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IPV and Sexual and Reproductive Health

Presentation to NYS DOH Family Planning Programs January 30, 2019

About OPDV

- The Office for the Prevention of Domestic Violence (OPDV), created in 1992, is the country's only executive level state agency dedicated to the issue of domestic violence. OPDV is located in Albany, New York.
- OPDV has three primary areas of focus:
  - advise the governor and legislature on policies and practices for NYS;
  - train NYS professionals from all areas about the intersection of domestic violence in their daily practice;
  - serve as a resource regarding the issue of domestic violence by disseminating regular public awareness campaigns, publishing materials for use by non-profits and victims, and highlighting best practices.

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Mission and Vision

- Mission
  - To improve New York State's response to and prevention of domestic violence with the goal of enhancing the safety of all New Yorkers in their intimate and family relationships.
- Vision
  - To create a State in which communities and systems are committed to supporting and promoting equality, dignity and respect so that individuals can feel safer in their intimate and family relationships.

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Learning Objectives

- After this webinar, participants will be able to:
  - Define intimate partner violence
  - Discuss the impact of IPV on reproductive and sexual health
  - Define reproductive & sexual coercion
  - Identify the intersections of Family Planning and IPV
  - Describe possible elements of a safety plan
  - Discuss the importance of screening for IPV
  - Identify strategies for collaborating with domestic violence service providers

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Intimate Partner Violence:

A. Can be present in the absence of physical violence
B. Is not gender specific
C. Can be present in adolescent relationships
D. Is under reported
E. All of the above

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What is Intimate Partner Violence?

A **pattern** of **coercive tactics,** which can include physical, psychological, sexual, economic and emotional abuse, perpetrated by one person against an intimate partner with the **goal** of establishing and maintaining **power and control** over the victim.

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Intimate Partner Violence

- Coercive
- One-sided
- Ongoing
- Severe
- Escalates
- Imbalance of power
- Desire to dominate and cause fear

Intimate Partner Violence

- Powerful single physical event or repeated, prolonged, chronic abuse
- Subjective experience
- Circumstances often include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, loss
- Complicated mix of biological, psychological and social phenomenon

Tactics of Power and Control

- Threats, Coercion and Intimidation
- Minimization, Blame and Denial
- Using Children
- Emotional Abuse
- Economic Abuse
- Reproductive Coercion
- Stalking
- Physical and Sexual Violence
- Isolation
- Privilege
- Technological Abuse
- Spiritual Abuse

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Statistics

- For 4 in 10 women who obtained care at a family planning center specializing in the provision of contraceptive care, that center was their only source of health care
- More than one-half (53%) of women seen at FPC reported physical or sexual IPV.
- More than one in three women in the United States have experienced rape, physical violence or stalking by an intimate partner in their lifetime
- One in three adolescents in the U.S. is a victim of physical, sexual, emotional or verbal abuse from a dating partner

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The Impact of IPV on Sexual and Reproductive Health

Family Planning Program Clinicians are in a Unique Position to:

A. Screen for IPV
B. Offer ongoing support to victims of IPV
C. Make referrals to IPV hotlines and services
D. All of the above
E. None of the above

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Reproductive & Sexual Health

- Women who have experienced IPV are consistently found to have poor sexual and reproductive health when compared to women who have not experienced IPV
- Nearly half (45.9%) of women experiencing physical abuse in a relationship also disclosed forced sex by their intimate partner

Sexual Abuse

- Almost 1/5 young women ages 18-24 have experienced forced sexual intercourse
- Women of reproductive age particularly those between the ages of 16-24 are at greatest risk of sexual coercion and violence
- 40% of pregnant women who have been exposed to abuse report that their pregnancy was unintended
- Women disclosing physical violence are nearly three times more likely to experience a sexually transmitted infection than women who don't disclose physical abuse

IPV is Associated with:

- Poor sexual and reproductive health
- Women not using their preferred contraceptive method
- Coerced pregnancies
- Repeat/coerced abortions
- Sexually transmitted infections including HIV/AIDS

Poor Pregnancy and Infant Health Outcomes

- Late entry into prenatal care
- Miscarriages and stillbirths
- Premature labor and birth
- Low birth weight or small for gestational age infants
- Fetal injury
- Maternal mortality

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Reproductive and Sexual Coercion

Examples of Reproductive Coercion Include:

A. Expressing the desire to have a baby with your intimate partner
B. Telling an intimate partner you aren't ready for a baby
C. Telling an intimate partner she has to have an abortion
D. Hiding or destroying an intimate partners birth control pills
E. C and D
F. All of the above

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Reproductive and Sexual Coercion

- Behavior intended 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.
- This behavior includes:
  - explicit attempts to impregnate a partner against her will
  - control outcomes of a pregnancy
  - coerce a partner to have unprotected sex
  - and interfere with contraceptive methods

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Reproductive & Sexual Coercion

- May occur in the presence or absence of physical or sexual violence
- Often intersects with STI & HIV diagnosis, transmission, treatment and partner notification
- May involve birth control sabotage
- May include coercion to be pregnant or terminate a pregnancy
- May include coercing an intimate partner to have unprotected sex
- May include abortion disclosure

Reproductive & Sexual Coercion

Reproductive control classifications based on various stages of the sexual relationship:

- Before sexual intercourse (pregnancy promotion, contraceptive sabotage)
- During sexual intercourse (sexual violence, condom manipulation, contraceptive sabotage)
- Post-conception (controlling pregnancy outcome, interfering with healthcare)

Reproductive and Sexual Coercion in LGBT Relationships

An Abusive Partner May:

- Threaten to “out” victim
- Tell their partner that police and counselors are homophobic
- Threaten to alienate their partner from the gay community
- Make them feel bad about their sexual orientation, sexual history or gender identity
- Monopolize resources
- Portray the violence as mutual
- Discourage seeking reproductive health services

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Intersections of Family Planning and IPV

A person may intentionally expose their partner to HIV or an STI as a tactic of IPV

A. True

B. False

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Opportunities for Intervention

- Unexpected pregnancy
- Pregnancy termination
- Positive STI or HIV tests
- Screening for IPV
- Request for birth control
- Observing controlling or abusive behavior
- Patient mentioning partner or relationship

STIs and IPV

- Female victims of IPV have a higher STI prevalence
- Female victims of IPV have a higher prevalence of STI risk behaviors
- IPV should be addressed in STI prevention messaging
- Abusive partners may intentionally expose their intimate partners to STIs
- Abusive partners may refuse to practice safe sex
- Abusive partners may threaten to harm or harm their partner if notified they have a STI
- Victims of IPV may fear telling their abusive partner that they have a STI
- Victims of IPV may feel unsafe to negotiate safe sex practices

HIV and IPV

- The causes of death for the HIV-positive women are both AIDS-related and non-AIDS-related
- Abuse at any point in a woman's life may hurt her ability to getting screened, begin HIV treatment and to take her medications as needed
- Violence and fear of violence can impede an abused partner's ability to negotiate safe sex behaviors such as condom use or refusing sex
- IPV can also be a precursor to engaging in sexually risky behaviors which in turn increases the risk of HIV infection.
- Having HIV may increase the risk of abuse

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Contraception and IPV

- Birth control sabotage
  - Hiding, withholding or destroying oral contraceptive
  - Removing or poking holes in condoms
  - Removing vaginal rings, IUDs and contraceptive patches
  - Not withdrawing when that was agreed upon birth control method
- Refusing to practice safe sex

Case Study: Teen Dating and Reproductive Coercion

Sondra is a 17-year-old high school student. During her appointment, you ask her about how satisfied she is with her current birth control method and what's important to her in a method. She says she is on "the pill" but wants to know if she can get something else. "My boyfriend sometimes hides my pills. I think he wants me to get pregnant 'cause I plan to go away to college next year after I graduate, and he doesn't want me to go." She also discloses that he doesn't hit her, but he screams at her, pushes and shoves her sometimes, throws things, and has kept her from leaving when they are fighting. **What do you say?**

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Pregnancy and IPV

- Many studies find that 3% to 9% of pregnant women are abused
- Rates go up as high as 50% in young, single, minority, low income mothers
- Studies show that IPV is more prevalent in homes where there are young children

Pregnancy

Victims of IPV report:

- That their abusive partners limited their ability to choose whether or not to have children
- That their abusive partners use coercive tactics to get them to have children
- That they underwent sterilization in response to the abuse
- Contradictory behaviors by their partners around family planning, such as not allowing birth control, then demanding that the participant terminate the pregnancy

Case Study: Unintended Pregnancy

Sally has been coming to the FP clinic for over a year. She is on oral contraceptives. She has confided that her boyfriend refuses to use a condom. When you tell her that her pregnancy test is positive she begins to cry and tell you how angry her boyfriend will be. She is visibly shaken and keeps saying “He is going to kill me.” **What do you do?**

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What Can Health Care Providers Do?

By assessing for reproductive control among women seeking reproductive health services, health care providers may be able to provide:

- Education
- Care
- Referral
- Counseling to help women protect their reproductive health and physical safety.

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Safety Assessment and Safety Planning

Assessing for Safety

- Safety must always be first priority
- Safety must be considered in every interaction and decision
- Safety is not only for the victim, but for the children, relatives, caregivers and offender
- Safety of the case manager, home visitor, and therapist must also be considered

For Safety Purposes

Don't:

- Interview potential victim in presence of possible abusive partner
- Interview potential victim in front of their children
- Disclose information the victim or children shared with you to the abusive partner
- Make assumptions about victim's or abusive partner's behavior

Do:

- Keep safety as priority
- Know and take seriously the fears and concerns of the victim
- Provide referral to domestic violence services
- Respect victims' wishes and allow them to make decisions
- Tell victims about confidentiality and the limits of confidentiality

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Assess Patient Safety & Refer

- Conduct quick assessment of safety
- Encourage patient to contact their local domestic violence service provider
- Ensure access to a private telephone
- Offer materials after discussing safety issues

What is a Safety Plan?

Personalized, practical tool that can help a victim prepare for and respond to dangerous situations

Can help with:

- Identifying options
- Preparing for crisis
- Reducing harm
- Planning to leave or separate from partner
- Remaining safe after leaving
- Planning to stay with an abusive partner

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Safety Planning

- Discuss barriers to safety
- Encourage telling others and asking for help
- Discuss what has been done previously to stay safe and reduce harm
- Help identify who has helped in the past, who can help presently and in the future
- Help identify safe place to go in an emergency situation
- Identify safe place to hide extra keys, documents, medications and money

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Case Study: Immediate Danger

Aisha is a 32-year-old female in to see you for a well-woman exam, to remove her expiring IUD and have a new one inserted. When you examine her, you see visible bruising on her upper arm and back. When you ask her about it, she immediately tears up and looks away. After you give her some time, and tell her you're there for her...she admits that her boyfriend gets rough with her sometimes. "He has a temper, and he works really hard... just gets really stressed out sometimes." You ask her if she feels safe right now. "Not really. I know it's not right. And, I want to leave, but every time I do he finds me and makes me come back home. He finds me at work. He came and got me from my sister's. I know it's not right...but I don't know what to do. I'm scared." **What do you say?**

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Screening

IPV screening:

A. Is recommended by most major medical organizations
B. Should only be done one time
C. Should not be done in front of the patient's friend
D. Should not be done because it may embarrass the patient
E. A and C
F. B and D
G. None of the above

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Screening for IPV is Recommended by:

- The Institute of Medicine
- Joint Commission
- American Medical Association
- World Health Organization
- American College of Obstetricians & Gynecologists
- American Academy of Pediatricians
- American Nurses Association

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Why is it Hard to Ask?

- Lack of time and training
- Lack knowledge about IPV and feeling inadequate to address
- Lack of knowledge of services available
- Don’t want to offend/shame/embarrass patient
- Frustration due to expectation that victim should leave abusive partner
- Afraid will make situation worse or patient will stop coming
- Presence of abuser at appointments

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Universal Screening

“Because intimate partner violence and abuse are so common, we screen for it routinely.”

Asking this question at each interaction with patients eliminates the discomfort of being singled out.

Case Study: Screening & Privacy

Estelle is with her boyfriend when you call her back from the waiting room. As she stands up to come back, her boyfriend stands up and follows her - she turns around and says something to him (suggesting she doesn't want him to come) but he keeps following her. **What do you say?**

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RADAR

Routinely screen patients

Ask direct questions

Document your findings

Assess patient safety

Review options and referrals

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Routine Screening

- Screen privately
- Convey a concerned and respectful attitude
- Assure confidentiality
- All female patients should be screened

Ask Direct Questions:

- Are you being threatened or hurt by anyone?
- Sometimes patients tell me their partners have hurt them. Is this happening to you?
- Are you in a relationship where you get hit, punched, kicked or hurt in any way?
- Do arguments ever end in your partner pushing, shoving or slapping you?

Documentation

- Can be critical later to access other systems
- Can establish a pattern of violence
- Can be used in:
  - Civil protection order proceedings
  - Criminal prosecution
  - Custody and visitation disputes
  - Eligibility for waivers and services

Offer Positive Messages - ABCD

- “You are not **A**lone.”
- “You are not to **B**lame for things your partner does.”
- “You are not **C**razy.”
- “You don’t **D**eserve to be treated this way.”

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Successful Screenings

Inform patients that:

- abuse in relationships is common
- no one deserves to be abused
- they are not alone
- it is not their fault
- resources and support are available
- you care about their safety and well-being
- the FPP program is a safe place

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Successful Screenings

Do not require:

- getting victims to acknowledge abuse
- getting victims to leave their abusive partner
- getting victims to call the hotline

Planting a Seed for Change

Ask about IPV to:

- Educate patients about IPV and health impacts
- Let patients know they can come to you about issues in their relationships
- Develop trusting relationship with patient
- Uncover abuse
- Improve safety
- Understand underlying causes of symptoms and behaviors

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Trauma-Informed Care and Settings

- Display posters and pamphlets that give message this is is a safe place to talk about IPV
- Assume you may be serving an IPV victim
- Provide tangible resources other than shelter referral
- Implement policy that requires some private time with patient

Self-Determination

- Allow victims to determine their goals
- Offer choices
- Empower victims to make decisions
- Ask victims: “How can I be helpful?”
- Say to victim, “it sounds likes its been scary, frustrating, exhausting” “you have made the best decisions under difficult circumstances”

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Working with Domestic Violence Service Providers

Family Planning Programs should:

A. Create an environment where patients are more likely to talk to their health care provider about their intimate relationships
B. Convince an IPV victim to leave their abusive partner
C. Build partnerships with Domestic Violence Services to enhance patient safety
D. None of the above
E. All of the above
F. A and C

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Domestic Violence Prevention Act & Laws

- Every county provides a domestic violence program
  - Residential
  - Non-residential services
- Victims can access shelter in any county
- Confidential shelter locations
- Intake prior to admission to a shelter

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Domestic Violence Prevention Act (1987) Core Services

- Emergency shelter
- 24-hour hotline
- Information and referral services
- Support groups
- Community education/outreach
- Counseling
- Children's services
- Medical services
- Transportation
- Follow-up
- Advocacy

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Accessing Domestic Violence Services

NYS Hotline 1(800) 942-6906

NYS Office of Children and Family Services list of IPV programs by county: http://ocfs.ny.gov/main/dv/dvList.asp

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Collaborate with DV Service Providers

- You don’t need to be the domestic violence expert
- 24-hour assistance is available
- Partner and build good, strong working relationships prior to crisis situations
- Fostering relationships

Benefits of DV and FPP Collaboration

- IPV clients timely access to FPP services
- FPP clients timely access to IPV services
- Client and patient safety and well-being is enhanced

How to Build Relationships with DV Service Providers

- Attend task force meetings
- Cross train with local DV service providers
- Call/stop by and introduce yourself to program managers and staff
- Offer to attend a DV program staff meeting and present on your programs and services
- Look for DV program staff at meetings and trainings and introduce yourself

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Case Study: Lack of Rural Resources for IPV

Grace is a 26-year-old stay-at-home mom. She has four children ages 2, 5, 7, and 8 and lives with her husband, a long-haul truck driver, in a small, rural community. When you ask her if she feels safe at home or if anyone hurts her, she tells you she feels safe when her husband isn't drinking, and when he is, she just tries to stay out of his way. "Where would I go? Who would take me in with 4 four kids? Who would put up with me when I need help? Nah, I'm good. I'll just lock the door when I need to. I know how to handle him." **What do you say?**

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Thank you

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Important Links and Numbers

OPDV website: www.opdv.ny.gov

Website for teen dating violence: www.ny.gov/datingabuse

NYS Domestic and Sexual Violence Hotline: 1-800-942-6906

Confidential ● 24 HRS/7 DAYS
English & española, multi-language accessibility
711: Deaf or Hard of Hearing
In NYC: 311 or 1-800-621-HOPE (4673)
TDD: 1-800-810-7444

OPDV phone number: (518) 457-5800

Facebook page: www.facebook.com/NYSdomesticviolence

Twitter handle: @NYSOPDV

Instagram handle: @NYSOPDV

YouTube page: www.youtube.com/NYSdomesticviolence

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