Between June 2012 and May 2013 the Virginia Sexual and Domestic Violence Action Alliance, building on the success of Project Connect1 and in collaboration with the Virginia Department of Health, began a pilot project to develop the capacity of four local domestic violence programs. The pilot focused on increasing screening for reproductive coercion within the context of intimate partner violence and increasing partnerships with local healthcare providers to respond to the related healthcare needs of survivors. The four local shelter-based domestic violence programs participating in the pilot included the Women’s Resource Center of the New River Valley, Empowerhouse in Fredericksburg, The Laurel Center in Winchester, and Transitions Family Violence Services in Hampton.

Overall, the implementation of the pilot was a success. All of the pilot sites reported they benefited from participating in the pilot. The pilot allowed them to incorporate reproductive coercion screening into their standard intake procedures, make overall improvements to their intake process, establish community partners with healthcare providers, and increase access to reproductive health resources that they did not have prior to the pilot.

Lessons learned based on Virginia’s reproductive coercion pilot:

• Prior to pilot, domestic violence program pilot sites had limited or no relationships with reproductive healthcare providers.

• Pilot programs that had baseline knowledge of reproductive coercion and reproductive health were able to modify policies and procedures and increase healthcare partnerships in a shorter amount of time, compared to those who did not have baseline knowledge of reproductive coercion and reproductive health. In addition, programs that were adequately staffed contributed to higher success.

• Pilot programs were more prepared when ALL domestic violence program staff (not just staff responsible for intake) participated in reproductive coercion screening training.

• During the orientation and training phase of the pilot it was apparent that domestic violence program staff was uneasy about asking questions about sexual health and experiences of reproductive coercion. In addition, overall staff knowledge about accurate reproductive health information and comprehensive healthy sexuality was limited.
• When domestic violence program staff experienced positive outcomes as a result of asking survivors about reproductive health, they were more confident in implementing the screening.

• Providing regular opportunity for the pilot sites to discuss the challenges and successes experienced during the implementation increased comfort level with topic and confidence in implementation.

• After the pilot, domestic violence program sites anticipated long term changes with local health care providers and family planning providers – relationships with healthcare workers was key!

• After the pilot, Domestic Violence Program staff are talking more about a variety of health related issues that correlate to intimate partner violence.

**Recommendations based on Virginia’s reproductive coercion pilot:**

1. Assess program capacity prior to implementing reproductive coercion screening. Comprehensive and ongoing training on reproductive health, reproductive and sexual coercion, and appropriate screening that is trauma-informed is essential.

2. Domestic Violence Program staff should practice/role play reproductive and sexual coercion screening to increase individual comfort level with topic.

3. Domestic Violence Program staff should be competent in the following topics: safety planning related to sexual and reproductive coercion, birth control/contraception (including the ability to dispel myths and misinformation regarding available options), sexually transmitted infections - STIs (including prevention and strategies to deal with exposure), and comprehensive healthy sexuality.

4. Domestic Violence Program staff should understand the health care system and have relationships with community health partners, such as family planning clinics, reproductive health care providers and community family planning/home visitation providers.

5. Domestic Violence Programs should establish referral protocols with community health partners that increase the ability to quickly provide the health related service the survivor of intimate partner violence identifies.

**Quotes from Domestic Violence Program pilot sites:**

• “Like others, women seem to respond better to health care providers providing information about health issues than an advocate.”

• “I learned not to worry too much about ‘No’ answers to the screening questions - even when we’re sharing safety card information and they indicate they haven’t experienced sexual coercion, we’re providing education – and they may use it the future.”
• “Having a nurse around (at the Shelter) has opened up so many positive things and more access to health services in the community.”

• “I have found asking screening questions is very valuable. We want to incorporate this in counseling services as well, beyond residential shelter.”

• “The project has opened our eyes about what we can do to help clients access the health care system, beyond reproductive health.”

Case Studies from Virginia’s reproductive and sexual coercion pilot:

• “Survivor is a 19 year old woman who was referred to The Laurel Center by local law enforcement. She was staying in a hotel with her partner when he became angry one night and began “torturing” her and threw her belongings out of the window. He also threatened to throw her down the stairs if she did not leave. She called the police and then was brought in to our shelter for a safe place to stay. During her intake, she did disclose that her previous partner “refused to wear condoms” and also threatened that “he would force her to have his child.” She did share that at one point she was fearful of becoming pregnant when she did not want to be.”

• “Survivor is a 43 year old woman who found out about The Laurel Center’s services online. She had left her abusive partner a few months earlier and had been living with unsupportive friends. They kicked her out of the house and she needed a place to stay. During her intake, she disclosed that she was a childhood survivor of incest. She also had been in 3 prior abusive intimate relationships. She shared that her previous partner had destroyed or tampered with her birth control and that he tried to force her to become pregnant while they were in a relationship.”

• “A young mother in her 30’s came into shelter. She is the mother of a school age child and an infant. The sexual coercion assessment allowed her to open up that she had recently had a miscarriage while living with the abuser. She had not gone to the doctor to receive medical services and was very concerned about her reproductive health from the miscarriage. She was immediately linked to the nurse at shelter who referred her to the hospital for emergency care due to the seriousness of her health condition. It is the belief of our shelter coordinator that had the assessment not been performed the client would have suffered in silence. She was able to disclose her miscarriage and the sexual coercion she was experiencing and ultimately obtain medical attention.”

• “Survivor came to our shelter after a violent incident that ended with her being physically assaulted. She had been in a relationship for three years, and this was the first time her abuser had physically hurt her. She stated that he was controlling in all the typical ways – isolating her, insisting that he know where she is and whom she is with, not giving her access to money, choosing her friends, etc. At some point, he started saying things like, “you should have my baby” and “you should have my kid.” She saw these behaviors and dismissed them for a couple of years.”

Program Spotlight: Creating a Culture of Wellness

The Haven Shelter and Services in Warsaw, a Northern Neck of Virginia, has undergone a transformative process to better address the health care needs of service participants, including addressing the issue of reproductive coercion.

As part of a pilot program funded by the Office on Women’s Health, the Haven was awarded a small grant that enabled us to better address the health care needs of persons who had experienced sexual and/or domestic violence. We approached the task by focusing on eating, fitness and smoking cessation. We contracted with a nurse to assist us in a whole shelter program review to assess where and how we needed to address our program and activities to be more health conscience. In assessing how we could promote good health amongst residents we quickly realized that our vision had to include promoting health and well being amongst the staff and volunteers as well – so we endeavored to make a whole culture shift to the shelter setting. Since the nurse we were working with was a nurse mid-wife, we also expanded our concept to include a focus on reproductive health.

Simultaneously we were addressing the issue of ensuring that our services were Trauma Informed. This process involved a review of our policies and procedures and updating them, a review of the shelter environment, making the appropriate environmental changes, and training the staff and volunteers on trauma issues, ensuring that they maintained a consistent understanding of how trauma impacts the individuals we serve. It also included training and support in recognizing the impact of trauma on us as advocates. It was in this context that we began addressing reproductive coercion with receiving our services.

Our work involved several aspects before we began to ask women questions about reproductive coercion. First, was understanding the term. Most of the staff were familiar with the behaviors that are involved in reproductive coercion but putting a name to it helped to frame the issue. It involves forced pregnancy, pressure to become pregnant, pressure to terminate or forcing termination of a pregnancy, tampering with birth control or refusing to use birth control. Essentially reproductive coercion is attempting to control a partner through attempts to control their reproductive health. Talking about reproductive coercion also means we open up conversations about other sexual abuse and sexual coercion that program participants have experienced. Staff had to be able to have these conversations in a trauma informed manner and be knowledgeable about safety planning options.

Safety planning options for reproductive coercion typically include health care providers. Staff had to be knowledgeable about what family planning health care providers were available in the community and build relationships with those providers. Staff had to be knowledgeable regarding birth control options and how to dispel myths and misinformation regarding available options. Sexual and reproductive coercion also involves a higher risk for exposure to sexually transmitted infections.
A big part of the response to these issues is connecting women with appropriate health care providers and supporting education on techniques and strategies to deal with exposure to STIs as well as prevention to exposure.

Training staff and building relationships with Family Planning Providers was a huge part of integrating information about reproductive coercion into our day to day work. Just as being able to provide program participants with accurate information and advocacy in the legal realm, we have to understand how the health care system works and forge relationships with those players in that system. Educating ourselves and building those relationships helps us to advocate on behalf of people who have experienced violence and helps them to access what they need to increase their options for safety. We find that the responses to the discussion of reproductive and sexual coercion vary greatly from those who find it difficult to engage in the conversation at all to those who are so relieved that someone is asking questions that they are able to talk and talk.

We were fortunate to be able to purchase brochures and information about birth control options, STIs, Emergency Contraception and other overall health care information in English and in Spanish to have them available for residents and staff. Much of this information is available and downloadable online. The Office on Women’s Health and Futures Without Violence both have a wealth of information on their websites to help educate both residents and staff when you are ready to begin discussions on reproductive coercion. Your local health department is also a valuable source of information on family planning information. As part of Project Connect in Virginia, all of the Family Planning providers in local Health Departments are required to receive training in addressing reproductive coercion and intimate partner violence. A good starting place is reaching out to your local Health Department and having a conversation on what your program has to offer and gaining understanding on what the local Health Department has to offer. If you have a Planned Parenthood Clinic in your service area, that can be another supportive organization to collaborate with.

The importance of addressing the overall health care needs in a trauma-informed manner can’t be overstated. A shelter environment that supports the overall health and well being of folks provides a much more supportive context to engage in these discussions. Providing the support and opportunity for women to open up about reproductive and sexual coercion gives us a greater understanding of the complex barriers so many individuals face in escaping abusive and violent relationships. It helps break down the isolation and shame that so many women carry, having experienced behaviors that they had no name for. Building alliances and relationships with healthcare and family planning providers also helps us reach provide more effective services to individuals who may be experiencing this form of control.

When we care about women’s overall health and well being, including their reproductive health, we can help women to build lives that are both healthy and safe. When we care about our own overall health and well being we can inspire others to do so as well.

For more information, contact: The Haven P.O. Box 1267 Warsaw, Virginia 22572 804-333-1099  http://www.havenshelter.org