Reproductive Coercion: State of the Science (2010-2022)

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Disclosures

- 1.5 NCPD Contact Hours and up to 1.5 CPH Recertification Credits may be earned upon successful completion.
- For successful completion, participants must attend the entire educational activity and complete the online course evaluation.
- The educational activity evaluation will be open at 4:30 P.M. on **September 28, 2023**, and close on **October 15, 2023.**
- No relevant financial relationship exists for anyone in the position to control content for this activity.
- This educational activity is being jointly provided by the Public Health Nursing Institute for Continuing Excellence and the North Carolina Public Health Association.
- The Public Health Nursing Institute for Continuing Excellence is approved as a provider of nursing continuing professional development by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Learning Objectives

1. Explain the concept of reproductive coercion.

2. Compare the three forms of reproductive coercion (e.g., contraceptive sabotage, pregnancy pressure, and pregnancy outcome pressure).

3. Identify the populations who are at an increased risk of experiencing reproductive coercion (e.g., age, race/ethnicity, sociodemographic characteristics).

4. Understand what types of interventions have been conducted in these populations focused on reducing the incidence of reproductive coercion.

5. Participate in a case study regarding reproductive coercion and an adolescent female seeking reproductive/sexual health services at a local health department.

Genesis of this Presentation

- Reproductive coercion is an important public health concern, and little is known about this concept in the literature.
- 2017 Building Bridges Conference – asked to speak on this topic….
- 2020 – Pilot study with two NC Health Departments (Cumberland and Harnett) and one walk-in clinic in Indianapolis…..found an 8% prevalence of RC among our sample.
- In 2021 we conducted a primary systematic review on reproductive coercion (RC) studies that include adolescents and young adult women in the United States published between 2010 to 2022.
- A total of 57 studies were included in the review and of these there were 49 descriptive and 8 intervention studies identified.

Reproductive Coercion Video

https://youtu.be/1Ggf1cOVTfo

What is Reproductive Coercion?

Behavior that interferes with the autonomous decision-making of a woman regarding reproductive health.

Involves behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.

Interferes with contraception use and pregnancy.

First identified in the literature in 2010.

ACOG Committee Opinion, February 2013; Grace & Anderson, 2018; Miller et al., 2010

Three Forms of Reproductive Coercion

- Contraceptive Sabotage

- Pregnancy Pressure

- Pregnancy Outcome Pressure

Contraceptive Sabotage

Active interference with a partner's contraceptive methods in an attempt to promote pregnancy.

Examples include:

- hiding, withholding or destroying condom
- not withdrawing when agreed upon as method of birth control
- removing vaginal rings, contraceptive patches, intrauterine devices
- condom refusal or removing mid-intercourse

ACOG Committee Opinion, 2013; Grace & Anderson, 2018

Pregnancy Pressure

Involves behavior intended to pressure a female partner to become pregnant when she does not wish to become pregnant.

Examples include:

- verbal and emotional pressure by a male partner
- threats to hurt the female partner if she does not agree to become pregnant
- pressure to stop using contraception

ACOG Committee Opinion, 2013

Pregnancy Outcome Pressure

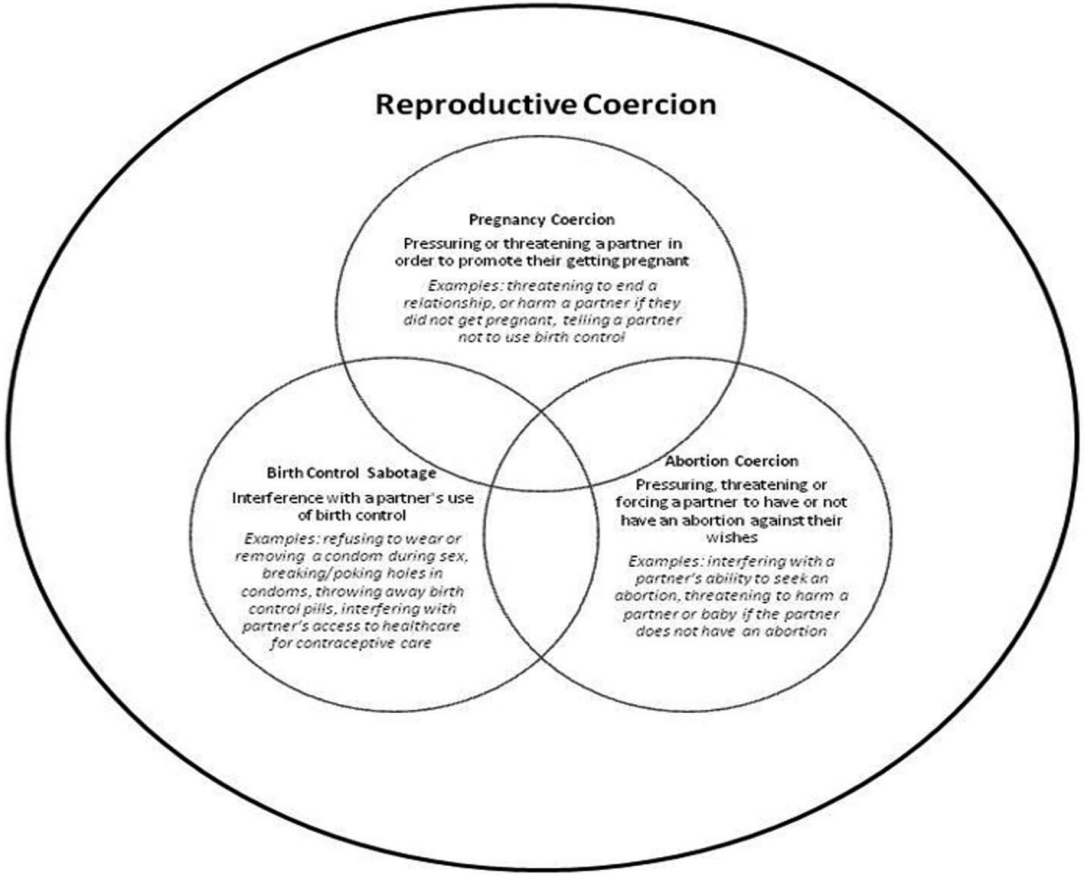
Male partners attempt to ensure a pregnancy outcome (both termination and pregnancy continuation) that is in opposition to the woman's desires.

Examples include:

- threats to hurt the partner if she does not do what he wants (either terminate or carry to term)
- injuring a female partner in a way that may cause a miscarriage

Homicide is a leading cause of pregnancy-associated mortality in the United States.

ACOG Committee Opinion, 2013; Nikolajski et al. 2015



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What is the Prevalence of Reproductive Coercion?

- The range of RC prevalence estimates varied by demographic characteristics such as race/ethnicity, age, study setting, socioeconomic status, and sexual behaviors.

- In addition, the prevalence of RC varied depending upon measurement (e.g., recent or lifetime) where lifetime rates were observed to be higher than recent experience.

- The overall range in prevalence estimates based on ever experiencing RC was 5.2% (Zachor et al., 2018) to 56.6% (Thiel de Bocanegra et al., 2010) among samples of mixed race/ethnicity.

- For those who reported recent RC exposure (defined as less than past 12 months), the range was 1.3% (Basile et al., 2021) to 27.7% (Paterno et al., 2021) among samples of mixed race/ethnicity.

Prevalence Continued – Race/Ethnicity

- Studies that included only non-Hispanic African American women in their samples reported prevalence rates up to 60% for ever experiencing RC (Holliday et al., 2018).
- In a study with American Indian/Alaskan Native women only, the prevalence rate was 45% lifetime and 14% within the past three months (Giacci et al., 2021).
- Hispanic women have reported rates up to 24% (Holliday et al., 2017) and among white women, the highest prevalence rate was also 24% when identified by race alone (Holliday et al., 2018).

Prevalence Continued – Age, SES, Sexual Behaviors

- Two studies reported a 20% and 19% prevalence estimate respectively for ever experiencing RC among adolescents aged 14-19 years of age (Kraft et al., 2021; Northridge et al., 2017).

- Alexander and colleagues (2016) surveyed women (18-25 years of age) who were from sites that provided services to low-income individuals as well as women who reported having sex with women and men (WSWM). They found a 38.3% prevalence rate for ever experiencing RC in this population.

- One study surveyed adolescent females (14-19 years of age) and for those who reported identifying as lesbian or bisexual or engage in sexual behaviors with female partners (i.e., sexual minority girls [SMG]), a prevalence estimate of ever experiencing RC was 12.3% (McCauley et al., 2014).

Prevalence Continued – Study Settings and Design

- Thiel de Bocanegra and colleagues (2010) conducted a qualitative study with women living in domestic violence shelters and reported 56.6% of the women experiencing birth control sabotage (one form of RC).

- The design of the study also was found to make a difference in reported rates with Thaller and Messing (2016) reported as being the first study to compare prevalence rates with face-to-face screenings by the healthcare professional to confidential surveys with the same sample. They found a 3.3% prevalence estimate among the screening sample of ever experiencing RC, and for the confidential survey sample, the prevalence of ever experiencing RC was 15.5%.

Other Populations at an Increased Risk of RC

- The literature presents reproductive coercion as a phenomenon that disproportionately affects:

  - women experiencing concurrent IPV
  - single women
  - women who present frequently to certain health services (i.e., STD clinics, family planning)
  - college women
  - postpartum women experiencing IPV
  - women seeking services in needle-exchange programs

Cha et al., 2015; Grace & Anderson, 2018; Sutherland et al., 2015

What interventions are available to help decrease Reproductive Coercion?

- In contrast to most IPV interventions which depend on programs or resources outside the clinical setting, health care providers can directly provide interventions that address RC within the clinical visit. (ACOG Committee Opinion, 2013)
- Screening and assessment is the cornerstone to detection and intervention of IPV and RC (Park et al., 2016)
- Currently in the literature there are only seven published studies focused on an intervention with the aim of harm reduction strategies in women experiencing RC.

Types of Interventions

The 8 studies identified in this review were conducted using 4 main interventions:

- Project Connect (Burton & Carlyle, 2015; Burton & Carlyle, 2021)
- Addressing Reproductive Coercion in Health Settings [ARCHES] (Miller et al., 2011; Miller et al., 2016; Miller et al., 2017)
- Trauma-Informed Personalized Scripts -TIPS-Plus and TIPS-Basic (Hill et al., 2019; Hill et al., 2021)
- Communication skills training using “Ask-Tell-Ask” and “N-U-R-S-E” types of communication with patient (Zachor et al., 2018).

Project Connect

- Project Connect is an initiative to improve public health responses to RC through provider trainings on screening, intervention, and follow-up preplanning.
- This initiative also provides specific tools for providers to use and is adaptable to culturally competent care and designed to reduce retraumatization in these women.
- This intervention utilized a qualitative design in the study through focus groups and interviewed healthcare providers (nurses, medical assistants, home visiting providers).
- Three themes emerged: “patient factors”, provider’s factors,” and “environmental factors”

Burton & Carlyle, 2015;2021

Addressing Reproductive Coercion in Health Settings [ARCHES]

- ARCHES is a provider delivered intervention and has 3 major elements: universal education and knowledge of RC, harm reduction counseling, and supported referrals to victim services.

- Miller et al. 2011; 2016 conducted randomized control trials and trained family planning counselors teaching on harm reduction, education on RC/IPV, and business card given with resources available in area.

- Two group design of those who received the intervention and those who did not. They found a 71% reduction in the odds of pregnancy coercion compared to participants in the control group (in first study). In their second study, they reported the intervention participants had an improved knowledge of partner violence resources and self-efficacy to enact harm reduction behaviors, and a higher RC score at baseline was associated with a decrease in RC one year later (T3).

- First longitudinal RCT study to evaluate the effectiveness of ARCHES, the only clinic-based intervention focusing on RC.

Miller et al., 2011;2016;2021

Trauma-Informed Personalized Scripts -TIPS-Plus and TIPS-Basic

- TIPS-Plus and TIPS-Basic intervention was developed as a follow up to ARCHES to address implementation barriers and explore the role of technology-based interventions.

- TIPS uses an interactive and user-friendly app with two main components: printed provider scripts about fear, safety, harm reduction strategies, universal education, and patient psychoeducational messages that are based on positive reward-related neuroscience.
- Both studies were randomized control trials with the interactive app to facilitate implementation of patient-provider discussions about IPV, RC, and STIs.

- They reported the provider scripts component of TIPS contributed more strongly to reductions in RC compared to the patient-activation component (interactive app).

Hill et al., 2019;2021

Interventions continued

- Providers should interview patients privately for at least a portion of the visit, and reception areas should clearly state a policy to normalize private interviews.

Examples of screening questions for RC:

- Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use a condom?

- Has your partner ever tried to get you pregnant when you did not want to be pregnant?

- Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?

- Does your partner support your decision about when or if you want to become pregnant?

ACOG Committee Opinion, 2013

Use of safety cards

- The safety card is a small, wallet sized card developed by the National Health Resource Center on Domestic Violence in partnership with ACOG.

- A proven strategy that is a part of the ARCHES intervention (harm reduction focus) and has been tested in three randomized control trials (Miller et al., 2011; Miller et al., 2016; Miller et al., 2017) and has shown positive results. Also used in the study by Zachor et al., 2018 and combined with communication skills training.

- The card can be requested online at https://store.futureswithoutviolence.org/product/did-you-know-your-relationship-affects-your-health-reproductive-health/

Main Take-aways from Intervention Studies

- To date, these studies have found a stronger association with improving provider trainings as compared to patient trainings on this topic.
- Of the eight intervention studies reported in this review, four were among women patients only (50%), two involved interventions with providers only (25%), and two included both women patients and providers (25%).
- These studies were published as early as 2011 and two studies were most recently published in 2021.

Clinical Implications

- Need to include education for RC in adolescent pregnancy prevention efforts as found more young women report RC compared to older women when asked by clinician.

  IPV-exposed women and postpartum contraceptive use is decreased. (Cha et al. 2015)

  Contraception method choice and continuation rates are affected by reproductive coercion. (Allsworth et al., 2013)

  Little is known yet regarding causality or chronology of events for women experiencing RC…is it the chicken or the egg which comes first? Most research is descriptive in literature. (Grace & Anderson, 2018)

So why is Reproductive Coercion important to us?

We have evidence in the literature to support our actions in our current practices while working with women of reproductive age.

We need to screen and assess the women we serve for reproductive coercion as know they are at an increased risk for unintended pregnancy, STIs, and forced pregnancy outcomes.

These are all public health concerns and interventions are available to help in our efforts.

WE ALL CAN MAKE A DIFFERENCE IN THE LIVES OF THESE WOMEN.

Case Study and Break Out into Small Groups

Case Description: Jennifer and Clay (pseudonyms) are an adolescent couple, both aged 16, who live in a predominantly lower socioeconomic neighborhood. Jennifer is a sophomore in high school, while Clay is not currently enrolled in school. They have been dating for a year and are sexually active. Their families are aware of their relationship but are not closely involved in their lives.

Case Background: Jennifer and Clay have been sexually active for the past six months. Jennifer has expressed her desire to use contraception, specifically birth control pills, to prevent pregnancy, as she is not ready to become a mother. However, Clay has consistently resisted the idea of contraception, claiming that it is unnecessary and that he "knows what he's doing." He has also made derogatory comments about birth control, calling it "unnatural."

Case Study and Break Out into Small Groups - CONTINUED

Signs of Reproductive Coercion:

1. **Sabotage of Birth Control**: Jennifer has found her birth control pills missing on several occasions. Clay has admitted to flushing them down the toilet because he doesn't want her to take them.
2. **Pressure to Get Pregnant**: Clay frequently tells Jennifer that he wants to have a baby with her and that it would prove their love. He has become increasingly insistent about this, even though Jennifer has repeatedly expressed her desire to delay parenthood.
3. **Isolation**: Clay has attempted to isolate Jennifer from her friends and family, making it difficult for her to seek support or discuss their relationship issues with anyone.
4. **Threats and Emotional Abuse**: When Jennifer continues to push for contraception, Clay threatens to break up with her and verbally belittles her, making her feel guilty for wanting to prevent pregnancy.

Case Study and Break Out into Small Groups - CONTINUED

Break into small groups and discuss this case study and consider the following issues:

1) Jennifer is a client in the family planning clinic, and you are the nurse who is interviewing her before she sees the provider:

   a) what questions can you ask Jennifer to screen for RC?
   b) what consequences of RC could Jennifer be experiencing? (e.g., physical, psychosocial, etc)
   c) what would you do if Jennifer shared with you these signs of RC she is experiencing?
   d) what resources are available in your county that you could refer her to or provide any educational material to her on RC?

Thank you for your attention and all that you do!
Questions?

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