CART-GRAC
Contraception Access Research Team
Groupe de recherche sur l'accessibilité à la contraception

The CONNECT Project:

Integrating Family Planning and Community Services for Women Experiencing Intimate Partner Violence

Opportunities and Priorities Identified through Stakeholder and Expert Consultations

Report of Proceedings,
September 28, 2015, Toronto, Ontario
and October 15, 2015, Vancouver, BC

Acknowledgements

Contents

Executive Summary

Women experiencing intimate partner violence (IPV), particularly reproductive coercion, are at increased risk of unintended pregnancy, which can exacerbate IPV. The Contraception Access Research Team- Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC) aimed to explore collaborations that could support improved family planning access for women accessing services for those experiencing violence, and improved ability to address safety and needs of women experiencing violence who access family planning services. We convened meetings in Toronto and Vancouver of experts and stakeholders from both community services for women experiencing violence, and from family planning services in the fall of 2015.

Several important themes and potential project priorities emerged throughout these discussions.

Both facilitated, inter-professional, inter-sectoral group discussions supported participants to share their experience, expertise, and perspectives. Participants explored potential for cross-training between the family planning-health and the community services for women experiencing violence, with a focus on improving safety for vulnerable women. Ideas were collected toward building a grant proposal to create and evaluate an informed, safe, and appropriate inter-sectoral collaborative service or staff training intervention.

The overall goals of the planning meetings were to:

- Explore the feasibility of projects based in one or a few centres in Ontario and in BC.
- Bring together the sectors of community services caring for women who experience violence and family planning health services to share and learn about each other's practices
- Discuss the focus and parameters of a potential pilot intervention: "The CONNECT Project".

This report will detail the cross-sectoral, interdisciplinary meetings that took place on September 28th, 2015 in Toronto, Ontario and on October 15th, 2015 in Vancouver, British Columbia on unceded Coast-Salish Territories.

Health policy leaders, directors of community programs and organizations serving women who experience violence, transition houses, women's health centres, family planning health services, physicians, nurses, health researchers, trainees and advocates gathered together for these two sessions of facilitated discussion.

> *The over-arching goal is to improve health and well-being for women who experience intimate partner violence and particularly reproductive coercion. We want to design and test an intervention that will help services support women to time and space their pregnancies and achieve their own reproductive goals.*
>
> – Dr. Wendy Norman

Key themes and priorities identified will be used as a basis for a proposal to the Public Health Agency of Canada and/or the Society of Family Planning, to create a program capable of sustainable service improvements.

Unifying Themes

- Clear need for education for health care workers for providing support and care for women experiencing intimate partner violence; and for community services workers for contraception/family planning, especially reproductive coercion
- Cross training, networking and resource sharing
- Create intervention for sustainable change
- Addressing resource and funding constraints; need to be able to work around financial barriers (ie. costs of IUDs), lengthy waiting lists, etc.
- How to include who wasn't able to be at the meeting today? Who are we missing, and how do we reach them?
- Key question: "Do you want to become pregnant in the next year?", as well as (at entry to services) "have you had unprotected intercourse in the last five days- do you need emergency contraception to prevent a pregnancy from starting?"

KEY TORONTO THEMES	KEY VANCOUVER THEMES
Hidden contraception, particularly long acting reversible methods, and Emergency Contraception are important missing elements in safety planning for women experiencing domestic violence or intimate partner violence, particularly reproductive coercion.	Hidden contraception, particularly long acting reversible methods, and Emergency Contraception are important missing elements in safety planning for women experiencing domestic violence or intimate partner violence, particularly reproductive coercion.
Champion model – cross training and support for a trusted community services staff member could facilitate family planning knowledge as close to conventional practice as possible	Champion model – cross training and support for a trusted community services staff member could facilitate family planning knowledge as close to conventional practice as possible
Shared decision-making aids could assist staff and women to best understand their contraceptive options	Need to meet women where they are at vs. expecting them to find us
Updating safety plans to consider safety from unintended pregnancy	Updating safety plans to consider safety from unintended pregnancy
Facilitated referrals between Community services for women who experience violence and family planning health services	Consider family planning health perspective on Interagency Case Assessment Teams (ICATs) which are convened to consider intervention for women at the most serious risk from partner violence
Culturally responsive models are a must when discussing reproductive coercion	Consider elements of "both" and "either" rather than one or the other intervention- blended models
	Consider connection with post-partum contraception

Critical Concerns

- Confidentiality for women experiencing IPV
- How to reach women with precarious status or those who fear deportation
- Informed and empowered language

GOAL: Improve the health of women experiencing intimate partner violence through empowering women with knowledge and methods to decide for themselves their preferred timing and spacing of pregnancies.

Interventions:

1. Education: cross training and task sharing for both health care professionals and community based organizations
   a. Webinar on contraceptive and sexual health education for community front line workers
   b. Webinar on intimate partner violence and inter-related issues for health care professionals
   c. Create a module on reproductive coercion for both community front line workers and health care professionals
   d. Public awareness campaign to increase knowledge of reproductive coercion, and current services and supports available

2. Champion Model
   a. Identify a champion in a community based organization, who will train their colleagues in reproductive coercion, collect data from other staff members on their referrals and experiences, and report this information to the research navigator.
   b. Identify a navigator from the research side who will connect with and support the champions in each organization. The navigator collects data from the champion instead of speaking with women experiencing intimate partner violence directly.

3. Embedded Model
   a. Embed a front line community worker in a health care setting to have different professionals join together as representatives of their own organizations.
   b. Build a network of trust and competence, so that health care professionals and front line community workers have confidence in referrals and supporting women experiencing IPV.
   c. In smaller areas, introduce Interagency Case Assessment Teams (ICATs).

Setting Priorities for an Intervention Study

On September 28th, 2015 and October 15th, 2015 the Contraception Access Research Team- Groupe de recherche sur l'accessibilité à la contraception (CART-GRAC) brought together a network of community health workers, front line workers in anti-violence programs, physicians, nurses, health policy analysts, government health workers, and counselors from across Ontario and British Columbia respectively, to determine priorities for a research design for an intervention study to identify the best way to connect community services for women experiencing intimate partner violence to family planning health services. By building strong partnerships between health services and domestic violence resources women will have increased access to reproductive health care, and women experiencing violence who are seeking health care will have referrals to community resources and support.

Objectives of the planning meeting included:

1. Understand what services and strategies community partners working with women experiencing intimate partner violence currently provide
2. Understand what services and strategies family planning health services currently provide
3. Identify possible areas of collaboration, integration, or cross-training
4. Explore the feasibility of an intervention study in Ontario and British Columbia
5. Discuss parameters and focus of the study

The first planning meeting was held in Toronto, Ontario on September 28th, 2015. After an overview of current literature and practices in the health setting around reproductive coercion, participants came together for a large group discussion. The goal of this meeting was to build a network between community partners and health service providers, and explore the feasibility for the CONNECT intervention.

The second meeting was held in Vancouver, British Columbia on October 15th, 2015. After an overview of literature on reproductive coercion, facilitated discussion built off of previous themes from the Toronto meeting, exploring the possible parameters of the CONNECT intervention project.

CONNECT'S GOAL is to improve the health of women experiencing intimate partner violence through empowering women with knowledge and methods to decide for themselves their preferred timing and spacing of pregnancies.

The big ideas and passionate discussions that arose from the planning meetings will be used to create a proposal and grant for a study to better understand the best way to support the integration of programs, as to better support women in achieving their reproductive goals.

Discussion about PHAC Grant

PHAC will not fund something that provides counseling or health services to women, nor a purely educational public campaign; rather they are looking for a proposal for a project that will lead to sustainable change. Is there some way to offer front line staff tools or information on reproductive coercion that might be relevant to share between family planning and community services?

In the letter of intent, stated was a possibility for a navigator to go between services. The possibility of shelters and other community services that serve women who are experiencing intimate partner violence having iPads / etc. to be sharing resources, and as a way to open the conversation about contraception use, and ask the staff questions. The navigator then comes in for an appointment with the woman who has already disclosed that she is being coerced, and needs assistance. The navigator as a research assistant would follow up with the identified women, and ask questions every three months as data collection. A measurement of reproductive coercion would be incorporated at intake and different points along the way, and correlate with outcomes along the way. PHAC is interested in a number of people served. Referrals to family planning services, and with a 'fast-track' component to mitigate waitlists and other potential barriers.

Understanding the Current Gaps

Brief presentations started off each meeting, as a way to build an understanding of what is currently happening in both Toronto and Vancouver.

Toronto

Drs. Robin Mason and Sheila Dunn set the context for the Toronto planning meeting with a presentation looking at the health impact of violence against women. Globally, up to one in three women will experience violence at some point in her life. Intimate partner violence (IPV) is associated with poor reproductive health, STIs, and unintended pregnancies. IPV increases the risk of unintended pregnancy for a variety of reasons including difficulty negotiating condom use, partner interference with access to health services, forced sex, verbal pressure and threats to become pregnant. **Reproductive coercion** are "threats or acts of violence against a partner's reproductive health or reproductive decision-making and is a collection of behaviours intended to pressure or coerce a partner into becoming pregnant or ending a pregnancy."

When working with women who are experiencing IPV and creating safety plans, health professionals and front line workers are generally foremost concerned about physical safety, with emotional and psychology safety taking priority after physical safety can be established. Very infrequently are there references to reproductive health and reproductive choices. There is an unmet need for contraception, especially considering the possible need for emergency contraception. If the emergency contraception pill is accessed within 24 hours of unprotected sex, the chance of becoming pregnant is reduced to 2%; if a Copper IUD is put in within 7 days of unprotected sex, the chance of becoming pregnant is reduced to less than 1%.

Connections between IPV and reproductive health services need to be developed: there is an unmet need for contraception within the IPV sector, and an unmet need in how family planning services are provided to women who may be experiencing IPV, both in screening and disclosure.

Dr. Wendy Norman, leader of CART-GRAC, gave a short presentation on the purpose of the meeting. Attention was drawn to the advancement of addressing reproductive coercion in family planning and anti-violence sectors in the United States,[1] and the possibilities of collaborating with other health care professionals, service providers, and government leaders to move health policy more in line and recognize the costs associated with unintended pregnancies, and understand what women need to better meet their sexual health goals and expectations. One way this was achieved was through the Canadian Sexual Health Survey. The Canadian Sexual Health Survey[2] is a door-to-door survey used to understand contraceptive and sexual health needs in British Columbia. One identified gap, especially in rural areas, was for more available information on contraception options.

The government of Canada recently created and awarded a Family Planning Applied Public Health Chair to Dr. Wendy Norman, and CIHR and PHAC both support CART-GRAC's projects: the chief medical officer reached out to Dr. Wendy Norman and asked for the exploration for designing a way to strengthen both family planning and community services to better serve women. The purpose of this meeting is to explore how to create a collaborative project in identifying women who could benefit, and how information and expertise can be shared to equip navigation from both sides.

Current State of Services

The next activity was an interactive sharing of expertise and knowledge. Toronto participants were invited to introduce a background of what their service or organization was currently providing, and to identify possible areas for collaboration. This was a chance to learn from the stories and experiences in each respective organization to discuss an appropriate approach for this project.

1 Lancet Series, November, 2014: http://www.thelancet.com/series/violence-against-women-and-girls

2 http://cart-grac.ubc.ca/canadian-sexual-health-survey/

IPV Services

Margarita Mendez, the executive director of Nellie's Shelter in Toronto, calls for a new model of risk assessment and safety planning in women's shelters. Access to contraception services must be integrated as part of safety planning. Women's Health in Women's Hands,[3] a community health center, relies on program planning for integrating pieces of addressing the health of racialized women, and bridging clinical and community services together.

Dr. Linda Baker, the director of the Learning Network at the Centre for Research & Education on Violence Against Women and Children, has been involved in online curriculum for threat assessment and management of IPV. It's a program meant to reach out to allied professionals to address the current gap through scenario-based learning. In terms of knowledge exchange, she identifies the need to look at some of the intersections of people who identify more clearly as working in terms of women's abuse, and stakeholders in terms of sexual violence – looking at the different intersections, emerging issues, and gaps. One initiative is a newsletter, which welcomes guest editors to highlight specific issues. Her team has just received funding from PHAC to be the knowledge hub for a number of initiatives to roll out on innovative trauma informed health promotion: it is a great form of knowledge exchange which primes the opportunity to open doors, and bring people together to discuss intersections in forced sexual experiences.

Charlene Bernasko, a counselor at Barbra Schlifer Commemorative Clinic, takes clients through an intake process before they receive counseling – this intake matches them with a counselor based on their intake form. In this way, all first client interactions talk about consensual sex and reproductive health; if a woman at the intake level discloses experiencing IPV, there are already questions to ask. Some programs are targeted to address particular intersections: there is a program geared toward young Muslin women who are experiencing family violence – first thing discussed is safety: exit strategies, then talk about the night after the wedding, how she can protect herself, and how she can access and protect her reproductive rights.

Irene Gabinet, the Transitional and Housing Support Advisory Group (THSP) program and committee coordinator at the Woman Abuse Council of Toronto, coordinates how the community can address systemic issues of domestic violence through transitional and housing support. They are looking at submitting a grant for the health committee to revitalize the issue of domestic violence being addressed in the health care sector; reproductive coercion needs to be integrated in this issue. There is a need to start having conversations at meetings, and to find out who talks about reproductive coercion in their safety planning – there is a gap in the knowledge exchange surrounding reproductive coercion within the front line workers.

Nicole Pietsch, the coordinator of Ontario Coalition of Rape Crisis Centres, discussed the importance for emotional and sexual safety planning for front line workers. Safety planning is comprised of a practical and concrete list, and training of how to initiate, respond, and follow through on issues raised, but reproductive coercion needs to be added. Sexual assault centres are doing crisis work, but they have the capacity to do more. There is a provincial campaign on bystander intervention, called 'Draw the Line.' The idea behind the campaign is to get people talking about sexual violence in the context of relationships, and create an action plan for bystanders.

Maya Roy, executive director of the Newcomer Women's Services in Toronto, works with the Ministry of Citizenship and Immigration. Any newcomer that comes in works with a settlement counselor to develop a plan of action. The issue is when there are not enough people knowing the right kinds of questions to ask, and what referrals to make. This is why health promotion is important; need to have that connection and relationship. There is a program called 'Neighbours and Friends,' which has grandmothers and aunties go out into the community and talk about gender based violence in the home through sharing circles, homes, parks, etc. The number one recommendation was more information access around sexual health. There is a gap around culturally responsive models. Another gap is to work with Indigenous partners and traditional teachers on women supporting each other on miscarriages; find similar kinds of support around reproductive coercion. Research in the community has started, but there is a gap using traditional knowledge.

> *We have to be sensitive to shifting the locus of control from the abusive partner to the health care provider – we need to be sensitive as health care providers: it's not empowerment if it's not her own power.*
>
> – Victoria Scott

3 http://www.whiwh.com/

It's only empowerment when she's in charge, and when it's her decision to have children. This is an opportunity to meet with people, and partner to bring connections together.

– Dr. Wendy Norman

Reproductive Health Services

Dr. Robin Mason reported that within the Women's College Hospital Research Institute, she develops education and training programs for healthcare providers on IPV and it's associated issues. She is currently developing specific educational modules on issues of reproductive choice and coercion. There is a website of three online curricula,[4] but she is interested in how to integrate these curricula into current methods of safety planning.

Victoria Scott, a nurse at the Bay Centre for Birth Control, offers a range of services. Nurses at her clinic screen for IPV; nurses check the charts, and take sexual health history – physicians see a significant number of charts, and only see if screening has been addressed. It is the outreach and planning that is a gap: how to aid contraception decision making in a client-centered environment?

Dr. Sheila Dunn, physician and associate professor at the University of Toronto, Department of Family & Community medicine, questions how family practice can incorporate specific questions regarding IPV. There are stamps for specific visits (IPV, but it is variably used) that go on electronic medical records (patient charts). One of the challenges, however, is the difficulty in addressing the complexity of an IPV disclosure in the allotted appointment time. However, it is important to address contraception use; assessing her control over her own contraceptive choices is just as important as addressing her high blood pressure.

Dr. Wendy Norman, leader of CART-GRAC, physician, and assistant professor at University of British Columbia, discussed hidden reproductive health services in British Columbia that can empower women to time and space their pregnancies as they desire. Dr. Wendy Norman and her team are creating a decision making aid for what a patient might want to see in a contraceptive method: make an app with bars to show the weight certain values play into your choice of contraceptive methods, and then explore what they mean in terms of your own parameters (side effects and things to know). You get to choose what is important for you. Eventually, clinics will have iPads with this app already loaded onit, so women can privately explore what works best for them.

Identified Gaps in Ontario Services

Dr. Ashley Waddington, an obstetrician/gynecologist and assistant professor at Queen's University, runs a specialty gynecologist clinic in a community that experiences high rates of IPV – most referrals com from health care providers, not community partners. There should be a focus on finding ways to integrate contraceptive education in community partners, as a way to facilitate referrals. In Kingston, she has connected with the sexual assault/domestic violence team to set up rapid referrals for contraception/IUDs. She teaches IPV to her gynecology students, and speaks with people in community organizations to let them know when her contraceptive clinics are available, and provides them with education.

Community partners and health professionals employ different terminology. Domestic violence (DV) resonates better with health care professionals, and trauma resonates better with community partners. Community partners find that DV doesn't consider sexual abuse, sexual assault, and ignores family violence. With DV, may miss support services to survivors of sexual assault and sexual abuse. Trauma may be less jargonistic, but to health care providers is suggestive of physical trauma.

Furthermore, it is important to keep in mind people who were not able to make it to these meetings – how this will affect services provided?

Points for Collaboration in Ontario

The main theme identified as a point of collaboration is education: education for community partners, as a way to integrate sexual health information and family planning services, and for health care services, as a way to discuss and understand domestic violence in terms of power, control, and coercion. Not only identifying when one is experiencing intimate partner violence, but how to react and move forward after the disclosure.

4 www.dveducation.ca

Vancouver

On October 15th, Dr. Wendy Norman lead an introduction to the CART-GRAC team and the CONNECT project planning so far, with an emphasis on the need for collaboration between family planning services and community partners.

Information sharing on intimate partner violence, reproductive coercion, and current approaches to contraception

Violence tends to escalate with unintended pregnancies; when women are able to time and space their pregnancies, children have a lesser chance of experiencing violence in the household, and have a better chance of economic security and attaining education themselves. The LANCET series[5] reveals that offering women control over the timing and spacing of their pregnancies through contraceptive use can be a source of empowerment, and can perpetuate further steps away from negative environments.

The Public Health Agency has presented the opportunity support research for the potential to reducing violence and unintended pregnancies. Unintended pregnancies can increase the risk of violence, and in the context of intimate partner violence, this increases the risk for unintended pregnancies. It is a spiral that is hard to escape from.

Reproductive coercion can take form of achieving a pregnancy by interfering with birth control methods or to end a pregnancy through coercion to terminate. One idea brought forward from the Ontario meeting was the idea of helping women to avoid unintended pregnancy as a key safety factor; to be in control to avoid unintended pregnancy.

The emergency contraception pill reduces the chance of becoming pregnant after unprotected sex to 2% by preventing the egg from being released; if a woman has a copper IUD inserted up to seven days after unprotected sex, the risk of becoming pregnant is reduced to about 1/300, and then also has ongoing contraception care. IUD's without strings can be inserted, so only a physician or health care professional is able to tell if a woman has one.

> *We want to empower women to make reproductive choices.*
>
> – Dr. Tamil Kendall

The American Public Health Association developed a key question that any professional working with a reproductive aged woman should ask: "Would you like to become pregnant in the next year?" This is an easy way to open up the conversation about birth control methods, and ways that they can protect themselves. Studies have shown that simply asking is enough to set women on a road to determine their own roles. IUDs and Depo-Provera are both highly effective contraceptive methods, and are protective against reproductive coercion – it is unseen, and no one knows that you are taking them. This can give women a sense of control.

The purpose of this meeting is to talk about what connections could be seen between services.

> *The cornerstone of anyone's autonomy is control over their bodies.*
>
> – Cheryl Davies

Connecting with Each Other

Participants each took a turn to introduce themselves, their organization, and what passion drew them to attend this meeting.

Jen [last name?], the meeting's facilitator, is drawn by the concept of equity and equality. An equitable service requires equal access.

Dr. Tamil Kendall sees women's health as tightly tied with women's rights and reproductive health, and the ability to reproduce or not reproduce when, how, and with whom they want. This in turn influences the life trajectory, health, and well-being; in society and within the global community.

Cheryl Davies always had a passion for women's reproductive rights, and addresses issues of reproductive coercion through a human rights perspective. Looking at violence, and how this constrains a woman's ability to make autonomous choices over all aspects of their lives.

5 Lancet Series, November, 2014: http://www.thelancet.com/series/violence-against-women-and-girls

Dr. Nancy Poole, the director of British Columbia Centre of Excellence for Women's Health, focuses on women's substance use and how that interacts with other issues. She is currently working to help service providers communicate more appropriately with women: when substance users want to disclose about their substance use with their physicians, the emphasis on helping service providers to start and support conversations. Issues around trauma and contraception need to be situated in more complex conversations: looking at the intersections of trauma, contraception, and substance use. Service providers don't need to be experts, but there is a need to create a safe and supportive space for the possibility of disclosure.

> *We can learn from each other to make spaces safer.*
>
> – Dr. Wendy Norman

Cheryl Couldwell, the executive director of Willow Women's Clinic, works with emergency IUD insertion, other methods of contraception, and medical abortions. Willow Women's Clinic provides approximately 170 medical abortions a month, and about 300 IUD insertions a month. Recognizing the need and the efficacy for copper IUD as emergency contraception, each day has two open appointments to make this possible. Staff will accommodate same day calls: the more that people are aware of the services that Willow offers, the more that can access these services. Make it more accessible for women who may not know these options.

Dr. Regina Renner is a researcher and physician in Nanaimo, who also takes a human rights, and reproductive rights framework when addressing women's safety.

Jennifer Breakspear is the executive director for Options for Sexual Health (Opts). Opts provides sexual health education in schools, with 60 nurse-run and volunteer-supported clinics throughout the province. Opts also runs the 1-800-SEX-SENSE line, which answers any question about reproductive health and sexuality, for people of all orientations. Healthy sexuality isn't possible if we can't enjoy our own human rights. One challenge that Opts is facing is how to engage with communities to ensure that people know about the services offered, and how to make them more accessible. Opts is operating under financial constraints, but are still doing whatever they can to enhance services and accessibility.

Stephanie Bouris, a policy analyst within Women's and Maternal Health, in the Healthy Populations and Development Branch, in the Ministry of Health, is currently working on the renewal of the women's health strategy for the province. Her passion has been in maternal global health, looking at the impact of immigration on women's health, and communication across languages and cultures.

Tracy Porteous, the executive director of Ending Violence Association of BC (EVA), works with advocacy counseling support. There are 240 counseling and outreach programs within EVA. Before funding was cut in 2001, EVA also supported sexual assault centres. She is excited to look at how to work collectively towards the liberation of women – which can't happen if they are living under threat. People who are providing support to women need to have the confidence and competence in skills and training to do their jobs in the best way possible. Always look for solutions; while there is a recognized need for a structural change, there are quick wins. Asking the 'key question' would be a good example of a quick win: the opportunity to write a 'one – pager' to different clinics and services to get the conversation started.

She works with Interagency Case Assessment Teams (ICATs), which are inter-disciplinary teams that come together for safety planning when a woman is at high risk for being killed. ICATs are comprised of antiviolence workers, CPS, immigrant workers – whomever might have a connection with the family. ICATs are used to do better risk assessment and safety planning. We know that pregnancy is a risk factor for fatality, and the more information we can receive about each other's services and practices the better. The province has stated that they are going to develop a sexual assault policy, but there is currently no budget or funding attached to that promise. There is potential connection with a new national group, which looks at the prevention of domestic violence homicides.

Anne M'mithiaru, the manager of residential programs at Atira Women's Resource Society, works with women and children who witness and experience abuse. Part of Atira's role is as a women's health and safety liaison in single room

occupancy (SRO) hotels. They work within the challenge of how to get women to the services; they have nurses which work within residential programs, but still need to get women to that program. She sees the need for increased access to contraception: only female condoms are available to their clients. This increases the risk of violence for sex workers when negotiating both male and female condom use. There are many instances of unprotected sex or disrupted birth control methods. This is particularly alarming, as many of these women will not be accessing emergency contraception or other medical services.

Pany Aghili, the executive director of Dixon Transition Society, provides services for women experiencing violence including counseling and a housing outreach program. She identified a gap in contraceptive need when women leave the house to go back to the abuser, or when they leave the facility and get involved in another relationship. They were looking at developing a workshop at the second stag program giving information about sexual health and contraception information.

> *We need to re-educate ourselves; our current mode of delivery is no longer working in our complexity.*
>
> – Dr. Nancy Poole

Pakka Liu is the training coordinator for BC Transition Housing. Contraception and women's contraception health is essential when we are talking about health in general – in particular, it is important to address the immigrant women population, women who may be newcomers or who may not have health insurance. How do we get the information out and services to these women?

Katie Streibel is a collective member at the Rape Crisis Centre and Transition House. The Transition House serves 120 women, and receives 1200 crisis calls a year. Health professionals make referrals to the Centre, who make a point to respect confidentiality and a woman's right to choose. Women need sexual autonomy and the right to access contraceptives and abortion, regardless of status. The Centre will provide accompaniments for women accessing medical services, and will find a way to help women pay for contraceptive costs or other associated costs.

Eva McMillan is the CART team coordinator of the health survey project. This project involves nurses going door to door throughout British Columbia, surveying what women want in terms of access and information of contraception. It is important to recognize that we don't live in isolation: our communities, and social determinants of health intersect and influence who we are.

Connecting Service Delivery in British Columbia

There was a short group discussion about the possibility of moving and integrating our services and perspectives for this project. It's not hard to imagine expanding or integrating more concepts together, but how to employ these ideas in the current climate of limited funding.

While we need to break down the silos, we need to figure out what to do without money: women's health and well being is at the bottom of most piles of funding. There needs to be a re-distribution of resources; funding is never addressed. This is an opportunity to come together and apply for a federal grant. The goal is that by the end of the day, we will have idea of what components to apply for: while this is a grant for a year or two, the point is to strive to do something to move towards sustainable change.

According to Dr. Tamil Kendall, there have been new resources within the Violence Free BC strategy. It is important to position violence as a public health issue – women who are experiencing violence need and use more health care services. Prevention and secondary prevention are important and relevant to shifting the discourse around violence.

Jennifer Breakspear brought up the realities of funding in our current political climate; federal leaders wouldn't even debate or consider women's issues. In order to achieve sustainable change, there has to be core systemic change. Criminal justice is the only current contributor to anti-violence campaigns; could use support from the Ministry of Health.

Pany Aghili was concerned about repositioning gender based violence to a public health issue; violence against women has an impact on public health – but there are institutional issues that if not addressed or acknowledged, we may be putting a medical model on a social issue. It's an equality issue.

Possible Interventions

Through facilitated discussions, there were three major interventions identified as having the greatest potential for impact: education/cross-training, a 'champion' model, and an 'embedded' model.

Education / Cross – Training

Across both meetings, there was a recognized need for cross training and networking to build relationships between community and health services, and to reframe the barriers between community services and health services. It is important to find a way to integrate services and informed care to provide women with the best support and treatment possible.

Reproductive health providers should be trained in issues pertaining to intimate partner violence, and front line workers should be informed about contraceptive options and further referrals. One possibility could be to begin by using the 'key question' in intakes. For transition houses, the best practice is to screen for emergency contraception needs at the intake, and create the space to include the 'key question' in outtakes, introduced within a broader conversation about sexual health and reproductive rights.

Educational projects coming out of this project include:

1) Creating educational modules for front line workers without a health care background so that they can feel more confident in identifying options and a safe place to refer clients.
2) Creating a module on reproductive coercion for both health care professionals and front line workers
3) Creating an educational module for health care providers on intimate partner violence, precarious status
4) General public awareness campaign; how to get service providers ready to respond, and how to get clients to be aware as well

The measurable outcome would be how many completed the module, with the possibility of getting some credit from it. These three educational modules could work together, with input from the health care side as well as the front line workers. Dr. Robin Mason has already created online modules for clinical practitioners, on how to address domestic violence in clinical settings.[6]

6 www.dveducation.ca

Champion Model

In keeping with conventional practice, there is the potential of identifying a champion in the existing staff in an organization that chooses to work with this project. The modeling experience would be that much closer to current practice, and the champion would already be familiar with the issues that the clients are facing. They would already be known to the clients, which would prevent the women to have to disclose multiple times. There may be staff in family planning services who are not comfortable talking with their patients about reproductive coercion.

CONNECT would offer an organization two hours a week of staff time, training time, and support for two years. The champion would also be responsible for training the other staff members in their organization to establish continuity in services. The champion would be responsible for disseminating information to the staff, as well as report back to CONNECT's navigator, who would act as a research assistant. The navigator would collect information on how many were referred for emergency contraception and how front line workers and health care workers were integrating one key question in screening, and the perceived result.

The navigator would initiate relationships with the community organizations, and support and train the champions in each organization. A co-champion project could include a 1-800 number to talk about local services, or a counselor to accompany women to health care services.

One challenge of the champion model is the lack of resources available for non-profit organizations.

How much staff time would this take?

Maya Roy praised the idea coming from a health promoter perspective, but had concerns coming from a managerial perspective. For a non-health based NGO, how much staff time would this take? Front line service workers would need training – would webinars be funded?

The creation of a webinar that could be completed on one's own time, and help with employment costs could be easily built in to help mitigate costs. Whoever completes the webinar could receive a credit or certificate.

Margarita Mendez suggested hiring a full time community staff person instead of splitting a current staff member's time. There is a need for access to different forms of contraception (ie. IUD without strings), and the need to develop a list of services that address coercion in a feminist approach.

Research needs to be done for a list of services to take on, how long the waiting list would be, what kinds of services and the qualifications of those offering services. Safety planning is a huge opportunity for this model.

Embedded Model

There has been research in the UK around effective interventions, and the health setting of the point person was important: embedding a violence worker in a health care setting might make it easier, as a woman does not have to access another service. It also prevents women from having to disclose multiple times. The Sheway Model[7] was discussed as a template, where different professionals join together as representatives of their own organizations – but all report back to the same place. While it may not necessarily be that women will get help in the same place, but having a trusted and knowledgeable person there to confer with may reduce barriers to referral.

In addition, embedding community violence workers in primary care builds a network of competence and trust, and health care professionals may feel confident in starting to explore whether someone is experiencing violence with their patients. The embedded model would be something to consider in a setting the size of Vancouver, but a model like the Interagency Case Assessment Teams (ICATs) may be more appropriate for a setting the size of Nanaimo.

One concern raised about the embedded model is that if women decide to report, the files written about them in the ICAT model could be used against them in court. There is complication in the ownership of files. Tracy has a contract that community based individuals sign with a clause that the Ministry of Health does not own the files, but that the programs do.

This intervention could include a webinar around emergency contraception, hidden contraception, and key questions to empower women's reproductive health decisions. This would help ICATs be more aware of these opportunities and interventions, and also as a way to voice concerns around confidentiality.

Tracy Porteous recognizes a huge opportunity to introduce the key question in other anti-violence programs outside of counseling, as counseling typically has long wait lists. ICATs and EVA's 240 anti-violence community programs are an excellent place to introduce this question into risk assessment and safety planning. In the practice point of view, as they train the ICATs, they could integrate the 'key question'. She also proposed the possibility of a patient navigator to help those families, women, and male offenders with the health aspect of violence. That isn't what anti-violence programs currently do; there is advocacy and accompaniment, but the health effects of violence are not typically addressed at the front end. Here lies the opportunity for a patient navigator working with services so that people can get connected with health services. The patient navigator would be as neutral as possible; someone that is well known to both health and anti-violence programs.

Katie Streibel brought up a concern about introducing CONNECT as an ICAT model, especially considering issues of info sharing and confidentiality. There is concern about not need to obtain a woman's consent before presenting and sharing her information with others. Professionals working in ICATs have discretion when sharing information. Tracy Porteous mentions that the only time permission isn't obtained is in high risk, life threatening situations. And then, the information is negotiated in that only pertinent information that needs to be shared to compile an accurate and complete safety plan can be made.

7 http://sheway.vcn.bc.ca/

Research Design

It was proposed to consider two different methods; do a "both and" instead of "either or" approach. Where is there interest for an integration champion, and how does that work; and where is there interest for health professionals to be embedded in services – and how does that shift the work when it is part of an integrated team. Think about planning multiple approaches, and not comparing them but noticing where there is interest in working one way over another.

Cross training is crucial; sharing information and resources is the underlying baseline for this project. Jennifer Breakspear notes that the Opts clinics have resources from anti-violence programs; however in that moment when a patient is accessing medical services, chances are she won't notice that flyer or pamphlet. Opts nurses are well trained in addressing patient issues of intimate partner violence and going out into communities rather than waiting for communities to come find them. The issue right now is the volume of clients combined with the loss of MSP and limited funding which affects how long clinics outside of the clinic can stay open for. What is missing is how the client gets to the door, and what barriers may be in place preventing other women from accessing services.

Task sharing is also an option to make services more available. It is helpful when recognizing professional time constraints. With widening the circle of involvement, information can also be transferred in a more sensitive way. It is important to find a language that does not make a woman feel like she is being coerced into a certain method or decision: instead, find the language to empower women to meet their own needs.

To combat lengthy waiting times, one option is to include a front-end intervention that is not specifically geared towards IPV counseling, but instead create the same space for women to gain management and coping tools through integrating different services. For example, Victoria's Sexual Assault Centres offer support sessions that are more about mindfulness or stress management than specifically sexual assault or addictions. This creates a more general, open space to talk about processing and managing stress. This could be applied to communities where there is little time or funding for clinics, but to create services as more of a group access. This also mitigates the concern of multiple disclosures. It is less of a medical model in this way: creating a space for women to talk normally rather than asking if they are in danger.

Tracy Porteous is currently working with an organization connected with sexual assault services to figure out ways to respond to survivors of sexual assault. Current strategies include creating disclosure tip sheets for health care practitioners that may not be skilled in disclosure management. This may be an opportunity to share and develop for other reproductive health concerns as well.

Questions about the research design

How to measure empowerment?

We want to empower women to be in charge of their own reproduction: the idea would be at the end of the year to divide women into cohorts – who were seeking to attain contraception protection, how those choices at the beginning were correlated with experiences at the end of experiencing IPV. Ask questions about what, if any, steps were taken by women to protect themselves.

How would you track the access point? Or what would that be for the point of design for theproject?

Look at what would help to respond to violence better, or to respond to sexual and reproductive health needs in a more informed way. Access points include what services are most frequented by women in urban vs. rural areas, and to track what supports keep women connected to services. Where is there interest for a champion model, and where is there interest for an embedded model?

Another possibility is addressing the inconsistency in health care provider's attention to violence. Have a baseline understanding of how much time it takes to do this intervention – if it will be more or less work for physicians, and if they use the 'key question' and appropriate referrals consistently.

We need to navigate with agencies to make it right according to the people they already know and trust.

– Dr. Nancy Poole

How would this look like for women who are in a precarious status?

Some women are sponsored by their abusers, or have expired visas – will she still be able to access these medical services?

While some community health centers will provide service to women who are experiencing immigration issues, the catchment area may be a point of concern: ie. the nurse who works at the clinic may go to the same church as the abuser.

How to include women who are not coming to medical services, or who are hard to reach?

Work places and medical clinics are too formal; there needs to be a space where women feel comfortable. There is a lot of distrust with the medical system; women are afraid of losing custody of their children if it is revealed that they are in an abusive relationship. She is treated like the one who is doing something wrong, and putting her child at risk. She will be under surveillance, increasing her stress rather than supporting her.

The project needs to be constructed in a way that will be accessible to all organizations, and all women – if there is a lot of paperwork, confusing/intimidating language, or concerns about confidentiality, women aren't going to participate.

Are there any criteria for women who are looking to participate in the project? Is there a model that allows it to be doable in different geographical areas throughout our province?

There's no criteria to date; it's just about working to connect organizations. Look at anyone who has experienced reproductive coercion, and then look at the reproductive coercion outcomes associated with the intervention.

How to incorporate this into risk assessment/safety planning tools?

One possibility is to have a consultation with front line workers: ask them what to pull out, how to integrate the intake or frame it in a way that addresses a woman's issues when she comes in the door – how to ask the question to invite women to participate in the project, while being mindful of issues surrounding confidentiality of participating in the project.

CONNECT should be as close to conventional practice as possible. The navigator could appear at each service for two hours and model what other staff could potentially assume: asking questions, going through processes with women to see if they want to get involved, and then services could then adapt how that would look.

How do we screen for lethal violence factors?

The best thing to do is just to ask the women what they want; a lot of women are worried about confidentiality and being able to choose how to proceed after a disclosure. The best way is to let her know that it is her decision, and that your door is open if/when she is ready to talk about it in the future. Best practice is to listen, and let her speak and share her experience. Domestic violence homicide is preventable: if service providers can recognize the red flags, they can work harder to connect her to other services and resources that might serve her better.

There is an identified trust gap for some women trying to access medical services. How could the navigator be supported to address that trust component?

Pakka Liu addresses that if a woman is scared of having her children being taken away or of being deported, talking to anyone perceived as an authority figure will be challenging. If there is going to be a patient navigator, they need to be community based. Even in a hospital setting they may be perceived as a social worker. If a patient navigator's main role is to be connecting women to resources, we need to make sure that the resources are available within a reasonable time frame (ie. addressing long waitlists).

Dr. Nancy Poole sends some of EVA's counselors into community neighbourhood house services to meet some clients. The idea is not to deliver counseling, but to get connected. It isn't traditional, but it has increased the number of women and children who get help with substance abuse issues. A bridge has been created to go out and connect with women, understand where they are coming from, and put a face to their services. This project's connector or navigator needs to act as the face of the reproductive health system.

In Toronto, participants were discussing a model in which a research assistant be the connecting piece, and then part of the project model supports full time equivalent staff members in the community services to defer costs of training and to have staff experts. The research person then connects with the 'champions' supports them, and collects information from them. Community organizations in Vancouver recognized that this model may be effective, on the condition that there is funding. Additionally, having opportunities to network with health experts is important. This increases possible contacts and referrals; if the community service worker knows and trusts a health care provider they feel better about making that connection. The research assistant / connector would need to introduce themselves and build relationships with the community services as well.

Should we re-frame the discussion from reproductive coercion to reproductive health more broadly, as to understand how the dynamics of violence affect women's ability or inability to experience reproductive choice?

Reproductive coercion is specific in terms of coercion to get pregnant, sabotaging birth control, and dynamics around violence and unwanted sex. Contraception negotiation is more complicated than that; it's only one specific expression of violence. Dr. Nancy Poole identified that in the addictions field, being pragmatic and normalizing concerns has the ability to open up further conversations, such as around contraception use. Coercion is within a wider story; it may be powerful to keep the story wider, the chance to have that normal conversation about wanting to be pregnant or not.

> *It is not the health care professional's role to make the decision for the woman in how to proceed, but to support her in her decisions moving forward. You won't cause harm if you believe her, assure her confidentiality, and let her take the lead.*
>
> – Katie Streibel

Are there opportunities that would help health care workers to create a safe place for women who haven't already disclosed, to bring concerns forward?

There is a fine line for physicians and health care providers in initiating conversations around intimate partner violence: there is a lack of training in how to move forward after that question has been asked. There needs to be training in both service delivery, but also in how to identify women who may be at risk. Front line anti-violence workers offered that when women are presented with information on how to protect themselves, they will take the steps needed to connect themselves.

Is there a connection with post-natal services?

A lot of women have misconceptions, such as not being able to get pregnant with breastfeeding. Post partum planning to be strengthened, as funding for community health nurses have been cut. A lot of women could be going home after birth with an IUD. Contraceptive care should be part of pre-natal care: to go home with a placement or with a prescription for some method of birth control.

Appendices

Appendix A: Participant Sectors

Meeting participants represented the following organizations:

Toronto Meeting

Learning Network, Centre for Research & Education on Violence Against Women & Children, Western Education, University of Western Ontario

Immigrant Women's Health Centre in Toronto

Ontario Association of Interval & Transition Houses

Barbra Schlifer Commemorative Clinic

Nellie's (Shelter, Education and Advocacy for all women and children)

Woman Abuse Council of Toronto

Newcomer Women's Services Toronto

Ontario Coalition of Rape Crisis Centres

Women's College Hospital & Bay Centre for Birth Control

Department of Family & Community Medicine, University of Toronto

Women's College Research Institute
Dalla Lana School of Public Health, University of Toronto

Department of Obstetrics and Gynecology, Queen's University

Department of Family Practice, University of British Columbia

Vancouver Meeting

Dixon Transition Society

Options for Sexual Health

Willow Women's Clinic

Ambulatory Care, BC Women's Hospital & Health Centre

Women's and Maternal Health; Healthy Populations and Development Branch; Division of Population and Public Health, Ministry of Health, Government of BC

BC Society of Transition Houses

Atira Women's Resource Society

BC Centre of Excellence for Women's Health

Ending Violence Association of BC

Vancouver Rape & Relief

Department of Obstetrics and Gynecology, University of British Columbia

Department of Family Practice, University of British Columbia

Appendix B: Agenda, Vancouver, BC

	PLANNING MEETING FOR THE CONNECT STUDY: INTEGRATING FAMILY PLANNING INTO COMMUNITY SERVICES FOR WOMEN EXPERIENCING IPV	CHAN CENTRE BC WOMEN'S HOSPITAL 12:30- 16:30 (SESSIONS 13:00 – 16:30)
Time	Activity	Speakers
Participants: Knowledge Users, researchers, community organizations, reproductive health care providers		
12:30- 13:00	Join us for networking before we get started!	
13:00 – 13:20	WELCOME AND OVERVIEW Introduction of the CONNECT project planning so far, and need for community service expertise.	Leads
13:20 – 13:40	CONNECTING WITH EACH OTHER Participants each take one minute to introduce themselves and current practices in their organization or agency regarding IPV and reproductive health	All
13:40 – 14:00	EDUCATION AND INFORMATION Information sharing on IPV, reproductive coercion and current approaches to contraception	Wendy +Facilitator
14:00 – 14:20	CONNECTING OUR SERVICE DELIVERY: Interactive group discussion on connecting ourselves to connect women to family planning services and opportunity:	All +Facilitator
14:20 – 14:35	BREAK	All
14:35 – 16:00	INTERVENTION STUDY RECOMMENDATIONS	
14:35 – 16:00	Small group dialogue circles exploring: • Strengthening Connections between Community Services and Health services • Training and awareness needs • Other support needs Rapid report outs on intervention study recommendations	All +Facilitator
16:00 – 16:15	Closing remarks	Wendy
16:15 – 16:30	Networking for those able to stay	All

Appendix C: Agenda, Toronto, ON

	PLANNING MEETING FOR THE CONNECT STUDY: INTEGRATING FAMILY PLANNING INTO COMMUNITY SERVICES FOR WOMEN EXPERIENCING IPV	SHERATON GATEWAY HOTEL (IN TERMINAL 3)
Time	Activity	Speakers
09:30- 10:00	Join us for refreshments and networking before we get started!	
10:00 – 10:20	Welcome, Meeting Objectives and Introductions	Co-Conference Chairs - Robin Mason & Sheila Dunn Janet Brown – Facilitator
10:20 – 10:50	Setting the Context • Public Health Agency of Canada grant opportunity • Introduction to the project thinking – our starting vision for discussion	Wendy Norman, PHAC-CIHR Chair, Family Planning Public Health Research Robin Mason and Sheila Dunn
10:50 – 11:30	Discuss and Refine Vision and Share Current State Participants comment on interest and feasibility All share current related practices in their organization or agency regarding IPV and reproductive health	All + Janet Brown + Note Taker
11:30- 11:45	Break	
11:45 – 12:30	Identify Parameters /Foci for Ontario Project Participants discuss scope and focus of an Ontario study considering for example – • Connecting women in community to family planning services – barriers and facilitators • Identification (Identifying an unmet need) • Knowledge & resources (providers, clients) • Themes – safety, choice, access	All + Janet Brown + Note Taker
12:30 – 13:00	Lunch	
13:00 – 13:50	Next Steps Discussion on Study Design and Process of Development of Grant Submission	Wendy Norman, Robin Mason and Sheila Dunn
13:50 – 14:00	Closing Remarks	Wendy Norman
14:00 - 14:30	Networking with coffee and cookies for those able to stay	

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