



Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention

facts
self-quiz
definitions
assessment
intervention



acknowledgements disclaimers

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Up the River Endeavors (URE) is a consortium of organizations and individuals brought together by an innovative philanthropist, Kenneth Malcolm Jones, whose personal goal is to address the fundamental question of how human beings can reconcile with nature so that we can ensure our own survival and that of other living things that share our planet. There are thirteen member organizations and a growing number of associate members (specialists who are invited to participate in one of our annual meetings) involved in URE. Seventy-five percent of participants are women and each participant is a decision-maker in their organization. Each organization individually addresses important issues such as gender relations, global warming, world peace and social justice. The URE consortium is collectively organized around the perspective that the various problems addressed by each organization have in common one or more root causes. The consortium endeavors to identify and address those root causes.

[Learn more at www.uptheriverendeavors.org](http://www.uptheriverendeavors.org)

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¹Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.



QUICK FACTS

Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.¹



ASSESSMENT TOOLS

Pre-assessment considerations and preparations, potential assessment questions and sample scripts, tips for facilitating the transition from assessment to intervention.



INTERVENTION TOOLS

Steps for validating a woman’s rights within her relationship, helping ensure her physical safety, and assisting her in taking control of her own fertility.

DISCLAIMERS

The contents of this toolkit are designed for informational purposes only, and are not intended as or implied to be a substitute for professional medical advice.

The language of this toolkit reflects the fact that reproductive coercion most often manifests within the context of an intimate, heterosexual relationship. Because women are more likely to be the targets of domestic violence than men (i.e., 3 in 10 women; 1 in 10 men),¹ we use traditional male/female pronouns and references throughout this toolkit when we refer to the abusive individual and the individual being abused. Additionally, the authors of this toolkit recognize that reproductive coercion may occur within the context of LGBTQ relationships, as well as non-sexual relationships (e.g., parent-child relationships) and other types of intimate relationships that may not be specified here. However, because we were unable to obtain empirical data on reproductive coercion in these relationships, we refer to reproductive coercion within heterosexual relationships throughout this toolkit.

To the best of our knowledge, the resources referred to throughout this toolkit provide unbiased and comprehensive information.

¹Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2011). *The national intimate partner and sexual violence survey (NISVS): 2010 summary report*. Atlanta (GA).

introductions

THE FEMINIST WOMEN'S HEALTH CENTER

The Feminist Women's Health Center (FWHC) is a non-profit reproductive healthcare organization based in Atlanta, Georgia that works to empower women so that they can make healthcare decisions in their best interest. Founded in 1977, FWHC's mission is to provide accessible, comprehensive gynecological healthcare to all who need it without judgment. As innovative healthcare leaders, we work collaboratively within our community and nationally to promote reproductive health, rights, and justice. We advocate for wellness, uncensored health information and fair public policies by educating the larger community and empowering our clients to make their

own decisions. Our multifaceted grassroots approach to reproductive healthcare affords us a deep understanding of the intersection between reproductive health and other social and health issues. As such, we strive to provide user-friendly, unbiased resources to our clients, community partners, and allies in an effort to enhance healthcare equity and access for our constituents.

This toolkit is one of many efforts to live up to our mission and it is our hope that you will find the resources here useful and applicable to you and those you care for.

Learn more at: www.feministcenter.org

THE NATIONAL COALITION AGAINST DOMESTIC VIOLENCE

The survivor-led and survivor-focused National Coalition Against Domestic Violence (NCADV) has worked for more than thirty-five years to end violence against women by raising awareness and educating the public about the effects of domestic abuse. Our work includes developing and sustaining ground-breaking public policy at the national level aimed at ending violence; assisting the 2,000+ urban and rural shelters and programs at the local, state, and regional

levels of the nation in the programming they offer to victims seeking safety and assistance; and offering programming that empowers and supports the long-term health and safety of victims of domestic violence. Currently, our constituency encompasses more than 90,000 programs, survivors, advocates, and allied individuals and is growing daily.

Learn more at: www.ncadv.org

THE NATIONAL ORGANIZATION FOR MEN AGAINST SEXISM

The National Organization for Men Against Sexism (NOMAS) is an activist organization of men and women supporting positive changes for men. NOMAS advocates a perspective that is pro-feminist, gay affirmative, anti-racist, dedicated to enhancing men's lives, and committed to justice on a broad range of social issues including class, age, religion, and

physical abilities. We affirm that working to make this nation's ideals of equality substantive is the finest expression of what it means to be men. As an organization for changing men, we strongly support the continuing struggle of women for full equality.

Learn more at www.nomas.org



executive summary

A holistic approach to health requires that healthcare professionals recognize how various aspects of health impact individuals, families, and communities. Partnerships and collaborations are a powerful way to link various healthcare communities to increase understanding and influence positive change with feasible solutions. The purpose of this project is to highlight how social and health issues intersect and impact our communities at large.

The Feminist Women's Health Center, The National Coalition Against Domestic Violence, and the National Organization for Men Against Sexism have partnered together for this project in an effort to bridge the gap between the fields of reproductive health and domestic violence; two fields that work for the good of our communities from different perspectives. Often times, the reproductive health and domestic violence communities function in silos; yet, a growing body of evidence is revealing the numerous ways in which domestic violence impacts reproductive health, and vice versa.

This toolkit provides credible, unbiased information for women and individuals working in the domestic violence and reproductive health communities. The following chapters are designed to empower women to take control of their own reproductive health, and to help domestic violence and healthcare workers recognize the intersections between their fields and respond with practical solutions.



REPRODUCTIVE COERCION **definitions**

Reproductive coercion: Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.¹

Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.

Pregnancy pressure: When an individual pressures or coerces a woman into becoming pregnant against her will.

Birth control sabotage: When an individual interferes with a woman's use of contraception to cause her to become pregnant against her will.

Pregnancy outcome control: When an individual pressures or coerces a woman into continuing or ending a pregnancy against her will.

Concealable contraception: Contraceptives that can be concealed from a sexual partner and that cannot be felt or tampered with (e.g., Implant, IUD, and Injection).

Reproductive autonomy: An individual's ability to control their own fertility and make decisions about their own reproductive health without being manipulated, intimidated, threatened, or harmed by others.

Reproductive health: Diseases, disorders, and conditions that effect the functioning of the reproductive organs during reproductive age. Poor reproductive health is associated with an increased risk of unintended pregnancy, negative pregnancy outcomes (e.g., miscarriage, premature birth, low birth weight, stillbirth, and infant death), and sexually transmitted infections.

Abuser/Batterer: The person in a relationship who uses various forms of abuse (physical, psychological, verbal, emotional, economic, sexual, reproductive, etc.) to gain and maintain control over their intimate partner.



REPRODUCTIVE COERCION **definitions**

Intimate Partner Violence (IPV) (can also be referred to as Domestic Violence)²: A pattern of abusive and threatening behaviors by an intimate partner or ex-partner that may include physical, emotional, economic, and sexual violence as well as intimidation, isolation, and coercion. IPV is a conscious, concerted effort on the part of an abusive individual to establish and exert power and control over another, usually by any means possible, and can manifest in numerous ways including:

- **Physical violence**—the use of physical force (e.g., shoving, choking, shaking, slapping, punching, burning, or use of a weapon, restraints, or one's size and strength against another person) with the potential for causing death, disability, injury, or physical harm.

- **Sexual violence**—(three categories): (1) the use of physical force to compel a person to engage in a sexual act unwillingly, whether or not the act is completed; (2) an attempted or completed sexual act involving a person who, because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure, is unable to understand the nature or condition of the act, decline participation, or communicate unwillingness to engage in the act; and (3) abusive sexual contact.

- **Threats of physical or sexual violence** with the intent to cause death, fear, terror, disability, injury, or physical harm through the use of words, gestures, or weapons.

- **Psychological/emotional/verbal violence:** acts, threats of acts, or coercive tactics which traumatize an abused individual (e.g., humiliating the victim, controlling what the victim can and cannot do, withholding information, isolating the victim from friends and family, denying access to money or other basic resources, demeaning the victim). In most cases, abusers use emotional and verbal violence before acts or threats of physical or sexual violence.



¹Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.

²Saltzman, L.E., Fanslow, J.L., McMahon, P.M., Shelley, G.A. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2002). *Intimate Partner Violence Surveillance: Uniform definitions and recommended data elements*, Version 2.0. Atlanta (GA).



REPRODUCTIVE COERCION **quick facts** for awareness-raising

WHAT IS REPRODUCTIVE COERCION?

Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.¹

Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.²

Women victimized by reproductive coercion may not recognize that these behaviors are abusive, particularly if there is no history of physical or sexual violence in their relationship.³

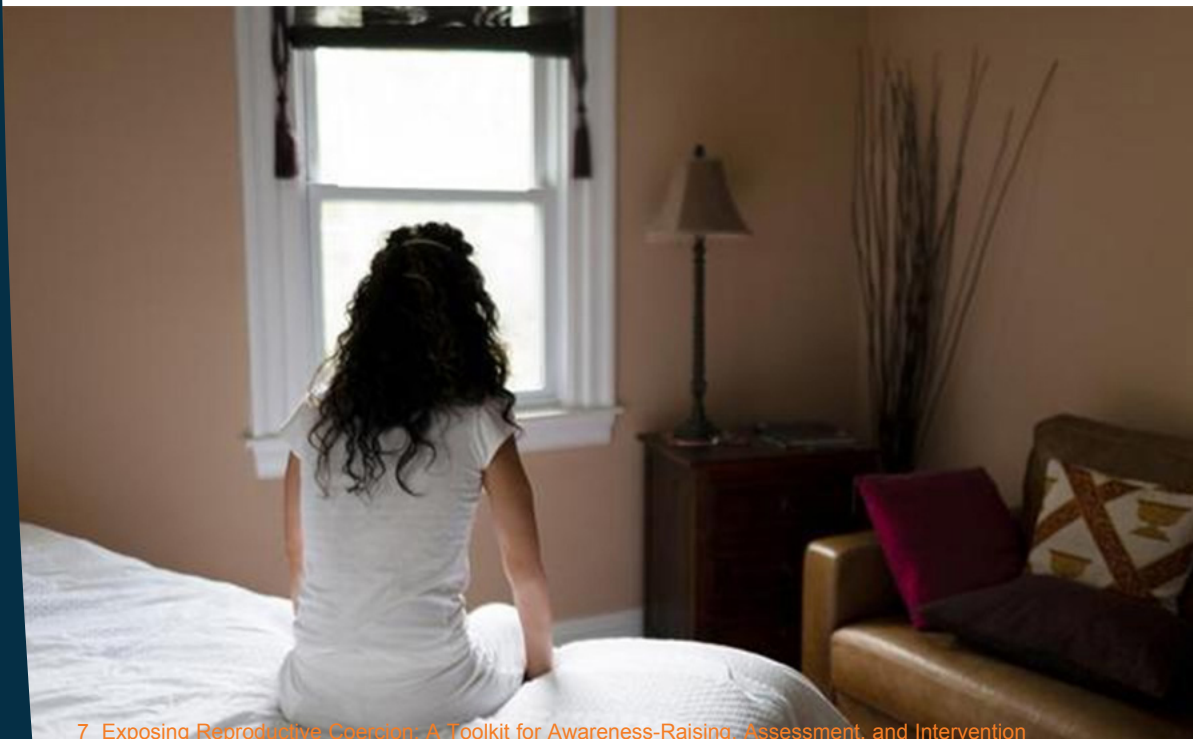
Example: A man may try to get his girlfriend pregnant against her will in order to keep her physically and financially tied to him forever.

WHAT DOES REPRODUCTIVE COERCION LOOK LIKE?

Pregnancy pressure: When an individual pressures or coerces a woman into becoming pregnant against her will.

Examples include:

- Threatening to hurt a woman physically, economically, or emotionally if she refuses to become pregnant;
- Making a woman feel guilty for not wanting to become pregnant;
- Accusing a woman of infidelity if she does not want to become pregnant.



Birth control sabotage: When an individual interferes with a woman's use of contraception to cause her to become pregnant against her will.

Examples include:

- Physically or economically preventing a woman from obtaining birth control;
- Hiding, throwing away, or destroying a woman's birth control pills;
- Pulling off contraceptive patches or pulling out vaginal rings;
- Refusing to use condoms, removing condoms, or poking holes in condoms;
- Refusing to pull out during sex when previously agreed upon.

Pregnancy outcome control: When an individual pressures or coerces a woman into continuing or ending a pregnancy against her will.

Examples include:

- Making a woman feel guilty for wanting to continue a pregnancy or have an abortion;
- Convincing a woman that she has no other option but to continue a pregnancy or have an abortion;
- Hurting a woman (or threatening to hurt a woman) physically and/or emotionally if she continues a pregnancy or has an abortion;
- Physically or economically preventing a woman from obtaining an abortion;
- Physically assaulting a woman in an attempt to induce a miscarriage.

REPRODUCTIVE COERCION AND INTIMATE PARTNER VIOLENCE (IPV)

Women victimized by their intimate partners are more likely to experience reproductive coercion than non-abused women.

- Roughly **25%** of women who report being physically or sexually abused by their intimate partners also report being pressured or forced to become pregnant.^{4,5}

Women victimized by their intimate partners have an increased risk of sexually transmitted infections (STIs) and unintended pregnancy as a result of pregnancy pressure and birth-control sabotage.

- A woman having an unintended pregnancy is **4x** more likely to be in an abusive relationship than a woman having a planned pregnancy.⁶
- Women who are being physically abused by their intimate partners are **3x** more likely to have an STI than non-abused women.⁷

For more information on IPV and reproductive health, please visit:
www.ncadv.org/programs/reproductive-coercion/Fact-sheet.pdf

Educating friends and family about reproductive coercion can help them recognize abusive behaviors in their own relationships and encourage them to take steps to protect themselves and their reproductive autonomy.

See citations in Appendix A on page 31 of *Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention*, located at www.feministcenter.org/RCtoolkit.pdf



REPRODUCTIVE COERCION **quick facts** for clinical practitioners

A growing body of research is providing evidence for a connection between intimate partner violence (IPV) and less obvious forms of coercion, such as reproductive coercion, that have major implications for reproductive and sexual health.^{1,2} The link between IPV and reproductive coercion likely explains why women who are abused by their intimate partners are at greater risk of sexually transmitted infections (STI) and unintended pregnancy.^{3,4}

WHAT IS REPRODUCTIVE COERCION?

Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.⁵ Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.⁶

Example: A man may try to get his girlfriend pregnant against her will in order to keep her physically and financially tied to him forever.

Women victimized by reproductive coercion may not recognize that these behaviors are abusive, particularly if there is no history of physical or sexual violence in their relationship.⁷

WOMEN DESCRIBING THEIR EXPERIENCES WITH REPRODUCTIVE COERCION:

“He was like, ‘I should just get you pregnant and have a baby with you so that I know you will be in my life forever.’”⁸

“I was on the birth control, and I was still taking it, and he ended up getting mad and flushing it down the toilet, so I ended up getting pregnant.”⁹

“And I told him right when I found out I was pregnant, I told him, ‘You know, I hate to say this, but I want to have an abortion.’ [He said], ‘No, you’re crazy. How can you say that? You can’t just kill your child!’ And he was just making me feel so guilty until, finally, I was just, like, ‘Okay, then. I’ll keep the baby.’”¹⁰

FACTS ABOUT REPRODUCTIVE COERCION AND IPV:

- 1 in 4 women in the U.S are abused by their intimate partner.¹¹
- Roughly 25% of women who report that they are being physically or sexually abused by their intimate partners also report being pressured or forced to become pregnant.^{12,13}
- Women victimized by their intimate partners have an increased risk of STIs and unintended pregnancy as a result of pregnancy pressure and birth-control sabotage as compared to non-abused women.^{14,15}

WHAT CAN I DO AS A CLINICIAN?

Assessment: Include questions about reproductive coercion on the self-administered questionnaire that patients fill out at the beginning of their visit. Incorporate questions and information about reproductive coercion into every verbal assessment you conduct with your patients.

Establish a safe and supportive atmosphere within your clinic that will facilitate discussions about sensitive topics such as reproductive coercion and IPV. A safe environment can promote full disclosure by patients and allow you to intervene in cases of IPV and reproductive coercion.

Inform patients about confidentiality and mandatory reporting requirements in your state, and conduct verbal assessments in a private space where conversations cannot be interrupted or overheard.

QUESTIONS THAT CAN BE USED TO ASSESS FOR REPRODUCTIVE COERCION MAY INCLUDE:

1. If she is not pregnant:
 - a. Do you and your partner agree on if and when you want to have a baby?
 - b. Has your partner ever pressured you to get pregnant when he knew you didn’t want to?
2. If she is not trying to become pregnant:
 - a. Do you and your partner use birth control every time you have sex?
 - b. Are you comfortable talking to your partner about using birth control?
3. If she is already pregnant:
 - a. Do you and your partner agree on what you should do about your pregnancy?
 - b. Is your partner pressuring you to continue your pregnancy or have an abortion?

For more information on assessing for reproductive coercion in a clinical setting, please visit:
www.ncadv.org/programs/reproductive-coercion/Assessment--clinical-practitioners.pdf

Intervention: If you feel that a patient is being victimized by reproductive coercion, the manner in which you intervene will vary based on the type and severity of the situation. In general, when intervening in cases of reproductive coercion clinical staff should:

1. Address the quality of the patient’s relationship,
2. Help the patient take control of her own fertility, and
3. Help ensure the patient’s physical safety. Clinical staff should also follow up any disclosure of reproductive coercion with questions to screen for other forms of IPV and vice versa.

For a sample intervention tool for clinical practitioners, please visit:
www.ncadv.org/programs/reproductive-coercion/Intervention--clinical-practitioners.pdf

Screening for reproductive coercion in a clinical setting can greatly reduce morbidity and mortality from reproductive and sexual health diseases and IPV. Clinical staff have an opportunity to assess risk, intervene, and provide resources and support to women who are victimized by reproductive coercion and other forms of IPV.

See citations in Appendix A on page 31 of *Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention*, located at www.feministcenter.org/RCToolkit.pdf.





REPRODUCTIVE COERCION **quick facts** for domestic violence workers

A growing body of research is providing evidence for a connection between intimate partner violence (IPV) and less obvious forms of coercion, such as reproductive coercion, that have major implications for reproductive and sexual health.^{1,2} The link between IPV and reproductive coercion likely explains why women who are abused by their intimate partners are at greater risk for sexually transmitted infections (STIs) and unintended pregnancy.^{3,4}

WHAT IS REPRODUCTIVE COERCION?



Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.⁵

Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.⁶

Example: A man may try to get his girlfriend pregnant against her will in order to keep her physically and financially tied to him forever.

Women victimized by reproductive coercion may not recognize that these behaviors are abusive, particularly if there is no history of physical or sexual violence in their relationship.⁷

REPRODUCTIVE COERCION CAN TAKE NUMEROUS FORMS. EXAMPLES INCLUDE:

Economic Abuse

- Refusing to contribute to the cost of using birth-control
- Refusing to help pay for emergency contraception or an abortion
- Refusing to help with the costs of supporting and raising the child if the pregnancy continues
- Forcing a woman to have multiple pregnancies and births within a short time frame so that she is unable to work outside the home, dependent on her abuser for financial and economic support, and less able to leave or escape without difficulty or risk (e.g., a pregnant woman with five children all under the age of six)

Emotional Abuse

- Calling a woman names, degrading her, or using profanity directed at her, in an effort to coerce her into choosing a certain pregnancy outcome
- Accusing a woman of infidelity if she wants to use contraception
- Denying paternity of the pregnancy
- Using manipulation or other emotional tactics that make a woman feel forced to get pregnant, have an abortion, or continue the pregnancy against her will

Physical Abuse

- Beating a woman if she talks about using birthcontrol or having an abortion
- Threatening to kill a woman if she has an abortion
- Threatening to kill a woman if she refuses to have an abortion
- Beating a woman at any point during a pregnancy in an attempt to cause a miscarriage
- Using physical violence or threats of violence to get a woman pregnant, force her to have an abortion, or continue the pregnancy against her will



Manipulative/Psychological Abuse

- Convincing a woman that taking birth control will make her infertile and ruin her future chances of having a child
- Sabotaging birth control in order to get a woman pregnant against her will (e.g., lying about pulling out or hiding or destroying birth control pills)
- Making a woman believe that she must not really be “in love” if she does not want to become or remain pregnant

A FEW FACTS ABOUT REPRODUCTIVE COERCION:

- Roughly 25% of women who report that they are being physically or sexually abused by their intimate partners also report being pressured or forced to become pregnant.^{8,9}
- Women victimized by their partners are less likely to use birth control, either because of their partner’s unwillingness to use birth control or because their partner demands that they become pregnant.¹⁰
- Reproductive coercion can occur prior to conception, during sexual intercourse, and after conception. Prior to conception, abusers may prevent their partner’s access to and use of effective contraception. During sexual intercourse, which can be forced, abusers can manipulate contraception to render it ineffective, which includes removing condoms during sex and refusing to withdraw when previously agreed upon. After conception, abusers can attempt to coerce their partners into continuing the pregnancy or having an abortion.¹¹

WHAT CAN I DO AS AN ADVOCATE?

As always, be sure to establish a safe, comfortable, inclusive, private environment for whomever you may be speaking with, as this promotes full disclosure.

When working with individuals victimized by IPV, be sure to incorporate questions and information about reproductive coercion into all your routines, including during hotline calls, safety planning, group sessions, and one-on-one time with those seeking your services. If you manage staff, educate your staff about reproductive coercion and see that the information is incorporated into your organization's written materials.

Establish good relationships with organizations in your local area and state that provide services for and information about women's reproductive health and wellness so you can refer individuals experiencing reproductive coercion to these places when needed. Feminist women's health clinics and/or local Planned Parenthoods provide non-biased, comprehensive information, resources, and services about women's reproductive health and wellness.

To find a local reproductive health clinic or organization near you, please visit:
www.ncadv.org/programs/reproductive-coercion/Resources.pdf

As an advocate, learning all you can about reproductive coercion will help you provide the best services possible to people victimized by their intimate partners. Screening for reproductive coercion can greatly reduce morbidity and mortality from reproductive and sexual health diseases and IPV.



QUESTIONS THAT CAN BE USED TO ASSESS FOR REPRODUCTIVE COERCION MAY INCLUDE:

- 1) Are you currently pregnant or planning to become pregnant?
- 2) If she is not pregnant:
 - a. Do you feel safe asking your partner to use birth control?
 - b. Do you feel like your partner is pressuring you to become pregnant?
 - c. Has your partner ever accused you of being unfaithful or tried to make you feel guilty because you wanted to use birth control?
- 3) If she is currently pregnant:
 - a. How do you feel about this pregnancy? How does your partner feel about the pregnancy?
 - b. Has your partner's behavior changed since he found out you were pregnant?
 - c. Are you afraid of your partner regarding this pregnancy for any reason?
 - d. Do you want to continue this pregnancy?
 - i. (If she wants to continue the pregnancy) Are you receiving prenatal care?
 - ii. (If she wants to terminate the pregnancy) Are you afraid of how your partner will react if you have an abortion? Are you afraid your partner will retaliate if you don't have an abortion?

For more information about assessing for reproductive coercion, please visit:
www.ncadv.org/programs/reproductive-coercion/Assessment--domestic-violence.pdf

To see a sample reproductive coercion intervention tool for domestic violence workers, please visit:
www.ncadv.org/programs/reproductive-coercion/Intervention--domestic-violence.pdf



See citations in Appendix A on page 31-32 of *Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention*, located at www.feministcenter.org/RCtoolkit.pdf.



REPRODUCTIVE COERCION **self quiz**

Am I experiencing reproductive coercion?*

WHAT IS REPRODUCTIVE COERCION?

Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.¹

Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.²

For more information about reproductive coercion, please visit:

www.ncadv.org/programs/reproductive-coercion/Quick-facts-awareness-raising.pdf

www.ncadv.org/programs/reproductive-coercion/informational-brochure.pdf

ASK YOURSELF:

- Am I afraid to ask my partner to use condoms/birth control?
- Has my partner ever pressured me to get pregnant when I didn't want to?
- Has my partner ever tampered with or thrown away my birth control?
- Has my partner ever refused to pull out during sex, even though he said he would?
- Has my partner ever accused me of not loving him because I did not want to become pregnant?
- Has my partner ever refused to use a condom when I asked him to?
- Has my partner ever made me feel ashamed, or threatened to hurt me, because I wanted to use birth control or have an abortion?
- Does my partner remove condoms during sex, or claim that condoms keep breaking during sex?
- Have I ever had to hide my birth control from my partner?
- Has my partner ever pressured me to get an abortion when I didn't want one?
- Has my partner ever accused me of cheating on him because I wanted to use birth control?

*Portions of this document were adapted from Chamberlain, PhD, MPH, L., & Levenson, MA, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings*. In (2 ed.). Futures Without Violence. Retrieved June 18, 2014, from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf.

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS:

Your partner may be trying to take control of your reproductive decisions, and your health and safety may be in danger.

Your partner may be trying to get you pregnant against your will in order to keep you physically or financially tied to him forever.

You are not alone, and you deserve to make your own decisions about your body and your future without being made to feel ashamed or afraid.

TAKE CONTROL OF YOUR REPRODUCTIVE HEALTH:

Talk to your health care provider about birth control that your partner cannot see, feel, or tamper with (**such as the IUD [intrauterine device], implant, or shot**).

- An IUD is a small and very safe medical device that sits inside your uterus and protects against pregnancy for up to 10 years.
- An IUD can be removed at any time if you want to become pregnant.
- The strings of your IUD can be cut so that your partner cannot feel them.

If you do not want to become pregnant, use emergency contraception (also called Plan B or the morning after pill) after any act of unprotected sex.

- You can also have a copper IUD implanted up to one week after unprotected sex to prevent pregnancy, and the copper IUD will then continue to prevent pregnancy for up to 10 years.

If you are concerned for your physical safety, call one of the domestic abuse hotlines listed below to find support and resources near you:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
www.thehotline.org

National Dating Abuse Hotline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

For more reproductive health and domestic violence resources, please visit:
www.ncadv.org/programs/reproductive-coercion/Resources.pdf

¹Miller, E., & Silverman, J. Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.

²Ibid.



facts about REPRODUCTIVE COERCION and intimate partner violence (IPV)

Reproductive coercion is the behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence. Reproductive coercion most-often manifests within the context of an intimate, heterosexual relationship, when a man uses pregnancy-controlling behaviors in an effort to maintain power, control, and domination over a woman.¹

Reproductive coercion is a form of domestic violence (DV), also known as intimate partner violence (IPV). Reproductive coercion can take numerous forms: economic (not giving a woman money to buy contraception or obtain an abortion), emotional (accusing her of infidelity if she requests contraception or denying paternity of a pregnancy), as well as physical (beating her up upon finding her contraception, threatening to kill her if she has or does not have an abortion, or purposefully harming her while she is pregnant in an attempt to cause a miscarriage).²

- Reproductive coercion can occur prior to conception, during sexual intercourse, and after conception.³
 - Prior to conception, abusers may prevent their partner's access to and use of effective contraception.
 - During sexual intercourse, which can be forced, abusers may manipulate contraception to render it ineffective, which includes removing condoms during sex and refusing to withdraw when previously agreed upon.
 - After conception, abusers may attempt to coerce their partner's into continuing the pregnancy or having an abortion.
- In one study of women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use, 21% disclosed physical abuse, and 14% said their partners threatened abandonment.⁴
- An estimated 10.3 million women in the United States report having or having had an intimate partner who had attempted to get them pregnant against their will, or who had refused to use a condom.^{5,6}
- IPV is associated with an increased risk for unintended pregnancy and sexually transmitted infections (STIs), women not [being able to] use their preferred contraceptive method, miscarriages, repeat abortion, a high number of sexual partners, and poor pregnancy outcomes.⁷
- In one study of family planning clinic patients, 15% of women experiencing physical violence also reported birth control sabotage.⁸
- A woman having an unintended pregnancy is 4x more likely to be victimized by their partner than a woman having a planned pregnancy.⁹
- When IPV is present in a relationship, the chance of an unintended pregnancy doubles.¹⁰
- Homicide is a leading cause of pregnancy-associated mortality in the United States; the majority of pregnancy-associated homicides are committed by an intimate partner.¹¹

- In 2007, the prevalence of IPV was nearly three times greater for women seeking an abortion compared with women who were continuing their pregnancies.¹²
- Women victimized by IPV are more likely to abuse alcohol or drugs, and more likely to engage in risky sexual behaviors (such as earlier initiation of sexual intercourse, having unprotected sexual intercourse, and having multiple sexual partners).^{13,14,15}
- Women victimized by 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.¹⁶
- A family planning clinic-based reproductive coercion intervention strategy that focused on awareness-raising and provided harm-reducing strategies for clients was shown to reduce pregnancy coercion by 71%.¹⁷
- Women in a reproductive coercion intervention group that focused on education and provided harm-reducing strategies were more likely to report ending a relationship because they decided the relationship was unhealthy, or because they felt unsafe.¹⁸
- In one survey of young women between the ages of 16 and 29 conducted at five family planning clinics, 75% of those who reported pregnancy coercion or birth control sabotage also reported a history of IPV. ¹⁹
- Reproductive coercion sometimes precedes physical and sexual abuse in a relationship.²⁰
- Women victimized by domestic abuse of any kind are 50% more likely to have a single or repeated stillbirth, or spontaneous abortion.²¹
- Women having 3 or more abortions are nearly 3x as likely to have a history of IPV than women having two or fewer abortions.²²
- In a study of women seeking abortion, nearly 40% had a history of intimate partner violence.²³



See citations in Appendix A on page 32 of *Exposing Reproductive Coercion: A Toolkit for Awareness-Raising, Assessment, and Intervention*, located at www.feministcenter.org/RCToolkit.pdf.



REPRODUCTIVE COERCION **Assessment tool** for clinical practitioners*

PRE-ASSESSMENT CONSIDERATIONS AND PREPARATIONS

CREATING A SAFE ENVIRONMENT FOR ASSESSMENT:

Establish a confidential and supportive atmosphere within your clinic that will facilitate discussions about sensitive topics such as reproductive coercion and intimate partner violence:

- Make educational materials about reproductive coercion and IPV available in both waiting rooms and exam rooms that are reflective of the constituency you serve.
- Have signage in all waiting areas announcing that, as part of clinic policy, all patients must speak with a clinician in private for at least a portion of their visit.
- Establish a private place where patients can be interviewed alone and where conversations cannot be overheard or interrupted.

ADDRESSING THE LIMITS OF CONFIDENTIALITY:

Always disclose the limits of confidentiality with all of your patients prior to assessment. Mandatory reporting requirements differ between states. If you are not familiar with the limits and laws surrounding confidentiality and mandatory reporting in your state or territory, contact your state domestic violence coalition or sexual assault coalition for information. If you are working with a minor who is being abused, contact child protection agencies in your city or state for reporting requirements for minors victimized by violence.

DEVELOPING PARTNERSHIPS WITH LOCAL/REGIONAL DOMESTIC VIOLENCE RESOURCES:



Establish relationships with organizations in your area that provide resources for individuals victimized by domestic violence, so that you can refer your patients to these organizations when necessary (and vice versa). To find local domestic violence resources in your area, please visit: www.ncadv.org/programs/reproductive-coercion/Resources.pdf

FACILITATING THE TRANSITION FROM ASSESSMENT TO INTERVENTION:

Establish a clear protocol for how clinic staff should proceed if they feel a patient is being victimized by reproductive coercion. To see a sample reproductive coercion intervention tool, please visit: www.ncadv.org/programs/reproductive-coercion/Intervention--clinical-practitioners.pdf

THE IMPORTANCE OF BOTH WRITTEN AND VERBAL ASSESSMENT

Questions that broadly address various forms of reproductive coercion should be included on the self-administered health assessment/medical history questionnaire that patients fill out at the beginning of their visit. If a patient's answers on their written assessment indicate that they are being victimized by reproductive coercion, then this information can be used to facilitate a private conversation about reproductive coercion during their visit.

Regardless of a patient's answers on their written assessment, clinicians should incorporate questions about reproductive coercion into the verbal assessment they conduct in private during a patient's visit. A patient may disclose information during a confidential verbal assessment that they felt uncomfortable disclosing on paper in the clinic waiting room, potentially with their male partner sitting nearby.

EXAMPLES OF POTENTIAL WRITTEN ASSESSMENT QUESTIONS

Pregnancy pressure:

- Do you and your partner agree on if and when you want to have a baby? (Yes/No/Sort of)

Birth control sabotage:

- Is your partner ok with your using birth control? (Yes/No/Sort of)

Condom usage:

- If you are not using another form of birth control, do you and your partner use condoms every time you have sex? (Yes/No)

Pregnancy outcome control:

- If you are pregnant, do you and your partner agree on what you should do about your pregnancy (continue the pregnancy or have an abortion)? (Yes/No/Sort of)

A patient's answers on their written assessment can be used to initiate a conversation about reproductive coercion in private during their visit.

SAMPLE SCRIPT:

"I see here that you're not using a form of hormonal birth control and that you and your partner do not use condoms every time you have sex. Are you and your partner trying to get pregnant? If not, we have found that a lot of women are uncomfortable negotiating condom use with their partners, so we have started asking all our clients about the topic. Are you comfortable talking to your partner about condoms? Does your partner agree to use condoms when you ask him to?"

*Portions of this document were adapted from Chamberlain, PhD, MPH, L., & Levenson, MA, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings*. In (2 ed.). Futures Without Violence. Retrieved June 18, 2014, from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf.



EXAMPLES OF POTENTIAL VERBAL ASSESSMENT QUESTIONS

Pregnancy Pressure:

- Has your partner ever pressured you to get pregnant when you didn't want to?
- Has your partner ever yelled at you, put you down, or threatened to leave you because you didn't want to get pregnant?

Birth Control Sabotage:

- Has your partner ever tampered with your birth control (thrown away your pills, pulled out your ring, poked holes in condoms)?
- Have you ever had to hide your birth control from your partner?

Condom usage:

- Do you feel comfortable talking to your partner about using condoms?
- Has your partner ever refused to use a condom when you asked him to?
- Has your partner ever gotten angry when you asked him to use a condom?
- Has your partner ever refused to pull out during sex even though he said he would?
- Has your partner ever removed a condom during sex?
- Do condoms seem to break a lot during sex?

Pregnancy outcome control:

- Does your partner know that you are pregnant?
- How would your partner react if he knew you were pregnant?
- Is your partner ok with your decision to continue your pregnancy/have an abortion?
- Is your partner pressuring you to do what he wants with your pregnancy (continue the pregnancy/have an abortion) even though it is not what you want?
- Are you worried about what your partner will do if you don't do what he wants with your pregnancy (continue the pregnancy/have an abortion)?

The manner in which you initiate a conversation about reproductive coercion will differ based on the services a patient is seeking at your facility.

SAMPLE SCRIPTS:

If a patient is seeking birth control...

"Because it happens so often, we've started talking to all of our patients about birth control sabotage. Is your partner ok with your using birth control? Has your partner ever tampered with your birth control?"

If a patient is deciding how to deal with an unintended pregnancy...

"A lot of times, partners disagree about how to deal with an unintended pregnancy. Does your partner have a strong opinion about what you should do with your pregnancy? Are you worried that your partner will be angry if you do not do what he wants with your pregnancy?"

REAL WOMEN DESCRIBING THEIR EXPERIENCES WITH REPRODUCTIVE COERCION¹

Pregnancy pressure:

"He was like, 'I should just get you pregnant and have a baby with you so that I know you will be in my life forever.' "

—A 19-year-old female

"I told him, like, 'We are not ready for kids. Our relationship is not even stable enough.' And he would be like, 'That's not true. It's never the right time to have a kid. You just don't want to be a part of me. You just don't want me to be around forever.' "

—A 28-year-old female

Birth control sabotage:

"He [used condoms] when we first started, and then he would fight with me over it, and he would just stop [using condoms] completely, and didn't care."

—A 16-year-old female

"I was on the birth control, and I was still taking it, and he ended up getting mad and flushing it down the toilet, so I ended up getting pregnant."

—A 17-year-old female

Pregnancy outcome control:

"And I told him right when I found out I was pregnant, I told him, 'You know, I hate to say this, but I want to have an abortion.' [He said], 'No, you're crazy. How can you say that? You can't just kill your child!' And he was just making me feel so guilty until, finally, I was just, like, 'Okay, then. I'll keep the baby.'"

—A 19-year-old female



¹ Moore, A., Frohworth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine*, 70(11), 1737-1744.



Intervention tool for clinical practitioners*

IF YOU FEEL THAT YOUR PATIENT IS BEING VICTIMIZED BY REPRODUCTIVE COERCION...

STEP 1: ADDRESS THE QUALITY OF HER RELATIONSHIP

- Express your concern for what she is going through, and let her know that she is not alone.
- Introduce the concept of reproductive coercion.
- Explain that reproductive coercion is a form of intimate partner violence (IPV) that can negatively impact a women's reproductive and overall health.
- Provide her with informational materials about reproductive coercion and offer to go over the information with her.
- Validate her rights and wishes within her relationship (e.g., she has the right to not want a child with her partner).
- Initiate a conversation about ways you can help her take control of her fertility.

Remember that women victimized by reproductive coercion may not recognize that these behaviors are abusive, particularly if there is no history of physical or sexual violence in their relationship.¹

For informational materials about reproductive coercion, please visit:

www.ncadv.org/programs/reproductive-coercion/Quick-facts-awareness-raising.pdf

www.ncadv.org/programs/reproductive-coercion/Selfquiz.pdf

www.ncadv.org/programs/reproductive-coercion/informational-brochure.pdf

SAMPLE SCRIPT:

“From what you’ve told me, it sounds like your partner may be trying to get you pregnant even though you’ve told him you don’t want a baby right now. Thank you for sharing this information with me. This happens to a lot of women, and I know it must be very stressful worrying that you’re going to get pregnant when you don’t want to. Your partner’s behavior sounds like reproductive coercion. Reproductive coercion is a form of intimate partner violence, where a man pressures or coerces a woman into becoming pregnant, or into continuing or ending a pregnancy. Remember that you deserve to make your own decisions about your body and your future without being made to feel afraid. I have informational materials on reproductive coercion that I can give you and go over with you, if you are interested. Right now, I would like to talk to you about forms of birth control that your partner will not be able to feel or tamper with...”

*Portions of this document were adapted from Chamberlain, PhD, MPH, L., & Levenson, MA, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings*. In (2 ed.). Futures Without Violence. Retrieved June 18, 2014, from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf.

STEP 2: HELP HER TAKE CONTROL OF HER FERTILITY

If she does not want to become pregnant, discuss the potential benefits of concealable contraceptives that her partner will not be able to see, feel, or tamper with.

- Implant (Implanon)
- Injection (Depo provera)
- IUD (Mirena or ParaGuard)
 - Mention that the strings of an IUD can be cut so that her partner will not be able to feel them.

If she has recently engaged in unprotected sex, and does not want to become pregnant, talk to her about emergency contraception.

- Morning after pill (Plan B)
 - Suggest that she take the morning after pill while she is still at the clinic, or send the pill home with her in an unmarked envelope so her partner does not discover the packaging materials in the trash.
- ParaGuard IUD
 - Inform her that the copper IUD acts as an emergency contraceptive if inserted within a week of unprotected sex, and that the copper IUD will continue to protect against pregnancy for up to ten years, or until she decides to have it removed.

If she is already pregnant, and **DOES NOT** want to continue the pregnancy:

- Provide her with information on where she can obtain a safe, legal, and confidential abortion.
- If there is a chance that her partner will check the recent calls on her cell phone, allow her to use your clinic's phone (if possible), or suggest that she use a friend's phone or a pay phone to call and make an appointment for an abortion.
 - To find an abortion provider in your area, please visit: www.ncadv.org/programs/reproductive-coercion/Resources.pdf

If she is already pregnant, and **WANTS** to continue the pregnancy:

- Discuss the importance of prenatal care for better pregnancy outcomes.
- If your facility does not provide prenatal care, refer her to prenatal care provider in your area.
 - To find prenatal care resources in your area, please visit: www.ncadv.org/programs/reproductive-coercion/Resources.pdf.
- If she is considering adoption, provide her with information on adoption and refer her to adoption services in your area.
 - To find adoption services in your area, please visit: www.ncadv.org/programs/reproductive-coercion/Resources.pdf





STEP 3: HELP ENSURE HER PHYSICAL SAFETY

If she is concerned about her physical safety, or admits that her partner has physically abused her in the past:

- Provide her with the contact information for local organizations that provide resources for individuals victimized by domestic violence.
 - If your clinic has an established partnership with a domestic violence organization in the area, offer to help her get in touch with a domestic violence advocate at that organization.
- If no local resources are available, refer her to an advocate from the multi-lingual National Domestic Violence Hotline: (800) 799-SAFE (4233) or www.ndvh.org
- If there is a chance that her partner will check the recent calls on her cell phone, allow her to use your clinic's phone (if possible), or suggest that she use a friend's phone or a pay phone to call a domestic violence organization or hotline.
- If she is experiencing physical abuse, you are obligated to report it to the state; explain the reporting process and involve her in the writing of the report.



¹ Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.

REPRODUCTIVE COERCION **Assessment tool** for domestic violence advocates

PRE-SCREENING CONSIDERATIONS AND PREPARATIONS

When working with people being victimized by their intimate partners, as always, be sure to establish a safe, comfortable, private, and supportive environment for whomever you may be speaking with, as this may put the person more at ease and promote full disclosure.

You should discuss the limits of confidentiality and mandatory reporting with every individual you serve. If you are not familiar with the limits and laws around confidentiality and mandatory reporting in your state or territory, contact your state domestic violence coalition or sexual assault coalition for information. If you are working with a minor being victimized, contact child protection agencies in your city or state for reporting requirements for minors experiencing violence.

Be sure to incorporate questions and information about reproductive coercion into all of your conversations with everyone you serve. A woman may not overtly realize that she is being victimized, she may not understand her rights in the relationship, or she may not know how to go about obtaining birth control or other family planning services.

If you haven't already done so, establish good relationships with organizations in your local area and state that provide services for and information about women's reproductive health and wellness so you can refer victims to these places when needed. Feminist women's health clinics and/or local Planned Parenthoods provide non-biased, comprehensive information, resources, and services about women's reproductive health and wellness.

To find a local reproductive health clinic or organization, please visit: www.ncadv.org/programs/reproductive-coercion/Resources.pdf

For more information about reproductive coercion, please visit: www.ncadv.org/programs/reproductive-coercion/Quick-facts-awareness-raising.pdf





REPRODUCTIVE COERCION **Assessment tool** for domestic violence advocates

SAMPLE SCREENING QUESTIONS FOR ADVOCATES TO ASSESS FOR REPRODUCTIVE COERCION

- Are you currently pregnant or planning to become pregnant?

IF SHE IS NOT PREGNANT:

- Do you feel safe asking your partner to use birth control/condoms when you have sex?
- Does your partner respect your thoughts and wants around having children?
- Do you feel like your partner is pressuring you to become pregnant?
- Has your partner ever accused you of being unfaithful or tried to make you feel guilty for wanting to use birth control?
- Has your partner ever threatened you in any way in order to get you pregnant, or done something to you because you did not wish to become pregnant?
- Does your partner refuse to use birth control (e.g., condoms) or refuse to allow you to use birth control (e.g., oral contraceptives)?
- To your knowledge, has your partner ever tampered with any birth control method you have used (e.g., poked holes in condoms, purposefully not pulled out before ejaculating into you against your wishes, pulled out a vaginal ring, ripped off contraceptive patches, hid or destroyed birth control pills, pulled out an IUD)?
- Has your partner forced or pressured you to have sex when you did not want to (tried to guilt you, verbally or physically abused you, or threatened you in any way)?
- Does your partner refuse to help you financially with birth control?
- Has your partner ever forced you to get an abortion?
- Do you secretly use a form of birth control that your partner is not aware of to prevent a pregnancy because you are afraid of his reaction if he found out?
- Has your partner tried to convince you that using birth control is wrong or bad for you?
- Has your partner used language suggesting that if you had a child together you would be bound to him forever?
- Are you interested in obtaining birth control that cannot be easily detected such as an IUD or birth control shot?

IF SHE IS CURRENTLY PREGNANT

- Is this a pregnancy you wanted and currently want?
- Are you fearful of your partner regarding this pregnancy for any reason?
- Has your partner denied paternity?
- Do you feel your partner is forcing you to have this baby against your will?
- Do you feel your partner is trying to convince you to terminate the pregnancy against your will?
- Are you receiving prenatal care, and if not, is your partner doing anything to prevent you from doing so?
- Has your partner done anything to hurt you or tried to do something that may make you miscarry?
- Do you feel you have financial support from your partner to help you through this pregnancy (or abortion if chosen)?
- Has your partner threatened you in any way because you want to continue the pregnancy (or because you want to terminate the pregnancy)?
- Has your partner either refused to help pay for the costs of raising the child, or said or done something to make you believe he won't help you financially?
- Has your partner's behavior become more erratic or aggressive since you became pregnant?
- If you are continuing the pregnancy, are you fearful of how your partner may behave after you have the baby?
- Are you fearful or concerned about how your partner may treat the child after it is born?
- Do you feel you have the emotional support you want and need from your partner regarding this pregnancy?
- Do you feel you have the support you may need after the baby is born either from your partner or from others?



REPRODUCTIVE COERCION **Intervention tool** for domestic violence advocates

As with all people you assist, your response to any person who discloses reproductive coercion will depend on the severity of the abuse. Responding will likely be the same as your response to someone being victimized by other types of intimate partner violence (IPV). The following includes information and language you may want to incorporate into conversations you have with those you are assisting who you think may be experiencing reproductive coercion. Keep in mind that women victimized by reproductive coercion may not recognize that these behaviors are abusive, particularly if there is no history of physical or sexual violence in their relationship.

ADDRESSING THE ISSUE

- Express your concerns about what she has told you and explain how it qualifies as IPV.
- Let her know that she is not alone and that reproductive coercion is common in abusive relationships, particularly for women who are of reproductive age.
- Give her more information about reproductive coercion and go over the information with her.

For informational materials about reproductive coercion, please visit: www.ncadv.org/programs/reproductive-coercion/informational-brochure.pdf

- Validate her rights and wishes within the relationship (e.g., she has a right to not want a child with this person; she has the right to pursue further education or a career if she wants; no one has the right to force her to have a child; she has the right to be physically, emotionally, and mentally safe).
- Respond to and/or combat any messages her abuser may be currently reinforcing (e.g., you must not love me if you don't want to have a baby with me; I'll get you pregnant so you will be in my life forever).
- If she is not pregnant, provide her with information about types of birth control that are easier

to hide, help connect her with a feminist women's health care center or other appropriate resource if she is looking to obtain birth control, obtain an abortion, or explore other alternatives.

- If she is pregnant, talk with her about her feelings about the pregnancy and how she wishes to proceed. If she is also being physically abused, work with her around how she may be able to keep herself and her baby safe (leaving if it is feasible, protecting her abdomen, stress reduction techniques, etc.).



- If she wants to continue her pregnancy, or is being coerced into continuing her pregnancy, be sure to go over all of her options in detail. Emphasize the importance of prenatal care. Refer her appropriately and assist with scheduling appointments. Be sure to talk to her about her plans for staying safe after the baby is born. Help connect her with any additional resources and support systems that may be necessary to facilitate her and her baby's health and wellness.

To find prenatal care resources in your area, visit:

www.ncadv.org/programs/reproductive-coercion/Resources.pdf.

- As in all situations, if the type of abuse is something you are obligated to report to the state, go over the reporting process with her in detail and involve her in the writing and wording of the report.

TYPES OF BIRTH CONTROL THAT MAY HELP KEEP A VICTIM OF INTIMATE PARTNER VIOLENCE SAFE

If she does not want to become pregnant, discuss the potential benefits of concealable contraceptives her partner will not be able to feel or tamper with.

- Implant (Implanon)
- Injection (Depo provera)
- IUD (Mirena or ParaGuard)
 - Mention that the strings of an IUD can be cut so that her partner will not be able to feel them.

If she recently engaged in unprotected sex, and does not want to become pregnant, talk to her about emergency contraception.

- Morning after pill (Plan B)
 - Suggest that she take the morning after pill while still at the clinic, or suggest she take the pill home with her in an unmarked envelope so that her partner does not discover the packaging materials in the trash.
- ParaGuard IUD
 - Inform her that the copper IUD acts as an emergency contraceptive if inserted within a week of unprotected sex, and that the copper IUD will continue to protect against pregnancy for up to ten years, or until she decides to have it removed.

If she is already pregnant, and **DOES NOT** want to continue the pregnancy, provide her with information about where she can obtain a safe, legal, and confidential abortion.

If no local resources are available, refer patient to an advocate from the multi-lingual National Domestic Violence Hotline 24 hours a day by dialing 800-799-SAFE (4233), TTY 800-787-3224.

More information about reproductive coercion can be found at: www.ncadv.org, www.feministcenter.org, and www.nomas.org



Quick facts for awareness-raising, pages 7-8:

- ¹Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.
- ²Ibid.
- ³Ibid.
- ⁴Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ⁵Blog. (n.d.). *The National Domestic Violence Hotline RSS2*. Retrieved June 18, 2014, from <http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion>.
- ⁶Gazmararian, J. A., Petersen, R., Spitz, A. M., Goodwin, M., Saltzman, L., & Marks, J. (2000). Violence and reproductive health: current knowledge and future research directions. *Maternal and Child Health Journal*, 4(2), 79-84.
- ⁷Coker, A. L., Smith, P., Bethea, L., King, M., & McKeown, R. (2000). Physical Health Consequences of Physical and Psychological Intimate Partner Violence. *Archives of Family Medicine*, 9, 451-457.

Quick facts for clinical practitioners, pages 9-10:

- ¹Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ²Blog. (n.d.). *The National Domestic Violence Hotline RSS2*. Retrieved June 18, 2014, from <http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion>.
- ³Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ⁴Stephenson, R., Koenig, M., Acharya, R., & Roy, T. (2008). Domestic violence, contraceptive use, and unwanted pregnancy in rural India. *Studies in Family Planning*, 39(1), 177-186.
- ⁵Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.
- ⁶Ibid.
- ⁷Ibid.
- ⁸Moore, A., Frohwrith, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science & Medicine*, 70(11), 1737-1744.
- ⁹Ibid.
- ¹⁰Ibid.
- ¹¹Breiding, M.J., Chen J., & Black, M.C. (2014). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. *Intimate Partner Violence in the United States. (2010)*. Atlanta (GA).
- ¹²Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ¹³Blog. (n.d.). *The National Domestic Violence Hotline RSS2*. Retrieved June 18, 2014, from <http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion>.
- ¹⁴Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ¹⁵Stephenson, R., Koenig, M., Acharya, R., & Roy, T. (2008). Domestic violence, contraceptive use, and unwanted pregnancy in rural India. *Studies in Family Planning*, 39(1), 177-186.

Quick facts for domestic violence workers, pages 11-14:

- ¹Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ²Blog. (n.d.). *The National Domestic Violence Hotline RSS2*. Retrieved June 18, 2014, from <http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion>.
- ³Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
- ⁴Stephenson, R., Koenig, M., Acharya, R., & Roy, T. (2008). Domestic violence, contraceptive use, and unwanted pregnancy in rural India. *Studies in Family Planning*, 39(1), 177-186.
- ⁵Miller, E., & Silverman, J. (2010). Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, 5(5), 511-516.
- ⁶Ibid.
- ⁷Ibid.

Quick facts for domestic violence workers, pages 11-14:

- ⁸Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception*, 81(4), 316-322.
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Facts about Reproductive Coercion and Intimate Partner Violence (IPV), pages 17-18:

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REPRODUCTIVE HEALTH

BIRTH CONTROL SABOTAGE

- Accusing a woman of infidelity if she wants to use birth control
- Telling a woman that birth control will ruin her future fertility
- Hiding, throwing away, or destroying birth control
- Pulling out contraceptive rings
- Pulling off contraceptive patches
- Poking holes in condoms
- Refusing to pull out during sex when previously agreed upon
- Refusing to use condoms
- Breaking/removing condoms during sex
- Physically or economically preventing a woman from obtaining birth control

PREGNANCY PRESSURE

- Pressuring a woman to get pregnant when she does not want to
- Threatening to hurt a woman physically, economically, or emotionally if she refuses to get pregnant
- Making a woman feel guilty for not wanting to become pregnant
- Accusing a woman of infidelity if she does not want to become pregnant
- Claiming that a woman must not be “in love” if she does not want to become pregnant

PREGNANCY OUTCOME CONTROL

- Forcing/pressuring a woman to continue a pregnancy or have an abortion against her will
- Making a woman feel guilty for wanting to continue a pregnancy or have an abortion
- Convincing a woman that she has no other option but to continue a pregnancy or have an abortion
- Hurting a woman (or threatening to hurt a woman) physically and/or emotionally if she continues a pregnancy or has an abortion
- Physically or economically preventing a woman from obtaining an abortion
- Physically assaulting a woman in an attempt to induce a miscarriage

INTIMATE PARTNER VIOLENCE

PHYSICAL ABUSE

- Beating, kicking, hitting, strangling, or using any form of physical violence to force a woman to become pregnant, continue a pregnancy, or have an abortion
- Purposefully harming a woman so that she miscarries, delivers early, or ends up having a child requiring special assistance
- Hurting or threatening to hurt others to force a woman to choose a particular pregnancy outcome
- Destroying a woman’s property or possessions to pressure her to comply with his reproductive wishes
- Raping a woman to get her pregnant

ECONOMIC ABUSE

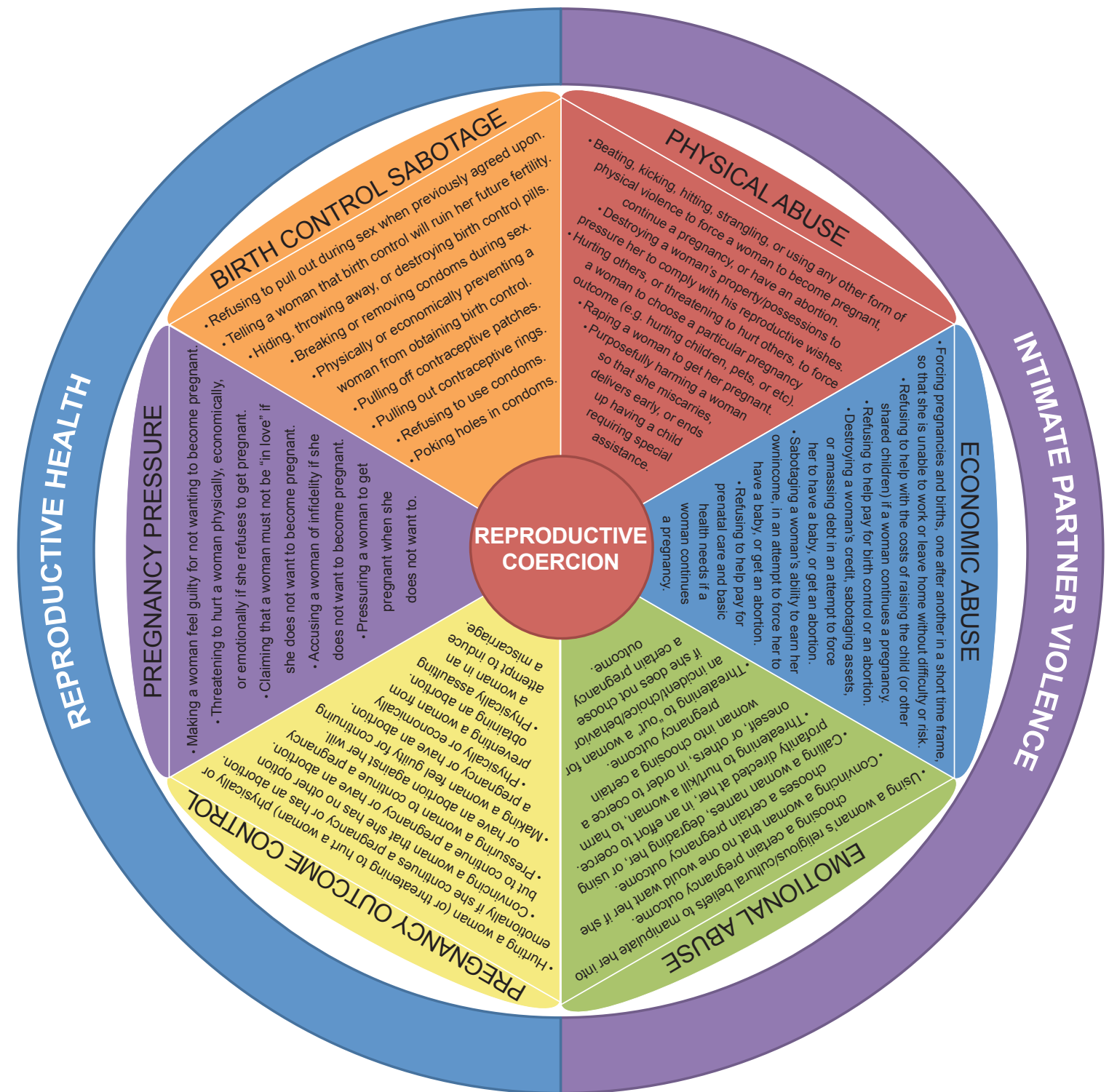
- Refusing to help pay for birth control or an abortion
- Refusing to help with the costs of raising the child (or other shared children) if a woman continues a pregnancy
- Refusing to help pay for prenatal care and basic health needs if a woman continues a pregnancy
- Forcing pregnancies and births, one after another within a short time frame, so that she is unable to work or leave the home without difficulty or risk
- Destroying a woman’s credit, sabotaging assets, or amassing debt in an attempt to force her to have a baby, or get an abortion
- Sabotaging a woman’s ability to earn her own income in an attempt to force her to have a baby, or get an abortion

EMOTIONAL ABUSE

- Convincing a woman that no other person would want her if she chooses a certain pregnancy outcome
- Calling a woman names, degrading her, or using profanity directed at her, in an effort to coerce her into choosing a certain pregnancy outcome
- Threatening to harm oneself, or others, to coerce a woman into choosing a certain pregnancy outcome
- Threatening to hurt/kill a woman if she does not choose a certain pregnancy outcome
- Threatening to “out” a woman for an incident/choice/behavior she may want to remain secret if she does not choose a certain pregnancy outcome
- Using a woman’s religious or cultural beliefs to manipulate her into choosing a certain pregnancy outcome

REPRODUCTIVE COERCION

Reproductive health and intimate partner violence (IPV) wheel



EXPOSING REPRODUCTIVE COERSION: A Toolkit for Awareness-Raising, Assessment, and Intervention

REPRODUCTIVE HEALTH RESOURCES*

If you are interested in obtaining birth control and you would like to find a family planning clinic near you:

Visit: www.hhs.gov/opa

If you are pregnant and you would like to find a comprehensive family planning clinic that provides abortion services near you:

National Abortion Federation
1-877-257-0012
www.prochoice.org

Feminist Abortion Network
www.feministnetwork.org

If you are pregnant and would like to find prenatal care resources near you:

Visit: www.womenshealth.gov/pregnancy/index.html

If you are pregnant and you would like to find adoption services near you:

Visit: www.friendsinadoption.com
www.yourbackline.org

Free, faith-based counseling for all pregnancy options:

Visit: www.faithaloud.org

If you are in the Atlanta area, the Feminist Women's Health Center provides comprehensive reproductive health care, including birth control, testing for sexually transmitted infections, and abortion services:

Feminist Women's Health Center
1-404-728-7900
www.feministcenter.org

DOMESTIC AND SEXUAL VIOLENCE RESOURCES

If you think that you are experiencing domestic or sexual violence and need help:

The National Domestic Violence Hotline
1-800-799-SAFE (4233)
www.ndvh.org

The National Coalition Against Domestic Violence
1-303-839-1852
www.ncadv.org

The National Organization for Men Against Sexism
1-720-446-3882
www.nomas.org

Rape, Abuse and Incest National Network
1-800-656-HOPE (4673)
www.rainn.org

National Sexual Violence Resource Center
1-877-739-3895
www.nsvrc.org



*To the best of our knowledge, the resources referred to on this page provide unbiased and comprehensive information.