



VIOLENCE AND REPRODUCTIVE HEALTH

A Resource on Reproductive Coercion

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 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 sequelae 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.
- 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. 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/>.

Authors:

Dr. Kathryn Fay, MD, MSCI (she/her)

Instructor, Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School
Women's Reproductive Health Research (WRHR) Scholar, Division of Family Planning, Brigham and Women's Hospital

Dr. Elizabeth Miller, MD, PhD(she/her)

Director, Division of Adolescent and Young Adult Medicine, UPMC Children's Hospital of Pittsburgh
Professor of Pediatrics, Public Health, and Clinical and Translational Science, University of Pittsburgh
School of Medicine

Kate Vander Tuig, MPH

Futures Without Violence



REFERENCES:

1. Peterson C, DeGue S, Florence C, Lokey CN. Lifetime Economic Burden of Rape Among U.S. Adults. *Am J Prev Med.* 2017;52(6):691-701.
2. Peterson C, Xu L, Florence C. Average medical cost of fatal and non-fatal injuries by type in the USA. *Inj Prev.* 2021;27(1):24-33.
3. Fang X, Brown DS, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse Negl.* 2012;36(2):156-165.
4. Smith SG, Zhang X, Basile KC, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release,. In: National Center for Injury Prevention and Control CfDCaP, ed. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2018.
5. Miller E, McCauley HL, Tancredi DJ, Decker MR, Anderson H, Silverman JG. Recent reproductive coercion and unintended pregnancy among female family planning clients. *Contraception.* 2014;89(2):122-128.
6. Kazmerski T, McCauley HL, Jones K, et al. Use of reproductive and sexual health services among female family planning clinic clients exposed to partner violence and reproductive coercion. *Matern Child Health J.* 2015;19(7):1490-1496.
7. Sutherland MA, Fantasia HC, Fontenot H. Reproductive coercion and partner violence among college women. *J Obstet Gynecol Neonatal Nurs.* 2015;44(2):218-227.
8. Katz J, Poleshuck EL, Beach B, Olin R. Reproductive Coercion by Male Sexual Partners: Associations With Partner Violence and College Women's Sexual Health. *J Interpers Violence.* 2015.
9. Hill A, Pallitto C, McCleary-Sills J, Garcia-Moreno C. A systematic review and meta-analysis of intimate partner violence during pregnancy and selected birth outcomes. *Int J Gynaecol Obstet.* 2016;133(3):269-276.
10. Fay KE, Yee LM. Birth Outcomes Among Women Affected by Reproductive Coercion. *J Midwifery Womens Health.* 2020;65(5):627-633.
11. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The Report of the 2015 U.S. Transgender Survey. In: Washington, DC: National Center for Transgender Equality.; 2016.
12. Clark LE, Allen RH, Goyal V, Raker C, Gottlieb AS. Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients. *Am J Obstet Gynecol.* 2014;210(1):42 e41-48.
13. Miller E, Decker MR, McCauley HL, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception.* 2010;81(4):316-322.
14. National Domestic Violence Hotline and the Family Violence Prevention Fund. 1 in 4 Callers to the National Domestic Violence Hotline Report Birth Control Sabotage and Pregnancy Coercion. <https://www.thehotline.org/news/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/#comments>. Published 2011. Accessed October 3, 2021.



15. Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. *Soc Sci Med.* 2010;70(11):1737-1744.
16. McCauley HL, Dick RN, Tancredi DJ, et al. Differences by sexual minority status in relationship abuse and sexual and reproductive health among adolescent females. *J Adolesc Health.* 2014;55(5):652-658.
17. Holliday CN, McCauley HL, Silverman JG, et al. Racial/Ethnic Differences in Women's Experiences of Reproductive Coercion, Intimate Partner Violence, and Unintended Pregnancy. *J Womens Health (Larchmt).* 2017;26(8):828-835.
18. Hill AL, Jones KA, McCauley HL, Tancredi DJ, Silverman JG, Miller E. Reproductive Coercion and Relationship Abuse Among Adolescents and Young Women Seeking Care at School Health Centers. *Obstet Gynecol.* 2019;134(2):351-359.
19. Dick RN, McCauley HL, Jones KA, et al. Cyber Dating Abuse Among Teens Using School-Based Health Centers. *Pediatrics.* 2014;134(6):1560-1567.
20. Gee RE, Mitra N, Wan F, Chavkin DE, Long JA. Power over parity: intimate partner violence and issues of fertility control. *Am J Obstet Gynecol.* 2009;201(2):148 e141-147.
21. Eichelberger KY, Doll K, Ekpo GE, Zerden ML. Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology. *Am J Public Health.* 2016;106(10):1771-1772.
22. Silverman JG, McCauley HL, Decker MR, Miller E, Reed E, Raj A. Coercive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspect Sex Reprod Health.* 2011;43(1):60-65.
23. Nikolajski C, Miller E, McCauley HL, et al. Race and reproductive coercion: a qualitative assessment. *Womens Health Issues.* 2015;25(3):216-223.
24. Teitelman AM, Tennille J, Bohinski JM, Jemmott LS, Jemmott JB, 3rd. Unwanted unprotected sex: condom coercion by male partners and self-silencing of condom negotiation among adolescent girls. *ANS Adv Nurs Sci.* 2011;34(3):243-259.
25. Northridge JL, Silver EJ, Talib HJ, Coupey SM. Reproductive Coercion in High School-Aged Girls: Associations with Reproductive Health Risk and Intimate Partner Violence. *J Pediatr Adolesc Gynecol.* 2017.
26. Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine.* 2000;9(5):451-457.
27. Silverman JG, Decker MR, McCauley HL, et al. Male perpetration of intimate partner violence and involvement in abortions and abortion-related conflict. *Am J Public Health.* 2010;100(8):1415-1417.
28. Chibber KS, Biggs MA, Roberts SC, Foster DG. The role of intimate partners in women's reasons for seeking abortion. *Womens Health Issues.* 2014;24(1):e131-138.
29. Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med.* 2014;12:144.



30. Workowski KA, Bachmann LH, Chan PA, et al. Sexually Transmitted Infections Treatment Guidelines, 2021,. MMWR Recommendations and Reports. 2021;70(4):1-187.
31. Decker MR, Miller E, McCauley HL, et al. Intimate partner violence and partner notification of sexually transmitted infections among adolescent and young adult family planning clinic patients. *Int J STD AIDS*. 2011;22(6):345-347.
32. Division of HIV Prevention NCfH, Viral Hepatitis, STD, and TB Prevention,. Is PrEP right for me? . Centers for Disease Control and Prevention. <https://www.cdc.gov/hiv/basics/prep/prep-decision.html>. Published 2021. Accessed October 4, 2021.
33. Mayer KH, Agwu A, Malebranche D. Barriers to the Wider Use of Pre-exposure Prophylaxis in the United States: A Narrative Review. *Adv Ther*. 2020;37(5):1778-1811.
34. Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clin Obstet Gynecol*. 2014;57(4):659-673.
35. Higgins JA, Kramer RD, Ryder KM. Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women. *Am J Public Health*. 2016;106(11):1932-1937.
36. Turok DK, Gero A, Simmons RG, et al. Levonorgestrel vs. Copper Intrauterine Devices for Emergency Contraception. *N Engl J Med*. 2021;384(4):335-344.
37. Foster DG, Gould H, Taylor J, Weitz TA. Attitudes and Decision Making Among Women Seeking Abortions at One U.S. Clinic. *Perspectives on Sexual and Reproductive Health*. 2012;44(2):117-124.
38. Perrucci AC. Decision Assessment and Counseling in Abortion Care. Lanham, MD: Rowman & Littlefield Publishers; 2012.
39. Grace KT. Caring for Women Experiencing Reproductive Coercion. *J Midwifery Womens Health*. 2016;61(1):112-115.

