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Women's Health Update

Bureau of Healthy Ohio, Ohio Department of Health



Update Focus: **Violence and Reproductive Health**

Letter from Debra Seltzer

I continue to be both shocked and deeply moved by the devastating experiences of victims of sexual and intimate violence. Through the leadership of Futures Without Violence and the Ohio Domestic Violence Network, we have been learning about the impact of reproductive coercion. This refers to ways in which abusive partners seek to control their intimate partners through methods such as sabotaging birth control and/or using pressure, deception, coercion, or force to control whether women get pregnant and/or the outcome once she is pregnant. Research shows that this type of abuse negatively affects the long term health of affected women and their future opportunities. Identifying that this type of sexual coercion is happening has been a catalyst for developing training and resources to help victims and those who work with them recognize and respond appropriately to this form of abuse. In this issue, you'll read about the important steps Ohio is taking to train medical and other professionals through Project Connect.

On a personal level, I was particularly inspired by a nurse who had completed a day-long training on this topic. She described how the class had transformed the way she perceives the young mothers with multiple children she sees regularly in her clinic. This training helped her reframe these women's experiences in terms of reproductive coercion where previously she had made negative assumptions about them.



The next challenge is to learn how to use lessons learned from these experiences as we work with young men and our entire community to create a future in which this type of violence does not happen at all.

Debra Seltzer
Program Administrator
SADVPP

VIOLENCE and Reproductive Health

Violence can lead to injury and death among women of all ages. Centers for Disease Control (CDC) continues a history of seeking insights into how to protect women of reproductive age from preventable causes of injury that can lead to excess morbidity and mortality. In 1997, the first meeting on pregnancy related violence was held to obtain expert

advice on the key scientific issues related to research on violence around the time of pregnancy. This meeting was one of the first formal collaborations between the CDC's Division of Reproductive Health and CDC's National Center for Injury Prevention and Control (NCIPC). In 2001, this effort was one of the highlights of the first national Summit

on Safe Motherhood, as scientists, health professionals and program managers noted that violence may play a key role in women's health before, during and after pregnancy. CDC continues this collaboration to gain a greater understanding of the role of violence in the lives of women of reproductive age.

What is Reproductive Coercion?

By **Laura Schumm**, Project Connect Coordinator, Ohio Domestic Violence Network (ODVN)

The **Family Violence Prevention Fund** defines reproductive coercion as behaviors that a partner uses to maintain power and control in a relationship related to one's reproductive health and expands the continuum of power and control used by batterers.

Reproductive coercion can be present in same sex and heterosexual relationship and examples include: explicit attempts to impregnate a female partner against her will, coercing a partner to engage in unwanted sexual acts, forced non condom use and intentionally exposing a partner to STI/HIV. Reproductive coercion also includes birth control sabotage, pregnancy pressure and pregnancy coercion.

- ■ **Birth Control Sabotage** is an active interference with contraceptive methods by someone who is, was, or wishes, to be involved in an intimate or dating relationship with an adult or adolescent.

Examples include:

- *Hiding, withholding, destroying, or refusing to pay for a partner's birth control pills.*
- *Pulling out vaginal rings or intrauterine devices.*
- *Breaking a condom on purpose.*
- *Accusing her of cheating if she asks to use contraception.*

- ■ **Pregnancy Pressure** involves behaviors that are intended to pressure a partner to become pregnant when she does not wish to be pregnant. These behaviors are expressed verbally, physically or in combination. **Examples include:**

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

- ■ **Pregnancy Coercion** involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of whether to terminate or continue a pregnancy.

Examples include:

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

“ I was on the birth control, and I was still taking it, and he ended up getting mad and flushing it down the toilet, so I ended up getting pregnant.

I found out that [before this] he talked to my friends and he told them that we were starting a family. I didn't know that. I didn't want to start a family. I wanted to finish school. ”

How does reproductive coercion affect a woman's reproductive health?

Women and especially teen girls experiencing Interpersonal violence (IPV) are at a higher risk for experiencing one or more forms of reproductive coercion, thereby increasing the risk of having an unintended pregnancy, rapid repeat pregnancies, exposure to STI/HIV and voluntary or coerced abortions. Experiencing IPV and reproductive coercion also puts a woman at higher risk of mental health issues, disordered eating, suicidality and substance abuse. Teen girls are more likely to report early sexual activity, multiple partners and often do not recognize sexually coercive behavior as sexual assault.

- Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls.¹
- Among teen mothers on public assistance who had experienced recent IPV, 66 percent disclosed birth control sabotage by their partner.²
- The risk of being a victim of sexual or intimate partner violence in the past year was nearly three times higher for women seeking an abortion compared to women continuing their pregnancies.³
- Adolescent mothers who experienced physical partner abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months.⁴
- Men who perpetrated IPV in the past year were more likely to report:
 - Inconsistent or no condom use during vaginal and anal sexual intercourse
 - Forcing sexual intercourse without a condom.⁵

Additional considerations

Traditionally, prevention and intervention of IPV, teen pregnancy and HIV have been done in silos and with little collaboration among agencies. However, if adolescent girls in

physically abusive relationships are three and a half times more likely to become pregnant, educating her on abstinence or consistent condom usage is useless if her partner is forcing her to have sex without some form of birth control. If teen mothers that experience physical violence within three months of delivery are twice as likely to have a repeat pregnancy, giving her condoms or a prescription for "the pill" upon delivery doesn't make sense if she is afraid of what her partner will do to her if he finds her with birth control. It also doesn't make sense to look at that teen as if she were irresponsible in her choices if the "choice" to have a child is coerced.

If men who perpetrated IPV report that they inconsistently use condoms and/or force intercourse without a condom, is it enough to send home a woman or girls with condoms after she is tested for an STI, if the choice to use them is out of her hands? It also doesn't make sense to simply teach men and women how to put on a condom without teaching them how to negotiate the usage of condoms or what a healthy relationship looks like. If women, who are fearful of their partner and have high STI knowledge, are using condoms more inconsistently than non-fearful women who have a low STI knowledge, is it enough to educate women and men on STI's and how they are contracted?

Providing comprehensive care to women and girls experiencing IPV and/or reproductive coercion is critical. The same is true with teen pregnancy prevention and STI/HIV prevention education. When having these conversations it is important to address the role that IPV and reproductive coercion play, as well as education on what a healthy relationship looks like. Furthermore, none of these conversations should be had without also including men and boys and their role in preventing IPV, premature fatherhood, spread of STI/HIV and developing healthy relationships. Building ones knowledge of reproductive coercion is the beginning to dismantling the silos we have built for such highly intertwined issues.

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Project *Connect*

Authorized by the ***Violence Against Women Act of 2005*** and funded by the Office on Women's Health with support from the Administration for Children and Families, **Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women** is a national initiative to change how adolescent health, reproductive health and home visiting programs respond to sexual and domestic violence. Research demonstrates that women in these programs are at high risk for abuse, and that there are evidence-based interventions that can improve maternal and child health, and decrease the risks for unplanned pregnancy, poor pregnancy outcomes and further abuse. One of the only programs offering a national coordinated public health model to improve the health response to domestic and sexual violence, Project Connect's multi-pronged approach includes creating and disseminating:

Enhanced clinical interventions to respond to domestic and sexual violence, including training and supporting materials for providers and health systems.

- **Patient education materials on the connection between abuse and their health.**
- **Policy and systems change at the local, state and national level.**
- **National training of providers through an eLearning platform.**
- **Pilot programs to offer basic health services within domestic and sexual violence programs.**
- **Evaluation and research on the health impact of abuse and the impact of health-based interventions.**

Project Connect is currently funding ten geographically and ethnically diverse communities across the nation: Arizona, Georgia, Ohio, Iowa, Maine, Michigan, Texas, Virginia, and two Native American communities in California (Southern Indian Health Council and Kima:w Medical Center). These sites provide much-needed services for women in abusive relationships including historically medically underserved communities that have high rates of domestic and sexual violence, such as rural/frontier areas, immigrant women and Native Americans.

Using input from health providers, domestic and sexual violence advocates, community members and policymakers, new education materials for providers and patients/clients have been developed by Futures Without Violence, including:

- **New clinical guidelines for reproductive health providers**
- **New training curriculum for home visitation programs**
- **New safety cards for adolescents talking about healthy relationships**
- **Twelve new video vignettes provide an electronic distance learning platform that will be used to train providers in adolescent, reproductive and maternal and child health programs nationwide.**

Coordinated state level teams of public health and domestic and sexual violence partners have been formed to create lasting health policy and coordinated response to victims. Examples of policy change include adding assessment of domestic and sexual violence into statewide nursing guidelines and improving data collection by adding new questions about domestic and sexual violence to statewide surveillance systems. **Futures Without Violence** also developed policy memos on the recently federally-funded home

visitation and teen pregnancy/parenting programs, which are being used by sites to shape program planning in their states.

Additional focus areas include:

Implementing an e-learning platform to train tens of thousands of additional physicians, nurses and students. In Spring 2011, free online CME trainings were offered to Project Connect sites, as well as national health associations, such as the American College of Obstetricians and Gynecologists.

Offering basic health services on site in select domestic and sexual violence programs in each Project Connect site. Program strategies include: utilizing mobile health vans, stationing public health nurses in family violence programs, integrating basic health assessment questions into domestic violence shelter intake and partnering with local providers for ongoing care.

Creating sustainability for the work of Project Connect at the state, local or tribal level. Futures Without Violence is providing guidance for sites to develop policy agendas and action plans to identify opportunities for program and policy changes that will support their work.

Evaluating the impact of Project Connect's clinical intervention on the health and safety of victims of abuse. In addition to the initiative-wide evaluation of provider behavior change, two states have partnered with local universities to conduct an in-depth evaluation of the effect that integrating the assessment of domestic and sexual violence into clinical settings has on clients.

Disseminating information on best practice models for integration in other states/tribes and service settings. Plans include an educational briefing and development of a report outlining model programs.

Project *Connect*

Securing Ohio's Future by Growing Healthy Relationships

Lisa M. Fry

Management Analyst

Ohio Department of Health, Family Planning Program

In 2010, the ODVN was one of 10 grant projects chosen by **Futures Without Violence** for **Project Connect** to educate family planning clients and adolescent health center clients about Intimate Partner Violence (IPV).

ODVN teamed up with the Ohio Department of Health (ODH) Reproductive Health and Wellness Program (RHWP) to improve screening, assessing and referring for IPV. In 2009, less than one percent of ODH family planning agencies reported client disclosure of IPV. The national average is about 20 percent.

RHWP chose four pilot sites: Huron County Health Department; Wood County Health Department; Public Health-Dayton and Montgomery County and KnoHoCo-Ashland Community Action to participate in Project Connect. Project Connect conducted focus groups with family planning staff to find out what were the current practices for screening, assessing and referring for IPV and if the staff had had previous training and knowledge of IPV.

Futures Without Violence hosted a conference in the fall of 2010 to provide training to family planning staff and domestic violence and sexual violence shelter staff. After implementing the new resource materials developed, two of the four pilot sites doubled their percentage of patients disclosing IPV. One agency went from 4.9 percent of patients disclosing sexual coercion in 2009 to 14 percent in the first half of 2011. Another agency went from .3 percent of patients disclosing domestic violence in 2009 to six percent in the first half of 2011.

Project Connect plans to convene a second round of focus group interviews, analyze the statistics and determine why some pilot sites have had more success than others.

Family Planning staff are looking forward to meeting with staff at the local domestic violence and sexual assault programs and participating in cross training with them. In Wood County, collaboration has progressed to the point that staff at the shelter call the nurse practitioner in the Family Planning program directly when a survivor needs an exam or test done that day, and the clinic has been able to respond promptly.

The American College of Obstetricians and Gynecologists (ACOG) recommends IPV screening of all women, including during pregnancy at the first prenatal visit, at least once per trimester, and at the postpartum checkup.¹ Universal IPV screening is also endorsed by the U. S. Surgeon General, American Association of Family Practitioners, American Medical Association, American Nurses Association, American Public Health Association, Joint Commission on Accreditation of Health Care Facilities, National Association for Social Workers and the National Institutes of Medicine.



IPV Screening Recommendations

The U.S. Prevention Services Task Force has stated that routine IPV questions directed toward women during medical exams are justified by the existence of a high prevalence of undetected abuse. They argue that routine screening is a low cost and effective method for identifying victims of IPV, whose desire for help may change over time. Left unaddressed, the severity and frequency of abuse can worsen over time, leading to serious health and potentially life threatening consequences.² Furthermore, in surveys of women who were physically abused,

92 percent stated they did not discuss these incidents with their physicians,^{3,4} yet four different studies demonstrated that the majority of abused women would like their health care provider to ask them privately about IPV.^{5, 6, 7, 8}

Most Ohioans are seen at some point by a health professional. The health care setting offers a critical opportunity for early detection and primary prevention of abuse. Since neither victims nor batterers have been found to fit a distinct personality profile, universal screening is more appropriate than targeting specific patient populations.^{2,3} Thus, it is not only important that medical, legal, and social service workers are trained to recognize the symptoms of IPV, but also that effective screening tools are consistently applied where appropriate.

NATIONAL WEB RESOURCES

American College of Obstetricians and Gynecologists
<http://www.acog.org>

American Medical Association
<http://www.ama-assn.org>

American Nurses Association
<http://www.nursingworld.org>

References

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Need crisis services for yourself or others?

NATIONAL DOMESTIC VIOLENCE HOTLINE*
(Organización Línea Nacional de Información sobre Violencia Doméstica)

This is a nationwide service offering crisis intervention, information about domestic violence and referrals to local service providers to victims of domestic violence and those calling on their behalf. Highly qualified and trained hotline advocates are available to answer every call. Assistance is available in both English and Spanish. Hotline advocates and volunteers also have access to translators in 139 languages.

National Domestic Violence
HOTLINE 

1-800-799-SAFE (7233)
1-800-787-3224 TTY For the Deaf

Assistance through e-mail at ndvh@ndvh.org

Crisis intervention and referrals to the Deaf through the TTY line and e-mail at deafhelp@ndvh.org

Informational materials on such topics as domestic violence, sexual assault, battering intervention and prevention programs

ORGANIZATIONS AND ASSOCIATIONS

ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS (ARHP)

Website: <http://www.arhp.org>

ARHP - West

1330 Broadway, Suite 1100
Oakland, CA 94612
Phone: (510) 986-8990
Fax: (510) 986-8960

ARHP – East

1901 L Street, NW Suite 300
Washington, DC 20036
Phone: (202) 466-3825
Fax: (202) 466-3826

The ARHP, founded in 1963 is a multidisciplinary association of professionals who provide reproductive health services or education, conduct reproductive health research, or influence reproductive health policy.

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Website: cdcinfo@cdc.gov

Division of Reproductive Health
4770 Buford Highway, NE MS K-20
Atlanta, Georgia 30341-3724
800-CDC-INFO
(800-232-4636)
TTY: (888)232-6348 / 24 Hours/Every Day

The CDC's Division of Reproductive Health mission is to promote optimal reproductive, maternal, and infant health and quality of life by influencing public policy, health care practice, community practices, and individual behaviors through scientific and programmatic expertise, leadership and support. CDC accomplishes its mission by working with partners throughout the nation and world to

- Conduct epidemiologic, behavioral, demographic, and health services research.
- Support national and state-based surveillance systems to monitor trends and investigate health issues.
- Support development of scientific and programmatic development within states and other jurisdictions.
- Provide technical assistance, consultation and training worldwide.
- Translate research findings into health care practice, public health policy and health promotion strategies.

FUTURES WITHOUT VIOLENCE

Website: <http://www.futureswithoutviolence.org>

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There are also offices located in Washington, D.C. and Boston, M.A.

Everyone has the right to live free of violence. Futures Without Violence, formerly Family Violence Prevention Fund, works to prevent and end violence against women and children around the world.

We advance the health, stability, education, and security of women and girls, men and boys worldwide. In 1994, Futures Without Violence was instrumental in developing the landmark Violence Against Women Act passed by the US Congress. We train professionals such as doctors, nurses, athletic coaches, and judges on improving responses to violence and abuse.

As well, we work with advocates, policy makers and others to build sustainable community leadership and educate people everywhere about the importance of respect and healthy relationships – the relationships that all individuals, families and communities need and deserve.



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JANUARY 2012
Violence and
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a look at ***Reproductive Coercion***

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WOMEN'S HEALTH PROGRAM

http://www.odh.ohio.gov/pdhPrograms/hprp/wom_hlt/sadvwhlth.aspx

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Sexual Assault and Domestic Violence Prevention Programs