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
American Journal of Obstetrics and Gynecology 2014

Definitions
Reproductive Coercion

Male behavior to control pregnancy & pregnancy-related outcomes

Miller et al. Contraception 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


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

Survey Design

3 Questions: IPV in Relationship with RC

7 Questions: PC

7 Questions: BCS

Results: Study Participants

N = 641
Response rate = 87.3%
Mean Age = 26.1 (SD 6.3)
Race/Ethnicity
- 41.8% Latina
- 27.0% White
- 16.4% Black
Education
- 43.5% HS/GED
- 45.7% Some College/+ Relationship Status
- 69.5% committed relationship/married
- 27.9% single
- 79.1% Medicaid/free care
Results: Prevalence
Reproductive Coercion, Pregnancy Coercion & Birth Control Sabotage

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

Results: Comparison of women who screen + for RC vs - RC

<table>
<thead>
<tr>
<th>Variable</th>
<th>Adjusted OR (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single/Dating</td>
<td>2.16 (1.26-3.70)</td>
<td>0.005</td>
</tr>
<tr>
<td>Committed</td>
<td>1.46 (0.75-2.85)</td>
<td>0.3</td>
</tr>
<tr>
<td>Married</td>
<td>5.57 (1.86-16.67)</td>
<td>0.002</td>
</tr>
<tr>
<td>Currently pregnant</td>
<td>0.60 (0.37-0.97)</td>
<td>0.04</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latina</td>
<td>1.00</td>
<td>Ref.</td>
</tr>
<tr>
<td>Black</td>
<td>1.37 (0.72-2.59)</td>
<td>0.3</td>
</tr>
<tr>
<td>White</td>
<td>0.67 (0.36-1.33)</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>1.50 (0.87-2.34)</td>
<td>0.3</td>
</tr>
<tr>
<td>More than one</td>
<td>2.50 (1.04-5.99)</td>
<td>0.04</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>1.01 (0.50-2.01)</td>
<td>1.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.00</td>
<td>Ref.</td>
</tr>
<tr>
<td>WIH Charity</td>
<td>2.27 (0.86-5.38)</td>
<td>0.06</td>
</tr>
<tr>
<td>Other/None/Don't know</td>
<td>1.99 (0.88-4.25)</td>
<td>0.3</td>
</tr>
</tbody>
</table>

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

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

Clark et al. Obstet Gynecol 2014

ACOG Committee Opinion No. 554. Obstet Gynecol 2013
Asking about Reproductive Coercion

Has your partner (or someone you were dating)

- Pressured you to become pregnant?
- Told you not to use birth control?
- Refused to use a condom so you would get pregnant?
- Pressured you to become pregnant?

Ask at: annual exams, new visits, during prenatal care

Chamberlian and Levenson, 2012
Committee Opinion 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
Acknowledgements

Vinita Goyal, MD, MSc
Christina Raker, ScD
Staff of the Women’s Primary Care Center at
Women and Infants Hospital of Rhode Island