Violence and Reproductive Health

Reproductive and sexual coercion and violence is a harmful, pervasive, and costly problem;[1-4]. Violence limits people's ability to optimize their health overall, and their reproductive and sexual health uniquely. Violence within a relationship or family can have lasting harmful effects for the survivor, their pregnancy, and children. A growing body of research indicates that intimate partner violence is associated with decreased contraceptive use, increased sexually transmitted infection risk, unintended pregnancy, and poor birth outcomes.[5-10] **Comprehensive sexual and reproductive health care access, delivered in a person-centered and healing justice informed approach, is critical.**

What is sexual and reproductive coercion?

Sexual and reproductive coercion is behavior that interferes with a person's ability to meet their reproductive and/or sexual goals, such as:

- Intentionally exposing a partner to a sexually transmitted infection (STI)
- Attempting to impregnate a person against their will
- Intentionally interfering with birth control
- Threatening or acting violent if a partner does not comply with the perpetrator's wishes regarding birth control or the decision whether to continue or end a pregnancy

Although this form of violence happens on an interpersonal level, it is useful to situate sexual and reproductive coercion in a social-ecological model which recognizes the array of influences including structural inequities and oppression that put individuals at increased risk of victimization and perpetration.

Who is affected by sexual and reproductive coercion?

This form of violence is prevalent.

- 1 in 3 people report experiencing intimate partner violence and 44% of women and 25% of men report rape or attempted rape. [4]
- Forty-seven percent of transgender people report prior sexual assault and 54% of transgender people report experiencing intimate partner violence[11]
- The majority of these intimate and gender-based offenses occur before the age of 25,[4] potentially impacting ideas of justice and safety, support-seeking behaviors, and future risk of violence thereafter

This form of violence affects patients/clients where clinicians and advocates work.

- 16% of individuals presenting for routine obstetrical and gynecologic care reported prior reproductive coercion[12]
- 26% of individuals presenting for family planning care reported prior reproductive coercion[13]
- 25% of callers to an intimate partner violence hotline reported prior reproductive coercion[14]
- 74% of individuals presenting to family planning or domestic violence shelters reported prior reproductive coercion[15]

This form of violence disproportionately affects some.

- Reproductive coercion may be more common among racial/ethnic and sexual minorities[5,7,12,13,16,17]
- Adolescents with partners more than five years older than them more often report reproductive coercion[18]
- Those affected by reproductive coercion are at elevated risk of other forms of violence[19,20]
- Racial/ethnic minorities suffer more from the sequalae of reproductive coercion, including greater barriers to abortion care, higher rates of maternal morbidity and mortality, increased risk of poor birth outcomes, and lower quality screening, treatment, and outcomes for cervical cancer[21]
- These differences are likely the result of systematic racism, structural inequities, and problematic power differences

What are the distinct reproductive health needs of survivors?

Survivors are at increased sexually transmitted infection risk.

- By definition, those affected are more likely to have sexual activity without a barrier method and/or have partners who refuse condom use or engage in condom destruction[18,22-24]
- As part of a resistance strategy, meaning strategies survivors use to achieve their reproductive and sexual goals despite partner coercion or violence, individuals are more likely to present for sexually transmitted infection testing more often[6]
- Affected individuals are at elevated risk of having a sexually transmitted infection[25,26]

Survivors report disruption of contraceptive goals.

- Report of reproductive coercion is associated with decreased sense of sexual and contraceptive self-efficacy (sense of control)[8]
- Individuals affected by reproductive coercion have a lower likelihood of using contraception at the time of last penile-vaginal intercourse[8]
- Recent reproductive coercion is associated with increased emergency contraception use;[6] this is an effective and important form of contraception, but may represent partner interference with a preferred contraceptive method

Survivors deserve access to comprehensive pregnancy management.

- Reproductive coercion is associated with both unintended pregnancy and undesired pregnancy.[5,10,13] Pregnancy intendedness is complex and nonbinary. Intentions, desires, and feelings related to pregnancy may also shift. All patients/clients deserve the support and resources to determine how they personally want to manage a pregnancy, whether abortion, adoption, or parenting.
- Partner pressure to both seek or avoid abortion have been reported, and perpetrators are more likely to compel pregnancy continuation.[27] Individuals who access abortion care state that a major reason for seeking abortion is to end an abusive relationship or avoid having children with an abusive person.[28] Being denied an abortion undermines fundamental rights for all who seek this healthcare, and not having access to comprehensive care including abortion represents a unique risk for ongoing violence for those with abusive partners.[29]

Clinicians are positioned to be partners in violence resistance.

Clinicians' existing skillset in delivering sexual and reproductive health care facilitates offering of harm reduction strategies to their patients, regardless of disclosure.

Sexually transmitted infection risk

- Screen according to higher risk guidelines: Clinicians can make individualized recommendations in accordance with Centers for Disease Control and Prevention guidelines based on profile (e.g. mutual monogamy, ability to use barrier methods) and testing results (e.g. positive gonorrhea, chlamydia, and/or trichomonas results warrant close interval retesting).[30]
- Recognize unique needs of partner notification: Clinicians can discuss options for partner notification following a positive result. Affected individuals may not feel safe disclosing these results.[31] Instead, clinician offices or public health departments can inform partners and facilitate treatment.
- Assess for acceptability of pre-exposure prophylaxis: Current guidelines suggest substantial risk of HIV transmission to cisgender women and transgender men who have recent bacterial sexually transmitted infection or who have condom-less penile-vaginal intercourse.[32] This harm reduction strategy is underutilized.[33]

Contraceptive control

- Use a patient-centered approach in the preference-driven care of contraception: Patient-centered contraceptive counseling is a well-established cornerstone of family planning care. Contraceptive discussions involve building trust while synergizing individual preferences with offering of a range of contraceptive methods.[34]
- Additional nuance can be considered for the contraceptive use among this population: Other considerations for those affected by reproductive coercion include desire for user-independent methods, like implants, to avoid partner-interference and/or interest in menstrual preservation in the case of partner cycle monitoring. Clinicians must take

care to avoid contribution to coercion through enthusiastic endorsement of long-acting reversible contraceptives.[35]

- Minimize barriers to emergency contraception: Emergency contraception may be a particularly important means of returning power over reproductive goals to the affected individual. Oral levonorgestrel (Plan B) is available over the counter. Ulipristal acetate requires a prescription and counseling regarding its use in proximity to other progestin-containing contraceptives. Clinicians may facilitate access through prescriptions before an urgent need arises. Clinicians should also be aware that both copper and levonorgestrel intrauterine devices provide highly effective emergency (and ongoing) contraception.[36]

Pregnancy management needs

- Determine preferred pregnancy management: The vast majority of individuals who present for abortion care are certain of their decision.[37] Family planning clinicians have sophisticated philosophy and practice in place to confirm that pregnancy decisions are made with certainty, without coercion, and with appropriate support.[38] This existing infrastructure can assist those affected by violence in navigating to the best, individual pregnancy outcome.
- Pregnancy continuation may benefit from additional support: For those who desire to continue their pregnancy, additional social support and safety measures throughout their prenatal course may be beneficial, as pregnancy itself may represent a time of increased risk of violence. Connecting with state domestic or sexual violence advocacy centers, hospital advocates, or social workers, if desired by the individual, is worth exploring. If these individuals are concerned about contraceptive interference after delivery, in-hospital delivery of care should be offered.
- No singular recommendation for mode of induced abortion: For those who desire to end their pregnancy, medication abortion and procedural abortion are options in the first trimester. The individual may desire medication abortion for its likeness to a miscarriage; others may desire a procedural intervention to avoid risk of tampering with medications at home by their partners.[39] The presence of violence may not be the singular deciding factor in pursuing a particular mode of abortion, such that these individuals should be counseled based on other preferences as well (e.g. preference for completion in one encounter as in a procedural abortion, preference for comfort of care outside of the clinic as in a medication approach)

For more information on trauma-informed approaches to addressing violence in reproductive and adolescent health settings, visit https://ipvhealth.org/health-professionals/educate-providers/.

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