The American College of
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WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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**Committee on Health Care for Underserved Women**

*This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

# Reproductive and Sexual Coercion

**ABSTRACT:** Reproductive and sexual coercion 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. This behavior includes explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods. Obstetrician–gynecologists are in a unique position to address reproductive and sexual coercion and provide screening and clinical interventions to improve health outcomes. Because of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for intimate partner violence and reproductive and sexual coercion at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup). Interventions include education on the effect of reproductive and sexual coercion and intimate partner violence on patients' health and choices, counseling on harm-reduction strategies, and prevention of unintended pregnancies by offering long-acting methods of contraception that are less detectable to partners.

## Background

Reproductive and sexual coercion 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 (1). Reproductive coercion is related to behavior that interferes with contraception use and pregnancy (1). The most common forms of reproductive coercion include sabotage of contraceptive methods, pregnancy coercion, and pregnancy pressure. Birth control sabotage is active interference with a partner's contraceptive methods in an attempt to promote pregnancy (1). Examples include hiding, withholding, or destroying a partner's oral contraceptives; breaking or poking holes in a condom on purpose or removing a condom during sex in an attempt to promote pregnancy; not withdrawing when that was the agreed upon method of contraception; and removing vaginal rings, contraceptive patches, or intrauterine devices (IUDs). Pregnancy pressure involves behavior intended to pressure a female partner to become pregnant when she does not wish to become pregnant (1). Pregnancy coercion involves coercive behavior such as threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision to terminate or continue a pregnancy (1). Examples of pregnancy pressure and coercion include threatening to hurt a partner who does not agree to become pregnant, forcing a partner to carry a pregnancy to term against her wishes through threats or acts of violence, forcing a female partner to terminate a pregnancy when she does not want to, or injuring a female partner in a way that may cause a miscarriage (1). Homicide is a leading cause of pregnancy-associated mortality in the United States (2, 3). In one study, the majority of pregnancy-associated homicides were committed by an intimate partner (2).

Sexual coercion includes a range of behavior that a partner may use related to sexual decision making to pressure or coerce a person to have sex without using physical force (1). This behavior includes repeatedly pressuring a partner to have sex, threatening to end a relationship if the person does not have sex, forcing sex without a condom or not allowing other prophylaxis use, intentionally exposing a partner to a sexually transmitted infection (STI), including human immunodeficiency virus (HIV), or threatening retaliation if notified of a positive STI test result (1).

One quarter of adolescent females reported that their abusive male partners were trying to get them pregnant

through interference with planned contraception, forcing the female partners to hide their contraceptive methods (4). In one study of family planning clinic patients, 15% of women experiencing physical violence also reported birth control sabotage (5). Among adolescent mothers on public assistance who experienced recent intimate partner violence (IPV), 66% experienced birth control sabotage by a dating partner (6). Compared with women not experiencing abuse, women experiencing physical abuse and women disclosing psychologic abuse by an intimate partner had an increased risk of developing an STI (7). Based on this information, health care providers should include reproductive and sexual coercion and IPV as part of the differential diagnosis when patients are seen for pregnancy testing or STI testing, emergency contraception, or with unplanned pregnancies because intervention is critical.

## Violence and Reproductive Health

Many women who experience reproductive and sexual coercion also experience physical or sexual violence. It may occur independent of physical or sexual violence. Evidence demonstrates that violence and poor reproductive health outcomes are strongly linked. Experiencing violence increases a woman's risk of unintended pregnancies. Women who have experienced IPV are more likely to report a lack of birth control use because of a partner's unwillingness to use birth control or because the partner wants a pregnancy (8). One study found that women with unintended pregnancies were four times more likely to experience IPV than women whose pregnancies were intended (9). In 2007, the prevalence of IPV was nearly three times greater for women seeking an abortion compared with women who were continuing their pregnancies (10). Males who perpetrated IPV in the past year were more likely to report inconsistent or no condom use during vaginal and anal intercourse as well as forced sexual intercourse without a condom, increasing the likelihood of unintended pregnancy (5, 11). A significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV, reproductive and sexual coercion, or both (5). Additional reproductive health issues with long-term implications for women who have experienced violence include earlier initiation of sexual intercourse, alcohol or drug abuse, STIs and HIV, miscarriages, and risky sexual health behavior, such as having unprotected sexual intercourse and having multiple sexual partners (12–14).

## Interventions

In contrast to most IPV interventions, which significantly depend on programs or resources outside the clinical setting, health care providers can directly provide interventions that address reproductive and sexual coercion. Interventions can include educating patients about safety planning and support services, offering harm-reduction strategies, and providing discreet and confidential methods of contraception such as IUDs, emergency contraception, depot medroxyprogesterone acetate injections, and etonogestrel implants.

Family planning, clinic-based interventions that focused on awareness of reproductive and sexual coercion and provided harm-reduction strategies to address reproductive and sexual coercion reduced pregnancy coercion by 71% among women who experienced IPV (15). In addition, women in the intervention group were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe (15). Integrating assessment and intervention for women who experience reproductive and sexual coercion into standard reproductive health care practices can enhance the quality of care and improve reproductive health outcomes. Because of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for IPV and reproductive and sexual coercion at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup). Some examples of screening questions include the following:

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

Additional questions can be found in Committee Opinion No. 518, *Intimate Partner Violence*, or at www.acog.org/About_ACOG/ACOG_Departments/Health_Care_for_Underserved_Women/~/media/Departments/Violence%20Against%20Women/Reproguidelines.pdf (1, 16).

Helping patients to conceal contraceptive methods may be necessary to help protect the patient. For example, oral emergency contraception is often packaged in a large box with bold labeling, which could easily be discovered by an abusive partner. Health care providers should consider harm-reduction strategies such as giving a patient a plain envelope for the emergency contraceptive pills. This enables her to remove the packaging so the pills will be less likely to be detected by her partner (1). A copper IUD should be considered instead of oral emergency contraception to provide long-term protection given the high frequency of unprotected sex when reproductive or sexual coercion is identified as the reason for requesting emergency contraception.

It is important to be aware that some partners who perpetrate IPV may monitor bleeding patterns and menstrual cycles. For women in this situation, the copper

IUD could be a safe long-term contraceptive option because it does not typically cause amenorrhea. Health care providers should consider trimming IUD strings inside the cervical canal to ensure they are undetectable and to prevent removal by a partner. It should be noted that many women still have misconceptions about IUDs and would benefit from counseling to address these issues (17).

Because STIs and HIV are highly correlated with abusive relationships, it is important to determine whether the patient feels safe and able to make decisions about condom use and partner notification. If a patient has a positive STI test result and is afraid of how a partner may react when she notifies him or her about the STI, it is important to consider requesting anonymous partner notification services through a local health department.

Futures Without Violence, formerly Family Violence Prevention Fund, a U.S.-based nonprofit organization that works to end violence against women and children around the world, developed small, easy to conceal, wallet-sized safety cards in both English and Spanish, that have been cobranded by the American College of Obstetricians and Gynecologists. The safety cards provide information that helps women make the connection between unhealthy relationships and reproductive health concerns such as unintended pregnancies. The safety cards also include self-administered questions for IPV and reproductive and sexual coercion, harm-reduction and safety planning strategies, and information about how to get help and resources.

Health care providers can use the safety card to facilitate screening and educate patients about the effect of IPV and reproductive and sexual coercion on reproductive health. Asking about IPV and reproductive and sexual coercion lets patients know that they are not alone and that it is safe to talk to the health care provider. Use of these cards provides a brief evidenced-based intervention that can be reviewed with a patient in less than 1 minute (15). Cards may be discretely provided at the annual visit or anytime there is a concern regarding reproductive and sexual coercion or IPV. It is important to remember that it still may not be safe for some patients who are currently experiencing abuse to leave the examination room with the safety card. For additional information on using this card in an office setting, refer to, *Addressing Intimate Partner Violence and Reproductive Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings*, available at: www.acog.org/About_ACOG/ACOG_Departments/Health_Care_for_Underserved_Women/~/media/Departments/Violence%20Against%20Women/Reproguidelines.pdf (1). To obtain copies of the safety cards, send requests by e-mail to underserved@acog.org.

If a patient responds affirmatively to screening questions, the health care provider should validate her experience and commend her for discussing and evaluating her health and relationships. She should be reassured that the situation is not her fault and further assessment of her safety should be elicited and discreet contraceptive options reviewed. For additional support, patients may be offered hotline numbers, use of the office phone to access suggested care, and referral to a domestic violence advocate for additional resources.

## Creating a Safe Environment for Assessment and Disclosure

Health care providers can create a safe and supportive environment for assessing and responding to reproductive and sexual coercion. Practices should have a written policy and provide training to health care providers and employees on IPV and reproductive and sexual coercion, how to offer referrals, and how to establish relationships with women's shelters and state health department violence prevention programs to enhance the services provided (1, 18). Private spaces should be made available to interview women without interruption and where conversations cannot be overheard (1). Having a clearly stated policy in the reception area helps the staff maintain the normal experience of seeing the patient alone without a friend or family member (1). For example, a sign could read, "In this clinic, we respect a patient's right to privacy and always see patients alone for some portion of the visit" (16). Health care providers may display educational posters that address IPV, reproductive and sexual coercion, and healthy relationships that are culturally sensitive, multicultural, and multilingual in bathrooms, reception areas, examination rooms, hallways, and other highly visible areas (1). Having information, including hotline numbers, safety cards, and resources, on display in common areas and in private locations, such as bathrooms and examination rooms, also can be helpful in educating patients who may not be ready to openly discuss their concerns at the present time (1).

Language is important in identifying and assisting patients who have experienced reproductive and sexual coercion. Health care providers must understand the vulnerabilities or triggers, both verbal and physical, that may affect these patients during an examination. Also, when obtaining a medical history, a patient experiencing reproductive and sexual coercion might not respond to the use of the term "rape" because it may occur with her partner and not a stranger. Using a more general term, such as "forced sex," may resonate more with the woman.

Before any assessment, health care providers should inform women about limitations of confidentiality and mandatory reporting legal requirements, which vary by state. A summary of state laws can be found at: www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf. Opponents of mandatory reporting repeatedly raise concerns for the patient's safety and confidentiality subsequent to reporting, the inadequate infrastructure of services for those who

experience violence, and the lack of data to support the assumed benefits of mandatory reporting. This suggests that mandatory reporting is not yet justified and should not be implemented without provisions that allow women to override or veto reporting requirements. However, some jurisdictions do mandate reporting, and health care providers should be familiar with these requirements. In addition, health care providers need to be familiar with relevant state privacy laws and federal regulations regarding the confidentiality of health information. It is important to note issues related to dating violence that involve a minor can also raise questions about mandatory child abuse reporting requirements and statutory rape laws (19). Child protective services, hospital legal counsel, and state medical societies' legal counsel may be helpful in delineating the requirements.

## Recommendations

The American College of Obstetricians and Gynecologists recommends the following for obstetrician–gynecologists to improve the health of women who have been or are experiencing reproductive and sexual coercion:

- Participate in education events regarding reproductive and sexual coercion that covers birth control sabotage, pregnancy pressure and coercion, and the effect of IPV on patients' health and choices.
- Routinely screen women and adolescent girls for reproductive and sexual coercion in a safe and supportive environment that respects confidentiality.
- Counsel patients on harm-reduction strategies and safety planning.
- Offer long-acting methods of contraception that are less detectable to partners, like IUDs and the contraceptive implant or injection.
- Include reproductive and sexual coercion and IPV as part of the differential diagnosis when patients are seen for pregnancy or STI testing, emergency contraception, or with unintended pregnancies.

## National Hotlines and Resources

*The following resources are for information purposes only. Referral to these sources and web sites does not imply the endorsement of the American College of Obstetricians and Gynecologists. These resources are not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice.*

Hotlines

- National Domestic Violence Hotline
  1-800-799-SAFE (7233)
- Rape Abuse & Incest National Network (RAINN) Hotline
  1-800-656-HOPE (4673)

Web Sites

- Futures Without Violence (previously known as Family Violence Prevention Fund)
  www.futureswithoutviolence.org
- National Coalition Against Domestic Violence
  www.ncadv.org
- National Network to End Domestic Violence
  www.nnedv.org
- National Resource Center on Domestic Violence
  www.nrcdv.org
- Office on Violence Against Women
  (U.S. Department of Justice)
  www.ovw.usdoj.gov

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