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Reproductive Coercion Among Women Living with HIV: An Unexplored Risk Factor for Negative Sexual and Mental Health Outcomes

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Abstract

Background—Unintended pregnancy is prevalent among women living with HIV, and is associated with poor health outcomes for women and babies. Reproductive coercion may be one unexplored mechanism for this elevated risk.

Methods—Past year reproductive coercion data were obtained via self-reported survey from a sample of women receiving HIV specialty care in Baltimore, MD.

Results—Eleven of the 67 women (16.4%) included in the sample reported past year reproductive coercion. Almost two thirds (64%) of women reporting reproductive coercion were also positive for recent PTSD symptoms compared to 27% of women who did not report reproductive coercion (Fisher's Exact $p=0.033$).

Discussion—The prevalence of reproductive coercion among our sample of in care women living with HIV suggests that attention should be paid to the impact of partner influence and coercive behaviors regarding pregnancy intentions. Because of the many potential negative consequences of unintended pregnancy for women living with HIV, it is important that providers be aware of such abuse and steps that can be taken to identify and support patients who are experiencing reproductive coercion.

Keywords

HIV; reproductive coercion; mental health; intimate partner violence

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Introduction

Globally, an estimated 4 in 10 pregnancies are unintended,¹ and prevalence estimates among women living with HIV are even higher, ranging from 51–90%.^{2–6} Unintended pregnancy is associated with delayed prenatal care, exposure to teratogens and harmful behaviors, preterm birth and low birthweight.⁷ For women living with HIV infection, there are added health concerns. Early initiation of antiretroviral therapy is essential to prevent vertical transmission of HIV and to achieve viral suppression (failure to achieve viral suppression may necessitate cesarean delivery, which is associated with additional health risks), and women who are already taking antiretroviral medications may require change to a non-teratogenic regimen prior to conception.⁸ The prevention of unintended pregnancy is a cornerstone of efforts to prevent mother-to-child transmission of HIV.⁹ Causes of unintended pregnancy are numerous, and prevalence varies by relationship status, income, education, age, race and ethnicity.⁷

Intimate partner violence (IPV) has been linked to increased rates of unintended pregnancy, however the specific mechanisms through which this occurs (e.g. forced sex, lack of condom use, presenting barriers to contraceptive access) are also not entirely understood.^{10,11} Reproductive coercion is one potential mechanism. Reproductive coercion in the context of a male-female partner relationship is commonly defined as a male partner's behaviors that interfere with autonomous reproductive decision-making of a female partner.^{12–14} This can include restriction of access to or use of birth control methods or the use of coercion, threat or force to influence the timing or outcome of a pregnancy.^{12,13,15} In the United States, prevalence of reproductive coercion has been explored in samples such as family planning clinics, obstetrics/gynecology clinics, community-based social services, IPV service provider settings (i.e., shelters, hospital-based IPV programs), and college campuses.^{16–21} Evidence linking reproductive coercion to unintended pregnancy has been limited but is persuasive.^{19,22,23} Prevalence of reproductive coercion has not previously been evaluated among women living with HIV. This brief report provides findings related to the prevalence of reproductive coercion among a sample of women living with HIV in Baltimore, MD.

Methods

As part of a study examining IPV in women living with HIV, a convenience sample of women was recruited from an HIV specialty clinic in Baltimore, MD. Women were able to approach the study team in the clinic directly during data collection days, or could contact a study phone number available on flyers posted throughout the clinic to assess eligibility and schedule survey data collection. Following eligibility screening and the consent process, women provided one-time survey data via self-administered, tablet computer-based surveys, and medical records data were reviewed. Participants received a \$10 gift card for their participation in the study, and all study procedures were approved by the Johns Hopkins Medical Institutions Institutional Review Board. For inclusion in the parent study, women had to be at least 18 years old, able to complete study measures in English, have been attending the study clinic for at least one year prior to enrolling, and report having been in a relationship during the one year prior to enrollment. We further limited analysis of reproductive coercion variables to women who were both of reproductive age (<45)²⁴ and

reported a past year male partner ($n=67$). Analyses were completed using SPSS Version 24. The resulting sample was primarily Black/African American (79.1%), unemployed (83.6%) and all of the women were currently enrolled in a public/government insurance option (i.e.: Medicaid, Medicare, Ryan White) (Table 1).

Measures

Reproductive coercion was measured with a 9-item instrument developed for use in family planning clinics, that has been utilized by researchers in both observational and intervention research.^{23,25} Nine yes or no questions assess for reproductive coercion, and includes two sub-domains of reproductive coercion. The first, birth control sabotage (five items), includes direct efforts by the male partner to interfere with a woman's birth control method and the second, pregnancy coercion (four items), includes coercive or violent behaviors intended to pressure a woman into becoming pregnant when she does not wish to be. A 'yes' answer to any of the nine questions about experiences in the past year was considered positive for reproductive coercion.

Past year IPV was measured using the Abuse Assessment Screen and the Severity of Violence Against Women Scales.^{26–28} The AAS is a four-item screening tool designed for clinical use, while the SVAWS is a 46-item research instrument covering nine domains of IPV including symbolic violence, threats of violence, physical violence, and sexual violence. Any 'yes' response to the AAS or an item in the moderate or severe physical or sexual violence domains of the SVAWS were coded as a positive response to past year IPV. Past two week symptoms of depression were assessed using the Center for Epidemiologic Studies Depression Scale (CES-D).^{29,30} The PTSD Checklist Civilian Version (PCL-C) was used to assess for past month PTSD symptoms.^{31,32}

Results

Prevalence of past year reproductive coercion was 16.4% (95% CI: 7–26%) with each of the sub-domains having a prevalence of approximately 10% (birth control sabotage, 10.4%, 95% CI: 3–18%; pregnancy coercion, 11.9%, 95% CI: 4–20%) (See Table 2). Individual item responses for the nine items ranged from 3% for the items regarding having a partner who has taken away or interfered with access to birth control and for having a partner who physically hurt them for not agreeing to pregnancy to 9% for the items regarding removing a condom during sex to promote pregnancy and threatening to have a child with another partner if she did not become pregnant (Table 2).

While the sample size limited our ability to examine factors associated with reproductive coercion, eight (73%) of the 11 women in the sample who reported past year reproductive coercion, also reported past year IPV while three women (27%) reported reproductive coercion without other past year abuse or violence (Fisher's Exact, $p=0.202$). A significant association was noted between reproductive coercion and past month PTSD symptoms, with 64% of women who reported reproductive coercion having a positive PTSD score (PCL-C >44) compared to 27% of women who did not report reproductive coercion (Fisher's Exact $p=0.033$). While more women who reported reproductive coercion also endorsed depressive

symptoms than those without reported reproductive coercion (55% vs. 33%), this relationship was not statistically significant ($p=0.189$).

Discussion

The reproductive coercion prevalence we found is consistent with the high end of prior estimates from urban family planning and obstetrics/gynecology settings (13–16%),^{16,17} lower than a lifetime estimate from women at-risk for acquiring HIV (31%),²¹ and higher than lifetime estimates from a nationally representative sample (8.6%)³³ and recent studies conducted in samples of mixed rural/urban family planning clinics and among female college students (5–8%).^{19,20} Our findings are also consistent with the known associations between reproductive coercion and other coercive, controlling behaviors found in the context of relationship abuse,^{13,34} with an overall high prevalence of IPV (54%) noted in our sample. The time frame chosen for reproductive coercion measurement (past one year for this study) likely plays a role in variations found in the literature.

The prevalence of reproductive coercion in this sample is concerning and warrants additional attention both clinically and in future research. HIV clinicians should be aware of reproductive coercion and its potential impact on the reproductive health care decisions of their patients. Brief screening, counseling and referral interventions have shown promise in decreasing reproductive coercion among young women in family planning clinic settings;^{25,35} whether similar interventions would prove effective in an HIV care setting is unknown. Additional work is warranted to explore reproductive coercion in the setting of HIV care to determine what interventions are most useful in assisting women in controlling their fertility and increasing safety. Recommendations for screening for IPV need to be augmented with at least one question about reproductive coercion, particularly in settings in which sexual and reproductive health services are being provided. Given the frequent co-occurrence of IPV and reproductive coercion, safety planning and health in abusive relationship interventions need to include attention to this particular form of coercion in order to prevent unintended pregnancy and other negative reproductive health outcomes. This is especially important for women living with HIV, due to the increased complexity of providing prenatal care to ensure positive pregnancy outcomes.

The association between reproductive coercion and PTSD symptoms is also consistent with prior work which has identified reproductive coercion as a risk factor for poorer mental health.³⁶ This finding is not surprising, given the previously identified links between reproductive coercion and both IPV and unintended pregnancy which have well documented correlations with increased mental health symptoms.^{37–39} While the degree of overlap in these traumatic life events makes pinpointing specific causes difficult, these findings highlight the need for trauma-informed care practices more broadly. Recognizing reproductive coercion as one potential trauma that patients may have experienced or be experiencing provides clinicians with opportunities to recognize the diverse range of responses patients may have to their experience, to provide safe spaces for disclosure and discussion about reproductive coercion, to offer patient-centered options for addressing reproductive coercion and its sequelae (e.g. long-acting reversible contraceptives, referral to mental health services, non-teratogenic antiretroviral therapy), and to actively prevent re-

traumatization of patients within the health care system (e.g. blaming patients for unintended pregnancies).

Limitations

Cross-sectional data from a small convenience sample limits our ability to generalize our conclusions. The use of retrospective self-report data introduces the possibility of recall bias. Lack of potentially relevant variables such as participants' reproductive health history or pregnancy intentions in this data set prevents us from identifying associations between reproductive coercion and reproductive health outcomes in the sample. Another unknown in this study is, partners' awareness of participants' HIV status, which may also impact decision-making regarding pregnancy intention and contraceptive use.

Conclusions

Reproductive coercion has the potential to negatively impact the physical and mental health of women, including those living with HIV. Etiology, outcomes, and even behaviors of reproductive coercion may be different in this population, which have not been examined in the literature. Women with HIV may be reluctant to disclose their diagnosis as a reason for not wanting to become pregnant to a partner who is pressuring them to get pregnant. Partners may exert pressure to avoid pregnancy or terminate a pregnancy out of fear of vertical transmission. Providers who work with women living with HIV should be aware of the need to assess for reproductive coercion when women present seeking pregnancy or reproductive health care. Further study in this population is warranted to explore the complex relationships between women's pregnancy intentions and their partners' behaviors in greater depth. Providers who work with women living with HIV should be aware of reproductive coercion, and follow guidelines for screening and intervention that are recommended for all women of childbearing age.⁴⁰

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Table 1

Participant characteristics (n=67)

	<i>n</i> (%)
Age (median, IQR)	41 (34–43)
Race	
Black/African American	53 (79.1)
White/Caucasian	6 (9.0)
Native American/American Indian	2 (3.0)
Other/multiple	4 (6.0)
Unknown	2 (3.0)
CES-D Score (mean, SD)	15.4 (9.1)
PCL-C Score (mean, SD)	37.9 (16.2)
Employed outside the home	
Yes	11 (16.4)
No	56 (83.6)
Type of insurance	
Public	67 (100)
Private	0 (0)
Children under 18 in the home	
Yes	29 (43.3)
No	38 (56.7)
Past year drug use	
Yes	37 (55.2)
No	30 (44.8)
Viral load	
Detectable (≥ 20 copies/ml)	30 (44.8)
Not detectable (<20 copies/ml)	37 (55.2)
CD4+ T cell count	
<200 cells/mm ³	9 (13.4)
≥ 200 cells/mm ³	58 (86.6)
Past year IPV	
Yes	36 (53.7)
No	31 (46.3)

Note: CES-D = Center for Epidemiologic Studies Depression Scale; PCL-C = PTSD Checklist – Civilian Version; IPV = intimate partner violence

Table 2

Prevalence of Reproductive Coercion, (n=67)

Item	n (%)
Any Reproductive Coercion	11 (16.4)
Any Pregnancy Coercion	8 (11.9)
Any Birth Control Sabotage	7 (10.4)
<i>Reproductive Coercion Subdomain In the past year, has someone you were dating or going out with:</i>	
Pregnancy Coercion	
Told you not to use any birth control (such as pills, shot, ring, etc.)?	3 (4.5)
Said he would leave you if you did not get pregnant?	3 (4.5)
Told you he would have a baby with someone else if you did not get pregnant?	6 (9.0)
Hurt you physically because you did not agree to get pregnant?	2 (3.0)
Birth Control Sabotage	
Taken off the condom while you were having sex so that you would get pregnant?	6 (9.0)
Put holes in the condom so you would get pregnant?	4 (6.0)
Broken a condom on purpose while you were having sex so you would get pregnant?	3 (4.5)
Taken your birth control (such as pills) away from you or kept you from going to the clinic to get birth control so that you would get pregnant?	2 (3.0)
Made you have sex without a condom so you would get pregnant?	5 (7.5)