Pregnancy Coercion and Birth Control Sabotage in Western North Carolina

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Objective: Pregnancy coercion by male sexual partners, including birth control sabotage, is associated with unintended pregnancies. Our objectives were to assess the prevalence, awareness, and relationships of these behaviors.
Study Design: A cross-sectional survey was administered to reproductive age, English-speaking women seeking gynecologic care from June 2010 through March 2011.
Results: Participants completed 328 surveys (56.4% response rate). Of the 319 contraception users, 118 (37%, 95% CI, 33.3%-49-7%) reported pregnancy coercion: 8 (3%) emotional coercion; 62 (19%) birth control sabotage; 48 (15%) both. Only 28 women (9.8%, 95% CI, 6.1%-13.5%) reported sabotage of female-controlled contraception. Pregnancy coercion was associated with unwanted pregnancies ($p = 0.002$) and terminations ($p = 0.012$). Most women (181, 57.5%) learned about pregnancy coercion from this survey.
Conclusion: Pregnancy coercion occurred for 1 in 3 women in WNC. Physicians should screen for these behaviors when screening for intimate partner violence, prescribing contraception or treating women with poor adherence or unintended pregnancies.

Keywords: Reproductive coercion; Pregnancy coercion; Birth control sabotage; Unintended pregnancy

Introduction

Many studies of intimate partner violence (IPV) and/or domestic violence have focused on physical, sexual, and/or emotional abuse in relationships and the consequences thereof. Unintended pregnancy has historically been considered a consequence of these types of abuse.[1] In 2009, researchers proposed a more overt process as an additional component of intimate partner violence called 'reproductive control or reproductive coercion'.[1-3]

Reproductive coercion was described as a pattern of specific behaviors by male sexual partners that violated women's reproductive autonomy and included control over contraceptive use such as sabotage, pregnancy coercion, and post-conception control. Controlling or coercive behaviors included threats, physical abuse, economic control, emotional abuse, and sexual assault in order to ensure the reproductive outcome desired by the sexual partner.[1-3] Birth control sabotage behaviors ranged from not paying for pills, flushing pills, poking holes in condoms, not withdrawing, or forcing sex without birth control with the intent of pregnancy.[4-5] When this type of reproductive coercion exists, a woman is in a situation that leads to unsafe sexual practices, unwanted pregnancy, and potential for pregnancy complications and unsafe abortion.[1-6]

Data on the prevalence of reproductive coercion by men was limited to few samples of women, primarily in northern California. Of the total sample of 1,278 women surveyed at family planning clinics, 53% experienced some type of IPV, 19% reported pregnancy coercion, 15% reported birth control sabotage, and 40% reported a related unintended pregnancy (unintended by the woman). Of note, even women who did not experience other forms of intimate partner violence reported pregnancy coercion and/or birth control sabotage.[2] Among women who had

experienced intimate partner violence, 74% reported experiencing reproductive coercion.[1] Among adolescents with similar intimate partner violence experiences, 26% experienced reproductive coercion.[6]

The prevalence of reproductive coercion in Western North Carolina is unknown. Likewise, patients' awareness of these behaviors and the specific methods of contraception least associated with birth control sabotage have not been reported. Our objectives were to assess the prevalence, awareness, and relationships of reproductive coercion, specifically pregnancy coercion and birth control sabotage with unwanted pregnancies, in Western North Carolina.

Materials and Methods

An Institutional Review Board approved, cross-sectional survey was administered in a busy residency clinic in Western North Carolina between June 2010 and March 2011. Consecutive, English-speaking patients, meeting inclusion criteria, voluntarily completed anonymous surveys in exam rooms while alone and waiting for a care provider. Patients had to be between the ages of 15 and 44, able to consent for their own medical care, and unaccompanied in the exam room (i.e., partner/family asked to remain in waiting room for survey and physical exam). Participation had to occur while licensed social workers were available in the building during eligible visits including: annual exams, postpartum exams $\geq$ 6 weeks postpartum, or other routine gynecological care. Excluded visits were an immediate follow-up to an emergency room visit, when office procedures were scheduled, and during post-operative follow-up. Completed surveys were sealed in self-addressed envelopes and returned to nurses or the check-out staff.

The 74-item, paper-pencil survey consisted of yes/no questions based on previously identified pregnancy coercion and birth control sabotage behaviors[1-2,4-5] as well as socio-demographics and pregnancy history questions including the number of total pregnancies during which a woman felt she did not want to be pregnant. The pregnancy coercion questions began with a stem, "Has someone you were dating or going out with ever…" and was followed by eight specific behaviors such as, "… told you he would have a baby with someone else if you didn't agree to get pregnant." The section on birth control sabotage was divided into eight types of birth control and asked specific questions regarding the lifetime use of that contraceptive option and specific interventions taken by a sexual partner to stop its use. These questions used the same stem, "Has someone you were dating or going out with ever…" followed by statements of active sabotage such as, "…flushed your birth control pills down the toilet," or "….physically removed your IUD against your will," or statements of passive-aggressive sabotage including the refusal to pay for or transport the patient to obtain the birth control. The list of specific sabotage behaviors concluded with questions of whether the patient has ever tried to hide that type of birth control from a partner and if the partner found it.

The last questions asked about whether patients thought hide-able birth control would help protect a woman from these behaviors and if the survey had been educational to the patient. The survey concluded with instructions for accessing behavioral medicine providers if desired.

Results, frequencies, and percentages were presented; the standard error of measure equaled $\pm$ 3.7%. The relationships between reproductive control and unwanted pregnancies and terminations were analyzed using Chi square as were differences in responses between women experiencing reproductive control versus those who had not, differences in rates of sabotage by birth control type, and differences in awareness of the concept of "reproductive coercion" by previous experience with the coercive behaviors.

Results

In total, 350 of 582 surveys were returned; 22 were excluded due to incompletion, evidence of a response bias (all yes or no answers) or failure to follow instructions to skip sections if a specific birth control method had not been used. A total of 328 surveys were usable for a 56.4% response rate.

Women described themselves primarily as white [228 (69.5%)], between the ages of 19 and 30 years [224 (68%)], partnered or married [172 (52.5%)], and having a high school diploma or further post-secondary education [124 (29.9%) or 135 (41.5%), respectively] (see Table 1).

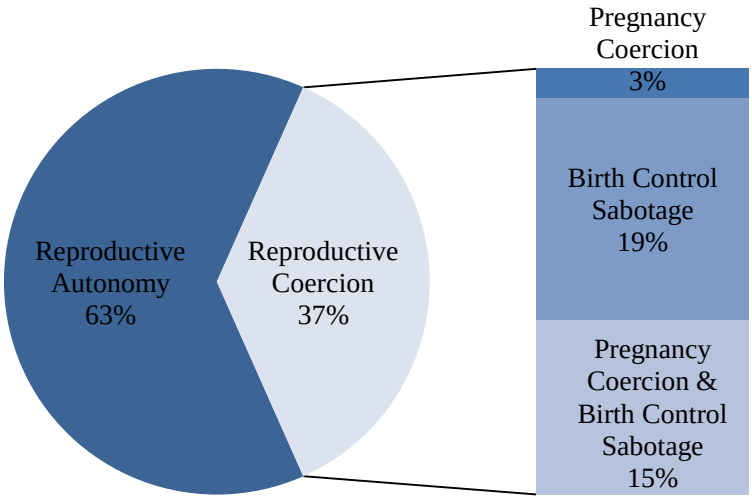
Table 1. Participants' Socio-demographic Characteristics and Pregnancy Histories, N = 328

Characteristics	n (%)	Characteristics	n (%)
Ages (years)		Current Relationship Status	
15-18	34 (10.4)	Single	125 (38.1)
19-21	62 (18.9)	Long term Partner	98 (29.9)
22-25	80 (24.4)	Married	74 (22.6)
26-30	82 (25)	Divorced/Widowed/Separated	17 (5.1)
31-35	36 (11)	Not reported	17 (5.1)
36-45	31 (9.5)		
Not reported	3 (0.9)		
Race/Ethnicity		Education	
White	228 (69.5)	< HS	66 (20.2)
Black	68 (20.7)	HS/GED	124 (37.8)
Hispanic	9 (2.7)	Post-secondary	93 (28.4)
Other	14 (4.3)	College degree or higher	42 (13.1)
Not reported	9 (3.4)	Not reported	2 (0.6)
Parity		Unwanted Pregnancy	
Nulliparous	52 (15.9)	0	199 (61.8)
1-5	271 (82.9)	1	68 (20.7)
6-7	4 (1.2)	2-3	38 (11.6)
Not reported	1 (0.3)	4-7	17 (5.1)
		Not reported	6 (1.8)
Elective Abortions		Miscarriages	
0	259 (79.0)	0	235 (71.6)
1	42 (12.8)	1	64 (19.5)
2-3	21 (6.4)	2-3	24 (7.3)
4-5	1 (0.3)	4-6	5 (1.5)
Not reported	3 (0.9)		

The majority of women were multiparous [275 (84.1%)]. Many women reported having had an unwanted pregnancy [123 (37.4%)] and 64 (18.5%) reported elective pregnancy terminations.

The vast majority of women [319 (97.3%)], reported use of birth control in their lifetime. Of the women reporting birth control use, 118 (37%, 95% CI, 33.3%-49.7%) reported ever having experienced reproductive control during their lifetime (see Figure 1).

Figure 1. Rates of Pregnancy Coercion and/or Birth Control Sabotage



A total of 56 women (17.1%) reported coercive behaviors by someone they were or had been dating, and 16 women (4.9%) reported hiding birth control and/or stopping birth control to prevent upsetting a sexual partner or being discovered using birth control (see Tables 2a and 2b).

Table 2a. Pregnancy Coercion

Answered Yes	N (%)
1. Told you NOT to use birth control (like the pill, shot, ring, etc)?	36 (11)
2. Said he would leave you if you did not get pregnant?	9 (2.7)
3. Told you he would have a baby with someone else if you didn't agree to get pregnant?	7 (2.1)
4. Hurt you physically because you did not agree to get pregnant?	6 (1.8)
5. Said he wanted you to have a baby so you were tied to him forever?	28 (8.5)
6. Accused you of being unfaithful if you would not get pregnant?	9 (2.7)
Answered Yes to any of the above questions	**56 (17.1)**

Table 2b. Coping Behaviors

Answered Yes	N (%)
1. Have you ever hidden birth control from a sexual partner because you were afraid he would get upset with you for using it?	11 (3.4)
2. Have you ever stopped using birth control or didn't get your birth control because you felt that you could not hide it from your partner?	11 (3.4)
Answered Yes to the two above questions	**16 (4.9)**

Any experience of reproductive coercion was related to both having had a previous elective abortion and/or an unintended pregnancy ($p = 0.005$ and $p = 0.006$, respectively).

Use, sabotage, and attempts to hide any of the eight types of birth control are shown in Table 3. Many women reported multiple types of birth control used with 287 (87.5%) having used a female-controlled method including birth control pills, rings, patches, injections, implants, and

intra-uterine devices (IUDs). Additionally, 305 (93%) reported use of male-controlled methods: condoms and withdrawal. Of the 110 women (34.5%, 95%CI 30.8%-38.2%) reporting birth control sabotage, only 28 women (9.8%, 95%CI, 6.1%-13.5%) report sabotage with a female-controlled birth control method.

Birth control sabotage was significantly more frequent for male-controlled methods [98 (32.1%, 95%CI, 28.4%-35.8%); p=0.0001]. No sabotage was reported with injectable forms of birth control; only 2 women (2.4%) reported any sabotage with IUDs. Few women reported attempting to hide specific types of birth control from their sexual partners.

Table 3. Birth Control Use and Sabotage

Answered Yes	Use	Sabotage*			Hid Birth Control Use	Partner Found Birth Control
	n (%)	Any n (%)	Active n (%)	Passive n (%)	n (%)	n (%)
Birth control pills	252 (76.8)	15 (6.0)	12 (4.8)	4 (1.6)	8 (3.2)	2 (37.5)
Nuvaring	57 (17.4)	9 (15.8)	9 (15.8)	0	2 (3.5)	1 (50%)
OrthoEvra patch	40 (12.2)	6 (15.0)	5 (12.5)	2 (5.0)	2 (5.1)	2 (100)
Depo Provera injection	109 (33.2)	3 (2.8)	NA	3 (2.8)	3 (2.8)	2 (66.7)
Intrauterine Device (IUD)	84 (25.6)	2 (2.4)	2 (2.4)	0	0	NA
Implanon or Norplant	24 (7.3)	2 (8.3)	2 (8.3)	0	1 (4.2)	0
Any female birth control	287 (87.5)	28 (9.8)				
Condoms	299 (91.2)	87 (29.1)	87 (29.1)	9 (3.0)	NA	
Withdrawal	146 (44.5)	38 (26.0)	38 (26.0)	NA	NA	
Any male birth control	305 (93.0)	98 (32.1)				
Any birth control	319 (97.3)	110 (34.5)				

Note. *Sabotage Categories: Active included throwing away, physically removing or forcing to have a doctor physically remove IUDs or implants, poking holes in, tearing/breaking or pretending to use condoms, and/or failing to withdraw as agreed. Passive included refusing to pay for or transport to obtain contraception.

When respondents were asked if they had previous awareness about reproductive coercion, the majority reported this survey was the first time they had heard about these types of behaviors, and about 1 in 3 reported they had learned something about relationships (see Table 4). Awareness of reproductive coercion was not related to previous experience with the behaviors (p>0/05).

Table 4. Awareness of Reproductive Coercion

Answered Yes	**Coerced or Sabotaged n (%)**	**Not Coerced or Sabotaged n (%)**
Is this survey the first time you have heard of these behaviors?	56 (51.9)	125 (60.4)
Did you learn anything that could help you in a relationship by taking this survey?	41 (38.3)	73 (35.3)

Comment

Reproductive coercion by sexual partners occurred for more than a third of surveyed women in Western North Carolina. Further, reproductive coercion was significantly associated with both unwanted pregnancies and elective terminations. The majority of women had not heard of these behaviors prior to participation in this survey. Even women who reported these behaviors with current or previous partners indicated this was the first time they heard of them outside of the context of their personal experiences.

This project represents the only data on reproductive coercion in our region to date. And though these results were not representative of the women who chose not to participate in the survey, the response rate of 56% was quite good for a long, paper-pencil survey on a sensitive topic.

Our results were limited further by the exclusion of women receiving prenatal care, those for whom English was not their first language, and women accompanied in exam rooms. We were concerned that forthright survey completion might compromise the safety of patients in relationships where intimate partner violence occurs should those partners be present in the exam room for the entire visit. The majority of our obstetric patients attended appointments with male partners; the majority of our non-English-speaking patients were obstetric patients.

In order to focus primarily on the women most likely to present to our residency clinic for family planning visits, we limited analysis to sexually active women of reproductive age with experience using contraception. Therefore, it is possible that we overestimated or underestimated lifetime prevalence among women of reproductive age not only due to self-selection, through non-participation, language constraints, and safety concerns, but also due to the exclusion of women never allowed to use birth control or unable to attend doctors' appointments alone. However, the percentage of women not experienced with contraception was low, at less than 3% of our total sample; we had no information about other excluded women's experiences.

The prevalence of pregnancy coercion reported by our participants was similar to that reported by women in northern California family planning clinics (18% vs. 19%); however, our prevalence of birth control sabotage was considerably higher (24% vs. 15%).[3] It is unclear whether these differences reflect regional variation in prevalence of this type of intimate partner violence or methodological variation.

Our data did corroborate reported relationships between reproductive coercion and unwanted pregnancies and elective abortions.[2,6] We chose to use the term "unwanted pregnancies" in our survey rather than "unintended pregnancies" as it represents a more specific subset of unplanned pregnancies; a qualitative difference exists in the struggle to cope with an unwanted event versus a mistimed event.

These results suggest public education, screening and counseling for reproductive coercion in our region need to be seriously considered. Furthermore, focus on these components of intimate partner violence may be integral to improving contraceptive adherence. Reducing or eliminating coerced, unwanted pregnancies and the difficult choices and consequences thereof borne by women will need to include more than patient education and counseling about birth control options and prescriptions.[3]

In February 2013, the American College of Obstetrics and Gynecology (ACOG) issued a committee opinion calling for ongoing screening of reproductive and sexual coercion for women seeking gynecologic and obstetric care.[8] Further, ACOG calls for counseling on harm reduction strategies with identified women and prescribing of less detectable, long acting methods of contraception (LARC).[6-7]

The inclusion of reproductive coercion in the College's focus is a tremendous step towards promoting women's reproductive autonomy. The development of valid, standardized, free

screening tools and educational resources for obstetricians in practice or in training is an important next step.

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