

What is Reproductive Coercion?

REPRODUCTIVE COERCION OCCURS PRIMARILY IN HETEROSEXUAL RELATIONSHIPS where the male partner attempts to take away or influence the female partner's decision-making when it comes to her reproductive health.

UNDERSTANDING REPRODUCTIVE COERCION

The most common forms of reproductive coercion include birth control sabotage, pregnancy pressure and pregnancy coercion.

- ***Birth control sabotage***: active interference with female contraceptive use to promote pregnancy. Examples of birth control sabotage include destroying or withholding contraception, preventing the female partner from going to a doctor or clinic to get contraception, poking holes in a condom on purpose, removing a condom during sex to promote a pregnancy and forcibly removing vaginal rings, contraceptive patches, or intrauterine devices (IUDs) (American Congress of Obstetricians and Gynecologists [ACOG], 2013).
- ***Pregnancy pressure*** : coercive behaviors used to promote pregnancy including threats of violence or actual violence if a woman does not comply with her partner's wishes to become pregnant (ACOG, 2013).
- ***Pregnancy coercion***: coercive behaviors used to control the outcome of a pregnancy. Examples of pregnancy coercion include forcing a woman to carry a pregnancy to term against her wishes, forcing a woman to terminate a pregnancy against her wishes, or injuring a female partner to cause a miscarriage (ACOG, 2013).



HOW COMMON IS REPRODUCTION COERCION?

Reproductive coercion is common, particularly among women who have also experienced physical or sexual intimate partner violence (Miller et al., 2010). In one study of women seeking services at family planning clinics, 15% of women had experienced birth control sabotage and 19% of women had experienced pregnancy coercion or pressure (Miller et al., 2010).

More than one third of women in that study with histories of intimate partner violence had also experienced some form of reproductive coercion. A recent nationally representative survey found that an estimated



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10.3 million U.S. women had experienced their partner pressuring them to get pregnant when they did not want to or had a sexual partner refuse to use a condom indicating that reproductive coercion is a problem for many women of reproductive age (Black et al., 2011).

Evidence from global settings has found that women may also experience pressure to get pregnant and control around pregnancy outcomes from others in their social network, including parents and in-laws (Gupta et al., 2012). Female partners may also deceive their male sexual partners by telling them they are taking birth control when they are actually not and encourage unprotected intercourse in order to get pregnant (Black et al., 2011). More research is needed to understand the types of reproductive coercion experienced by males and the associated health impacts. This document focuses on the impact of reproductive coercion by male partners in heterosexual relationships on women's reproductive decision making.

"The first couple of times, the condom seemed to break every time. You know what I mean, and it was just kind of funny, like, the first six times the condom broke. Six condoms, that's kind of rare. I could understand one but six times? Then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid."

– 17-year-old female who started Depo-Provera without partner's knowledge (Miller et al., 2007)

THE LINK BETWEEN PARTNER VIOLENCE, REPRODUCTIVE COERCION AND HEALTH

Several decades of research has indicated that physical and sexual intimate partner violence is associated with poor reproductive health in women (ACOG, 2013). For example, unintended pregnancy - defined broadly as pregnancy that was not planned, was unexpected or mistimed, or not wanted by a woman - is at least two times more likely among women with histories of intimate partner violence compared to those women who have never been in an abusive relationship (Gazmararian et al., 2000; Pallitto, Campbel, & O'Campo, 2005). Forced sex, fear of negotiating condom and contraceptive use, and inconsistent condom use all influence risk for unintended pregnancy among women in unhealthy or abusive relationships. Reproductive coercion is now recognized by leading health organizations as an additional mechanism for the association between intimate partner violence and unintended pregnancy (ACOG, 2013).

STRATEGIES FOR INTERVENTION

Women experiencing reproductive coercion may not necessarily recognize such coercive behaviors as unhealthy or abusive, especially if there is no history of physical or other forms of sexual violence in their relationship. Health care providers are in a unique position to increase awareness among their female patients about the impact of unhealthy relationships on their health, including pregnancy risk associated with reproductive coercion. The American Congress of Obstetricians and Gynecologists (2013) has recommended that all reproductive health care providers assess for reproductive coercion in their patients. Providers are instructed to have a conversation with clients about their reproductive health needs in the context of healthy and unhealthy relationships, gauge partner influence over their contraceptive use and condom use, and discuss strategies women can employ to have control in their reproductive health decision making, such as using longer acting reversible contraceptives that their partner cannot control.

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A key component of this clinical intervention includes connecting women with community resources that have expertise in domestic and sexual violence. Because women experiencing reproductive coercion may not self-identify as abused, and thus, may not seek services on their own, a strong collaboration between advocates in the sexual assault and domestic violence fields, and local health care providers is critical. Advocates and clinicians, alike, will feel more comfortable referring to their community partners if they are familiar with the scope of services provided as well as the names of staff and management of their community partners.

Training to facilitate supported referrals to community partners

When clinics decide to implement training on reproductive coercion, it is most effective for advocates to be an active part of the process. It is recommended that advocates meet with clinic staff, discuss the services that are offered by the local agency, and walk providers through what will happen when a referral is made to

their organization. Clinicians should know their local advocate partners on a first name basis, and vice versa. Advocates can emphasize that clinicians do not have to be the experts on reproductive coercion and other forms of abuse. Rather, a strong partnership with the rape crisis center and domestic violence agency may help clinicians feel supported to discuss reproductive coercion with their patients because they know and are comfortable working closely with the advocates to keep their clients safe. Such dialogue between clinics and advocates should ideally happen on a regular basis in the event of refresher trainings or new hires to the clinic.

Creating referral resources for clinics

Advocates can also help their clinical partners by creating a referral list of other local resources in the community that may be useful to a woman in an abusive relationship. In addition to contact information for the local domestic violence shelter, these resources may include local legal aid organizations, food pantries, and national and local hotline numbers.

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ABOUT THE AUTHOR

Heather McCauley, ScD, ScM is a Postdoctoral Fellow in the Department of Pediatrics, University of Pittsburgh School of Medicine Division of Adolescent Medicine at the Children's Hospital of Pittsburgh of UPMC.

ADDITIONAL RESOURCES

Futures Without Violence:
<http://www.futureswithoutviolence.org>

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