

Improving Health Outcomes and Contraceptive Access by Addressing Coercion in Intimate Partner Violence



*A collaboration between healthcare providers and
domestic and sexual violence services*



*The work reported in this document was supported by
New Morning Foundation.*



Overview

Relationship health and intimate partner violence have a considerable impact on overall health. The 2010-2012 National Intimate Partner and Sexual Violence Survey (NISVS) found that people with a history of sexual and intimate partner violence reported significantly higher levels of chronic pain, frequent headaches, asthma, difficulty sleeping, irritable bowel syndrome, and poor mental health outcomes.¹ This puts healthcare providers in a unique position to offer support and improve health outcomes by recognizing and being responsive to the abuse that patients have.

Additionally, survivors of intimate partner violence and sexual assault are at higher risk for unintended pregnancies and sexually transmitted infections.² A 2010 survey conducted by the National Hotline on Domestic Violence found that 25% of callers who could get pregnant³ said that their partner or ex-partner attempted to control their reproductive health by coercing or pressuring them to become pregnant.⁴ The healthcare system can play an important role in patient education, assessment, intervention, and prevention of reproductive coercion, an often undetected form of victimization.

The Reproductive Coercion Prevention and Response Project at the South Carolina Coalition Against Domestic Violence and Sexual Assault (SCCADVASA) seeks to improve collaboration between healthcare systems and domestic and sexual violence services to increase access to healthcare services, including emergency contraception, after coercive sex, sexual assault, or relationship abuse and increase access to community-based sexual and domestic violence support services. Addressing these issues in both healthcare settings and community-based organizations will contribute to overall health and safety, and will decrease unintended pregnancy in South Carolina.

From April through October 2018, SCCADVASA engaged physicians, nurses (NP & RN), contraceptive coordinators, and community health workers throughout the state in surveys and interviews. The following is a report of what we learned from those healthcare providers, a summary of strengths of current practices, opportunities for growth, and, where noted, additional input from community-based domestic and sexual violence service providers. SCCADVASA would like to thank everyone who participated in the interviews and surveys, who shared their knowledge and insight, and who showed their investment in these issues. Each person who contributed to this project demonstrated a sincere commitment to the wellbeing of patients and survivors. We would also like to thank the New Morning Foundation, whose financial support made this project possible.

¹Retrieved from <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf> November 14, 2018.

²Chamberlain, Linda, PhD, MPH & Levenson, Rebecca, MA (2013). *Addressing Intimate Partner Violence Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings* (Third Edition). Retrieved from Futures without Violence website: <https://www.futureswithoutviolence.org/addressing-intimate-partner-violence/> November 14, 2018.

³The discourse around reproductive rights, intimate partner violence, and sexual violence has historically centered the experiences of cisgender, heterosexual women. Recognizing that reproductive justice and LGBTQ inclusivity are closely intertwined, this report will strive to use gender-inclusive language.

⁴Retrieved from <https://www.thehotline.org/2011/02/15/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/> November 14, 2018.

“We are in a unique position to help someone.”

Provider Perspectives on their Role

When asked about screening for reproductive coercion and referring to community based organizations, providers questioned whether it fit into their role. Even when acknowledging the significant health impact of abusive relationships, providers struggle with competing priorities and concerns over becoming “too holistic.”

Embracing Relationship Health as Part of Overall Health

“When you think about your role as a doctor or a nurse you want to think of health as the more holistic, the whole person, so [discussing relationship health] absolutely is an appropriate way to go, but you have to know how to build rapport and ask those questions sensitively, not just assume it’s somebody else’s problem because we know it’s out there and we probably do miss a lot of opportunities.”

Competing Priorities

“If you want to be a holistic healthcare provider, you can add and add and add everything in the world. But that’s not effective always.”

“There’s just so many competing priorities for the bedside nurse and all the people providing care.”

Acute Care Settings – That’s Not Our Role

“We don’t really take ownership of that part of a woman’s health. We’ve had women come in who were stabbed in the belly or who have to be monitored because they were pushed down the stairs. But we’re not there to fix that problem, we just refer to social work. Honestly I don’t know what happens to them from there.”

“In my role in an acute care setting, I don’t open that door in terms of talking about reproductively coercive behaviors unless the patient brings it up.”

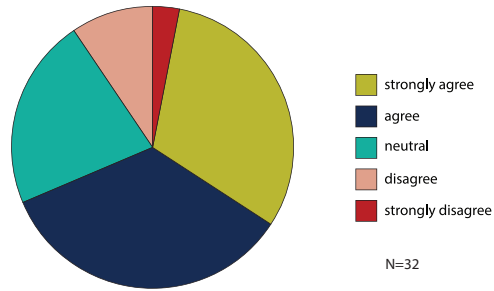
Domestic and Sexual Violence Advocate Perspectives

Discussing Reproductive Coercion and Sexual Abuse

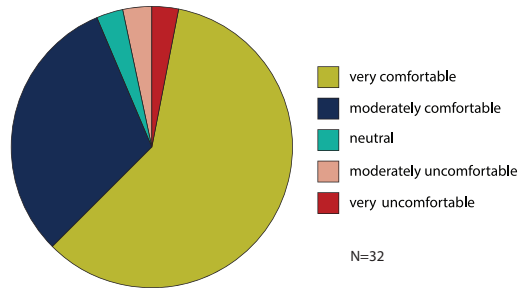
“Sexual coercion or sexual sabotage come up and people say things like, ‘My boyfriend flushed my pills down the toilet,’ or, ‘My significant other has not been wanting to use condoms,’ or, ‘I believe someone sabotaged my condoms.’ People will say, ‘That happened to me and I didn’t even realize it until you just told me about it right now.’ They’ll say, ‘That happened to me and as a result I have five kids.’”

“Clients don’t always realize sexual abuse is a thing, especially when it relates to an intimate partner relationship. A lot of times we think of strangers and rape. We don’t think our boyfriends, our husbands, our girlfriends, our wives can do these things.”

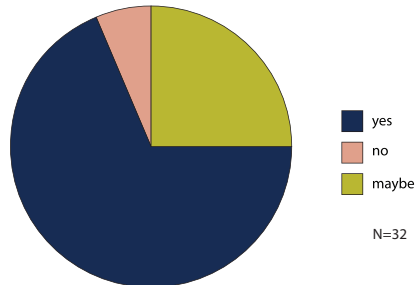
Q. "Addressing relationship health, including reproductive coercion, with patients is a priority for my department or clinic."



Q. "Do you personally feel comfortable discussing a client's unhealthy or abusive relationship?"



Q. "Would a client coming in for services be engaged in any conversation about relationship health with you or another staff member?"



Patient Factors and Barriers to Care

Healthcare providers observe numerous barriers keeping patients from accessing appropriate healthcare. These barriers are exacerbated by power dynamics within intimate partner relationships, community dynamics, and the limited ability of systems to respond to reproductive coercion and abuse.

Socio-economic Status or Lack of Insurance

“They don’t have free access to funding because the power broker in the relationship is keeping all the money.”

“Thinking of women I serve that are low income, mentally ill, have addiction, have financial issues, don’t have cars... [They are] in crisis mode, living day to day.”

“One client found out a partner was cheating on her, confronted him about it, and he broke her jaw in two places. She went to get health care and did not have insurance, so she was only given Tylenol and sent home. When she went home again, her partner raped her and she got pregnant.”

Language and Migration

“Migrant seasonal farmworkers, Spanish speaking patients, immigrants who may not be documented. [The] nature of being transient creates a feeling of inability to reach out to any law enforcement. They [lack the ability] to speak [English] and we suspect their partner restricts them from learning the language.”

Culture

“In some populations, there is a cultural expectation of women in the family role. They [are expected] to have children [and to] have children consistently. [Many of them are] discouraged from using contraception and [their] spouse[s] have a say in the use. We have clients who don’t proceed with getting it [contraception] because of spouse or family’s expectations.”

The Nature of Abuse Makes it Difficult to Address

“By the nature of what the concern is, it’s difficult to validate.”

“I don’t know that I’m always aware it’s going on.”

Domestic and Sexual Violence Advocate Perspectives

Barriers to Accessing Healthcare

“Because communities are so tight-knit and they know [local health care providers] might go to church with them, their children might go to school together... Feeling like my provider will know too much about me if I talk about this.”

“Overall knowledge of what’s out there. A lot of clients don’t know what’s in their own community.”

“Transportation is a barrier.”

“A lot of clients we serve don’t have insurance, so it’s unlikely they would follow up with primary care unless there was a pregnancy involved.”

Screening and Educating Patients, Regardless of Disclosure

Some providers screen for relationship abuse or discuss relationship health with all patients, while others do it only in certain situations. Methods range from using established screening tools,⁵ such as HARK,⁶ to more open, informal discussion. Universal education and/or screening⁷ is the recommended best practice. Universal education, in particular, allows providers to support all patients without the patient needing to disclose abuse. This can be done with a tool such as the CUES⁸ intervention. By starting the conversation, healthcare providers open the door for patients to seek help even if it happens at a later visit. Posters or other printed materials can be a useful supplement or starting point, especially for providers who are concerned about the time it would take to have a discussion.

Universal Discussion

“We always include that information and make it as if it’s a general part of our conversation so the patient doesn’t feel targeted and the [partner] in the room doesn’t feel targeted. We don’t want them to shut down because they feel like we may know something they didn’t tell us.”

“Just because we don’t think they’re going to admit to it doesn’t mean we don’t ask and don’t give information.”

“We keep sexual violence hotline numbers in the restroom so patients can see it when they’re hopefully by themselves.”

“We’re always giving information whether we think they’re going to act on it or not. You might not tell me today and that’s fine.”

“In our Nurse Practitioner program, that is part of the health visit, all NP students are required to talk about that and screen for it.”

Situational Discussion

“As a general rule we don’t currently screen. It only comes up as part of the conversation when the provider is picking up on something.”

“Many of them [adults] I’ve been taking care of for a long time and I probably in my brain assume that everything is remaining okay.”

“It depends on the way client presents to me. Mood changes with discussion of contraception or sexual activity. During exam not responding to me in the way that I expect. Or physical exam findings.”

Domestic and Sexual Violence Advocate Perspectives

Getting Time Alone with Patients

“The perpetrator typically comes to the doctor’s office, so I’ve encouraged OBGYNs to find some time to speak directly alone with the patient, even if they have to excuse the partner to do a urine sample [with the patient]. They have to get them separated at least long enough to ask if they’re safe, if they’re ok.”

Nuances of Asking About Abuse and Trauma

“Sometimes providers ... are not empathetic. They’re very by-the-book and instead of building rapport they just go through the questions. Sometimes there have been cases of victim blaming, especially if the client was open about drug use or alcohol during the time an assault happened.”

⁵Multiple Screening Tools: <https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf>

⁶HARK: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/table/T1/>

⁷U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality

<https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/partnerviolence.html> December 3, 2018.

⁸CUES: <https://ipvhealth.org/health-professionals/educate-providers/#>

Responding to Suspected or Disclosed Abuse

When asked how their healthcare recommendations would be impacted if they knew or suspected a patient was experiencing abuse, providers emphasized continuing to center the patient's autonomy and decision-making at all times. They also discussed strategies to support a patient desiring contraception while in an abusive or coercive relationship and ways to ensure the patient could access contraception with less risk of interference from an abusive partner. Many providers also expressed a gap in their knowledge of other resources and support systems they could offer patients to address the abuse itself.

Finding Workarounds for Contraceptive Access

"Patient asked me to speak to her husband and explain other benefits of the IUD beyond contraception and not mention that it was a contraceptive tool, just that it would help the dysmenorrhea that she had."

"I know some patients might want to get Paragard [copper IUD] because it's important to keep getting their period every month so partner won't know she is trying to prevent pregnancy. In one instance, staff figured out a way to keep it secret and make sure to get the IUD inserted after delivery without partner knowing."

Unsure About Next Steps

"The 'what next' is why people are hesitant to perform the screening."

"Couldn't even tell if she's interested in leaving the relationship. When someone is having a baby it's not first thing on their mind to get rid of partner, even if they are abusive. I don't know. But I don't know what they would be needing."

"If a situation came up, we'd be looking for that resource [in the moment]."

Continual Respect for Patient Autonomy

"We're careful with it because we don't want to push anyone away. Know that first time someone experiences domestic violence is not necessarily the last time, so we don't want [them] to feel pushed into doing anything."

Contraceptive Care that is Responsive to Needs

"If they don't want to leave the situation, we could still help them with contraceptive tools and refer to a counselor."

Connecting with Local Service Providers for Referrals

Healthcare providers value the relationships they have established with community-based domestic and sexual violence services, but many providers expressed a need to establish or strengthen those relationships and increase their own knowledge of community-based services in order to better support patients. Domestic and sexual violence advocates expressed a similar desire to build relationships with healthcare providers and increase capacity to guide clients through accessing appropriate healthcare services.

Established Relationships

“We are able to refer to [the domestic violence organization] and they also refer to us from their shelter. We have regular in-services with this organization so we’re kept abreast of changes in their organization and they know about us as well.”

“I have no barriers to making referrals with some organizations because of personal connections inside the organizations. I know their direct phone numbers.”

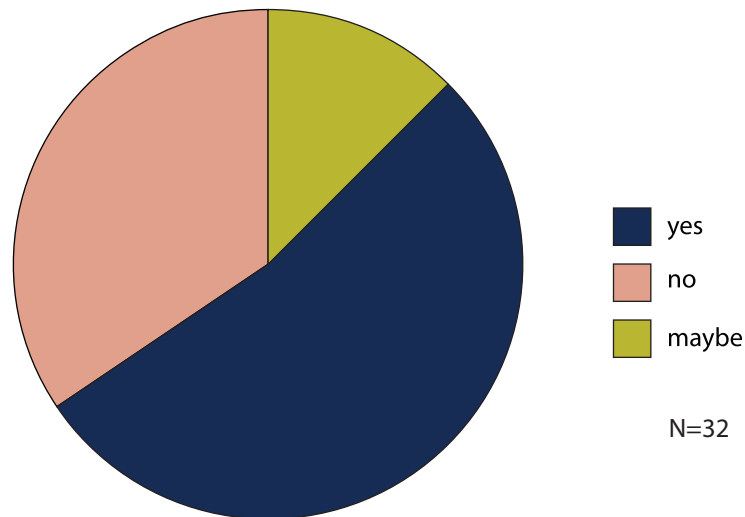
Limited Knowledge of Local Resources and How to Access Services

“I know about them [the local sexual violence organization], but I don’t even know where patients go to access services.”

“I need information about how patients access the system, how hard is it to get a patient in [to the local sexual or domestic violence organization], who pays for the visit, how does that work, are there patients they don’t see, is there an age limit, is there a place of residence...”

“We need more inter-facility talks.”

“Do you have an established relationship with any sexual or domestic violence organizations in your community?”



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Domestic & Sexual Violence Advocate Perspectives

Need for Stronger Relationships

"We offer a lot of trainings. It could be difficult for nurses to come because we provide trainings during our office hours."

"If they would be more present in things that we offer or more inviting to us coming as opposed to just in response to a call [for sexual assault crisis response]."

Preparing Clients

"Could we prep clients for questions they'll have to answer [at a medical visit] so it won't be as traumatic for them? Figure out what they [healthcare] will need so we can make that process easier for a client."

"Educating the victim so they themselves will know how to access healthcare. We are still there as a support system for them and help guide them through the maze."

"Our safety plan asks if you have a doctor that you are comfortable sharing that information with. And then we go over what that may look like and how that may be beneficial."

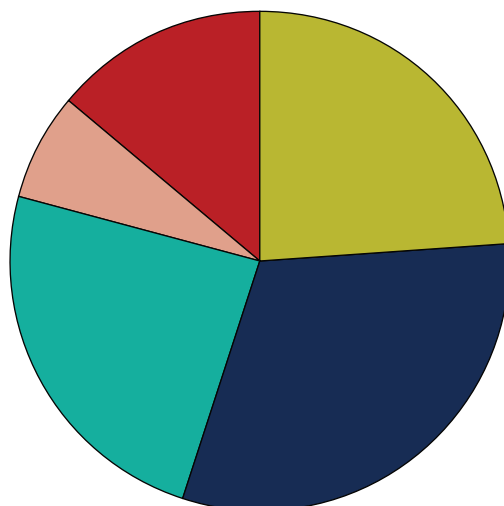
Improved Collaboration

"Our relationship could be strengthened. We could find out what their concerns are. There may be things where they don't understand our protocols as an agency and all that we're capable of doing in terms of assistance and vice versa."

"If our agency could train [healthcare staff] what to look for. From the nurse to the person that checks them in and even those 'docs in a box,' everyone needs to know. Ideally nobody is held back from recognizing some type of trauma."

"Maybe schedule a time and take lunch and sit down and talk with that healthcare provider and let them know what we're trying to do and let them know what we're dealing with in the community – individuals that they serve – so that they can be more vigilant regarding trauma of any kind."

"How confident do you feel that healthcare providers are giving survivors valuable information about reproductive healthcare that takes into account their situation and any abuse they have experienced?"



- very confident
- moderately confident
- not very confident
- not at all confident
- I don't know

N=29

Emergency Contraception Access

Health care providers understand that offering emergency contraception (EC) will help patients who are victims of reproductive coercion to have more control over their reproductive lives. The most common types of EC are Plan B/Next Choice (over-the-counter), Ella (by prescription only), and the Copper IUD.

Pro-Universal Education

"It's part of our regular encounter with teens. We talk about EC, we give out a prescription [if needed based on age], we tell them how to use it, how effective it is. We tell them it's not sitting out there, you've got to go up to the counter. We tell them all that so they can be prepared."

"We give all teens a prescription for EC, even if they don't need it. We kind of like for them [16+ year olds] to take it because we think it reminds them. It's a little reinforcement that hey, if I need it, I know I have it."

Desire for Increased Access

"Plan B over the counter, they have to ask the pharmacist for that. That needs to go away. It's so humiliating and embarrassing from the get-go and then they have to ask someone to give it to them. That law needs to change. And then some pharmacists don't even have to give it based on their feelings and culture. That's totally wrong. This should be patient-driven, based on their need, so they can just get it over the counter like they would get Tylenol."



Domestic and Sexual Violence Service Provider Perspectives

Healthcare providers supported the idea of making over-the-counter EC available in community organizations such as domestic violence shelters and sexual violence organizations. We asked domestic and sexual violence direct service providers whether they thought making over-the-counter emergency contraception available as needed would be a possibility for their organization.

Responses from domestic violence organizations (services include emergency shelter):

- Five providers (38.5%) said yes, they would consider adding it to their shelter medication policies.
- Two providers (15.4%) said no, they would not consider including emergency contraception in their policies.
- Six providers (46.2%) responded that they were unsure.

Responses from sexual assault organizations (community-based services only):

- Three providers (18.8%) said yes, they would consider making over-the-counter emergency contraception available in office.
- Seven providers (43.8%) said no, they would not make OTC emergency contraception available to clients coming into their office.
- Six providers (37.5%) were unsure.

The number of domestic and sexual violence service providers who were open to or unsure about including a policy for emergency contraception access suggests that further discussion and cross training between healthcare experts and domestic and sexual violence service providers could be beneficial for exploring the possibilities of this access point.

Negative Responses: Legal/Liability

"I have no personal reservations other than concern about side effects they might experience and hold us responsible for."

"Due to liability issues, we would probably refer them to the health department for services."

"As a state employee in the position of case manager it would all depend on South Carolina Legislature or heads to set such policy."

Negative Responses: Lack of Medical Expertise

"Not being a medical facility nor having a medical background would make me feel uncomfortable with giving out such over-the-counter medication."

"No personal reservations but unsure about guidelines about giving medication (specifically Ella which requires a prescription) in a non-medical setting. We usually send folks for a sexual assault forensic exam if they need those type of services post assault."

"We are not physicians. If it is needed we would refer them to a resource that can provide that."

"My hesitation is I would want to think in more detail about the logistics of this, needs of having a medical provider to guide us in how to do this safely and if we have the needed funds and infrastructure."

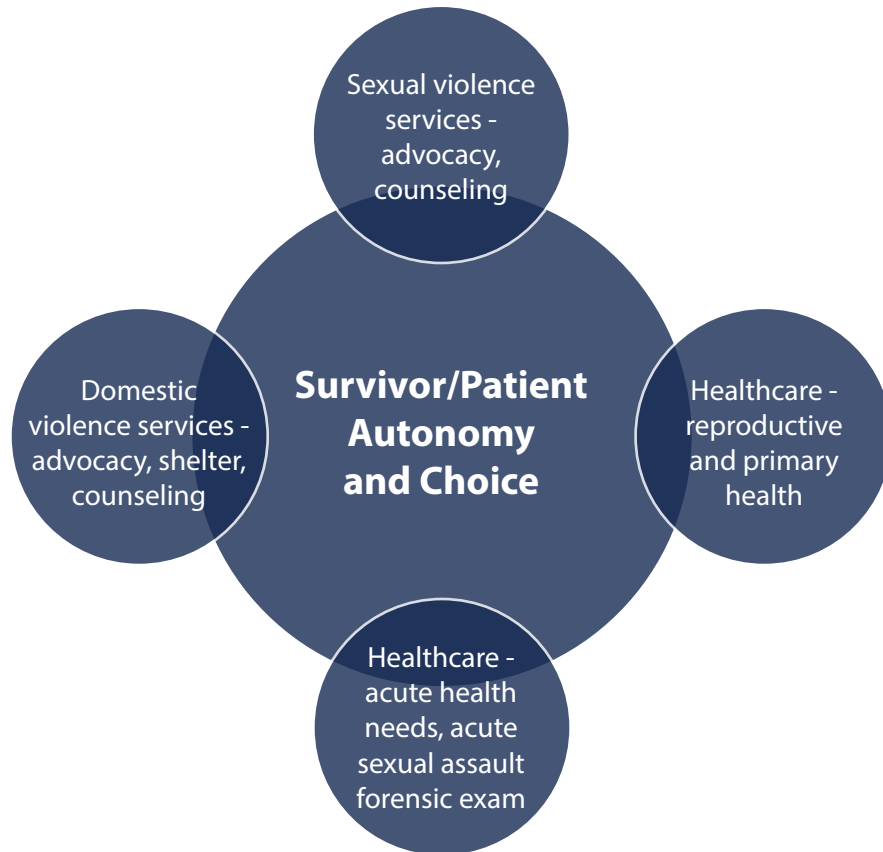
Positive Response-Universal Access

"We provide OTC medications as a way to remove barriers for our clients who may not be able to access them due to transportation or safety issues. If a client were requesting that type of medication specifically, our refusal to provide it would seem, to me, to be based on staff's feelings about that particular medication vs. the client's needs. If we are going to provide some OTC medications we should provide access to all."

"For example, we may not always have OTC allergy medication on hand but if a client requested it we could provide it, so while we may not keep OTC emergency contraception on hand, if a client requests it we should similarly provide it. OTC medications are intended for people to be able to access and make decisions about taking without interference and I do not see it as our role to make a medical decision."

Recommendations

During the interviews and surveys, healthcare providers and domestic and sexual violence advocates emphasized the importance of patient or survivor autonomy and centering the individual's needs and choices. This shared philosophy provides a starting point for collaboration. SCCADVASA also recommends approaching this work from a trauma-informed framework that emphasizes the human right to autonomy, prioritizes meaningful access to care, and centers marginalized communities to address intersectional forms of oppression.



Strengthening relationships between healthcare services and domestic violence and sexual assault organizations will equip healthcare providers with the tools to support patients, refer patients to community resources, address relationship health as a key factor in overall health, and better empower patients to autonomously make decisions about their reproductive lives. Domestic and sexual violence organizations will also be able to effectively guide survivors through healthcare systems and confidently refer to healthcare providers who are responsive to the specific health needs of survivors. SCCADVASA will continue to support collaboration between healthcare providers and domestic and sexual violence agencies through ongoing projects such as this one, training, and technical assistance.

To learn more, request resources or training, and connect with your local domestic and sexual violence organizations, contact SCCADVASA:

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