



WISCONSIN COALITION AGAINST SEXUAL ASSAULT

Reproductive Health Needs for SA Survivors

A RESOURCE FOR ADVOCATES

Wisconsin Coalition Against Sexual Assault (WCASA)
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TABLE OF CONTENTS

Acronyms	3
Framework – Philosophy	4
Acknowledgments	5
Building Networks Project	5
Introduction	6
Background	7
Overview of Reproductive Health/Family Planning Clinics	8
Essential Services.....	8
Contraceptive Services & Supplies.....	8
Emergency Contraception.....	9
Pregnancy Related Services	10
Abortion Services.....	11
STI Detection, Treatment & Prevention.....	13
Health Care Coverage & Benefits	14
Medical Home Screening & Referral	15
Post-Violence Care	15
Services Clinics Do Not Provide.....	17
FP/RH Clinic Locations in Wisconsin.....	18
Planned Parenthood Services in Wisconsin	19
Free Clinic Locations in Wisconsin.....	19
How To Assess for Health Needs	20
Tools.....	20
Note on Minors.....	20
General Health Assessment.....	20
Acute Sexual Assault Assessment	21
Sexual Assault in the Context of Intimate Partner Violence (IPV) Assessment	22
Ongoing Health Care Needs.....	23
Past Trauma/Adverse Childhood Experiences.....	23
Creating Relationships	26
Language of Collaboration.....	26
Initial Set Up.....	26
Shared Goals or Purpose.....	27

Clearly Defined Roles & Responsibilities.....	27
Steps to Partnership Sustainability.....	27
Memorandum of Understanding	28
Policy	28
Procedure	28
Training	29
Important Considerations	30
Reproductive Justice	30
Culturally Responsive Care	30
LGBTQ Survivors	32
Trauma Informed Practices	33
Safety	33
Trust.....	34
Choice	34
Collaboration.....	35
Empowerment	35
Cultural Competency	35
Comprehensive Sexual Education.....	36
Spotting Crisis Pregnancy Centers (CPCs)	36
Services to Minors	37
Closing	39
References	40

ACRONYMS

ACA	Affordable Care Act
ACE	Adverse Childhood Events
ACOG	American Congress of Obstetricians and Gynecologists
API	Asian Pacific Islander
BC	BadgerCare
CCR	Coordinated Community Response
CCRV	Compassionate Care for Rape Victims
CDC	Centers for Disease Control & Prevention
CPC	Crisis Pregnancy Center
DHS	Department of Health Services
EC	Emergency Contraception
ECRL	Emergency Contraception Response Line
FP/RH	Family Planning and Reproductive Health
FPOS	Family Planning Only Services
GYT	Get Yourself Tested
HCET	Health Care Education and Training
HIV	Human Immunodeficiency Virus
IPSV	Intimate Partner Sexual Violence
IPV	Intimate Partner Violence
IUD	Intrauterine Device
LARC	Long-acting Reversible Contraception
MDT	Multi-disciplinary Team
MOU	Memorandum of Understanding
NISVS	National Intimate Partner and Sexual Violence Survey
NSVRC	National Sexual Violence Resource Center
PNCC	Prenatal Care Coordination
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
SASP	Sexual Assault Service Provider
STI	Sexually Transmitted Infection
TIC	Trauma Informed Care
USPSTF	U.S. Preventive Services Task Force
VAPS	Video Assisted Patient Services (VAPS)
WAWH	Wisconsin Alliance for Women's Health
WCASA	Wisconsin Coalition Against Sexual Assault
WIC	Women, Infants & Children Program

FRAMEWORK – PHILOSOPHY

The Wisconsin Coalition Against Sexual Assault (WCASA) identifies reproductive health as a core issue for sexual assault survivors and views healthy sexuality as the basis for sexual violence prevention. Additionally, the work of reproductive justice “links sexuality, health, and human rights to social justice movements by placing abortion and reproductive health issues in the larger context of the well-being and health of women, families and communities because reproductive justice seamlessly integrates those individual and group human rights particularly important to marginalized communities.”¹

WCASA Vision:

A socially just world in which all people value equity and healthy sexuality

WCASA Mission:

Creating the social change necessary to end sexual violence

WCASA Foundation:

To end sexual violence, we must also end all forms of oppression

WCASA, 2017

WCASA believes that the sexual violence prevention concepts of empowerment, body autonomy, and consent are also pivotal to reproductive health, including abortion access. People need to have decision-making authority over their own bodies, whether it is the choice to participate in sexual activity, to use birth control, or to terminate a pregnancy. Restricting any of these choices sends a strong message that people's bodies are not their own.

Survivors are often confronted with a variety of barriers when seeking support after an assault, including access to high-quality, non-judgmental medical care. While some restrictions to reproductive health care offer exemption for victims of sexual assault, they often require victims to report the incident (to law enforcement or their medical provider) to access services. This is yet another means of controlling people's decisions, often at the expense of their health and well-being.

WCASA supports policies that give people and survivors full access to decisions related to their reproductive health care. This transfers power back to survivors and promotes healing and justice.

¹ (Ross, 2011)

ACKNOWLEDGMENTS

WCASA has worked in collaboration with partners to develop this resource to support Sexual Assault Service Providers (SASPs) and encourage communities to develop relationships to support the reproductive health needs of survivors.

This resource was informed by the Building Networks for Advocacy & Reproductive Health Project. Building Networks brought together partners at state and local levels to identify best practices for collaboration between sexual assault service providers (SASPs) and Family Planning and Reproductive Health providers (FP/RH). At the state level, partners included: Health Care Education and Training (HCET); Department of Health Services (DHS); and WCASA. Four local projects were selected, with representatives from the local SASP and FP/RH clinic participating in the 18-month project. It is through their expertise and passion that we identified tools and resources to improve services to survivors related to their reproductive health needs.

Specifically, we'd like to acknowledge the following people for their support of the Building Networks Project and the development of this resource:

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HCET: Michelle Watkins; Ann Kronser; Carly Marco; Shannon Ruth-Leigh

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Building Networks Project

Iron County
SASP: DOVE, inc.
FP/RH: Iron County Reproductive Health

La Crosse County
SASP: New Horizons
FP/RH: Essential Health Clinic

Price County
SASP: Embrace
FP/RH: Price County Public Health

Sauk County
SASP: Hope House
FP/RH: Healthfirst

INTRODUCTION

Sexual violence is a significant public health problem, impacting nearly 2 million people in Wisconsin. Victims of sexual assault come from every walk of life – this epidemic knows no boundaries. Sexual violence affects us all.

While we often associate sexual assault with a criminal justice response, the health care response is critical as well. Victims can, but aren't limited to experiencing:²

- Chronic pain
- Gastrointestinal complications
- Migraines
- Sexually transmitted infections (STIs)
- Cervical cancer
- Genital injuries
- Pregnancy
- Depression
- Generalized anxiety
- PTSD
- Suicidal ideation and suicide
- Harmful substance use
- Unhealthy diet-related behaviors
- Engaging in high-risk sexual behavior

Sexual Violence Defined

Any act or behavior (verbal or physical) that is sexual in nature and conducted through force, threats, coercion, manipulation, or abuse of power.

- Sexual violence is a tool of oppression often used to intimidate, target, and exploit historically marginalized communities and populations.
- Sexual violence affects people of all identities, ages, and abilities. Perpetrators of sexual violence come from all walks of life and identities. They can be acquaintances, family members, intimate partners, trusted individuals, or strangers.

Sexual violence is **never the fault of the victim/survivor**. Perpetrators are fully responsible for their actions.

WCASA, 2017

Sexual violence can have a profound effect on a person's well-being, and the healing process is different for everyone. As many of the physical consequences overlap with the specific services Family Planning & Reproductive Health (FP/RH) clinics provide, clinics will most likely encounter victims even if they do not disclose. FP/RH services are a significant part of the healing process for victims. Services should always be **victim-centered**. To provide best-practice services, all SASPs should partner with their FP/RH clinics.

FP/RH providers can provide important services to survivors after an assault – regardless of whether the survivor has chosen to have a forensic medical exam (FME). For survivors who decline an FME or who are past the time for an FME, your FP/RH provider can offer services to meet the common medical concerns survivors face. For survivors who have an FME, your FP/RH provider can offer the important follow-up testing for STIs and pregnancy.

The purpose of this guide is to give a brief overview of the type of services FP/RH clinics provide, explain how advocates can assist victims in accessing the health care they need, and outline methods for collaboration between FP/RH clinics and advocates.

² (Centers for Disease Control and Prevention, 2017)

The terms “victim” and “survivor” are often used interchangeably. While most SASPs may prefer the term survivor, most health care clinicians use the term victim. Since this resource is meant to help SASPs build connections with their health counterparts, we will be using the terms most common within the health system: victim and patient.

Finally, it is vital to highlight the disparate experiences of marginalized communities. Experiences with institutionalized racism may make it difficult for victims, people of color, and other marginalized groups to trust the systems and institutions that are supposed to help them, including both SASPs and FP/RH clinics. It will take intentional work from both partners to reach all survivors, particularly those most marginalized in our communities.

Background

The Building Networks for Advocacy and Reproductive Health Project was a pilot to identify best practices in solidifying collaborative practice between FP/RH clinics and SASPs. Specifically, the project focused on the following activities:

- A formalized policy within both organizations describing procedures for implementing, monitoring, and sustaining the relationship between agencies
- A policy for initiating and following up on referrals between agencies
- A process for measuring and tracking referrals
- Tools to screen and document client trauma history
- Tools to screen and document client access to health care
- A system for providing emergency contraception at advocacy sites
- Policy and procedures for training new and existing staff on the collaborative practice
- Evaluation activities to determine impact

Four pilot communities were identified, and within each, the local FP/RH clinic and SASP spent 18 months building the foundations of formal collaboration. In addition to developing and formalizing partnerships, Building Networks also focused on improving knowledge and skills for screening and assessment. Findings from the project helped inform the contents of this guide, which can be used to guide the formalization or establishment of FP/RH and advocacy partnerships.

OVERVIEW OF REPRODUCTIVE HEALTH/FAMILY PLANNING CLINICS

Most of the FP/RH clinics in Wisconsin are made up of public health nurses and vary in number of staff. In many rural counties, the nurses are short-staffed, often working alone. Currently, they are funded either by the state through the Department of Health Services or by Planned Parenthood. All 72 counties in Wisconsin have at least one FP/RH clinic. Although the terminology may be a bit different than that of SASPs, the core principles are similar: they are patient-centered and trauma-informed.

Essential Services

All FP/RH clinics offer the same comprehensive essential services that include:³

1. Contraceptive services and supplies
2. STI detection, treatment, and prevention (risk reduction) services
3. Pregnancy related services including testing and preconception care
4. Specialized reproductive health primary care
5. Health care coverage and benefits eligibility screening, enrollment, and referral services
6. Medical home screening and referral services
7. Post-violence care services

The following section is a detailed breakdown of the most relevant services for victims. Most of what is written below comes from the [Women's Health-Family Planning/Reproductive Health Program Handbook](#).⁴

Contraceptive Services & Supplies

The following services should be provided by all FP/RH clinics in the state:⁵

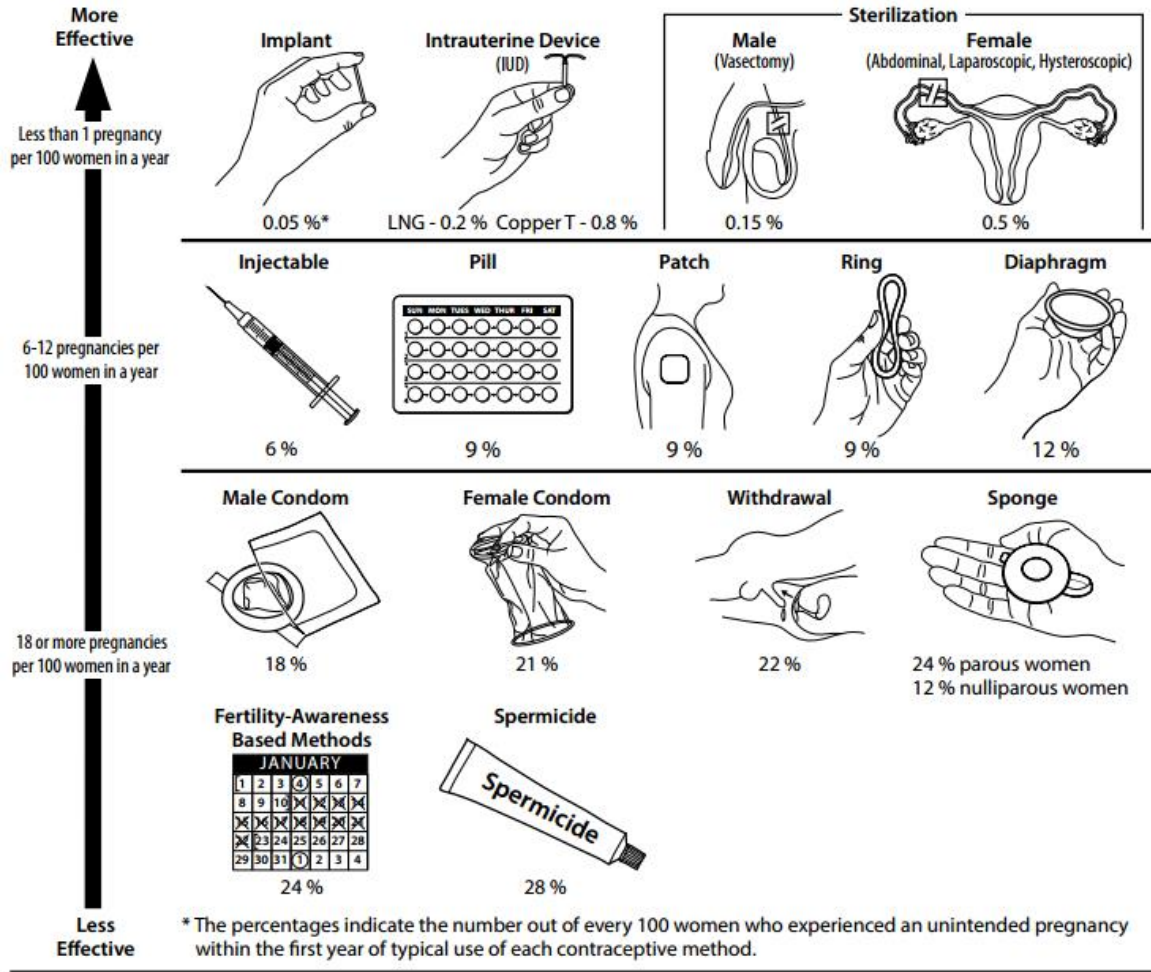
- Patient education and guidance for informed decisions regarding contraceptive methods
- Health and medical assessments pertinent to preferred contraceptive methods
- Prescription of contraceptive methods
- Distribution of contraceptive supplies (initial and on-going)
- Immediate intervention for emergency contraception
- Periodic assessments on chosen contraception method
- Ongoing access for information and contraception management
- Follow-up as needed to support success of chosen contraception method

All clinics can provide various types of moderately effective contraception including injectables, pills, patches, and rings (see figure on next page). A few clinics can offer highly effective contraception: long-acting reversible contraception (LARC) such as the implant or the Intrauterine Device (IUD). Some clinics that are a part of a local health department will not be able to provide LARCs, while others can.

³ (Health Care Education and Training Inc, 2017)

⁴ (Health Care Education and Training Inc., 2016)

⁵ (Health Care Education and Training Inc, 2017)



CDC, 2011

Emergency Contraception

Pregnancy concerns are commonly identified by survivors and can be the impetus for them seeking out information about medical care. Emergency contraception (EC), when administered in a timely manner, can be an effective method to prevent pregnancy.

The probability of becoming pregnant from a single, random, unprotected act of intercourse is 5%, increasing to at least 10% mid-cycle, and may be as high as 30% on the day of ovulation.⁶ EC is a "safe and effective method of pregnancy prevention. It is a high dose of ordinary birth control pills that can prevent pregnancy when taken within 5 days (120 hours) after intercourse."⁷ EC is not an abortifacient.

There are 2 types of EC pills available in the US:

1. Progestin-only
 - *Plan B One-Step***
 - *Next Choice One Dose***

⁶ (Wisconsin Alliance for Women's Health, 2015)

⁷ (Wisconsin Alliance for Women's Health, 2015)

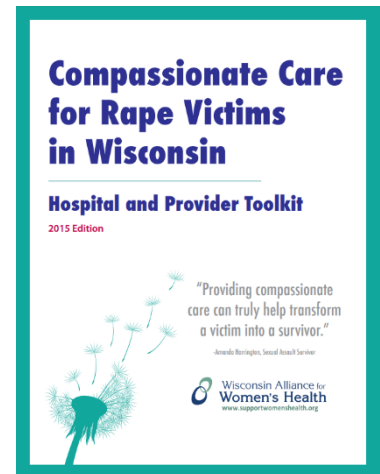
- My Way
 - Take Action
2. Ulipristal acetate (ella)

***Available over-the-counter*

Common side effects of all EC are nausea and vomiting. Although not recommended for people who are pregnant as it is not effective, there is no evidence to suggest that taking EC will harm an existing pregnancy. Otherwise, all victims should be offered EC as a safe, pregnancy preventing option.

EC pills can cost between \$35 to \$60 when purchased at a pharmacy. For those with Medicaid, it should cover EC costs. For those with private insurers, advocates may want to help victims by calling the insurers to check coverage and the specific EC brands they will reimburse.⁸ Nurses at the FP/RH clinics can go over the options and answer any questions or concerns the victim may have. Additional information can be found at The Kaiser Family Foundation’s [Emergency Contraception Website](#). To help locate a provider for EC, click [here](#).

What is perhaps the most important for advocates to know is that, with the enactment of the Compassionate Care for Rape Victims (CCRV) Act, **all health care professionals must offer emergency contraception (EC) for all victims**. The Wisconsin Alliance for Women’s Health (WAWH) has developed a [toolkit](#) for hospitals and providers, as well as partnered with WCASA on a [webinar](#) for advocates.



Due to the misconceptions about EC, survivors commonly encounter barriers when accessing the medication. Advocates play an important role to ensuring that survivors have access to EC and may have to intervene to ensure CCRV is being followed by hospitals.

All hospitals, regardless of religious affiliation, must provide EC immediately on-site.

Wisconsin Alliance for Women's Health, 2015

Pregnancy Related Services

The following pregnancy-related services are provided by all clinics in the state:⁹

- Provider-initiated discussions regarding reproductive life plans and pre-conceptual health
- Patient education and guidance that supports reproductive health planning
- Health and medical assessments pertinent to patient’s pregnancy status and intentions
- Short-term care coordination and follow-up to assure the patient has accessed appropriate care

⁸ (Office of Population Research, Princeton University, 2017)

⁹ (Health Care Education and Training Inc, 2017)

- Pathways for care established within the community to facilitate timely and successful pregnancy-related care
- Linkages with pregnancy support services including Women, Infants, and Children (WIC) program and prenatal care coordination (PNCC) services
- Linkages with prenatal care providers for timely high-risk medical intervention

All clinics will have [dual protection](#) kits available – kits that include items to reduce unintended pregnancy as well as STIs.¹⁰

For walk-in pregnancy testing, clinics follow this protocol:

1. Positive Test
 - a. Express enrollment into BadgerCare (Medicaid)
 - b. Referral for services (PNCC, WIC, Prenatal Care)
2. Negative Test
 - a. Quick start on a method of birth control if pregnancy is not desired

For More Information:

WIC:

<https://www.dhs.wisconsin.gov/wic/index.htm>

PNCC:

<https://www.dhs.wisconsin.gov/mch/pncc.htm>

Abortion Services

As of the time of this publication (2020), abortions are legal for up to 20 weeks pregnant in Wisconsin.¹¹

Wisconsin Statute 253.07

“Family planning” means voluntary action by individuals to prevent or aid conception. “Family planning” **does not include the performance, promotion, encouragement or counseling in favor of, or referral either directly or through an intermediary for, voluntary termination of pregnancy**, but may include the providing of nondirective information explaining any of the following:

1. Prenatal care and delivery.
2. Infant care, foster care or adoption.

However, state-funded FP/RH clinics are restricted by statute 253.07, which states that they are not funded to perform or provide referral for abortion.¹² It is difficult to know how each county’s clinic handles these guidelines and building a close relationship with the local clinic is critical to understanding how they can and cannot help regarding abortion services.

Recognizing these legal limitations, **advocates should assume it is their role to determine the victim’s desire for abortion services and to connect them with those services.** It is therefore crucial that advocates are familiar with their closest abortion provider and how to access that care.

There are only 3 locations in all of Wisconsin that provide abortion:

1. [Planned Parenthood, Madison](#)
2. [Planned Parenthood, Milwaukee](#)
3. [Affiliated Medical Services, Milwaukee](#)

¹⁰ (Health Care Education and Training Inc., 2013)

¹¹ (Ritsche, 2015)

¹² (Wisconsin State Legislature, 2018)

A new website created in 2020, [Abortion Finder](#), allows people to anonymously and confidentially locate abortion providers in the United States. The website provides information and definitions related to abortion, as well as information on abortion laws in each state.

There are 2 different types of abortions all three can provide:

1. Medication Abortion
 - Can be provided up to 10 weeks into pregnancy
 - Costs up to \$800 (not including transportation, accommodation, childcare, etc.)
2. Surgical Abortion
 - Can be provided up to 19 weeks into pregnancy
 - Costs up to \$1500 (not including transportation, accommodation, childcare, etc.)

Ultrasound

- Uses sound waves to create pictures of reproductive organs
- There are two ways to do an ultrasound – through the skin on the abdomen or through the inside of the vagina

Planned Parenthood, 2018

Wisconsin law currently requires counseling and an ultrasound during the first clinical visit before an abortion can be provided. Patients then must wait at least 24 hours before the provider can perform the abortion. It is important for advocates to know that during the first clinical visit, someone employed at the clinic will provide counseling. They are *required by law* to say certain things that dissuade people from abortions. Know that most providers are patient-centered and care first and foremost about the patient.

Many people in Wisconsin travel to neighboring states such as Minnesota or Illinois for abortion care. If you are near a border, you may want to explore these options, which may offer additional services and be closer than services in Wisconsin. For more detailed information by state, please see: [An Overview of Abortion Laws](#) from Guttmacher Institute.¹³

Minors

Patients under age 18 who are seeking an abortion have two options:¹⁴

1. Permission from a parent, foster parent, aunt, uncle, grandparent or sibling over age 25
2. Judicial bypass from this requirement

Financial Resources

[National Network of Abortion Funds](#) connects patients with organizations that can support financial and logistical needs to access abortion services. They recommend the following steps:¹⁵

1. Find out if you have insurance that covers abortion.
2. Make an appointment at a clinic for your abortion before searching for funding.
3. Add up how much you can cover on your own.
4. Search to find abortion funds that can help cover expenses.

¹³ (Guttmacher Institute, 2018)

¹⁴ (Affiliated Medical Services, 2006)

¹⁵ (National Network of Abortion Funds, 2018)

5. Read the instructions before you contact an abortion fund.
6. Contact many places – local, state, and national funds may be available.

This site lists three organizations in Wisconsin, including:

[Options Fund](#) is for patients in northwest Wisconsin (generally within the 715-area code and some areas within the 534-area code). The Options Fund may be able to help pay for abortions even if you need to travel outside of the area to get an abortion.

[Freedom Fund](#) is for patients in central or northern Wisconsin. This all-volunteer organization may be able to help with costs associated with an abortion, including travel expenses.

[Women's Medical Fund](#) (WMF) provides financial assistance to qualifying patients.¹⁶ WMF usually grants up to half the cost of an abortion, though they will give more if necessary. There is an application process.

[Planned Parenthood of Wisconsin Justice Fund](#) is a donor-supported resource that provides financial assistance to low-income women and teens who are seeking abortion care.

An additional service identified for patients in the Midwest is:

[Midwest Access Coalition](#) (MAC) helps people traveling to, from, and within the Midwest access a safe, legal abortion with support in the following areas: travel coordination and costs, lodging, food, medicine, and emotional support.¹⁷

STI Detection, Treatment & Prevention

In alignment with CDC standards, all FP/RH clinics offer the following STI services:¹⁸

- Patient education, guidance, and reinforcement for risk awareness and prevention
- STI screening and assessment
- Onsite specimen collection and testing
- Onsite treatment for most common STIs
- Managed treatment when treatment is not available onsite
- Follow up and retesting
- [Dual protection](#) supplies
- Community awareness initiatives including GYT

Get Yourself Tested (GYT)

This national campaign "is a youthful, empowering social movement to encourage young people to get tested and treated, as needed, for STDs and HIV."

CDC

Clinics should provide the services with these standards in place:

- Same day specimen collection and/or testing/treatment if positive results

¹⁶ (Women's Medical Fund, 2018)

¹⁷ (Midwest Access Coalition, 2018)

¹⁸ (Centers for Disease Control and Prevention, 2009)

- Normalization of conversation regarding partners, sexual practices and other sexual health issues
- Risk-based testing protocols
- Multiple test options offered
- Timely notification of positive test results and treatment
- Onsite treatment for the most prevalent STIs
- Actively managed treatment when treatment is not available onsite
- Coordinated patient-partner treatment
- Assisted intervention for partner notification
- Follow-up reminders and retesting

There are no protocols in place for partner interventions when there has been a sexual assault. If the victim knows the perpetrator and would like to obtain treatment for that person, that is something the nurse can provide. This is called expedited partner therapy¹⁹ and is covered but not practiced in these situations, unless asked by the victim.

Your local FP/RH clinic will be able to help with any other questions a victim may have.

Health Care Coverage & Benefits

FP/RH clinics are expected to help identify health care coverage status and needs of their patients. Clinic staff assess eligibility for available coverage and actively facilitate enrollment. Services they provide to achieve this include:²⁰

- Provider-initiated discussions to assess coverage and needs
- Screening to determine eligibility for BadgerCare (BC) or Family Planning Only Services (FPOS)
- Patient education
- Temporary or express enrollment for patients eligible for BC or FPOS
- Active application assistance
- Referral for other available coverage
- Follow up on status of enrollment
- Tracking during temporary or express enrollment to ensure continuous enrollment
- BC Express enrollment for early prenatal and pregnancy related care
- Affordable Care Act (ACA) open enrollment and mapping
- Informing clients how to appropriately use FPOS insurance
- Discount options for uninsured patients ineligible for health insurance

For sexual assault advocates, the important takeaway is that nurses at FP/RH clinics will help victims figure out insurance and payment options for services they need. This should not be an obstacle to care. For those with insurance, most plans cover all the basic procedures needed after an assault. If the victim does not have insurance, they will most likely be covered under either BadgerCare or FPOS. The only victims who are not covered are people who are undocumented. This is another key reason why it

¹⁹ (Milwaukee Health Department, 2010)

²⁰ (Health Care Education and Training Inc., 2016)

is so critical for advocates to have a strong relationship with their local FP/RH clinics. Ask the local clinic to learn more about how they can or cannot cover service to undocumented victims.

Medical Home Screening & Referral

The services provided under this component of care include:²¹

- Screening to determine if patients have a source of health care coverage
- Identify patient's non-reproductive preventive health care needs
- Assess patient's need for RH care
- Identify medical home availability
- Assess if patient's needs are met if provided through another health care service
- Provide and/or arrange for other ongoing primary care as needed through a medical home
- Provide care coordination for patients with no medical home

Medical Home

A team-based health care delivery model led by a health care provider that is intended to provide comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

HCET, 2016

In summary, advocates should know that even if they bring a victim for specific services, FP/RH clinicians can help victims get set up with primary care. Having an assigned health provider is critical to trust for future disclosures and effective ongoing screening for other health needs including mental health.

Post-Violence Care

Most of this section's components, as well as its required "qualities and characteristics" of services, come from trusted, expert sources within the health care arena, especially among reproductive health issues: The [American Congress of Obstetricians and Gynecologists \(ACOG\)](#),²² the [US Preventive Services Task Force \(USPSTF\)](#),²³ and the [Centers for Disease Control and Prevention \(CDC\)](#).²⁴ Other resources that were used include The [National Intimate Partner and Sexual Violence Survey \(NISVS\)](#),²⁵ [Futures Without Violence](#),²⁶ and the [National Council for Behavioral Health](#).²⁷

The key points for an advocate to know are that research shows most health care professionals are not trained to work with victims of violence and find themselves at a loss when there is a disclosure. Most FP/RH nurses are not Sexual Assault Nurse Examiner (SANE) trained. Nurses at FP/RH clinics will provide the expertise when it comes to STI screening, pregnancy testing and other health concerns, **but in an**

²¹ (Health Care Education and Training Inc., 2016)

²² (American Congress of Obstetricians and Gynecologists, 2017)

²³ (US Preventive Services Task Force, 2018)

²⁴ (Centers for Disease Control and Prevention, 2017)

²⁵ (Centers for Disease Control and Prevention, 2017)

²⁶ (Futures Without Violence, 2014)

²⁷ (National Council for Behavioral Health, 2017)

ideal partnership, they will depend on the advocate to understand and address trauma, criminal justice processes or other community resources available.

Additionally, most of the evidence for post-violence care in health care is focused on intimate partner violence (IPV). FP/RH clinics commonly use screening tools that include rape, but they are limited in that they focus on sexual violence in the context of relationships. The screening tools may not get at the other aspects of sexual violence – including incest, past sexual abuse, acquaintance rape, hook-up violence, sex trafficking, sexual coercion, and harassment.

Professional organizations that provide standards and protocols for care are where most FP/RH providers look to for screening questions. These questions include:

- Are you in immediate danger?
- Within the last year, have you ever been humiliated or emotionally abused in other ways by your partner or ex-partner?
- Within the last year, have you been afraid of your partner or ex-partner?
- Within the last year have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
- Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?
- Has the violence gotten worse or is it getting scarier?
- Would you like to talk to someone about this?

While these questions are important in screening for violence, they can be limiting in the type of violence patients will disclose. It is important for advocates to understand the screening questions being used by FP/RH providers and the fact that they screen mostly for IPV. Through building relationships with FP/RH providers, advocates can support training related to the full spectrum of sexual violence to better identify and meet the needs of *all* sexual violence survivors.

All FP/RH clinics are required to follow 2 essential components:

1. An evidence-based set of interventions/services, and
2. A process for building relationships with local community post-violence advocacy and service agencies.

Clinicians are asked to provide the following interventions:

- A safe environment/physical space is maintained for assessment and disclosure
- Language interpretation services when necessary
- Sequential interview process that is trauma-informed and victim-centered with evidence-based screening tools and validating language
- Managed reporting practices including:
 - Thorough and careful assessment of positive screening responses
 - Trauma-informed practices throughout assessment and reporting
 - Patient-provider relationship role is maintained
 - Maximum patient privacy protections and the integrity of the confidential relationship to the full extent of the law is maintained

- Positive screening scripts are used including:
 - Acknowledgement of trauma: validation and normalization
 - Validating statements
 - Assessment of safety
 - Managed referrals
 - Facilitating successful initial connections with community resources
 - Offering a private space to make phone calls
- Screening is incorporated into routine medical history and interviews with all
- Practicing “**No Wrong Door**”

The FP/RH clinic handbook also contains an extensive list of other qualities and characteristics their services should include.²⁸ Below highlights a few of these:

- Empowerment-focused philosophy and approaches
- Take-away resource materials, such as safety procedures, hotline numbers, referrals
- Adequate staff training
- Trustworthiness and transparency
- Service environments meet criteria recommended for trauma-informed care and sexual assault violence intervention practices

No Wrong Door

- Assessment of services in community
- Documentation of referral partnerships using MOU
- Use of Video Assisted Patient Services (VAPS) as a tool for consultation – tool for rural areas
- Building relationships with existing local advocacy and service agencies
- Community network of partnerships for responsive care and support
- Establishing and maintaining good relationships with local advocacy programs

HCET, 2016

Finally, it cannot be said enough: a strong collaboration between FP/RH clinics and SASPs is not only mutually beneficial to the agencies, but most importantly, what is best for the victim. Clinicians and advocates have differing yet equally critical skills that all victims will need. They are most victim-centered when used together and streamlined through partnership.

Services Clinics Do **Not** Provide

Although clinics do their best to provide all the services their patients need, there are some important services a victim may need that local FP/RH clinics are not equipped to handle. These include:

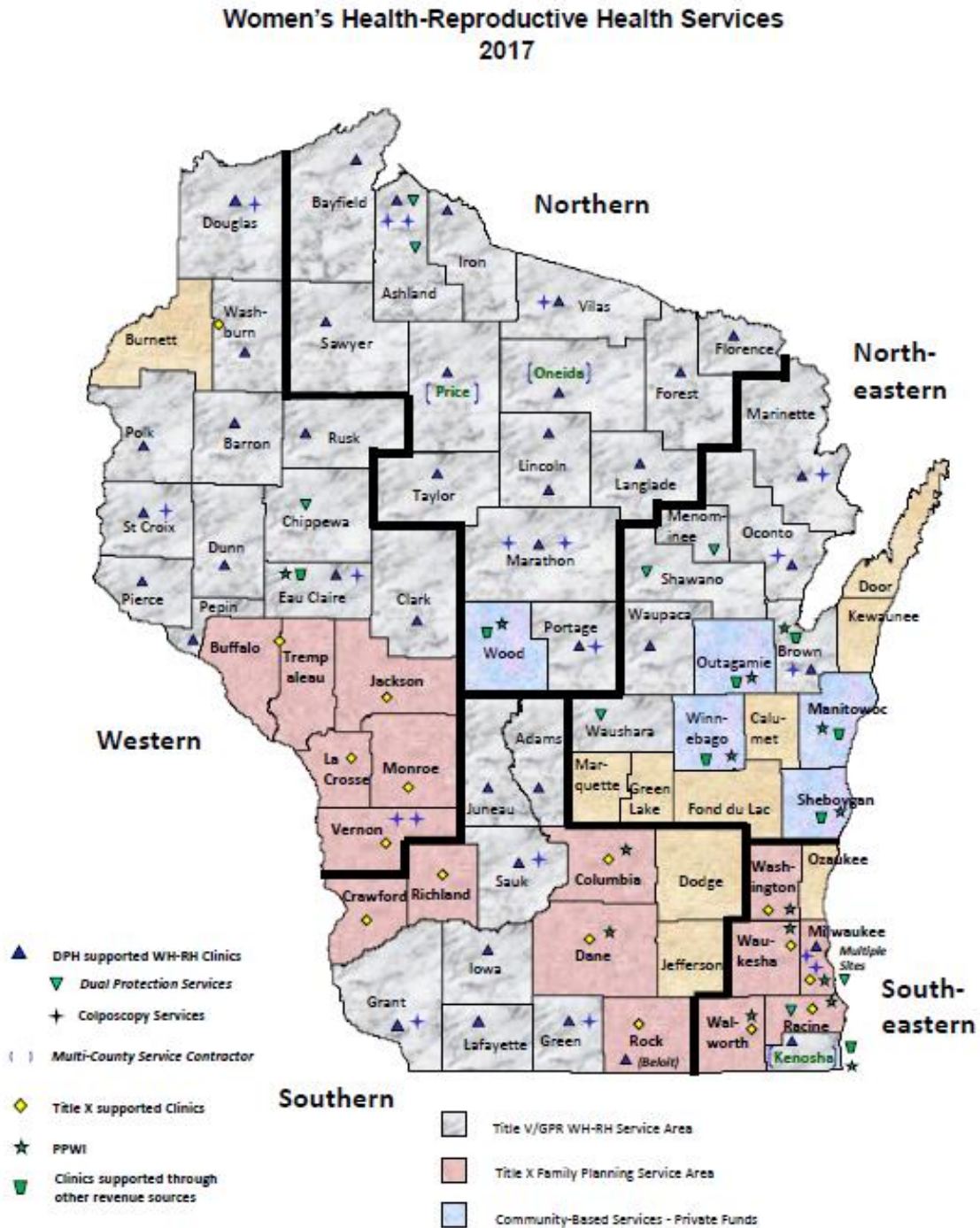
- Behavioral health/counseling
- Radiology and x-ray capabilities
- Surgical procedures
- Forensic exams (SANE)
- Abortion services

However, please note that the nurses may be excellent resources for your questions and will be able to refer to local services.

²⁸ (Health Care Education and Training Inc., 2016)

FP/RH Clinic Locations in Wisconsin

This map, provided by HCET, identifies RH services in Wisconsin. For a complete listing of all FP/RH clinics in each of the 72 counties, please see the [Directory of Services for Women, Children and Families](#).



Planned Parenthood Services in Wisconsin

The mission of Planned Parenthood of Wisconsin is to empower all individuals to manage their sexual and reproductive health through patient services, education, and advocacy.²⁹ Planned Parenthood offers comprehensive sexual and reproductive health services, including:³⁰

Wellness & Preventive Care	<ul style="list-style-type: none"> • Preventative Health Exams • Birth Control • Gynecological Exams (including infection evaluation and treatment) • Midlife Services
Reproductive Health Care	<ul style="list-style-type: none"> • Abortion Care (Madison & Milwaukee only) • Colposcopy (follow-up care for abnormal pap tests)
Labs & Tests	<ul style="list-style-type: none"> • Cancer Screenings (pap test, breast, and testicular exams) • Pregnancy Testing and Options • HIV Testing and Education • STD (Sexually Transmitted Disease) Education, Testing & Treatment
Vaccinations	<ul style="list-style-type: none"> • HPV (Human Papilloma Virus) Education, Screening and Vaccination
Male Services	<ul style="list-style-type: none"> • STD Education, Testing and Treatment • HIV Testing and Education • HPV Education, Screening and Vaccination • Reproductive and Sexual Health Care Education and Information

There are 21 Planned Parenthood health centers throughout Wisconsin.³¹ Two of their clinics (Madison and Milwaukee) represent two of only three abortion providers in Wisconsin (see: Abortion Services on page 11). To make an appointment at Planned Parenthood, call 1-800-230-PLAN to find the health center nearest you. You can also get honest and confidential information about sex and relationships by texting "safersex" to 69866.

Free Clinic Locations in Wisconsin

Additional medical services are provided by free (and income-based) clinics in communities across Wisconsin. You can find more information at [FreeClinics.com](https://www.freeclinics.com), an online directory of free and affordable health clinics. Most clinics listed in the database receive federal grants, state subsidies, or are owned and operated by non-profit organizations and provide services that are either free or at a reduced rate.

There are 135 clinics in the State of Wisconsin.

²⁹ (Planned Parenthood of Wisconsin, Inc., 2018a)

³⁰ (Planned Parenthood of Wisconsin, Inc., 2018b)

³¹ (Planned Parenthood, 2018a)

HOW TO ASSESS FOR HEALTH NEEDS

One finding that the Building Networks project confirmed is the importance of an established relationship with local medical providers, specifically FP/RH clinics, to make the needed referrals. While advocates generally don't "screen" victims, it is important for advocates to understand the medical needs of survivors in order to make appropriate referrals. Historically, sexual assault medical advocacy has focused on *immediate* health needs to make referrals for forensic evidence collection. While that is an important part of advocacy, it is not the only medical need survivors experience. Advocates should understand the *comprehensive* health needs of survivors when connecting them to services.

Tools

The following medical assessment tool was developed by WCASA and their partners in the Building Networks project. Below is a snapshot of what is provided in the tool. For the full document, please see: [Medical Assessment Tool for Sexual Assault Advocates](#).

This tool is intended to be used by programs who have already established relationships with their local FP/RH provider, as there are multiple opportunities for referrals to services. Because of the complex medical needs of survivors, it addresses five categories of health issues:

1. General health
2. Acute sexual assault
3. Sexual assault within the context of interpersonal violence
4. Ongoing health care needs
5. Past trauma/Adverse Childhood Experiences (ACEs)

Note on Minors

Advocates, by law, are not mandatory reporters. It is best practice to offer confidential services to minors. It is important to note that all medical personnel are mandatory reporters of sexual assault, which may impact their reporting decisions. Be sure to review mandatory reporting requirements for medical personnel during the decision-making process with the survivor. It is the advocate's job to ensure that minors know how to access confidential services, including medical services. Minors can access certain health care services confidentially, including testing for pregnancy and STIs. However, there are exceptions to this. For more information, see [WCASA's Mandatory Reporting InfoSheet](#).

General Health Assessment

To be asked during ALL intakes

Do you have any immediate health care needs or concerns?	
Do you have any immediate concerns related to your health as a result of the incident?	
YES:	Ask appropriate follow-up questions to assess needs and make referrals.
NO:	No further questions needed.

Advocates commonly assess for needs in relation to the incident but sometimes fail to assess for other health needs that could impact services. Possible health care needs could include diabetes, asthma, heart conditions, etc., which could be impacted by trauma and create emergency health care needs.

Acute Sexual Assault Assessment

To be asked when history indicates a “recent” assault

There are 3 important areas when working with a survivor who indicates a “recent” sexual assault – **forensic/medical care, pregnancy** and **STIs**. Please note that not all may be necessary for each victim depending on age, sex, type of assault, etc. Also, if there is already a plan to refer to a FP/RH clinic, emergency department, or SANE program, these questions will not be necessary; all should be addressed as part of those examinations.

OPTIONS IN FORENSIC/MEDICAL CARE:

You have options in seeking medical care and having a forensic examination. Let’s take some time to discuss all of them.

1.	Medical Exam Only
2.	Forensic/Medical Exam and Police Report
3.	Forensic/Medical Exam and No Police Report
4.	No Exam and No police report

Take the time to explore these options, particularly if the survivor is unsure. Make sure not to pressure the survivor into any option and offer your support and advocacy regardless of their decision.

Currently, SANE services are not offered in every county across the state. While forensic exams may be conducted in emergency departments, it is considered best practice to have those exams performed by a trained examiner. If there isn’t a SANE program in your area, you may want to explore where the nearest program is and arrange for transportation. For more information about the Wisconsin SANE Programs, please see the Department of Justice [Medical Forensics Program website](#).³²

³² (Wisconsin Department of Justice, 2018)

PREGNANCY CONCERNS:

Even though the chance of pregnancy may be low, sometimes it can be a worry, and that's normal. There is (free & confidential) testing available locally. If it is something you're worried about, we can talk about options. Is pregnancy a concern for you?

YES:	Refer to FP/RH provider for services. Resources to consider: <ul style="list-style-type: none">• Emergency contraception/EC* (available over-the-counter or by referral)• Pregnancy test (available over-the-counter or by referral)
NO:	Explore why to determine next steps: <ul style="list-style-type: none">• Possible reasons might include type of assault wouldn't cause pregnancy, current birth control use, already pregnant, other medical reasons, lack of understanding about pregnancy

STI/STI CONCERNS:

Even though the chances of contracting sexually transmitted diseases may be low, sometimes it can be a worry, and that's normal. There is (free & confidential) testing available locally, and resources for treatment if needed. Are STIs something you're worried about?

YES:	Refer to FP/RH provider for services. Resources to consider: <ul style="list-style-type: none">• Prophylactic regimen for preventive treatment of STIs• STI testing
NO:	Explore why to determine next steps: <ul style="list-style-type: none">• Possible reasons might include: type of assault wouldn't cause STI; use of condom during assault; lack of understanding about STIs

Sexual Assault in the Context of Intimate Partner Violence (IPV) Assessment

To be used in incidents of Intimate Partner Sexual Violence (IPSV)

It is important to understand the dynamics of SV in the context of IPV. Many victims of IPV will not identify with terms like rape and sexual assault in reference to their relationship with their partner. It also may be necessary to assess for SV multiple times when providing ongoing services to IPV victims, as they may not disclose the SV right away.

Has your partner destroyed or tampered with your birth control, refused to use birth control, or prevented you from using it?

Has your partner forced you to become pregnant when you didn't want to or to terminate a pregnancy that you didn't want to?

Does your partner make you have sex when you don't want to? Or are you afraid to say no when you don't want to have sex?

YES:	Follow-up with additional IPV services including safety planning, lethality assessment, shelter, and any other needs. <ul style="list-style-type: none">• If your agency does not provide these services, be sure to develop a response and referral process with your local DV provider.
NO:	No further questions.

Ongoing Health Care Needs

To be used in subsequent visits with survivor (nonacute)

While we don't expect advocates to be experts on health insurance, we are hoping you can identify referrals in your community to help. You can find more information about local health care resources at [HealthCare.gov](https://www.healthcare.gov).³³

Do you (or your children) have any health concerns or medical issues we should know about?

Are you (or your children) on any medication that we should be aware of?

YES:	Ask appropriate follow-up questions to assess needs and make referrals. <ul style="list-style-type: none">• Survivors may need help refilling prescriptions
NO:	No further questions.

Do you (and your children) have health insurance?

YES:	No further questions.
NO:	Ask appropriate follow-up questions and make referrals.

Past Trauma/Adverse Childhood Experiences

To be used in subsequent visits with survivor (nonacute)

³³ (U.S. Centers for Medicare & Medicaid Services, 2018)

The Adverse Childhood Experiences (ACE) screening was developed from a 1995 study. It is one of the largest investigations of childhood abuse and neglect and later-life health and well-being.³⁴ The screening involves asking 10 questions (as seen below), and a positive response for each question is 1 point. Those with a score of 0 have 0 adverse childhood events, as defined by the study; those with 10 have 10 different adverse childhood events, as defined by the study. For more information about what an ACE score means, please see this resource from [ACESTooHigh](#).³⁵

The ACE Assessment is not always appropriate to discuss with survivors, particularly immediately after an assault or in the early stage in your relationship. Furthermore, an ACE assessment can be triggering and some studies have shown that they should not be done unless there are behavioral health specialists available for follow up. Work with your local community partners, including the FP/RH clinics, to decide what works best for your community.

10 Question ACE Assessment
<p><i>Did a parent or other adult in the household often or very often...</i> Swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?</p>
<p><i>Did a parent or other adult in the household often or very often...</i> Push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?</p>
<p><i>Did an adult or person at least 5 years older than you ever...</i> Touch or fondle you or have you touch their body in a sexual way? Attempt or have oral, anal, or vaginal intercourse with you?</p>
<p><i>Did you often or very often feel that...</i> No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?</p>
<p><i>Did you often or very often feel that...</i> You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?</p>
<p><i>Was your parent...</i> Often or very often pushed, grabbed, slapped, or had something thrown at them? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?</p>

³⁴ (Centers for Disease Control and Prevention, 2016)

³⁵ (Aces Too High, 2018)

<i>Were your parents ever separated or divorced?</i>
<i>Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?</i>
<i>Was a household member depressed or mentally ill, or did a household member attempt suicide?</i>
<i>Did a household member go to prison?</i>

Knowledge about ACEs should not be used as a diagnosis. While the relationship between ACEs and negative outcomes are causal, they are not definite or unchangeable. Instead, understanding trauma history throughout the lifespan can be helpful both for survivors and service providers to identify needs and recognize trauma responses. While many understand the impact that trauma has on immediate mental health and wellness, we sometimes miss the potential for long-term impact on physical health. ACEs help us understand these linkages and offer opportunities for earlier intervention to prevent negative outcomes for survivors.

CREATING RELATIONSHIPS

Experience and research have shown that when systems that serve victims collaborate, the experience for the victim is improved. Advocates are the sole service provider in place to help victims walk through the entire aftermath of an assault, whether that includes interacting with the health care system and/or criminal justice system. When an advocate has strong relationships and understanding with these systems in their community, the victim benefits and is more at-ease.

One of the strongest examples of collaboration is known as a multi-disciplinary team (MDT). A MDT is a group of professionals from diverse disciplines who come together to provide comprehensive assessment of gender-based violence and the community's response to it. The two most common types of MDTs that respond to sexual violence in Wisconsin are Sexual Assault Response Teams (SARTs) and Coordinated Community Response teams (CCRs). It is from their guidebooks and protocols that the following sections on collaboration processes come.

FP/RH providers are often left out of MDTs. SARTs are often criminal justice focused and typically have four disciplines that make up the core team: law enforcement, prosecution, SANE, and community-based advocates. CCRs are much broader and depending on community needs can involve various sectors, including but not limited to schools, clergy, other health care professionals, and community members. SASPs can support FP/RH provider access to MDTs, which can help in meeting the medical needs of survivors and filling health care gaps in communities.

Language of Collaboration

According to the Fieldstone Alliance, collaboration is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone."³⁶ This relationship includes commitment to mutual relationships and goals, a jointly developed structure and shared responsibility, mutual authority and accountability for success, and sharing of resources and awards.

In an effective collaboration, members are committed as much to the common collaborative objectives as they are to their own organizational goals. As a result of a successful collaboration, services for victims are coordinated and improved, and both advocacy and FP/RH clinics can respond more effectively with new expertise developed through the process.

Initial Set Up

If there is no existing relationship, the first step is to have an introductory face-to-face meeting to get to know each other, the agencies, and each other's work. The initial conversation between agencies does not have to be a formal event. Each agency should share information that is public record but that helps in understanding its challenges and opportunities. The Building Networks pilot project highlighted key areas that are important for this initial discussion around partnering:

³⁶ (Mattessich, Murray-Close, & Monsey, 2001)

1. Organizational structure
2. Location
3. Resources
4. Services offered (to individuals and the community)
5. Community activities that each agency participates in

As the relationship develops, other key elements to a strong partnership come into play. The following sections address these elements.

Shared Goals or Purpose

The purpose is the ultimate result that the partnership desires. It is important to establish a solid, mutual purpose to build the foundation of the relationship and to ensure that all agree and are committed. SASPs and FP/RH providers, while offering different services, have shared values related to survivor/patient-centered care. This can provide the basis for a relationship and lead to the development of shared goals about survivor/patient health and safety.

Clearly Defined Roles & Responsibilities

Having a clear understanding of what services the other can and cannot provide is critical. Both agencies are there for the victim in different capacities. A good partnership includes recognizing each other's specialty area and ensuring utilization of unique expertise. The partnership should be built on mutual respect for each other's roles.

Collaboration Tip

One way partners can learn more about their roles and responsibilities is to walk through case examples. For instance, the FP/RH provider can share their process for assessment and referral for sexual violence; similarly, advocates can walk through their process. Not only is this a good way to learn more about each other's work, it can help you identify other opportunities for collaboration like training, shared resources, etc.

Steps to Partnership Sustainability

During the Building Networks Project, the initial feedback received from both the FP/RH clinics and SASPs was that when a partnership existed, it was often based on individual relationships: "I know a nurse at the clinic, so I refer there all the time." Unfortunately, this creates a fragile, unsustainable partnership that can end based on changes in employees: "I used to know someone at the advocacy agency, but since she left, I haven't been in touch with them."

The Building Networks Project found that stronger, more sustainable partnership includes:

1. A Memorandum of Understanding (MOU) confirming the partnership between agencies at the organizational level
2. A policy outlining how each agency will fulfill their responsibilities in the MOU
3. A set of procedures describing the specific actions that meet the policy

Memorandum of Understanding

A MOU is a document signed by two or more parties that outlines the agreement between those parties. MOUs are used to create guidelines for each party as they contribute their efforts and resources toward important projects. MOUs are less formal than contracts in that they are not legally binding, and they typically include fewer details and complexities, but they are more formal than handshake agreements. MOUs can have no ending date or can specify being reviewed and reauthorized in a given rotation. Futures Without Violence developed [this sample MOU](#) that can be used as a starting point.³⁷

Key points to include in a MOU are:

- Purpose of having a MOU
- Description of services you will provide
- How cases will be processed (or not processed) internally
- Process of referral from your agency to others
- How and what information will be exchanged
- Frequency with which exchange of information will occur
- How confidentiality of victims will be addressed
- Length of time the MOU will be in effect
- How and when evaluation of its effectiveness will be reviewed (if you are trying something new, evaluate it in 4-6 months to allow room for “tweaking”)

Depending on the issues, establishing parameters for a partnership can be a time-intensive process that includes various stages of negotiation and compromise. Be patient!

Policy

Once agreement between agencies is completed via MOU, each agency should develop a policy outlining their role in meeting the MOU agreement.

The policy should be created and approved following the guidelines of the agency. The policy must describe how the organization intends to provide services, actions, or business in a way that meets the agreement made in the MOU. The policy provides a set of guiding principles to help with future decision-making.

Procedure

Articulating procedure follows policy development. Procedures describe specifically how the policy will be carried out. It is ideal for the procedure to be inserted into the employee manual. Procedures generally include:

- Who will do what tasks
- What steps are required for each task
- Which forms or documents to use
- What documentation is required
- How the impact of the policy/procedures will be determined

³⁷ (Futures Without Violence, 2018)

Training

At the beginning of the partnership, all staff at each agency need to be trained. Adequate training will assure that the partnership is carried out properly and the “No Wrong Door” philosophy for services is achieved.

Initial training should include:

- Why and how the partnership developed
- The MOU, policies, and procedures
- Overview of core services provided by each agency
- Forms used for communication between agencies
- Forms used for documentation of referral and follow-up
- How the partnership is sustained
- Intended outcomes and how they will be evaluated

Training should then be incorporated into new staff training for all positions. In-person introductions of new staff to partner agency staff adds to the comfort not only in making referrals but in the quality of care that will be received.

Collaboration Tip

Regular cross-training is important for FP/RH and SASP partners to increase their capacity and maintain their relationship. Communities that have been successful at this have made it a regular part of their annual training schedule.

It is up to you to determine what works best for your partnership. The important part is that it is formalized process that isn't solely dependent on the relationships of individual staff.

IMPORTANT CONSIDERATIONS

Reproductive Justice

To understand reproductive justice, one must first have a clear understanding of reproductive rights. "The reproductive rights framework has historically focused on protecting everyone's legal rights to abortion and contraception, and their freedom to make reproductive choices."³⁸

Recognizing the movement at the time centered middle- and upper-class White women, a group of Black women coined the term in June of 1994 to be more inclusive of women of color, and other marginalized women and trans people.

Reproductive justice places reproductive rights in a social framework. "Reproductive justice gives voice to poor women, women of color, incarcerated women, immigrant women, female youth, women with disabilities and other women and girls on the margins who have been subject to reproductive coercion and discrimination."³⁹

SisterSong, the largest national multi-ethnic reproductive justice collective, defines the movement as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities (*SisterSong, Inc.*).

A reproductive justice framework should be core to sexual assault services, as it is based on the full achievement and protection of human rights. It also acknowledges the inequality that exists in communities, specifically for people of color. An important piece of this for advocates is an understanding of the historical context in which people of color have experienced health services. There is a long history of poor and discriminatory practices that marginalized communities have experienced and this legacy is passed down each generation. Victims from these communities may have a hard time trusting clinicians – and advocates – for good reason. Understanding this historical context is the first step advocates and clinicians can take in building relationships and trust.

Culturally Responsive Care

With the U.S. continuing to change dramatically and become more diverse, it is more important than ever to provide services in ways that reflect the complexities of the communities we serve. In fact, by 2050, non-Hispanic whites will comprise only 50% of our total population.⁴⁰

Reproductive Justice is...

...the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights.

The Reproductive Justice framework 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.

Ross, 2011

³⁸ (Gilliam, Neustadt, & Gordon, 2009)

³⁹ (Gilliam, Neustadt, & Gordon, 2009)

⁴⁰ (Office of Justice Programs, 2011)

Practicing cultural humility is a lifelong endeavor. What can be challenging is there is not a prescriptive, step-by-step way that guarantees someone is doing a good job. A lot of the work is about self-reflection, honesty about one's own limitations and biases, and being uncomfortable. It is a continuous learning process built on the foundation of keeping an open mind and recognizing that you are not the expert in someone else's culture and therefore you are always learning.

It is important to recognize the culture that health care and advocacy is a part of. As is noted on the website "Dimensions of Culture":⁴¹

- Everyone has a culture.
- There is an American medical culture and it is very different from many of the cultures that our patients and their families come from.
- We need to understand where our American medical culture differs from other cultures in significant ways that impact communication and influence health outcomes for patients.
- Resistance to cultural difference is part of being human, and reactions to cultural difference are automatic, often subconscious, and can have strong influence on the patient-provider relationship.
- A provider's culture is influenced by their own personal values and beliefs, as well as those of the western medical culture.
- A provider's ability to communicate effectively in cross-cultural interactions is greatly enhanced by their grasp of cross-cultural communication skills.
- Culturally sensitive care requires a broad understanding of how culture affects health beliefs and behaviors.
- Providing linguistically appropriate care requires being able to assess the need for interpreters in the clinical setting and interact with interpreters effectively.

Exercises in Self Reflection

Identify your own cultural and family beliefs and values.

Define your own personal culture/identity: ethnicity, age, experience, education, socio-economic status, gender, sexual orientation, religion...

Are you aware of your personal biases and assumptions about people with different values than yours?

Challenge yourself in identifying your own values as the "norm."

Describe a time when you became aware of being different from other people.

Fletcher, 2007

These important points are not only applicable to the health care community, but any service agency working with clients.

Perhaps the most critical point to remember here is that culture does not only refer to someone's ethnicity or race. Culture refers to "integrated patterns of human behavior" including "thought, communication, language, beliefs, values, practices, customs, courtesies, rituals, roles, and relationships."⁴² Do not make assumptions about someone's culture.

Remember, victims come from all walks of life and experience different levels and types of barriers in seeking services, whether advocacy or health care. As both advocates and clinicians do their best to provide the same quality of services to all victims, it's important

⁴¹ (Carteret, 2010)

⁴² (Pires, 2002)

to keep in mind that access can be complicated by things like geographic isolation, language barriers, cultural intolerance, disability, lack of social support, and mistrust.⁴³

Service providers who are doing their best to be culturally responsive have done so by:⁴⁴

- Collaborating with formal and informal support networks within diverse communities
- Getting to know the full community through outreach
- Allocating sufficient fiscal resources to meet the unique needs of diverse populations
- Having clearly written and consistently implemented policies that address multicultural populations
- Collecting and analyzing data in the service area and continuing to do this periodically

LGBTQ Survivors

It is also important to remember that not all survivors who have reproductive health care needs are cisgender women, and not all identify as heterosexual. A great resource for more information on the barriers and other issues to be aware of when assisting lesbian, gay, bisexual, transgender, and non-binary survivors is the National LGBTQ Task Force's [Queering Reproductive Justice Toolkit](#).⁴⁵

The toolkit explains that gendered language and assumptions that reproductive health is a "woman's issue" prioritizes cisgender women and can lead to patients not receiving the medical care they need. Transgender men, gender nonconforming, and intersex people can also get pregnant, but due to widespread ignorance of LGBTQ health needs, many receive inadequate reproductive health care.⁴⁵

Advocating for LGBTQ Survivors

As advocates, it is important that we identify and correct these beliefs and practices where we see them, especially when they appear in our own work: the lives of transgender, nonconforming, and intersex people depend on it.

National LGBTQ Task Force, 2017

The toolkit suggests that, "Instead of relying on the vague categories of sex, we can use language that actually describes the physical or social condition at hand. For example, 'people who can get pregnant' instead of 'female' in the context of birth control, or 'individuals at risk for prostate cancer' instead of 'males.' Doing so not only avoids reinforcing the belief that sex is a self-apparent, biological category, but it also encourages us to use language that is more precise."⁴⁵

Advocates must understand equitable access to reproductive healthcare. LGBTQ+ people, especially transgender and nonbinary people, may not have access to culturally informative and affirming healthcare, let alone reproductive healthcare. Many medical professionals have not received training on healthcare for transgender and nonbinary people, which includes gender-affirming hormone therapy (GHT) and gender affirmation surgeries. Access to GHT is a part of bodily autonomy and an integral part of transgender affirming healthcare. GHT can be inaccessible for a lot of people because of complications with healthcare and cost. Planned Parenthood offers GHT at a few of their clinics, click [here](#) for more information.

⁴³ (Office of Justice Programs, 2011)

⁴⁴ (Office of Justice Programs, 2011)

⁴⁵ (National LGBTQ Task Force, 2017)

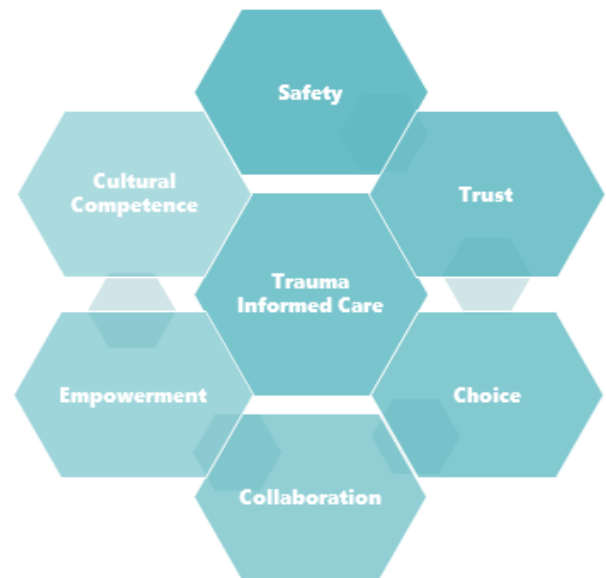
Trauma Informed Practices

Trauma Informed Care (TIC) has become something of a buzzword. Unfortunately, it is commonly used without a shared understanding of what it truly means when it comes to providing services.

At its core, a trauma-informed approach to caring for victims means that advocates and clinicians “integrate an understanding of a survivor’s history and the entire context of their experience” into the way they interact and provide services.⁴⁶ Trauma informed care puts the survivor’s strengths at the center of the services.

Trauma informed services have 6 basic elements that are “applied to all activities and interactions with agency clients and with agency workers.”⁴⁷

The following section was taken from the NSVRC guide on trauma-informed practices called [Building Cultures of Care](#).⁴⁸



Safety

Safety encompasses both physical and emotional safety. Address the following questions to ensure that programs are providing safety:

Safety & Survivors

- Where and when are services delivered? In the office, agency, home, or community? What safety considerations are important in the location of various services?
- What signs and other visual materials are there? Are they welcoming? Clear? Legible?
- How would you describe the reception and waiting areas, interview rooms, etc.? Are they comforting and inviting?
- Are survivors provided with clear explanations and information about each step and procedure?
- Does each contact conclude with information about what comes next?
- What events have occurred that indicate lack of safety — physically or emotionally? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of them happening again?
- Are staff attentive to signs of survivor discomfort or unease? Do they understand these signs in a trauma-informed way?

⁴⁶ (The National Sexual Assault Coalition Resource and The National Sexual Violence Resource Center, 2013)

⁴⁷ (The National Sexual Assault Coalition Resource and The National Sexual Violence Resource Center, 2013)

⁴⁸ (Sexual Assault Demonstration Initiative, 2013)

Safety & Staff

- Do staff members feel physically safe? Do staff members provide services in locations other than the office? If so, what safety considerations are important?
- Do staff members feel emotionally safe? In relationships with administrators and supervisors, do staff members feel supported?
- Do staff members feel comfortable bringing their concerns, vulnerabilities, and emotional responses to survivor care to team meetings, supervision sessions, or a supervisor?

Trust

Trust & Survivors

- Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?
- How does the program handle role clarity and accomplishing multiple tasks? (e.g., especially in counseling or case management where there are significant possibilities for more personal and less professional relationships)
- What is involved in the informed consent process? Is both the information provided and consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the survivor have a genuine choice to withhold consent or give partial consent?

Trust & Staff

- Do program directors and supervisors have an understanding of the work of direct-care staff? Is there an understanding of the emotional impact of direct care? How is this communicated?
- Is self-care encouraged and supported with policy and practice?
- Do program directors and supervisors make their expectations of staff clear? Are these consistent and fair for all staff positions, including support staff?
- Do program directors and supervisors make specific plans for program implementation and changes clear? Is there consistent follow through on announced plans?

Choice

Choice & Survivors

- How much choice does each survivor have over what services they receive?
- Does the survivor choose how contact is made?
- Does the program build small choices to make a difference to survivors? (e.g., When would you like me to call? Is this the best number for you? What other ways would you like me to reach you or would you prefer to get in touch with me?)
- Does the survivor have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Choice & Staff

- Is there a balance of autonomy and clear guidelines in performing job duties? Is there attention paid to ways in which staff members can make choices in how they meet job requirements?

- Are staff members given the opportunity to have meaningful input into factors affecting their work: size and diversity of caseload, hours and flex-time, when to take vacation or other leave, kinds of training that are offered, approaches to care, location, and décor of office space?

Collaboration

Collaboration & Survivors

- Do survivors have a significant role in planning and evaluating the program's services? How is this "built in" to the agency's activities?
- Do staff communicate respect for the survivor's life experiences and history, allowing the survivor to place them in context (recognizing survivor strengths and skills)?
- Are survivors involved at service planning meetings? Are their priorities sought and validated in formulating the plan?
- Does the program cultivate a model of doing "with" rather than "to" or "for" survivors?

Collaboration & Staff

- Does the agency have a thoughtful and planned response to implementing change that encourages collaboration among staff at all levels?
- Are staff members encouraged to provide feedback and ideas to their team and the larger agency?
- Do program directors and supervisors communicate that staff members' opinions are valued even if they are not always implemented?

Empowerment

Empowerment & Survivors

- In routine service provision, how are each survivor's strengths and skills recognized?
- Does the program communicate a sense of realistic optimism about the capacity of survivors to reach their goals?
- Does the program foster the involvement of survivors in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?
- For each contact, how can the survivor feel validated and affirmed?

Empowerment & Staff

- Are each staff member's strengths and skills used to provide the best quality of care to survivors and a high degree of job satisfaction to that staff member?
- Are staff members offered development, training, or other support opportunities to assist with work-related challenges or difficulties? To build on staff skills and abilities? To further their career goals?
- Do all staff members receive annual training in areas related to trauma, including the impact of workplace stressors?

Cultural Competency

Cultural Competency & Survivors

- In routine services, how is the cultural competence of the services provided assessed?

- Is the agency structure, location, design, and décor representative of the communities that it serves?
- Are services available in the preferred language of survivors?
- Are there culturally specific programs that work in the community? Is there a partnership with them?
- Is the intake paperwork inclusive of transgender and nonbinary survivors?

Cultural Competency & Staff

- Do staff members receive ongoing training and supervision on cultural competency?
- Does the program work with partnering agencies that have expertise in or experience working with different cultures for ongoing training and consultation?
- Does the program respect and observe a variety of religious and spiritual holidays?
- Is there diversity in staff representation at all levels of the agency?
- Does the program provide ongoing opportunities for staff to share their cultures with each other (e.g., potlucks, incorporating different types of art and music)?

Comprehensive Sexual Education

Comprehensive sexual education are evidence-based school programs (kindergarten through high school) that cover the topics of:⁴⁹

- Human Development (including reproduction, puberty, sexual orientation, and gender identity)
- Relationships (including families, friendships, romantic relationships, and dating)
- Personal Skills (including communication, negotiation, and decision-making)
- Sexual Behavior (including abstinence and sexuality throughout life)
- Sexual Health (including sexually transmitted infections, contraception, and pregnancy)
- Society and Culture (including gender roles, diversity, and sexuality in the media)

Comprehensive sex education’s components that focus on promoting healthy relationship skills, gender roles, and sexuality are critical to instilling counter-messages to rape culture and victim-blaming from an early age. People should be able to see themselves in the education; therefore, should be inclusive of LGBTQ+ people and disabled people. Comprehensive sex education is a true partnership between reproductive health and sexual assault advocacy.

Spotting Crisis Pregnancy Centers (CPCs)

CPCs are anti-choice organizations that do not offer comprehensive healthcare, yet say they do.

According to Planned Parenthood, CPCs often:⁵⁰

- Are not staffed by doctors, nurses, ultrasound techs, or any other real health care professionals.
- Say that abortion causes breast cancer, sterility, and long-term psychological damage (which are false claims).

⁴⁹ (Planned Parenthood, 2017)

⁵⁰ (Planned Parenthood, 2014)

- Provide misleading information about the side effects and failure rates of birth control and condoms.
- Use manipulative tactics to get people who are pregnant to delay real counseling or medical care until it's too late for a legal abortion.
- Subject people to religious and ideological propaganda against abortion, birth control, condoms, and/or sexual activity instead of giving non-biased, factual information about their sexual health.
- Set up shop very close to legitimate reproductive health centers hoping to confuse patients.

While some CPCs may provide appropriate support and information on unintended pregnancies, some not only intentionally misinform but “force women to watch anti-abortion films, slide-shows, photographs, and hear biased lectures.”⁵¹ The easiest way to spot a CPC from a real reproductive health service agency is to call and inquire about their services. If they do not provide comprehensive services – specifically birth control, STI testing, condoms, abortion referrals – they are most likely a CPC.⁵² Often, they may not give the specifics of their services over the phone and instead require an in-person visit (another warning flag). For CPC locations in Wisconsin, please see [this list](#).

Services to Minors

In Wisconsin, minors are defined as anyone under the age of 18. Wisconsin law does not list sexual assault advocates as mandatory reporters. For more information about Mandatory Reporting, please see the [WCASA InfoSheet](#). Providing services to minors can be challenging as state statutes on privilege and confidentiality can look different for this group; funding requirements may also impact privilege and confidentiality. It is important to have agency policies that reflect the law and clearly state agency practices. Confidentiality is vital for advocates to be able to offer options and maintain survivor decision-making authority – including for minors.

Wisconsin state law protects minors’ rights to accessing confidential sexual and reproductive health care.⁵³ This includes services such as:

- Contraception
- Any pregnancy-related care including pregnancy tests and prenatal care
- STI testing and treatment
- HIV testing and treatment

However, advocates should know that confidentiality may be broken if:⁵⁴

- The minor waives confidentiality
- The minor is on their parent or guardian’s insurance as information may show up on the bill
- The provider is concerned about the minor’s safety

⁵¹ (NARAL Pro-Choice America, 2017)

⁵² (Planned Parenthood, 2014)

⁵³ (Wisconsin Adolescent Health Care Communication Program, 2013)

⁵⁴ (Wisconsin Adolescent Health Care Communication Program, 2013)

This last point is especially important as it encompasses *any sexual contact that was not voluntary* (in other words: sexual assault). This is *not* to say that minors should avoid accessing health care, but to emphasize that minors should know that if they tell a health care provider about a sexual assault, medical providers are required by law to report it. Advocates should be clear about any limitations to confidential services when referring a victim for health care.

As previously mentioned, minors cannot get an abortion confidentially (see: Abortion Services, p11).

CLOSING

Sexual assault survivors have diverse medical needs. While efforts in sexual assault advocacy have focused primarily on the immediate needs after an assault – specifically, forensic medical exams – it is important for advocates to develop services to meet the comprehensive medical needs of survivors. This tool was developed to help advocates learn more about reproductive health services in the state to better serve survivors.

Access to reproductive health services is impacted by provider beliefs and values. As with all SASP services, it is not the role of an advocate to make value-based judgments about the decisions survivors make. This is particularly important when supporting survivors through medical decisions – including accessing birth control, emergency contraception, or abortion. To support access and minimize barriers, SASPs should take proactive steps, including the following:

- Be clear about agency philosophy related to reproductive access and choice
- Discuss personal values and their potential impact on service delivery
- Identify providers that offer comprehensive reproductive health services
- Develop relationships with providers, including procedures for referrals and services
- Include resources for comprehensive medical services in victim packets
- Educate staff on the reproductive health needs of survivors
- Be aware of legislative actions that limit access and choice for survivors

Medical issues for survivors are complex and can be challenging for advocates to address for many reasons. For one, medical systems and services are complicated. Advocates are not expected to be experts on things like medical insurance, hospital procedures, or billing, but they can develop relationships with community partners to help survivors navigate these complicated systems. Ultimately, the role of the advocate related to reproductive health care and access is similar to the role they play in other systems. SASPs need to identify these services as a core need for survivors and prioritize efforts to develop and enhance these services.

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