

**Reproductive Coercion**

*Identification & Intervention in the  
Clinical Setting:  
Current Practice and Future  
Directions*

Lindsay Clark, MD  
Rebecca H. Allen, MD, MPH  
Amy S. Gottlieb, MD

*Reproductive coercion and co-occurring  
intimate partner violence in obstetrics and  
gynecology patients*

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**Definitions**  
*Reproductive Coercion*

Male behavior to control pregnancy &  
pregnancy-related outcomes

Miller et al. *Contraception* 2010

**Definitions**  
*Reproductive Coercion*

- Pregnancy Coercion (PC)
  - Intimidation
  - Violence
  - Threats to leave the relationship
- Birth Control Sabotage (BCS)
  - Flushing OCPs down the toilet
  - Breaking or removing condoms
  - Inhibiting the partner's ability to obtain contraception

Miller et al. *Contraception* 2010; Moore et al. *Social Science and Medicine* 2010; Thiel de Bocanegra et al. *Violence Against Women* 2010

**Prevalence**  
*Reproductive Coercion*

- **Centers for Disease Control - 2010**
  - > 9000 women
  - Telephone interviews with trained staff
  - 8.6% reported partners' trying to get them pregnant when they didn't want to be or refusing to use a condom
- **Miller et al. - 2010**
  - Family planning clinics
  - > 1200 women
  - 19% reported h/o pregnancy coercion
  - 15% reported h/o birth control sabotage

National Intimate Partner and Sexual Violence Survey, CDC/National Center for Injury Prevention and Control, 2011, Miller et al. *Contraception* 2010

**Reproductive Coercion**

Goal = Fertility Control

Goal ≠ Particular Reproductive  
Outcome

*(May also involve pressure to terminate pregnancy)*

### Reproductive Coercion

- HC providers well-positioned to interrupt cycle:
  - BC sabotage*
  - ↓
  - Power over pregnancy resolution*
  - ↓
  - Unwanted births/terminations*
- Contraceptive “non-compliance” = RC?
- Offer long-acting, “hidden” birth control

### Reproductive Coercion: A Prevalence Study

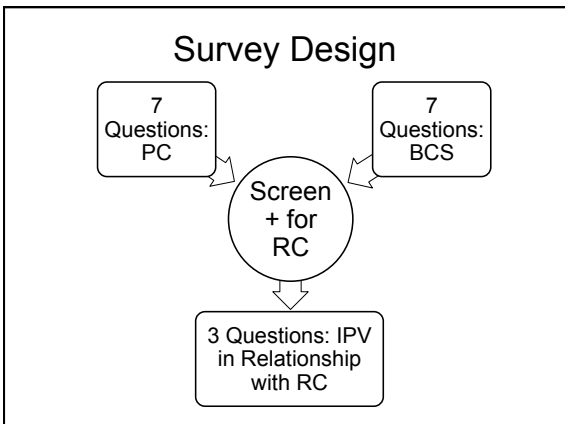
- Early research focused on high risk populations
- Limited data on how RC impacts more general clinical population of women
- Limited understanding relationship between RC and IPV

### Study Objectives

- Primary Objective:
  - Estimate prevalence of RC in a general, hospital-based obstetrics & gynecology clinic
- Secondary Objective:
  - Estimate prevalence of IPV in relationships where reproductive coercion has occurred

### Study Population

- Women presenting to a university-based clinic for general obstetrics or gynecology care
- Inclusion criteria:
  - Ages 18-44
  - Able to read English



### Results: Study Participants

N = 641	Education
Response rate = 87.3%	– 43.5% HS/GED
Mean Age = 26.1 (SD 6.3)	– <u>45.7%</u> Some College/+
Race/Ethnicity	Relationship Status
– 41.8% Latina	– 69.5% committed relationship/married
– 27.0% White	– 27.9% single
– 16.4% Black	<u>79.1%</u> Medicaid/free care

### Results: Prevalence Reproductive Coercion, Pregnancy Coercion & Birth Control Sabotage

Variable	N/Total	%	95% CI
Reproductive coercion	103/641	<u>16.1%</u>	13.0-18.7%
Pregnancy coercion	74/641	<u>11.5%</u>	9.1-14.0%
Birth control sabotage	58/641	<u>9.0%</u>	6.8-11.3%

### Results:

#### Comparison of women who screen + for RC vs - RC

Variable	Adjusted OR (95% CI)	P
<b>Relationship</b>		
Single/Dating	2.16 (1.26-3.70)	0.005
Committed	1.00	Ref.
Married	1.46 (0.75-2.85)	0.3
Other/Don't know	5.57 (1.86-16.67)	0.002
Currently pregnant	0.60 (0.37-0.97)	0.04
<b>Race/ethnicity</b>		
Latina	1.00	Ref.
Black	1.37 (0.72-2.59)	0.3
White	0.67 (0.36-1.33)	0.2
Other	1.50 (0.67-3.34)	0.3
More than one	2.50 (1.04-5.99)	0.04
<b>Insurance</b>		
Private	1.01 (0.50-2.01)	1.0
Medicaid	1.00	Ref.
WIH Charity	2.27 (0.96-5.38)	0.06
Other/None/Don't know	1.66 (0.66-4.25)	0.3

### Results: IPV Prevalence

32% of women reporting RC screened positive for IPV in same relationship

### Results: Provider Role

#### "It would have been helpful if a provider had":

- asked whether partner messed with birth control (3%)
- asked whether partner pressured patient to become pregnant (14%)
- **discussed hidden forms of birth control (20%)**

### Lessons learned

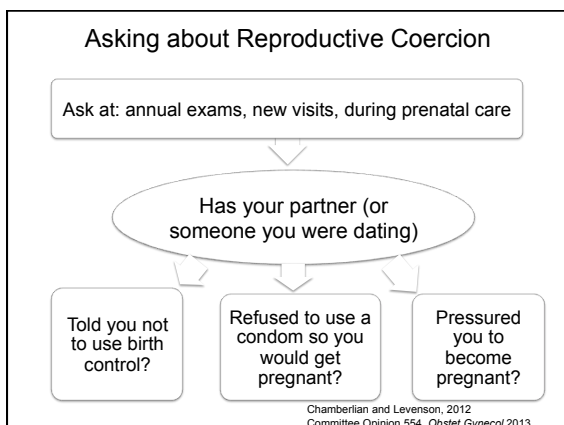
- RC is prevalent and often accompanied by IPV
- Women's health providers uniquely positioned to screen and offer interventions for RC
- Patients feel screening would be helpful
- Patients want providers to talk with them about hidden birth control

Clark et al. *Obstet Gynecol* 2014

### Reproductive Coercion Guideline: *American Congress of Obstetricians & Gynecologists*

1. Be familiar with RC
2. Routinely screen women for RC
3. Consider RC as a reason for contraception "non-compliance"
4. Offer hidden forms of contraception
5. Discuss safety plans

ACOG Committee Opinion No. 554. *Obstet Gynecol* 2013



## HIDDEN FORMS OF CONTRACEPTION

### Depo-Provera

- 150 mg medroxyprogesterone acetate
- IM injection every 3 months
- Effective: 6% annual failure rate
- Requires office visits every 3 months
- Alters menstrual cycle

Trussell. *Contraception*, 2011

### Intrauterine Device (IUD)

- Placed inside the uterus by provider
- Strings can be trimmed so device is undetectable
- Copper IUD
  - Highly effective: 0.8% annual failure rate
  - Can use for 10 years
  - No effects on menstruation
- Levonorgestrel Intrauterine System
  - Highly effective: 0.2% annual failure rate
  - Can use for 5 years
  - Amenorrhea

Trussell. *Contraception*, 2011

### Contraceptive Implant

- Etonogestrel rod placed in arm by provider
- Highly effective: 0.05% annual failure rate
- Effective for 3 years
- Alters menstrual cycle
- Rod may be easily felt

Trussell. *Contraception*, 2011

### Conclusions

- Reproductive coercion is common and often associated with intimate partner violence
- Ask about reproductive coercion and partner abuse at routine health care visits, especially when discussing family planning
- If patient heterosexually active and not using contraception, ask WHY?
- Offer hidden forms of birth control

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