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INSIDE

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With Domestic Violence Increasing, Family Planning Providers Should Screen for Signs

By Melinda Young

Recent research suggests domestic violence may be increasing during the COVID-19 pandemic. Family planning clinics will need creative techniques to screen for signs as many visits continue through telehealth.

"These actions during COVID-19 of physical distancing, sheltering in place, and others have dramatically increased the risk for violence across the globe," says **Nelia Viveiros**, LLB, EdD, vice chancellor for diversity, equity, and inclusion at the University of Colorado Denver Anschutz Medical Campus.

> "THESE ACTIONS DURING COVID-19 OF PHYSICAL DISTANCING, SHELTERING IN PLACE, AND OTHERS HAVE DRAMATICALLY INCREASED THE RISK FOR VIOLENCE ACROSS THE GLOBE."

Family planning clinicians still have an opportunity to help women affected by intimate partner violence (IPV), but during the pandemic, these provider-patient encounters often take place through telemedicine, making screening trickier.

One technique is to give women ways to change the topic or get off the phone quickly if an abusive partner enters the room when the patient is on a telehealth call, says **Catherine Kaukinen**, PhD, professor and chair of criminal justice and co-lead of the

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Violence Against Women Cluster at the University of Central Florida.

"If your partner comes in, pretend this is the U.S. Census or pretend we're a telemarketer and drop off the phone very quickly," Kaukinen suggests. "They can say, 'We're going to talk about some sensitive issues and whether these apply to you.'"

Then, tell the woman to give them a safe word to change the topic if the call suddenly seems dangerous because the abuser enters the room or becomes suspicious.

"Family planning providers should be able to switch quickly and talk about the gynecological exam," Kaukinen says. "Quickly and nimbly get off that topic."

Clinicians should acknowledge that with telehealth, the patient's partner could be there, listening, she adds.

Although research is ongoing and definite conclusions are not yet available, early indications are that domestic violence hotlines saw an increase in calls during the lockdown period of March and April 2020, says **Jhumka Gupta**, ScD, associate professor in the department of global and community health at George Mason University in Fairfax, VA. Increases in hotline calls occurred both in the United States and globally, she notes.

In New York City, domestic violence hotline calls increased by 30% in April 2020 when compared with April 2019, Viveiros says. *(More information is available at: https://on.ny.gov/3c3hoyA.)* People being abused in their homes might not even be able to call a hotline because they are being watched more closely by their abusers.

"Regardless of whether women call the hotline or not, there's this idea that the pandemic, the lockdown, and the aftermath can increase vulnerability to violence, as well as exacerbate existing violence, for various reasons," Gupta says. *(See a list of reasons domestic violence is on rise in this issue.)*

Researchers note even national leaders' disparaging comments about women create an environment that condones or tolerates domestic violence. For instance, the authors of a recent study noted name-calling comments about women, such as when President Trump called the Michigan governor "Gretchen 'half' Whitmer," create a climate of hostility and negativity toward women.[1] Other study results revealed the pandemic's effect on the risk of IPV is likely to affect vulnerable populations, including minority women and those with histories of victimization and mental health issues.[2]

EXECUTIVE SUMMARY

Emerging research suggests a wave of increased domestic violence accompanying the pandemic and its stay-at-home restrictions.

- Family planning providers can help women affected by intimate partner violence by screening them at in-person visits and telehealth visits.
- Domestic violence hotlines saw increases in calls in April 2020, compared with April 2019.
- The increase in domestic violence has particularly affected vulnerable populations, including minority women.

"My research, going on right now, is mostly with Latina immigrant women with low income, who have been facing fear for a long time now," Gupta says. "It's the pandemic on top of ongoing fear of violence against their communities, increased surveillance against their communities, and this affects their ability to get help."

Family planning providers should not forget these vulnerable populations and the potential of IPV. "There has been so much anti-immigrant sentiment targeting immigrant women, they just don't want to go to the authorities right now out of fear of being targeted," Gupta explains. "Any service provider who is working with this community should be able to say to the women, 'This information is not going to be shared with immigration authorities,' and reassure them that it is confidential."

Also, pandemic-enhanced stressors, such as high male unemployment and homeschooling of children, contribute to the problem.[2]

The pandemic's quarantine has meant that many survivors of IPV have had to shelter in place with their abusers, says **Eva PenzeyMoog**, designer and founder of The Inclusive Safety Project of Chicago. The project's goal is to end technology-facilitated domestic violence.

"This proximity gives abusers so many more ways to enact control, while the survivor has less access to their usual support networks," PenzeyMoog says. "We know that shelters and hotlines have seen a notable increase in the number of people reaching out for help."

A domestic violence disaster-response protocol needs to include technology, according to the authors of a recent study. The authors also recommend victims and those supporting them encourage use of the One Love app, which includes a danger checklist and validates their experience of abuse.[3]

Family planning providers can continue to screen patients for IPV, but now these screening sessions might take place virtually or through telehealth visits. This will require more creativity from providers, as direct and private screening questions might not be possible during a video or audio counseling session between patients and clinicians. *(See story in this issue on ways to make screening safe through telehealth visits.)*

"What we're learning more and more is that, especially during telehealth visits, screening that asks someone directly, 'Are you experiencing violence in your home?' might not be the best way to go because of safety and privacy concerns," Gupta says.

A safer approach is not to ask women to disclose their IPV status, but to give them information and resources. "That is way more normalizing it," Gupta explains. "You're not putting a woman in a difficult position to answer that question if her partner is nearby." Also, if the woman is not experiencing intimate partner violence, she can share the information with someone else, she adds.

Results of a recent study revealed police departments in one province of China reported three times more situations of IPV than before the outbreak. Some domestic partners used physical distancing measures to further isolate women from resources that could help them. In the United Kingdom, one project that tracked violence found deaths from domestic abuse had more than doubled in March and April 2020, compared with the average rate previously.[4]

"Intimate partner violence is an issue, pandemic or not," Gupta says. "But it can be exacerbated in the pandemic."

The pandemic can be used as weapon by violent partners. "Rather than physically assaulting female partners, they might use emotional abuse, threatening to kill a pet, or threatening to take custody of a child," Kaukinen explains. "If a woman works in a grocery store or an essential industry and is daily exposed to COVID, the male partner might use that in a divorce, saying he will have the court give him custody."

Or the partner might threaten to take the child to a party or some other crowded place without a mask. "COVID could be used as a tool to terrorize and frighten an emotionally abused current partner or separated partner," Kaukinen says.

Healthcare providers should start a discussion with IPV patients about safety planning and de-escalating violence. "They could tailor that message to a pandemic situation," Gupta says. "Women could have a code word to use with family and friends in case they need help right away. Or they could think about having women familiarize themselves with the types of safety services that are available so they have that information in case there is an escalation."

Family planning providers should keep in mind that screening patients for IPV is not a one-and-done action.

"Maybe there are patients they've already screened once, and then they have an assumption that we cleared her last time," Kaukinen says. "You have to find dynamic ways to reach out to women and protect their safety." ■

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Chief Reasons Domestic Violence Is Increasing

Pandemic conditions contribute

Pandemics, economic recessions, natural disasters, and other crises can lead to increases in intimate partner violence (IPV) or domestic violence for a variety of reasons.

Women and children are particularly vulnerable when disasters such as COVID-19 strike. These are some reasons why this occurs:

• More time spent at home. The COVID-19 pandemic led to a worldwide shutdown of businesses and activities. The United States and other countries asked people to stay home whenever possible. This shutdown slowed the spread of COVID-19, but also made life more dangerous for women who are abused by their intimate partners.

Women were in their homes with partners who might be abusive for longer periods and who now had more opportunities for violence, says **Jhumka Gupta**, ScD, associate professor in the department of global and community health at George Mason University in Fairfax, VA.

• Family financial stress. The pandemic resulted in millions of lost jobs in the first half of 2020. Although some government programs helped beleaguered families, many people lost income. Also, the imbalance of wage-earning could cause stress and violence among intimate partners. "There might be economic abuse against women," Gupta says. "If a woman still has an income, while the man does not, then that can also increase vulnerability to violence."

• Increased isolation. "There's also the idea that more isolation occurs during the pandemic," Gupta says. "Isolation is something that an abusive partner uses as an effective tool to keep women away from family and friends."

During the pandemic, the partner does not have to work as hard to keep the abused woman from meeting with family members or friends who might notice bruises or hear about the abuse, she adds.

• Scaled-back support services. "At the beginning of the pandemic, a lot of services for domestic violence had to pivot, so there might be a lag," Gupta notes.

Even family planning clinics and other healthcare providers reduced or stopped in-person visits. Clinicians' eyes were not on women who might be experiencing domestic violence.

"So often, the healthcare provider might be the only person out there who has access to the woman. With the pandemic, there was a scaling back of resources in the healthcare setting," Gupta explains. "They were overwhelmed." ■

Safely Screen Patients for Intimate Partner Violence During Telehealth Visits

Screening patients for intimate partner violence (IPV) when clinician-patient encounters take place remotely is challenging. *Contraceptive Technology Update* (*CTU*) asked IPV researcher **Eva PenzeyMoog**, designer and founder of The Inclusive Safety Project of Chicago, about technology's dangers and drawbacks and how family planning centers could continue to screen and help patients as the COVID-19 pandemic continues to disrupt the usual patient-provider visits.

CTU: *How can family planning physicians, nurses, and other providers use technology to screen and help patients experiencing IPV? For example, how could they safely screen patients via telemedicine or a video call?*

PenzeyMoog: It's really important for doctors and nurses to understand the various ways the tech they're using might be infiltrated by an abuser, as well as to remember the abuser might simply be in the same room or listening at the door.

In terms of getting around an abuser in the room, one thing that doctors can do is suggest the patient use headphones so they can ask the screening questions about intimate partner violence and the survivor can give one-word answers that don't reveal the actual nature of the conversation.

"ONE THING PHYSICIANS CAN DO NOW IS DO THEIR BEST TO THINK ABOUT THE WORST POSSIBLE OUTCOME: THAT AN ABUSER IS WATCHING THE APPOINTMENT THROUGH SPYWARE."

It's important to think of the absolute worst scenarios and plan for it. If I were the doctor, I wouldn't say "Can you put on headphones? That will give us more privacy," because that might tip an eavesdropping abuser off. Instead, I'd say "I'm having trouble hearing you, there's some background noise. If you have headphones, using those will really help."

When it comes to how an abuser might infiltrate the tech, a deeper exploration needs to happen for each piece of software that physicians are using to communicate with their patients. When it comes to apps with messaging, abusers might be looking through messages. We should expect that abusers will know the code to open the survivor's phone, and that they'll know their passwords as well. When it comes to videoconferencing software, physicians should be aware that abusers might be using spyware (also known as "stalkerware") that can record everything happening on the survivor's phone, tablet, or laptop. Spyware typically is much harder to identify since it's designed to be completely secret. When we bring spyware, things can get really tricky for the person, in this case the physician, who is trying to understand if their patient is experiencing IPV and help them.

Ultimately, a deeper exploration needs to happen into how to get around this. But one thing physicians can do now is do their best to think about the worst possible outcome: that an abuser is watching the appointment through spyware and that if the survivor goes into detail about the abuse that the abuser might increase his violence in order to regain control.

One idea is that if a patient responds that yes, they are experiencing IPV, that the physician move on and do the rest of the appointment. At the end, tell the patient that they will need to be seen

EXECUTIVE SUMMARY

As telehealth visits play an important role in family planning during the pandemic, providers should be aware their patients might be closely monitored by their partners, especially in cases of intimate partner violence.

- Abusers might check the woman's phone messages, digital communication, and apps with messaging.
- During videoconferencing, abusers might use spyware that can record everything on the woman's phone, laptop, or tablet.
- Physicians should keep in mind the abuser might hear the woman describe the violence, then might increase violence to regain control.

in person for further examination, or that there's some procedure that simply can't be recreated with a virtual appointment. This would give the survivor a really good excuse to get out of the house, since abusers are often really controlling about things like this, but a doctor's appointment is very legitimate.

Then, the physician could try to help the patient in person and give them resources on paper or have them add a number for a domestic violence hotline in their phone under some other name. Of course, doing something like this has to be weighed against the risks of seeing someone in person during the pandemic. Ultimately, further guidelines should be developed with input from both technology experts and IPV experts.

One other really important note is to not make assumptions about the patient. If they seem uncomfortable when you ask about IPV, it may be because they know they're being listened to or monitored, and are keeping themselves safe by pretending everything is fine. Survivors are the ones who know their abusers best, who know what might set them off, who know the steps they need to take to stay safe. The patient might already have received help, might be actively planning their escape, or might be waiting for the right moment to make a call.

Ask about IPV and do what you can to support them, but keep in mind that if a patient seems eager to drop the subject, they may be keeping themselves safe. This would be a good indicator that maybe you should ask for an in-person appointment to ask about IPV further, but don't ever try to force someone to disclose their abuse, as it may make things more dangerous for them in the short term.

CTU: *Researchers have said calls to IPV hotlines have increased. In your research, what have you found are some of the biggest concerns IPV victims are experiencing and how are they seeking help?*

PenzeyMoog: One of the biggest concerns is that survivors have, in many cases, lost the respites they had from their abusers: leaving the house for work every day, driving their children to school and activities, visiting parents, even just going to the grocery store. We're being encouraged to stay home as much as possible, which means less in-person contact with support networks and more time in the physical proximity of an abuser.

There's been a clear shift from in-person support from domestic violence shelters and agencies to support happening over the phone, online, and in virtual chat sessions. Even though it's devastating to see how much the numbers of calls and chats are increasing, it's heartening, in a way, to know that survivors are reaching out to seek help. It means they're finding ways to contact support services, often using ingenious methods to do it without their abuser noticing.

CTU: *What are some of the best practices and recommendations — especially those from a healthcare provider's perspective — for dealing with IPV?*

PenzeyMoog: Since I'm a technologist, I'll speak from that lens. Assume that patients may not have privacy, that their device may be being monitoring, that it's even possible someone is watching your conversation in real time.

Don't conflate a virtual appointment with the privacy of in-person appointments. Assume the worst and plan for that, and remember that your patient may be in a situation where they can't safely disclose the abuse. ■

Weathering the COVID-19 Pandemic Proved Challenging for Clinics

Most continue with some telehealth services

Family planning centers across the United States focused on telehealth and found creative ways to serve their clients after the COVID-19 pandemic rolled across North America in the winter and spring of 2020.

Contraceptive Technology Update (*CTU*) asked clinic leaders to participate in a Q&A about their operations during the pandemic.

CTU: *How did your family planning facility weather the pandemic as it evolved after the national shutdown ended (i.e., did all contraceptive services resume at a pre-pandemic level)? For instance, did your center return to in-person visits for all or some services? How much did additional infection prevention activities affect your resources? Which — if any — telehealth services have continued?*

Catriona Reynolds: In-person services resumed in May, limited to visits that require in-person care. The first day of in-person services,

we saw someone with a breast lump, removed an IUD [intrauterine device], and placed a Nexplanon [arm implant]. We continue to use telehealth for all visits that do not require an in-person examination. The conversation, education, and counseling elements of in-person visits are performed by telehealth. The client only enters the building for the physical exam/procedure portion of the visit. We installed air extraction in the exam rooms and provide reusable fabric masks to any client or visitor who needs one.

Interestingly, emergency contraception has been more frequent than before the pandemic. We're still trying to figure that one out.

Whitney Howell: The Georgia Department of Public Health is the lead agency responsible for responding to the COVID-19 pandemic. As a result, significant numbers of public health staff have been diverted from their normal roles to support testing for COVID-19 as well as case investigation and contact tracing efforts. To support this response, county health departments and clinics in our district are operating under a continuity of operations plan, which identifies essential services to be provided during emergencies.

Family planning and contraceptive services are considered essential, and our clinics have continued to provide in-person services at all of our locations. Early in the pandemic, there was a stark decline in the number of clients coming to the health department for in-person visits. When compared to last year, we have experienced a 25% decrease in the number of our clients seeking family planning services.

More recently, patients have begun seeking care again, and demand for services is high. We continue to adapt to meet this need; for example, by calling in prescriptions to local pharmacies to allow third parties to pick up for individuals who may be quarantining or isolating.

Evelyn Kieltyka: Maine Family Planning (nor our sub-recipients) never completely closed to in-person visits at the beginning of the pandemic. We have been fortunate in Maine to have a very progressive and data-driven public health response to COVID-19. In August 2020, in consultation with our medical director and staff, we began giving patients the option of telehealth and in-person office visits. What we were hearing from patients was "I just want to come in to the office to be seen. I've been putting this off, but I have an issue that needs an in-person visit."

We are doing all the COVID-19 screening questions and only allowing the patient in the office. In addition, patient appointments are spaced out so no two people are in the office at the same time. Rooms are cleaned after each visit, and patients must wear a mask — no exceptions. Screening questions are asked while the patient is in their car so that the time in the office in minimized. So far, things are going well.

Jennifer Howell and Kelly Verling: Our Sexual Health Program is an integrated program offering

Special Report: Pandemic Response and Preparedness

Family planning clinics and contraceptive providers have had to search for creative ways to stay open and continue providing services during the COVID-19 pandemic. *Contraceptive Technology Update* interviewed these seven family panning providers in this Q&A special report:

- **Jennifer Howell**, MPH, sexual health program coordinator, Washoe County Health District, Reno, NV.
- **Whitney Howell**, DNP, APRN, FNP-BC, RN, district nursing and clinical director, Georgia Department of Public Health, Northeast Health District, Athens, GA.
- **Evelyn Kieltyka**, MSN, MS, FNP-BC, senior vice president of program services, Maine Family Planning.
- **Amy Paris**, MD, MS, director of family planning, Dartmouth-Hitchcock Medical Center, assistant professor of obstetrics and gynecolog, Geisel School of Medicine, Lebanon, NH.
- **Catriona Reynolds**, chief executive officer, Kachemak Bay Family Planning Clinic, Homer, AK.
- **Jean Smith**, RN, BSN, PHN, public health nurse, Richland County Health Department, Wahpeton, ND.
- **Kelly Verling**, RN, BSN, public health nurse supervisor, Washoe County Health District, Reno, NV. ■

family planning, STI [sexually transmitted infection], and HIV prevention services. At the beginning of the COVID-19 pandemic, the sexual health clinic had visits available for clients experiencing STI symptoms, and we facilitated syphilis treatment for community providers. We provided all family planning services, including method refills, partner delivered therapy [PDT], and family planning emergencies.

Method refills and condom distribution, along with PDT, were available for curbside pickup. Clients called the clinic from the parking lot upon arrival to ensure social distancing between clients. Screening for COVID symptoms, including temperature, occurred prior to entry into the clinic. If they were experiencing COVID symptoms, staff actively referred clients for COVID testing.

As our state moved to the next phase of opening, the clinic expanded to a full offering of services on June 1. Because our clinic was open during the pandemic, telehealth appointments were limited to triaging client concerns.

COVID transmission prevention efforts started in March and continue to present. Staff were fit-tested for N95 mask use. PPE [personal protective equipment] was provided to include gowns and face shields. The level of PPE used depends on the staff member's preference, with a minimum amount of PPE required. When in common areas or sharing offices, staff are required to wear a face covering. Meetings have been modified to allow for online meetings or in-person meetings with social distancing and required face covering. Environmental protections include a vigorous cleaning schedule of commonly touched items and exam rooms. Staff have been required to participate in a training covering COVID transmission prevention methods.

Amy Paris: We were fortunate that we never had to close down our clinic or hospital to time-sensitive contraceptive services. We continued to offer those in person. We converted anything that could safely be a telehealth visit to telehealth, and we resumed full, in-person visits in the hospital and clinic, including contraceptives.

> "BEFORE THE PANDEMIC, WE DID NOT HAVE A TELEHEALTH OPTION. ... OUR HOSPITAL WAS VERY RESPONSIVE AND QUICK TO COME UP WITH A GOOD PLATFORM."

We have maintained telehealth options. For any gynecological issue that does not require an in-person physical exam or vital signs, we continue to offer patients telehealth visits where we have a platform that is friendly. If [patients] are unable to download it, we offer a phone visit. We offer birth control counseling over telehealth. Any troubleshooting of issues that do not require an in-person exam, we offer telehealth.

Our clinic is open, so all new patient visits and consults are offered in person. Our established patients are seen in person. Most contraceptive visits are in person because of the nature of their needs for a physical exam.

When a patient has been seen in the last year, they have a contraceptive in record, and they don't need an in-person visit, so we might consider telehealth. The decision between in-person and telehealth is very patient-driven: No one gets a telehealth visit if they don't want one.

Dartmouth-Hitchcock serves a large geographic area, from eastern Vermont and New Hampshire, and some patients drive far to get here. If they prefer telehealth, we can offer that. Before the pandemic, we did not have a telehealth option. This has been a completely new development, and our hospital was very responsive and quick to come up with a good platform and implement it. Patient feedback has been very positive. Even though patients don't need telehealth, because we're fully open for in-person visits, we still offer telehealth. Some patients prefer telehealth, and that's been a silver lining of the pandemic.

Jean Smith: It was a slow return, as many college students finished their year early and returned home. We didn't see college students this spring and summer — as we normally would have pre-pandemic. Now, starting in September, we have increased our telemedicine visits for new college students coming in, including many first-year students. We've offered telemed visits for many, if not all, college students to accommodate their class schedules.

In July, we had a full schedule for in-person clinic visits, but rescheduled due to a death in my family. Starting in August, we have had a full schedule for appointments needing an in-person visit, such as annuals with Pap tests, or problem visits. We screen them for COVID prior to letting them in the facility and ask that they fill out the paperwork prior to the appointment. We allow an hour for

all appointments, allowing time to adequately disinfect all areas used.

All telemed/telehealth services have resumed, effective in May. We schedule the telemed visits on demand or when it works for the clients' and providers' schedules.

Pre-pandemic, a provider would see clients in person one day per month with some appointments via telemed. But now clients are requesting the telemed visits, and if appropriate, we would rather conduct the appointment via a telemed visit.

Our telemed appointments are not conducted from a client's dorm room or home. They still have to come to the family planning clinic, and from that point we dial up for the telemed appointment with our offsite provider. We still can perform the vitals and either start their contraceptive injection that day or send them home with a three-month pill supply.

Also, pre-pandemic, there wasn't a lot of interest from ND Family Planning clinics in doing telemed visits. But since the pandemic, I've helped two family planning clinics get up and running with a telemed program, and they report being very busy. ■

Family Planning Centers Prepare for Fall as COVID-19 Pandemic Continues

Women across the United States will not lose access to contraception, thanks to family planning providers working to prepare for a fall with both flu and COVID-19. Providers and leaders describe their work in this Q&A.

CTU: *What are you doing to prepare for a flu/COVID-19 fall and winter? Are there any techniques you learned during the first half of 2020 that should help your facility handle what comes next?*

Amy Paris: I would say we are lucky and unique that we are in a region with a low prevalence of disease, and we never had the predicted spike we were all afraid of. During that time, we restructured our workforce to prepare and offer obstetrics and emergency services.

Things have reverted to a pre-pandemic model. We learned a lot from that preparation we made, and I think we would probably go back to the model and take advantage of all the thinking and resource allocation we did in March and April.

Other than that, I am not privy to specific preparations the hospital is doing. Anything could happen. We never had to completely close down during the first wave, so I am confident we have implemented PPE [personal protective equipment] for all workers. We wear masks for every patient encounter, every patient has a mask and temperature check, and we haven't stopped that stuff. That's part of why we are able to stay open and keep our staff safe.

We'll continue to take all the precautions we need to stop the spread of infection in the hospital, and — knock on wood — it's gone very well. We've had very intentional planning and good work on the part of the infection control service. We'll continue to take all the precautions we have taken and see what happens in our local community in New Hampshire and Vermont on prevalence of disease. But I'm very optimistic in that we handled the first wave and that we can continue to do that even if we have another spike.

Jennifer Howell and Kelly Verling: Perhaps the most challenging component to the COVID response has been the assignment of staff to the COVID response. Clinic aides, nurses, and disease investigation staff were assigned to contact tracing, the call center that triaged community inquiries, and testing activities. Remaining staff maintained the limited clinic operations. As clinic services expanded, staff working on COVID have returned to their normal duties, with some exceptions.

It is likely that staffing challenges may present during the influenza/COVID response in the fall, to support vaccination clinics, with the likelihood of challenges increasing when a COVID vaccine is made available.

We have learned what staffing levels are required for different service levels and what flexibility is required to support the pandemic response. Having adequate supply levels, including PPE, also is a valuable lesson learned as we move into another phase of COVID response.

Jean Smith: We've been offering more telemedicine visits to decrease exposure, and I've been striving for efficiency in my duties — trying to limit idle time with the clients.

Whitney Howell: In addition to family planning services, our clinics also provide influenza vaccines, which are currently available to the general public at all of our health department locations. To prepare for the upcoming flu season, we

are organizing school-based and community-based flu clinic events, including a drive-thru for flu shots. We have seen that a drive-thru model can be a very successful method to bring testing for the coronavirus to the community, and we are hopeful for similar outcomes with a drive-thru flu shot clinic. Additionally, we are preparing for the distribution of a COVID-19 vaccine when it becomes available.

Evelyn Kieltyka: We are discussing flu/COVID-19 preparation. As in the early days, we are following the data and recommendations from the Maine Center for Disease Control and Prevention. Right now, we plan on continuing in-person visits. What we have learned from the early days is that we need to streamline our telehealth visits to make them shorter. We are doing that now.

Catriona Reynolds: We are encouraging staff, clients, and the community at large to get flu shots. We now have systems in place to respond to what the current local infection rate is, and provide services accordingly.

We are a small staff, so we do not have huge capacity for covering when staff are absent. Preventive measures among staff are key. We do hope that if/when staff have to quarantine or have COVID-19, they will be able to continue to work remotely. Of course, if someone experiences severe symptoms, that will not be possible.

We now have solid systems in place for remote work, curbside services, and telehealth. At times of increased lockdown, we will be able to provide more complete care to clients.

CTU: *How are you coping with the emotional toll the pandemic has taken on healthcare professionals and staff?*

Kieltyka: Staff have been fantastic through all of this. But winter is coming — and in Maine, it's a long season. We send out weekly staff emails about stress reduction and such. We also are meeting bi-monthly, via Zoom, to discuss what is going on in our clinical practices. I think it's just good to see each other since we can't get together.

"I FEEL IT'S WHAT PUBLIC HEALTH IS ALL ABOUT: PREVENT, PROMOTE, AND PROTECT THE PUBLIC IN WHATEVER CAPACITY WE'RE CALLED TO. THAT'S WHY WE'RE IN THE PUBLIC HEALTH FIELD — NEVER A DULL MOMENT."

Smith: It has been very emotionally draining helping the state of North Dakota in the COVID-19 tracing team for cases and contacts as well as maintaining our normal public health duties. Both our provider and I, along with many of my co-workers, take calls after hours and on weekends/holidays to help with the COVID-19 tracing team.

Many of us have had only a couple days off since this all began. But I feel it's what public health is all about: prevent, promote, and protect the public in whatever capacity we're called to. That's why we're in the public health field — never a dull moment. Like my mom always says, "This, too, shall pass."

Reynolds: The emotional toll is real. Fortunately, individuals are impacted in different ways and at different times, so when one person is struggling, others are able to step in to pick up any slack and offer support.

Finding ways to create connection and to foster the feeling of being part of a team are an intentional part of our practice. We started using Microsoft Teams, and that has been a wonderful way to collaborate, even if miles apart.

Perhaps most importantly, we meet as a staff for fika twice a week. Fika is a concept, a state of mind, an attitude, and an important part of Swedish culture. It means making time for friends and colleagues to share a cup of coffee or tea and a little something to eat.

At Kachemak Bay Family Planning Clinic, our fika includes five minutes for body regulation, such as breathing exercise, meditation, stretching, Capacitar practice, or journaling prompt. It also has program updates and news, "watercooler conversation," and some outro music.

We also have an employee assistance program that provides counseling or coaching for staff and their family members.

Howell and Verling: Our staff have remained resilient, flexible, and committed to the Sexual Health Program, along with the COVID response. Staff are encouraged to take time off; however, there are limitations on the amount of leave that can be taken. Staff also have been reminded of our employee assistance program services that are available at no cost. In addition, staff have been supportive of each other when faced with exposures,

quarantine, and the daily stressors of working in a pandemic.

Paris: I feel that we're so fortunate here because we did not see the type of things that people in New York and Louisiana saw with their hospitals being slammed with sick patients and having faced the possibility of running short of ventilators. That kind of trauma didn't happen here. We have taken care of COVID patients and pregnant COVID patients. I think there is a level of emotional fatigue that happens when we've had to be on guard for so long. We had to be so careful and wear PPE all day. That is exhausting, and everyone is feeling that exhaustion to some degree. We're doing all the things necessary to stay resilient. We come home to our families, count our blessings, practice gratitude, and focus on all the positives and the fact that this is not going to be forever.

I think that our hospital has done a pretty good job of taking care of us by providing PPE and enforcing strong infection control guidelines. For example, when people walk through the door, we risk-stratify them and put a mask on them.

On a basic level, that makes us and the staff feel protected. There also are hospital wellness resources that staff can access. But this is a hard job and it's a difficult time, and we're all doing the best we can do.

Howell: Everyone in the Georgia Department of Public Health is working very, very hard right now. The long hours and intense sense of responsibility for the well-being of our community do take a toll, but we are finding ways to support one another. People who work in public health really care about serving others, and we do our best to keep that larger goal of protecting our community in focus. ■

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CME/CE QUESTIONS

1. **Domestic violence hotline calls increased during the early months of the pandemic. In what city did hotline calls increase by 30% in April 2020 when compared with April 2019?**

   a. Wuhan, China
   b. Melbourne, Australia
   c. New York City
   d. Los Angeles

2. **What is a technique a family planning provider can use to safely screen patients for intimate partner violence (IPV) during telemedicine visits, according to IPV researcher Eva PenzeyMoog?**

   a. Ask patients to describe their recent abuse and how their bodies were hurt.
   b. Suggest the patient use headphones for privacy, and the patient can give one-word answers that would not alert the abuser to the nature of the conversation.
   c. Send patients questions to answer via an app or social media messaging service.
   d. Do not screen over the phone or in a video call because of safety issues.

3. **Compared with the previous year, the Georgia Department of Public Health, Northeast Health District, experienced which of the following during the early part of the pandemic?**

   a. 15% increase in clients seeking family planning services
   b. 17% increase in family planning services
   c. 25% decrease in family planning services
   d. 38% decrease in family planning services

4. **The pandemic has led to an increase in intimate partner violence possibly due to:**

   a. family financial stress and increased isolation.
   b. increased testosterone levels due to pandemic fear.
   c. greater access to guns.
   d. fewer arrests and responses to domestic violence calls.

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