girls diagnosed with a STI/HIV have experienced dating violence[45]
- Women who are HIV-positive experience **more frequent and severe abuse** compared to HIV-negative women who are also in abusive relationships[46]
- 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 STIs are an inevitable part of their lives,** stigma, and victimization[47]

IPV perpetration and victimization are associated with a wide range of sexual risk behaviors. Drug-involved male perpetrators of IPV are more likely to have more than one intimate partner, buy sex, not use condoms, inject drugs, and coerce their partners into having sex.[48]

For women, being in an abusive relationship increases the likelihood of:

- Multiple sex partners[21]
- Inconsistent or nonuse of condoms[21,43]
- Unprotected anal sex[49]
- Having a partner with known HIV risk factors[21]
- Exchanging sex for money, drugs, or shelter[43]

"The guy I was going out with introduced me to drugs. He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn't want to get out there no more in the streets doing it, and that's when he broke my cheekbone and everything. That's when I got infected [with AIDS] by him because he kept forcing me to have sex."[50]

PART 3: GUIDELINES FOR RESPONDING TO IPV AND REPRODUCTIVE COERCION IN THE REPRODUCTIVE HEALTH SETTING

PREPARE
TRAIN
INFORM
ASK AND EDUCATE
INTERVENE
REFER

PREPARE

Create a Safe Environment for Assessment and Disclosure

There are several important steps you can take to create a safe and supportive environment for asking clients about IPV and reproductive coercion. These steps include:

- Having a written policy and providing training on IPV and reproductive coercion including the appropriate steps to inform clients about confidentiality and reporting requirements
- Having a private place to interview clients alone where conversations cannot be overheard or interrupted
- Displaying educational posters addressing IPV, reproductive coercion, and healthy relationships that are multicultural and multilingual in bathrooms, waiting rooms, exam rooms, hallways, and other highly visible areas

- Having information including hotline numbers, safety cards, and resource cards on display in common areas and in private locations for victims and perpetrators such as bathrooms and exam rooms

The Family Violence Prevention Fund (www.endabuse.org) has a culturally diverse selection of posters, educational brochures, and safety cards.

Develop Referral Lists and Partner with Local Resources

There is a wide array of resources available for victims of abuse on how to get help. Contact the following entities to learn more about these resources:

- The domestic violence coalition in your state (for a listing go to: http://www.nnedv.org/resources/coalitions.html)
- The violence prevention program in your state health department
- Meet with local domestic and sexual violence programs to understand the services they provide. Arrangements can often be made so that staff can call a domestic violence advocate for advice and discuss a scenario hypothetically, if needed, to understand how to best meet the needs of a client who is experiencing abuse

TRAIN

Training on IPV and Reproductive Coercion

Core training on IPV and on reproductive coercion should be mandatory for all clinic staff that have contact with clients.

Ongoing training opportunities should be available for new hires and staff who want to repeat the training.

Refresher training is important to introduce advances in the field and offer opportunities for staff to discuss progress, challenges, and opportunities.

Training should include staff from domestic violence and sexual assault programs.

WHO should receive training on IPV and reproductive coercion?

- Physicians
- Nurses and nursing assistants
- Nurse practitioners
- Midwives
- Physician Assistants
- Public health professionals
- Social workers
- Medical interpreters
- Mental health professionals
- Sex therapists
- Clergy
- Health educators

Training is often extended to other support staff such as security guards, parking lot attendants, and housekeepers who may observe abusive and/or threatening behaviors and have safety concerns.

Training Resources

Making the Connection: Intimate Partner Violence and Public Health is a free resource developed by the Family Violence Prevention Fund that can be used for self-directed training and to provide training to your staff and students (download at **www.endabuse.org/health**). The toolkit consists of a PowerPoint presentation, speaker's notes, and an extensive bibliography. The following reproductive health-related topics are addressed in this toolkit:

- IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- IPV and Sexually Transmitted Infections/HIV
- IPV and Women's Health

Free eLearning Activity: Online education opportunities on violence and reproductive coercion are also available. Go to **www.endabuse.org/health** for information on new training opportunities as they become available.

INFORM

Always Discuss the Limits of Confidentiality PRIOR to Doing Assessment

Mandatory reporting requirements are different in each state and territory. Consider contacting the following entities for information and resources specific to your state/region:

- **Children protection/child welfare services** in your state for information about reporting requirements for minors experiencing and/or exposed to violence
- The **domestic violence coalition** in your state which may have legal advocates or other experts that provide information and training on reporting requirements for IPV. For a complete list go to **www.nnedv.org/resources/coalitions.html**

While reproductive coercion is not included in most legal definitions of IPV, some forms such as forced sex would typically be part of the legal definition of IPV. Issues related to dating violence involving a minor can also raise questions about mandatory child abuse reporting requirements and statutory rape laws.

In addition, providers need to be familiar with relevant state privacy laws and federal regulations regarding the confidentiality of health information.

Make sure that you have accurate, up-to-date information about mandatory reporting laws for your state. Always disclose limits of confidentiality prior to doing any assessment with clients. The script below is an example of how to disclose limits of confidentiality with a patient before doing assessment for IPV and reproductive coercion.

Sample Script to Inform Client About Limits of Confidentiality:

"I'm really glad you came in today. I am going to be asking you a lot of questions, to make sure that you are OK and that you get what you need from today's visit. Before we 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 by someone, are planning on hurting yourself (suicidal), or are planning on hurting someone else."

ASK AND EDUCATE

Asking Questions about IPV and Reproductive Coercion

While assessment questions for IPV may be embedded in self-administered questionnaires or computerized interviews, **asking questions about IPV and reproductive coercion also needs to be part of the face-to-face assessment between the provider and the client.**

The client's responses to these questions will help to inform the provider about the best way to proceed relative to the treatment plan, potential complications, compliance considerations, other health risks, and safety concerns. This informed approach will ultimately save time and enhance the quality of care and reproductive health outcomes.

Clinical Scenario:

A provider seeing a client who is seeking contraceptive care should ask if it is safe for her to talk with her partner about birth control. If the client says it is not safe to talk with her partner about birth control or she discloses birth control sabotage, the provider should focus the discussion on long-acting, reversible birth control methods that are less vulnerable to partner detection and interference. This conversation can also open the door for more in-depth assessment about IPV as the client recognizes that the provider understands her concerns and validates her experiences.

Provider Tip:

Asking these questions will help providers to develop a client's treatment plan, identify potential complications and compliance considerations, and assess other health risks and safety concerns. This approach will save time and improve outcomes.

Remember before you ask—always discuss limits of confidentiality

Before you ask—normalize:

"So we've started talking to all our clients about healthy relationships and this card is a self-administered quiz I want to go over with you ..."

What to ask:

"Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?"

"Does your partner refuse to use condoms when *you* ask?"

"Has he ever tried to force or pressure you to become pregnant when you didn't want to be?"

"Are you afraid your partner will hurt you if you tell him you have an STI and he needs to be treated?"

How Often Should You Ask?

Annually and with each new partner

When Should You Ask?

During any reproductive health appointments—(Pregnancy tests, STI/HIV tests, initial and annual visits, abortions, birth control options counseling)

Where Should You Ask?

When the client is by herself without parents, partners, or friends present

Some clients may not feel safe or comfortable disclosing IPV or reproductive coercion when asked. Regardless of whether a client discloses abuse or not, assessment is also an opportunity to educate clients about how abusive and controlling behaviors in a relationship can affect their reproductive health. The safety cards, described below, can be offered to every client as part of client education on healthy relationships, indicators of reproductive and sexual coercion, and how to get help.

Educate: The FVPF Safety Cards for Reproductive Health

The FVPF has developed safety cards on reproductive coercion and violence for adults and teens that are available at no cost through their website (www.endabuse.org/health). Samples are provided at the end of this section; the cards are available in English and Spanish. These cards are designed for clients to answer questions about their relationships, including whether their partners are interfering with their ability to make choices about their reproductive health. Approximately the size of a business card (shown below), the safety cards include:

- Questions about elements of healthy and unhealthy relationships
- Questions asking whether they experience IPV, birth control sabotage, pregnancy pressure, forced sex, and other controlling behaviors
- Suggestions for what to do if they are experiencing IPV and/or reproductive coercion
- Hotline numbers

These cards can also be used as a prompt and guide by health care providers to assess for IPV and reproductive coercion by adjusting the wording (ex. "Does my partner…" to "Does your partner…").

Promoting Prevention

Part of client education is talking about healthy relationships. The reproductive health care provider can also play an important role in preventing abuse by offering education and anticipatory guidance about what a healthy relationship looks like, particularly for adolescent boys and girls. Examples are shown below.

Universal Messages about Healthy Relationships:

"One of the things that I talk to all my patients about is how you deserve to be treated by the people you go out with. You have the right to:

- Be treated with kindness
- Be with your friends when you want to be
- Wear what you want to wear
- Feel safe and have your boundaries be respected
- Go only as far as you want to go with touching, kissing, or doing anything sexual
- Speak up about any controlling behavior including textual harassment such as receiving too many texts, phone calls, or embarrassing posts about you on Facebook or other sites"

INTERVENE

Ask about other control and abuse in her relationship

Sample Script:

"What you are telling me about your relationship makes me wonder if there are other things that make you uncomfortable. Has there ever been a situation where he has hurt you or pushed you to have sex when you didn't want too?"

Basic guidelines for responding to IPV in the health care setting are outlined in the ***National Consensus Guidelines on Responding to Domestic Violence Victimization in Health Care Settings*** (see Appendix B.) Intervention strategies discussed in the Consensus Guidelines include:

- How to do a health and safety assessment
- Suggested language to provide validation to a client who discloses abuse
- How to respond to safety issues
- How to document a client's disclosure and abuse history
- Strategies for offering information and making referrals to local agencies
- Confidentiality procedures and mandated reporting

Offer Visit-Specific Harm Reduction Strategies

Making the link between violence and reproductive health can improve efficiency and effectiveness by helping providers focus their counseling on risk factors or behaviors that are compromising a client's reproductive health and discussing interventions that are most likely to succeed.

For example, research has shown that under high levels of fear of abuse, women with high STI knowledge were more likely to use condoms inconsistently than nonfearful women with low STI knowledge.[51] More HIV education without addressing the role of abuse is unlikely to lead to safer sex practices in this scenario.

An integrated approach that informs clients about the risk of contracting STIs/HIV in abusive relationships, teaches condom negotiation skills within the context of abusive relationships, and offers less detectable, female-controlled protective strategies can lead to improved reproductive health outcomes and enhanced quality of care.

Some examples of scripts that demonstrate harm reduction counseling when a client discloses IPV and/or reproductive coercion are shown below.

What to do if you get a "yes" to pregnancy pressure or birth control sabotage:

> "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 your partner doesn't have to know about…like the IUD, Implanon, and emergency contraception."

What to do if you get a "yes" to difficulty negotiating condoms:

"I've had many girls talk to me about condoms breaking or coming off during sex. It's awful when you have to worry about getting pregnant when you don't want to be."

"Even though condoms can prevent sexually transmitted infections, the safest and most reliable birth control method for you may be one that that the person you are sleeping with can't mess with. Have you ever thought about using the IUD, or Implanon?"

"I want to make sure you know about the morning after pill and emergency contraception so that you have back up if the other methods don't work."

What to do to regarding partner notification of a positive STI

"I know it can be hard to talk about this—especially if you are worried your partner will blame you for the STI. What do you think will happen when he hears that he needs to get treated? Are you worried that he might hurt you?"

"As you may know, we have to tell the people that you have slept with about the infection. There are a couple of ways we can do this to help you be safer:"

- "We can talk to him about it in clinic and explain about transmission in case he gets angry or blames you"
- "We can have someone call him anonymously from the health department saying that someone he has slept with in the past year has (name of STI) and he needs to come and be treated."
- "If you decide you want to tell him yourself, you may want to tell him in a public place with lots of people around where you can leave easily if you need to."

Offer Supported Referral

The other key strategy for addressing reproductive coercion and IPV as an integral part of reproductive health care is supported referral. The first step in developing supported referral is to connect reproductive health providers with existing support services for IPV in the community. Making this connection is mutually beneficial.

- Domestic violence advocates from shelters/advocacy programs are an excellent resource for training and advocacy
- Domestic violence advocates will become more aware of what reproductive health services are available for women experiencing IPV
- Reproductive health care providers will become more familiar with what services for IPV are available locally and have a specific name/person to contact when referring patients

When doing supported referral, the provider may call the shelter or IPV program for a client or have the client call from the clinic. Helping clients link directly with domestic violence advocates from the reproductive health care setting can offer a safer option for clients experiencing abuse. This approach can also increase clients' comfort level when reaching out for assistance and increase the likelihood of following through with referrals.

Sample FVPF Safety Cards for Reproductive Health

Tear out these sample cards and fold them to wallet size. To order additional free cards for your practice go to: endabuse.org/health

What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- Make you feel safe and comfortable.
- Not pressure you or try to get you drunk or high because they want to have sex with you.
- Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

FOLD >

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- Tell your friend what you have seen in their relationship concerns you.
- Talk in a private place, and don't tell other friends what was said.
- Show them www.loveisrespect.org and give them a copy of this card.
- If you or someone you know is feeling so sad that they plan to hurt themselves and wish they could die—get help. Suicide Hotline: 1-800-273-8255

FOLD >

Family Violence Prevention Fund

www.endabuse.org

Funded in part by the Administration for Children, Youth and Families, U.S. Department of Health and Human Services and the U.S. Department Office of Women's Health.

If you or someone you know ever just wants to talk and sort things out with people who care, you can call these numbers. All of these hotlines are confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest, National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)

FOLD >

Hanging out or Hooking up?

A partner forcing you to have sex, messing with your birth control and refusing to use condoms are all signs of an unhealthy relationship. How your partner treats you can affect your health; knowing this can help you have more control over your body.

Here are steps to help you take control:

1. Talk to someone you trust about what's going on with your partner.
2. Talk to your health care provider about birth control that you can control and that your partner doesn't have to know about.
3. Talk to your health care provider about ways you can keep yourself safe from getting infections.

If your SAFETY is at risk:

1. Call 911 if you are in immediate danger.
2. Prepare an emergency kit in case you have to leave suddenly with: money, check books, keys, medicines, a change of clothes, and important documents.
3. Talk to your health care provider who can provide a private phone for you to use to call for help.

Family Violence Prevention Fund

www.endabuse.org

Funded in part by the U.S. Department of Health and Human Services, Administration for Children and Families.

If you are being hurt by a partner it is not your fault. You deserve to be safe and healthy.

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

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800 799-7233
TTY 1-800 787-3224

Teen Domestic Violence Hotline
1-866 331-9474

Sexual Assault Hotline
1-800 656-4673

DID YOU KNOW YOUR RELATIONSHIP AFFECTS YOUR HEALTH?

How is it Going

Does the person you are seeing (like a boyfriend or a girlfriend):

- ✓ Treat you well?
- ✓ Respect you (including what you feel comfortable with sexually)?
- ✓ Give you space to hang out with your friends?
- ✓ Support you (even if they don't agree with you)?

If you answered YES—it sounds like they care about you.

And on a Bad Day?

How often does the person you are seeing:

- ✓ Put you down or make you feel embarrassed or ashamed?
- ✓ Pressure you to go to the next step when you're not ready?
- ✓ Control where you go, what you wear or what you do?
- ✓ Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.

Everybody Texts

Getting a lot of texts can feel good–"Wow, this person really likes me."
What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.
Be honest. "You know I really like you, but I really don't like it when you, like, text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatsnotcool.com.

What About Sex?

Can you talk to the person you are seeing about:

- ✓ How far you want to go sexually?
- ✓ What you don't want to do?

Can you talk to the person you are seeing about:

- ✓ Preventing STDs by using condoms?
- ✓ Birth control?

If you answered NO to any of these questions, maybe this person is pushing you to do things you don't want to do. Or you might not feel comfortable bringing this up. Try using this card as a conversation starter. "I got this card in a clinic and wanted to talk about it with you."

Are you in a HEALTHY relationship?

Ask yourself:

- ✓ Does my partner listen when I say no to sex?
- ✓ Does my partner support my using birth control?
- ✓ Is my partner kind to me and respectful of my choices?

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 an UNHEALTHY relationship?

Ask yourself:

- ✓ Does my partner mess with my birth control?
- ✓ 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.

Is your BODY being affected?

Ask yourself:

1. Has my partner given me an STD (sexually transmitted disease)?
2. Have I had pregnancies I didn't want?
3. Have I had a lot of unprotected sex I didn't plan to have?
4. Have I hidden birth control from my partner so he won't get me pregnant?

If you answered *YES* to any of these questions, your partner may be trying to control your body.

Pressure to get Pregnant?

Ask yourself
Has my partner ever:

1. Tried to force or pressure me to become pregnant?
2. Told me he would leave me if I didn't get pregnant?
3. Told me he would have a baby with someone else if I didn't get pregnant?
4. Hurt me physically because I didn't agree to get pregnant?

If you answered *YES* to *ANY* of these questions, you may be at high risk for an unplanned pregnancy.

Sample Script for Supported Referral Using the FVPF Safety Cards:

"I just want you to know that on the back of this safety card there are national hotline numbers with folks who are available 24/7 if you want to talk. They can connect you to local shelter services if you need more urgent help. Also, I know (insert name of local advocate) who I can put you on the phone with right now if you would just like to talk to her."

Respect Her Answer:

If she says yes to relationship problems but doesn't disclose more than something vague:

> "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 a card with a hotline number on it. You can call the number anytime. They really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. The hotline staff has contact with lots of women who have experienced this or know about it in a personal way."

What to say when she says: "No, this isn't happening to me."

> "I'm really glad to hear nothing like this is going on for you. We are giving this card to all of our clients so that they will know how to help a friend or a family member having difficulties in their relationship."

PART 4: POLICY IMPLICATIONS AND SYSTEMS RESPONSE

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. A formalized protocol is an essential step to institutionalizing a trauma-informed, coordinated response that addresses IPV and reproductive coercion.

All reproductive health care settings should have a written protocol for identifying and responding to IPV that includes reproductive coercion.

For entities that already have a protocol for IPV, the protocol should be reviewed and expanded to address reproductive coercion.

The protocol should include the following elements:

1. Training requirements for staff
   a. Content of training
   b. Staff proficiencies for knowledge and skills
2. Confidentiality procedures
3. Assessment strategies including setting, frequency, and cultural and language considerations
4. Harm reduction counseling for clients disclosing IPV and/or reproductive coercion
5. Follow-up and 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 is in place. However, provider compliance was only 30% when there was minimal administrative support and monitoring during the first year of implementing the protocol.[1]

Institutionalizing changes in practices and policies require a systemic approach where screening and responding to IPV and reproductive coercion are integrated into reproductive health program design, implementation, and evaluation.[52]

In a study comparing approaches in two different healthcare settings (an obstetrics and gynecology and a general medicine clinic), the following elements were associated with providers' comfort and confidence in addressing IPV[53]:

- Presence of systemic prioritization of and resources for IPV
- On-site resources
- Adequate time
- Focused IPV training
- Team or systemic approach

Creating Change

Strategies that will help to institutionalize a trauma-informed, coordinated response to IPV and reproductive coercion include:

1. Implement and routinely update workplace policies to:
   a. Include language on ensuring a violence-free workplace
   b. Offer support for staff exposed to violence including services through employee assistance programs
   c. Describe plans for how to address stalking and workplace harassment by an abusive partner
   d. For more information please see the FVPF website on workplace response to abuse at **www.workplacesrespond.org**

2. Promote awareness that life experiences of staff may influence their comfort level and effectiveness with addressing IPV and reproductive coercion

3. Create a network of clinicians within your organization who have expertise on this issue and will champion the cause

4. Examine opportunities for reimbursement strategies that allow compensation for addressing IPV and reproductive coercion in the reproductive health care setting

5. Develop program quality improvement goals for addressing IPV and reproductive coercion through a consensus process with staff and monitor your organization's progress

6. Celebrate successes and set aside specific times to discuss difficult cases

The Family Violence Prevention Fund has developed a quality assurance/quality improvement (QA/QI) tool (see Appendix C) for implementing and evaluating a trauma-informed, coordinated response to IPV and reproductive coercion in the reproductive health care setting. The QA/QI tool, which uses a checklist format, can help clinics and programs to identify their goals and monitor their progress.

Topics addressed in the QA/QI tool are:

- Assessment methods
- Intervention strategies
- Networking and training
- Self care and support
- Data and evaluation
- Education and prevention
- Environment and resources

This section closes with two examples of promising practices:

1. A system-wide approach to implementing a trauma-informed, coordinated response to IPV and reproductive coercion in family planning clinics through public health partnerships
2. A cost-effective family planning initiative that has been instrumental in decreasing teenage pregnancy rates

PROMISING PRACTICE: SYSTEM-WIDE PUBLIC HEALTH RESPONSE

The Massachusetts Department of Public Health (MDPH) is a leader in its ongoing commitment to institutionalize trauma-informed care for victims of violence across all public health programs. As part of this initiative, the MDPH Division of Violence and Injury Prevention and the MDPH Family Planning Program have worked in partnership to provide training and technical assistance on IPV and reproductive coercion to family planning agencies. Initially supported through a Safe Families grant (Centers for Disease Control and Prevention and the Association of Maternal Child Health Association), a series of on-site trainings for family planning providers were held throughout the state. MDPH has integrated requirements for violence screening and staff training on violence issues into its contractual program standards for family planning agencies. As part of quality assurance, MDPH staff conduct periodic site visits to assess screening practices and observe counseling visits for IPV and reproductive coercion.

The MDPH identified the following strategies as essential elements to developing and sustaining a system-wide response:

- Bring in local resources (e.g. domestic violence agencies and rape crisis centers)
- Educate providers about reproductive control
- Offer multiple trainings
- Support violence screening, when appropriate, as a best practice to enhance reproductive health

PROMISING PRACTICE: FAMILY PACT OF CALIFORNIA

The Guttmacher Institute recently published their national findings about teen pregnancy rates in the United States. **The State of California's Family PACT (Family Planning, Access, Care, and Treatment)** program was shown to be the most successful model in the U.S.

- California Family PACT provides free family planning and contraceptive methods to women and men at or below 200% of the poverty level
- Family PACT serves one million women per year and 100,000 men per year
- California's teen pregnancy rate declined by 52% between 1992 and 2005, the steepest drop registered by any state during that period—far exceeding the national decline of 37%
- Public health experts credit this record decline to California's comprehensive and evidence-based teen pregnancy prevention efforts dating back to the 1990's
- This coordinated effort has saved millions in tax dollars each year through the prevention of unintended pregnancy among adolescents

In October 2010, Family PACT co-branded reproductive coercion safety cards with the FVPF and sent samples to 3,200 Family PACT providers throughout the state of California. The safety cards and posters, available in Spanish and English, are featured in Family PACT's catalog of materials and provided at no cost to service providers and clients statewide.

APPENDIX A

Source: Family Violence Prevention Fund. *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings.* Referencing sections of the Danger Assessment tool by Jacquelyn C. Campbell, Ph.D., R.N. Copyright 1985, 1988. Pages 38-39.

Suggested Assessment Questions and Strategies

The following sample assessment questions can also be used to develop a strategy most comfortable for each individual.

Framing questions:

- "Because violence is so common in many people's lives, I've begun to ask all my patients about it"
- "I am concerned that your symptoms may have been caused by someone hurting you"
- "I don't know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely"

Direct verbal questions:

- "Are you in a relationship with a person who physically hurts or threatens you?"
- "Did someone cause these injuries? Was it your partner/husband?"
- "Has your partner or ex-partner ever hit you or physically hurt you?"
- "Do you (or did you ever) feel controlled or isolated by your partner?"
- "Do you ever feel afraid of your partner? Do you feel you are in danger?"
- "Is it safe for you to go home?"
- "Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?"
- "Has any of this happened to you in previous relationships?"

Effective assessment strategies when working cross culturally:

It is important to adapt your assessment questions and approach in order to be culturally relevant to individual patients. Listen to patients, pay attention to words that are used in different cultural settings and integrate those into assessment questions. For example: for coastal Inuit groups, "acting funny" describes IPV, in some Latino communities, "disrespects you" indicates IPV. Focusing on actions and behaviors as opposed to culturally specific terminology can also help, or some groups may be more willing to discuss abuse if you use general questions. Be aware of verbal and non-verbal cultural cues (eye contact or not, patterns of silence, spacing and active listening during the interview).

SOME EXAMPLES INCLUDE:

- Use your patient's language: "Does your boyfriend disrespect you?"
- Be culturally specific: "Abuse is widespread and can happen even in lesbian relationships. Does your partner ever try to hurt you?"
- Focus on behaviors: "Has your partner ever hit, shoved, or threatened to kill you?"
- Begin by being indirect: "If a family member or friend was being hurt or threatened by a partner, do you know of resources that could help them?

Validated Abuse Assessment Tools

Abuse Assessment Screen

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
   - ❑ Yes
   - ❑ No

   If yes, by whom?

   Total number of times

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
   - ❑ Yes
   - ❑ No

   If yes, by whom?

   Total number of times

3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   - ❑ Yes
   - ❑ No

   If yes, by whom?

   Total number of times

4. Within the last year, has anyone forced you to have sexual activities?
   - ❑ Yes
   - ❑ No

   If yes, by whom?

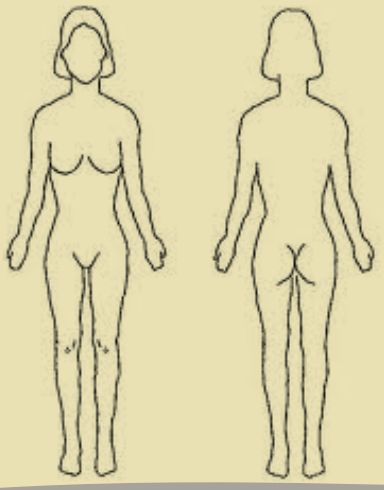
   Total number of times

5. Are you afraid of your partner or anyone you listed above?
   - ❑ Yes
   - ❑ No

Mark the area of injury on a body map and score each incident according to the following scale:

If any of the descriptions for the higher number apply, use the higher number.

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon



APPENDIX B

Source: Family Violence Prevention Fund. *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings.* Pages: 14-19

Health and Safety Assessment

The goals of the assessment are to a) create a supportive environment in which the patient can discuss the abuse, b) enable the provider to gather information about health problems associated with the abuse, and c) assess the immediate and long-term health and safety needs for the patient in order to develop and implement a response.

When should assessment occur?

- Initial assessment should occur immediately after disclosure
- Repeat and/or expanded assessments should occur during follow-up appointments
- At least one follow-up appointment (or referral) should be offered after disclosure of current or past abuse with health care provider, social worker or DV advocate

What should assessment include?

For the patient who discloses current abuse, assessment should include at a minimum:

ASSESSMENT OF IMMEDIATE SAFETY

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Have there been threats or direct abuse of the children (if s/he has children)?"
- "Are you afraid your life may be in danger?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"
- "Has your partner used weapons, alcohol or drugs?"
- "Has your partner ever held you or your children against your will?"
- "Does your partner ever watch you closely, follow you or stalk you?"
- "Has your partner ever threatened to kill you, him/herself or your children?"

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment.

Assess the impact of the IPV (past or present) on the patient's health:

There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these health care risks and assess:

- How the (current or past) IPV victimization affects the presenting health issue
- "Does your partner control your access to health care or how you care for yourself?"
- How the (current or past) IPV victimization relates to other associated health issues

Assessment of the pattern and history of current abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"
- "Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?"
- "Have other family members, children or pets been hurt by your partner?"
- "Does your partner control your activities, money or children?"

For the patient that discloses past history of IPV victimization:

- "When did the abuse occur?"
- "Do you feel you are still at risk?"
- "Are you in contact with your ex-partner?" "Do you share children or custody?"
- "How do you think the abuse has affected you emotionally and physically?"

What to do if a patient says "no":

- Respect her/his response
- Let the patient know that you are available should the situation ever change
- Assess again at previously recommended intervals
- If patient says "no" but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms

Interventions with Victims of IPV

Interventions will vary based on the severity of the abuse, the patient's decisions about what s/he wants for assistance at that time and if the abuse is happening currently. It is important to let the patient know that you will help regardless of whether s/he decides to stay in or leave the abusive relationship. For all patients who disclose current abuse providers should:

Provide validation:

- Listen non-judgmentally
- "I am concerned for your safety (and the safety of your children)"
- "You are not alone and help is available"
- "You don't deserve the abuse and it is not your fault"
- "Stopping the abuse is the responsibility of your partner not you"

Provide information:

- "Domestic violence is common and happens in all kinds of relationships"
- "Violence tends to continue and often becomes more frequent and severe"
- "Abuse can impact your health in many ways"
- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones"

Respond to safety issues:

Offer the patient a brochure about safety planning and go over it with her/him

- Review ideas about keeping information private and safe from the abuser
- Offer the patient immediate and private access to an advocate in person or via phone
- Offer to have a provider or advocate discuss safety then or at a later appointment
- If the patient wants immediate police assistance, offer to place the call
- Reinforce the patient's autonomy in making decisions regarding her/his safety
- If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained

Make referrals to local resources:

- Describe any advocacy and support systems within the health care setting
- Refer patient to advocacy and support services within the community
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or lesbian, gay, transgender or bisexual clients)
- Offer a choice of available referrals including on-site advocates, social workers, local DV resources or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224

For the patient who discloses past but not current IPV victimization:

- "Domestic violence is common and happens in all kinds of relationships"
- "Abuse can impact your health in many ways"
- "What happened to you may be related to health problems now"
- "How do you feel about this now? Is there anything I can do for you now?"
- If the patient feels the issue is still affecting them physically or emotionally, offer to set up an appointment to discuss it further with a primary care provider, mental health provider, social worker or DV advocate, depending on the patient's needs

Reporting IPV to law enforcement or social service agencies:

Some states have requirements to report current victimization to law enforcement, or social services. Providers should:

- Learn applicable statutes in your state
- If you practice in a state with a mandated reporting law, inform patients about any limits of confidentiality prior to conducting assessment

Confidentiality procedures:

Inappropriate disclosure of health information may violate patient/provider confidentiality and threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV should respect patient

confidentiality and autonomy and serve to improve the safety and health status of victims of IPV. The federal medical records privacy regulations issued in August 2002 (in effect April 14, 2003) have specific implications for victims of violence.

PRIOR TO IMPLEMENTING A DOMESTIC VIOLENCE PROGRAM:

- Review relevant state privacy laws
- Follow the federal regulations and privacy principles for victims of IPV

Documentation

Documentation should be conducted by a health care provider who is authorized to record in the patient's medical record. Providers should document the patient's statements and avoid pejorative or judgmental documentation (e.g. write "patient declines services" rather than "patient refuses services", "patient states" rather than "patient alleges").

Document relevant history:

- Chief complaint or history of present illness
- Record details of the abuse and its relationship to the presenting problem
- Document any concurrent medical problems that may be related to the abuse
- For current IPV victims, document a summary of past and current abuse including:
- Social history, including relationship to abuser and abuser's name if possible
- Patient's statement about what happened, not what lead up to the abuse (e.g. "boyfriend John Smith hit me in the face" not "patient arguing over money")
- Include the date, time, and location of incidents where possible
- Patient's appearance and demeanor (e.g. "tearful, shirt ripped" not "distraught")
- Any objects or weapons used in an assault (e.g. knife, iron, closed or open fist)
- Patients accounts of any threats made or other psychological abuse
- Names or descriptions of any witnesses to the abuse

Document results of physical examination:

- Findings related to IPV, neurological, gynecological, mental status exam if indicated
- If there are injuries, (present or past) describe type, color, texture, size, and location
- Use a body map and/or photographs to supplement written description
- Obtain a consent form prior to photographing patient. Include a label and date

Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse

Document results of assessment, intervention and referral:

- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide and health impact of IPV

- Document referrals made and options discussed
- Document follow-up arrangements

If patient does not disclose IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse
- If you suspect abuse, document your reasons for concerns: i.e. "physical findings are not congruent with history or description," "patient presents with indications of abuse"

Follow-Up and Continuity of Care for Victims

At least one follow-up appointment (or referral) with a health care provider, social worker or DV advocate should be offered after disclosure of current or past abuse:

- "If you like, we can set up a follow-up appointment (or referral) to discuss this further"
- "Is there a number or address that is safe to use to contact you?"
- "Are there days/hours when we can reach you alone?"
- "Is it safe for us to make an appointment reminder call?"

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV
- Communicate concern and assess both safety and coping or survival strategies:
- "I am still concerned for your health and safety"
- "Have you sought counseling, a support group or other assistance?"
- "Has there been any escalation in the severity or frequency of the abuse?"
- "Have you developed or used a safety plan?"
- "Told any family or friends about the abuse?"
- "Have you talked with your children about the abuse and what to do to stay safe?"
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.)

For current and previous victims of IPV:

- Ensure that patient has a connection to a primary care provider
- Coordinate and monitor an integrated care plan with community based experts as needed, or other health care specialists, trained social workers or mental health care providers as needed

APPENDIX C

Reproductive Health, Domestic Violence, Sexual Violence, and Reproductive Coercion (DV/SV/RC):
Quality Assessment/Quality Improvement Tool

Name/Title:

Agency/Program Name:

Date:

Assessment Methods

1. Does your family planning program have a written protocol for screening and responding to clients for:

	Yes (if so, please attach)	No	N/A	Don't Know
Intimate partner violence*				
Sexual assault*				
Child abuse*				
Relationship violence				
Unwanted sex				
Reproductive & sexual coercion (birth control sabotage, pregnancy pressure, STI/HIV risk, and partner notification risk)				

2. How are clients screened for domestic and sexual violence and reproductive coercion?

	Yes	No	N/A	Don't Know
Clients answer questions on a medical/health history form				
Staff review the medical/health history form and ask additional/follow-up questions				
Staff ask the clients questions				
Screening occurs in a private place				

3. Are there screening questions for domestic and sexual violence that staff ask at:

New Patients	Yes (verbal or written?)	No	N/A	Don't Know
Initial visit				
Annual/comprehensive visit				
Birth control counseling visit				
EC visit				
STD visit				

New Patients (continued)	Yes (verbal or written?)	No	N/A	Don't Know
HIV C&T visit				
Pregnancy test visit				
Other visit (eg.: Depo revisit)				
Established Patients	**Yes (verbal or written?)**	**No**	**N/A**	**Don't Know**
Annual/comprehensive visit				
Birth control counseling visit				
EC visit				
STD visit				
HIV C&T visit				
Pregnancy test visit				
Other visit (eg.: Depo revisit)				

4. Which staff are primarily responsible for screening clients for domestic and sexual violence? (please pick one)

	Counselor	Medical Assistant	Doctor or Clinician	RN
Initial visit				
Annual/comprehensive visit				
Birth control counseling visit				
EC visit				
STD visit				
HIV C&T visit				
Pregnancy test visit				
Other visit (eg.: Depo revisit)				

5. How often are clients screened for domestic and sexual violence?

- ❑ With each new sexual partner
- ❑ At least every six months
- ❑ At least once a year
- ❑ No established time interval

6. Are there sample wording, scripts, prompts, questions, or information on medical/health history/risk assessment forms for staff to:

	Yes (if so, please attach)	No	N/A	Don't Know
Explain to clients why they are being screened for domestic and sexual violence				

	Yes (if so, please attach)	No	N/A	Don't Know
Inform clients about confidentiality and any mandated reporting requirements				
Ask clients about domestic and sexual violence and reproductive coercion (with sample questions)				
Educate clients about impact of domestic and sexual violence on reproductive health				

Scope of Assessment

1. On the medical/health history/assessment form(s) which of the following are addressed:

	Form/Visit Type	Yes	No	Don't Know
Birth control sabotage (e.g. partner support/interference with birth control decisions)				
Childhood exposure to intimate partner violence				
Childhood sexual abuse				
Childhood physical abuse				
History of suicide attempts				

Intervention Strategies

1. Do the family planning program staff have:

	Yes	No	N/A	Don't Know
Sample wording or scripts about what to say and do when a client discloses domestic and sexual violence or reproductive coercion				
Sample or scripted tools and instructions on how to do safety planning with clients who disclose current domestic and sexual violence				
Instructions on how to file a report when needed				
Safety cards or other information to give clients when domestic and sexual violence is disclosed or suspected				
Give card to all clients. If they say they don't need, suggest the card might be useful for a friend or family member				

	Yes	No	N/A	Don't Know
An on-call advocate or counselor who can provide on-site follow-up with the client who discloses domestic or sexual violence				
A safe place where the client can use a phone to talk to a violence advocate/ shelter/support services at your facility				

2. Do the family planning program staff have resource lists that:

	Yes	No	N/A	Don't Know
Identify referrals and resources such as shelters and legal advocacy for clients who disclose domestic and sexual violence				
Identify referrals and resources for clients who disclose sexual assault				
Identify referrals and resources for perpetrators of domestic and sexual violence				
Include a contact person for each referral agency				

3. Is there a staff person responsible for updating these lists?

4. Are these lists updated at least once a year?

Network and Training

1. Within the last year has the family planning program staff had contact with representatives from any of the following agencies (contact means--called to refer a client, called for assistance with a client, called for information about program):

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

2. Are there any family planning staff who are especially skilled/comfortable dealing with domestic and sexual violence issues that other staff can turn to for help? (please include staff title/position)

❑ Yes ❑ No

If yes, please include staff title/position:

3. Do your protocols advise staff on what to do if they do not feel comfortable or adequately skilled to help a client when domestic and sexual violence is disclosed? (Example: Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)

❑ Yes ❑ No

4. Do any of your agency's 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:

5. 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 client? If yes, please describe.

❑ Yes ❑ No

If yes, please describe:

6. Within the last two years have representatives from any of the following agencies either been contacted to schedule a training or have come to the family planning program and conducted a training for staff:

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

7. What type of training(s) do new family planning staff receive on domestic and sexual violence?

8. Does your staff receive booster training on assessment and intervention for sexual and domestic violence at least once a year?

❑ Yes ❑ No ❑ N/A ❑ Don't Know

Self-Care and Support

1. Does your family planning program:

	Yes	No	N/A	Don't Know
Have a protocol for what to do if a staff person is experiencing domestic and sexual violence				

	Yes	No	N/A	Don't Know
Have a protocol for what to do if a perpetrator is on-site and displaying threatening behaviors or trying to get information				
Provide individual clinical supervision for staff where they can discuss any concerns/ discomfort relating to screening domestic and sexual violence cases				
Provide other types (group supervision, case presentation) of opportunities for staff to discuss any concerns, issues, etc... relating to domestic and sexual violence cases				
Have an employee assistance program (EAP) that staff can access for help with current or past victimization				
Data and Evaluation				
1. Does your family planning program:				
	Yes	**No**	**N/A**	**Don't Know**
Record the number of clients screened for domestic and sexual violence and reproductive coercion				
Record the number of clients who disclose domestic and sexual violence and reproductive coercion				
Record use of longer-acting contraceptives among clients and reproductive coercion				
Annually review all clinic protocols relating to violence (both client and staff related)				
Do any of your client satisfaction surveys include any questions soliciting clients' opinions about assessment and intervention strategies for domestic and sexual violence and reproductive coercion				
Education and Prevention				
1. Does your family planning program:				
	Yes	**No**	**N/A**	**Don't Know**
Provide information to clients on how violence can impact reproductive health				
Provide information to clients on healthy relationships				

	Yes	No	N/A	Don't Know
Does your program sponsor any client or community education to talk about healthy relationships or indicators of abuse				
Environment and Resources				
1. Does your family planning program:				
	Yes	**No**	**N/A**	**Don't Know**
Have brochures or information about domestic and sexual violence that clients can take				
Have brochures, cards, or information for clients about how domestic and sexual violence affects children				
Have posters about domestic and sexual violence or reproductive coercion displayed				
Have posters about forced or unwanted sex displayed				
Have adolescent focused brochures, cards or information about dating violence				
Any specific to LGBTQ relationship violence				
Foster care youth relationship violence				
Have these brochures/cards/posters been placed in an easily visible location				
Have these brochures/cards/posters been reviewed by underserved communities for inclusivity, linguistic and cultural relevance? Have a staff person who is responsible for restocking patient material				

*** Note:** The definitions of intimate partner violence, sexual assault, and child abuse overlap. In this document we will use the term "domestic and sexual violence" to refer to any of these types of violence which occur across the lifespan. For the purposes of this assessment: intimate partner violence includes adolescent relationship abuse and physical and sexual assault in adult intimate relationships, sexual assault refers to adult experience, and child abuse includes childhood sexual and physical abuse.

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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 the Family Violence Prevention Fund, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking 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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