

Original Publication

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Health Education for Women and Children: A Community-Engaged Mutual Learning Curriculum for Health Trainees

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Citation: Ragavan M, Karpel H, Bogetz A, Lucha S, Bruce J. Health education for women and children: a community-engaged mutual learning curriculum for health trainees. *MedEdPORTAL*. 2016;12:10492.

https://doi.org/10.15766/mep_2374-8265.10492

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Abstract

Introduction: Intimate partner violence (IPV) affects the physical and psychological health of survivors and their children; however, to our knowledge, no comprehensive health curriculum exists for this population. As a partnership between a transitional housing program (THP) and an academic medical center, we developed a health education curriculum for female IPV survivors using the principles of community-based participatory research (CBPR). **Methods:** After partnering with a community-based organization, and recruiting participants (IPV survivors), the curriculum is then taught by health trainees. The materials needed to facilitate the 10 workshops are provided and include: a facilitator's guide; workshop materials, including PowerPoint slides and handouts; a training guide for a community partner to teach facilitators about IPV; a sample focus group guide for curricular evaluation that aligns with CBPR methodologies; a sample time line for curricular implementation; and CBPR resources. **Results:** The curriculum was implemented for two 9-month periods between September 2014 and June 2016. During the first session, 80% of women attended at least one workshop and during the second session, 65% of women did the same. Participants and staff at the THP found the curriculum engaging and requested that it be implemented yearly. **Discussion:** The community-academic partnership offered prehealth and health trainees the opportunity to learn effective methods of delivering health education and to understand some of the challenges associated with surviving IPV. Such education can be provided to trainees at any stage and across multiple specialties (e.g., medical, nursing, public health, or social work). There is potential to replicate this mutual learning curriculum in a wide variety of other settings serving mothers and children.

Keywords

Intimate Partner Violence, CBPR, Child Health, Program Evaluation, Patient Education as Topic, Community-Based Participatory Research, Program Development, Women's Health, Community Health Care, Health Education

Educational Objectives

By the end of each 90-minute workshop, intimate partner violence (IPV) survivors will be able to:

1. Describe at least three strategies to incorporate the information provided during the workshop into their and their children's daily lives.
2. Practice at least one activity related to the workshop topic.
3. Identify at least one workshop-related resource in their local communities.

By the end of each 90-minute workshop, workshop facilitators (health trainees) will be able to:

1. Deliver health education to a vulnerable population, which may be translated into their clinical careers.
2. Communicate with women about the health topics discussed in the workshop.
3. Identify at least one workshop-related resource in their local communities.
4. Describe at least one asset and one challenge present in the participants' lives.

Appendices

- A. Facilitators Guide.docx
- B. Workshop 1 - Cardiovascular Activity & Walking.pptx
- C. Workshop 2, Part 1 - Healthy Cooking.pptx
- D. Workshop 2, Part 2 - Recipes.pptx
- E. Workshop 3 - Healthy Grocery Shopping on a Budget.pptx
- F. Workshop 4 - Mindful Eating.pptx
- G. Workshop 5 - Reading With Children.pptx
- H. Workshop Handouts.docx
- I. IPV Training Guide for Community Partners.docx
- J. Sample Time Line.docx
- K. Sample Focus Group Guide .docx
- L. Additional CBPR Resources .docx

All appendices are peer reviewed as integral parts of the Original Publication.

By the end of the series of workshops and completion of the curricular evaluation, IPV survivors will be able to:

1. Provide direct feedback on the strengths and weaknesses of the workshops.

By the end of the series of workshops and completion of the curricular evaluation, facilitators will be able to:

1. Describe at least three strengths and three weakness of the workshops.
2. Describe at least one way to improve the workshops based on participant feedback.

Introduction

Intimate partner violence (IPV) impacts the health, well-being, and quality of life of adult survivors and their children.¹ IPV affects both men and women but is more prevalent among women.² Experiencing IPV may cause a variety of symptoms in adults, including physical trauma, decreased self-esteem, postpartum and chronic depression, adverse obstetric outcomes, and post-traumatic stress disorder (PTSD).^{3,4} Childhood exposure to IPV is associated with developmental delay, depression, PTSD, obesity, and school difficulties.⁵⁻⁷ Parenting after IPV can be challenging due to maternal and child mental health symptoms and unsupported mother-child relationships.⁸ In addition, adults affected by IPV are less likely to have a trusted relationship with a primary health care provider, and their children are more likely to be underimmunized and not have access to regular well-child care.^{9,10} However, multiple factors, including social support, resilience, and nonjudgmental conversations with trusted health care providers, have been shown to mitigate the negative health effects of IPV.¹¹⁻¹³

Despite suffering multiple health morbidities, IPV survivors have limited access to health education. In particular, there is a lack of health curricula developed for this vulnerable population that use a community-based participatory research (CBPR) approach. Key principles of CBPR include choosing research interests of importance to the community, building on community resources, involving an iterative evaluation process, providing mutual learning opportunities, and balancing research and action.^{14,15} This approach may be particularly important when designing programs for IPV survivors, as abuse often leads to feelings of isolation and disempowerment.^{16,17} Also lacking is health programming developed for IPV survivors through partnerships between community-based organizations and academic centers. In a recent article, Yuan et al. described the importance of strong community-academic partnerships when addressing violence prevention as well as a dearth of such initiatives.¹⁸ Finally, although there are other IPV-focused MedEdPORTAL curricula, such as interactive experiences with survivors,¹⁹ simulated patient cases,²⁰ educational models,²¹ and video vignettes,²² there are no curricula, to our knowledge, that provide health trainees the opportunity to learn about IPV by teaching health education modules to IPV survivors. There are also no curricula focused on joint mother-child programming. Learning how to support mother-child relationships is important for future health care providers, as it has implications for the health of women and their children.²³ Finally, there is a dearth of curricula that include the trainees in continual iterative curricular development and evaluation; developing these skills may be useful for trainees interested in clinical, research, or public health careers.

Therefore, our goal was to develop and implement a health curriculum for IPV survivors residing at a transitional housing program (THP) in northern California that addressed their self-identified needs and empowered them to improve their and their children's health. We aimed to also create opportunities for mutual learning where, through teaching the workshops, health trainees from the academic center could learn more about the health effects of IPV and obstacles that IPV survivors face. This curriculum allows trainees to transcend the classroom and engage in these topics in community-based settings. It may also provide trainees the opportunity to develop the art of learning from patients' experiences and narratives rather than utilizing a didactic approach when providing health education counseling to families.

Prior to curricular development, we conducted a comprehensive needs assessment with the women and staff at the THP to better understand what health programming would be most useful for them. The majority of women residing at the THP have children and wanted to incorporate pediatric topics into the workshops. Participants requested practical health education workshops on multiple topics, including nutrition, physical activity, child development, parent-child communication, partnering with health care providers, stress management for both the women and their children, self-compassion, and connections to local resources. Results of the needs assessment have been published elsewhere.²⁴

The curriculum was developed in June 2014, implemented from September 2014 to June 2015, and modified in June 2015 based on results from an evaluation with IPV survivors and staff who work at the THP. It is now in its second year of implementation. This curriculum is unique in that it is strengths-focused, community-engaged, sensitive to the experiences of IPV survivors, and run as an equal community-academic partnership.

Methods

The target audience of this resource includes the following groups:

- **IPV survivors (or participants):** The workshops were developed for adult females who have experienced IPV, although adolescents and older children may also find the materials useful. The majority of the women residing at the THP have children. Although we developed these workshops in partnership with IPV survivors, this curriculum could be used with women who have not experienced IPV, as described in the Discussion section. The role of the IPV survivors includes participating during workshops and providing feedback for curricular revision.
- **Community partner:** a community-based organization that partners with the academic center. This curriculum was developed as a partnership with a THP serving IPV survivors, although the curriculum could be easily replicated in other settings, as described in the Discussion section. The role of the community partner includes training the facilitators, recruiting participants, and providing general oversight.
- **Workshop facilitators:** health trainees who conduct the workshops. The workshops are designed to be taught by health trainees (e.g., prehealth, medical, public health, or nursing students; medical residents; or social work and psychology students), and therefore, when we use the term *facilitator*, we are referring to health trainees. However, as an alternative, nurses, physicians, or social workers may facilitate the workshops. The role of the workshop facilitator includes preparing for and teaching the workshops, conducting curricular evaluations, and revising the curriculum to meet the needs of the IPV survivors participating in the workshops.
- **Faculty advisors:** faculty from the academic center (or health care providers in the community, depending on programmatic needs). Their role is to provide supervision and oversight to the facilitators. They should be knowledgeable about women's and children's health, CBPR, and health education delivery.

Appendix J includes a thorough delineation of each of these roles as well as a sample time line for program development and implementation.

Curricular Development

Using the data from the needs assessment (as described above),²⁴ we created a curriculum consisting of 10 interactive workshops. Each workshop was developed by content experts from Stanford University and local community organizations. The content experts included dietitians, pediatricians, psychologists, and experts from community-based organizations (such as representatives from a fitness organization).

Workshop development comprised multiple steps, including the following:

- **Step 1:** The content expert developed the curriculum based on current evidence. The curriculum was written as a facilitator's guide to ensure longevity and sustainability (see Appendix A). The facilitator's guide was designed to be used by individuals with or without content-level expertise.

- Step 2: The manager of the THP reviewed and edited all workshop materials to ensure they were sensitive to the experiences of IPV survivors. This step was critical to stay aligned with a CBPR approach during curricular development.
- Step 3: The first author, Maya Ragavan, a pediatric resident (at time of implementation) who has worked with IPV survivors for several years, reviewed the final version of the curriculum. She and the THP's manager also worked together to ensure that all PowerPoints and handouts would be easily understood by IPV survivors and were sensitive to their past histories of trauma.

The above-mentioned process was repeated separately for each of the 10 workshops. Of note, we also taught an additional workshop on accessing health insurance and community-based resources. This workshop was facilitated by a volunteer from the county where the THP is located. Due to the specific and technical nature of this talk, we opted for county employees (as opposed to health trainees) to teach this workshop annually. No curriculum was created for this workshop, as the county employees provided their own materials.

Curricular Implementation, Evaluation, and Revision

The curriculum has been implemented twice over two 9-month periods (September 2014-June 2015 and September 2015-June 2016). The workshops occur monthly or bimonthly from 6:00 p.m. to 7:30 p.m. at the THP. Each workshop includes didactic components, group-based activities, and discussion. The workshops were developed for women; however, many are also appropriate for school-age children or adolescents. In the first year, the individual content experts who developed each workshop served as the facilitators. We decided on this approach to resolve any problems with the materials and ensure that the facilitator's guide was comprehensive enough for trainees to use in the future.

Following completion of the first year of the curriculum, we conducted focus groups with 22 participants (20 women and two staff employed by the THP) to evaluate the strengths, challenges, and sustainability of the curriculum. Stanford University's Institutional Review Board approved the evaluation methods and materials. Thematic analysis revealed both curricular strengths and areas for improvement (described in the Results section). Most importantly, women requested more continuity of instructors, prompting our decision to have three health trainees (specifically, premedical students) facilitate the workshops in the future. We also added workshops on stress management and reproductive coercion, as requested by participants, and removed a workshop on weight training, which the instructor felt was too technical to be taught by health trainees.

The curriculum included in this publication consists of the 10 revised workshops as well as two additional suggestions for workshop topics, which should be taught by content experts. The curriculum is currently being implemented on an annual basis at the THP, with one workshop taught monthly by three premedical students. Faculty advisors with expertise in CBPR, IPV, and women's and children's health provide supervision to the students. Prior to working with the IPV survivors, the students receive a thorough training by the THP's manager and faculty advisers. During the training, they discuss the definition and prevalence of IPV, the way IPV affects the health of survivors and their families, communication tips when working with IPV survivors, and services offered by the THP (see Appendix I). The students also review a short document on IPV, which can be found in the facilitator's guide (Appendix A). The THP's case manager advertises the workshops to IPV survivors via email, text messages, flyers, and word of mouth.

Instructions for Curricular Implementation

The first step in implementing this curriculum is for the academic center to partner with a community-based organization, which can train the facilitators, recruit participants, and provide general oversight during the workshops. It may be helpful to have the curriculum integrated into the community health division at the academic center to help with sustainability (at our institution, the curriculum is housed within the Office of Community Health). As described above, this curriculum took place at a THP serving IPV survivors; however, the materials are widely applicable to other settings.

Workshop facilitators can be any type of health trainee, as described above. As an alternative, community physicians, social workers, nurses, or any group with basic health knowledge and an interest in underserved medicine can serve as facilitators. We recommend identifying a group of two to four facilitators who can commit to conducting all workshops to provide continuity for participants. Facilitators should be chosen at least 2 months in advance so they have ample time to review the materials.

The facilitator's guide (Appendix A) provides step-by-step instructions on how to facilitate each of the following 10 workshops.

1. Cardiovascular Activity: Walking.
2. MyPlate and Healthy Cooking Class.
3. Healthy Grocery Shopping on a Budget.
4. Mindful Eating.
5. Reading With Your Children.
6. Parent-Teen Communication.
7. Partnering With Your Health Care Provider.
8. Teen Health.
9. Self-Compassion and Mindfulness.
10. Managing Stress.

The PowerPoint slides for the five workshops that include a presentation are included in Appendices B-G (all pictures were taken by the authors or are available under a Creative Commons license). The handouts for all 10 workshops are included as one document (Appendix H).

The facilitator's guide also includes two additional workshop topics—sexual (or reproductive) coercion and health access—and instructions for implementation with the help of a content expert. Community-specific components of the curriculum are clearly delineated and will need to be developed by facilitators and community partners prior to implementation. For example, the workshop on cardiovascular activities and walking includes a group walk. Instructors will thus need to locate a safe walking path prior to the workshop. References and further resources are also provided. This curriculum can be taught in its entirety or as individual modules, depending on the community partner's needs and preferences. Workshop facilitators should work closely with the community partner to create a workshop schedule and recruitment plan. Faculty advisors should also be identified to provide direct supervision and feedback to the facilitators.

In addition, we have included several documents that support the development of strong community-academic partnerships as well as interval evaluation of the curriculum, both of which are important in order to stay aligned with a CBPR approach. We strongly suggest that prior to the start of the curriculum, facilitators receive training on IPV, preferably by community partner staff, and have included a guide developing this training (Appendix I). A sample time line for curricular implementation and suggestions for dividing responsibilities between the community partner and academic center (Appendix J) are included to induce a sense of coleadership. As an informal evaluation, either annually or at midyear, facilitators should conduct a focus group (Appendix K) with oversight provided by the community partner and faculty from the academic center. For those who want to learn more about CBPR, we have included additional articles to read (Appendix L).

Results

Eighty percent (37 out of 46) of women residing at the THP attended at least one workshop from September 2014 through June 2015. Fifty percent (23 out of 46) attended three or more, and 33% (15 out of 46) attended six or more. Between four and 12 women attended each workshop. Thirty out of 46

women (65%) attended at least one workshop during the second year of implementation, with four to 10 women attending each workshop.

The curriculum has received positive feedback overall. In particular, women appreciated workshops that included interactive activities, practical tips to apply knowledge to their and their children's daily lives, and group bonding. Examples of participant feedback include the following:

- “My health improved and it got me and my son back into walking. I think that every class that was brought here was just unbelievably rich. They were also easy to attend since they were at our home.”
- “I liked the yoga exercises. I had never done yoga before and it felt good. I felt relaxed because before my body was tense. And the best part was that it is practical and you can do it from home.”

Despite participants' enjoyment of the curriculum, multiple suggestions for improvement were provided. Women discussed the barriers they faced attending workshops, particularly having busy schedules and suffering from mental health symptoms secondary to the trauma they had survived. Additionally, women and staff requested continuity of instructors to build trust and rapport. This was considered important to maximize participation and facilitate engagement with the curricular materials. Examples of suggestions from participants (unless otherwise noted) include the following:

- “I liked the content but if I had a suggestion, I would say maybe having the same few people [facilitators] every time. You need to establish trust if you want people to come and be invested.”
- “Some people are so depressed because of the violence. Even for me, at first, I was so sad I didn't want to come out of my room. So, perhaps those of us who attend [the workshops], we can help the others by motivating them to come.”
- “They [the facilitators] don't have to be a guru in every subject once they have the guide. I think the important thing is consistency . . . that they [the women] see the same people [and] that they get comfortable with those people” (THP's case manager).

The curriculum has been refined based on these data and sustained as a collaboration between the community partner and academic center. Ongoing feedback in the second year indicates that women and staff appreciate these changes, particularly the continuity of instructors and continued emphasis on utilizing a community-engaged and strengths-based approach. Attendance continues to vary; however, we are providing more advertising prior to the workshops and asking women who frequent the workshops to invite their friends and neighbors.

The facilitators have also found the experience rewarding both professionally and personally. They felt prepared to teach the workshops using the facilitator's guide. However, they requested more guidance when addressing sensitive topics and approaching questions they do not know how to answer.

- “We have done an excellent job of preparing the manual and handouts. We have a lot of the information needed to implement the curriculum.”
- “I would like to have more resources available for the facilitators. I think [we need] more training on what to do if someone asks a personal question.”

Based on this feedback, we have added more debriefing sessions for the facilitators throughout the year and plan on incorporating further communication skills training.

A hope of ours was that the premedical students would learn from the experience of facilitating the workshops. The students emphasized that participating in this program built their active listening, empathy, and communication skills, which they felt could be translated to their future health professions. They also learned about the struggles IPV survivors face, in terms of both health needs and barriers to utilizing the health care system. Finally, students developed programmatic skills such as curricular development, conducting focus groups, preparing community-asset maps, and analyzing qualitative data.

- “Knowing how to communicate effectively is so important as a doctor. I think it [facilitating workshops] was really helpful, it taught me how to explain things and come up with creative ways to get a concept across.”
- “This program taught me about domestic violence [IPV]. For example, during the partnering with the health care provider workshop, I heard how not supported women felt by doctors. I think it helped me see how I would like to be as a future doctor. I think there is a disconnect between doctors and patients overall, but I learned that this disconnect is exacerbated with IPV survivors.”
- “The entire project helped me professionally. I know how to talk with patients about health education now. It also has provided a model for me on how to develop a health curriculum if I want to do that in the future. Finally, it gave me a sense of what can be done in the community.”
- “This program also gave me skills in curricular development and qualitative research. I think I was able to develop those skills because the program became student led, and thus the responsibility [of completing those tasks] was transferred to the students.”

Discussion

The goal of this curriculum was to provide comprehensive, skills-based, health education workshops to IPV survivors using a CBPR approach. Although we developed and implemented this curriculum with IPV survivors residing at a THP, the materials in this publication provide a thorough foundation to replicate the curriculum with women in a wide variety of settings, including shelters, youth groups, day cares, pediatric or family medicine primary care clinics, obstetric clinics as part of prenatal counseling, or any community organization providing services to women and children. The curriculum can also be used with women who have not experienced IPV; in this situation, the materials focused on participants’ histories of violence can be omitted or adapted. Additionally, most of the women residing at the THP have children, which is why we incorporated children’s health into the majority of the workshops. However, many of the workshops, such as those on nutrition, physical activity, partnering with health care providers, self-care, and stress management, can be adapted for use with women without children.

A welcome outcome of having premedical students facilitate the workshops was that it allowed for mutual learning. Facilitators increased their comfort in delivering health education, empowering IPV survivors, and developing and evaluating health curricula. Other studies have reported success implementing health curricula at homeless shelters as a way to promote reciprocal community health learning for premedical students, medical students, and residents.²⁵⁻²⁷ Our initiative showed similar results with a program specifically for IPV survivors, with the additional benefits of providing facilitators the opportunity to advance their communication, empathy, and curricular development skills. There are opportunities for a variety of health trainees to facilitate the workshops as part of their course work. Supervision from experts at the academic center and the community partner is important to ensure optimal learning for both IPV survivors and health trainees.

We recognize limitations with this curriculum. First, this program was designed for one THP serving female IPV survivors and may require some adaptation for use in other communities. Second, attendance at each workshop was voluntary, so results must be interpreted with this in mind. However, mandatory programming conflicts with the community partner’s mission, and we agree that voluntary participation is important. Third, barriers to attendance, which include participants’ scheduling conflicts and mental health symptoms secondary to the trauma they have survived, are important for facilitators and community partners to discuss as they prepare for implementation. Peer support and motivation may be a useful approach.

Despite these limitations, there are multiple opportunities for academic centers to replicate this curriculum with a wide variety of community partners. Next steps for this project are to implement the curriculum in other settings, including shelters, community support groups, day cares, primary care clinics, and other organizations that serve women and children. We developed this curriculum for women; however, with some adaptation, the materials could be used with a male audience. We would also like to create a series

of videos so women who are unable to attend a given workshop may still engage with and learn from the materials. Finally, we recommend that larger quantitative studies examine the potential health outcomes of this curriculum, including whether participants report changes in health knowledge and attitudes, risky health behaviors, and disease morbidity. It will also be useful to assess whether trainees, after facilitating this curriculum, report any changes in confidence surrounding communication skills, delivering health education, and working with IPV survivors.

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Acknowledgments

We thank the individuals who helped develop the workshops, including Marilynn Lozano, Bryan Lian, Heidi Feldman, Beth Barber, Harise Stein, Johanna Thompson-Hollands, Veronica Alvarez, and Cecily Mcgaw. We also thank Lisa Chamberlain, Wanda Nallan, and Samantha Cedillo for their support.

Disclosures

We received funding from a Community Access to Child Health (CATCH) grant from the American Academy of Pediatrics, a Lucile Packard Children's Hospital Community Advocacy grant, and a Stanford University Community-Based Research grant.

Funding/Support

None to report.

Prior Presentations

A brief overview of the curriculum has been presented at the American Public Health Association's Annual Conference (Chicago, IL; October 2015), the National Health and Domestic Violence Conference (Washington, DC; March 2015), and the Regional Academic Pediatric Association Conference (Monterey, CA; January 2016).

Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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Received: April 8, 2016 | Accepted: September 29, 2016 | Published: November 3, 2016