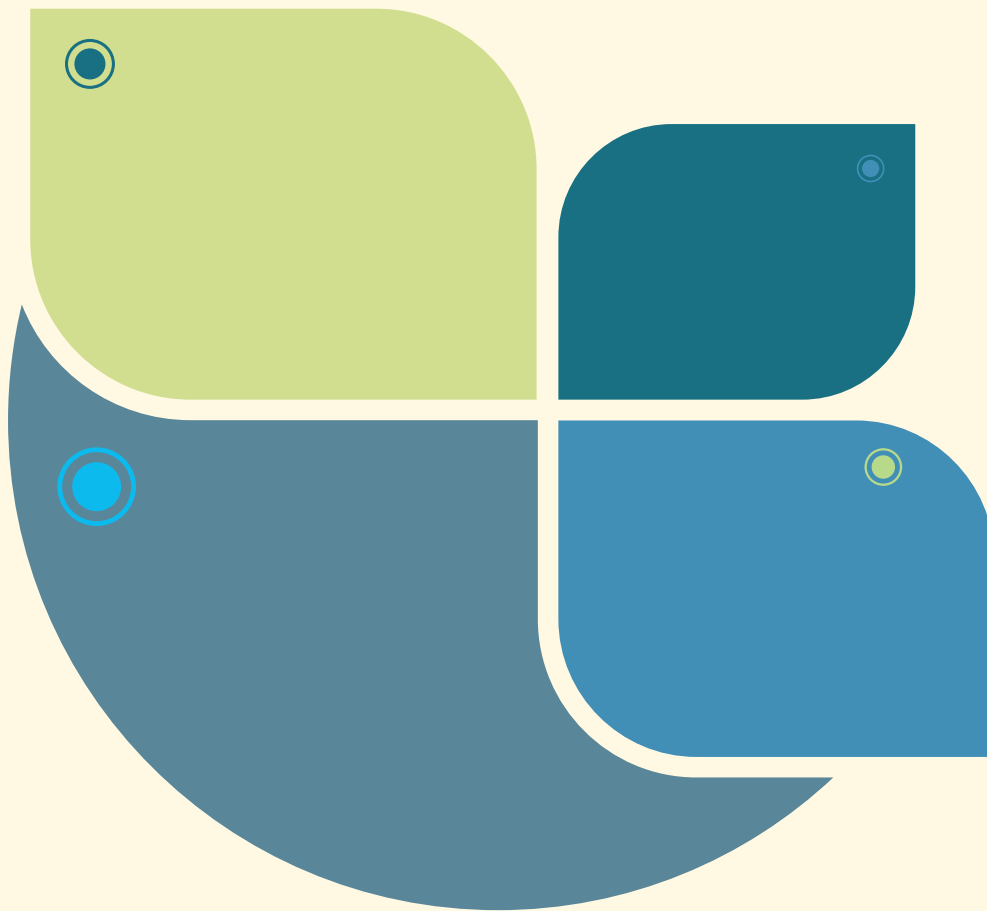


Reproductive Justice



In this issue:

Reproductive Justice Terms
for Advocates

If You Really Care About Intimate
Partner Violence, You Should Care
About Reproductive Justice

Advocacy for Sexual Assault Survivors
During the Childbearing Year

Re-Envisioning Medical Advocacy
for Pregnant and Parenting Survivors

Reproductive Justice
and Disability Rights

Facts on Reproductive Health
and Violence Against Women

Comparison of Birth Control Methods
that Clients Can Use Without Their
Partners' Knowledge

Reproductive Violence & Black Women

Advancing Reproductive Justice
in Immigrant Communities

The Impact of Childhood Sexual Abuse
on a Woman's Later Childbearing
Experiences

Program Highlight:
New Hope Domestic Violence
and Sexual Assault Services

Emergency Contraception
in Washington State

Question Oppression

Resources

Letter from the Editor

Reproductive Justice and Sexual Violence: Making Connections
By Toby Shulruff, Guest Editor



Emergency contraception. Forced sterilization. Rapid repeat pregnancy. Survivors giving birth. These issues and more are examples of the intersection of sexual violence and reproductive health.

For women of color, the issues frequently covered under the heading of “reproductive rights” (access to birth control and abortion) were too generally assumed to focus on “all women” and didn’t include the clear assertion of the right to have a child (including prenatal care, rates of infant and maternal mortality, environmental safety, workplace protections, informed consent for birth control and/or sterilization, and more). Reproductive justice work exists at the intersection of women’s health, environmental justice, and social justice.

Ten years ago, Loretta Ross gave the keynote at WCSAP’s Annual Conference. Ross, co-founder of SisterSong Women of Color Reproductive Justice Collective, spoke with a strong and clear voice about where the reproductive rights movement had missed the central concerns of women of color, and where the anti-sexual violence movement had, too. Since the reproductive justice movement began, many activists from historically marginalized communities have incorporated this framework, or explored how to do so.

Why is reproductive justice important for advocates?

The people we work with, like all people, face major decisions throughout their lives about sexual activity, birth control, pregnancy, raising children. They may confront infections, cancers, and other diseases affecting the reproductive organs. Some of these issues may come up in relation to a sexual assault, while other decisions will be part of the full lives they lead aside from being a survivor. Even so, their experience as survivors will most likely impact their choices, their experience of medical care, and their relationships with partners, children, and family.

This issue of *Connections* includes more answers to the question of why reproductive justice is important for advocates, reprinted from Law Students for Reproductive Justice, SisterSong, the National Latina Institute for Reproductive Health, and Futures Without Violence.

In “The Full Measure of Hope and Possibility,” Joelle Brouner, a long-time advocate in the anti-sexual violence and disability communities in Washington State, and a Community Voices partner on WCSAP’s project on Ending Violence Against Women with Disabilities, explores how a reproductive justice framework is valuable to disability rights work.

This issue also includes a focus on supporting survivors during the childbearing year (pregnancy, birth, and postpartum). For the past three years, WCSAP has been involved in a project focusing on pregnant and parenting survivors, and we have learned a great deal about issues our field must address. Courtney Long, an advocate in Skagit County and a doula, writes about how sexual assault advocacy and birth support go hand in hand. Kelsey Peronto, an advocate from Whatcom County, talks about her experience supporting a survivor through birthing. Suzi Fode writes about her program’s efforts to make emergency contraception available at New Hope.

We are fortunate to have Penny Simkin, mother of modern childbirth education, right here in Washington State. She shares her perspective on the challenges survivors face and the support advocates can offer. Also included are: a timeline of WCSAP’s work to make emergency contraception available to survivors; some basics on reproductive justice, reproductive anatomy, and birth control methods.



WCSAP
Washington Coalition of
Sexual Assault Programs



Reproductive Justice

The mission of the Washington Coalition of Sexual Assault Programs is to unite agencies engaged in the elimination of sexual violence through education, advocacy, victim services, and social change.

Connections Magazine is published biannually and mailed to subscribing members of WCSAP. For membership information and to view articles online visit: www.wcsap.org

Guest Editor: Toby Shulruff

Design © Debi Bodett
www.DebiBodett.com

Connections | Volume XVI SPRING 2013

TABLE OF CONTENTS

Reproductive Justice Terms for Advocates	1
Linda Chamberlain and Rebecca Levenson	
If You Really Care About Intimate Partner Violence, You Should Care About Reproductive Justice	2
Law Students for Reproductive Justice & National Women's Law Center	
Advocacy with Sexual Assault Survivors During the Childbearing Year	6
Courtney Long	
Re-Envisioning Medical Advocacy for Pregnant and Parenting Survivors of Intimate Partner Violence & Sexual Assault	10
Kelsey Peronto	
A Full Measure of Hope and Possibility: Reproductive Justice and Disability Rights	12
Joelle Brouner	
Facts on Reproductive Health and Violence Against Women	15
Futures Without Violence	
Comparison of Birth Control Methods that Clients Can Use Without Their Partners' Knowledge	17
Linda Chamberlin and Rebecca Levenson Futures Without Violence	
Reproductive Violence & Black Women	18
Charity Woods, SisterSong	
Advancing Reproductive Justice in Immigrant Communities: Promotoras/es de Salud as a Model	21
National Latina Institute for Reproductive Health	
The Impact of Childhood Sexual Abuse on a Woman's Later Childbearing Experiences	23
Penny Simkin	
Program Highlight: New Hope Domestic Violence and Sexual Assault Services	25
A Timeline of Emergency Contraception in Washington State ...	26
Question Oppression	28
Resources	28



Reproductive Justice

Terms for Advocates

Reproductive Coercion

Reproductive coercion can be present in same sex or heterosexual relationships. Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- Explicit attempts to impregnate a female partner against her will
- Controlling the outcomes of a pregnancy
- Coercing a partner to engage in unwanted sexual acts
- Forced non-condom use
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a STI/HIV

While these forms of coercion are especially common among women experiencing physical or sexual violence by an intimate partner, they may occur independent of physical or sexual violence in a relationship and expand the continuum of power and control that can occur in an unhealthy relationship. The following definitions are examples of reproductive coercion.

Birth Control Sabotage

Birth control sabotage is active interference with contraceptive methods by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.

Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking a condom on purpose
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure

Pregnancy pressure involves behaviors that are intended to pressure a partner to become pregnant when she does not wish to be pregnant. These behaviors may be verbal or physical threats or a combination of both.

Examples of pregnancy pressure include:

- I'll leave you if you don't get pregnant
- I'll have a baby with someone else if you don't become pregnant
- I'll hurt you if you don't agree to become pregnant

Pregnancy Coercion

Pregnancy coercion involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of whether to terminate or continue a pregnancy.

Examples of pregnancy coercion include:

- Forcing a woman to carry to term against her wishes through threats or acts of violence
- Forcing a partner to terminate a pregnancy when she does not want to
- Injuring a partner in a way that she may have a miscarriage

From Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion, by Linda Chamberlain, PhD, MPH and Rebecca Levenson, MA.

If You Really Care About Intimate Partner Violence¹, You Should Care About Reproductive Justice

Reprinted with Permission from
Law Students for Reproductive Justice & National Women's Law Center

What is Reproductive Justice?

The reproductive justice (RJ) movement places reproductive health and rights within a social justice framework.² The movement supports the right of individuals to have the children they want, raise the children they have, and plan their families through safe, legal access to abortion and contraception. In order to make these rights a reality, the movement recognizes that reproductive justice will only be achieved when all people have the resources, as well as the economic, social, and political power to make healthy decisions about their bodies, sexuality, and reproduction.³

A society that respects the sexual and procreative rights of each individual will be a society with less violence against women, and that provides greater support to those who experience violence within their relationships. By advancing RJ, you are working toward the elimination of violence against women.

A society that respects the
sexual and procreative rights
of each individual will be
a society with less violence against
women, and that provides greater
support to those who experience
violence within their relationships.

How Can Advancing Reproductive Justice Reduce Violence Against Women?

Addressing the racial and socioeconomic inequities that deny some women reproductive justice will also reduce instances of violence and help victims escape their abusive relationship.

Intimate Partner Violence (IPV), including sexual, physical, emotional, and economic abuse, affects the lives of women across all races and income levels.⁴ Nonetheless, women of different racial and socioeconomic

¹ While men may also experience partner violence, and violence may occur between same-sex partners or among family members such as siblings or between parent and child, this fact sheet addresses the type of violence most closely related to limitations on reproductive justice, that between a male perpetrator and a female victim. Eighty-five percent of IPV victims are women. SHANNAN CATALANO, U.S. DEP'T OF JUSTICE, SPECIAL REPORT: INTIMATE PARTNER VIOLENCE, 1993-2010 at 3 (2012), available at <http://bjs.gov/content/pub/pdf/ipv9310.pdf>.

² SisterSong, What is Reproductive Justice?, http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81 (last visited April 25, 2013).

³ FORWARD TOGETHER, THE EMERJ REPROD. JUSTICE LENS TOOLKIT: IDENTIFYING REPROD. JUSTICE ISSUES IN YOUR CMTY 1 (2008), available at <http://forwardtogether.org/assets/docs/ACRJ-RJ-Lens-Toolkit.pdf>.

⁴ NAT'L COAL. AGAINST DOMESTIC VIOLENCE, DOMESTIC VIOLENCE FACTS 1 (2007), available at [http://www.ncadv.org/files/DomesticViolenceFactSheet\(National\).pdf](http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf).

backgrounds experience different rates of violence. Poverty, unemployment, and substance use are all predictors of IPV.⁵ IPV may contribute to higher rates of unintended pregnancy and escalate during pregnancy.⁶ One study found that a woman's odds of experiencing IPV rose by 10% with each pregnancy.⁷

Historic inequities in access to education and economic opportunity result in socioeconomic disparities and contribute to racial and ethnic disparities in IPV. American Indian and Alaskan women have higher rates of nonfatal IPV as compared to either Black or White women,⁸ but Black women account for 22% of all intimate partner homicide victims.⁹ Linguistic and cultural barriers may keep many women from seeking help. Some women may fear authorities even more than their batterer.¹⁰ A batterer may threaten to expose the victim's immigration status as a way to maintain control. In states such as New York, law enforcement departments encourage all crime victims to report abuse by directing officers not to "inquire about the immigration status of crime victims, witness, or others who call or approach the police seeking assistance."¹¹ By contrast, states with strictly enforced anti-immigration laws deter immigrant women from interacting with law enforcement and reporting abuse.¹² In some places, women can be evicted after calling the police to report IPV.¹³ Other women may have trouble accessing culturally appropriate services in the language they are most comfortable speaking.¹⁴

The social and economic costs of IPV include isolation from friends and family, inability to work, loss of wages, lack of participation in regular activities,¹⁵ and limited ability to care for themselves and their children.¹⁶ These outcomes perpetuate a lack of control and autonomy for victims, exacerbating the power their abusers may have over them.

⁵ UNIV. OF MINN. INST. ON DOMESTIC VIOLENCE IN THE AFRICAN AM. CMTY., FACT SHEET: INTIMATE PARTNER VIOLENCE (IPV) IN THE AFRICAN AM. CMTY., available at http://www.dvinstitute.org/media/publications/FactSheet.IDVAAC_AAPCFV-Community%20Insights.pdf (last visited April 25, 2013).

⁶ L. Roth et al., Predictors of Intimate Partner Violence Among Women Requesting Medical Abortion, 78 *CONTRACEPTION* 190 (2008).

⁷ Rebekah E. Gee et al., Power Over Parity: Intimate Partner Violence and Issues of Fertility Control, 201 *AM. J. OF OBSTETRICS AND GYNECOLOGY* 148.e1 (2009), available at <http://www.ajog.org/article/PIIS0002937809004426/abstract>.

⁸ Bureau of Justice Statistics, Intimate Partner Violence in the U.S.: Victim Characteristics (2007), available at <http://www.ojp.usdoj.gov/bjs/intimate/victims.htm>.

⁹ Black women are only 8% of the U.S. population. UNIV. OF MINN. INST. ON DOMESTIC VIOLENCE IN THE AFRICAN AM. CMT, supra note 5.

¹⁰ N.Y.C. Mayor's Office to Combat Domestic Violence, Special Issues: Immigrants, <http://www.nyc.gov/html/ocdv/html/issues/immigrants.shtml> (last visited Apr. 25, 2013).

¹¹ Id.

¹² Arizona Immigration Law Affects Victims of Domestic Violence, FOX NEWS LATINO, Oct. 10, 2012, available at <http://latino.foxnews.com/latino/news/2012/10/10/arizona-immigration-law-affects-victims-domestic-violence/>; Some Immigrant Women, Victims of Domestic Violence, Afraid to Seek Help, PUB. RADIO INT'L, Mar. 21, 2013, available at <http://www.pri.org/stories/politics-society/social-justice/some-immigrant-women-victims-of-domestic-violenceafraid-to-seek-help-13299.html>.

¹³ Sandra Park, American Civil Liberties Union, Shut Up or Get Out: PA City Punishes Domestic Violence Victims Who Call the Police, <http://www.aclu.org/blog/womens-rights-lgbt-rights-racial-justice-criminal-law-reform/shut-or-get-out-pa-city-punishes> (last visited April 26, 2013).


¹⁴ NATIONAL LATINO ALLIANCE FOR THE ELIMINATION OF DOMESTIC VIOLENCE, DEVELOPING LINGUISTICALLY AND CULTURALLY RESPONSIVE MATERIALS FOR LATINA SURVIVORS OF DOMESTIC VIOLENCE 1 (2004), available at http://www.dvalianza.org/images/stories/ResourcePubs/booklets_info/r_devlinguistic.pdf.

¹⁵ Ctrs. for Disease Control & Prevention, Intimate Partner Violence: Consequences, <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html>, (last visited Apr. 25, 2013).

¹⁶ COMM.ON HEALTH CARE FOR UNDERSERVED WOMEN, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM.OP.: INTIMATE PARTNER VIOLENCE 2 (2012), available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co518.pdf?dmc=1&ts=20130425T1349509026>.

Further, while it is difficult for any woman experiencing violence to end her relationship, the need to provide for a child makes escaping far more difficult for some mothers. Children who are exposed to violence also face long term effects, and are more likely to have violent relationships themselves.¹⁷

Controlling a woman's sexual and reproductive life is often a component of abuse, so restrictions on access to family planning and abortion keep women both physically and financially vulnerable.

 **Controlling a woman's sexual and reproductive life is often a component of abuse, so restrictions on access to family planning and abortion keep women both physically and financially vulnerable.**

An abuser may try to get a woman pregnant in order to keep her economically dependent and physically vulnerable. Health professionals report seeing cases of young men who use various techniques to control women's reproductive lives, including demanding unprotected sex, lying about "pulling out," hiding or destroying birth control, and preventing abortion.¹⁸

Governmental restrictions on family planning and abortion services only further abusers' efforts to control their victims. Because a woman experiencing IPV has greater difficulties negotiating contraception with her abusive partner, it is especially important that she has access to methods that are not dependent on a partner's cooperation, or that can be used without her partner's knowledge.¹⁹

In striking down a requirement that women notify their husbands before obtaining an abortion, the Supreme Court acknowledged, in *Planned Parenthood v. Casey*, that such a requirement could result in a woman being abused. The Supreme Court explains that requiring a woman to notify her husband of a pregnancy "is frequently a flashpoint for battering and violence," including physical and psychological abuse.²⁰ Nevertheless, states continue to pass laws that limit women's access to abortion, even going so far as to prohibit abortions as early as six weeks.²¹ Although these bans severely restrict all women's access to abortion, victims of IPV may face extra hurdles in seeking abortion care, making it harder for them to access abortion in such a limited time frame. Because pregnancy increases the risk of IPV, these bans may actually increase IPV by forcing women in abusive relationships to carry a pregnancy to term.

When women are not provided the basic resources to raise their children, including those related to health services, they may be left economically dependent on their abusers.

Reproductive justice demands that we work to improve economic conditions for women who want to parent. A woman may stay with an abuser if he is the only means of financial support for her child. Policies that improve economic conditions for women and their families help women escape violent relationships.

Women may feel forced to stay in abusive relationships for fear of not being able to feed their children. Abusers may limit a victim's access to financial resources, external support networks, and employment as means of

¹⁷ NAT'L COALITION AGAINST DOMESTIC VIOLENCE, *supra* note 4.

¹⁸ Elizabeth Miller, et al., Adolescent Intimate Partner Violence and Contraceptive Nonuse among Adolescent Females Utilizing Teen Clinics, 42 J. OF ADOLESCENT HEALTH 8 (Feb. 2008).

¹⁹ Rebekah E. Gee et al., *supra* note 7. Such methods might include hormonal shots, implants, the IUD or oral contraceptives, though there is a risk that pills could be discovered. For information on contraceptive options, please visit <http://www.plannedparenthood.org/health-topics/birth-control-4211.htm>.

²⁰ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 889 (1992).

²¹ H.B. 1456, 63rd Leg. Assemb., Reg. Sess. (N.d. 2013) (to be codified under N.D. CENT. CODE § 14-02.1 (2013));

control. This economic coercion may force the victim to choose between remaining in the abusive relationship and economic hardship—including poverty and homelessness—for herself and her children.²² Likewise, policies that increase women’s ability to care for their children, such as strong child support enforcement,²³ and subsidized child care,²⁴ increase low-income women’s ability to escape violent relationships.

An abuser may also force a woman to stay by threatening to seek sole custody of her child. Judges, unaware of the dynamics of abuse, may actually penalize a woman who is in an abusive relationship by removing her children from her, instead of invoking the power of the state to protect her from abuse.²⁵

How You Can Combat Intimate Partner Violence and Support Reproductive Justice

- Advocate for access to comprehensive reproductive health care. Because abusers often isolate their victims, contact with a health care provider can present a rare opportunity for a woman who is being abused to get help.
- Oppose restrictions on access to family planning services and abortion, which are especially burdensome to women who are experiencing violence and do not want to become pregnant or continue their pregnancies.
- Support laws and policies that improve economic conditions for low-income women, so women have the financial ability to leave abusive relationships.
- Help spread the word about provisions in the health care law that can help combat IPV and protect women. The health care law:
 - » Will prohibit insurance plans from denying coverage to women because of intimate partner violence beginning in 2014.²⁶
 - » Requires health insurance to cover routine screening and counseling of intimate partner violence with no cost sharing.²⁷
 - » Requires health insurance plans to cover contraception with no cost sharing, including longer term forms of contraception, such as the intrauterine device, which can be used without a woman’s partner knowing.²⁸
 - » Provides grants to States to implement evidence-based Maternal, Infant, and Early Childhood Visitation programs that offer home based services to pregnant women and families with newborns. In one study, up to 48% of the women surveyed who had participated in a home visiting program reported incidents of intimate partner violence.²⁹ Home visitation programs are, therefore, in a unique position to identify intimate partner violence and provide resources and assistance to help women leave violent relationships.

22 NAT’L COALITION AGAINST DOMESTIC VIOLENCE, ECON. ABUSE, available at http://www.uncfsp.org/projects/userfiles/File/DCE-STOP_NOW/NCADV_Economic_Abuse_Fact_Sheet.pdf, (last visited Apr. 25, 2013).

23 Vicki Turetsky, Ctr. for Law and Soc. Policy, Child Support: Ripple Effects Throughout the Community (2008), available at http://clasppublications/child_support_ripple_effects_formatted.pdf.

24 To find out how you can advocate for increased funding for child care, please visit the National Women’s Law Center’s Child Care page at <http://www.nwlc.org/display.cfm?section=childcare>.

25 Daniel G. Saunders, Child Custody and Visitation Decisions in Domestic Violence Cases: Legal Trends, Risk Factors, and Safety Concerns (National Resource Center on Domestic Violence 2007).

26 FUTURES WITHOUT VIOLENCE, HOW THE AFFORDABLE CARE ACT (ACA) AFFECTS VICTIMS OF DOMESTIC, SEXUAL, AND DATING VIOLENCE (2012), available at <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/ACA%20and%20DV%20final.pdf>

27 NAT’L WOMEN’S LAW CTR., WOMEN’S ACCESS TO PREVENTATIVE SERVS. AFFIRMED BY HHS (2013), available at <http://www.nwlc.org/resource/women%E2%80%99s-access-preventive-services-affirmed-hhs>.

28 NAT’L WOMEN’S LAW CTR., CONTRACEPTIVE COVERAGE IN THE HEALTH CARE LAW: FREQUENTLY ASKED QUESTIONS (2013), available at <http://www.nwlc.org/resource/contraceptive-coverage-health-care-law-frequently-asked-questions>.

29 FUTURES WITHOUT VIOLENCE, *supra* note 24.

Advocacy with Sexual Assault Survivors

During the Childbearing Year

By Courtney Long, Skagit Domestic Violence & Sexual Assault Services

Tips for OB/GYN Appointments

When Scheduling/Prior to Appointment

- Consider making the initial appointment one in which you are just meeting the practitioner – no physical exam.
- Ask for a longer appointment. Explain that you have something to talk about with the practitioner (doctor, nurse practitioner, midwife, etc.) that you aren't comfortable talking about over the phone.
- Consider the time of day. Are you a morning person? Would an afternoon appointment cause you to feel stressed throughout your day?
- Make a list of what you can expect during the appointment and what might be upsetting. Work on a "plan of action" to help if you start to become stressed, such as deep breathing, visualization, or other strategies.
- Write down any questions that you may have for your practitioner in advance, so that you don't have to worry about forgetting something important during your appointment.

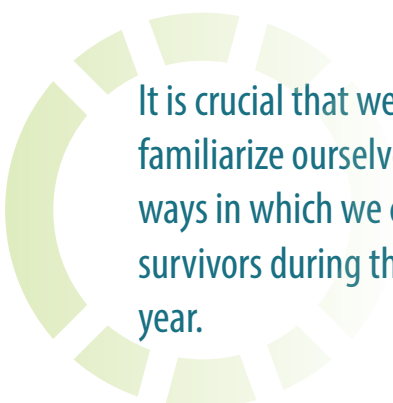
Day of Appointment

- Avoid caffeine, or anything that may increase your anxiety the day of the appointment.
- Ask to be shown what will happen during your appointment; ask to have everything explained step-by-step.
- Ask to have a female nurse present during your exam.
- Choose what position will be most comfortable during your internal exam. For example, you can request the top of the table up, if possible, so that you can see what is happening.
- Wear a skirt that you can keep on during your exam. Wear or bring long socks. Both will help with feeling exposed during your exam.
- Consider having a support person present.
- If you are in extreme discomfort or pain, ask for a different sized speculum.
- If you are pregnant, and this is a routine checkup, ask if an internal exam is really necessary. Most practitioners check cervical dilation because they assume the patient wants to know. Knowing your dilation does not affect when you go into labor, and can often cause mothers to be more stressed about when labor will begin.

Remember

- You can ask to stop at any point during an exam.

Pregnancy, childbirth, and caring for a newborn are life-altering events that generally inspire a myriad of emotions: excitement, joy, trepidation, and nervousness, to name a few. The excitement of becoming a parent, or adding another child to the family, can be mingled with uncertainty about the responsibilities of parenthood and nervousness about the upcoming birth. For survivors of sexual assault, these feelings can be coupled with worries, fears, and sensations specific to their experience. Since current estimates are that 1 in 3 women will have experienced some sort of sexual trauma in their lifetime, it is reasonable to infer that a significant number of women could benefit from sexual assault support services during pregnancy and beyond. It is crucial that we, as advocates, familiarize ourselves with the ways in which we could support survivors during the childbearing year, in addition to developing working relationships with doctors, midwives, doulas, and other practitioners.



It is crucial that we, as advocates, familiarize ourselves with the ways in which we could support survivors during the childbearing year.

Pregnancy

For some survivors of sexual assault, pregnancy can challenge coping skills that may have developed over many years. Strategies such as using drugs and alcohol, disordered eating, smoking, and other risky behaviors are no longer available to them (or pose a danger to their child if continued). Working on triggers and alternative coping skills is critical, with a

Advocates can also highlight the importance of choosing a doctor or midwife with whom the pregnant survivor feels comfortable.

priority on helping to remove shame or guilt. Most likely, pregnant survivors are already hearing from medical practitioners, friends, family, and the media that their behaviors could endanger their child. Some survivors avoid maternity care because they do not want to be judged or forced to stop a behavior that may feel impossible to give up. An advocate's support with these issues might make seeking care possible.

Other concerns survivors may have include:

- a loss of control over their body
- worries about weight gain or not gaining enough weight
- fear of losing the baby due to damage from the abuse
- being touched by many people
- gynecological exams

For those survivors who rely on having strict control over their bodies, pregnancy can be particularly challenging. Not only is their body changing in ways that they have no control over, but they may struggle with how others respond and react to their pregnant bodies. The general public seems to lose a sense of boundaries when they are in close proximity to a pregnant individual. Perfect strangers appear to have no qualms about touching an individual's belly, or asking personal questions. Supportive partners can feel as though they have a vested interest in their pregnant partner's body – suddenly becoming more interested in what they are eating or how much they are working, for example. It can be very helpful for advocates to work with survivors on developing boundaries to use with strangers and loved ones.

Advocates can also highlight the importance of choosing a doctor or midwife with whom the pregnant survivor feels comfortable, so she can discuss the details of exams and her fears, and feel safe sharing her history. Additionally, advocates might suggest the services of a doula, a "trained and experienced professional who provides continuous physical, emotional, and informational support to the pregnant survivor before, during and just after birth, and who provides emotional and practical support during the postpartum period" (DONA International, 2013). Doula care, in essence, is specialized advocacy with the focus being to educate, support, and empower women during their pregnancy and childbirth.

Childbirth

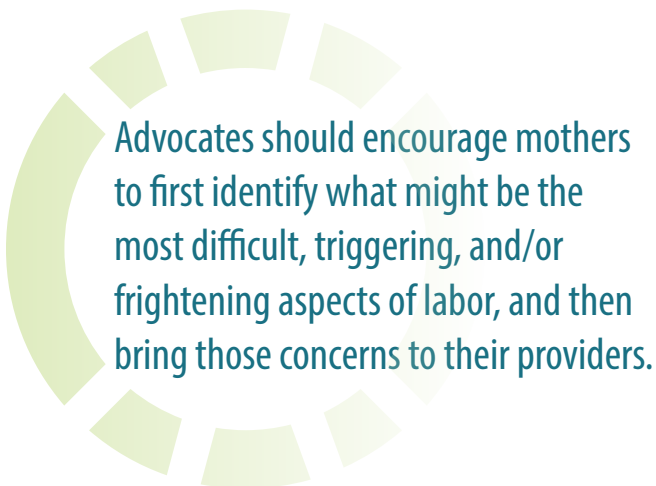
Many worries that survivors have surrounding childbirth are universal; most women have concerns about the pain of childbirth and if they will be able to cope, nudity during the birth, who will be in the room, loss of control, and the unknown. For sexual assault survivors, these concerns can be magnified and more complex. The pain of childbirth can be triggering, and may cause some survivors to have flashbacks or dissociate (feel detached from reality). It is important to talk with survivors about what strategies they feel will work best during labor with regard to pain management. Pain medication might be the right choice for some survivors, but for others it may enhance the feeling of being out of control. Additionally, narcotics could be problematic for people with a history of drug abuse. Advocates can encourage survivors to discuss with their support people what strategies will be the most effective during labor for pain management, and if they start to dissociate, or relive previous trauma. Advocates can also provide resources on basic relaxation techniques such as breathing exercises and meditation.



Some aspects of hospital birth, such as being required to wear a revealing hospital gown, or feeling confined to a bed by monitors, can be negotiated once the survivor has been given the power to question what is truly "required." Nudity in front of the doctors, nurses, and other hospital staff could cause survivors to feel vulnerable. Many survivors laboring in hospitals choose instead to wear loose skirts and tanks or t-shirts so that they feel less exposed. Constant fetal monitoring, or any procedure that confines the mother to the bed, has been reported by some survivors as a reminder of being restrained during an assault. Repeated cervical checks are often described by survivors as traumatic, and can, as a result, slow down a mother's labor. Any of these procedures can be declined by the survivor,

but that is unlikely to happen if that option has not been addressed in advance.

For some mothers, having their child outside the hospital environment (at home) can be the most empowering space as they are less likely to have invasive procedures, they are surrounded by their own belongings, and they often feel they have a stronger sense of control and privacy in their own home. Regardless of where the survivor chooses to give birth, advocates should encourage mothers to first identify what might be the most difficult, triggering, and/or frightening aspects of labor, and then bring those concerns to their providers, so that they can begin to address them long before labor begins. Doulas can be a wonderful resource for assisting mothers with birth plans, practicing breathing exercises, and empowering and supporting mothers in getting their needs met during labor.



Advocates should encourage mothers to first identify what might be the most difficult, triggering, and/or frightening aspects of labor, and then bring those concerns to their providers.

Postpartum

For most survivors of sexual assault, a separate set of challenges accompany the arrival of their new baby. A survivor may have difficulties with connecting with a son, if her abuser was male. A survivor may feel sad that her child is a girl, because the mother feels her daughter is vulnerable to the same traumas she experienced. Parents may worry that they won't be able to protect their child. It is important that survivors be reassured that every parent has fears about how to be a parent, and that it is healthy and normal to want to protect her child.

Some parents may have fears that as a sexual assault survivor, they may be at risk for assaulting their child. This fear can cause them to be worried about diaper

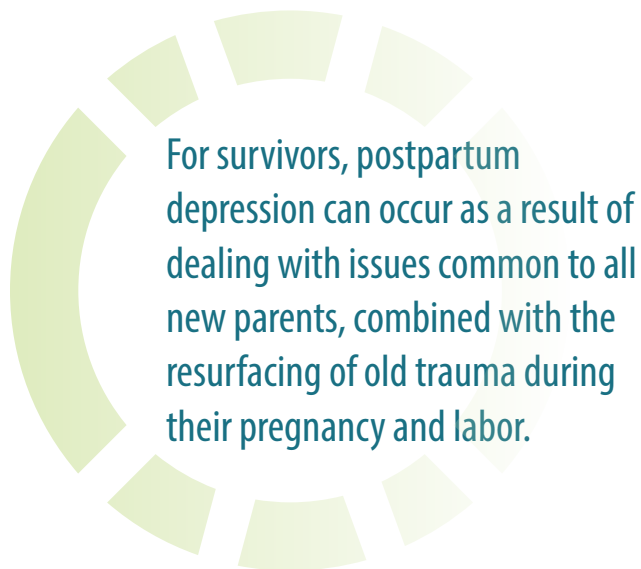
changes, and fearful of touching their children in ways that may be construed as inappropriate. Advocates can help by exploring with survivors what is reasonable and healthy touch with their children. In addition, advocates can help alleviate these fears by clarifying that correlation does not imply causation; just because some perpetrators were themselves victims, this does not mean that all victims will become perpetrators. Male survivors in particular can internalize the "victim becomes predator" idea, and may distance themselves from their children to protect them. Similarly, parents may be very fearful about allowing other adults around their children. If parents were involved in a childbirth class, encourage them to attend or host a follow-up gathering after all the babies from the class are born. It can be very helpful for new parents to be around other new parents; it can normalize and demystify some of their concerns. Seeing other parents change diapers and feed their children can be a valuable resource for individuals who may never have had healthy parenting modeled for them.

Another area in which survivors struggle is with breastfeeding (or nursing). Some people worry that it may be triggering; it could feel "dirty" or feel like the abuse they experienced. Breastfeeding at night might be a trigger if that is the time their abuse occurred. They may feel judged or ostracized if they choose not to breastfeed. It is important for advocates to convey that whatever is right for the mother with regard to breastfeeding will also be right for her baby. If breastfeeding is an important goal, and the mother is struggling, lactation consultants can be a valuable resource. Keep in mind that lactation consultants usually utilize a "hands-on" approach when helping. If the survivor anticipates that being a problem, she can request that the consultant position their hands over her own, or request all advice to be given "hands-off." If breastfeeding at night proves to be difficult, you can suggest pumping breast milk during the day and having a family member feed the baby at night, turning on the light when nursing, getting out of bed to feed the baby, and/or holding the baby's hand while nursing.

Postpartum Depression

Postpartum depression is a form of depression that can affect mothers (and occasionally other caregivers) after the birth of their child. It is generally thought to

be brought on by a combination of hormones, lack of sleep, adjusting to the new baby, and/or additional factors. The cause of postpartum depression may not be clear, and it can come on suddenly. For survivors, postpartum depression can occur as a result of dealing with issues common to all new parents, combined with the resurfacing of old trauma during their pregnancy and labor. In addition, some survivors may become aware of an assault for the first time during childbirth. For these parents, the postpartum period takes on a whole new context, wherein they are trying to adjust to new parenthood, along with addressing the memories that surfaced during their child's birth.



Regardless of the cause of postpartum depression, it is always important to treat it as significant and pay attention to cues that the mother would benefit from a referral to an appropriate medical and mental health practitioner. Postpartum depression, when left untreated, does have the potential to lead to a debilitating depression and/or behaviors that could endanger the parent or child.

Reference

DONA International (2013). *What is a doula?* Retrieved from <http://www.dona.org/mothers/index.php>.

Courtney Long is the Sexual Assault Services Coordinator for Skagit Domestic Violence and Sexual Assault Services. Her focus is on direct advocacy, outreach, prevention, and education, and she coordinates SDVSAS's response to the Skagit County Children's Advocacy Center. Courtney is passionate about women's reproductive health and its intersections with sexual and domestic violence. She has been a childbirth doula for more than seven years and has taught childbirth education classes. She has also worked as a healthcare advocate for low-income families.

Outreach

There are many ways in which advocates can support sexual assault survivors within the childbearing year, in addition to direct advocacy. Developing relationships with local doctors, nurse-midwives, direct-entry midwives, and doulas is a good start. Some other examples are: offer to train staff members in their clinics about the dynamics of sexual abuse; offer to come to a childbirth class to discuss the services your agency provides; ask to distribute agency cards and brochures at pediatrician's offices and at your local WIC office. If you find a place where pregnant women or new parents and caregivers are coming together, there is a strong possibility that there will be sexual assault survivors who would benefit from your services.

Re-Envisioning Medical Advocacy for Pregnant and Parenting Survivors of IPV and Sexual Assault



by Kelsey Peronto, Domestic Violence & Sexual Assault Services of Whatcom County (DVSAS)

I have been the Education and Outreach Coordinator at DVSAS for the past ten months. In the four years prior to that, I was an Advocacy Counselor, meeting with survivors of domestic violence and sexual assault one-on-one for 40 hours a week. Prior to my job transition, DVSAS was one of several pilot sites awarded the Pregnant and Parenting Women and Teens (PPWT) Grant by WCSAP and the Washington State Coalition Against Domestic Violence (WSCADV). I was tasked with organizing a multidisciplinary community taskforce of service providers who work with pregnant and parenting survivors of intimate partner violence, sexual assault, and stalking. Our particular focus was on reproductive coercion and trauma-informed care. These were both things I thought I knew about—I had heard of my clients' partners interfering with their birth control and trying to control their reproductive choices. I practiced trauma-informed care every day with my clients because they were all survivors of trauma. But this project enabled me to re-envision what supportive medical advocacy meant in a unique and special way.

When I transitioned from Advocacy Counselor to Education and Outreach Coordinator, I kept a small caseload of clients that I had worked with for multiple years. One of my clients, Jane [name has been changed], came to me two years prior when she found out her abusive ex-partner had sexually abused two of her daughters. She was devastated—she wanted to protect them, but he had made threats to kill her in the past and she was scared of the impending report to Child Protective Services (CPS). She'd made the decision to leave the relationship after years of physical and emotional abuse and was still very afraid of what her ex might do. We sat together while her daughters talked to CPS, and began meeting regularly after that.

Jane's children's disclosure of sexual abuse to her was particularly upsetting because she herself is a survivor

of childhood sexual abuse. In addition to the grief and anger about what happened to her daughters, she needed to process her own triggers, all while dealing with the criminal trial process. Jane had met someone else after splitting from her ex, and one week on the phone she told me she thought she might be pregnant. I was surprised, not just by the news but because I felt like I knew what to say. I asked her how she felt about it, what choices she thought she might make, and if she could make them freely, how her partner might take the news, and if she had access to healthcare. We had honest, open, and caring discussions about family planning and birth control. She decided she wanted to parent the babies—she was having twins.

About six months into her pregnancy, Jane told me during one of our appointments that she was unsure whether she would be able to have a support person with her during the twins' birth. She had five other children who needed to be cared for at home and her partner would be responsible for this. Due to the abuse in her previous relationship, Jane had become increasingly isolated from friends and family and didn't feel she had someone who could be there for her. Then she asked me something surprising: she told me I was always able to calm her down when she was overwhelmed and that she trusted me. Could I go to her birth?

I was taken aback—no one had ever asked me this before. I wasn't sure if I was creating some kind of conflict of interest. I was scared of blood and hospitals. My experience with babies was limited, and truthfully I did not know how I felt. I asked Jane if I could talk to my supervisor and answer her when we met the next week. As soon as she left for the day I knew I wanted to honor her request and be there. My supervisor's feelings reflected my own: this was a kind of medical advocacy that was different. Jane is a survivor, and survivors of sexual abuse have unique and sometimes triggering experiences with birth.

Rather than limiting our medical advocacy services to on-calls for sexual assault examinations, we could provide trauma-informed care as trusted support people. I told Jane I would be there and we formed a plan for her to call our 24-hour helpline with special instructions to advocates to contact me if she was in labor. I started consulting with my friends who are doulas and parents and reading *When Survivors Give Birth* by Penny Simkin and Phyllis Klaus.

I was on call the week she went into labor. Our answering service dispatched me at 3:02 am, and I made it to the hospital's Childbirth Center at 3:45. Jane had just gotten there and the nursing staff was monitoring her progress and taking her family history. I was pleased to recognize the nurse team lead from a training I had conducted about intimate partner violence, sexual assault, reproductive coercion, and trauma-informed care a few months before. She asked Jane if she felt safe at home and Jane stated, "Well, now I do." Based on her answer, the nurse team lead asked her if there was a time she had felt unsafe at home. Jane started to explain her family history and turned to me: "Will you tell them about my ex? I don't want to talk about it when I am here." I explained her history, checking for permission from her the whole way, and then asked her if there was anything else she would like me to share or anything she would amend about what I had told the nurse. She said "Just that I also went through that stuff when I was a kid."

We talked about what this history meant for Jane: it was important for medical staff to tell her that they would touch her and why before they actually touched her. She wanted to deliver the twins vaginally. Hospital policy determined that Jane would deliver in the operating room (OR) and would need an epidural in case an emergency caesarian section was necessary. Jane had never had an epidural before and was scared about going numb and losing control of her body. The anesthetist explained what sensations she could expect to feel, that she would still have the urge to push and he did not want her to be completely numb—it was important to him that she was comfortable and in control. Her doctors let her know that they trusted her to best care for her babies.

Immediately after the epidural process, Jane was dilated to nine centimeters and it was time to go to the OR. Adrenaline rushed over me as we prepared to go back and I was briefly afraid I might faint. Jane started crying and told me she was glad I was there to

support her since her partner couldn't be there. She asked me to take pictures for him so he wouldn't have to miss seeing his twins' birth. In the OR, I stood by her side and held her hand; I told Jane she was strong and that she was doing great; I asked her how she was feeling and what she needed from me; I told her to push when the doctors did. There was a moment of perfect silence in the room, and then a cry—the first twin was born. Six minutes later, his brother followed. Both were healthy, safe, and delivered in a caring, trauma-informed environment the way Jane wanted them delivered.

I stayed with Jane for more than 13 hours, and returned to see her every day she was in the hospital. During these meetings, she shared some of the most insightful, emotional, and profound processing I have ever heard as an advocate. We talked about her older children, about the cycles of abuse in her family (the effects of which they were still struggling with), and how she didn't want that for these two beautiful newborns. We talked about her birth experience and feeling cared for and valued. We talked about how far she has come in the past two years, examples of her strengths and boundaries, her hopes for the future. She kept telling me how grateful she was that I was there for her, and all I could think was how lucky I was to be a part of it. It was the greatest honor of my life that this person trusted me enough to share this personal and challenging experience with her. When I left the hospital the first day and got into my car, I immediately started crying and laughing—I was surprised I hadn't already. At the risk of sounding oversentimental, it felt like it was meant to be. Before the PPWT grant I might not have considered the possibility of attending a client's birth, I would not have felt qualified or prepared to be there, and I would have missed out on the most amazing experience of my professional life.

Kelsey Peronto is the Education and Outreach Coordinator at Domestic Violence and Sexual Assault Services (DVSAS) Whatcom County. For the past five years, she has worked with women, men, and youth in the community to support survivors and end gender based violence. She had the great fortune to stumble into the PPWT project to unite her passion for reproductive justice, community organizing, and healthy relationships. Pregnancy is no longer her number one greatest fear.



The Full Measure of Hope and Possibility: Reproductive Justice and Disability Rights

By Joelle Brouner

It is time for individuals with disabilities to live boldly and to stake a claim on the future. Communities of people with disabilities can, and should, project the expectation that coming generations will thrive.

Frankly, it is hard for anyone who knows the history of people with disabilities to believe that future generations will flourish. Until the 1970s, it was common for parents of children with developmental or physical disabilities to surrender them to the state to be institutionalized. The children were raised by staff instead of family. Today, in Washington State, more than 800 people still reside in institutions built to house people with developmental disabilities (Janet Adams, Washington State Developmental Disabilities Administration, personal communication, May 22, 2013).

Institutionalization also occurs because disability has been historically linked to criminality. This notion stems from the earliest understanding of disability as sin. People with disabilities are overrepresented in the prison population. Studies indicate that between 8 and 19 percent of prisoners have serious psychiatric disabilities (Human Rights Watch, 2009).

Once a person is isolated, segregated, and counted as part of an inmate population, that person may be subjected to treatment rarely experienced by free people. Historically, institutionalized people were involuntarily sterilized. More than sixty-three thousand men and women with disabilities in the U.S. were subjected to sterilization between 1904 and 1975

(Hubbard, 2006). Extreme measures are still taken to prevent people with disabilities from expressing themselves sexually or procreating. For example, in 2006 in Seattle, Children's Medical Center broke the law by using hormones to permanently attenuate the growth of a 6-year-old girl with intellectual and physical disabilities. Surgeons also removed her breast buds, ovaries, and uterus (Carlson, Smith, & Walker, 2012).

Under the muck and mire of this history of oppression, growing numbers of people with disabilities have been resisting. For 40 years, one of the least understood movements for social change, the disability rights movement, has been developing against the longest odds. While some progress is undeniable, so is the need for this movement to evolve.

Reproductive justice (RJ) provides a useful and underutilized framework for strategists within the disability rights movement to approach the history and concerns of people with disabilities more effectively. RJ was developed by women of color in the late 1980s and early '90s to link discussions of reproductive rights with social justice. Discussion of reproductive rights is typically limited to two topics: preserving access to contraception, and assuring the availability of safe, legal abortion. Although those issues are important, for so many people there is a much broader set of concerns that shape whether reproductive rights are realized.

According to Loretta Ross, National Coordinator of SisterSong Women of Color Reproductive Health Collective (2013):

We need to incorporate reproductive justice into the heart of the disability rights movement.



Reproductive justice analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community — and these conditions are not just a matter of individual choice and access. Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny. Moving beyond a demand for privacy and respect for individual decision making to include the social supports necessary for our individual decisions to be optimally realized, this framework also includes obligations from our government for protecting women's human rights. Our options for making choices have to be safe, affordable, and accessible, three minimal cornerstones of government support for all individual life decisions.

One of the key problems addressed by reproductive justice is the isolation of abortion from other social justice issues that concern communities of color: issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns.

The dirty secret is that the U.S. disability rights movement is infected by bravado. This attitude is understandable, coming as it does from a group of men who have a history of flying by the seats of their pants. The most visible leaders in the movement are white men, many of whom acquired disabilities while pursuing adventure or participating in combat. While there is a contingent of strong women who do some of the most valuable work, they are not as visible. Unfortunately, the mix of unaddressed self-loathing and machismo is not inspiring. It is taboo to say so. There is no room to talk about emotional pain in a movement where most leaders became politicized by getting hurt. So the pain gets swallowed like a potent shot of spirits; it eats at each of us and we turn it on each other. After all these years we need a different approach. We need to incorporate reproductive justice into the heart of the disability rights movement.

Borrowing the RJ framework and fully integrating it into the analysis of disability rights would increase capacity within the movement to address the historical impact on people with disabilities of being removed from family and typical household structures. It would create a much needed opportunity to discuss how it felt to lose a sense of home or how to endure the fear of being institutionalized or otherwise incarcerated. Although we must continue to fight to the last until every institution is closed, we have to be equally diligent about recognizing the way that the institutional mindset has inculcated the culture of our disability communities. We need ways to grieve for all the times we had to ask for permission, when permission should not have been necessary. Communities of people with disabilities need a framework to collectively process the dehumanization of being understood as objects to be warehoused rather than as people with the full measure of hope and possibility.

Part of claiming that full measure of hope and possibility is claiming our sexuality.

There is an inherent link between sex and power. Individually, what sex means depends on who is having it. Often it is associated with passion, discovery, recognition, desire, comfort, defiance, hope, relief, creativity, connection, celebration, equality, transgression, fascination, love, and, ultimately, survival. These are the insights that every movement for liberation counts on to persist. How subversive would it be for the disability rights movement to highlight the ways that the ideas, bodies, and minds of people with disabilities are sexy (in all their imperfection) as a strategy for challenging the status quo? In this time of backlash, when service systems are being dismantled and people with disabilities are enduring losses, trauma, and grief, how could anything be more relevant or radical than asserting that as individuals, people with disabilities are worthy of experiencing the revelations that come from sexual expression?

We need ways to grieve for all the times
we had to ask for permission, when
permission should not have been necessary.



In disability communities, people who experienced involuntary sterilization are still with us and are known. They are still here to share their stories, but we rarely ask them to. Perhaps it is too painful. RJ provides a way to have that dialogue and to honor those who experienced this sexualized violence while inviting us to examine the current ways that people with disabilities are discouraged from having children. As in any other group, there are those with disabilities who do not want to have children. Unlike other groups, those with disabilities are presumed not to want or be able to raise a child. Families, doctors, service systems, and the state create multiple disincentives for people with disabilities to have children. The disincentives can be as basic as promoting provider-controlled contraception, or as complicated as a person believing she is choosing not to have a child when the reality is that her so-called choice is based on the lack of services and supports available to parents with disabilities and their children. In most states parents with disabilities have fewer legal rights than their nondisabled peers. RJ provides a framework for individuals and communities of people with disabilities to take stock of their history and to analyze the most personal ways that oppression manifests in their lives. Most importantly, RJ encourages people to imagine alternatives.

Imagination is a seed that sprouts a vision.

RJ encourages thinkers to draw connections between the past and present with a holistic analysis of social justice. People with disabilities can benefit now, more than ever, from integrating the reproductive justice framework into the heart of our disability rights movement. What better way to demonstrate self-respect and bring new energy to the disability rights movement than to use the reproductive justice framework to stake a claim on the future and to espouse a vision for achieving it?

References

Carlson, D., Smith, C., & Walker, N. (2012). *Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights*. Retrieved from the National Disability Rights Network website, <http://www.ndrn.org/en/media/publications/483-devaluing-people-with-disabilities.html>.

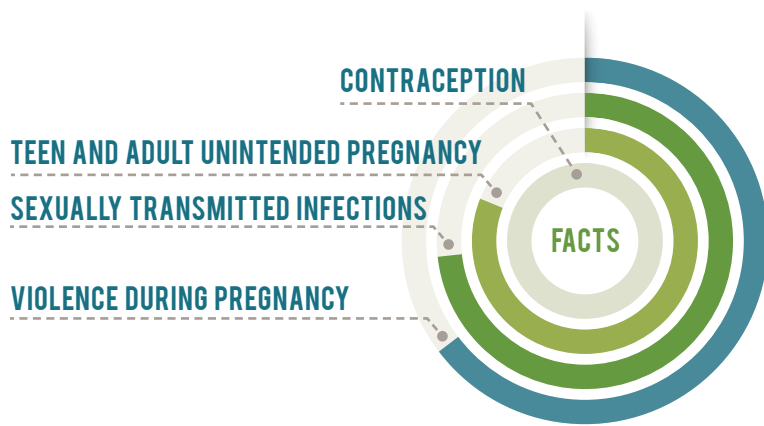
Hubbard, R. (2006). Abortion and disability: Who should and who should not inhabit the world? In L.J. Davis (Ed.), *The Disability Studies Reader* (2nd ed., pp. 93-204). New York: Routledge.

Human Rights Watch (2009). *Mental illness, human rights, and US prisons: Human Rights Watch statement for the record to the Senate Judiciary Committee Subcommittee on Human Rights and the Law*. Retrieved from Human Rights Watch website: http://www.hrw.org/news/2009/09/22/mental-illness-human-rights-and-us-prisons#_Prisons_and_Prisoners

SisterSong (2013). *Why is reproductive justice important for women of color?* Retrieved from the SisterSong Women of Color Reproductive Justice website, http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81.

Joelle Brouner is a disability rights activist who lives in Lacey, Washington. She has also been an advocate for survivors of sexual assault and domestic violence with and without disabilities. Joelle Brouner is currently the executive director of the Washington State Rehabilitation Council.





Facts

on Reproductive Health and Violence Against Women

Reprinted with Permission from
 Futures Without Violence (formerly the Family Violence Prevention Fund)

Violence against women is a costly and pervasive problem, and women of reproductive age – in particular, those ages 16 to 24 – are at greatest risk. Violence limits women's ability to manage their reproductive health and exposes them to sexually transmitted diseases. Abuse during pregnancy can have lasting harmful effects for a woman, the developing fetus, and newborn(s).

- ⊙ On average, almost 500 women (483) are raped or sexually assaulted each day in this country.¹
- ⊙ One in five Boston public high school girls report physical or sexual abuse by a dating partner.²
- ⊙ According to the World Health Organization, six to 59 percent of women in countries around the world experience sexual violence (being physically forced to have sex against their will, having sex because they were afraid of what their partners might do, or being forced to do something sexual that was humiliating or degrading) from an intimate partner at some time in their lives.³

Contraception:

- ⊙ Some women have trouble getting prompt access to emergency contraception – a safe, effective back-up birth control method that can prevent pregnancy when taken within days of unprotected intercourse.
- ⊙ A study of 474 adolescent mothers on public assistance found that 51 percent, and two in three of those who experienced domestic violence at the hands of their boyfriends, experienced some form of birth control sabotage by a dating partner.⁴

¹ National Crime Victimization Survey: Criminal Victimization, 2005. U.S. Department of Justice, Bureau of Justice Statistics. Retrieved September 2006. Available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/cv05.pdf>

² Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight control, Sexual Risk Behavior, Pregnancy and Suicidality. JAMA. 2001;286(5):572-579.

³ Garcia-Moreno C. 2005. Multi-Country Study on Women's Health and Domestic Violence Against Women. World Health Organization. Geneva, Switzerland. Countries studied include: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand and the United Republic of Tanzania. Available at http://www.who.int/gender/violence/who_multicountry_study/en/

⁴ Domestic Violence and Birth Control Sabotage: A Report from the Teen Parent Project. 2000. Center for Impact Research. Chicago, IL. Available at <http://www.impactresearch.org/documents/dvandbirthcontrol.pdf>

Teen and Adult Unintended Pregnancy:

- ⦿ As many as two-thirds of adolescents who become pregnant were sexually or physically abused some time in their lives.⁵
- ⦿ Some 25 to 50 percent of adolescent mothers experience partner violence before, during, or just after their pregnancy.⁶
- ⦿ Forty percent of pregnant women who have been exposed to abuse report that their pregnancy was unintended, compared to just eight percent of non-abused women.⁷

Sexually Transmitted Infections:

- ⦿ Violence is linked to a wide range of reproductive health issues including STD and HIV transmission, miscarriages, risky sexual health behavior, and more.⁸
- ⦿ Women disclosing physical violence are nearly three times more likely to experience a sexually transmitted infection than women who don't disclose physical abuse.⁹
- ⦿ One in three adolescents tested for sexually transmitted infections and HIV have experienced domestic violence.¹⁰

Violence during Pregnancy:

- ⦿ Homicide is the second leading cause of traumatic death for pregnant and recently pregnant women in the U.S., accounting for 31 percent of maternal injury deaths.¹¹
- ⦿ Women experiencing abuse in the year prior to and/or during a recent pregnancy are 40 to 60 percent more likely than non-abused women to report high-blood pressure, vaginal bleeding, severe nausea, kidney or urinary tract infections, and hospitalization during pregnancy and are 37 percent more likely to deliver preterm. Children born to abused mothers are 17 percent more likely to be born underweight and more than 30 percent more likely than other children to require intensive care upon birth.¹²
- ⦿ Few doctors screen their patients for abuse,¹³ even though up to one in 12 pregnant women are battered.¹⁴
- ⦿ Women who were screened for abuse and given a wallet-sized referral reported fewer threats of violence, assaults, or even harassment at work.¹⁵

⁵ Leiderman, Sally and Cair Almo. 2001. Interpersonal Violence and Adolescent Pregnancy: Prevalence and Implications for Practice and Policy. Center for Assessment and Policy Development and the National Organization on Adolescent Pregnancy, Parenting, and Prevention. Available at <http://capd.traininghelpdesk.com/pubfiles/pub-2001-10-01.pdf>

⁶ Ibid.

⁷ Hathaway JE; Mucci, LA, Silverman JG, Brooks DR, Mathews R, Pavlos CA, Health Status and Health Care Use of Massachusetts Women Reporting Partner Abuse. American Journal of Preventive Medicine. 2000; 19(4): 318-321.

⁸ Violence Against Women: Effects on Reproductive Health. Outlook. 20(1). 2002. Available at http://www.path.org/files/EOL20_1.pdf.

⁹ Coker, AL, Smith PH, Bethea L, King MR, McKeown RE. Physical Health Consequences of Physical and Psychological Intimate Partner Violence. Archives of Family Medicine. 2000; 9 451-457.

¹⁰ Decker, MR, Silverman, JG and Raj, A; 2005 Pediatrics: Vol. 116 No. 2 August 2005, pp. e272-e276.

¹¹ Chang J, Berg C, Saltzman L, Herndon J. 2005. Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999. American Journal of Public Health. 95(3): 471-477.

¹² Silverman, JG, Decker, MR, Reed, E, Raj, A. Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. American Journal of Obstetrics and Gynecology 2006; 195(1): 140-148.

¹³ Parsons, L., et.al. 2000. Violence Against Women and Reproductive Health: Toward Defining a Role for Reproductive Health Care Services. Maternal and Child Health Journal. 4(2): 135.

¹⁴ Gazmararian JA, Petersen R, Spitz AM, Goodwin MM, Saltzman LE, Marks JS. Violence and reproductive health: current knowledge and future research directions. Maternal and Child Health Journal. 2000;4(2): 79-84.

¹⁵ McFarlane, Judith M.; Groff, Janet Y.; O'Brien, Jennifer A.; Watson, Kathy; 2006. Nursing Research. 55(1):52-61

Comparison of Birth Control Methods

that Clients Can use Without Their Partners' Knowledge

By Linda Chamberlain and Rebecca Levenson, Futures Without Violence

3 YRS

Implanon

- ★ **How Does it Work?** A matchstick-sized tube of hormones (the same ones that are in birth control pills) are inserted in your inner arm.
- ★ **How Long is it Effective?** 3 years
- ★ **Helpful Hint** - Unlike previous implantable methods (Norplant), it is generally invisible to the naked eye and scarring is rare.
- ★ **Risks of Detection** - Implanon might be detected if palpated. Periods may stop completely. This may be a less safe option if a partner closely monitors menstrual cycles.

5-12 YRS

Intrauterine Device (IUD) (Mirena & ParaGuard)

- ★ **How Does it Work?** The small T-shaped device, which prevents pregnancy by changing the lining of your uterus so an egg cannot implant, is inserted into your uterus.
- ★ **How Long is it Effective?**
ParaGuard: 12 years; Mirena: 5 years
- ★ **Helpful Hint** - Mirena has a small amount of hormone that is released that can lessen cramping around the time of your period and make the bleeding less heavy.
- ★ **Risks of Detection** - The IUD has a string that hangs out the cervical opening. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel them or pull the device out of her.

[Editor's Note: Earlier this year a third IUD was approved by the FDA. Skyla is a smaller IUD, marketed specifically to women who have never been pregnant and younger women (both Mirena and ParaGuard can also be used by women who have never been pregnant or given birth). Skyla has the same hormones as the Mirena IUD, but lasts for 3 years. With Mirena and Skyla periods may change or stop completely. This may be a less safe option if a partner closely monitors menstrual cycles.]

3 MNTHS

Depo-Provera ("the birth control shot")

- ★ **How Does it Work?** Depo-Provera is a shot that provides hormones—the same ones that are in birth control pills—that prevent a woman from ovulating.
- ★ **How Long is it Effective?** 3 months
- ★ **Helpful Hint** - Once administered, there is no way to stop the effects of the shot.
- ★ **Risks of Detection** - Periods may stop completely. This may be a less safe option if a partner closely monitors menstrual cycles.

SINGLE
DOSE

Emergency Contraception (EC or the "Morning After Pill")

- ★ **How Does it Work?** Either a single dose or series of hormones are given within 72-hours* of unprotected sex to prevent pregnancy.
- ★ **How Long is it Effective?** Single dose—must be taken after every instance of unprotected sex.
- ★ **Helpful Hints** - Clients can get emergency contraception to keep on hand before unprotected sex occurs. EC is NOT abortion—just like "regular" birth control pills, it prevents ovulation.
- ★ **Risks of Detection** - Clients can remove the pills from the packaging so that partners will not know what they are.

[*Editor's Note: Although the FDA approved the use of emergency contraception up to 72 hours after unprotected intercourse, research has proven that EC can work up to 120 hours.]

All of these methods (except Emergency Contraception which can be purchased over the counter at a pharmacy by men or women [...]) must be prescribed by a doctor or nurse practitioner. Clients can call 1-800-230-PLAN to find a health care provider near them who can prescribe birth control. Talk to your client about safety planning around doctor's office reminder calls and scheduling visits—if making appointments for birth control may put them at risk with a partner.

Source: Chamberlain, L., & Levenson, R. (2011). Healthy moms, healthy babies: A train the trainers curriculum on domestic violence, reproductive coercion, and children exposed (Appendix I, page 196). Retrieved from Futures Without Violence website:<http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Healthy%20Moms%20Happy%20Babies%202013-7-13.pdf>

Reproductive Violence and Black Women

By Charity Woods, SisterSong Membership Program Associate
Reprinted with Permission from SisterSong

Approximately 40% of Black women report coercive contact of a sexual nature by age 18.

Black females experience intimate partner violence at a rate 35% higher than that of white females, and about 2.5 times the rate of women of other races.

African American women of reproductive age – particularly women 16-24 – are at the greatest risk of intimate partner violence [editor's note: compared to women in other age groups].

Reproductive violence among Black women needs to be lifted to the same level of recognition as domestic violence, child abuse, and rape, because too few people understand the intersections between reproductive justice and violence committed against African American women and girls.

Reproductive violence is coercive behavior that interferes with a woman's ability to control her reproductive life. Examples include: attempting to impregnate a woman against her will; intentionally interfering with birth control; intentionally exposing a partner to a sexually transmitted infection (STI); or threatening or acting violent if a partner does not comply with the abuser's wishes regarding contraception or the decision whether to terminate or continue a pregnancy. Early work on defining reproductive violence and coercion has been pioneered by the Family Violence Prevention Fund [Editor's Note: *now known as Futures Without Violence*].

Often sexual violence and reproductive violence are viewed as being two separate subjects. However reproductive violence is a major indicator of abuse and indicators suggest that there is a strong association between intimate partner violence (IPV) and unintended pregnancy, abortion, and sexually transmitted disease. For example, recent statistics from the Centers for Disease Control (CDC) suggest that 49% of African American teenagers may have an STI. Without intersecting this statistic with the sexual violence experienced by at least ? of young Black girls, this data out of context creates the perception that Black girls are irresponsibly promiscuous, rather than being survivors of childhood sexual abuse, often committed by much older men.

The basis of reproductive justice is the human right of a woman to bear children, not to bear children, and to mother as she wishes. However, at the heart of reproductive justice are the intersections of race, gender identity, sexual orientation, ability, immigration status, age, economics, and sexuality.



**MOST SEXUAL ASSAULTS
AGAINST BLACK WOMEN
GO UNREPORTED**

**BLACK FEMALES EXPERIENCE
IPV AT A RATE OF 35% HIGHER
THAN THAT OF WHITE FEMALES**

35% HIGHER ↑

Through the more comprehensive lens of reproductive justice, many social and health issues can more effectively be addressed.

It is clear when examining IPV and reproductive violence, the statistics for Black women are alarming.

- African American women of reproductive age – particularly women 16-24 – are at greatest risk of intimate partner violence. (Futures Without Violence)
- Approximately 40% of Black women report coercive contact of a sexual nature by age 18. (Black Women's Health Imperative)
- Black females experience intimate partner violence at a rate 35% higher than that of white females, and about 2.5 times the rate of women of other races. (Bureau of Justice Statistics, 2001). However, they are less likely than white women to use social services, battered women's programs, or go to the hospital because of domestic violence.
- Approximately one in three Black women is abused by a husband or partner in the course of a lifetime. (US Department of Justice, Findings from the NVAWS, The National Violence Against Women Survey, July 2000)
- Most sexual assaults against Black women are unreported. For every Black woman that reports her rape, at least 15 Black women do not report theirs. (Bureau of Justice Statistics, US Department of Justice)
- African American women who are abused have more physical ailments and mental health issues. They are less likely to practice safe sex, and are more likely to abuse substances than comparable women without a history of abuse. (American Journal of Public Health)

Many researchers have examined these statistics further to find natural links between reproductive violence and IPV. According to the CDC, women who had mistimed or unwanted pregnancies reported significantly higher levels of abuse at any time during the 12 months before conception or during pregnancy (12.6% and 15.3%, respectively) compared with those with intended pregnancies (5.3%). Higher rates of abuse were reported by women who were younger, Black, unmarried, less educated, on Medicaid, living in crowded conditions, entering prenatal care late, or smoking during the third trimester.

What does this all mean? These statistics clearly demonstrate that Black women experience sexual assault and violence as well as poor reproductive health outcomes to a disturbing degree, and often are victimized at a very young age. Yet, due to a variety of factors, it is often difficult for them to get the services they need. Black women encounter many barriers when seeking to use social services, sexual assault crisis centers, or going to the hospital, particularly if the people who work at these agencies are not trained in cultural competence. In order to not only effectively treat and assist Black female survivors of abuse, but to change the systemic perpetuity and culture of abuse, a reproductive justice framework is imperative. The efficacy of outreach to Black women survivors and potential victims is negatively affected by using a linear, exclusive, and often outdated model.

The reproductive justice framework changes the conversation and approach. It compels us to look at the intersectionality and multi-layered conditions in the Black community. It teaches us that there are other intrinsic factors at play, and inclusive and comprehensive responses are crucial. For African American women some of those factors include but are not limited to:

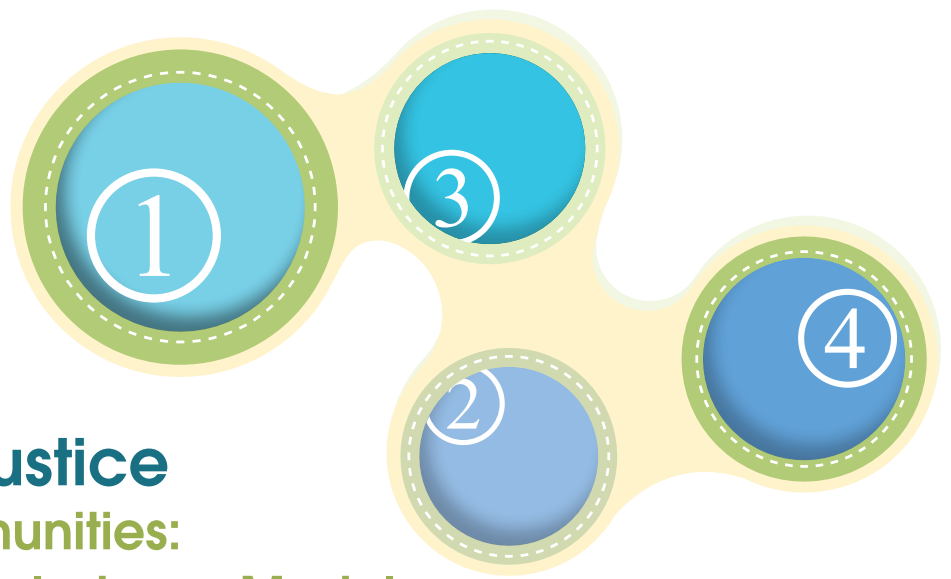
- Cultural and/or religious beliefs that restrain the survivor from leaving the abusive relationship or involving outsiders. For example, traditionally Black women have been raised to believe they shouldn't "take their business to the streets" or "air dirty laundry."
- Distrust of law enforcement, the criminal justice system, and social services due to classism and racism (often called "state violence" towards women).
- Lack of service providers that look like the survivor or share common experiences.
- Assumptions by providers based on race and ethnicity.
- Lack of economic independence that we call "economic violence," forcing the survivor to stay with the abuser.
- Attitudes and stereotypes about the prevalence of domestic violence and sexual assault in the Black community. (Virginia Sexual and Domestic Violence Action Alliance)

[Editor's note: See *Sexual Violence Awareness Fact Sheet: African American Black Women*, Virginia Sexual and Domestic Violence Action Alliance, <http://www.vsdvalliance.org/secPublications/svfsaa.pdf>]

For advocates, service delivery agencies, activists and survivors, it is critical to understand these issues to provide culturally appropriate services and sensitive strategies to combat reproductive violence.

The history of Black women in this country reveals that our bodies and our reproductive choices have always been subjugated in some form. Understanding reproductive justice can help us to have a context and effectively process the diverse aspects of our experiences socially, economically, sexually, culturally, environmentally, etc., thereby forming the groundwork for successful violence prevention. Incorporating a reproductive justice framework into health care, advocacy and education offers the potential to enhance the quality of life of Black women by alleviating disparities and mitigating our marginalization as it relates to not just violence but other harms.

**We can empower where
there is disempowerment.**



Advancing Reproductive Justice in Immigrant Communities: Promotoras/es de Salud as a Model

Excerpts reprinted with permission from the National Latina Institute for Reproductive Health

"A framework that allows for a variety of opinions and that connects women's lived realities to the way they access health care struck a chord with the promotoras in a way that a reproductive choice analysis could never have done."

— Veronica Bayetti Flores, Senior Policy Analyst, describing reproductive justice

The National Latina Institute for Reproductive Health's (NLIRH) work with promotoras and immigrant women in the Rio Grande Valley, Texas—from its work with La Voz Latina to its collaboration with Migrant Health Promotion for the Annual Conference for Promotoras/es—has confirmed that the reproductive justice framework resonates within these communities. This framework resonates with their lived experiences as women, immigrants, mothers and daughters. How these identities intersect is at the core of reproductive justice. Intersectionality recognizes that women of color are impacted by multiple oppressions. These factors must be addressed when advancing their reproductive health care needs. For women in rural communities, their access to transportation is inseparable from their access to reproductive health care. Moreover, like so many Latinas, women in the Rio Grande Valley are acutely aware that their immigration status has an impact on the health of their families.

PROMOTORAS OR PROMOTORES,
as defined by Migrant Health Promotion
(2013), are "community members who
promote health in their own communities.
They provide leadership, peer education
and resources to support community
empowerment, or *capacitación*."

The reproductive justice framework also serves as an entry point for immigrant women and Latinas to have safe conversations around abortion. In NLIRH's work with Latina immigrant women, we have found that, contrary to myths portraying these women as staunchly anti-choice, their views lie on a broad spectrum. The label of "pro-choice" is an English term defined within a narrow U.S. context, and therefore often does not resonate with immigrant communities. So although an immigrant woman may never identify as "pro-choice," her core values and politics around sexual and reproductive health and rights are actually aligned with the values of the reproductive justice movement. NLIRH has found that the majority of

Latinas want women to have access to a full range of reproductive health care, including abortion if they choose it. As Veronica Bayetti Flores, Senior Policy Analyst at NLIRH, puts it, “A framework that allows for a variety of opinions and that connects women’s lived realities to the way they access health care struck a chord with the promotoras in a way that a reproductive choice analysis could never have done.” In effect, the reproductive justice framework de-polarizes the choice debate and moves abortion away from being a black and white issue to one allowing more nuances.

Growing and advancing a reproductive justice movement that is inclusive of immigrant communities requires that we build on community strengths, such as promotor/a programs, and create new models of organizing. Promotor/a programs provide opportunities to engage new leaders, build our base, and advance reproductive justice within traditionally marginalized communities. Reproductive justice organizations can also play a vital role in advancing reproductive justice within immigrant communities by building relationships with trusted organizations serving immigrant communities and leveraging those relationships to introduce new people to the reproductive justice framework and engage them in our movement.

Growing and advancing a reproductive justice movement that is inclusive of immigrant communities requires that we build on community strengths, such as promotor/a programs, and create new models of organizing.

In 2008, there were 14.4 million Latinas living in the U.S., with 52% of these being immigrant women (Center for American Progress Action Fund, 2008). Immigrant women, as a group, bring their own set of strengths and face many challenges in navigating infrastructures like the health care system or public transportation. Promotoras/es and promotoras/es programs serve to bridge a gap between the experiences of immigrant families and the U.S. health care system. As a result, they contribute to ensuring families receive vital services, including reproductive and other primary health care, by reaching traditionally

marginalized immigrant communities and engaging them through various efforts, which include advocacy and organizing.

Promotoras/es are continually facing different barriers to accessing services and see these as intrinsically linked and all equally important to addressing the reproductive oppression faced by their communities. Moreover, a part of a promotor/a’s work is to identify and nurture new leaders within the communities they serve. In effect, the reproductive justice framework, given its core principles of intersectionality and leadership development, has a natural synergy with the principles of promotoras/es and provides an opportunity for advancing the reproductive justice movement.

For reproductive justice organizations, there exists a tremendous opportunity to expand and advance this movement by collaborating with trusted organizations and promotores/as in immigrant communities. NLIRH’s partnership with the promotoras/es has proven to be a successful model for organizing immigrant women around reproductive justice, and we are committed to continuing to work and develop leadership with this community of constituents.

The full article is available at

<http://latinainstitute.org/sites/default/files/publications/special-reports/NLIRH-AdvancingRJ-ImmCommunities-Jan2010.pdf>

References

Migrant Health Promotion (2013). *Who are promotores(as)?* Retrieved from http://migranthealth.org/index.php?option=com_content&view=article&id=41:who-are-promotoresas&catid=11:our-programs&Itemid=38.

Center for American Progress Action Fund (2008). *U.S. Latinas by the numbers*. Retrieved from: http://www.americanprogressaction.org/wp-content/uploads/issues/2008/pdf/latinas_numbers.pdf

The Impact of Childhood Sexual Abuse on a Woman's Later Childbearing Experiences

Penny Simkin, PT

The incidence of childhood sexual abuse is high in every country (between 25 and 40% in girls and almost that high in boys) so we know that the incidence among childbearing women is about the same. And yet, knowledge of how powerfully women can be affected by a history of sexual (and other types of) abuse is hardly acknowledged or addressed in typical maternity care. Relatively little attention is focused on the unique challenges faced by a survivor during pregnancy, birth, and feeding and parenting a newborn. In fact, although most family and medical history forms that women fill out when they enter prenatal care include questions about sexual and physical abuse, domestic violence, etc., many survivors decline to disclose their history on such forms. They worry about what might be done with the information, or simply don't want to open that "can of worms" while trying to prepare for a baby. Other survivors truly have no recall of abuse, though memories may come up at a later time. Lastly, it is common for the caregiver [Editor's note: in this article caregiver refers to medical provider] never to address it, even when a woman has disclosed an abuse history on the form. Avoiding the issue contributes to poorer clinical and emotional outcomes for mother and baby.

I'll try to describe some important effects of sexual abuse and how we can assist survivors during this challenging time. The good news is that there is great potential for substantial healing and empowerment for the woman when her needs are understood, supported, and validated. I have found working with survivors during the vulnerable childbearing year to be mutually rewarding, and it isn't rocket science!

Most of what I have learned has come from survivors themselves, who have shared their stories and concerns with me in one-on-one sessions that I offer as part of my childbirth education practice. I have also learned much from my colleague, Phyllis Klaus, a skilled psychotherapist and co-author of our book, "When Survivors Give Birth." In discussing the specific concerns and fears that come up with childbearing survivors, themes emerge that have to do with the following:

- Need for control over what is done to her (issues of restraint, feeling trapped, tied down, hooked up), issues with helplessness or loss of self-control (crying out, struggling, resisting), which increases her sense of vulnerability or weakness
- Pain, injury, or bodily damage during birth (vaginal tear, episiotomy), invasion (vaginal exams, needle phobia with blood draws, intravenous line, etc.), cesarean surgery
- Discomfort over feeling dependent on partner, advocate, caregiver, doula (she has learned that people you have to depend on hurt you)
- Distrust of authority figures, strangers (people whom she trusted or who had power over her have hurt her in the past)
- Shame and being judged over body image, behavior, "weakness," secretions, vocalizing
- Exposure, (modesty, people staring, looking and feeling inside, watching her during breastfeeding)
- Worries about not being a good parent (related to the fact that she did not receive good parenting or protection from the abuse), and not knowing how to protect her child from abuse

Each survivor has her own individual set of triggers that fit one or more of the themes above. The adult manifestations and their severity vary, and depend on such factors as: the age of the victim at the time of the abuse; the nature, duration, and severity of the abuse; the presence or absence in the victim's life of one or more loving "safe" individuals; the innate resilience of the individual; and opportunities for healing as a result of excellent therapy and mindful self-care. Repressed memories tend to surface under circumstances of excessive emotional or physical stress, or during particular life transitions, one of which comes during the childbearing year, encompassing pregnancy, birth, and new parenthood, including breastfeeding.

Relationship Between Client and Caregiver

Not surprisingly, for women who were violated during childhood by adults in authority and power, adults whom they loved, trusted, and on whom they were dependent, the client-caregiver relationship may be a replay of the past. Doctors or midwives are often older, more knowledgeable, and are in their own “territory” (office, clinic, or hospital). They remain clothed and upright; and do painful or intrusive things to the woman. The woman, on the other hand, has less knowledge, is in a strange environment, remains partially unclothed, is lying down, and submits to the procedures being done to her. This is a potentially disempowering situation.

Women who were victimized by a male (which is most often the case) often prefer a female caregiver, in the expectation that a female will be safer. Because of their more personal and less intervention-oriented style of care, midwives may be preferred over medical doctors. If, however, the female caregiver then acts the same way or does the same things as a male (same tests, vaginal exams) would do, the woman may feel betrayed. She may replay some of the old experiences of being let down, confused, or hurt by her own mother’s complicity (knowing or unknowing) in the abuse, and/or failure to protect her.

As we can see, a survivor may have difficulty trusting her caregiver. Sometimes caregivers feel resentful, and that they have to prove themselves to the client, while the client feels she is trying to gain some control, establish herself as an equal, and assure herself that she can trust her caregiver.

Survivors sometimes also test us, their advocates, by questioning our knowledge, or telling us our suggestions don’t work.

Being challenged is always difficult, and we are as likely as anyone else to become defensive, hurt or angry. It helps if we can remind ourselves that we are not really the target of her dissatisfaction; we represent someone else from years ago, who taught her to be skeptical or untrusting. We can and should see beneath the surface, recognize that the survivor has special needs, and treat her with kindness, patience, and respect.

The Role of the Childbirth Educator, Advocate, or Counselor

We can be helpful and empowering to survivors, mostly by being good listeners, and treating them with respect and empathy.

- If a client seems hostile, non-participatory, or challenging, try not to become defensive, or to take it personally. Remember—she (or he) has very good reason for the lack of trust and negative attitude. You may symbolize other authority figures in her life who misused their power.
- Recognize that some women may have preferences for their birth and infant care and feeding that you disagree with. Your job is to inform, not to indoctrinate. Once informed, the woman considers the information, along with her needs, fears, and priorities and comes up with the most suitable plan for her. Your support and validation play a key role in making this experience as good for her as possible.
- Become familiar with resources and therapists in your community who can help sexual abuse survivors with parenting issues, emotional difficulties, etc. Encourage them to seek out these resources whenever they feel ready.
- Be ready to listen respectfully and empathetically if a woman discloses past sexual abuse or other issues to you.
- Recognize that a traumatic birth experience may, in effect, be a symbolic re-enactment of a woman’s abuse, triggering some of the same feelings she had while being abused. It is striking how similar the language describing traumatic birth is to language describing sexual assault or abuse.
- Lastly, it is comforting to know that respectful considerate, individualized support and clinical care can contribute to a healing and empowering birth experience that will remain with the woman as a lifelong positive memory.



In conclusion, pregnancy and birth may present a particular challenge to the sexual abuse survivor. Too often, her special needs are misunderstood or ignored. By treating each woman with understanding, empathy, and respect, the advocate, counselor, or caregiver validates her needs and wishes, and can then help her to discover and develop her own best way to participate in this most challenging life experience.

Truly, this is no more than every woman deserves.

Penny Simkin is a physical therapist, childbirth educator, and birth doula. She has written many birth-related books, including (with Phyllis Klaus), When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women, which is a good source of further information on this important topic.

Simkin Center for Allied Birth Professions – www.bastyr.edu/simkin-center/when-survivors-give-birth

Editor's Note: On March 23, 2010, Washington became the seventh state to restrict the practice of shackling incarcerated women during childbearing. The bill, passed overwhelmingly by both houses of the Washington Legislature, was signed into law by Governor Christine Gregoire. The law prohibits the use of restraints during labor and delivery and restricts the use of shackles during the third trimester and during postpartum recovery. It also bans the use of waist chains and leg irons at any point in pregnancy. <http://legalvoice.org/focus/health/shackling.html>

PROGRAM HIGHLIGHTS



New Hope Domestic Violence and Sexual Assault Services Serving Grant and Adams Counties

Suzi Fode – Program Director

WCSAP: Can you tell us about how your new program offering emergency contraception on site got started?

To create change among advocates, our point advocate on this project, Becky Garcia, introduced the information about reproductive and sexual coercion and the program to the advocate team. We educated and got buy-in from the advocates. Our advocates roleplayed at a team meeting to practice talking about pregnancy and Plan B [emergency contraceptive medication] in order to become more comfortable talking or asking questions about pregnancy options and emergency contraception. We also participated in a Skype training with WSCADV and WCSAP staff to receive technical assistance on how to best educate and support clients facing these issues.

Our intake process has changed to include statements

such as, “Many women coming into our shelter and/or services may be pregnant or are concerned they are pregnant. We have information about and have access to pregnancy tests and emergency contraception.” By stating it in this way, clients will not assume that we are concerned that they personally are or could be pregnant; rather, they will hear that it is common for our clients to be in that position and we therefore we make all clients aware of those services.

We now can offer access to pregnancy tests and emergency contraception directly in addition to referring to our partners—Columbia Basin Health Association, local medical clinics, and pharmacies. This is huge, as we have no 24-hour pharmacies in our two counties. When young women or teens come into services, particularly outside of “office hours,” immediate access to health support is now available through our advocates.



A Timeline

of Emergency Contraception in Washington State

WCSAP's efforts to ensure access to emergency contraception (EC) for survivors have been at the forefront for over a decade. This timeline includes key moments in that work.

What is Emergency Contraception (EC)?

- EC is most commonly a pill or pills consisting of hormones which are used to prevent fertilization (conception) by inhibiting ovulation.
- The ParaGuard IUD can also be used as emergency contraception. The ParaGuard IUD helps to prevent fertilization (egg and sperm meeting) by interfering with the movement of the sperm toward the egg. The ParaGuard IUD also causes changes in the lining of the uterus to reduce the likelihood of a fertilized egg implanting. IUDs are usually not recommended following a sexual assault.
- EC in the form of DES (diethylstilbestrol) was primarily used in the 1960s and 1970s to prevent pregnancy in rape victims. Later, the Yuzpe regimen was developed as an off-label use (in a higher dose) of regular birth control pills. Plan B and other pills developed specifically as EC were not available until the late 1990s.

Why WCSAP fought for access to EC for survivors

- In 2002, victims of sexual assault were able to access EC in "some ERs some of the time." WCSAP testified that, "in the immediate aftermath of an assault, there is a narrow window of opportunity in which a victim can be administered EC. Due to the time-sensitive nature of that remedy, it is imperative that a victim be guaranteed access to EC when she enters the emergency room."
- "Sexual assault victims who need medication from pharmacists need urgent help and may already feel vulnerable and scared. Repealing the current rule will further perpetuate their victimization and sense of powerlessness and will jeopardize the health and personal well-being of sexual assault victims across Washington."

Timeline

1997

Washington State becomes a pilot site for "behind-the-counter" availability of EC, meaning that a pharmacist could dispense EC without a doctor's prescription.

2000

NARAL conducts a survey showing there was no standard availability of EC for sexual assault victims in hospitals, and shares the results with WCSAP.

2002

WCSAP and allied organizations successfully work to pass legislation providing access to EC in emergency rooms.

2005

Planned Parenthood Votes and Legal Voice hear concerns about women being denied birth control at pharmacy counters.

2006

FDA approves behind-the-counter access to Plan B for women 18 years of age or older.

The state Board of Pharmacy supports a rule that would protect pharmacy workers' consciences (i.e, they could refrain from carrying and dispensing Plan B and refer patients elsewhere).

2007

March 23 - a U.S. judge orders the FDA to allow 17-year-olds to acquire Plan B without a prescription.

Rhiannon Andreini is denied EC (and lectured about it) at Ralph's Thriftway in Olympia, beginning the case now known as *Stormans et al. v. Selecky et al.*

A federal court in Tacoma issues an injunction suspending enforcement of the rules requiring pharmacies to dispense all lawful medications.

2009

July 8 - Ninth Circuit Court of Appeals overturns the lower court ruling, vacating the injunction. The court held that the regulations requiring pharmacies to dispense all lawful medications must take effect, finding that the trial court abused its discretion in enjoining the pharmacy rule. Immediately after the Ninth Circuit's ruling, the pharmacists asked that court to reconsider its decision.

October - in response to that request, the Ninth Circuit strongly reaffirms its earlier decision, finding "the new rules do not aim to suppress, target, or single out in any way the practice of religion, but, rather, their objective was to increase access to all lawfully prescribed medications." The court specifically recognizes that the trial court "erred in finding that access to Plan B

was not a problem, especially given that state officials have already made findings suggesting the opposite."

2010

July 7 - a challenge is brought by two pharmacists and a pharmacy to the State Board of Pharmacy rule requiring all licensed pharmacies to fill patients' prescriptions. The State and the plaintiffs who brought the suit seek a delay while the State Board of Pharmacy (BOP) completes a new rule-making process to make changes to the policies being litigated.

November 4 - The Board of Pharmacy votes to proceed officially with rule-making.

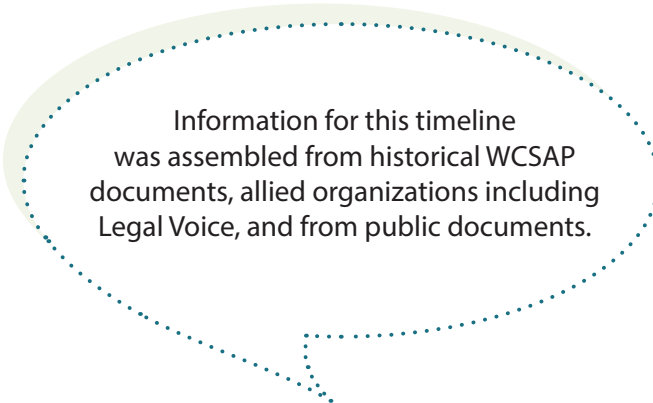
December 16 - The Board of Pharmacy votes to keep the existing rules. The public comment site receives more than 5300 comments on the issue (including those of WCSAP members). Of the comments, 80% support keeping the existing rule.

2012

August 19 - WCSAP joins with other state and national organizations in filing an amicus brief with the Ninth Circuit Court of Appeals.

2013

The federal government withdrew its appeal of the court ruling lifting age and point-of-sale restrictions when purchasing EC. Emergency contraception will be available on store shelves (not behind the pharmacy counter) and can be sold to anyone (regardless of age or sex, and without an ID) later this year. The exact timeline is determined by the manufacturer, FDA, and retailers and is currently undefined. Check WCSAP's recorded webinars page for a recent webinar on emergency contraception and advocacy.



Information for this timeline was assembled from historical WCSAP documents, allied organizations including Legal Voice, and from public documents.

Question Oppression



Exploring the Connections Between Sexual Violence & Oppression

Use these questions to explore the connections between sexual violence and oppression with staff, volunteers, or board members. Try discussing one or more at a staff meeting, in-service, volunteer training, or board retreat.

What barriers might a survivor encounter in accessing effective reproductive health services? Consider how other aspects of a survivor's identity (race/ethnicity, sexual orientation, disabilities, economic factors, etc.) might affect this same question.

What communities have historically experienced disproportionate rates of forced sterilization? High rates of infant or maternal mortality? Lack of access to quality reproductive health care? In what ways have institutions supported or actively ignored these examples?

In what ways is your program prepared to support a survivor's needs related to reproductive justice? How can you remove barriers and promote access for survivors in your community?

Resources



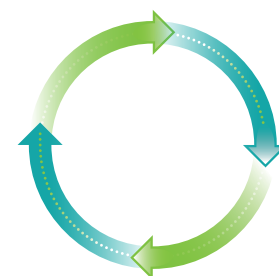
Did you know . . . that WCSAP members have access to check out our library items? It's true. We mail them to you, you mail them back.

In this Issue

- **Law Students for Reproductive Justice** – www.lsrj.org
- **Futures Without Violence** – www.futureswithoutviolence.org
- **SisterSong** – www.sistersong.net
- **National Latina Institute for Reproductive Health** – www.latinainstitute.org
- **Penny Simkin** – www.pennysimkin.com

WCSAP Resources – Available online at www.wcsap.org

- **Pregnant and Parenting Survivors**
<http://www.wcsap.org/pregnant-and-parenting-survivors>
- **Reproductive Health Advocacy Strategies for Sexual Assault Survivors**
<http://www.wcsap.org/reproductive-health-advocacy-strategies-sexual-assault-survivors>
- **Reproductive and Sexual Coercion Screening Comes to OB/GYN Offices**
<http://www.wcsap.org/reproductive-and-sexual-coercion-screening>
- **Proceedings Report of the Community Voices Partners' Meetings on Ending Violence Against Women with Disabilities**
<http://www.wcsap.org/proceedings-report-community-voices-partners-meetings-ending-violence-against-women-disabilities>





WCSAP
Washington Coalition of
Sexual Assault Programs

Non-Profit
US Postage
PAID
Olympia, WA
Permit #282

Washington Coalition of Sexual Assault Programs

WCSAP
4317 6th Ave SE, Suite 102
Olympia, WA 98503
(360) 754-7583
(360) 709-0305 TTY
(360) 786-8707 FAX

*For information about becoming a member of WCSAP,
please e-mail us at info@wcsap.org, or call (360) 754-7583.*

Connections is **YOUR** magazine.

We invite guest authors to submit pieces on a variety of topics, and welcome your submissions on advocacy approaches, media reviews, and creative work like original art or poetry.

We would also like to feature highlights of your agency and the advocacy work you are doing.

Direct submissions to
advocacy@wcsap.org

www.wcsap.org