NAVIGATING REPRODUCTIVE AUTONOMY IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE: PERSPECTIVES OF SURVIVORS AND SERVICE PROVIDERS

by

Jessica Catherine Grace, LMSW

PhD in Health Sciences, 2024

A Dissertation

Submitted to the Faculty of

Harris College of Nursing and Health Sciences

Texas Christian University

in partial fulfillment of the requirements for the degree of

PhD in Health Sciences

May

2024

APPROVAL

NAVIGATING REPRODUCTIVE AUTONOMY IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE: PERSPECTIVES OF SURVIVORS AND SERVICE PROVIDERS

by

Jessica Catherine Grace

Dissertation approved:

Nada Elias-Lambert

Nada Elias-Lambert, Major Professor

Kathy A. Baker

Kathy Baker, Committee Member

Erika Thompson

Erika Thompson, Committee Member

To my sons Adam &
Alistair.

And to all those impacted
by intimate partner
violence, both the
survivors that participated
in this research, and the
lives we lost too soon.

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the support and encouragement of many mentors, colleagues, family, and friends. I would like to acknowledge every person that played a role in helping me achieve this final step. First, to my advisor, Dr. Nada Elias-Lambert, thank you for your guidance and support throughout this process. Your reminder to strive for "perseverance, not perfection" helped me get through the most challenging parts of this process, and I am incredibly grateful for all you have done to support this research and my personal success. I also want to thank you for modeling how to champion other women in academia.

To the other members of my dissertation committee; Dr. Kathy Baker and Dr. Erika Thompson, thank you for providing your expertise and feedback in crafting my research methodology and design. Dr. Baker, thank you for the countless printed articles, always pushing me to consider new concepts and approaches to qualitative research. Dr. Thompson, thank you for your encouragement and for bringing your public health lens and reproductive health expertise to my committee. Additionally, thanks for providing flexibility in my work schedule so that I could write and conduct data collection for this dissertation.

To my personal mentor and friend Dr. Emily Spence. Thank you for showing me the value of community-based research and for encouraging me to pursue the doctoral program at TCU. You have influenced this work in many ways and am thankful for your feedback and advice.

To my fellow cohort members; Darryl, Michael, and Jhala. Thanks for the laughter and group texts that kept me moving forward. I love the community that we built together

in this program and can’t wait to see the amazing things that each of you accomplish.

Additionally, I want to state my appreciation to the administration of Harris College at Texas Christian University for providing student grant funds to support this research. And to all the PhD faculty within Harris College, for putting up with our cohort, and being willing to teach and support doctoral students even when there was little personal benefit.

I want to also acknowledge the community agencies that provided space and allowed me to recruit participants at their facilities. Specifically, my appreciation for the leadership of Safe Haven of Tarrant County, One Safe Place, Genesis Women’s Shelter and Support, and The Family Place. A special thanks to each of the survivors and service providers who participated in this research and were willing to share their stories.

And finally, to my family, who have held me up throughout this entire journey. To my boys, Adam, and Alistair, thank you for sacrificing moments with your mom and for enduring the occasional stress while writing this dissertation. Thanks for reminding me of my goal and saying that “if doing this work allows me to help more people, then I should do it.” You are my inspiration for creating a world without violence. And to my husband and partner, Justin, thank you for your love and patience. You stepped in and took on increased responsibilities, so that I could concentrate on my research and writing. Throughout it all, you have been my biggest supporter. I could not have done this without you by my side.

ABSTRACT

NAVIGATING REPRODUCTIVE AUTONOMY IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE: EXPERIENCES OF SURVIVORS AND SERVICE PROVIDERS

by

Jessica Catherine Grace

PhD in Health Sciences, 2024

Nada Elias-Lambert, Advisor, Department Chair

This dissertation comprises three articles examining the ways in which women in intimate partner violence (IPV) relationships navigate decisions regarding their sexual and reproductive health (SRH), with a focus on informing SRH services within IPV agencies. The first article presents findings from a qualitative interpretive meta-synthesis (QIMS) of existing literature, exploring the reproductive decision-making processes of women experiencing abuse. The subsequent articles report on empirical studies exploring the responsiveness of IPV service agencies in assessing the SRH needs of their clients. Utilizing individual interviews and focus groups, both survivors and service providers contribute insights into their experiences with SRH discussions, identify barriers to screening within current agency protocols, and propose recommendations for the formation of a comprehensive SRH assessment framework aimed at facilitating these conversations.

TABLE OF CONTENTS

CHAPTER I: INTRODUCTION

Intimate partner violence (IPV) is a public health issue that impacts millions of people across the globe (Sardinha et al., 2022). IPV refers to any form of physical or sexual violence, stalking, or psychological aggression by a current or former dating partner or spouse and is increasingly common in the United States (Centers for Disease Control and Prevention [CDC], 2022). It is projected that 1 in 3 US women will experience IPV over the course of their lifetime, a prevalence rate greater than that of depression (8.4%; Center for Behavioral Health Statistics and Quality, 2022) or illicit drug use (8.9%; Merikangas & McClair, 2012).

IPV has negative impacts on both individuals and communities. In a report conducted by the CDC, the projected lifetime economic cost associated with IPV was $3.6 trillion (Petersen et al., 2018). This figure includes healthcare expenses associated with IPV-related injuries, lost productivity from paid work, cost of law enforcement, emergency response, legal and court fees, childcare expenses, and other related costs (Petersen et al., 2018). Consequently, identifying methods to reduce rates of IPV is not only beneficial for the persons directly impacted, but for the overall health of our society.

IPV is associated with negative health outcomes that impact the physical, mental, and social well-being of survivors. Historically, the healthcare response to IPV has centered on the more visible, physical impacts of IPV, such as broken bones and bruises, which impact nearly 41% of IPV survivors (Basile et al., 2011). However, as research into the connection between trauma and long-term health consequences has broadened, there has been a corresponding rise in studies that examine how experiences of trauma, such as IPV, affect both immediate and long-term health (Felitti et al., 1998). Individuals who experience IPV are at an increased risk for mental health conditions such as depression and PTSD, and have a greater risk for chronic pain, cardiovascular and gastrointestinal problems, and gynecological disorders (Campbell et al., 2002, Coker et al., 2002).

Women experiencing IPV also have poor sexual and reproductive health (SRH) outcomes. These include greater risk of acquiring sexually transmitted infections (STIs), unintended pregnancies and miscarriages, and gynecological disorders and cancers (Campbell et al. 2002). For women in IPV relationships, their bodily autonomy is often limited. Their partners may not allow them to use birth control or sabotage efforts when they try to use contraception. Abusive partners may pressure women to get an abortion or to engage in risky sexual practices. These behaviors are classified as “reproductive coercion” and are common in the context of IPV. In the 2010 study by Miller and colleagues, researchers discovered that 35% of women in IPV relationships report experiencing some form of reproductive coercion by their partner (Miller et al., 2010). Researchers defined reproductive coercion as a male partner’s attempts to control the reproductive autonomy of his partner through (1) pregnancy coercion, (2) birth control sabotage, and (3) control of pregnancy outcomes (Miller et al., 2010). It is this loss of autonomy in SRH health decisions that makes women in IPV relationships vulnerable and at greater risk for sexual and gynecological problems.

The population most likely to be impacted by IPV is individuals who identify as female and within child-bearing age, which is why mitigating the impact of violence on reproductive health is particularly urgent (Leemis et al., 2022, Riveria et al., 2009). Traditional strategies to reduce STIs and unintended pregnancies tend to focus on condom negotiation, which is not always feasible or safe in the context of an abusive relationship (Koenig & Moore, 2000). Therefore, further research is needed to develop strategies that effectively meet the needs of this population. Without a clear understanding of the experiences of IPV survivors when making decisions about their SRH, we cannot implement strategies that will be effective in risk mitigation or that will enhance the reproductive autonomy of survivors of IPV. Outcomes related to survivors' reproductive health will continue to worsen, especially as forms of reproductive healthcare are increasingly politicized and restricted within specific geographic areas of the United States (Kulczycki, 2022). Further research is needed that includes the perspectives of IPV survivors and service providers to design interventions or strategies that address their needs.

Theoretical framework

This study utilized Critical feminist theory as the framework for its research approach. Although there are many approaches to feminist research, the primary researcher in this study adheres to the foundational feminist belief which proposes that when power and oppression are acknowledged and disrupted, understanding, advocacy, and change can occur (Arinder, 2020). Feminist theory offers a framework to examine how power structures influence societal responses to IPV and women's health issues. According to Lather (1991), a leading scholar in this approach, "the aim of feminist ideological research is to correct both the invisibility and distortion of the female experience in ways relevant to ending women's unequal social position" (Creswell & Poth, 2016, Lather, 1991). When exploring the association between IPV and SRH outcomes, it is clear to see how gender-based power dynamics, societal structures, and cultural norms influence SRH outcomes for survivors of IPV. These issues are predominantly experienced by women, and in patriarchal societies where men have historically controlled all positions of power, these concerns have largely been overlooked or dismissed. However, the foundation of the feminist movement and its corresponding research has possessed its own blind spot, by centering the anti-violence movement on white women's experiences and overlooking the role of race on survivor experiences (Crenshaw, 1989; Gill, 2018; Kendall, 2021).

The critical aspect of this framework incorporates intersectionality into its research design. Intersectionality builds upon the beliefs that undergird feminist theory but also "places emphasis on the ways that multiple forms of inequality or disadvantage compound themselves and create obstacles that often are not understood among conventional ways of thinking" (Crenshaw, 1989). Given that black and Hispanic IPV survivors are disproportionately impacted by reproductive coercion and negative SRH health outcomes (Prather et al., 2016. Randolph et al., 2011), this dissertation required exploring how race and other marginalized identities factor into survivor experiences. Working from this lens, the researcher employed data collection strategies that explored the racial, cultural, and religious experiences of IPV survivors and service providers. An intersectional lens also provides a way to understand how context impacts individual decision-making, which was a key aspect of this dissertation research. By understanding how factors related to race, culture, and religion impacted the experiences of survivors of IPV, this research can aid in the development of approaches that consider those factors, ultimately contributing to the creation of interventions and policies that are sensitive, inclusive, and empowering to survivors.

Connection between manuscripts

The overarching goal of this dissertation research is to provide a comprehensive understanding of how women experiencing intimate partner violence (IPV) make reproductive health decisions, with the overall aim to guide practice interventions that specifically address the SRH needs of survivors. The three manuscripts that are included in this dissertation achieve that goal in the following ways.

The first manuscript in this dissertation, Reproductive Decision-Making of Survivors of Intimate Partner Violence, serves as the foundation for this dissertation project. By utilizing the Qualitative Interpretative Meta-Synthesis (QIMS) framework, this researcher was able to synthesize the existing qualitative research from the perspectives of IPV survivors in SRH decision-making. This study looked at survivor populations both inside and outside of the United States, and studies where the voices of female survivors were incorporated in the research process. The synthesis resulted in a total of eight studies and highlighted shared themes across geographic areas and study settings. These included the shared experiences of reproductive control experienced by male partners and the distinct coping strategies that women use to mitigate health risks and assert reproductive autonomy. Additionally, these findings provided greater support for the use of intersectional lenses when conducting research with this population. Race and cultural factors played a critical role in shaping the individual decision-making of survivors and their access to resources. This manuscript underscores the importance of considering the diverse and complex factors that impact survivors' decision-making processes. It also provides guidance on how providers should navigate conversations around sensitive SRH topics such as family planning and contraception.

The second manuscript sought to explore the role of IPV service providers in responding to the SRH needs of their clients. Through qualitative methodology and one on one interviews with agency staff, this researcher explored whether those working with IPV survivors were aware of the increased SRH risks for their clients, and what they were doing to assess or respond to those needs. This researcher's social work experience in IPV agency settings and a review of the literature suggested that a majority of IPV agencies provide few, if any, services to address the SRH needs of their clients. Utilizing Bronfenbrenner's ecological systems theory as the guiding framework, this researcher explored contributing factors at the individual, agency, and community levels. The findings of this study identified a willingness by service providers to engage in discussions around SRH needs, but a lack of knowledge and resources to do this effectively. Service providers also emphasized a lack of proper assessment tools. This study identified the challenges faced by service providers in providing comprehensive care to survivors and the need for SRH-specific screening tools, training, and resources.

The third manuscript builds upon the findings from the previous study by directly responding to the recommendations that emerged. The study aim was to elicit the perspectives of IPV survivors and IPV service providers in the development of a SRH assessment framework for use in agency settings. This third manuscript addresses the gap between the experiences of survivors and the capabilities of service providers with the goal of enabling more effective and supportive care. Through incorporating insights from both IPV survivors and service providers, this research aids in the construction of a practical and sensitive framework that can be utilized within IPV agencies to address survivors' SRH needs appropriately. By conducting research that informs the development of tools for service providers, it is objective of this researcher to enhance the quality of care and support available to survivors of IPV.

Manuscript #1: Reproductive decision-making in abusive relationships: A qualitative interpretive meta-synthesis on the experiences of women

Jessica Grace, LMSW, PhD Candidate

Harris College of Nursing and Health Sciences

Texas Christian University

Abstract

Women who experience intimate partner violence (IPV) are at increased risk of negative reproductive health outcomes. However, strategies addressing the sexual and reproductive health (SRH) needs of survivors often overlook their perspectives. This study conducted a qualitative interpretive meta-synthesis (QIMS) of existing literature to explore the reproductive decision-making of women in abusive relationships. A systematic search of the literature was completed to identify articles that included the perspectives of women in IPV relationships around sexual or reproductive health decisions, utilized a qualitative methodology, and included participant quotations. The search yielded 789 articles, and after screening, 8 articles were included in the QIMS. Through coding and synthesis, original themes and quotes were consolidated into 4 new themes:(1) the interconnectedness of IPV and reproductive coercion, (2) covert strategies to assert reproductive control, (3) the influence of cultural and community beliefs (4) a need for a trauma sensitive health care response. The synthesis underscores crucial insights for addressing SRH needs in practice.

Reproductive decision-making in abusive relationships: A qualitative interpretive meta-synthesis on the experiences of women

There is a well-established connection between women experiencing intimate partner violence (IPV) and poor sexual and reproductive health (SRH) outcomes. Although advancements in medical research have improved access and prevention options, women experiencing IPV are four times more likely to acquire human immunodeficiency virus (HIV) than their peers in non-abusive relationships (Coker, 2007). Female survivors of IPV also have higher rates of unintended pregnancy, miscarriage, other sexually transmitted infections (STIs), and are at greater risk for gynecological disorders and cancer (Campbell, 2002; Coker, 2007). This group of women is also more likely to have unprotected intercourse and experience reproductive coercion at the hands of their partner (Koenig & Moore, 2000, Miller et al., 2010). It is the lack of autonomy that exists within IPV relationships that makes prevention and protection for these women especially difficult.

As researchers have examined the link between IPV and sexual health outcomes, various strategies for this population have been explored. This has included expanding education and awareness of different methods of contraception; testing the acceptability of Pre-exposure Prophylaxis (PreP), a human immunodeficiency virus (HIV) prevention medication for women experiencing IPV; and training healthcare providers to screen for reproductive coercion (O'Malley et al., 2020, Willie et al., 2017). Most studies have utilized quantitative methodology to assess the efficacy of an intervention or provide a statistical analysis of the prevalence of these challenges. Yet to improve outcomes for female survivors of IPV, it is essential to understand the lived experiences of these women. By examining how IPV survivors navigate SRH decisions, we can better inform policy and practice interventions that are targeted to the needs of survivors. Qualitative research is well positioned to do this, as its methodology centers on highlighting the voice of participants. It is the objective of this review is to synthesize the available qualitative studies that speak to the experiences of female victims of IPV in how they make decisions related to their SRH.

Qualitative Interpretive Meta-Synthesis (QIMS)

To understand the reproductive health decision-making of women in IPV relationships, this study utilized the Qualitative Interpretive Meta-Synthesis (QIMS) framework as proposed by Aguirre and Bolton (2013). QIMS is a method of qualitative synthesis that emerged relatively recently, therefore the literature utilizing the QIMS approach is limited. However, a range of topics associated with IPV have been approached using QIMS such as children's exposure to IPV (Ravi & Casolaro, 2018), military-connected spousal abuse survivor narratives (Highfill & Chen, 2022), and experiences of postpartum depression among marginalized women (Maxwell, Robinson, & Rogers, 2018). To date, no QIMS has been conducted on the topic of SRH decision-making by IPV survivors. This study utilized the QIMS methodology to synthesize qualitative literature focusing on reproductive health decision-making to come to a deeper understanding of factors that impact the reproductive health decisions of IPV survivors.

QIMS is a methodology that allows researchers to come to a deeper understanding of a phenomenon or shared experience (Aguirre & Bolton, 2013). QIMS allows researchers to synthesize qualitative findings on a topic across the literature to reveal insights into participants' experiences with a specific phenomenon (Aguirre & Bolton, 2013). QIMS methodology is designed to incorporate social work ethics and values into a framework that allows for interpretive analysis of qualitative data (Aguirre & Bolton, 2013). This is accomplished by not only reviewing the original authors' published themes but also reviewing the participant quotations included within the manuscript. The themes and quotations are extracted and compiled into a new data set to capture participants' experiences of a shared phenomenon across the literature. QIMS follows a set analysis process that involves developing a research question, completing a systematic search of existing literature, and finally analyzing identified articles through theme extraction, theme synthesis, and triangulation (Aguirre & Bolton, 2013). In addition to the analysis process, it is important for researchers to bracket, or disclose, their experiences with a phenomenon to increase the trustworthiness of the synthesis.

Methods

Instrumentation

In qualitative research, the researchers serve as the instruments of data collection (Creswell & Poth, 2016). For this reason, the credibility of the authors is to be noted. In this research, the first author served as the primary analyst, drawing on her expertise from working with survivors IPV. The second author acted as a co-analyst, offering an external viewpoint to validate the conclusions drawn by the first author.

First author

As a licensed master's level social worker (LMSW), my research interests are centered on IPV and SRH. Although I have never experienced IPV, I have had family members and friends who have. I have had the privilege to work with countless women impacted by IPV over the course of my 17-year career in social work. These settings have included shelter facilities, housing programs, and outreach centers for women who have experienced violence. My interest in this topic comes from working with these women and hearing about their experiences with sexual violence and trauma. Additionally, I have observed a lack of awareness around sexual health resources by many of my coworkers and colleagues. I approach this research from an etic perspective.

Second author

As a PhD-level LMSW, my research interests center on the prevention of gender-based violence with a specific focus on bystander intervention programs to promote culture change and prevent sexual violence and other oppressive behaviors. I have worked in the gender-based violence prevention field for over 20 years. I have also been an active community organizer to advocate for macro level change to support survivors of gender-based violence. Though I have not experienced IPV, I have worked in many social work settings and community spaces in support of IPV survivors. I have supported IPV survivors and continue to advocate to prevent the behaviors that perpetuate IPV in our communities. I am also a current university faculty member and currently teach an undergraduate Intimate Partner Violence course each Spring. I approach this topic from the etic perspective.

Study Selection

The research objective of this study was to synthesize the available qualitative literature on the reproductive health decision-making experiences of female victims of IPV. From this aim, the authors formed the criteria for the literature search. Studies selected for inclusion were (1) those that included female victims of IPV, (2) discussed the experience of reproductive health decision-making, and the (3) study design utilized was a form of qualitative data collection. For purposes of this review, “intimate partner violence” refers to abuse that occurs within a romantic relationship and can involve past or current partners. Reproductive health refers to choices that impact sexual well-being and the reproductive system. This can include choices about contraception, sexual practices, family planning, STI prevention and treatment, and abortion. Qualitative methods can include semi-structured interviews, focus groups, observations, or case studies. Only studies published in English and within the past twenty years; 2002-2022, were included. Articles or publications prior to this date were removed as part of the exclusion criteria.

Search Strategy

The search strategy aimed to locate both published and unpublished studies. An initial limited search of SocIndex (EBSCO) was undertaken to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles and the subject terms used to describe the articles were used to develop a full search strategy for five EBSCO based databases; MEDLINE, PsyInfo, SocIndex, Family Studies Abstracts, and Family and Society Studies WorldWide. These EBSCO-based databases were selected as they are commonly referenced within the public health and social science fields. Additional searches for subject terms, and synonyms within individual databases informed the final keywords used for the review. The keywords used for the search were “intimate partner violence” or “domestic violence” or “spousal abuse” or marital violence” or “dating violence” or “coercion”. Additional keyword search for reproductive health included “contraceptive devices”, “condoms”, “HIV prevention”, “sexually transmitted”, and “birth control”.

Decision-making, intervention, and choice behavior were the final group of keywords searched. Duplicates were removed, and inclusion criteria were used to screen articles. The remaining articles were retrieved for full-text and assessed for eligibility by two independent reviewers. An additional article was added at this stage that met inclusion criteria but had not come up in the original search, and was known by the author due to her familiarity of the research focus. Three of the studies that met inclusion also included the perspectives of service providers and key informants in addition to those of the women experiencing IPV. Although the aim of this QIMS was to focus solely on the experiences of IPV survivors in these studies, the data and quotes from other participants in those studies were identified separately from those of the IPV survivors. Because of this distinction, this researcher decided to include these studies as part of the synthesis. Only quotes and themes attributed to the female IPV survivors were utilized in the synthesis. The PRISMA chart in Figure 1.1 details the search process, which resulted in eight studies included in this meta-synthesis. Table 1.1 provides a summary of participant demographics, study design, and location of the study for each article included in this QIMS.

Data Analysis

Data extraction of the original study themes was the next step in the process. In QIMS, it is important to use the same language and concepts provided by the authors to eliminate potential researcher bias and ensure an accurate representation of the phenomena being explored. The original themes and subthemes are identified and categorized in Table 1.2.

Theme Synthesis

After the original themes were extracted, the researcher started the process of analyzing these themes for shared meaning and concepts. This included reading through each article and coding any frequently used concepts, words, and participant quotes that represented the original themes. From there, the researcher moved into grouping those codes into categories that were similar across studies. The researcher noted the frequency of common phrases such as “contraceptive sabotage” and “pregnancy coercion” and how experiences related or varied from participants in other studies. Use of memos highlighted these connections throughout analysis helped create an understanding of the overall experiences of these women. A secondary reviewer evaluated the articles independently to determine if similar categories and themes emerged. Both reviewers met together to discuss their analysis and reconcile any differences. In the case of any disagreements between the reviewers, these were resolved through discussion.

Triangulation

Three forms of triangulation were used in this study: data collection, source, and analyst

(Patton, 2002). Data collection triangulation involved reviewing studies to ensure a diversity of data collection methods were used. Studies in this synthesis include focus groups, interviews, and observations. Source triangulation involves utilizing multiple sources of data to ensure an accurate representation of resulting themes. In qualitative research, participant voices are the primary source of data. Across the eight studies included in this QIMS, 254 female participant perspectives were incorporated. Additionally, these participants represent perspectives from different geographic areas of the world and study settings. Analyst or "investigator" triangulation was used between both researchers to ensure an objective analysis of themes and reduce potential bias.

Results

The initial database search resulted in 1,206 related studies. After duplicates were removed (n=417), 789 studies were screened through inclusion criteria and an abstract review. Thirty-two full-text articles were retrieved for more detailed evaluation, resulting in the selection of seven eligible articles. Reference checking led to the addition of one article being added that was not previously identified in the search. Eight qualitative articles were included in the final QIMS. This included five studies that were conducted within the United States, and three that were conducted in Kenya and Pakistan. Studies were published between 2008-2022, with the majority (n=6) being within the past five years. Study settings included both urban and rural communities, and participants were recruited through domestic violence shelters, family planning clinics, communities, and abortion clinics. Participants across all studies identified as women who had experienced IPV.

Themes

There were four major themes that emerged across the studies to provide a synergistic understanding of the reproductive health decision making of female IPV survivors. These include (1) the interconnectedness of IPV and reproductive coercion, (2) covert strategies to assert reproductive health control, (3) the influence of cultural and family beliefs, and (4) a need for a trauma informed health care response. Table 1.3 details how these new themes align with the original themes of the articles.

Interconnectedness of IPV and Reproductive Coercion

The shared experience of reproductive coercion by male partners was a theme consistently described by women across all study settings. This was most pronounced when it came to decisions around pregnancy and family planning. Women described a range of behaviors by their male partners that included pressure to become pregnant, acts of contraception sabotage, and attempts to control pregnancy outcomes (Bagwell-Gray, 2019; Boyce, 2020, Grace et al., 2020; Hussain & Khan, 2008, Moore et al., 2010, Meier et al, 2021, O'Conner-Terry et al.,2022, Wood et al.,2021). This pressure was most evident when a woman expressed a desire to prevent pregnancy or use birth control. Several women described that these attempts at family planning were often met with anger and threats by their male partners. "He told me that if I am not willing to give birth to another child then he will start looking for alternatives somewhere…to get other women who are willing to have kids for him" (Boyce et al., 2020). Women in every study reported experiencing acts of contraception sabotage by male partners, such as tampering with birth control pills or attempting to remove an implant. As this participant described:

> There was another time I started using the Ring [the NuvaRing, a hormone-releasing ring placed in the vagina to prevent pregnancy that must be changed monthly] and he pulled it out of me. [He asked] What's this, who advised you to be using this kind of stuff? I said, thought I could actually hide this one, not knowing you will come up inside of me and pull it out of me (Moore et al., 2010).

Sometimes this sabotage was indirect through methods that included throwing away clinic appointment cards or leaving their partner without money to pay for her Depo-shots (injectable birth control) (Bagwell-Gray, 2019; Boyce, 2020, Grace et al., 2020; Hussain & Khan, 2008, Moore et al., 2010, Meier et al, 2021, O'Conner-Terry et al., 2022, Wood et al., 2021). In other situations, women described physical violence and safety concerns. As this woman's husband said, "if I find out you had an abortion; I will kill you." She went on to say, "so I really was forced into having my son." Another woman described the opposite experience with her husband pressuring her into having an abortion through threats of violence; "He sat there and was like, "If you don't get it done, I'm throwing you down the steps, or I'm doing something!" (Moore et al., 2010).

The shared experiences of reproductive coercion across geographic settings and study populations demonstrates the interconnectedness that exists between physical abuse and reproductive coercion in IPV relationships. Taking away reproductive autonomy is another way that abusers seek to control or dominate their partner. Although all IPV is rooted in power and control, these studies illustrate the unique barriers women face. For a woman in an IPV relationship to choose to protect herself from SRH risks is often a decision that results in additional harm and safety concerns.

Covert Strategies to Mitigate SRH Risk

Despite known risks, women in all studies described strategies they used to protect themselves and prevent unwanted pregnancies. These included use of "discrete" forms of contraception that are less visible to a partner. As a participant from Kenya described using a female condom;

> If you insert it early enough, it will feel like your body. When you want to have sex, you have to be the one inserting the penis. And the man won't know if you have the female

> condom, if you are bright. (Wood et al., 2021)

Method switching (alternating birth control methods to avoid discovery) and injectable forms of birth control (such as the Depo shot) were other strategies that women utilized without their partner's knowledge. "You wait until your partner is not around, and rush to the nearest clinic, get an injection, and hide the clinic card" (Boyce et al., 2020, Grace et al., 2020). A few participants described asserting full reproductive control and getting tubal ligation (permanent sterilization) without telling their partners. This eliminated fears of unwanted pregnancies, since in most cases, male partners refused to use any form of contraception.

> I have had sterilization. My husband opposed it and did not want me to stop having children. I told him we have four sons and four daughters—how am I supposed to take care of them? When he went to [city name] for 2 weeks, I got the operation done. He came back and said, you have done this without my permission, I will not forgive you (Hussain & Khan, 2008).

The use of covert strategies, in light of real safety concerns, highlights that women in IPV relationships are acutely aware of the risks to their SRH health and are actively pursuing methods to mitigate those harms within the context of their relationships. This theme dismisses the idea that women in IPV relationships need to be educated about the risks posed to them, but instead supported in identifying methods that work within the dynamics of their relationships and can reduce harm.

Influence of Cultural and Community Beliefs

This synthesis included studies that took place in the United States and in other parts of the world, specifically Kenya and Pakistan. The dynamics of the communities where each of these women resided heavily influenced their attitudes and decision-making around SRH options. Although women in all settings described similar experiences of reproductive coercion, cultural factors played a role in their decision-making and access to SRH resources. For example, in Pakistan, the authors of that study noted that marital rape is not recognized, as it is a commonly held belief that it is a man’s right to expect sex from his wife (Hussain & Khan, 2008). This cultural norm or belief was illustrated in the differences in responses by older women in that community versus those of younger female survivors. As this older woman stated, “This is part of marriage—many men behave like this, but young women these days think only of themselves.” (Hussain & Khan, 2008). This statement demonstrates the additional barriers that exist for women in these environments even from other female survivors when seeking support or options around SRH decisions.

These belief systems were not unique to women living outside of the United States. Similar beliefs were expressed by participants in the studies facilitated in the United States. Whether based in culture, religion, or familial norms, many women described belief systems that reinforced the loss of their bodily autonomy. As this participant expressed: “I believe that we are still looked at as less of a person because we are women . . . I believe that society believes that women’s bodies don’t belong to them”. Or as this woman described in the context of marriage; “he decided that because I was his wife, it was his body” (Meier et al., 2020).

Cultural influences also contributed to the choices women considered for themselves. This woman shared that her beliefs prohibited the use of birth control; “I'm really into my culture and my values my traditions . . . And [not using birth control is] just what Creator wants us for us, what he wants in our lives.” (Bagwell-Gray, 2019). These belief systems whether rooted in cultural, religious, or family norms, can be a critical factor in how women consider their own reproductive autonomy and the decisions they make. It also highlights the challenge of identifying and responding to sexual coercion within the context of IPV relationships, especially when an individual belief system enables or condones certain forms of abuse.

Trauma Sensitive Healthcare Response

Across study settings, the need for trauma sensitive reproductive healthcare was another theme that emerged. Three of the eight studies included in this synthesis were facilitated with women receiving services in healthcare settings including community health clinics, family planning clinics, and an abortion clinic (Boyce et al., 2020, Grace et al., 2020, Moore et al., 2010). As previously mentioned, women in every setting described using contraception, and often that meant accessing care from a healthcare provider. Although some women mentioned attempts by their partners to interfere in accessing healthcare, many women still were able to access contraception. In these cases, women mentioned the need for providers to understand how experiencing IPV complicates their choices. This participant described how even the concept of family planning denotes a certain level of autonomy, not always accessible to women in IPV relationships;

> I didn’t plan none of my children. I think planning is quite a privilege. Your upbringing, your background, whether your family has a lot of say on what kind of life you’re supposed to live...I think all of those things make a difference *(*Meier et al., 2022).

For the women that were able to access healthcare providers, they were quick to identify the importance of confidentiality by providers when discussing contraceptive choices. This was particularly true for women in communities with limited providers and where patient anonymity is reduced.

> She knows me, and chances are that she knows my husband. So, when I go to the facility, and [she] provides me with the family planning services, [she] might tell her husband, and then her husband goes and tells my husband that I am on family planning. Yet, you were doing these things privately. Maybe my husband does not want [me to use family planning]. You, see? This will turn into a fight in the house. (Boyce et al., 2020).

Confidentiality by providers must also acknowledge the unequal power dynamics that exist in IPV relationships and that often women experiencing IPV are making reproductive health decisions without their partner's knowledge or consent. (Boyce et al., 2020, Grace et al., 2020, O'Conner-Terry et al., 2022). These choices may contribute to increased violence if discovered, and why women across studies emphasized how critical it was for providers to listen to the needs of women. As this woman stated;

> If a woman's coming in and asking for birth control because she's being abused and she don't want a child, give it to her! Some doctors now, want the partner consent! What the fuck is that? That's not fair to those women! That should be their right, whether they have kids or not! Just because the partner does, don't mean she has to make a kid for him! That's her right to go on birth control, not nobody else's. (O'Conner-Terry et al., 2022).

Discussion

This qualitative synthesis explored the reproductive decision-making of women in abusive relationships. To our knowledge, this is the first qualitative synthesis reported on this topic. One finding consistent across studies was the prevalence of reproductive coercion experienced by these women. Reproductive coercion refers to direct or indirect acts of pregnancy coercion, birth control sabotage or condom negotiation by male partners (Miller et al., 2010) Most literature indicates reproductive coercion rates within IPV relationships are around 35%, however, this synthesis provides a greater understanding of the sexual dynamics that exist in these types of relationships and factors that may be impacting disclosure (Miller et al., 2010). We can hear through women's voices how particular belief systems and cultural norms can create barriers for identifying and responding to reproductive coercion, especially when the partner is married to the abuser. This is consistent with previous findings that have highlighted the challenge of defining sexual violence within the context of an intimate partnership (Bagwell-Gray et al., 2015). As we also see in this synthesis, women often struggle to identify experiencing sexual abuse or violence in marriages, and that places greater responsibility on providers to understand these dynamics and respond appropriately. This synthesis supports previous calls for consistent terminology and measures to identify sexual or reproductive coercion, rape, or sexual violence within IPV relationships to create a more supportive and effective response (Bagwell-Gray et al., 2015).

The use of covert strategies to assert reproductive control was another consistent finding across study settings. In many cases, the use of contraception required deception and lying to their partners, with potentially dangerous results. In most of these cases, women were seeking to avoid unwanted pregnancies. Several women recognized that their partners were using pregnancy to exert more economic control over them to ensure they remained in the relationship. They understood that more children would make it harder for them financially to leave and increase reliance on their partner. This finding provides greater evidence that women in IPV relationships are often aware of their SRH risks and uniquely skilled at navigating reproductive decisions in the context of abusive circumstances, however, they may not have access to their preferred SRH care or the resources that they need.

Finally, this synthesis highlights the opportunity that exists for service providers in listening to the experiences of women and incorporating their insights into the services they provide for survivors. For individuals engaging in any work with IPV survivors, they must recognize and address the prevalence of reproductive coercion and the impact that it has on women’s health and their futures. Although most IPV education states that IPV is rooted in issues of power and control, too often how that control is manifested over survivors in a sexual or reproductive health manner is ignored (National Domestic Violence Hotline, 2024). The popular Duluth Model Power and Control wheel used in most IPV agencies mentions sexual violence, yet literature suggests that most IPV agencies do not assess for SRH needs arising from experiencing sexual coercion (Domestic Abuse Intervention Project, 1993; Cavanaugh & Ward, 2021). This synthesis supports the need for further education and training for service providers around navigating these discussions and the importance of survivor-informed approaches to service response.

Implications for social work

This meta-synthesis provides a greater understanding of the experiences of women in IPV relationships as they navigate reproductive health choices. The findings for this study have several implications for social work practice. First, this study highlighted that reproductive coercion is a common experience for women in IPV relationships, and that those working with survivors need to be skilled in navigating discussions around SRH. This includes training staff on assessing for reproductive coercion and expanding awareness of reproductive health resources for survivors. Next, agencies must recognize how individual and cultural beliefs influence the way women view reproductive choices and seek to exhibit cultural humility and sensitivity when discussing health care options and resources. Finally, this study reminds practitioners that most women in IPV relationships are aware of the personal SRH risks but often dynamics of IPV relationships make accessing certain forms of contraception or resources dangerous. For this reason, sexual safety should be considered when completing traditional safety planning with survivors.

Limitations

Aguirre and Bolton (2013) highlight that the limitations of QIMS are like those of any qualitative study, the subjectivity of the data analysis and potential researcher bias. Researchers in this study sought to address those limitations through adhering closely to the QIMS methodology and utilizing several forms of triangulation. However, researcher bias cannot ever be eliminated. Additionally, although the studies in the synthesis incorporated the voices of 254 survivors of IPV, this sample cannot be fully representative of the spectrum of experiences of women in IPV relationships across the world.

References

Aguirre, R. T. P., & Bolton, K. W. (2013). Qualitative interpretive meta-synthesis in social work research: Uncharted territory. *Journal of Social Work*, 0(0), 1-16. https://doi.org/10.1177/1468017313476797

Bagwell-Gray, M. E. (2019). Women's healing journey from intimate partner violence: Establishing positive sexuality. *Qualitative Health Research*, *29*(6), 779-795.

Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence, & Abuse*, *16*(3), 316-335. https://doi-org.ezproxy.tcu.edu/10.1177/1524838014557290

Boyce, S. C., Uysal, J., DeLong, S. M., Carter, N., Undie, C. C., Liambila, W., ... & Silverman, J. G. (2020). Women's and girls' experiences of reproductive coercion and opportunities for intervention in family planning clinics in Nairobi, Kenya: A qualitative study. *Reproductive Health*, *17*, 1-12.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Cavanaugh, C., & Ward, K. (2021). HIV/STI prevention interventions for women who have experienced intimate partner violence: A systematic review and look at whether the interventions were designed for disseminations. *AIDS and Behavior*, *25*(11), 3605-3616

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, & Abuse*, *8*(2), 149-177.

Domestic Abuse Prevention Project (n.d., circa 1993). *Power and control wheel.* National Center on Domestic and Sexual Violence. http://www.ncdsv.org

Grace, K. T., R. Decker, M., A. Alexander, K., Miller, E., Campbell, J., Perrin, N. A., & Glass, N. E. (2020). Reproductive coercion among Latina women and strategies for minimizing harm. *Journal of Midwifery & Women's Health*, *65*(5), 717-717.

Hussain, R., & Khan, A. (2008). Women's perceptions and experiences of sexual violence in marital relationships and its effect on reproductive health. *Health Care for Women International*, *29*(5), 468-483.

Highfill, M. C., & Chen, Z. (2022). A qualitative interpretive meta-synthesis of military-connected spousal abuse survivor narratives. *The British Journal of Social Work, 52*(1), 177-197. doi: 10.1093/bjsw/bcaa226

Koenig, L. J., & Moore, J. (2000). Women, violence, and HIV: a critical evaluation with implications for HIV services. *Maternal and Child Health Journal*, *4*, 103-109.

Maxwell, D., Robinson, S. R., & Rogers, K. (2018). "I keep it to myself": A qualitative meta-interpretive synthesis of experiences of postpartum depression among marginalised women. *Health and Social Care in the Community, 27*, 23-26. doi: 10.1111/hsc.12645

Meier, S., Brig, K., Delay, C., Sundstrom, B., Schwab-Reese, L., & DeMaria, A. L. (2021). "I'm more open to talking about it": women's experiences with sexual abuse and reproductive health. *Journal of Interpersonal Violence*, *36*(23-24), NP13136-NP13161.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, *81*(4), 316–322. https://doi.org/10.1016/j.contraception.2009.12.004

Moore, A. M., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine*, *70*(11), 1737-1744.

National Domestic Violence Hotline website (2024). Identify Abuse, Power, and Control. https://www.thehotline.org/identify-abuse/power-and-control

O'Connor-Terry, C., Burton, D., Gowda, T., Laing, A., & Chang, J. C. (2022). Challenges of seeking reproductive health care in people experiencing intimate partner violence. *Journal of Interpersonal Violence*, *37*(7-8), NP5167-NP5186.

O'Malley, T. L., Hawk, M. E., Egan, J. E., Krier, S. E., & Burke, J. G. (2020). Intimate partner violence and pre-exposure prophylaxis (PrEP): A rapid review of current evidence for women's HIV prevention. *AIDS and Behavior*, *24*, 1342-1357.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. Sage.

Ravi, K. E., & Casolaro, T. E. (2018). Children's exposure to intimate partner violence: A qualitative interpretive meta-synthesis. *Child and Adolescent Social Work Journal*, *35*, 283-295. doi: 10.1007/s10560-017-0525-1

Willie, T., Kershaw, T., Campbell, J. C., & Alexander, K. A. (2017). Intimate partner violence and PrEP acceptability among low-income, young black women: Exploring the mediating role of reproductive coercion. *AIDS and Behavior*, 21(8), 2261–2269. https://doi.org.ezproxy.tcu.edu/10.1007/s10461-017-1767-9

Wood, S. N., Kennedy, S. R., Hameeduddin, Z., Asira, B., Tallam, C., Akumu, I., ... & Decker, M. R. (2021). “Being married doesn’t mean you have to reach the end of the world”: Safety planning with intimate partner violence survivors and service providers in three urban informal settlements in Nairobi, Kenya. *Journal of Interpersonal Violence*, *36*(19-20), NP10979-NP11005.

Figure 1.1: Quorum Chart

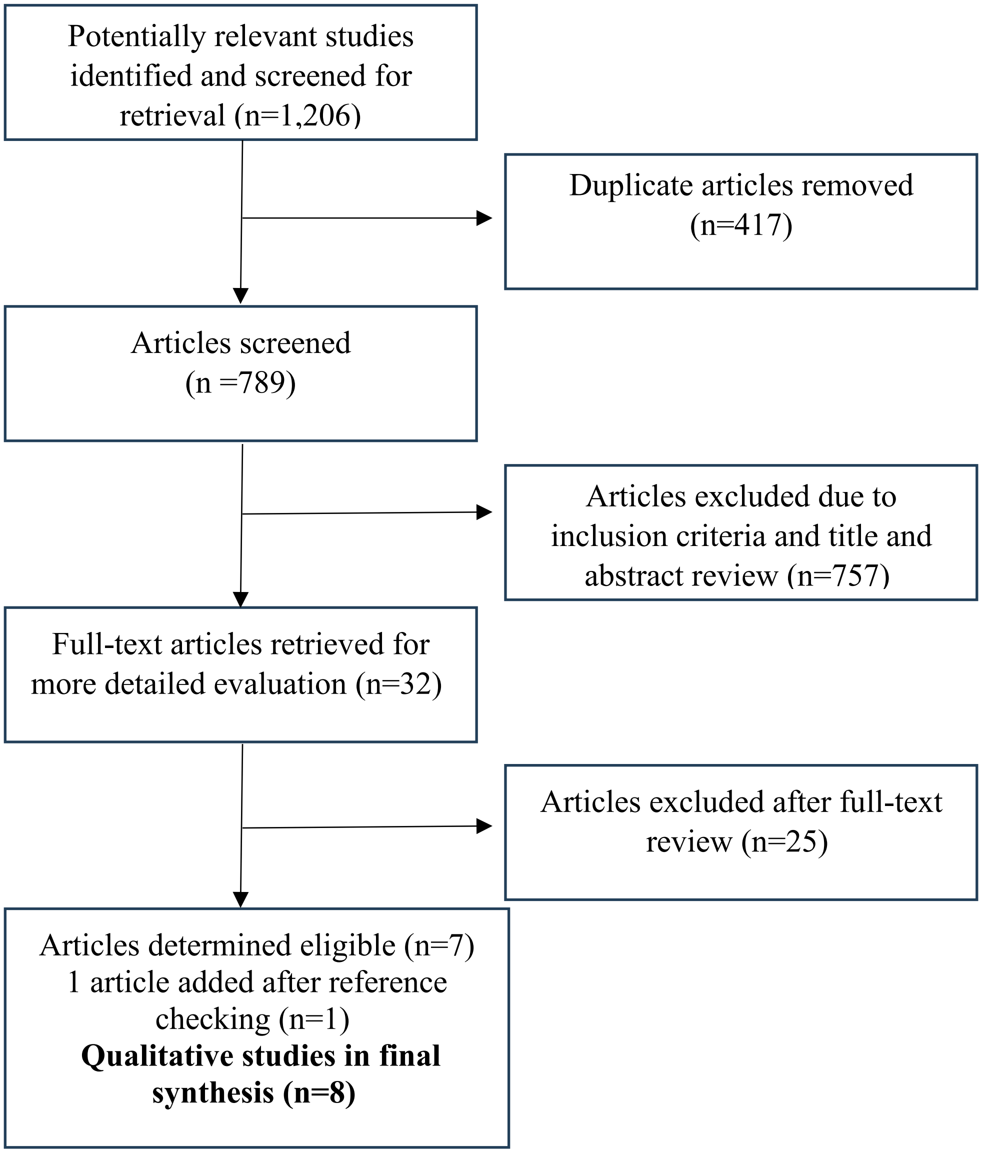


Table 1.1

Study Characteristics

Authors	Tradition and data collection method	Sample size	Gender, ages, race, ethnicity	Study setting	Location
Bagwell-Gray, 2019	Qualitative descriptive, semi-structured interviews	28 Women	Women, Mean age: 39.4, 57% white 14% black	Metropolitan area in Southwest US	Southwest USA
Boyce et al., 2020	Phenomenology & grounded theory. Focus groups and interviews	40 women: [30 focus group participants,10 interviews]	Women, aged 15-49	Family planning clinics	Kenya
Grace et al., 2020	Exploratory semi-structured interviews	13 Women	Latina women, Mean age 30.7	Federally qualified health clinic	Northeast USA
Hussain & Khan, 2008	Qualitative, in-depth interviews	10 women	Pakistani women, ages 20-40	Multiethnic, urban, low to middle income neighborhoods	Pakistan
Meier et al., 2022	Qualitative descriptive, grounded theory, in-depth interviews	16 women	16 women, mean age 47.3, 43.8% White, 43.8% Black, 12.5% Hispanic	4-5 counties in South Carolina	Southeast USA
Moore et al., 2010	Qualitative descriptive, semi-structured interviews	71 women	Women, aged 18-49, 33% white, 53% black, and 11% Hispanic.	Family planning clinics, free-standing abortion clinic, and domestic violence shelter	Metropolitan areas in the United States (1 in the Midwest, 2 on the East Coast)
O-Connor-Terry et al., 2022	Qualitative, exploratory study	27 women	27 women, Mean age 40, 69% Black, 23% White	DV shelter	Northeast USA
Wood et al., 2021	Focus group discussions, individual interview	49 women; [48 focus group participants, 1 interview]	Women, mean age 32.3, Ethnicity: Kikuyu and Lihua	Settlements	Kenya

Table 1.2

Themes Extracted from Original Studies

Article	Theme
Bagwell-Gray, 2018	Sexual Safety Interrupted ▪ Experiencing sexual intimate partner violence (IPV) ▪ Experiencing negative sexual health outcomes ▪ Knowing sexual health strategies but not using them ▪ Using sexual health practices, when possible, within the confines of partner control ▪ Coping with sexual trauma through sexual risk-taking ▪ Being prevented (by partner) from sexual health exams
Boyce et al., 2020	Pregnancy coercion ▪ Physically violent pregnancy coercion ▪ Pregnancy coercion by in-laws Contraception sabotage-direct ▪ Contraceptive sabotage-indirect Strategies of coping with reproductive coercion (RC) ▪ Covert contraception use ▪ Method switching ▪ Peer support Provider behavior that restricts family planning Provider behavior that enables family planning
Grace et al., 2020	Types of RC Behaviors ▪ Pregnancy pressure & manipulation ▪ Contraception sabotage ▪ Controlling pregnancy outcomes Co-Occurrence of RC and IPV RC Safety and Harm Reduction Strategies ▪ Less detectable contraception ▪ Deception and stalling ▪ Help-seeking Impact of immigrant or citizenship status (as coercive tactic) Machismo (hypermasculinity)

	Strength and bravery Importance of family
Meier et al., 2022	Sexual abuse and reproductive health ownership Reproductive health effects of sexual abuse Making the invisible visible
Hussain & Khan, 2008	Strong interrelationship between physical and sexual abuse. Reproductive health effects of nonconsensual sex (unwanted pregnancy, induced abortions, and dynamics of contraceptive use) Impact of violence during pregnancy Role of familial support during childbearing years.
O-Connor-Terry et al., 2022	Unequal power dynamics in a relationship reinforce the need for confidentiality in reproductive health care Contraceptive care should be accessible and comprehensive. Pregnancy options counseling must be nuanced and nondirective.
Wood et al., 2021	Sexual and reproductive health safety strategies ▪ Explain to partner the impact of forceful sex when things are going well in relationship. ▪ Use family planning to remove stress in household/increase familial care ▪ Do not resist verbally during sex—it may be ineffective and could contribute to gossip ▪ Take HIV PrEP, though it is more difficult with regular partners ▪ Use female condoms covertly to protect sexual health ▪ Practice family planning covertly when partner disagrees ▪ Store contraceptive pills in a safe place from partner

Moore et al., 2010	Before sexual intercourse ▪ Pregnancy promotion ▪ Contraception sabotage During sexual intercourse ▪ Sexual violence ▪ Condom manipulation ▪ Contraceptive sabotage Post-conception ▪ Controlling pregnancy outcomes ▪ Interfering with healthcare

Notes: IPV = intimate partner violence, RC = reproductive coercion

Table 1.3

Proposed New Themes

Proposed New Theme	Original Themes That Align with New Proposed Themes
Interconnectedness of IPV and reproductive coercion	Contraceptive sabotage-direct & indirect, pregnancy coercion (Boyce et al., 2020) Pregnancy pressure & manipulation, contraception sabotage (Grace et al., 2020) Experiencing sexual IPV (Bagwell-Gray, 2019) Strong interrelationship between physical and sexual abuse (Hussain & Khan, 2008) Pregnancy promotion, Contraception sabotage Sexual violence (during sexual intercourse), Condom manipulation (Moore et al., 2010)
Covert strategies to assert reproductive control	Strategies of coping with RC-Covert contraception use -Method switching (Boyce et al., 2020) Less detectable contraception, Deception, and stalling (Grace et al., 2020) Use female condoms covertly to protect sexual health, Practice family planning covertly when partner disagrees (Wood et al., 2021) Sexual abuse and reproductive health ownership (Meier et al., 2022) Using sexual health practices, when possible, within the confines of partner control (Bagwell-Gray, 2019)
Influence of cultural and community beliefs	Pregnancy coercion by in-laws (Boyce et al., 2020) Impact of immigrant or citizenship status (as coercive tactic), Machismo-hypermasculinity, (Grace et al., 2020) Role of familial support during childbearing years (Hussain and Khan, 2008)

Trauma sensitive healthcare response	Post-conception-Interfering with healthcare (Moore et al., 2010) Unequal power dynamics in a relationship reinforce the need for confidentiality in reproductive health care (O’Connor-Terry et al., 2022) Contraceptive care should be accessible and comprehensive, Pregnancy options counseling must be nuanced and nondirective (O’Connor-Terry et al., 2022) Reproductive health effects of nonconsensual sex (unwanted pregnancy, induced abortions, and dynamics of contraceptive use), Impact of violence during pregnancy (Hussain and Khan, 2008) Reproductive health effects of sexual abuse (Meier et al., 2022) Provider behavior that restricts/enables family planning (Boyce et al., 2020) Experiencing negative sexual health outcomes, Coping with sexual trauma through sexual risk-taking, Being prevented (by partner) from sexual health exams (Bagwell-Gray, 2019)

Notes: IPV = intimate partner violence, RC = reproductive coercion

Manuscript #2: Health needs of intimate partner violence survivors: Exploring the role of service providers

Jessica Grace, LMSW, PhD Candidate

Harris College of Nursing and Health Sciences,

Texas Christian University

Abstract:

Experiencing intimate partner violence (IPV) is associated with a series of negative sexual and reproductive health (SRH) outcomes for female survivors. These include increased risk for sexually transmitted infections (STIs), higher rates of unintended pregnancy, miscarriage, and gynecological disorders. Although agencies serving survivors provide a range of services to their clients, few offer any assistance related to SRH needs. This study sought to explore the perspectives of staff at IPV agencies to assess the factors that influenced when and how they discussed SRH risks with clients. Using qualitative methodology, the primary researcher conducted semi-structured interviews with six service providers at IPV agencies in an urban county in the southwestern United States. Interviews were audiotaped, professionally transcribed, and coded into categories. Thematic analysis was used to analyze participant data and identify final themes, and triangulation between researchers was used to enhance rigor. The findings highlight the perceived staff barriers to discussing sexual health with clients, agency processes that may hinder discussion of these topics, and the need for professional training around sexual health education.

Health needs of intimate partner violence survivors: Exploring the role of service providers

Intimate partner violence (IPV) impacts nearly one in three women in the United States and is associated with a variety of negative health outcomes including heart disease, gastrointestinal disorders, and high blood pressure (Campbell, 2002; Smith et al., 2018). Although there has been a growing recognition of the physical health impacts of IPV in the past decade, less awareness has been focused on the negative sexual and reproductive health (SRH) outcomes experienced by survivors. Female survivors of IPV are four times more likely to acquire sexually transmitted infections (STI) including Human Immunodeficiency Virus (HIV), experience higher rates of unintended pregnancy and miscarriage, and have an increased likelihood of developing gynecological disorders and cancer (Coker, 2007; Dunkle & Decker, 2013; Gielen et al., 2007).

Responses to the sexual and reproductive health needs of IPV survivors are often lacking. Although some have pointed to a lack of training or awareness of the sexual health risks associated with IPV as the problem, this assumes that with increased knowledge, service delivery would change. However, the lack of research in this area provides little evidence to support that claim. In one of the only studies where IPV advocates were questioned about sexual health topics, 27% of those providers said they believed clients did not want to talk about sexual health topics (Cavanaugh & Ward, 2021; McGirr et al., 2020). Whether or not this perception is accurate, it highlights how the individual beliefs or impressions of staff could influence the provision of certain services. There are currently no studies that have explored the perspectives of those working with IPV survivors to assess how their own experiences, beliefs, and attitudes influence the provision of sexual health services to their clients. The aim of this study was to elicit a deeper understanding of the perspectives of staff at IPV agencies around discussing sexual and reproductive health needs with survivors.

Sexual Health Needs Response

Although there is a well-established connection between women experiencing IPV and negative sexual health outcomes, effective mitigation strategies for this population are absent. Research has highlighted the challenge of condom negotiation in the context of abusive relationships, the potential of Pre-exposure prophylaxis (PrEP) as an alternative method for women experiencing IPV (O'Malley et al., 2020; Willie et al., 2017; 2020) and sexual health safety planning as a promising intervention strategy (Dunkle & Decker, 2013; Rountree et al, 2008; Wille et al., 2020). However, little research has focused on the role of IPV service providers (emergency shelter staff, intake workers, counselors, advocates) in recognizing and responding to the sexual health needs of their clients. In the only published study where domestic violence (DV) advocates were questioned about HIV, although most agreed that more education and services were needed, only 23% reported ever having a conversation about sexual health with their clients (Cavanaugh & Ward, 2021).

Agencies serving IPV survivors have an opportunity to support women experiencing IPV by providing SRH services to their clients. Current data suggests that most IPV agencies offer few, if any, services to address SRH (Rountree et al., 2008) that examined provision of HIV services within domestic violence shelters, the authors found that 23% of those shelters offered HIV prevention services to survivors in their care (Cavanaugh & Ward, 2021). Data related to other forms of SRH services provided at IPV agencies could not be found.

Sexual Violence and IPV

Previous studies have highlighted the challenges of identifying sexual violence within the context of IPV, noting that the service response for IPV and sexual violence are often different (Bagwell-Gray et al., 2015; Barker et al., 2019). Without consistent metrics or definitions, difficulty tracking the prevalence of intimate partner sexual violence creates barriers to solutions. Additionally, many survivors of IPV do not perceive sexual violence as abuse within the context of a committed relationship or marriage. It may be hard for a woman to acknowledge "rape" by her husband, but when asked direct questions about her experiences, we gain more insight. In 2010, the term "reproductive coercion" was first used to describe the loss of reproductive autonomy within IPV relationships (Miller et al., 2010). Reproductive coercion (RC) refers to any behavior that interferes with the autonomous reproductive decision-making of a woman (Grace & Anderson, 2018). Between 8%-16% of women in the United States experience reproductive coercion. For women in IPV relationships, the percentage increases to 35% reporting some form of reproductive coercion by their partner (Miller et al., 2010). It is this lack of reproductive autonomy that leads to the increased sexual health risks and poor reproductive outcomes for this population.

Methods

This study used a qualitative-descriptive methodology to explore the perspectives of staff at IPV agencies and their experiences discussing SRH topics with clients. Since this study sought to gather data in relatively new area of research, qualitative descriptive methodology was determined to be the most appropriate design to gather staff perspectives. It was also important to the primary researcher to amplify the voices of the participants, allowing themes and patterns to emerge naturally without a predetermined direction (Creswell & Poth, 2016). Using participant quotes in dissemination activities was anticipated and emphasized the use of a qualitative methodology.

Recruitment

Participants were recruited through IPV agencies in a metropolitan area of the Southwestern United States. These agencies included a domestic violence service agency and family justice center. Several smaller agencies serving survivors of IPV co-locate onsite at the family justice center and their staff were included in recruitment efforts. The sample met the following inclusion criteria: 1) over the age of 18 and 2) currently working in a role providing direct services to survivors of IPV. Exclusion criteria included agency staff that did not provide direct services to survivors and those that did not work within agencies in the same geographic county. Individuals in supervisory or administrative roles were eligible to participate if they provided direct client services as part of their position. Recruitment flyers were disseminated via email to staff at these agencies and interested individuals were instructed to contact the research team by email. Once screened for eligibility, participants were sent a link to an electronic survey administered through Qualtrics to review the consent information and complete a brief demographic survey. Participants were informed that their participation was voluntary, and they could choose not to answer any questions. Upon completion of the survey, participants were scheduled for their interview. All recruitment procedures were approved by the university institutional review board.

Data Collection

Semi-structured virtual interviews were conducted via Zoom and lasted between 30 and 60 minutes. Interviews included the primary researcher who facilitated the interview and the research participant. Each interview was audio-recorded for transcription purposes. A back up recording device was used to address any potential technology issues. The interviews were directed by an interview guide created by the researchers (see Appendix A). Using the lens of ecological systems theory, interview questions were structured to explore system level factors that may influence staff discussion of SRH topics. This included exploring individual beliefs and values at a micro level, client interactions at a meso level, agency policy and procedures at an exo-system level, and community context at a macro system level.

Data analysis

Interviews were audio recorded and transcribed using a professional transcription service. Transcripts were then uploaded into Dedoose, a qualitative software program to assist with data analysis. Using Dedoose, members of the research team independently reviewed interview transcripts and began coding of emergent themes. After initial coding, both researchers met in person to compare and discuss emerging themes. Any difference in codes were resolved through discussion and review of memoing conducted during the interviews. A coding manual was created to provide a clear description for each code category. Thematic analysis and synthesis were used to condense codes into a series of themes that captured the voice of the participants. This was done in collaboration with both members of the research team until final themes were determined.

The research team utilized triangulation strategies to enhance the rigor of the study. This included investigator triangulation, where multiple observers view and code the data to reduce observer bias and ensure high interrater reliability. For this study, this was done by a team of two, and the fact that both researchers produced similar themes enhanced the validity of the key themes. Additionally, the researchers used perspective triangulation (multiple perspectives to interpret the data) as they identified relationships among the codes.

Results

Participants included six IPV service providers, ranging in age from 26 to 39 years old. All participants identified as female and race was split evenly across Caucasian (2), African

American (2), and Hispanic (2). Professional experience serving survivors of IPV ranged from one to six years, and the majority (66%) of participants identified as Christian. When asked about the role that religion played in their lives, 50% responded as “very important” while the remainder of participants responded either “neutral”, “not important” or “not at all important”. Half of the respondents responded that their political ideology would be considered “liberal” with one participant identifying as “moderate” and the others selecting “something not listed”. Specific participant demographics are provided in Table 2.1

Themes

General themes have been grouped into three categories that reflect agency, individual, and client-specific factors that influenced participant experience discussing SRH with clients. Three main themes emerged from the interviews: 1) Agency Support Regarding SRH 2) Provider Self-Efficacy, and 3) Complex Needs of IPV survivors. The themes are described in greater detail below and accompanied by participant quotes that were made during the interviews.

Agency Support Regarding SRH

The need for agency support regarding the provision of SRH services was a theme present in every participant interview. Despite the varying levels of professional experience among our interviewees, none of the participants reported receiving any training or education on the increased SRH needs for survivors of IPV. This was particularly interesting to one participant as she reflected on the number of professional trainings she has been required to attend at her agency; “It seems crazy… I've sat in on 5,000 webinars. But I feel like that (*sexual or reproductive health*) would pop out, but nothing of note”.

Additionally, participants pointed to a lack of SRH screening questions within their intake as a barrier to conversations. Several participants stated that their demographic intake paperwork includes a question related to healthcare, but that it was not specifically related to SRH. The Danger Assessment (Campbell et al., 2003) was also mentioned by participants as a potential prompt to screen for SRH needs. The Danger Assessment is a tool used to assess the lethality risk level posed to IPV victims by their partners. It determines levels of risk based on abuse experienced and includes a question related to sexual assault (Campbell et al., 2003). If a client identifies sexual assault on that form, participants stated that could trigger a conversation about related sexual health needs. However, providers also stated that survivors are often confused by the concept of sexual violence within their marriage or relationship. As one provider stated:

> I feel like we get a lot of clients that don't realize that…so when they're filling out a form, you put the type of abuse and a lot of them will write a question mark next to sexual abuse because they think like, well, he was my husband and so I consented before and things like that.

Finally, most participants thought that their agency leadership would be supportive of discussing SRH with clients. When asked what actions demonstrated that support, participants said things like “inclusion is a priority in our agency” or “administrators are receptive to staff requests”. However, none of the participants could identify any specific actions by their agency that provided evidence of that support. When asked about the impact of state reproductive healthcare restrictions on service delivery and whether their agency had provided any guidance, none of the participants had received any correspondence from their leadership on the potential impact on their agency or clients. This was contrasted to both internal and external statements circulated by agency leadership immediately after other significant public events such as the school shooting in Uvalde, Texas. This participant noted the difference in response during her interview:

> In terms of training or mass emailing-- when Uvalde happened, there was an email sent regarding that and how to talk to parents and articles on grief. But yeah, when Roe v. Wade was overturned, I can't think of anything- like, Okay. Hey, this is the impact it might have on clients. Here are some ways we can guide them.

Provider Self-Efficacy

The next theme that emerged was the varying degrees of confidence that participants expressed in navigating SRH needs with survivors. Every participant said that their conversations about SRH needs were rare, and typically motivated by clients expressing a direct need. Some participants stated that they might initiate sexual health conversations if there was a perceived need or if they felt the client needed greater education. As this provider stated:

> I explain consent probably in every single intake I do because people just don't understand it the way that, you know, social workers understand it. And so kind of explaining that to them and talking about that comes up a lot.

Secondly, participants had varied experiences with personal sexual health education, with some having completed comprehensive sex education in childhood and related sexuality courses in college. Another participant described her background as being in a strict religious family where discussion of sex was discouraged and any personal sexual health knowledge came from her own pursuit of this information:

> I did grow up in a religious household. We didn’t really have those conversations like I am expected to. The conversations are basically, “wait until marriage, don’t be sexually active.” No conversations about contraceptives or safe sex. I don’t even think my family knows what HIV stands for. So, a lot of it has just been educating myself, asking questions. I think that even if I wasn’t in a situation where I work in social services, I would do a lot of relying on media, the internet, or finding my own resources.

The varying levels of education held by participants led to varying levels of confidence discussing SRH topics. Most participants stated they were willing to engage in these conversations but didn’t always feel skilled enough to navigate conversations about sexually transmitted infections or abortion resources. One participant stated she felt more confident discussing sexual assault with a client than an STI:

> Sadly, it's [most comfortable sexual health topics] probably if somebody has experienced a sexual assault and what the steps look like following that. If they want to be examined, knowing kind of the criminal justice side of the process and what might happen when you're at the hospital. More so than discussing STIs. Just my lack of knowledge in what that might look like for an individual.

Complex Needs of IPV Survivors

The final theme that was evident in participant interviews was the complicated needs experienced by survivors of IPV. Participants expressed that their clients often have a variety of needs when coming to their agency and do not always view SRH as important in comparison. One participant explained it this way, “because they're coming in in crisis, usually for something else, and so they're putting their personal health on the back burner because they're thinking more about their immediate need, not their health.” Although several participants mentioned the safety of their clients was their biggest priority, they did believe that SRH was important to address with survivors of IPV. As one participant shared this example:

> We’ve had clients that have had been pregnant for the past 10, 15 years because they're not getting those resources of birth control or they are being forced to be intimate with their partner. Their partner may not allow them to get abortions. They feel like to survive they need to be giving children to these men. I had one client recently who her partner exposed her to an STD and she had no idea and was forcing her to continue being with them.

Discussion

This study was one of the first studies that explored the role of service providers in assessing the SRH needs of survivors of IPV. These findings provide insight into the perceived barriers for discussing these topics with clients and offer implications for policy and practice at both the individual and agency level.

Service providers are uniquely positioned to provide SRH education and resources to survivors of IPV but must be empowered with the tools to do this effectively. This is where agency policies can make a difference. During these interviews, all participants agreed that the topic of sexual health rarely came up in their sessions with clients, but also stated that their agency did not include any intake questions that screened for SRH needs. Several participants referenced other screening measures or forms utilized within their intake paperwork to assess risk and prompt further discussion of related needs. The two most frequently referenced questions that triggered SRH conversations by staff were the Danger assessment question related to experiencing sexual assault, and a universal question about healthcare needs on the client demographic form. Even in the case of the Danger Assessment tool (Campbell et al., 2003) the response from staff seemed to be focused on a criminal justice response or educating around consent, and not on the related health implications from experiencing sexual violence. Understanding the increased health risks associated with experiencing sexual violence and its prevalence within IPV survivors, suggests that implementing a method for SRH screening seems appropriate. Adding a series of questions or an additional instrument for SRH needs would address several of the needs voiced by participants. It would be a relatively easy solution to implement, provide a safe way for clients to bring up their sexual health needs, and reduce staff role confusion over who should initiate these conversations.

Adding a SRH screening measure is not the only agency practice implication to come from these findings. Implementing a new screening and assessment process without providing additional training or education on follow up resources does not enhance service delivery for survivors. All the participants in this study indicated a lack of training around SRH, which highlights an opportunity for the development of trauma sensitive sexual health education for IPV service providers. This would not only provide education to staff about the increased SRH risks for survivors of IPV but address specific SRH topics that staff may not be comfortable discussing. In this study, the area that participants were least comfortable discussing was sexually transmitted infections (STIs). Additional research is needed to elicit input from IPV survivors and service providers to inform additional course content and trauma sensitive approaches for training and implementation.

At an individual level, this study demonstrated that personal factors do influence the comfort level of providers in discussing SRH topics and their overall sexual health knowledge. This difference in staff perspectives reinforces the need for guidance from agency leadership around prioritizing SRH assessment. For clients entering IPV agencies, the services they receive should not be contingent on which service provider they encounter. By offering screening questions and training, agencies can ensure that all survivor needs are being addressed and staff have the resources and training needed to provide that assistance.

Finally, IPV agency leadership should be encouraged to learn that staff felt supported and believed their leadership was receptive to the needs of its employees. However, providing clear guidance for agency staff around potentially controversial reproductive health services such as referrals for abortion or emergency contraception is needed. Even before the Dobbs decision (Dobbs vs Jackson Women's Health Organization, 2021) where Roe v Wade was overturned, SRH was a polarizing topic within certain religious and cultural traditions. In states like Texas, where this study was conducted, the influence of conservative politics has implemented additional barriers to care, not only for abortion but also accessing forms of birth control and contraception. For social workers working in this field, they may be confronted with beliefs or choices that contrast with their personal beliefs and views, and this study explored that with participants.

None of the participants in our study worked for faith-based organizations and were able to discuss a range of healthcare options. Yet, that was not clear from speaking with participants. Most staff were operating without guidance on whether there were limits on the type of services they could refer to or provide and no one seemed aware of what the current restrictions were within the state. Agency leaders need to provide tangible guidance of their stance on SRH matters to eliminate any ambiguity for staff. Crafting agency policies that reflect a commitment to these values and support for the autonomy of IPV survivors in all areas, is one possible solution. Forging partnerships with local family planning clinics or other agencies providing sexual health services to provide services onsite is another way to visibly support clients and staff. This finding suggests an additional opportunity for social work educators to incorporate coursework that addresses situations when professional and personal values conflict, especially in geographic areas where changing legislation is restricting service delivery.

Limitations

Due to the small sample size and purposive sampling method, study findings cannot be generalized to a larger population of IPV service providers. Participants in this study largely identified as Christian and stated that religion played a very important role in their life. Religious beliefs can influence how individuals discuss certain sexual health issues, particularly when it comes to reproductive health care such as abortion and contraception. However, these beliefs can differ by religious expression and as a result, participants of other faith traditions might respond differently than the participants in this study. Additionally, all participants had worked with IPV survivors for less than six years, with one-third reporting experience of less than two years, making them all early career professionals.

Conclusion

Improving the SRH outcomes for survivors of IPV cannot happen without the support and involvement of service providers in the field. This study adds further evidence to support the inclusion of IPV service providers in responding to the SRH needs of survivors. Participants in this study were willing to engage in SRH conversations with their clients but identified barriers in their current environment that need to be addressed. These barriers exist at the individual and agency level and offer potential solutions for agency leadership and stakeholders. Addressing these challenges can create safe environments for SRH conversations to occur and enhance collaboration between IPV agencies and SRH providers.

Table 2.1

Characteristics of the Study Sample

Variables	Frequency (n)	Percentage (%)
Gender		
Female	6	100%
Race		
Black/African American	2	33%
Hispanic/Latino	2	33%
White	2	33%
Religion		
Christian	4	66%
No religion	1	16%
Not listed	1	16%
Total	6	100%

Appendix A: Interview Guide Questions

Perception of Sexual and Reproductive Health (SRH) Risks

- What are the sexual and reproductive health needs of your clients?
- On a scale of 1-10, taking into consideration all the needs of your clients, how would you rate the importance of your clients' sexual and reproductive health needs? Explain your answer.

Current Sexual and Reproductive Health Service Delivery

- Does your agency require any type of screening or assessment of the sexual/reproductive health needs of your clients?
  - If yes, what does that look like? What type of needs are included/addressed? (Contraception, HIV/STI testing/prevention, birth control, gynecological exams, pregnancy tests, prenatal care, etc.)
  - If no, what motivates you to discuss these needs with your clients?
- How often do you discuss sexual and reproductive health with your clients? (At every encounter, during initial needs assessment only when client brings it up, never)
- Who typically initiates these SRH conversations? (Service provider, client)
- Follow up: When you have these discussions, what type of needs/services are the most often requested?

Experience with Sexual and Reproductive Health (SRH) Education

- Over the course of your life (both personal and professional) what type of SRH education have you received?
  - How was this education presented? Who facilitated the training (family member, physician, religious leader, teacher)?
  - What topics were covered?
- Have you attended trainings that discussed the increased sexual and reproductive health risks for IPV survivors?
  - If yes, what knowledge and skills did those trainings offer to support these types of discussions?
  - If not, how aware are you about SRH risks for IPV survivors?
- Does your agency provide any sexual and reproductive health resources to clients, either onsite or through referrals with external community partners? (STI/HIV testing, pregnancy tests, emergency contraception, women's healthcare, contraception, etc)
  - If yes, what are those services?
  - If no, why not?
- What has been your experience working with community partners that provide SRH services?
- How accessible are those resources to survivors of IPV?

Service Provider Confidence in delivery of SRH education

- On a scale of 1-10, how confident do you feel discussing sexual and reproductive health with your clients?
- What SRH topics do you feel the most comfortable discussing?
- What SRH topics are you the least comfortable discussing?

Service Provider Beliefs

- How important do you believe it is for you to discuss SRH needs with your clients?
- What factors (or beliefs) influence your own decisions around sexual and reproductive health choices? (Religious beliefs, cultural expectations, family, or partner)
- Have those beliefs/factors ever influenced how you provide services to clients? If yes, please explain. If not, explain how you prevent that from happening.
- If your agency implemented a new SRH screening and referral procedure that you must start utilizing immediately, would you have any concerns?
  - If yes, what concerns would you have?
  - If not, why not?
- Describe how you would handle a client-seeking a reproductive health choice that you personally disagree with.

Organizational Policies

- Describe any polices or procedures at your agency that may hinder discussion or delivery of SRH services.
- Describe any polices or procedures at your agency that promotes discussion or delivery of SRH services.
- Is your agency leadership supportive of discussing SRH with clients?
  - What specific actions demonstrate this?

Perceived barriers

- From your perspective, what internal barriers exist for responding to the SRH needs of survivors of IPV?
- From your perspective, what external barriers exist in responding to the SRH needs of survivors of IPV?
- What ideas do you have for improving SRH services for survivors of IPV?
- If you could change anything about how SRH services are provided to survivors of IPV, what would you change?

Societal Impact

- Recent events in the US (i.e. Overturning of Roe v Wade) has put increased attention on SRH resources for women in Texas. How has this impacted the way you discuss SRH needs with clients?
- How has this impacted your agency/organizational response to SRH needs?
- Have you received any guidance related to recent changes in legislation?

References

Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence, & Abuse*, *16*(3), 316-335.

Barker, L. C., Stewart, D. E., & Vigod, S. N. (2019). Intimate partner sexual violence: An often-overlooked problem. *Journal of Women's Health*, *28*(3), 363-374.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C. R., Campbell, D., Curry, M. A., ... & Wilt, S. A. (2003). Assessing risk factors for intimate partner homicide.

Cavanaugh, C., & Ward, K. (2021). HIV/STI prevention interventions for women who have experienced intimate partner violence: a systematic review and look at whether the interventions were designed for disseminations. *AIDS and Behavior*, *25*(11), 3605-3616.

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, & Abuse*, *8*(2), 149-177.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Dobbs v. Jackson Women’s Health Organization, 599 U.S. (2021) https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf

Dunkle, K. L., & Decker, M. R. (2013). Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups. *American journal of reproductive immunology*, *69*, 20-26.

Gielen, A. C., Ghandour, R. M., Burke, J. G., Mahoney, P., McDonnell, K. A., & O'Campo, P. (2007). HIV/AIDS and intimate partner violence: Intersecting women's health issues in the United States. *Trauma, Violence, & Abuse*, *8*(2), 178-198.

Grace, K. T., & Anderson, J. C. (2018). Reproductive coercion: a systematic review. *Trauma, Violence, & Abuse*, *19*(4), 371-390.

McGirr, S. A., Bomsta, H. D., Vandegrift, C., Gregory, K., Hamilton, B. A., & Sullivan, C. M. (2020). An examination of domestic violence advocates' responses to reproductive coercion. *Journal of interpersonal violence*, *35*(9-10), 2082-2106.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., ... & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, *81*(4), 316-322.

O'Malley, T. L., Hawk, M. E., Egan, J. E., Krier, S. E., & Burke, J. G. (2020). Intimate partner violence and pre-exposure prophylaxis (PrEP): A rapid review of current evidence for women's HIV prevention. *AIDS and Behavior*, *24*, 1342-1357.

Rountree, M. A., Pomeroy, E. C., & Marsiglia, F. F. (2008). Domestic violence shelters as prevention agents for HIV/AIDS? *Health & Social Work*, *33*(3), 221-228

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M. J., & Chen, J. (2018). The national intimate partner and sexual violence survey: 2015 data brief–updated release.

Willie, T., Kershaw, T., Campbell, J. C., & Alexander, K. A. (2017). Intimate partner violence and PrEP acceptability among low-income, young black women: Exploring the mediating role of reproductive coercion. *AIDS and Behavior*, *21*, 2261-2269.

Willie, T. C., Keene, D. E., Stockman, J. K., Alexander, K. A., Calabrese, S. K., & Kershaw, T. S. (2020). Intimate partner violence influences women's engagement in the early stages of the HIV pre-exposure prophylaxis (PrEP) care continuum: Using doubly robust estimation. *AIDS and Behavior*, *24*, 560-567.

Manuscript #3: Designing a Sexual and Reproductive Health Assessment Tool for Intimate Partner Violence Survivors

Jessica Grace, LMSW, PhD Candidate

Harris College of Nursing and Health Sciences,

Texas Christian University

Abstract:

Intimate partner violence (IPV) often leads to adverse sexual and reproductive health (SRH) outcomes for women. Despite the recognized importance of addressing SRH needs, few agencies providing services to IPV survivors offer any form of screening or assessment. Previous research identified the need for an SRH assessment tool tailored to the context of IPV agencies. This study aimed to gather feedback and insights from both IPV survivors and service providers at these agencies to inform the development of such a tool. Focus groups and interviews were conducted with survivors and providers from participating IPV agencies, exploring content, delivery methods, and resource needs. Thematic analysis of the data revealed key themes related to implementing SRH assessment within IPV agencies. The result of this study is a proposed phased SRH framework informed by the perspectives of survivors and service providers, offering a valuable resource for enhancing SRH services in IPV agency settings.

Designing a Sexual and Reproductive Health Assessment Tool for Intimate Partner Violence Survivors

There is a well-established connection between women experiencing IPV and negative sexual health outcomes (Campbell, 2002; Gielen, et al., 2007, McGirr, et al.,2020). Agencies serving IPV survivors have a unique opportunity to support women experiencing IPV by providing access to sexual and reproductive health (SRH) information and resources. Current data suggests that most IPV agencies offer few, if any, services to address SRH (Rountree et al., 2008). This study seeks to build upon the findings from a qualitative study conducted by this researcher where IPV agency staff were interviewed about their experience discussing SRH topics with their clients. The results indicated that SRH conversations with clients were rare within IPV agencies, but that staff were willing to engage in these conversations if provided with the training, support, and resources needed (Grace & Elias-Lambert, 2023).

There were two major recommendations that emerged from the data. These included (1) the need for an SRH assessment tool during intake, and (2) enhanced sexual health education training for IPV service providers. This study utilized qualitative methodology to elicit the feedback and perspectives of IPV survivors and service providers to inform the creation of a SRH assessment tool. Through focus groups and interviews with IPV survivors, this researcher explored how experiences with IPV impact women's SRH decisions, and how that perspective can guide services providers in assessing SRH risks and needs. Through focus groups and interviews with service providers, this researcher explored how experiences conducting assessments with survivors can guide implementation of a new SRH assessment approach. As a result of this study, the researcher proposes a framework for screening and assessing the SRH needs of survivors within IPV agency settings. This framework was developed in collaboration with survivors and providers, thus incorporating the perspectives of those impacted directly in the research process.

Reproductive Coercion

Intimate partner violence (IPV) is defined by the World Health Organization as “any behavior within an intimate relationship that causes physical, sexual, or psychological harm (World Health Organization, 2023). Reproductive coercion (RC) constitutes a form of IPV involving behaviors aimed at interfering in a woman’s reproductive decision-making (Grace & Anderson, 2018). The literature commonly portrays this as a scenario where a male partner asserts control over a female partner, as there is limited research examining whether similar dynamics occur in same-sex relationships (Miller et al., 2010; 2011, Moore et al., 2010).

RC can include actions such as pregnancy coercion, birth control sabotage, or attempting to control the outcome of a pregnancy (Miller et al., 2010; 2011, Moore et al., 2010). Countless studies have described the negative impact that experiencing RC has on SRH, including greater risk for unintended pregnancies; contracting a sexually transmitted infection (STI), including HIV; and greater rates of gynecological cancers (Anderson et al., 2017; Campbell, 2002; Coker, 2007; Gielen et al., 2007). Research indicates that RC frequently takes place within the context of IPV relationships, suggesting that anywhere between 10% to 35% of IPV survivors experience some form of RC (Miller et al., 2010; 2011). Given its prevalence and impact on the health of IPV survivors, identifying effective strategies for responding to IPV and RC is a public health priority.

SRH Assessment in Healthcare

Researchers have noted the challenges that exist in screening for RC and in developing approaches to mitigate these health impacts on survivors (Bagwell-Gray et al., 2015). To date, most of the studies exploring the intersection of RC and IPV have emerged from healthcare, in clinical settings such as family planning clinics or women’s health centers (Decker et al., 2017, Miller et al., 2011; Moya et al., 2016; Ramachandran et al., 2013). These studies have encompassed various efforts, such as piloting screening tools for RC, assessing educational interventions on RC and IPV, and developing trauma informed scripts to aid providers in SRH conversations (Decker et al., 2017; Miller et al., 2011). Despite these approaches demonstrating some level of success, screening rates for RC and IPV within healthcare settings remain low (Burton & Caryle, 2021). Some studies have explored healthcare provider’s perceptions of screening for RC and IPV, and identified time, training, and confidence as the most cited barriers to screening in clinical settings (Burton & Carlye, 2021; Stumbar et al., 2010). Lack of training and confidence were attributed to providers being uninformed about the connection between IPV and SRH outcomes, as well as lacking confidence in handling potential disclosures of RC (Burton & Carlye, 2021; Ramachandaran et al., 2017).

These barriers highlight the necessity for new approaches to educate and support RC screening and assessment for IPV survivors, particularly if providers in reproductive health settings feel unequipped to navigate discussions in this area. Moreover, research highlights the challenges survivors face in even accessing healthcare providers, particularly in geographic areas where many are uninsured and unable to afford necessary care (O-Conner-Terry et al., 2022; Moya et al., 2016). Consequently, researchers have recommended that to improve SRH screening and response, healthcare providers should collaborate with professionals such as social workers, who possess more direct experience with IPV survivors (Park et al., 2016).

Survivor-Informed Approaches

While it has been recommended that IPV service providers play a role in addressing the SRH needs of survivors, there is a lack of studies in the literature that specifically focus on this strategy. In the studies conducted with IPV service providers around SRH topics, findings suggest that discussions about SRH are rare within IPV agencies. (Cavanaugh & Ward, 2021; McGirr et al., 2020). This aligns with data indicating that the provision of SRH services is limited at most IPV agencies (Rountree et al., 2008). Thus, opportunities exist for IPV service providers, skilled in trauma informed care and in navigating conversations around abuse, to participate in assessing the SRH needs of survivors.

Although survivor perspectives on SRH screening and assessment are limited in the literature, studies indicate that IPV survivors favor programs that integrate healthcare and IPV-related services (Dichter et al., 2021). Research including survivors' perspectives on their SRH decision-making reveals their awareness of the health risks posed by their abusive partners. However, survivors report challenges in accessing SRH resources and support. Survivors in these studies emphasize the importance a trauma informed healthcare response, highlighting the need for service providers to understand how IPV affects their SRH choices and behavior (Moore et al., 2010; O’Connor-Terry et al., 2022; Hussain & Khan, 2008; Boyce et al., 2020) Additionally, research suggests the necessity of exploring harm-reduction methods and sexual safety planning strategies informed by survivor experiences (Bagwell-Gray et al., 2020, Stockman et al., 2013; Park et al., 2016).

Methods

This study adopted a constructivist, grounded theory design to explore the perspectives of IPV survivors and service providers in the development of a SRH assessment framework.

Grounded theory is a qualitative research approach that aims to develop theories or concepts grounded in empirical data (Creswell & Poth, 2016). When applied to the creation of an assessment framework as in this study, grounded theory can provide insight and understanding of the context, needs, and experiences of the target population (Sawyer & Brady, 2022). It also provides the researcher an opportunity to explore the perspectives, challenges, and resources of individuals affected by a specific issue, which in this case is the SRH needs of survivors of IPV. This study utilized the constructivist approach advocated by Charmaz (2006). In contrast to traditional grounded theory, this design is more interpretive in nature, utilizes reflexivity that is congruent with a feminist theoretical framework, views the research process as collaborative between researcher and participants, and allows for more flexibility in design structure (Birks & Mill, 2015; Charmaz, 2006; Creswell & Poth, 2016). These factors played a key role in the selection of this design, as engaging IPV survivors in research can present unique challenges in accessing the population and in the ability for follow-up. This has created a gap in interventions informed by those experiencing IPV and an understanding of their SRH needs. It is the stance of this researcher that the process of developing assessment tools and interventions must be centered in the experiences of survivors and requires the use of a flexible, transformative-based research design.

In addition, this study sought to incorporate the perspectives of IPV service providers into the development of this SRH assessment tool. In the previous study facilitated by this researcher, interviews with IPV service providers highlighted the need for some form of SRH assessment tool for those working within IPV agencies. With the foundation of this study emerging from those findings, it was imperative that service provider perspectives continue in the research process. Using qualitative methodology such as critical grounded theory ensured that the voices of all participants were centered in the research process and that any emerging themes, tools, or constructs were sensitive to the needs of this population.

Participants

The target population for this study was twofold; (1) female survivors of IPV and (2) direct care staff employed at IPV agencies. Inclusion criteria for IPV survivors was individuals 18 years of age or older, English-speaking, and a current or former client of an agency serving survivors of IPV in the Dallas/Fort Worth (DFW) metropolitan area. Inclusion criteria for service providers was individuals 18 years of age or older, English-speaking, and employed as direct service provider at an IPV agency located in the DFW metropolitan area. Agency provider participants included case managers, counselors, intake coordinators, and social workers in residential and non-residential IPV settings. Supervisors that did not provide direct services to survivors were excluded from participation in the study. Survivor participants included current clients of partnering IPV agencies that include services such as emergency shelter, counseling, outreach, and housing programs.

To create a framework to be used within IPV agencies, it was important to this researcher to include individuals that understand the dynamics of those settings. For this reason, this study included participants with experiences receiving services at an IPV agency and service providers who currently work at an IPV agency. This is consistent with a transformative or feminist research lens, where the individuals most directly impacted by the research are included in the development process (McPhail et al., 2007; Plummer & Young, 2010). Frequently, not only are the survivors of IPV left out of the research process but also the direct service providers who are responsible for implementing the assessments or interventions.

The study included 12 service provider participants and 17 IPV survivors for a total of 29 study participants. All participants identified as female, and the majority identified as straight or heterosexual. The mean age for service providers was 36.8 years old, while the mean age for survivors was 38.8 years old. Participant race varied slightly across groups, with participants identifying mostly as African American, Hispanic, or White. Demographics for both participant groups are shown in Table 3.1.

Recruitment

The study population was a purposive sample recruited in partnership with three IPV service agencies in the DFW metropolitan area. These agencies operate in two counties with a combined population of 4.7 million people within the surrounding metropolitan area of 7.6 million people. Each of these agencies provide multiple programs and services to individuals experiencing IPV across different facilities. These programs include but are limited to emergency shelter, short-term housing support, a 24/7 crisis hotline, counseling, legal assistance, health clinic, and advocacy. The primary researcher for this study has several years of experience working with community partners on related initiatives and reached out to agency directors with study information and recruitment flyers for dissemination in their programs.

When requested, this researcher attended agency staff and client meetings to elicit participation and distribute flyers. Anyone who met the inclusion criteria was invited to participate. Agency leadership collaborated with this researcher to determine the most-opportune timing of focus groups to elicit participation of both service providers and survivors. The groups for IPV survivors were conducted on weekday evenings, when other agency events were taking place. The groups for service providers took place in the afternoon between first and second shifts. In some settings, childcare was provided for the children of participants, however that was not the case in all facilities. The data collection process took three months to reach a sufficient sample size for this study.

Information Power

Determining sample size in qualitative research has always posed challenges due to the absence of calculations commonly found in quantitative studies. Qualitative studies often follow Sandelowski's guidance which states that “qualitative samples should be large enough to allow the unfolding of a new and richly textured understanding for the phenomenon under study, but small enough so that the deep, case-oriented analysis of qualitative data is not precluded (Sandelowski, 1995).” In simpler terms, researchers should seek the sample size necessary to achieve the study’s purpose (Kuzel, 1999, Patton, 2015). However, the interpretation and description of this guidance varies across studies. Many researchers justify their sample size based on previous literature or explain it in terms of achieving saturation. In the grounded theory framework, saturation involves a system of ongoing analysis and is achieved when no new themes or concepts emerge from the data (Glaser & Strauss, 1999). In this study, a constructivist grounded theory research design was employed. Due to the unique challenges of accessing the target population of survivors of IPV, a different approach was needed to ensure a representative sample. This population is vulnerable and hard to reach, even when working in collaboration with community partners.

To address this concern, this researcher applied the concept of information power to evaluate the adequacy of the sample size. Information power is a concept that emerged from qualitative research to aid researchers in determining the extent to which the sample adequately represents the target population. Unlike the commonly cited notion of data saturation, information power assesses the study sample across five dimensions; (1) study aim, (2) sample specificity, (3) use of established theory, (4) quality of dialogue, and (5) analysis strategy (Malterud et al., 2016). Information power is enhanced by the breadth and depth of the data, rather than the sheer number of participants.

Throughout the scheduling of focus groups and interviews, this researcher continuously revisited the data to track emerging concepts and their alignment with the five dimensions of information power. With the study's objective centered on capturing the perspectives of both IPV survivors and providers, this researcher sought a diverse sample of participants from different agency settings, programs, demographics, and experiences with IPV. The diversity of the sample contributed to the specificity dimension of information power, as participants ranged from women freshly out of IPV relationships to those distanced from such situations for years. The sample reflected different age groups including women across the reproductive life cycle, from childbearing age to post-menopausal. The quality of the dialogue for this sample was robust, evident in the dialogue facilitated by the researcher who utilized prompts to delve deeper into the participant perspectives. Both focus groups and individual interviews were employed to gather a wide array of viewpoints and allow detailed exploration. This researcher ensured engagement among participants with differing views. Given the study's focus on conceptualizing a SRH assessment framework, the sample of 29 total participants was deemed sufficient.

Instrumentation and Data Description

Data was collected through focus group discussions and interviews with participants. The primary researcher served as the moderator for focus groups and utilized an IRB-approved interview guide (see Appendix B) to lead the discussion. The interview guide included a series of open-ended questions followed by probing questions as needed to elicit further details from participants. Questions explored the perspectives of survivors and providers around screening and assessing the SRH needs of clients at IPV agencies, as well as questions about delivery method, and SRH resource linkage. Consistent with grounded theory methodology, the researcher reviewed transcripts shortly after data collection to compare with previous groups and to assess information power. Each group discussion and interview were audio-recorded and transcribed for data analysis. Memos taken by this researcher were also included as data. This study received university Institutional Review Board (IRB) approval.

Data Collection

Data was collected through semi-structured focus groups and individual interviews with survivors and providers onsite at participating IPV agencies. Focus groups were selected because they are an efficient way to gather data from multiple participants at a time and can create a shared sense of belonging between participants that encourages greater detail to emerge (Peters, 1993). The flexible nature of this data collection method also gave the researcher insight into the participants' descriptions of their experiences and encouraged opportunities to explore new ideas as a group (Litosseliti, 2003). Interviews were utilized for participants who could not attend a focus group or when only one individual showed up for the focus group. The IRB protocol was written to include both forms of data collection.

This study included five focus groups and three individual interviews. Focus groups were facilitated separately for providers and survivors, with three of the focus groups being with service providers and two with IPV survivors. Focus groups were conducted in person and recorded with an audio device for data analysis. Groups were facilitated onsite at IPV agencies in a reserved conference room or classroom that ensured privacy for the participants. This researcher served as the moderator and took notes throughout the session. The focus groups ranged in size from 2 to 11 participants and lasted between 40 and 75 minutes long. Interviews were facilitated by this researcher with two survivors and one service provider. Interviews lasted between 20-60 minutes in length.

Prior to facilitating the focus groups and interviews, participants were informed of the purpose of the study, signed an informed consent to participate, and were assured that participation was voluntary. The research protocol was restated at the beginning of each group. Focus group guidelines outlined the expected procedures for participants, and participants were asked to verbally agree to adhere to those procedures. Since both focus groups and interviews took place at IPV agencies, this researcher made it clear that any information collected would not be shared with IPV agency leadership or other staff members.

All study documents and audio recordings were stored in an approved secure online data storage system that was password protected. Documents were only accessible by approved protocol personnel on a password-protected computer. After each focus group or interview was transcribed, the audio recordings were destroyed. Additionally, all identifying information was removed from transcripts to ensure the confidentiality of participants throughout the data analysis process and in the final dissemination of findings.

Data Analysis

In accordance with grounded theory, this study involved collecting and analyzing data to generate an assessment framework that emerged from the data itself, rather than being preconceived or imposed (Birks & Mills, 2015; Glaser & Strauss, 1967). After each audio recording was transcribed, the primary researcher reviewed the transcripts and began initial coding. During this phase, the goal was to generate as many codes as possible from the early data (Bryant & Charmarz, 2007; Charmarz, 2006) Important words or groups of words were labeled and identified using the qualitative software program Dedoose.

In a constructivist grounded approach, Charmaz (2006) emphasizes keeping codes as close to the data as possible and advocates embedding actions in the codes in an iterative process. Once the initial coding was completed, the codes were compared against one another and in collaboration with another member of the research team to group into larger categories. Analysis moved into focused coding once categories were created (Chun Tie et al., 2019). Memoing was used during each analysis phase to serve as an audit trail to document the researcher’s perceptions, thought processes, and to provide justification for methodological choices. Memoing was also used to enhance the rigor of the study. The data analysis continued through this iterative process and triangulation helped ensure that final themes and concepts accurately reflected the participant data.

Enhancing Trustworthiness

This study used several techniques to enhance the trustworthiness or rigor of the research. As mentioned previously, the primary researcher utilized memoing throughout the data analysis process to document any perceptions, decisions, changes in the direction of the research, and rationale for choices. This created an audit trail to enhance dependability. This researcher incorporated three forms of triangulation; (1) Investigator triangulation, where multiple observers view and code the data to reduce observer bias and ensure high interrater reliability: (2) method triangulation, which involves the use of multiple data collection methods which included focus groups, session notes, and memos; and (3) data source triangulation, which refers to the collection of data from different groups of people such as IPV survivors and service providers (Carter et al., 2014). Due to the challenges of accessing the target population and potential safety concerns, member checking was not feasible in this study.

Results

As this researcher analyzed the data across the IPV survivor and service provider populations, three categories of themes emerged. These themes included (1) Survivor Outlook (2) Existing SRH processes, and (3) Tool Recommendations. Each theme represents perspectives from both provider and survivor populations, and when perspectives diverged between groups, they are noted in the findings. Additionally, each theme consists of subthemes that provide greater detail and corresponding participant quotes. Barriers to implementation are addressed in the discussion of the study findings.

Survivor Outlook

Survivors in this study provided insight into the mindset and needs of IPV survivors when interacting with IPV agencies. Although the survivors in this study represented different programs and agencies, most of the women stated that their point of entry into IPV agencies was through an emergency shelter. These women described the impact of trauma on how they experienced the intake process. Survivors identified the SRH needs they considered most urgent for women experiencing IPV and how those should be considered and approached by service providers. This theme is broken into two subthemes that detail the impact of trauma and the specific SRH needs of survivors.

Impact of Trauma

Throughout all the interviews and focus groups, survivors emphasized how experiencing IPV impacts their thought processes and interactions with service providers. As survivors reflected on their own intake experiences at IPV agencies, they described feeling overwhelmed and, in some cases, retraumatized by the experience. This was especially true for women that were forced to repeat their story to different people throughout the process to receive services, as this survivor described,

> When I came, the intake over the phone had you tell your story. The first day that I got here, I had to tell my story. The next day that I got here, had to tell the story again. These were three different intake people… Just overwhelmed.

Other survivors mentioned needing to "take a breath" when it came to completing paperwork and difficulty processing the information they were being given. Shame and guilt were terms used by several survivors to describe how they felt needing to ask for help. A few women expressed anger at their abusers for putting them in this situation and forcing them to rely on others. As this survivor described her frustrations,

> We're asking for so much because it's wrecked our lives so much. And so, I'm constantly apologizing, and I hate apologizing. I hate it when other people apologize. And I'm always like, "Don't apologize for needs." But I internally have to fight that battle of like, "I should be able to do this for myself and I can't This man took everything from us," kind of thing. And it's just like I used to be capable and now I need help and now I feel like an inconvenience.

Many service providers in this study were aware that experiencing IPV could influence a survivors' willingness to talk about certain topics and described using trauma informed care principles in their service delivery approach. This provider spoke directly to the impact of trauma on her clients and how important it was for providers to respond in ways that promote safety and trust.

> Just being very mindful about trauma in the brain and then how a survivor may present when they're having to potentially talk about something that is very triggering or traumatic for them. And so I think the person who's asking the question really has to be mindful about what that is like for a client.

Specific Survivor Needs

When survivors were asked what the most urgent SRH needs were for survivors of IPV, the most common responses were sexually transmitted infection (STI)/HIV testing, well women exams, pregnancy tests, emergency contraception, and access to birth control. Screening for postpartum depression and menopausal needs were mentioned as important factors to consider for specific clients. When the same question was posed to service providers, the most common responses were birth control, STI/HIV testing, emergency contraception, and pregnancy tests. A different response that emerged from the providers was the need for client education on consent and forced sex in marriage. Service providers across settings described conversations with women that didn't understand that sexual abuse could happen in the context of a marriage. As this provider stated, ‘the clients don't understand that they don't have to have sex. They have sex because he's my husband and he makes me and he forces me. And they think it's okay.”

Providers stated that more training or education around consent would be beneficial in identifying potential SRH needs and recognizing sexual coercion as a form of IPV. Although survivors didn't address this specifically, it is important to note that many survivors in this study did describe experiencing acts of sexual violence or coercion by their partners but struggled with defining that as a form of IPV. As this survivor described,

> He would wait till I took my night medication that puts me to sleep because I have night terrors and things, and then he would have sex with me without my knowledge. And I think that happens more often than not. And because it's your partner, you make it somehow be okay in your own head.

Although abortion was mentioned a few times by both groups, service providers were uncertain about statewide restrictions or agency policies related to helping clients access abortion. In the few situations where providers mentioned having clients that were considering abortion, clients either decided to continue with their pregnancies or secured assistance from another provider However this provider recognized that guidance on abortion care was needed to prepare for future situations: “With abortion care and policies in Texas, being sure that we all know kind of what can we do, what can't we do legally, and policy-wise, and within the agency, things like that. What is the plan?” Although the interview guide focused on primarily SRH needs, participants did mention other needs such as mental health counseling, postpartum support, mammograms, transportation, and childcare. This highlights the complexity of needs that exists for IPV survivors.

Existing SRH Processes

Participants in both groups stated that any type of screening or assessing for SRH needs was rare within IPV agencies. A few survivors and providers indicated that their agency had a health-related question included in their intake paperwork. However, that was not the case with every agency represented in this study. For those that indicated having a health-related question, it was typically around general health needs or specific to injuries experienced from recent violence. No survivors responded yes to having been asked about specific SRH needs such as pregnancy tests, STI/HIV testing, birth control, or well-women’s exams. The only exception to this was in the IPV agency that had a health clinic onsite. Participants in that setting stated that when receiving medical services at this facility, the onsite nurse did ask about SRH needs.

Although most participants stated that SRH assessments were rare, a few providers mentioned having had SRH conversations with clients. These conversations were almost always triggered by a disclosure of sexual abuse. When probed about the content of these conversations, providers described discussions that centered on sexual coercion in IPV and how that relates to other forms of abuse. This provider facilitates groups for survivors and said that the topic of sexual abuse does come up frequently in this setting,

> We do talk a lot about sexual abuse that our survivors have experienced. And so, I think that may be like what I think is what we talk about the most. And then also like in our processing groups too, we do talk about sexual coercion and not allowing survivors to have access to birth control and things like that.

Few of these providers mentioned connecting the client to any internal or external SRH resources as part of these conversations. However, this demonstrates that there are IPV service providers currently navigating these conversations.

Several providers in this study stated they were open to screening for SRH needs and were aware of the unique SRH risk factors present for survivors of IPV. Despite this, most of the providers were hesitant to bring up SRH needs for fear of triggering or retraumatizing a client. As this provider stated,

> We want to be cautious as far as how much we're wanting them to open up because they are traumatized. It's an emotional roller coaster, …a new environment. So, it's like, I don't want to overwhelm you even further than you already are.

One consideration that may influence this hesitancy is that several of the service providers in this study identified as counselors. This type of provider may feel more skilled in navigating therapeutic dialogue around abuse and relationships but less prepared to screen or assess specific SRH needs. One provider who identified as a counselor, recognized the need to work more collaboratively within agencies to connect survivors to services.

> I definitely think for the sexual and reproductive abuse and health conversations, it would definitely be a good joint clinical and advocacy joint project that we could do. If we're talking about sexual and reproductive abuse as the clinician talking with our group clients, and then maybe having an advocate come in and talk about like, "Okay. Here are the resources. Here are the different things. Here's a place for pregnancy testing. Here's a place where you can get low-cost birth control.

In this setting clinical refers to therapists and their processing groups, while advocates help survivors connect to external community resources. Providers from both clinical and advocacy roles at this agency participated in this study and agreed that this collaboration would be beneficial when assessing and responding to SRH needs of shared clients.

As a result of this hesitancy, providers were more likely to wait until a client mentioned a SRH need before responding. Survivors in all settings stated that leaving it up to survivors to initiate conversations about SRH needs will mean that those needs will be ignored because survivors will not bring it up on their own. As this survivor stated, she needs a provider to take the lead,

> I definitely need a woman exam. It's been now eight years, so probably would be good. But it's already an uncomfortable thing. I'm never going to ask for that. But if I get [from a provider], "Hey, why don't you reach out to the advocate? I won't".

This is one area where the perspectives of survivor and providers in this study diverged, as survivors felt it was the responsibility of service providers to initiate those conversations, while providers were waiting for survivors to initiate those requests.

SRH Priority

Despite their complex needs, survivors felt that screening for SRH needs was important and should be universal at IPV agencies. There was some disagreement as to the timing of when these assessments should take place, but overall survivors agreed that screening for emergency SRH needs should be asked of all participants at intake or upon entry into a program. Survivors identified emergency needs as access to emergency contraception, abortion, and pregnancy tests. When asked about the importance of SRH needs when compared to other needs experienced by survivors, some survivors resisted prioritizing one type of need as more important than another. As this survivor stated, specific SRH services are critically important for survivors that enter services immediately after a sexual assault,

> I mean, like she said, she comes in and her baby needs formula. I think that's still a very important question. Women coming out of the hospitals or off the streets, being raped or whatever, I would feel like a Plan B is an important thing. So I think it's varied depending upon what that person's needs are. So for somebody, it might not be. But for someone who they had something happen to them, it's going to be an important need for them.

Other survivors stated that their perception of SRH was preventative care, and so other needs were more important, especially during intake. Providers largely thought that SRH needs were secondary to other basic needs that survivors have when entering services.

Most survivors in the study stated that asking an SRH question was not perceived as triggering if survivors were given the option to respond. Survivors stated that although one woman may not want to discuss their SRH needs, for others, offering that question could open the door to a conversation they would have never initiated on their own. As this participant described,

> I had no idea even how to just be like, "No, I was raped." And it's like if someone would just sit there and maybe just ask maybe I wouldn't have spiraled out of control…And I wanted to, like deep down, I wanted to talk to somebody. I just didn't know who or how, or you feel ashamed.

Another survivor stated that she felt opening the door for SRH conversations could help reduce the shame and guilt that so often comes with experiencing sexual abuse and violence, especially after women return to an abusive partner. As she described,

> I think if we talk about sexual health, I think it could also, break cycles. Like I need these other resources for sexual health, and I don't even know where to go or talk about it. Now I'm over traumatized… some cycles could be broken if you just have one sit-down, one little thing, - this normally comes after I do certain things. After certain things have happened, now I might need to look into it. I went back to the abusive man, he raped me, it’s a cycle.

This shows that talking through these experiences and SRH needs can be healing for survivors and does not necessarily ‘re-traumatize them. In every focus group and interview, survivor participants continued to emphasize the responsibility of service providers in asking these questions as evidenced in the following quotes “regardless no matter what, ask the question, because we are not going to tell”, “I think it should be asked”, “just ask, get it out”, “by just offering services, letting them know that they exist. It takes the mental load off, and “it would feel very loving and proactive.”

SRH Tool Recommendations

The final theme reflects the recommendations offered by the survivors and providers in this study around the creation of an SRH assessment tool for IPV agencies. During both focus groups and interviews, this researcher used question prompts to elicit discussion around the ideal process for assessing SRH needs with IPV survivors. Participants in both groups were asked their thoughts on the inclusion of specific SRH content, implementation strategies, potential questions, preferred length, and suggestions for linking survivors to external resources. The subthemes are grouped in the following categories to reflect participant recommendations in the areas of Content/Structure, Delivery, and Resource linkage.

Content & Structure

All participants were asked their thoughts about the structure and content of a proposed SRH assessment tool. Survivors described the importance of focusing on immediate needs at intake such as emergency contraction and abortion access, while addressing less urgent needs such as well-women's exams and birth control later when a survivor has had time to process and adapt to the agency setting. Survivors in the study placed an emphasis on the timing of certain questions rather than the nature of the questions themselves. When asked if any question or topic should not be discussed, most survivors stated that they couldn't think of anything; however, one survivor suggested that any conversations around family planning such as asking a woman if she is considering having more children should not be asked until rapport has been established. As she stated here,

> That's a question for after we get these things done first. Let's assess what we need to do to get out of this situation and then we'll think about that later. I think right now is not a good time for that.

Survivors and participants described support for a phased approach to SRH screening and assessment, guided by choice and facilitated by providers. Survivors recommended that providers start with a brief screening at intake, with a drop-down checklist of potential SRH needs. The survivors stated this would assist clients in identifying the available resources and eliminate any confusion around the terms “sexual and reproductive health”. An example of a suggested question for this screening from participants was “Are you needing help with any sexual health needs? If yes, please select what type of needs from this dropdown list?” Survivors and providers suggested that a more comprehensive assessment could occur later, when survivors are better equipped to process information. In a more in-depth assessment, questions pertaining to experiences of sexual trauma and broader women’s health needs such as gynecological services and mammograms could be explored. Examples of suggested questions from participants in this area included; “do you have any women's health or reproductive issues that you'd like to discuss, do you have any sexual concerns, and do you believe you have experienced sexual trauma?”

Several survivors described a need to include some form of assessment and education on how previous experiences with coercive sex may impact future intimate relationships. This was recommended for survivors farther along in their healing journey and removed from crisis. One survivor referred to this as ‘preventative relationship care” and could include discussions of family planning goals and navigating sexual boundaries. As this survivor described the psychological impact of IPV on sexual norms,

> There's also within the psychological realm of that sex was used as another tool of control and coercion and was not normal. You come here and you don't necessarily know what normal is. And so that is, I think, another whole area of education that needs to be

> restored in someone who's been through a situation. It's like they teach you how to look for relationship green flags and avoid cycling that way. But you also don't know what normal sexual relations look like. Your self-esteem has been shredded and your stability has been shredded. And so that doesn't just grow back normally in a sexual relationship either.

Examples of questions offered by survivors for this level of assessment included “What are your thoughts or plans for future relationships or decision to have more children? and What is your knowledge around sexual health and how to keep yourself safe sexually?

There were mixed responses within both groups on how to consider the cultural or religious beliefs of survivors in any assessment strategy. Most providers believed it would be helpful to know whether a client has religious or cultural beliefs that prohibit certain forms of SRH care and suggested including a question to acknowledge those beliefs. This provider suggested asking the question in this manner; “I’d love to talk about sexual/reproductive health with you. Are there any cultural religious beliefs that you think might impact this conversation that you want me to know about”. Most survivors also thought that asking a simple question about beliefs would be appropriate, although a few women disagreed stating that someone’s religious views aren’t relevant to the conversation, as expressed here,

> I don't feel like religious beliefs would matter. I mean, I just personally don't feel like it's necessary because it wouldn't matter. I mean if you're Muslim or Mormon? I mean, what would it matter if you were abused in whatever way? I feel like they all are-- it all ties back to the same.

Service providers noted the importance of including questions in the assessment that were inclusive of survivors in same-sex and polyamorous relationships When asked for suggestions on questions to include for those populations, providers stated they didn’t have specific ideas, but felt that it was important to include those perspectives as most tools are centered on heterosexual relationships. This provider stated it this way,

> I think maybe it's a different screening tool, or there's three different questions at the bottom of that screening tool that's specific to a same-sex sexual relationship or something like that. But I think it would have to be addressed straight on instead of being like, "Well, in your situation." Instead of having to curve a question to fit them, making sure there is something that already fits them.

Survivors in this study also stated that including questions for individuals in same-sex relationships was important, however most participants identified as “straight’ so eliciting the perspectives of LGBTQ survivors is needed for crafting this component of the tool.

Delivery

Delivery refers to the administration of the questions or tool to survivors. Participants in both groups recommended that the initial screening be brief, take no longer than 5 minutes to complete, and include only a few questions. Survivor responses varied when it came to whether the tool should be administered verbally or through a paper questionnaire. Some survivors expressed support for the use of an app for SRH screening, while other survivors expressed opposition towards the use of an app in this setting. Each modality had appeal to certain survivors in the study with the overall recommendation being that providers should offer choice to survivors in how they answer these questions. As this woman said, “I think we should keep it optional for both, as far as those who prefer paper, to write it down, and those who prefer to speak verbally, because we are all different.”

Survivors were aware that many service providers feel uncomfortable discussing certain topics and emphasized the importance of educating and training staff to navigate SRH conversations effectively. If staff are not skilled in SRH topics, then survivors recommended involving a nurse or other healthcare provider who is more knowledgeable about these topics as this survivor stated,

> It should be done by the nurse or somebody that's in that field because I-- not just saying that I know, but I know a lot of the intake people, a lot of the case manager people, they are not experienced in that level. I'm not saying all of them, but I just know off top, a lot of them are not experienced in that level. So I don't feel comfortable with sharing that information because I feel like it's just going down the drain.

Participants in both groups stressed that any tool or questions be administered in a sensitive and gentle manner, keeping in mind the mental state of survivor before proceeding. As one provider shared that a recent client came into the shelter directly from a mental health facility, and that any attempts to engage in assessment at that point would have been futile; “That girl came in right from the mental hospital. And she had medication. She was just sitting there. So there was no point in me trying to extract something”. Providers felt that it was important to be mindful of the language used in conversations and seek ways to normalize the discussion. This provider likened it to how they are trained to talk in suicide assessments,

> I'm just thinking of the way we were trained to talk even about you know suicide assessments where we say, "Sometimes when women are in this sort of situation, these can be some things that happen." I'm wondering if these have ever happened to you without whatever scenario it is. So I'm wondering if maybe kind of generalizing it and just to kind of normalize it might be a helpful way to do it.

Trauma informed interpreters or bilingual staff was another recommendation from providers when considering any type of SRH assessment. The agencies that participated in this study serve many Spanish-speaking clients who were unable to participate in this study due to the limitations on this researcher.

Resource Linkage

Any assessment aims not only to discern the needs of survivors, but also to ensure effective responses to address those needs. When asked about linking survivors to SRH resources, participants in both groups offered internal and external suggestions. Internal suggestions were directed toward IPV agencies providing more SRH services onsite. Both providers and survivors recommended that this include providing kits with SRH information and resources directly to survivors at intake. , As this woman described; “I feel like when somebody comes in there and intake, they should be given a goody bag full of condoms, pads, and tampons” Others added that pregnancy tests, birth control information, and emergency contraception could be included in these kits. Providers recommended adding SRH resources on their current resource referral cards, organizing onsite events focused on SRH needs, and developing psychoeducational groups focused on reproductive health topics. These types of groups are already offered at agencies, but topics could be customized as this provider shared; “They're drop-in groups, but even once every couple of months, but maybe having one about just reproductive health or well women's health.”

External resource suggestions from providers and survivors were largely focused on enhancing healthcare access, particularly since two of the participating IPV agencies do not offer any type of healthcare services and many survivors lack health insurance. Participants in both groups strongly recommended enhanced collaboration between IPV agencies and women healthcare providers. Survivors also expressed the need for better inter-agency collaboration between the different provider roles involved with survivors, including intake staff, case managers, housing specialists, and therapists. This would minimize the need for survivors to repeatedly recount their stories, as this survivor described,

> I feel like you already do an application to even come here, okay, to be approved. Then when you get here, seconds when you hit the door, like they're re-asking it again. And I'm a person. I don't like to keep saying the same thing over, especially when you're just leaving the situation. Like there's no breath when you get here.

Transportation and childcare were the two most identified barriers expressed by survivors across settings, highlighting the challenge of survivors accessing SRH care if they are external from the IPV agency. These barriers were experienced by survivors across the service spectrum from those currently residing in emergency shelter, as well as survivors who had moved into their own housing and were several years removed from their IPV experience.

Discussion

Numerous studies link IPV with adverse SRH outcomes for female survivors (Campbell, 2002; Coker, 2007; Gielen et al., 2007, McGirr et al.,2020). Despite this, most IPV agencies do not include any form of SRH screening or assessment into their services (Cavanaugh & Ward, 2021; Rountree et al., 2008). This study interviewed survivors and service providers to gather input on integrating an assessment for SRH needs within IPV agency settings. The findings not only yielded recommendations for an SRH assessment framework, but also insight into the challenges and opportunities to implement SRH assessment into standard IPV service delivery.

As evidenced in the first theme, survivor participants shared how experiencing trauma impacts their perceptions of people and how they interact with service providers. Survivors in this study described these impacts as having difficulty taking in information or feeling incapacitated to ask for help. This outlook makes it hard for survivors to express needs or have open conversations with service providers. These findings support what IPV survivors in previous studies have stated about the need for trauma informed approaches that aid in building trust and safety, especially around sensitive topics such as SRH (Hussain & Khan, 2008; O'Connor-Terry et al., 2022). The women in this study shared how the long-lasting impacts of trauma make healing and becoming self-sufficient more challenging, and often put them in conflict with the time limitations of assistance at IPV agencies. The responses in this study suggest that IPV service providers should examine whether their services reflect the needs of survivors and consider whether ongoing support services are feasible.

Additionally, we see in this study a reluctance within IPV agencies to engage in SRH discussions despite research indicating that survivors of IPV often experience sexual or reproductive coercion in their relationships (Grace & Anderson, 2018; Logan et al., 2007; Miller et al., 2010). While the service providers in this study preferred to wait for survivors to initiate conversations about SRH needs, survivors in the study felt it was the responsibility of providers to take the lead in facilitating some form of SRH screening with survivors. This differentiates current practices around SRH assessment in IPV agencies and those informed by survivors. It also highlights a thread across disciplines where both healthcare providers and staff in IPV agencies express discomfort in discussing the intersecting issues of RC and IPV with survivors.

Survivors in this study acknowledged that not all women in IPV relationships may want to discuss SRH topics. However, they felt that initiating dialogue on SRH topics could help reduce the shame and stigma that many survivors experience around sexual abuse. In line with findings from previous studies involving IPV survivors, several women in this study had experienced sexual abuse either during childhood or in previous relationships, resulting in persistent feelings of shame. IPV service providers can play a crucial role in normalizing SRH conversations and preventing the transfer of stigma being passed on to the next generation of survivor's children.

Finally, this study proposes a framework for an SRH assessment strategy that is informed by IPV survivors and direct service providers. This framework incorporates components of screening and assessment to offer a comprehensive approach to SRH needs across the spectrum of the IPV survivor experience. While the term "assessment" was consistently used throughout this article to describe the resulting framework, during data analysis it became clear that participants indicated a need to incorporate some element of "screening". Although the difference between screening and assessment may seem minor, clarifying this distinction is critical for the eventual application and effectiveness of the framework.

Screening refers to a process of identifying the presence of a particular problem or need (SAMSHA, 2009). The outcome is normally a simple yes or no. Assessment refers to a process that seeks to define the nature of that problem, determine its severity, and develop specific recommendations for addressing the problem (SAMSHA, 2009). Assessment can also include evaluating an individual's strengths and resources.

The recommended SRH approach that emerged from this study includes components of both screening and assessment across a phased framework. This phased approach considers the unique characteristics and needs of survivors across the service spectrum. Survivors that participated in this study included individuals in emergency IPV shelters, only a few days removed from their abuser, as well as survivors' years along in the healing process. Since IPV agencies serve women at various stages, this framework proposes varying degrees of responses at each level. It also factors in the "crisis" state of survivors upon entry into IPV agencies, and what is most appropriate to address at that time.

The framework is broken into three "phases" to respond to the SRH needs of survivors as articulated by participants in this study (See Figure 1). The initial phase in the framework involves a brief screening that would be done at intake or shortly after the first encounter of a survivor with an IPV service provider. This screening should be brief, consisting of 1-2 questions that focus on immediate SRH needs, and include a drop-down list of potential SRH needs, for individuals that indicated need. Identifying specific needs such as pregnancy tests, birth control, and abortion care, would be included to eliminate any confusion around the terms "sexual" or "reproductive "health. As with all phases of this framework, answering would be optional, and contingent on the current mental state of the survivor. Immediate or time sensitive needs such as emergency contraception, abortion care services, and pregnancy tests would be prioritized during this phase, and connection to those resources should be immediate.

The next phase in the framework is recommended to happen later in the service delivery process. For those in emergency shelter programs, this could be anywhere from a few days after intake to a week later. For individuals seeking non-residential services, this would be offered when more basic needs are addressed, potentially in the 3rd or-4th session with a provider. In this phase, providers would follow up on identified needs from the initial screening, as well as conduct a more detailed assessment of survivors' SRH experiences. This enables providers to assess sexual or reproductive coercion and provide information on its relation to other forms of abuse.

In addition, during this phase, efforts should be included to link survivors with related healthcare resources such as well-women's exams and mammograms. It is crucial that service providers conducting the assessment in this phase are adequately trained to handle discussions around sexual or reproductive coercion and to refer survivors to external community resources. The trauma informed principles of providing choice and control to survivors should be applied here and assessment specifics should remain optional. Regardless of responses, all survivors should be provided information on sexual and reproductive coercion along with related SRH resources via a resource card or brochure.

The final phase in the framework is intended for survivors that are further along in their healing journey and removed from their abusive relationship. This phase was recommended by survivors to assess the impact of abuse on their understanding of sex and help survivors prepare for healthy sexual relationships in the future. This phase would include an element of education and processing that would need to be facilitated by a skilled service provider. Included in this phase would be tools to assist survivors in identifying sexual boundaries and promote personal safety.

Although traditional IPV education includes identifying red flags in relationships, survivors in this study stated that more is needed to consider how experiences with body shaming and forced sex from previous partners distorts their view of sexual encounters. This phase would assess a survivor's sexual and reproductive goals both in future relationships and in choices on whether to reproduce. Assessing preferred contraceptive methods based on those goals and access to those options would also be included. Additionally, any trauma sensitive sexual education that could be offered by IPV agencies would be recommended at this phase to help survivors build positive experiences around sex that are not associated with trauma.

This framework for responding to the SRH needs of survivors requires a comprehensive approach to implementation. Throughout data collection, participants identified barriers that could pose challenges for implementation at both the individual and agency levels. It is important to recognize that implementing screening for SRH needs isn't helpful if there is no follow up action. Agencies considering SRH screening must first undertake the necessary steps to procure access to pregnancy tests and emergency contraception. In states where restrictions exist, providers must have a clear understanding of the legal constraints surrounding abortion and the facilities that provide such care. This requires being aware of agency polices regarding assisting survivors in accessing abortion services. Individual barriers such as transportation and childcare can make it difficult to connect survivors with external resources, underscoring the value in collaborating to provide onsite services.

Given the heightened risk of cervical and gynecological cancers among IPV survivors, improving healthcare access is critical in addressing their SRH needs (Bagwell-Gray & Ramaswamy, 2022). However, many survivors lack healthcare access due to living in geographic areas with limited resources. For instance, in Texas, where this study was conducted and Medicaid expansion was not implemented, state data suggests that 46% of IPV survivors in the state lack health insurance (Texas Council of Family Violence [TCFV], 2022). This same report states that RC rates among survivors in Texas are three times greater than the national average (TCFV, 2022). These findings underscore the urgent need for SRH approaches that connect healthcare providers with IPV agencies in underserved regions like Texas.

Onsite health care partnerships emerged as a significant strength among the participants in our study. This is consistent with a previous study indicating that IPV survivors favor programs integrating healthcare and IPV-related services (Dichter et al., 2021). The onsite clinic at this agency enabled survivors to have immediate access to healthcare services, regardless of their health insurance status. For service providers, it streamlined the assessment of SRH medical needs through experienced healthcare staff, who were also well-versed in IPV. However, establishing and maintaining those partnerships requires considerable effort and resources on the part of the IPV agency. For settings where this arrangement is not feasible, IPV agencies should seek to collaborate with external community clinics and family planning providers. Moreover, IPV agencies should assess whether their program policies discourage survivors from disclosing their SRH needs. In this study, certain service providers described agency policies that forbid survivors from hosting guests. If these policies affect housing stability, survivors might hesitate to disclose SRH needs, such as a need for pregnancy tests or STI testing.

Limitations

The sample in this study included 29 participants, consisting of 12 service providers and 17 survivors. While efforts were made to purposively select participants from various program types and agencies, all participants resided within the same metropolitan area in the Southwestern United States. Additionally, participants across both survivor and provider groups identified mostly identified as “heterosexual” or “straight” and were all English speaking. As a result, perspectives identified by IPV survivors in this study cannot fully represent the experiences of all IPV survivors, particularly those in rural areas, who identify as LGBTQ, or speak another language besides English.

Data relied on self-reports from participants, and the use of focus groups increased the potential of social desirability bias, as some participants may not have disclosed their true feelings when those differed from that of the other participants. As with any form of qualitative analysis, there is inherently the potential of researcher bias, despite this researcher employing triangulation methods to mitigate bias.

Conclusion

This study offers several implications for clinical practice, policy, and research. By actively involving survivors and service providers in the development of assessment tools, this research ensures that the proposed methods are tailored to the needs and perspectives of those directly impacted. This inclusive approach enhances the relevance and effectiveness of interventions implemented in clinical practice. In addition, the study provides IPV service providers with a structured framework for assessing the SRH needs of survivors. The phased framework outlined in the study, along with suggested implementation strategies, offers practical guidance for professionals working in the field.

The findings of this study have the potential to raise awareness of the SRH needs of survivors of IPV. By fostering collaboration between IPV agencies and SRH community partners, this research promotes the delivery of comprehensive services that address the complex needs of survivors of IPV. Such collaborations can ultimately enhance the overall response to IPV within the social work field. The results emphasize the necessity of advocating for policies at the agency, state, and federal levels that facilitate access to SRH for survivors of IPV. With certain SRH services being restricted, the health and safety risks posed to IPV survivors are exacerbated. Agency leaders must develop policies guiding staff in navigating abortion care for clients and providing current state-specific guidelines.

This study contributes to the literature an IPV survivor and provider-informed approach to SRH assessment. It supports the crucial role of IPV service providers in addressing the SRH needs of survivors with limited access to healthcare. Future research directions include exploring SRH strategies for LGBTQ and Spanish speaking survivors and evaluating the feasibility of developing and implementing healthcare based SRH tools in IPV agency settings.

References

Anderson, J. C., Grace, K. T., & Miller, E. (2017). Reproductive coercion among women living with HIV: an unexplored risk factor for negative sexual and mental health outcomes. *AIDS*, *31*(16), 2261-2265.

Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence, & Abuse*, *16*(3), 316-335. https://doi-org.ezproxy.tcu.edu/10.1177/1524838014557290

Bagwell-Gray, M. E., Jen, S., & Schuetz, N. (2020). How intimate partner violence and intersectional identities converge to influence women's sexual health across environmental contexts. *Social Work*, *65*(4), 349-357.

Bagwell-Gray, M.E., & Ramaswamy, M. (2022). Cervical cancer screening and prevention among survivors of intimate partner violence. *Health & Social Work*, *47*(2), 102-112.

Birks, M., & Mills, J. (2015). Grounded theory: *A practical guide*. Sage.

Boyce, S. C., Uysal, J., DeLong, S. M., Carter, N., Undie, C. C., Liambila, W., Wendoh, S. & Silverman, J. G. (2020). Women's and girls' experiences of reproductive coercion and opportunities for intervention in family planning clinics in Nairobi, Kenya: a qualitative study. *Reproductive Health*, *17*, 1-12.

Bryant, A., & Charmaz, K. (Eds.). (2007). *The Sage handbook of grounded theory*. Sage.

Burton, C. W., & Carlyle, K. E. (2015). Screening and intervening: Evaluating a training program on intimate partner violence and reproductive coercion for family planning and home visiting providers. *Family & Community Health*, *38*(3), 227. https://doi.org/10.1097/FCH.0000000000000076

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545–547. https://doi.org/10.1188/14.ONF.545-547

Cavanaugh, C., & Ward, K. (2021). HIV/STI prevention interventions for women who have experienced intimate partner violence: A systematic review and look at whether the interventions were designed for disseminations. *AIDS and Behavior*, *25*(11), 3605-3616

Charmaz K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis*. Thousand Oaks, CA: Sage

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 2050312118822927. https://doi.org/10.1177/2050312118822927

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, & Abuse*, *8*(2), 149-177.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Decker, M. R., Flessa, S., Pillai, R. V., Dick, R. N., Quam, J., Cheng, D., McDonald-Mosley, R., Alexander, K. A., Holliday, C. N., & Miller, E. (2017). Implementing trauma-informed partner violence assessment in family planning clinics. *Journal of Women's Health (2002)*, *26*(9), 957–965. https://doi.org/10.1089/jwh.2016.6093

Dichter, M. E., Ogden, S. N., Tuepker, A., Iverson, K. M., & True, G. (2021). Survivors' input on health care-connected services for intimate partner violence. *Journal of Women's Health*, *30*(12), 1744–1750. https://doi.org/10.1089/jwh.2020.8585

Gielen, A. C., Ghandour, R. M., Burke, J. G., Mahoney, P., McDonnell, K. A., & O'Campo, P. (2007). HIV/AIDS and intimate partner violence: Intersecting women's health issues in the United States. *Trauma, Violence, & Abuse*, *8*(2), 178-198.

Glaser B.G., & Strauss A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Grace, J., & Elias-Lambert N. (2023) *Health needs of intimate partner violence survivors: Exploring the role of service providers* [Manuscript in preparation]. Department of Social Work, Texas Christian University.

Grace, K. T., & Anderson, J. C. (2018). Reproductive coercion: a systematic review. *Trauma, Violence, & Abuse*, *19*(4), 371-390.

Hussain, R., & Khan, A. (2008). Women's perceptions and experiences of sexual violence in marital relationships and its effect on reproductive health. *Health Care for Women International*, *29*(5), 468-483.

Kuzel, A. (1999). Sampling in qualitative inquiry. Doing Qualitative Research. 2nd. Edited by Crabtree BF, Miller WL.

Litosseliti, L. (2003). *Using focus groups in research.* Continuum

Logan, T. K., Shannon, L., & Cole, J. (2007). Stalking victimization in the context of intimate partner violence. *Violence and Victims*, *22*(6), 669-683..

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26*(13), 1753-1760.

McGirr, S. A., Bomsta, H. D., Vandegrift, C., Gregory, K., Hamilton, B. A., & Sullivan, C. M. (2020). An examination of domestic violence advocates' responses to reproductive coercion. *Journal of Interpersonal Violence*, *35*(9-10), 2082-2106

McPhail, B. A., Busch, N. B., Kulkarni, S., & Rice, G. (2007). An integrative feminist model: The evolving feminist perspective on intimate partner violence. *Violence Against Women*, *13*(8), 817–841. https://doi.org/10.1177/1077801207302039

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, *81*(4), 316–322. https://doi.org/10.1016/j.contraception.2009.12.004

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2011). A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*, *83*(3), 274–280. https://doi.org/10.1016/j.contraception.2010.07.013

Moore, A. M., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine*, *70*(11), 1737-1744.

Moya, E. M., Chávez-Baray, S. M., Martínez, O., & Aguirre-Polanco, A. (2016). Exploring intimate partner violence and sexual health needs in the southwestern United States: Perspectives from health and human services workers. *Health & Social Work*, *41*(1), e29–e37. https://doi.org/10.1093/hsw/hlv080

O'Connor-Terry, C., Burton, D., Gowda, T., Laing, A., & Chang, J. C. (2022). Challenges of seeking reproductive health care in people experiencing intimate partner violence. *Journal of Interpersonal Violence*, *37*(7-8), NP5167-NP5186.

Park, J., Nordstrom, S. K., Weber, K. M., & Irwin, T. (2016). Reproductive coercion: uncloaking an imbalance of social power. *American Journal of Obstetrics and Gynecology*, *214*(1), 74-78.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. Sage.

Peters D. A. (1993). Improving quality requires consumer input: using focus groups. *Journal of Nursing Care quality*, *7*(2), 34–41. https://doi.org/10.1097/00001786-199301000-00006

Plummer M., & Young .LE. (2010). Grounded theory and feminist inquiry: Revitalizing links to the past. *Western Journal of Nursing Research*, 32(3):305-321. doi:10.1177/0193945909351298

Ramachandran, D. V., Covarrubias, L., Watson, C., & Decker, M. R. (2013). How you screen is as important as whether you screen: A qualitative analysis of violence screening practices in reproductive health clinics. *Journal of Community Health*, *38*(5), 856–863. https://doi.org/10.1007/s10900-013-9690-0

Rountree, M. A., Pomeroy, E. C., & Marsiglia, F. F. (2008). Domestic violence shelters as prevention agents for HIV/AIDS? *Health & Social Work*, *33*(3), 221-228

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179-183.

Sawyer, J. M., & Brady, S. R. (2022). Applying critical grounded theory to community intervention development methodology: Designing the critical difference engagement approach. *International Journal of Qualitative Methods*, *21*, 16094069221141308. https://doi.org/10.1177/16094069221141308

Stockman, J. K., Lucea, M. B., & Campbell, J. C. (2013). Forced sexual initiation, sexual intimate partner violence and HIV risk in women: A global review of the literature. *AIDS and Behavior*, *17*(3), 832–847. https://doi.org/10.1007/s10461-012-0361-4

Stumbar, S., Ward-Peterson, M., & Lupi, C. (2019). A pilot project exploring medical students' barriers to screening for intimate partner violence and reproductive coercion. *PRiMER*: *Peer-Review Reports in Medical Education Research*, *3*. https://doi.org/10.22454/PRiMER.2019.929284

Substance Abuse and Mental Health Services Administration [SAMHSA] (2009). *Substance abuse treatment: Addressing the specific needs of women: Treatment improvement protocol (TIP) Series*, 51.4 Screening and Assessment. Accessed from: https://www.ncbi.nlm.nih.gov/books/NBK83253/

Texas Council on Family Violence (2022). *State of the State report.* https://tcfv.org/wp-content/uploads/2022-State-of-the-State_FINAL.BB-Updated.pdf

World Health Organization. (2024). *Violence Against Women*. Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Table 3.1

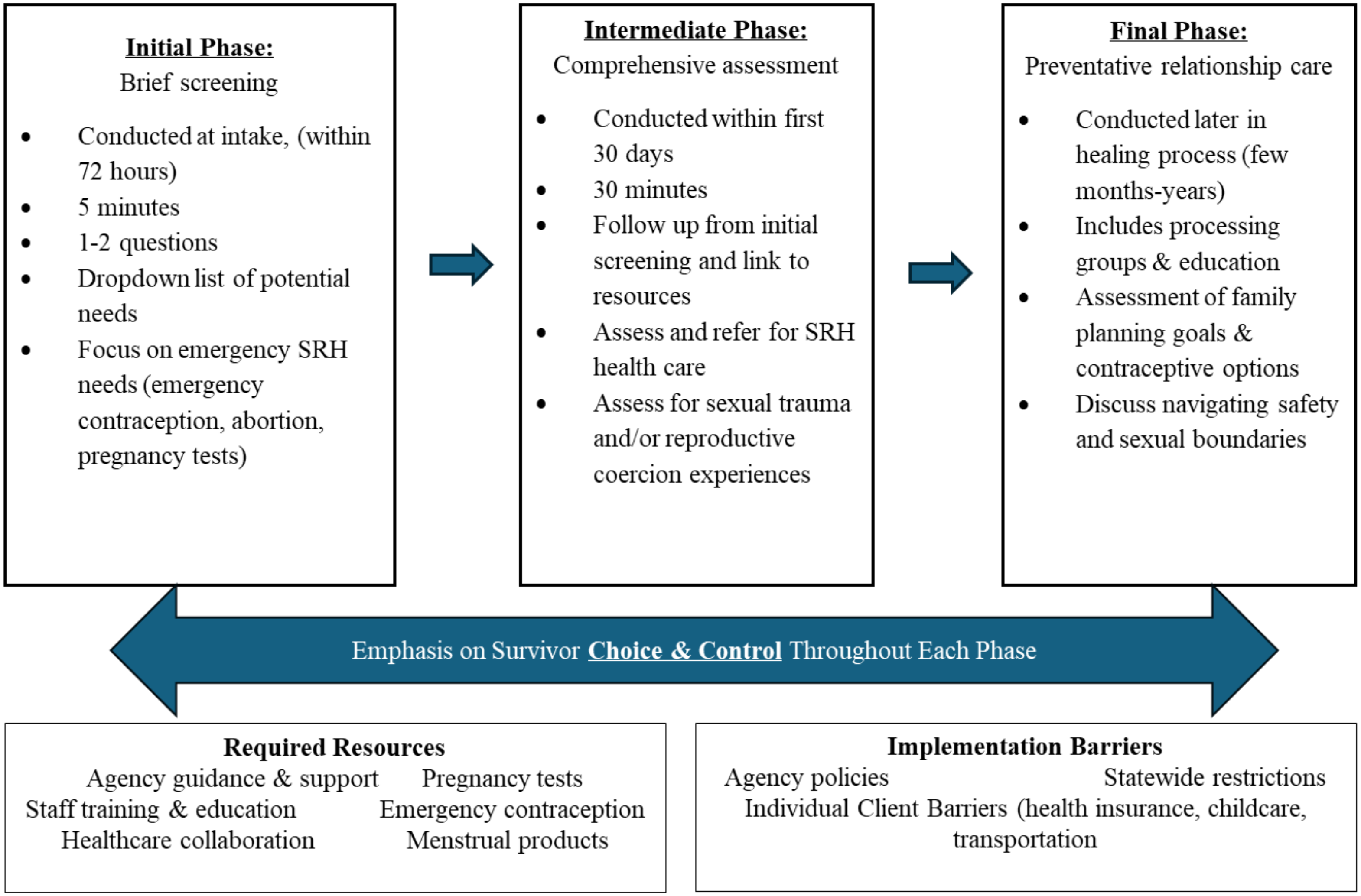
Participant Demographics for Providers and Survivors

Variables	Service Providers n=12		IPV Survivors n=17	
	No	%	No	%
Sex				
Female	12	100%	17	100%
Race				
Black/African American	4	33.3%	7	41%
Hispanic/Latino	4	33.3%	3	18%
White	3	25%	7	41%
Native American	1	8.3%	0	0%
Age				
18-24	2	1%	0	0%
25-34	4	33.3%	7	41%
35-54	4	33.3%	4	24%
55+	2	17%	6	35%
Sexual orientation				
Heterosexual	9	75%	14	82%
Bisexual	0	0%	1	6%
Lesbian	1	8.3%	0	0%
Undisclosed	2	17%	2	12%

Figure 1

SRH Screening & Assessment Framework for IPV Survivors

(as informed by IPV survivors & service providers)



Appendix B: Focus Group Interview Guide

The goal of these focus groups is to gain feedback on the development of a sexual and reproductive health (SRH) assessment tool for Intimate Partner Violence survivors. Possible questions for this focus group include but are not limited to:

- Content of an SRH Tool
    - **<u>For IPV survivors</u>**
        - Describe any experiences you have had where agency staff asked about your SRH needs.
            - Examples of SRH needs include any of the following: pregnancy testing, birth control, HIV/STI testing, emergency contraception (plan B), abortion care, pregnancy-related/prenatal care, well-women exams, abortion care, or postpartum resources.
            - *If this has happened*: What did the staff do well,and what could they have done better?
            - *If this has never happened:* What do you wish they would have asked?
        - What do you consider the most urgent SRH needs of survivors of Intimate Partner Violence (IPV)?
        - What SRH (*see examples listed above*) needs would you like service providers to ask about during the intake process?
        - Anything that you don't think should be included in an SRH assessment tool? Why or why not?

    - **<u>For IPV providers</u>**
        - Describe any ways that you have assessed your clients for their SRH needs.
            - Examples of SRH needs include any of the following: pregnancy testing, birth control, HIV/STI testing, emergency contraception (plan B), abortion care, pregnancy-related/prenatal care, well-women exams, abortion care, or postpartum resources.
            - *If you have done this*: What works well when discussing SRH needs with clients? What do you think you could do better?
            - *If you have never assessed for SRH needs*: How do you think you would approach this topic with clients?
        - What do you consider the most urgent sexual and reproductive health (SRH) needs of survivors of Intimate Partner Violence (IPV)?
        - What questions do you think are needed to assess your client's SRH needs?
        - Anything that you don't think should be included in an SRH assessment tool? Why or why not?

- Delivery of an SRH tool
    - **<u>IPV providers & Survivors</u>**
        - How should staff ask SRH screening questions to clients?

    - What is the preferred way to ask these questions? (ex. Questionnaire completed by the client, verbally administered by the provider, embedded into current intake paperwork)
    - What factors should service providers/staff consider when screening for SRH needs?
    - How should racial, religious, or cultural influences be incorporated into the assessment process?
  - **<u>For IPV Providers Only:</u>**
    - What other supports do providers need to effectively screen and assess for SRH?
- Length/Duration of Tool
  - **<u>IPV providers & Survivors</u>**
    - What is the ideal length of time for completing this assessment tool? Should there be a certain number of questions? What is too long?
    - When should these questions be asked during the intake process? Should this be included with a specific section?
- SRH Resource linkage and follow-up
  - **<u>IPV providers & Survivors</u>**
    - What additional resources are needed to support the implementation of a SRH assessment tool within IPV agencies?
  - **<u>For IPV providers only</u>**
    - How might providers help link clients to SRH resources after the completion of assessment tool?

Chapter 5: Conclusion

The goal of this dissertation project was to provide a comprehensive understanding of the SRH needs of survivors of IPV, with the overall aim to guide practice interventions and policies that enhance services provided to survivors. Through the articles that make up this dissertation, this researcher sought to accomplish this objective by providing a foundational overview of what is currently known about women's reproductive decision-making in the context of IPV, exploring the role that IPV service providers have in responding to SRH needs, and proposing a framework for SRH assessment that can be implemented within agencies serving survivors.

The articles that make up this dissertation build upon one another and provide a comprehensive understanding of the experiences of survivors and the unique challenges that exist in assessing and responding to their SRH needs. Although there is a vast amount of literature linking IPV and poor sexual health outcomes, effective strategies for improving screening and assessment of SRH for survivors are needed. It is also clear that the perspectives of survivors are often missing in this response. Through the synthesis of available qualitative studies that included survivor perspectives in the first manuscript and in the focus groups with survivors in the final study, this dissertation helps dispel the idea that survivors are not aware of their increased SRH risks. The findings from these manuscripts not only demonstrate that survivors are aware of their SRH risks but are actively utilizing strategies to assert their reproductive autonomy and mitigate personal harm. Additionally, survivors in both manuscripts one and three, emphasized the importance of talking about SRH health needs, and voiced support for service providers to initiate those conversations.

This dissertation suggests that despite growing awareness and training around the intersection of IPV and poor SRH outcomes, current strategies have not increased disclosure rates or resulted in enhanced SRH services, within healthcare settings or at agencies serving survivors. Upon reviewing existing literature and exploring past approaches aimed at recognizing SRH needs among IPV survivors, it became evident that there is a notable discomfort in addressing the implications of sexual violence on women's health. This discomfort emerged in the literature involving healthcare providers and in the conversations with IPV service providers noted in manuscripts two and three. Barriers such as a lack of training and confidence were cited as reasons for this hesitation from both survivors and service providers, so these findings support the call for greater cross-collaboration and training between health care providers and social service agencies. However, this hesitancy presents a dynamic that prompts further questions, given that both healthcare providers noted in the literature and the IPV service providers that participated in this research engage in conversations about SRH topics and IPV daily. The data suggests that when these two areas (IPV and SRH) intersect, providers feel less comfortable discussing SRH needs with survivors. This elicits further exploration into the type of training or education needed to increase provider confidence when navigating SRH conversations with IPV survivors.

The use of critical feminist theory as a framework for this study provides another lens to view the findings of this dissertation, particularly when exploring the challenges that exist in discussing and addressing women's sexual health. As stated in the introduction, this researcher adheres to Lather's view that states "the aim of feminist ideological research is to correct both the invisibility and distortion of the female experience in ways relevant to ending women's unequal social position" (Lather, 1991). This dissertation adds to the feminist literature by highlighting and centering the experiences of female survivors around topics that predominantly impact women: IPV and reproductive health. The very nature of IPV is rooted in issues of power and control, and its continued existence relies on societal structures where women's voices are ignored and have less value than their male counterparts. In the first manuscript, we saw examples of patriarchal, heteronormative norms emerge in specific geographic settings, in religious beliefs, and in familial and cultural traditions, as voiced by female survivors. Similar statements emerged in the focus groups and interviews with survivors in manuscript three. This emerged in stated views about marriage and the right of husbands to force sex from their wives, which both survivor and service provider participants mentioned as a challenge in identifying and responding to sexual coercion in IPV. In addition, gender inequities in healthcare continue to present barriers for survivors, due to a healthcare system that was designed for and controlled by men. This has led to less research and awareness of women's health care needs in general, including those related to SRH. These inequities are more pronounced for survivors of color who must navigate the intersecting identities of being both female and a woman of color.

Consequently, the lack of knowledge about women's SRH needs can lead to stigmatization and shame when talking about sex. This becomes significant when considering the findings of manuscript three, where survivors expressed a desire for service providers to lead discussions on identifying healthy sexual behavior and boundaries when preparing for future relationships. This "preventative relationship care" phase of the framework asks that service providers aid in normalizing SRH conversations to dismantle the stigma and shame that is embedded into societal norms and reflected in survivor experiences. By doing this, IPV service providers can aid survivors in reclaiming a positive sexuality after experiencing sexual violence.

However, for this to occur, service providers must be equipped with the necessary tools and information to effectively facilitate these conversations. In the second manuscript, interviews conducted with direct service providers revealed disparities in their own sexual education experiences. Some providers disclosed receiving minimal or no sexual education during childhood, leading to limited comfort in discussing certain topics such as STI’s or methods of birth control. Given that many states have yet to implement evidence-based sexual education in public schools, it cannot be assumed that staff at IPV agencies automatically possess the knowledge required to facilitate these conversations. This emphasizes the significance of the study recommendations to enhance education and training for providers, including both general SRH education and the specific needs of IPV survivors.

This dissertation fills a gap in the literature by proposing a SRH assessment framework specifically designed for use in IPV agencies. The proposed framework that is described in manuscript three, was informed by survivors with direct experience in receiving IPV-related services. Additionally, the inclusion of service providers in the research process as evidenced in both manuscripts two and three, helped acknowledge and address potential barriers to implementation in practice settings. The concept of creating a SRH assessment tool or framework was the direct result of the recommendations stated by IPV service providers in manuscript two. This is a distinction from previous studies addressing IPV and SRH, as service provider perspectives are often missing from the literature. Manuscript two provides further insight into the provider perceived barriers to SRH conversations and guided the research design that was utilized in manuscript three. Not only does this dissertation add to the scientific literature to provide a better understanding of the SRH needs of survivors, but these findings have immediate practice applications. The results of this dissertation provide the foundation to create a simple SRH assessment framework for implementing screening and assessment in IPV agencies, that can be adapted based on the size and resources of the agency. The phased approach offers applications across the service spectrum and can be implemented in stages, as agencies build their SRH services and healthcare collaborations.

This dissertation suggests several avenues for future research to build upon these findings. Upon completing this dissertation, the findings and proposed SRH framework will be shared with IPV agency leadership and stakeholders. The aim is to collaborate on piloting a study focused on implementing a SRH screening measure. This research would involve examining existing SRH measures used in healthcare settings to assess their suitability for IPV survivors. Alternatively, it could include developing a new measure that incorporates additional factors from the studies. Evaluating the efficacy of these measures in facilitating SRH discussions and connecting survivors to appropriate resources would be a key aspect of future studies. Future research would also aim to gather the perspectives of Spanish-speaking survivors and individuals that identify as sexual minorities. This would expand understanding of the specific SRH needs of these communities and ensure that any measures implemented are inclusive and responsive across diverse survivor populations. Additionally, the findings from each article of this dissertation underscore the importance of interdisciplinary education for healthcare providers and social service providers. This researcher aims to utilize this research to expand trauma informed sexual health education for all professionals that engage with survivors of sexual violence.

References

Arinder, Jo Ann. (2020). Feminist Theory. In J. Egbert & M. Roe (Eds). Theoretical models for teaching and research. Open education resource (OER) https://opentext.wsu.edu/theoreticalmodelsforteachingandresearch/front-matter/theoretical-models-for-teaching-and-research

Basile, K. C., Black, M. C., Breiding, M. J., Chen, J., Merrick, M. T., Smith, S. G., ... & Walters, M. L. (2011). National intimate partner and sexual violence survey: 2010 summary report.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331–1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Center for Behavioral Health Statistics and Quality. (2022). *Errata for key substance use and mental health indicators in the United States: Results from the 2020 national survey on drug use and health.* Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report

Centers for Disease Control and Prevention. (2022, October 11). *Fast facts: Preventing intimate partner violence*. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma*, *Violence, & Abuse*, *8*(2), 149-177.

Crenshaw, K.M. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, Feminist theory and antiracist politics. *University of Chicago Legal Forum*, *140*, 139–67.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258.

Gill, A. (2018). Survivor-centered research: Towards an intersectional gender-based violence movement. *Journal of Family Violence*, *33*(8), 559–562. https://doi.org/10.1007/s10896-018-9993-0

Kendall, M. (2021). *Hood feminism: Notes from the women that a movement forgot*. Penguin Books.

Koenig, L. J., & Moore, J. (2000). Women, violence, and HIV: a critical evaluation with implications for HIV services. *Maternal and Child Health Journal*, *4*, 103-109.

Kulczycki A. (2022). Dobbs: Navigating the new quagmire and its impacts on abortion and reproductive health care. *Health Education & Behavior49*(6), 924-928. https://doi:10.1177/10901981221125430

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York, NY: Routledge.

Leemis R.W., Friar N., Khatiwada S., Chen M.S., Kresnow M., Smith S.G., Caslin, S., & Basile, K.C. (2022). *The national intimate partner and sexual violence survey: Report on intimate partner violence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Merikangas, K. R., & McClair, V. L. (2012). Epidemiology of substance use disorders. *Human Genetics*, *131*(6), 779–789. https://doi.org/10.1007/s00439-012-1168-0

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, *81*(4), 316–322. https://doi.org/10.1016/j.contraception.2009.12.004

Petersen C, Kearns M.C., McIntosh W.L., Estefan L.F., Nicolaidis C, McCollister K.E., & Florence C. (2018). Lifetime economic burden of intimate partner violence among U.S. adults. *American Journal of Preventive Medicine,* 55(4), 433–444.

Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries, W. L. (2016). The impact of racism on the sexual and reproductive health of African American women. *Journal of Women's Health, 25*(7), 664–671. https://doi.org/10.1089/jwh.2015.5637

Randolph, M.E, Gamble, H.L., & Buscemi, J. (2011). The influence of trauma history and relationship power on latinas' sexual risk for HIV/STIs. *International Journal of Sexual Health*, *23*(2), 111–119. https://doi.org/10.1080/19317611.2011.566306

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet*, *399*(10327), 803–813. https://doi.org/10.1016/S0140-6736(21)02664-7