

Editorial

Reproductive coercion: connecting the dots between partner violence and unintended pregnancy[☆]

Reproductive health professionals are in a critical position to reach women victimized by abusive relationships. In the general population, physical and sexual violence victimization by an intimate partner affects an estimated one in four women across the life span, with one in five adolescent girls reporting such abuse [1–3]. The prevalence of intimate partner violence reported among women utilizing sexual health services and seeking care in gynecologic and adolescent clinics is generally double these population-based estimates [4–7]. This is not surprising, as such victimization is consistently associated with increased pregnancy and sexually transmitted infection (STI), with abused women demonstrating disproportionately higher rates of seeking care at family planning and other health services related to sexual health, such as HIV and STI testing [8–16].

Moreover, mounting evidence that unintended pregnancy occurs more commonly in abusive relationships highlights that victimized women face compromised decision making regarding contraceptive use and family planning, including condom use [17–22]. Forced sex, fear of violence if she refuses sex and difficulties negotiating contraception and condom use in the context of an abusive relationship all contribute to increased risk for unintended pregnancy and STIs. Thus, in settings where women seek care for sexual and reproductive health services, providers are well situated to build a bridge to further services for a significant number of women affected by partner violence. We suggest that providers can actually do more than simply offering a woman victim advocacy hotline numbers, based on new research findings.

In the April issue of *Contraception*, we highlighted a phenomenon we labeled “reproductive coercion”: explicit male behaviors to promote pregnancy (unwanted by the woman). Reproductive coercion can include “birth control sabotage” (interference with contraception) and/or “preg-

nancy coercion,” such as telling a woman not to use contraception and threatening to leave her if she doesn’t get pregnant [23–26]. While reproductive coercion was associated with unintended pregnancy in our study, we found that the risk for unintended pregnancy doubled among those women reporting both partner violence and reproductive coercion. This is certainly not surprising, as women in abusive relationships are more likely to fear the consequences of resistance to such coercive behaviors.

Reproductive coercion provides a new lens on contraceptive decision making and counseling women regarding pregnancy prevention options. This evidence linking partner violence, male influences on contraceptive decision making and unintended pregnancies underscores the need to strengthen connections between family planning practices and policies with efforts to reduce intimate partner violence [27]. Reproductive health care providers should receive specific tools to assess for reproductive coercion and strategies to help affected clients. These tools and strategies include safety cards and posters that educate clients about reproductive coercion and methods of contraception that partners cannot interfere with (i.e., intrauterine devices, injectable contraceptives), policies that ensure clients have access to emergency contraception as well as longer acting and hidden forms of contraception, and training for providers on how to offer referrals to domestic violence hotlines and shelter resources. Planned Parenthood Federation of America has been working in tandem with the Family Violence Prevention Fund to implement these tools and strategies. This effort began with Planned Parenthood Shasta/Diablo (partner in this recent study) and has continued with affiliates in Los Angeles and Santa Barbara.

Screening and counseling related to reproductive coercion have benefits even for patients who may not currently identify themselves as being in a coercive relationship. Conversations on this topic may encourage women to recognize how an unhealthy relationship might be constraining her reproductive autonomy and affecting her health, while simultaneously providing an opportunity to introduce strategies to protect her sexual and reproductive health.

For adolescents in particular, assessment of a male partner’s reproductive coercion may help to explain a

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young woman's inconsistent contraceptive use. Education and harm reduction strategies may be especially helpful for this population, as teens may misinterpret a partner's controlling behaviors as evidence of his love, may not recognize such behaviors as abusive or coercive and may be particularly susceptible to such tactics based on conflicting peer pressures as well as her own ambivalence regarding pregnancy. Prior to assuming that a non-adherent teen needs additional education or motivation, assessment for partner violence and reproductive coercion may help to identify those young women struggling in an unhealthy relationship.

This work also has important implications for pregnancy prevention programs. Comprehensive sexuality education curricula that integrate discussions of partner violence, reproductive coercion and the contrast with healthy relationships are desperately needed. This information might increase girls' and women's self-efficacy in negotiating contraceptive and condom use while providing skills and knowledge on how to seek help for an unhealthy relationship. Of course, prevention programs that directly engage men and boys in reducing unintended pregnancy and promoting healthy, respectful, gender-equitable relationships are also needed.

Many questions emerge from this initial study. Pregnancy-controlling behaviors are certainly not exclusive to abusive relationships, but women experiencing partner violence appear to be at higher risk for experiencing reproductive coercion, and the experience of partner violence amplifies the impact of such coercion on women's risk for unintended pregnancy [6,23,24]. How reproductive coercion operates in the absence of violence requires further study. In addition, does partner violence manifest before attempts to control a woman's pregnancy and the outcomes of that pregnancy? Or do coercive behaviors that include attempts to control her body and reproductive outcomes foreshadow physical and sexual violence in the relationship? And related to this, why might men engage in such controlling behaviors? How do they recognize and understand reproductive coercion? And finally, what might we do to reduce the prevalence of this range of behaviors among young men?

In conclusion, the addition of this concept of reproductive coercion may help providers in reframing inconsistent contraceptive use, moving us away from regarding this simply as a woman's problem with noncompliance. We in the reproductive health field must strive to create sensitive, stigma-free spaces for women struggling in unhealthy relationships and contribute concretely towards promoting their safety and reducing their risk for unintended pregnancy.

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