

Addressing Intimate Partner Violence Reproductive and Sexual Coercion:

A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings

Third Edition



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

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FUTURES
WITHOUT VIOLENCE

Our vision is now our name.

Formerly Family Violence Prevention Fund

PRODUCED BY

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This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The recommendations do not dictate an exclusive course of treatment or of practice. Variations taking into account the needs of the individual patient, resources, and information unique to the institution or type of practice may be appropriate.

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PART 1: INTRODUCTION

Futures Without Violence (Futures), formerly the Family Violence Prevention Fund, is a leading advocate for addressing intimate partner violence (IPV)—also referred to as domestic violence in the health care setting. Futures produces numerous data-informed publications, programs, and resources to promote routine assessment and effective responses by health care providers.

The American College of Obstetricians and Gynecologists (the College), a national medical organization representing over 56,000 members who provide health care for women, is dedicated to the advancement of women's health through continuing medical education, practice, research and advocacy. The College was the first national medical organization to formally recognize the problem of domestic violence over 25 years ago and continues to address this problem through its Guidelines for Women's Health Care, Guidelines for Perinatal Care, Committee Opinions, and slide lecture kits. Its most recent opinion on intimate partner violence was published in February 2012 (See Appendix C for Committee Opinion).

This new resource, *Addressing Intimate Partner Violence Reproductive and Sexual Coercion*, cobranded by the College, focuses on the crucial role of the health care provider in identifying and addressing IPV and reproductive coercion.

What is Trauma-Informed Care?

Information provided on the Substance Abuse and Mental Health Services Administration (SAMSHA) website indicates that 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 (<http://www.samhsa.gov/nctic/trauma.asp>). 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.

Background

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 IPV and coercive behaviors related to patients' reproductive health. The goal of this resource is to reframe the way in which health care systems respond to IPV and reproductive and sexual coercion. The health care provider is the hub of a wheel in a trauma-informed, coordinated health care response that includes universal education and prevention.

This guide highlights research that demonstrates how a brief intervention using a safety card to educate female patients about reproductive and sexual coercion can improve reproductive health outcomes and promote healthy, safe, and consensual relationships. Safety cards and other resources for integrating and sustaining a trauma-informed, coordinated response to IPV and reproductive and sexual coercion are included in this publication.

In 2011, the Institute of Medicine (IOM) issued guidelines for preventive health services for women that recommend routine domestic violence (intimate partner violence) screening. The guidelines endorsed by Department of Health and Human Services require that new health insurance plans cover domestic violence screening as part of women's preventive services. Under the Affordable Care Act, new health plans must reimburse domestic violence screening and counseling as part of preventive health care services at no additional cost.

Addressing Intimate Partner Violence Reproductive and Sexual Coercion Guide expands 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 sexually transmitted infections (STIs)/HIV and associated risk behaviors.

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 patient's personal circumstances
- Offering patients information and resources that will empower them to have more reproductive control and be safer

The Guide includes:

- Definitions of IPV, adolescent relationship abuse, reproductive coercion and related terminology
- A brief overview of the prevalence of IPV and reproductive and sexual coercion
- The latest research on the impact of IPV and reproductive and sexual coercion on women's and girls' reproductive health
- Strategies for addressing reproductive and sexual coercion with patients seeking reproductive health care services

- Safety cards to use as a brief intervention to ask and educate patients about reproductive and sexual coercion
- An overview of preparing your practice or program and keys for success including developing relationships with local domestic violence advocates and community programs
- A quality assessment/quality improvement tool to implement and sustain a trauma-informed, coordinated response to IPV and reproductive and sexual coercion
- Policy implications and recommendations

The information provided in this document focuses on the link between reproductive health and violence against women. Additional information on assessing and responding to IPV in the health care setting is provided in the *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*.¹ For more information on The College's IPV Committee Opinion: see Appendix C.

This guide is applicable, but not limited to, the following settings:

- Family planning clinics
- OB/GYN and women's health care settings
- Prenatal care 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 IPV is provided in the *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. 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 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 and sexual coercion, and reproductive health have enhanced our understanding of the dynamics and health effects of abusive adult and teen relationships. This has led to expanded terminology to describe forms of abuse and controlling behaviors related to reproductive health. For the purpose of this guide, working definitions for key terms are provided below.



Reproductive and Sexual Coercion

Reproductive and sexual 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. Most forms of behavior used to maintain power and control in a relationship impacting reproductive health disproportionately affect females. There are, however, some forms of reproductive and sexual coercion that males experience which are included in the definitions below.

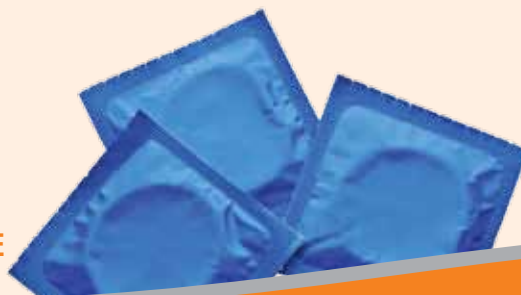
Reproductive Coercion

Reproductive coercion is related to behaviors that interfere with contraception use and/or pregnancy. Two types of reproductive coercion, birth control sabotage and pregnancy pressure and coercion, are described below.

Birth Control Sabotage

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

Pregnancy pressure 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

All experiences of sexual violence, including rape, impact sexual and reproductive health. Over the past twenty years, the healthcare field has made tremendous strides in responding to sexual assault, through such innovative programs as Sexual Assault Response Teams (SARTS), and Sexual Assault Nurse Examiners (SANE). This guide further supports those programs, with interventions to address a specific aspect of sexual violence within the context of a relationship: sexual coercion.

Sexual coercion 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, which may occur in heterosexual or same sex relationships include:

- Repeatedly pressuring a partner to have sex when they do 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
- Retaliation by a partner if notified of a positive STI result

Males and Reproductive and Sexual Coercion

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.³ Research on the impact of reproductive and sexual coercion on men's reproductive health is urgently needed. This research is essential to inform the development and evaluation of evidence-based interventions for males who experience reproductive and sexual coercion.



What Messages Do We Want to Share with Adolescent and Adult Males?

Male patients need to hear the same messages about the importance of healthy relationships, consensual sex, and consensual contraception to prevent unwanted pregnancies as female patients. Strategies for assessment, harm reduction, and intervention described in these guidelines can be adapted for male patients. As research evidence is being accumulated, clinical experience will help to inform best practices for male patients.

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.⁴ 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.⁵

Health care providers have an essential role in prevention by discussing healthy, consensual, and safe relationships with all patients. Some of the screening and intervention strategies described in the guidelines can be adapted for male patients. It is anticipated that future research will provide more information on how to better serve men, same sex couples, and other at-risk populations.

Magnitude of the Problem

IPV and reproductive and sexual coercion are health issues that disproportionately affect women. Women are at significantly higher risk than men of experiencing IPV, of sustaining serious injuries, and being killed by an intimate partner.^{6,7}

- Approximately **1 in 4 women** have been physically and/or sexually assaulted by a current or former partner⁶
- **Nearly half (45.9%)** of women experiencing physical abuse in a relationship also disclose forced sex by their intimate partner⁸
- In a nationally representative sample, **1 in 4 women** reported lifetime coerced sex; among women reporting coerced sex, more than one-third were 15 years old or younger at the time of their first coerced sexual experience⁹

Several studies have examined the prevalence of sexual coercion among adolescents and young adults.

- **19.6% of female and 8.2% of male** undergraduate students reported unwanted sexual contact in the past six months¹⁰
- **23% of female college students and 7% of male college students** reported one or more experiences of unwanted sexual intercourse¹¹
- A survey of 10th and 11th graders revealed that **over half of girls and 13.1% of boys** had been victims of sexual coercion, defined as sexual behaviors involving verbal coercion, threats of force, or use of drugs or alcohol¹²
- Females were **more likely** than males to report that their perpetrator used physical force during coerced sex^{10,11}

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from interviews with gay and bisexual men suggest that 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.¹³

Studies on the prevalence of IPV and sexual victimization among female patients seen in the health care settings underscore the need for routine assessment and trauma-informed care.

- **Two in five (40%)** of female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization¹⁴
- **More than one-half (53%)** of women seen at family planning clinics reported physical or sexual IPV¹⁵

This guide focuses 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. This guide provides an overview of recent research on the impact of relationship violence on family planning, abortion services, and STIs/HIV. Since the relationship between IPV and poor pregnancy outcomes is well documented elsewhere, this document does not address the impact of IPV on maternal, fetal, and infant health.

Health care providers have an essential role in prevention of IPV and reproductive and sexual coercion by discussing healthy, consensual, and safe relationships with all patients. Some of the screening and intervention strategies described in this guide can be adapted for male patients. It is anticipated that future research will provide more information on how to better serve men, same sex couples, and other at-risk populations.





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 non-monogamy, unplanned pregnancies, induced abortions, STIs and sexual dysfunction.**¹⁶

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 non-abused girls.¹⁴

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.¹⁸



“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.”¹⁹

Contraceptive Use and Birth Control Sabotage

Women who have experienced IPV are more likely to report a lack of birth control use because of a partner’s unwillingness to use birth control or desire for pregnancy.²⁰ Abused women are also more likely to have not used birth control due to affordability and are more likely to have used emergency contraception when compared to nonabused women.²⁰ 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 Futures indicates that a significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV and/or reproductive and sexual coercion. In family planning clinics, 15% of female patients with a history of physical and/or sexual IPV reported birth control sabotage.¹⁵

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 partner²¹
- 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 women²²
- Among women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use²³

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom.^{24,25,26,27,28} In a literature review on relationship violence, condom use and HIV risk among adolescent girls, physical partner violence was routinely associated with inconsistent or non-condom use.²⁹ Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships,³⁰ while girls **experiencing dating violence are half as likely to use condoms** consistently compared to non-abused girls.³¹ The connection between IPV and not using condoms is not limited to physical violence. In a national study of adolescents, girls’ current involvement in verbally abusive relationships was associated with not using a condom during the most recent sexual intercourse.²⁴

“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.”³²

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



Teen Pregnancy

Adolescent relationship abuse (also referred to as teen dating violence) increases the risk of teen pregnancy.

- Adolescent girls who are currently involved in physically abusive relationships are **3.5 times** more likely to become pregnant than non-abused girls³¹
- **Adolescent mothers who experience physical partner abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months³³**
- In a qualitative study of adolescent girls who experienced dating violence, **one-quarter (26.4%)** reported that their partners were trying to get them pregnant³²

Connecting Pregnancy Pressure and Unintended Pregnancies

While there is limited body of research demonstrating a connection between IPV and unintended pregnancies, a review of U.S. and international research identified several studies that have shown that women who experience IPV are more likely to become pregnant when they did not intend to be pregnant.³⁴ A number of studies describe women’s experiences of being pressured to become pregnant, which helps to explain why IPV may be associated with an increased risk of unintended pregnancies.

- Among female patients seen at family planning clinics, **1 in 4 women** who had experienced physical or sexual IPV also reported pregnancy pressure¹⁵
- Women with unwanted pregnancies are **4 times** more likely to experience physical violence by a husband or partner compared to women with intended pregnancies³⁵
- A survey conducted by the National Hotline on Domestic Violence found that **25% of women** said that their partner or ex-partner had tried to force or pressure them to become pregnant³⁶

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. Partners may also coerce women who do not want to terminate their pregnancies into having an abortion.



“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.”³⁷

- 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.”³⁸

A significant proportion of women seeking abortions have a history of lifetime or current IPV. Reproductive and sexual 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 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^{39,40,41,42}
- Women and teens who seek abortions are nearly **3 times** more likely to have been victimized by an intimate partner in the past year compared to women who continue their pregnancies⁴²
- 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/violence⁴³

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.^{44,45,46} **According to the American Foundation for AIDS Research, violence is both a significant cause and a significant consequence of HIV infection in women.**⁴⁷ A history of IPV is a common denominator in studies of women who are HIV-positive.^{48,49,50} 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.⁵¹ The following studies demonstrate the complex relationship 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 non-abused women⁵²
- **More than one-half (51.6%)** of adolescent girls diagnosed with a STI/HIV experience dating violence⁵³
- Women who are HIV-positive experience **more frequent and severe abuse** compared to HIV-negative women who are also in abusive relationships⁵⁴
- 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 victimization⁵⁵

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 multiple intimate partners, buy sex, not use condoms, use drugs, and coerce their partners into having sex.⁵⁶

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

- Her having multiple sex partners²⁶
- Inconsistent or nonuse of condoms^{26,50}
- Unprotected anal sex⁴⁷
- Having a partner with known HIV risk factors²⁶
- Exchanging sex for money, drugs, or shelter⁵⁰
- Alcohol or drug use before sex⁵⁷

“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.”⁵⁸

Important Considerations for Safe Partner Notification

Patient-initiated partner notification for treatment of STIs/HIV can compromise a patient’s safety if she is in an abusive relationship. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of a STI.⁵⁷ 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.⁵⁹ Some of the women reported threats of harm or actual harm in response to notifying their partner of an STI.



PART 3: GUIDE FOR RESPONDING TO IPV AND REPRODUCTIVE AND SEXUAL COERCION IN THE HEALTH CARE SETTING

PREPARING YOUR PRACTICE/PROGRAM ASSESSMENT, HARM REDUCTION AND INTERVENTION SUPPORTED REFERRAL DOCUMENTATION AND FOLLOW-UP

PREPARING YOUR PRACTICE

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 patients about IPV and reproductive and sexual coercion. These steps include:

- Having a written policy and providing training on IPV and reproductive and sexual coercion including the appropriate steps to inform patients about confidentiality and reporting requirements
- Having a private place to interview patients alone where conversations cannot be overheard or interrupted
- Displaying educational posters addressing IPV, reproductive and sexual 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 patients such as bathrooms and exam rooms

PROVIDER TIP:

It is essential to find out, prior to asking questions about IPV and reproductive and sexual coercion, whether a patient has sex with men, women, or both so you can focus assessment on questions that are relevant to the patient. For example, for a woman who is engaging only in same sex relationships, questions would focus on IPV and sexual coercion and it would not be necessary to ask questions about birth control sabotage.

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Futures (www.FuturesWithoutViolence.org) has a culturally diverse selection of posters, educational brochures, and safety cards.



Develop Referral Lists and Partner with Local/Regional Resources

There is a range of referrals and resources available for victims of abuse in many communities. Contact the following entities to find out contact information for a referral list and to have resources available at your facility:

- The domestic violence coalition in your state (for a listing go to: nnedv.org/resources/coalitions.html)
- Meet with local domestic and sexual violence program professionals 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 patient who is experiencing abuse
- The violence prevention program in your state health department

Training on IPV and Reproductive Coercion

Core training on IPV and on reproductive and sexual coercion will be most effective if all clinic staff that has contact with patients are trained. When possible, training should include staff from domestic violence and sexual assault programs.

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.

WHO should receive training on IPV and reproductive and sexual coercion?

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

Training on IPV 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 for patients.

Training Resources

Making the Connection: Intimate Partner Violence and Public Health is a free resource developed by Futures that can be used for self-directed training and to provide training to your staff and students (download at www.futureswithoutviolence.org/section/our_work/health/_making_connection). The toolkit consists of a PowerPoint presentation, speakers' notes, and an extensive bibliography. The following reproductive health-related topics are addressed in the 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 and sexual coercion with free CME are also available. Go to www.FuturesWithoutViolence.org/health for information on new training opportunities as they become available.



ASSESSMENT, HARM REDUCTION AND INTERVENTION

Getting Started: Always Discuss the Limits of Confidentiality Prior to Assessment

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

- **Child protection/child welfare services** in your state for information about reporting requirements for minors experiencing and/or exposed to violence
- The **domestic violence coalition and sexual assault coalition** in your state 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

Many forms of reproductive and sexual coercion described in this guide are not included in most legal definitions of IPV. Some forms, however, such as forced sex, may be included the legal definition of IPV. In addition to IPV laws, teen dating violence 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 and up-to-date information about mandatory reporting laws for your state.

Always disclose limits of confidentiality prior to doing any assessment with patients. 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 (fill in the blank for visit type). Before we get started I want you to know that everything you share with me is confidential, unless (fill in state law here—likely this script will look very different for an adolescent than an adult) you have been injured by a weapon, forced to have sex by someone, or are suicidal—those things I would have to report, ok?”

Verbal Assessment is Essential

While assessment questions for IPV may be embedded in self-administered medical history forms, **asking questions about IPV and reproductive and sexual coercion also needs to be part of the face-to-face assessment between the provider and the patient.**

The patient’s responses to these questions will help 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.



Brief, Evidence-based Assessment and Intervention with Safety Card

The Safety Card for Reproductive Health, developed by Futures and co-branded by the College, is a wallet-size card that includes self-administered questions for IPV and reproductive and sexual coercion, harm reduction and safety planning strategies, and information about how to get help and resources. Providers can use the safety card to facilitate screening and educate patients about the impact of IPV and reproductive and sexual coercion on reproductive health.

The safety card can be reviewed with a patient in less than one minute.

In a randomized controlled trial, women seen at four family planning clinics were asked questions about IPV and reproductive and sexual coercion and reviewed the safety card with their providers. The time required to review the safety card with a patient varied from less than a minute to longer discussions when IPV and/or reproductive and sexual coercion were disclosed. Among women who reported IPV in the past three months at the time of initial assessment and received the safety card intervention, there was a 71% reduction in the odds of pregnancy pressure and coercion at the follow-up, 12 to 24 weeks later.⁶⁰ Women who received information about safety were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of IPV. This intervention is based on more than two decades of research, including other randomized controlled trials, which has shown that assessment combined with a small safety card can reduce violence and improve safety behaviors among female patients disclosing IPV.^{59,61,62,63}

Women who received information about safety were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of IPV.

Tear out this sample card and fold it to wallet size. To order additional free cards for your practice go to: www.FuturesWithoutViolence.org/health

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.

FOLD >

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.

FOLD >

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families. (Grant #90EV0414)

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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

FOLD >



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 shipped into an envelope or empty pill bottle so your partner won't know.

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.

Is your BODY being affected?

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.

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?

How can using the safety card help with screening given many women choose not to disclose what is happening to them?

Some patients may not feel safe or comfortable disclosing IPV or reproductive and sexual coercion when asked. Research also shows that cultural stereotypes about rape and sexual assault influence a woman's perceptions of sexually coercive experiences. Coerced sex by an intimate partner may not be perceived as a *real* sexual assault or rape. Sexual coercion by a dating partner, especially when alcohol is involved, may be minimized due to cultural stereotypes.⁶⁴

Regardless of whether a patient discloses abuse, assessment is an opportunity to educate patients about how abusive and controlling behaviors in a relationship can affect her reproductive health. The safety card provides information that helps women to make the connection between unhealthy relationships and reproductive health concerns such as unintended pregnancies. **Asking about IPV and reproductive and sexual coercion lets patients know that they are not alone and that you are a safe person to talk to.** The safety card includes information about safety strategies and referrals a patient can refer to after her visit. The safety card was designed as a small, easy to conceal card based on strategies used by domestic violence advocates who are experts on safety concerns and safety planning with IPV victims. It is important to remember that it may not be safe for some patients who are currently experiencing abuse to leave the clinic with the safety card.

Remember before you ask—always discuss limits of confidentiality**How Often Should You Ask?****At least annually.****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?****In a private setting such as the exam room and only when the patient is by herself without parents, partners, or friends present.****SAFETY TIP**

One key recommendation for clinics or providers in private practice is to develop a sign for your waiting room that says: **In this clinic, we respect a patient’s right to privacy and always see patients alone for some portion of their visit.** Having a clearly stated policy like this helps the staff normalize the experience of seeing the patient alone without a friend or family member there—especially if there is an established pattern allowing partners or family members in during the entire visits. Displaying the policy on a sign in the waiting room takes the burden off the patient needing to ask to be seen alone, while allowing the staff member to point to the sign if there is any opposition from the patient’s partner.

PROVIDER TIP

Asking questions about IPV and reproductive and sexual coercion will help you develop a patient’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.

Making the link between violence and reproductive health uncovers risk factors that are compromising a patient’s reproductive health and allows providers to offer interventions that are the most likely to succeed.

For example, research has shown that women with high STI knowledge under high levels of fear of abuse were more likely to use condoms inconsistently than non-fearful women with low STI knowledge.⁶⁵ More HIV education without addressing the role of abuse is unlikely to lead to safer sex practices in this scenario.

Using the safety card integrates assessment with patient education. This integrated approach informs patients about the increased 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 that can lead to improved reproductive health outcomes and enhanced quality of care.

Examples of scripts that demonstrate how to counsel a patient about harm reduction strategies when IPV and/or reproductive and sexual coercion is disclosed, including sample scripts for different types of visits and clinical scenarios, are shown below.

Strategic Safety Card Use: Promoting Prevention, Assessment and Intervention for IPV, Reproductive and Sexual Coercion


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.

Part of patient education is talking about healthy, safe, and consensual relationships. Health care providers 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 girls—but this is true for adult women too.

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

Sample Script:

“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?”



Are you in a HEALTHY 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.*

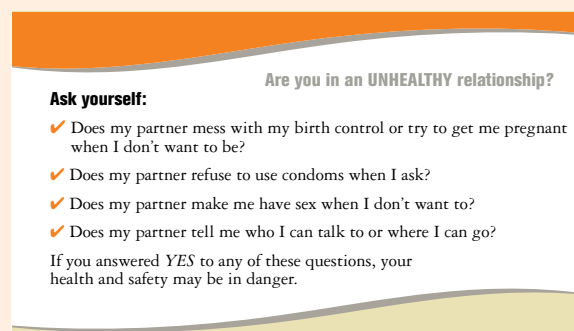
Birth Control Options Counseling:

PROVIDER TIP:

Before spending valuable time counseling a patient about various contraceptive methods, assess if she is at risk for reproductive coercion. By changing the pronouns in the self-quiz found in the safety card, providers use the questions to facilitate face-to-face assessment during a patient encounter.

Sample Script:

“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 tampered with your birth control or tried to get you pregnant when you didn’t want to be?”



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.

Harm Reduction Strategy:

If her answer is yes, talk with her about contraceptive options that are less vulnerable to being tampered with.

Sample Script:


“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—take a look at this section of the safety card called “Taking Control”.

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.



Clinical protocols regarding the use intrauterine devices (IUDs) in nulliparous women and adolescent girls need to be updated to reflect current evidence. Recent recommendations clearly state that IUDs offer a safe and appropriate option for nulliparous women and teens. In 2011, the American College of Obstetricians and Gynecologists (the College) issued a Practice Bulletin supporting IUDs for these populations.⁶⁶ There are no studies that have demonstrated an increased risk of pelvic inflammatory disease (PID) in nulliparous IUD users and there is no evidence that IUD use is associated with subsequent infertility. In fact, IUDs may be the best contraceptive method for those experiencing reproductive coercion who want to prevent or defer pregnancy.

SAFETY FIRST!

It is important to be aware that some controlling partners may monitor bleeding patterns and menstrual cycles. For these women, the safest option may be the Copper T IUD as it does not change their cycle.

For IUD users, it is also recommended to discuss cutting the strings short in the cervical canal so the device cannot be felt or detected by her partner.

When Condoms Are the Preferred Contraceptive Method

Ask the patient if she is comfortable asking her partner to use condoms and if her partner is supportive of her choice.

Sample Script:

“Anytime someone tells me they use condoms as their main method of contraception—I always ask if using condoms is something that you are able to talk with him about? Does he ever get mad at you for asking? Do they break often?”

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.

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

Sample Script:


‘I have had a lot a patients tell me they are (fill in blank) uncomfortable asking, worried about breakage or not sure what to do when he gets mad. There is another method you might consider that doesn't have hormones that doesn't depend upon him using condoms”

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.



Emergency Contraceptive Visit

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 the sex was consensual or if any contraceptive tampering may be occurring. Because some patients may not feel comfortable disclosing what is happening to them—it is helpful to review the harm reduction portion of the card so that all EC patients know about this strategy whether they disclose or not.

Sample Script:

“Was the sex you had consensual, something you wanted to do? Are you at all concerned that a 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 emergency contraception 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.”

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.



Harm Reduction Strategy:

Emergency contraception is often packaged in a large box with bold labeling and could easily be discovered in a purse or a backpack by an abusive partner. Consider offering harm reduction strategies such as giving a patient an envelope so that she can remove the EC from the packaging and then conceal it in the envelope so it is less likely to be detected by her partner.

Pregnancy Test Visits

The panel, “Who controls PREGNANCY Decisions?” of the safety card should be reviewed with patients for all positive or negative pregnancy test results. *Pregnancy options counseling should also include these key assessment questions.*

Sample Script:

“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?”

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.

Additional information about responding to IPV in health care settings are outlined in the *National Consensus Guidelines on Responding to Domestic Violence Victimization in Health Care Settings*.¹

Harm Reduction Strategy:

If a patient discloses that she is afraid of her partner, follow up by offering referrals to local domestic violence programs and reminding her about the National Domestic Violence Hotline shown on the back of the safety card.

Testing for Sexually Transmitted Infections (STIs)

Because STI/HIV is highly correlated with abusive relationships it is important to make sure the patient is safe and able to make decisions about condoms.

Sample Script:

“Anytime patients come in for STI/HIV testing, we always ask if they feel comfortable talking to their partners about using condoms.”

“Are you afraid to ask your partner to use condoms or does he ever get mad at you for asking?”

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.

Positive STI Test Result—Seeking Treatment for STI Exposure

Harm Reduction Strategy:

“I want to go over the “Getting Help” panel of the safety card with you ... I know this isn't a perfect answer, but often controlling partners have multiple sex partners and it is possible that the STI notification call could be about someone other than you—this may reduce the likelihood that you would be hurt by your partner when he finds out he has an STI. We can have someone call your partner 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.”

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.

If the patient says she is afraid of how her partner may react if she notifies him about the STI, consider calling the partner yourself, especially if asking your health department to make the call is not an option.

ALWAYS FOLLOW UP POSITIVE DISCLOSURES OF REPRODUCTIVE COERCION WITH ADDITIONAL IPV QUESTIONS

Any positive disclosure of reproductive or sexual coercion should be followed up by questions about other abuse in her relationship.

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. This harm reduction strategy makes it less likely that the abusive partner will associate the STI exposure with their current partner who may be seeking services at a local clinic/program.

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 made you have sex when you didn’t want to?”

SUPPORTED REFERRAL

Another integral part of reproductive health care is called supported referral and is a strategy for addressing reproductive and sexual coercion and IPV. 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 safer strategy that increases access to services.

A key step in developing supported referral is to connect with existing support services for IPV in the community. Making this connection is mutually beneficial.

- Domestic violence and sexual assault advocates from shelters/advocacy programs are an excellent resource for training and advocacy
- Domestic violence and sexual assault advocates will become more aware of what reproductive health services are available for women experiencing IPV

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.



Supported Referral Using the Futures Safety Card

The safety card can also be used to discuss safety planning and resources that are available for patients who are experiencing IPV and/or reproductive and sexual coercion. A sample script for how to use the safety card as an intervention tool is provided below.

Sample Script:

“I 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 like to talk to her.”

HARM REDUCTION STRATEGY:

Abusive partners often monitor phones and text messages so it is important to offer use of a private phone in the clinic to a patient so she can make the call to a shelter or advocacy program without the number being traced by her partner.

Respect Her Answer

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

Sample Script:

“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. 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.”

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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

What to say when she says: “No, this isn’t happening to me.”

Sample Script:

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

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.

Trauma Informed Reporting When Mandated Reporting is Required for a Positive Disclosure

What is Trauma Informed Reporting?

Trauma-informed reporting provides a foundation for trauma-informed care. As described in the first section of this guide, becoming trauma-informed means looking at all aspects of services through a trauma lens that increases awareness of how service delivery and policies can exacerbate trauma and vulnerabilities among trauma survivors. This comprehensive approach includes the actual process of making a mandated report to minimize the risk of further trauma or danger as a result of a report being made.

Trauma-informed reporting begins 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. For example, if a female teen patient is upset about the need to report, one way to support her and show respect to what she is saying is to ask her if she would like to have input in the reporting process. Sample scripts to facilitate trauma-informed reporting are provided below.

Always Acknowledge Patients’ Feelings:

“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...”

Offer Ways to Involve Patients in the Reporting Process:

Sample Script for Adolescent Patient:

“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).”

DOCUMENTATION AND FOLLOW-UP

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

- Confirmation that the patient was screened for IPV and reproductive and sexual coercion or the reason why screening could not be done and any plans or 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 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.

Refer to the **National Consensus Guidelines** provided in Appendix A for additional information on documentation and follow-up for IPV. This resource provides practical strategies for documentation such as the importance of using the patient's own words to describe what happened and avoiding judgmental statements such as "patient refuses help."

What about boys and men?

The opportunities for screening, education, and prevention with male patients are similar to those described for female patients. Share pro-active messages with all male patients that emphasize the importance of healthy, safe, and consensual relationships. Counseling about safe sex and STI prevention should include messaging on how condom use can prevent unintended pregnancies and STIs. Male patients need to understand how victimization such as sexual coercion may impact their reproductive and sexual health and risk-taking behaviors.

Find out what resources are available for male patients by contacting local domestic violence and sexual assault programs/shelters or the National Hotline. Learn about innovative programs and practices for boys and men such as the Planned Parenthood Program described here.

Planned Parenthood:

THE NATIONAL ADOPTION OF THE INTERVENTION

PROMISING PRACTICE

The Planned Parenthood Association of Hidalgo County, Texas offers programs for male teens and adults. The teen program educates young males and first-time fathers about healthy relationships and links youth to community resources. Another program at Planned Parenthood reaches out to men who have been incarcerated, are in half-way houses, or substance abuse programs to help them transition back into their lives, relationships, and families. Meeting in groups, the men discuss a wide range of issues related to healthy relationships and fatherhood including manhood, sexuality, communication, and family violence. Participants are also connected to health care services.



PART 4: POLICY IMPLICATIONS AND SYSTEMS RESPONSE

System-wide changes regarding 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 and sexual coercion.

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

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

Consider including the following elements:

1. Training requirements for staff
 - a. Content of training
 - b. 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.¹ 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.⁶⁷

In a study comparing approaches in two different healthcare settings (an obstetrics and gynecology clinic and a general medicine clinic), the following elements were positively associated with providers' comfort level and confidence in addressing IPV⁶⁸:

- Systemic prioritization of IPV and resources
- On-site resources
- Adequate time
- Focused IPV training
- Team approach

Creating Change and Helping Staff Exposed to Violence

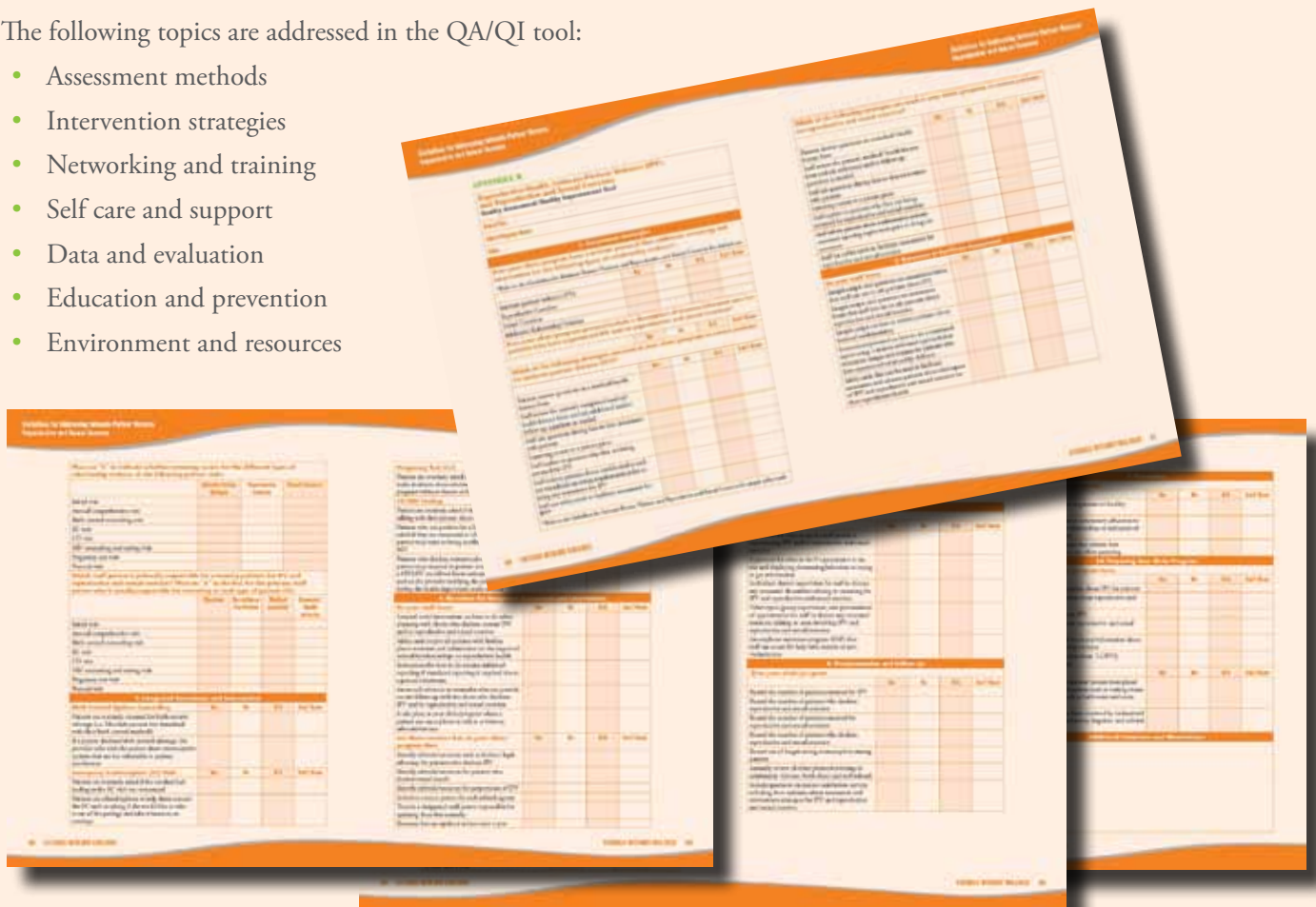
The following strategies provide a framework for institutionalizing a trauma-informed, coordinated response to IPV and reproductive and sexual coercion, while creating a safer and more supportive working environment for staff that experience victimization. More information on workplace policies for IPV and reproductive and sexual coercion can be found at another Futures website: www.workplacesrespond.org

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
2. Promote awareness that life experiences of the staff may influence their comfort level and effectiveness with addressing IPV and reproductive and sexual coercion with patients
3. Examine opportunities for reimbursement strategies that allow compensation for addressing IPV and reproductive and sexual coercion in the health care setting
4. Create a network of clinicians within your organization who have expertise on this issue and will champion the cause
5. Develop program quality improvement goals that address 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

Futures has developed a quality assurance/quality improvement (QA/QI) tool (See Appendix B) for family planning clinics, that may be adapted for physicians in private practice. This tool was developed for implementing and evaluating a trauma-informed, coordinated response to IPV and reproductive and sexual coercion 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.

The following topics are addressed in the QA/QI tool:

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



This section closes with examples of promising practices:

1. Application of this guide system-wide in more than 800 reproductive health clinics serving more than 3.5 million clients annually
2. A system-wide approach to implementing a trauma-informed, coordinated response to IPV and reproductive and sexual coercion in family planning clinics through public health partnerships
3. A cost-effective family planning initiative that has been instrumental in decreasing teenage pregnancy rates

PROMISING PRACTICE: SYSTEM-WIDE PUBLIC HEALTH RESPONSE

By March 2012, Planned Parenthood affiliates will integrate reproductive and sexual coercion screening into their reproductive health care services by implementing an adapted version of *Addressing Intimate Partner Violence Reproductive and Sexual Coercion*. Futures was approached by Planned Parenthood to adapt the guide for their providers, making their organization the first to require routine screening for reproductive and sexual coercion throughout their network of nearly 800 health centers serving three million women, men, and young people nationwide.

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 and sexual coercion safety cards with Futures 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 patients 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.

Information in this appendix is adapted from the following resource: 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.

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?”
- “Has the violence gotten worse or is it getting scarier? Is it happening more often?”

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?”

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:

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

Documentation

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:

- 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, as opposed to 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:

- 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 or OB/GYN 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

If patient does not disclose current or past IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse
- If you suspect abuse, document your reasons for concern: i.e. “Findings are not congruent w/ history or description”, “patient presents with indicators of violence”

APPENDIX B

Reproductive Health, Intimate Partner Violence (IPV), and Reproductive and Sexual Coercion: Quality Assessment/Quality Improvement Tool				
Name/Title:				
Clinic/Program Name:				
Date:				
1. Assessment Strategies				
Does your clinic/program have a written protocol that addresses screening and intervention for the following types of relationship violence*:				
<i>*Refer to Addressing Intimate Partner Violence Reproductive and Sexual Coercion for definitions.</i>				
	Yes	No	N/A	Don't Know
Intimate partner violence (IPV)				
Reproductive Coercion				
Sexual Coercion				
Adolescent Relationship Violence				
Does your clinic/program protocol include a description of trauma-informed care for patients who have experienced IPV and/or reproductive and sexual coercion?				
	Yes	No	N/A	Don't Know
Which of the following strategies are used at your clinic/program to screen patients for intimate partner violence (IPV)?				
	Yes	No	N/A	Don't Know
Patients answer questions on a medical/health history form				
Staff review the patient's completed medical/health history form and ask additional and/or follow-up questions as needed				
Staff ask questions during face-to-face assessment with patients				
Screening occurs in a private place				
Staff explain to patients why they are being screened for IPV				
Staff inform patients about confidentiality and any mandated reporting requirements prior to doing any assessment for IPV				
Staff use safety cards to facilitate assessment for IPV*				
<i>* Refer to Addressing Intimate Partner Violence Reproductive and Sexual Coercion for sample safety cards.</i>				

Which of the following strategies are used at your clinic/program to screen patients for reproductive and sexual coercion?				
	Yes	No	N/A	Don't Know
Patients answer questions on a medical/health history form				
Staff review the patient's medical/health history form and ask additional and/or follow-up questions as needed				
Staff ask questions during face-to-face assessment with patients				
Screening occurs in a private place				
Staff explain to patients why they are being screened for reproductive and sexual coercion				
Staff inform patients about confidentiality and any mandated reporting requirements prior to doing any assessment				
Staff use safety cards to facilitate assessment for reproductive and sexual coercion				
2. Resources to Facilitate Assessment				
Do your staff have:	Yes	No	N/A	Don't Know
Sample scripts and questions on assessment forms that staff can use to ask patients about IPV				
Sample scripts and questions on assessment forms that staff can use to ask patients about reproductive and sexual coercion				
Sample scripts on how to inform patients about limits of confidentiality				
Instructions/protocol on how to do a mandated report using a trauma-informed approach that minimizes danger and trauma for patients who have experienced relationship violence				
Safety cards that can be used to facilitate assessment and educate patients about the impact of IPV and reproductive and sexual coercion on their reproductive health				

Place an "X" to indicate whether screening occurs for the different types of relationship violence at the following patient visits:				
	Intimate Partner Violence	Reproductive Coercion	Sexual Coercion	
Initial visit				
Annual/comprehensive visit				
Birth control counseling visit				
EC visit				
STI visit				
HIV counseling and testing visit				
Pregnancy test visit				
Prenatal visit				
Which staff person is primarily responsible for screening patients for IPV and reproductive and sexual coercion? Place an "X" in the box for the primary staff person who is usually responsible for screening at each type of patient visit.				
	Physician	Nurse/NP/ CNM/PA	Medical Assistant	Counselor/ Health Educator
Initial visit				
Annual/comprehensive visit				
Birth control counseling visit				
EC visit				
STI visit				
HIV counseling and testing visit				
Pregnancy test visit				
Prenatal visit				
3. Integrated Assessment and Intervention				
Birth Control Options Counseling	Yes	No	N/A	Don't Know
Patients are routinely screened for birth control sabotage (i.e. Has their partner ever interfered with their birth control method?)				
If a patient discloses birth control sabotage, the provider talks with the patient about contraceptive options that are less vulnerable to partner interference				
Emergency Contraceptive (EC) Visit	Yes	No	N/A	Don't Know
Patients are routinely asked if the sex they had leading to the EC visit was consensual				
Patients are offered options to help them conceal the EC such as asking if she would like to take it out of the package and take it home in an envelope				

Pregnancy Test Visit	Yes	No	N/A	Don't Know
Patients are routinely asked if they are able to make decisions about whether they want to be pregnant without threats or fear from a partner				
STI/HIV Testing	Yes	No	N/A	Don't Know
Patients are routinely asked if they feel comfortable talking with their partner about using condoms				
Patients who test positive for a STI/HIV are asked if they are concerned or afraid of how their partner may react to being notified about the STI/HIV				
Patients who disclose concerns about how their partner may respond to partner notification about a STI/HIV are offered harm reduction strategies such as the provider notifying the partner or having the health department make contact				
4. Resources for Integrated Assessment and Intervention				
Do your staff have:	Yes	No	N/A	Don't Know
Scripted tools/instructions on how to do safety planning with clients who disclose current IPV and/or reproductive and sexual coercion				
Safety cards to give all patients with hotline phone numbers and information on the impact of unhealthy relationships on reproductive health				
Instructions for how to do trauma-informed reporting if mandated reporting is required due to a patient's disclosure				
An on-call advocate or counselor who can provide on-site follow-up with the client who discloses IPV and/or reproductive and sexual coercion				
A safe place at your clinic/program where a patient can use a phone to talk to a violence advocate/services				
Are there resource lists at your clinic/program that:	Yes	No	N/A	Don't Know
Identify referrals/resources such as shelters or legal advocacy for patients who disclose IPV				
Identify referrals/resources for patients who disclose sexual assault				
Identify referrals/resources for perpetrators of IPV				
Include a contact person for each referral agency				
There is a designated staff person responsible for updating these lists annually				
Resource lists are updated at least once a year				

5. Networking and Staff Support				
Within the last year has your clinic staff had contact with representatives from any of the following agencies (contact means called for assistance with a patient, called for information about services, or other direct contact with an agency representative)?				
	Yes	No	N/A	Don't Know
Domestic violence advocates/shelter staff				
Rape crisis center staff/advocates				
Child protective services				
Batterer's intervention group				
Legal advocacy/legal services				
Law enforcement				
	Yes	No	N/A	Don't Know
There is someone on staff who is especially comfortable with screening and intervention for IPV with patients				
There is someone on staff who is especially comfortable with screening and intervention for reproductive and sexual coercion with patients				
We have a protocol that advises staff on what to do if they do not feel comfortable or adequately skilled to help a patient who discloses IPV and/or reproductive and sexual coercion				
	Yes	No	N/A	Don't Know
We have someone on staff who participates in a local domestic violence task force or related subcommittee				
We have a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence with a patient				
6. Training				
	Yes	No	N/A	Don't Know
Your staff receives annual training on IPV				
Your staff has received training on reproductive and sexual coercion in the past two years				
Your staff has received training on trauma-informed care in the past two years				
Newly hired staff receive training on IPV				
Newly hired staff receive training on reproductive and sexual coercion				
Domestic violence advocates are invited to your clinic/program to network and/or provide training at least once a year				

7. Self Care and Support

Does your clinic/program staff have:

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

8. Documentation and Follow-up

Does your clinic/program:

	Yes	No	N/A	Don't Know
Record the number of patients screened for IPV				
Record the number of patients who disclose reproductive and sexual coercion				
Record the number of patients screened for reproductive and sexual coercion				
Record the number of patients who disclose reproductive and sexual coercion				
Record use of longer-acting contraceptives among patients				
Annually review all clinic protocols relating to relationship violence (both client and staff related)				
Include questions on patient satisfaction surveys soliciting their opinions about assessment and intervention strategies for IPV and reproductive and sexual coercion				

9. Prevention				
Does your clinic/program:				
	Yes	No	N/A	Don't Know
Provide information to patients on healthy relationships				
Sponsor any patient or community education to talk about healthy relationships or indicators of relationship violence				
Offer parenting classes that address how relationship violence can affect parenting				
10. Preparing Your Clinic/Program				
Does your clinic/program have:				
	Yes	No	N/A	Don't Know
Brochures/information about IPV for patients				
Brochures/information about reproductive and sexual coercion				
Posters/displays about IPV				
Posters/displays about reproductive and sexual coercion				
Adolescent-focused brochures/information about adolescent relationship violence				
Brochures/information about LGBTQ relationship violence				
	Yes	No	N/A	Don't Know
Are brochures/information/posters placed in easily visible locations such as waiting rooms and private areas such as bathrooms and exam rooms?				
Have these resource been reviewed by underserved communities for inclusivity and linguistic and cultural relevance?				
Additional Comments and Observations:				

APPENDIX C



The American College of
Obstetricians and Gynecologists

WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 518 • February 2012

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Intimate Partner Violence

ABSTRACT: Intimate partner violence (IPV) is a significant yet preventable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (HIV). Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women’s health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women’s preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.

Intimate partner violence (IPV) is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion (1). These types of behavior are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and is aimed at establishing control of one partner over the other (1). It can occur among heterosexual or same-sex couples and can be experienced by both men and women in every community regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death.

More than one in three women in the United States have experienced rape, physical violence, or stalking by an intimate partner in their lifetime (2). In the United States, women experience 4.8 million incidents of physical or sexual assault annually (3). However, the true prevalence of IPV is unknown because many victims are afraid to disclose their personal experiences of violence. Intimate

partner violence caused 2,340 deaths in 2007; of this number, 1,640 were female and 700 were male (4).

Patterns of Intimate Partner Violence

Intimate partner violence encompasses subjection of a partner to physical abuse, psychologic abuse, sexual violence, and reproductive coercion. Physical abuse can include throwing objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with any form of weapon, or using a weapon. Psychologic abuse erodes a woman’s sense of self-worth and can include harassment; verbal abuse such as name calling, degradation, and blaming; threats; stalking; and isolation. Often, the abuser progressively isolates the woman from family and friends and may deprive her of food, money, transportation, and access to health care (5). Sexual violence includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape (6). Reproductive coercion involves behavior used to maintain power and control in a relationship related to reproductive health and can occur in the absence of physical or sexual violence. A partner may sabotage efforts at contraception, refuse to practice safe sex, intentionally

Used with permission. Intimate partner violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:412-7

expose a partner to a sexually transmitted infection (STI) or human immunodeficiency virus (HIV), control the outcome of a pregnancy (by forcing the woman to continue the pregnancy or to have an abortion or to injure her in a way to cause a miscarriage), forbid sterilization, or control access to other reproductive health services (1).

Approximately 20% of women seeking care in family planning clinics who had a history of abuse also experienced pregnancy coercion and 15% reported birth control sabotage (7). In addition to unintended pregnancy risk, there are also risks specific to partner notification of an STI, which should be taken into account especially when considering expedited partner treatment. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of an STI. In a study with a culturally diverse sample of women seeking care at family planning clinics, clients 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 (8). Some women reported threats of harm or actual harm in response to notifying their partners of an STI (9). Expedited partner therapy is only recommended after a health care provider has assessed for and confirmed that there is no risk of IPV associated with partner notification. It is also not intended for child abuse, sexual assault, or any situation where there is a question of safety.

Consequences of Intimate Partner Violence

Some women subjected to IPV present with acute injuries to the head, face, breasts, abdomen, genitalia, or reproductive system, whereas others have nonacute presentations of abuse such as reports of chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections. These nonacute symptoms often represent clinical manifestations of internalized stress (ie, somatization). This stress can lead to post-traumatic stress disorder, which is often associated with depression, anxiety disorders, substance abuse, and suicide. Research confirms the long-term physical and psychological consequences of ongoing or past violence (10).

Approximately 324,000 pregnant women are abused each year in the United States (11). Although more research is needed, IPV has been associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight (11–14). In addition, the severity of violence may sometimes escalate during pregnancy or the postpartum period (15, 16). Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner (14). High rates of birth

control sabotage and pregnancy pressure and coercion in abusive relationships are correlated with unintended pregnancies (1, 7).

The societal and economic effects of IPV are profound. Approximately one quarter of a million hospital visits occur as a result of IPV annually (17). The cost of intimate partner rape, physical assault, and stalking totals more than \$8.3 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores (17, 18). Additional medical costs are associated with ongoing treatment of alcoholism, attempted suicide, mental health symptoms, pregnancy, and pediatric-related problems associated with concomitant child abuse and witnessing abuse. Intangible costs include women's decreased quality of life, undiagnosed depression, and lowered self-esteem. Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children (19). Efforts to control health care costs should focus on early detection and prevention of IPV (18).

Special Populations

Adolescents

Approximately one out of ten female high-school students in the United States reported experiencing physical violence from their dating partners in the previous year (20). Of those who reported ever having had sexual intercourse, one out of five girls experienced dating violence. These girls were also more likely to have experienced pregnancy and STIs, including HIV, and to report tobacco use and mental health problems, including suicide attempts (20). It is important for adolescents to be aware of behavior that aims to maintain power and control in a relationship such as monitoring cell phone usage, digital dating abuse (including posting nude pictures against her will, stalking her through social networks, and humiliating her through social networks), telling a partner what to wear, controlling whether the partner goes to school that day, as well as manipulating contraceptive use (1). Early recognition is critical in this population because adolescent violence can be associated with partner violence in adult life.

Immigrant Women

Women from different backgrounds may have different perceptions about IPV and need culturally relevant care that is sensitive to language barriers, acculturation, accessibility issues, and racism. Immigrant women may be hesitant to report IPV because of fears of deportation. It is important to increase awareness that a U Nonimmigrant Visa allows immigrants who have been subjected to substantial physical or mental abuse caused by IPV or other crimes to remain in the United States if it is justified on humanitarian grounds, ensures family unity, or is otherwise in the public interest (21).

Women With Disabilities

Women with physical and developmental disabilities usually are less able to care for themselves and are more reliant on their partners or caregivers for help. This sets up a dangerous dynamic where abusers may be in a position to physically abuse their victims by withholding medication, preventing use of assistive equipment such as canes or wheelchairs, and sabotaging other personal service needs such as help with bathing, bathroom functions, or eating. Also, many violence shelters do not accept women with disabilities or are not trained to respond adequately to the needs of women with disabilities.

Older Women

An estimated 1–2 million U.S. citizens aged 65 years or older have been injured, exploited, or mistreated by someone caring for them (22). For the obstetrician–gynecologist, the importance of elder abuse relates to the increasing number of older women in the population (23). Older women seek care for pelvic floor relaxation, sexual dysfunction, breast and reproductive tract cancer, and other problems. Elder abuse can occur in the patient’s home, the home of the caregiver, or in a residential facility in which the patient is residing. There is no typical victim of elder abuse. Elder abuse occurs in all racial, social, educational, economic, and cultural settings. Victims of elder abuse know their perpetrator 90% of the time (24). Approximately two thirds of abusers are adult children or partners (24). Abuse can be physical, sexual, and psychologic and includes neglect (refusal or failure to fulfill caregiving obligations), abandonment, and financial exploitation (illegal or improper exploitation of funds or other assets through undue influence or misuse of power of attorney). For more information go to: http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Elder_Abuse__An_Introduction_for_the_Clinician.aspx.

Role of Health Care Providers

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support, and reviewing available prevention and referral options. Health care providers are often the first professionals to offer care to women who are abused. The U.S. Department of Health and Human Services has endorsed the Institute of Medicine’s recommendation that IPV screening and counseling be a core part of women’s health visits (25). Adequate training and education among health care providers will provide the skills and confidence they need to work with patients, colleagues, and health care systems to combat violence and abuse (26). Obstetrician–gynecologists are in the unique position to provide assistance for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of annual examinations, family planning, pregnancy, and

follow-up visits for ongoing care. Screening all patients at various times is also important because some women do not disclose abuse the first time they are asked. Health care providers should screen all women for IPV at periodic intervals, such as annual examinations and new patient visits. Signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner should prompt an assessment for IPV. Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup. Studies have shown that patient self-administered or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening (27, 28). Screening for IPV should be done privately. Health care providers should avoid questions that use stigmatizing terms such as “abuse,” “rape,” “battered,” or “violence” (see sample questions in Box 1) and use culturally relevant language instead. They should use a strategy that does not convey judgment and one with which they are comfortable. Written protocols will facilitate the routine assessment process:

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure that staff receives training about IPV and that training is regularly offered.

Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure.

Box 1. Sample Intimate Partner Violence Screening Questions ←

While providing privacy, screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy, and the postpartum checkup.

Framing Statement

“We’ve started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health.”*

Confidentiality

“Before we get started, I want you to know that everything here is confidential, meaning that I won’t talk to anyone else about what is said unless you tell me that. . . (insert the laws in your state about what is necessary to disclose).”*

Sample Questions

“Has your current partner ever threatened you or made you feel afraid?”

(Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages)†

“Has your partner ever hit, choked, or physically hurt you?”

(“Hurt” includes being hit, slapped, kicked, bitten, pushed, or shoved.)‡

For women of reproductive age:

“Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?”*

“Does your partner support your decision about when or if you want to become pregnant?”*

“Has your partner ever tampered with your birth control or tried to get you pregnant when you didn’t want to be?”*

For women with disabilities:

“Has your partner prevented you from using a wheelchair, cane, respirator, or other assistive device?”‡

“Has your partner refused to help you with an important personal need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink or threatened not to help you with these personal needs?”‡

*Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf. Retrieved October 12, 2011. Modified and reprinted with permission.

†Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco (CA): FVPF; 2004. Available at: <http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>. Retrieved October 12, 2011. Modified and reprinted with permission.

‡Center for Research on Women with Disabilities. Development of the abuse assessment screen-disability (AAS-D). In: Violence against women with physical disabilities: final report submitted to the Centers for Disease Control and Prevention. Houston (TX): Baylor College of Medicine; 2002. p. II-1–II-16. Available at <http://www.bcm.edu/crowd/index.cfm?pmid=2137>. Retrieved October 18, 2011. Modified and reprinted with permission.

Futures Without Violence and the American College of Obstetricians and Gynecologists have developed patient education cards about IPV and reproductive coercion for adults and teens that are available in English and Spanish. For more information visit <http://fvpfstore.stores.yahoo.net/safetycards1.html>.

If the clinician ascertains that a patient is involved in a violent relationship, he or she should acknowledge the trauma and assess the immediate safety of the patient and her children while assisting the patient in the development of a safety plan. Risk factors for intimate

partner homicide include having experienced previous acts of violence, estrangement from partner, threats to life, threats with a weapon, previous nonfatal strangulation, and partner access to a gun (29). Patients should be offered information that includes community resources (mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and appropriate referrals. Clinicians should not try to force patients to accept assistance or secretly place information in her purse or carrying case because the perpetrator may find the material and increase aggression. To assist

clinicians in responding to IPV, a local domestic violence agency is often the best resource. It is important to note that when abuse is identified, it is very useful to offer a private phone for the patient to use to call a domestic violence agency. Controlling partners often monitor cell phone call logs and Internet usage. Offering a private phone to call the National Domestic Violence hotline is a simple but important part of supporting a victim of violence. The National Domestic Violence hotline is a multilingual resource that can connect a patient to local domestic violence programs, help with safety planning, and provide support. A protocol with all the information needed to perform an IPV assessment should be kept on site. Futures Without Violence also provides educational materials, IPV assessment and safety assessment tools (including scripts for clinical assessment of IPV and reproductive coercion), and free technical assistance specifically for health care providers and settings. For more information, visit www.futureswithoutviolence.org/section/our_work/health.

Reporting of the abuse of children is mandatory; however, reporting IPV, particularly mandatory reporting, is controversial. Although the intent of mandatory reporting is to identify and protect individuals before the next act of violence, the individual's safety, in fact, may be jeopardized (30). Most states do not mandate reporting of IPV or only mandate reporting in certain circumstances (31). To ensure compliance with state laws and federal regulations, it is important to contact the local law enforcement or domestic violence agency to become familiar with the laws in a specific jurisdiction. A summary of state laws can be found at: www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf. All fifty states and the District of Columbia have laws in effect authorizing the provision of adult protective services in cases of elder abuse or the abuse of individuals with disabilities, although the laws vary significantly between states. Physicians generally are mandated to report abuse in these instances. A current listing of state laws on elder abuse can be found at: www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/State_Resources.aspx.

Documentation of the clinical interaction provides important evidence for any future legal proceedings. Accurate reflection of the patient's condition, including any pertinent photographs or body maps, should be included with direct and specific quotations. The health care provider should review with the patient in advance what form of future communication is best because medical bills and follow-up phone calls may prompt retaliation from the abuser. Despite encountering violence, a patient may deny her circumstances based on fear of retaliation from her partner, fear of involvement with law enforcement and the justice system, embarrassment, or shame. Even if women do not reveal violence to their physicians, hearing validating messages and knowing that options and resources may be available could help prompt them to seek help on their own in the future.

Conclusion

Based on the prevalence and health burden of IPV among women, education about IPV; screening at periodic intervals, including during obstetric visits; and ongoing clinical care can improve the lives of women who experience IPV. Preventing the lifelong consequences associated with IPV can have a positive effect on the reproductive, perinatal, and overall health of all women.

Intimate Partner Violence National Resources

Hotlines

- National Domestic Violence Hotline
1-800-799-SAFE (7233)
- Rape Abuse & Incest National Network (RAINN) Hotline
1-800-656-HOPE (4673)

Web Sites

- Futures Without Violence (previously known as Family Violence Prevention Fund)
www.futureswithoutviolence.org
- National Coalition Against Domestic Violence
www.ncadv.org
- National Network to End Domestic Violence
www.nnedv.org
- National Resource Center on Domestic Violence
www.nrcdv.org
- Office on Violence Against Women
(U.S. Department of Justice)
www.usdoj.gov/ovw

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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 Futures Without Violence, 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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