

Violence Prevention: Rethinking the Standard of Care for Family Planning

Policy Brief

For more than a decade, public health policies have been enacted to reduce health disparities in communities of color. Much progress has been made in recent years, yet disparities persist, particularly among Latinos. In 2009, The Family Violence Prevention Fund (FVPF) began a project aimed at reducing health disparities among Latinas by addressing the contributing factor of exposure to violence.

Domestic violence impacts all communities, regardless of race or economic status. Approximately 1 in 4 women report ever having experienced physical or sexual violence by an intimate partner¹. We know that exposure to violence can lead to poor physical and mental health outcomes, including increasing risk for sexually transmitted diseases and unintended pregnancy – and that the health consequences commonly associated with abuse disproportionately impact women of color. Raising awareness about violence as a common denominator of poor health outcomes is the first step in changing social norms and ultimately improving the health of Latinas in California.

The Promise of Family Planning in Violence Prevention

While many women may never seek services from a domestic violence center, they are very likely to need and seek reproductive health care, providing family planning providers a unique opportunity in screening for intimate partner violence. In fact, clients seeking reproductive health services are more than twice as likely to report intimate partner violence than the general population². In a recent study, over half of all women visiting a family planning clinic reported experiencing violence in an intimate relationship at least once in their lifetime³.

Family planning clients are more than twice as likely to report intimate partner violence than the general population.

There are 20 years of research connecting intimate partner violence (IPV) and control to poor reproductive health outcomes. Women experiencing intimate partner violence are more likely to have intercourse at a young age⁴, report not using their preferred method of contraception in the past 12 months (including condoms)⁵, are more likely to have unintended pregnancies and sexually transmitted diseases⁶.

Over the past 10 years the FVPF has been partnering with leaders in the field of academic medicine and reproductive health experts to better understand how to accomplish two goals simultaneously—improve

Policy Recommendations

✓ **Integrate**

Integrate proven interventions into clinical practice.

✓ **Educate**

Support providers by making education and training widely and easily accessible.

✓ **Communicate**

Engage community health workers, promotoras, and other partners to raise community awareness about intimate partner violence and resources.

women’s safety and their reproductive health. From this partnership, the term “Reproductive Coercion” was developed, to help educate providers and the public about a form of IPV that otherwise may go unnoticed or unspoken. Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health such as explicit attempts to impregnate a partner against her will and controlling the outcomes of a pregnancy.

In 2008 the FVPF partnered with colleagues at Harvard school of public health and Dr. Elizabeth Miller, Principle Investigator of an NIH funded study to develop a brief intervention for improving safety and reducing poor reproductive health outcomes in family planning settings. The intervention showed remarkable success. Women who were asked and counseled about reproductive coercion were 70% less likely to continue to experience reproductive coercion in a relationship and 60% more likely to end a relationship that they newly identified as unhealthy⁷. This was the first study to show that a simple, easily adaptable intervention can significantly reduce the impact of reproductive coercion, which ultimately will lead to a reduction in unintended pregnancy and sexually transmitted infections.

A simple intervention reduced reproductive coercion by 70% and led 60% of women to leave an unhealthy relationship.

Esta Soler, Founder and President of the Family Violence Prevention Fund states: *“We need to build on these results by making this intervention the norm in health care settings throughout the nation as quickly as possible.”*

As the health care system moves toward a culture of prevention, making use of assessment and educational opportunities in reproductive health care becomes an increasingly important approach to reducing the negative health outcomes related to IPV. Given the high rates of abuse reported in family planning settings and the health risks associated with abuse, Reproductive health care visits should be viewed as opportunities to reduce risk for unplanned pregnancy and sexually transmitted infection through violence prevention, not just to dispense contraception and screen for sexually transmitted disease.

During a stakeholder interview for this project, Laurie Weaver, Chief of the California Office of Family Planning describes the promise of family planning in reducing intimate partner violence. *“It’s more than just about the consequences of unprotected sex. It’s about support for having a healthy relationship, a move to safety.”*

Policy Recommendations

California’s publicly funded family planning program (Family PACT/FPACT) provides reproductive health services to approximately 1.6 million men and women each year. With a network of over 3,200 public and private providers, including community clinics and school health centers, this successful public health program serves as a model for the nation. The majority (88%) of Family PACT patients are women and all have incomes at or below 200% of the federal poverty level. Approximately 64% of Family PACT clients are Latino and almost half speak Spanish as a primary language. While the State of CA leads the nation overall in the most effective programming to reduce unintended pregnancies—the data demonstrates a need more tailored efforts among three vulnerable groups-- foster youth, victims of domestic violence and Latinas. Efforts to improve reproductive health outcomes of Latinos in California must necessarily include Family PACT and its network of providers.

☑ *Integrating Intimate Partner Violence Assessment and Response into Reproductive Health Services*

Family planning providers should be provided with the training and tools to integrate screening for IPV and reproductive coercion as part of the standard of care in their programs. This change requires a multi-level approach: protocol changes, prompts reminding providers to screen and tools to frame questions and integrate them into standardized forms and electronic health records. Making discussions about reproductive coercion part of routine care normalizes assessment and empowers providers and patients to make a connection between exposure to violence and health behaviors and outcomes. In addition, universal screening and education benefits clients who may not be experiencing IPV, but who may be in otherwise unhealthy relationships that might evolve into violence or those who may have friends or family members who are experiencing IPV.

For the past four years, the Family Violence Prevention Fund and the Family PACT program have been collaborating on a project to provide training and resources for providers statewide. Family PACT has integrated FVPF-developed materials into provider trainings, and developed resources for providers and clients that specifically address the interface between IPV and family planning. These include patient information and safety cards, provider webinars and other e-learning tools. In addition, FFACT has begun to encourage the integration of screening questions for IPV and reproductive coercion on their standardized forms and developed a policy for routine screening for forced sex at emergency contraceptive visits.

While much progress has been made to improve training and resources for Family PACT providers, more needs to be done to ensure that family planning providers are equipped to address a key factor in improving reproductive health. First, reimbursement for IPV and reproductive coercion needs to be explicitly allowable for family planning visits. Just as Family PACT reimburses providers for time spent educating patients about contraceptive options, time spent discussing barriers to contraception (such as IPV) is a cost-effective use of resources. *Providers should be made aware that IPV screening is an allowable service during the educational counseling sessions that are currently reimbursable under Family PACT's comprehensive services program.*

Second, integration of reproductive health services and IPV screening needs to be expanded beyond the Family PACT program. The state's Medicaid program (including Medicaid Managed Care) should also revise its policies to ensure that patient seeking reproductive health services, including family planning and prenatal care, are provided the same high quality comprehensive screening and education as those in the Family PACT program. *Medicaid should follow the same policies and standards regarding IPV screening as Family PACT.*

☑ *Policies for Emergency or Long-Acting Contraception*

Family planning providers should develop policies to ensure that clients who are experiencing IPV have ongoing access to information about emergency contraception or long-acting, invisible contraceptive methods. Providing clients with reliable contraceptive choices can diminish the immediate risk of unintended pregnancy so that the provider and the client can then focus on addressing safety and other health risks. *Health plans, including Medicaid, should reimburse for contraceptive counseling and allow providers discretion in dispensing the most appropriate contraceptive option for clients experiencing IPV. This includes removing limits on number of doses of emergency contraception and expanding formularies to include more long-acting forms of contraception.*

☑ Provider Training

Family PACT has integrated modules about IPV and reproductive coercion screening into routine continuing education training available for providers, and developed resources for providers and clients that specifically address the interface between IPV and family planning. These educational sessions provide hands-on tools for providers to screen for IPV and to support clients in making decisions to improve both their health and their safety. Ongoing training of new and existing providers should be standard policy in order to ensure continuity and address new developments in the field. *Adoption of FVPF e-learning activities related to the intersection of IPV and reproductive health outcomes should be mandatory continuing medical education for clinicians providing reproductive health services. Provider trainings should be available in multiple languages and be both linguistically and culturally appropriate to the client population served.*

☑ Community Resources

Community health workers and promotoras can play a key role in addressing IPV by raising awareness and educating about the links between IPV and reproductive health outcomes. These community-based health workers have a variety of titles and roles in the health care system, including peer educator, health advocate, outreach worker, among others. Family planning providers can extend their reach by partnering with or hiring community health workers to provide community-based and prevention-focused care. *Community health worker services should be reimbursed through the outreach and education components of the Family PACT program and should have access to trainings and resources offered to other health care providers.*

Conclusions

A core function of family planning is screening for risk factors that might impede appropriate use of contraception and disease prevention methods. Exposure to IPV and reproductive coercion may be one of the most important risk factors related to reproductive health outcomes and should be integrated into reproductive health care practice in a systematic way. Screening and response to IPV should be a system-wide effort, not delegated to one particular staff person or category. Monitoring of appropriate screening and intervention should be included in standard quality of care evaluations and improvements. Making system changes to address IPV in the reproductive health setting may be one of the most impactful improvements in health care delivery for women.

Making system changes to address intimate partner violence in the reproductive health setting may be one of the most impactful improvements in health care delivery for women.

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